IAHP Yarnes

Indigenous Australians' Health Programme
Yarning • Action • Reflection • National • Evaluation • Systems

Final report of the evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander primary health care through the Indigenous Australians' Health Programme

Supporting Material

28 June 2023

IAHP Yarnes

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Yarning • Action • Reflection • National • Evaluation • Systems

About this document

This document contains supporting materials for the findings and recommendations of the 6-year evaluation of the Indigenous Australians' Health Programme (IAHP), that are set out in the Final Report document.

The aim of this evaluation was to strengthen the appropriateness and effectiveness of comprehensive primary health care systems for Aboriginal and Torres Strait Islander people.

This evaluation was fully funded by the Australian Government Department of Health and Aged Care (referred to in this document as the department).

This document should be read alongside the Final Report document.

This evaluation was undertaken by a consortium led by Allen + Clarke Consulting, University of Queensland and Monaghan Dreaming.

RECOMMENDED CITATION

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Acknowledgement of Country

The IAHP Yarnes Evaluation team acknowledges the Traditional Custodians of the land we work on and the communities that we work with. We acknowledge their history, culture and Elders past, present and emerging.

The original artwork in the IAHP Yarnes Evaluation project was produced by Emma Walke. Emma is a Bunjalung Aboriginal woman from nothern NSW.

Emma was part of the evaluation team which designed and set-up the evaluation. Here is her description of the artwork:

> Because I don't speak for every Country, and because we are working across many of them, the work seeks to represent Indigenous Australia. I feel that colour makes a statement so I have used colours that can be linked to many of our communities and countries, land or sea based. The colours represent our people and the land they come from-ochres/yellows represent desert and hills and the cliffs where our ochres come from. Blues for ocean and blue greens for rivers.
>
> The circles are universal in the way they represent groups or clans of people, the markings inside some of the circles represent individuals.
>
> The dots and slashes are representational of tracks and time lines. There are a few blank circles-they represent the missing, the lost peoples.
>
> I thought I would try and incorporate the colours to show respect for them.

Contents

APPENDIX A: EVALUATION SITE DESCRIPTIONS AND CONTEXT

About Appendix A

Appendix A introduces each of the 17 evaluation sites and site partners. It provides a brief description of:

- the key characteristics of each site
- each site partner and the IAHP program funding they receive.

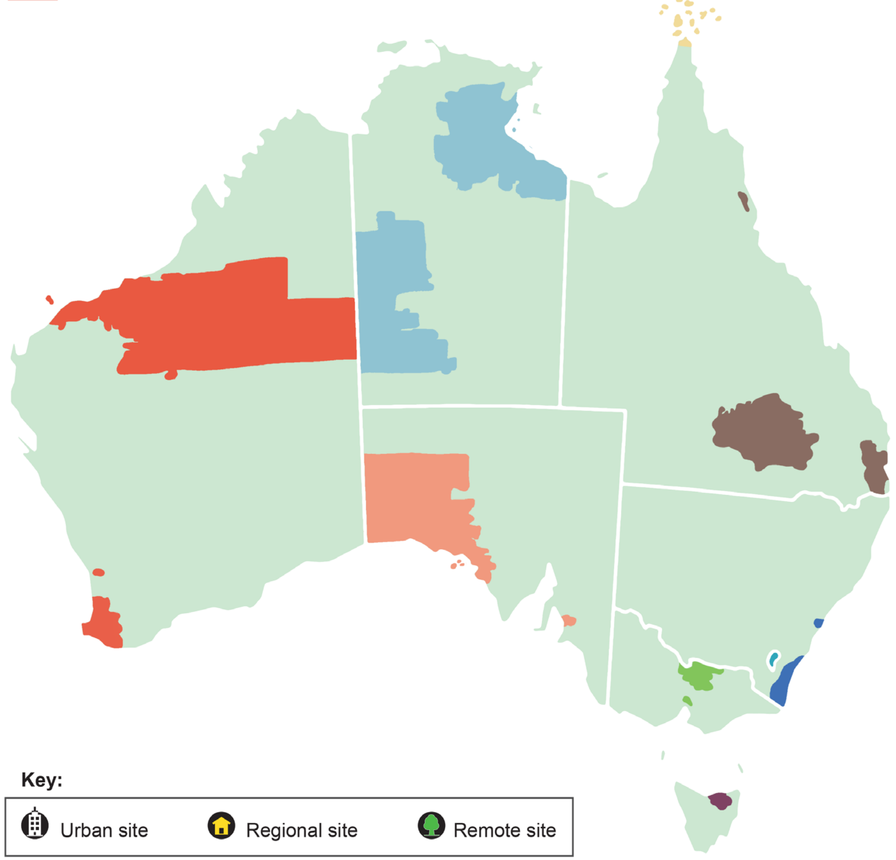
A quick reference guide to the 17 evaluation sites and partners is provided on the following page.

Data in this document was sourced from:

- interviews with health service managers and Primary Health Network (PHN) managers and staff
- site partners' annual reports, websites, and newsletters
- PHN websites, strategic plans, fact sheets, and needs assessment reports
- Australian Bureau of Statistics, Estimates of Aboriginal and Torres Strait Islander Australians, June 2016
- GrantConnect (a website with information on current Australian Government grant opportunities and grants awarded).

Figure A-1: Evaluation sites and site partners

ACT	**Site 1: Canberra**	🏢	Winnunga Nimmityjah Aboriginal Health and Community Services	Capital Health Network
NSW	**Site 2: SW Sydney**	🏢	Tharawal Aboriginal Corporation	South Western Sydney PHN
	Site 3: South Coast	🏠	Katungul Aboriginal Corporation Regional Health and Community	South Eastern NSW PHN (Coordinare Limited)
NT	**Site 4: Katherine East**	🌳	Sunrise Health Service	Northern Territory PHN
	Site 5: Central Australia	🌳	Central Australia Aboriginal Congress Corporation NT Regional Health Services	Northern Territory PHN
TSI	**Site 6: Torres Strait Islands**	🌳	Torres Health Indigenous Corporation	Northern Queensland PHN
Qld	**Site 7: Mareeba-Atherton**	🏠	Mulungu Aboriginal Corporation Primary Health Care Service	Northern Queensland PHN
	Site 8: Charleville-Roma	🌳	Charleville & Western Area Aboriginal and Torres Strait Islanders Community Health	Western Queensland PHN
	Site 9: Brisbane	🏢	Institute for Urban Indigenous Health	Brisbane North PHN
SA	**Site 10: North Adelaide**	🏢	Nunkuwarrin Yunti of South Australia Inc	Adelaide PHN
	Site 11: Ceduna-Far West Coast	🌳 🌳 🌳	Yadu Health Oak Valley (Maralinga) Aboriginal Corporation Tullawon Health Service Inc	Country SA PHN
Tas	**Site 12: Launceston**	🏠	Tasmanian Aboriginal Corporation	Primary Health Tasmania
Vic	**Site 13: North Melbourne**	🏢	Victorian Aboriginal Health Service	North Western Melbourne PHN
	Site 14: Echuca & Shepparton-Mooroopna	🏠 🏠 🏠	Rumbalara Aboriginal Co-operative Njernda Aboriginal Corporation Cummeragunja Housing & Development Aboriginal Corporation	Murray PHN
WA	**Site 15: Pilbara**	🌳 🌳 🌳	Wirraka Maya Health Service Puntukurnu Aboriginal Medical Service Mawarnkarra Health Service	Western Australia Primary Health Alliance
	Site 16: Perth NE	🏢	Derbarl Yerrigan Health Service	Western Australia Primary Health Alliance
	Site 17: Southwest	🏠	Southwest Aboriginal Medical Service	Western Australia Primary Health Alliance



Key:

🏢 Urban site 🏠 Regional site 🌳 Remote site

A 1 Description of the 17 evaluation sites

A 1.1 Site No & Name

Site level broad information

Site No:	*Area*	*State*
Evaluation partners		
List of evaluation partners		
Geographical characteristics		
Description	*Details of the area, in relation to the nearest capital city, number of SA2s, and other areas of note*	*Map Image*
Remoteness	*Level*	
Population characteristics		
Total population		#
Aboriginal and Torres Strait Islander population		#
Percentage of total population identified as Aboriginal and Torres Strait Islander people		#
Health service characteristics		
Information about the number of hospitals, GPs, and ACCHOs in this site.		

Service level information (for each service in the site)

SERVICE LOGO	*Service name*
Description	
Details about the history of the service, it's board, and services provided.	
Clients	
Details about number of clients and episodes of care if publicly available information was located.	
Workforce	
Details about number and types of staff if publicly available information was located.	
IAHP funding	
Details about whether the service receives IAHP funding, and percentage of annual that comes from the IAHP.	

APPENDIX B: LIST OF EVALUATION REPORTS

About Appendix B

Appendix B contains a list of the reports produced by the evaluation since 2018.

Not all of these documents are publicly available.

Table B-1: Evaluation reports

Report	Date	Description
Monitoring and Evaluation Design Report	2018	Sets out the proposed design for the evaluation.
Quantitative Data Feasibility Assessment	2020	Presents the findings of an assessment of the suitability of routinely collected data sets for use in the evaluation.
Year One Report Summary	2020	Provides an overview of the site engagement processes and outcomes in the first year of implementation phase of the evaluation.
Quantitative Data Specification Extraction and Analysis	2020	Sets out preliminary indicators to inform a data request and extraction processes and provides an initial data analysis plan to support ethics applications and co-design processes.
Aboriginal and Torres Strait Islander primary health care system's initial response to COVID-19	2021	Summarises the findings of Collaborative 1.
Interim Report - Cycle 1	2021	Summarises interim findings from Cycle 1 of the evaluation.
Description of Cycle 1 methods	2021	Companion document to Cycle 1 Interim Report detailing the methods used, with a focus on the qualitative data collection methods.
Technical report	2021	Companion document to Cycle 1 Interim Report detailing the development and testing of an analytic framework and the findings from the state and territory level analysis of publicly available data.
Aboriginal and Torres Strait Islander Health Workers and Practitioners Training Pipeline	2022	Summarises the findings of Collaborative 2.
Collaborative on adapting and validating a tool to identify, measure, and monitor institutional racism in Primary Health Networks (PHNs)	2022	Summarises the findings of Collaborative 3.
Interim Report-Cycle 2	2022	Summarises interim findings from Cycle 2 of the evaluation.
Collaborative on understanding health needs	2023	Summarises the findings of Collaborative 4.
Collaborative on improving PHC data environment	2023	Summarises the findings of Collaborative 5.
Final report	2023	This report.

Report	Date	Description
Report on Key Evaluation Question 5	2023	Reflections on the methodological approaches used in the evaluation.
Integrated care report	2023	Summarises the findings of the evaluation related to supporting integrated care.

APPENDIX C: EVALUATION METHODOLOGY

About Appendix C

Appendix C includes information about:

- the evaluation brief
- the evaluation team and roles
- the evaluation methodology over 5 years, from design and planning through to implementation of three cycles of iterative generation, gathering, analysis and reporting of data
- strengths, limitations and adaptations of the evaluation and methodology.

APPENDIX C CONTENTS

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C 1 Introduction to the evaluation

Co-design approaches grounded the evaluation in the experiences and expertise of the health sector. Co-design processes facilitated shared decision-making, knowledge sharing, and translation throughout the evaluation. Through the co-design process, five key evaluation questions (KEQs) were identified. More specific evaluation questions sit under the high-level KEQs.

Key evaluation questions

1. How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?
2. What difference is the IAHP making to the PHC system?
3. What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?
4. How can faster progress be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?
5. How well are the methodological approaches used in the evaluation achieving its aims?

The evaluation used mixed methods, combining a variety of qualitative and quantitative approaches to data collection, analysis and interpretation. The evaluation was implemented across three evaluation cycles (2020 to 2023) and in four settings:

1. Evaluation sites in 17 geographic places across Australia (see **Appendix A: Evaluation site descriptions and context**).
2. State and territory organisations and government, with a focus on engagement with government health departments and peak bodies for ACCHSs.
3. National organisations and government, with a focus on engagement with the Department of Health and Aged Care, Department of Social Services, National Indigenous Australians' Agency (NIAA), National Aboriginal Community Controlled Health Organisation (NACCHO) and peak bodies for Aboriginal and Torres Strait Islander health professionals.
4. Cross-cutting collaboratives, which bring people together across or within these settings (according to topic).

Figure C-1 includes a high-level overview of the data collection methods, methods of analysis and different data sets that was part of the mixed-methods evaluation design.

In total, the evaluation involved 1,089 participants over Cycles 1-3. Note that the total number of participants does not equal the number of unique individuals who participated. Some individuals participated in two or more activities (for example, yarn, interview, workshop, or collaborative), with a small number participating in over five activities.

Figure C-1: Methods, analysis, and data sets

LITERATURE AND DOCUMENTS REVIEW

Gathering, coding and reviewing documents (including policy papers, strategies, plans, reports, journal articles, book chapters and web content), to...

- ...gather information on a specific topic or concept ✓
- ...provide an overview of current knowledge and literature ✓
- ...identify relevant theories, methods, and existing research to apply or explore further ✓
- ...analyse, synthesize, and critically evaluate how findings contribute to the state of knowledge on the subject ✓

YARNS, INTERVIEWS AND WORKSHOPS

Methods

- Yarning workshops and interviews with community members and Aboriginal and Torres Strait Islander health staff
- Semi-structured interviews with PHN, ACCHS staff and state, territory and national stakeholders
- Individual patient journey interviews
- Collective Action for Change (CA4C) workshops

Analysis

- Schema analysis to understand values, including the development of Babuny tree framework
- Grounded theory analysis to understand experiences
- Content and thematic analysis to summarisehigh-level findings and understand the difference IAHP is making
- Development of funding and reporting profiles involving six ACCHSs.

PRIMARY DATA SETS:

- Interview transcripts
- Interview summaries
- System maps from CA4C workshops
- CA4C summary reports
- Funding and reporting profiles

CROSS CUTTING COLLABORATIVES

Methods

- **COLLABORATIVE 1**: Aboriginal and Torres Strait Islander PHC system's initial response to Covid-19
- **COLLABORATIVE 2**: Aboriginal and Torres Strait Islander Health Workers and Practitioners training pipeline
- **COLLABORATIVE 3**: Adapting and validating a tool to identify, measure, and monitor institutional racism in PHNs
- **COLLABORATIVE 4**: Understanding health needs
- **COLLABORATIVE 5** : Improving PHC data environment
- Research project on Integrated Care

Analysis

- Situational analysis
- Document analysis
- Grounded theory analysis
- Content analysis to summaries
- Auditing of PHN publicly available information

PRIMARY DATA SETS:

- Interview transcripts
- Validated tool to identify, measure, and monitor institutional racism in PHNs
- Collaborative reports

QUANTITATIVE METHOD AND ANALYSIS

Methods

- Data Feasibility Assessment (DFA)
- Data Selection and Extraction Analysis (DSEA), incl. KEQ mapping and data indicator identification
- Submission of data requests to data custodians
- Harvesting of publicly available data from five data sources
- IAHP funding data requests
- Harvesting of IAHP funding data from site partners and public records

Analysis

- Review of qualitative interviews to identify priorities/measures for the primary analysis
- Traffic light framework analysis
- Multilinear regression analysis
- Principal component analysis
- Hierarchical clustering
- In-depth case studies

PRIMARY DATA SETS:

- 79 data sources through DFA
- 10 custom data sets received from 3 data custodians
- 5 publicly available data sources identified
- IAHP funding data from the department and GrantConnect

CONTRIBUTION ANALYSIS

Methods

- Re-coding of health service, PHN, state, territory and national engagement interviews
- Semi-structured interviews to discuss contribution cases
- Review panel to discuss contribution cases

Analysis

- Integration of quantitative findings on KEQs, health outcomes and IAHP funding
- Grounded theory coding and analysis
- Contribution analysis and sense checking process
- Development of five contribution cases
- Collaborative analysis with review panel participants

PRIMARY DATA SETS:

- Five contribution cases
- Interview transcripts
- Contribution case diagrams

SENSE -MAKING AND DATA INTEGRATION

Methods

- Emerging findings workshops
- Reporting and communication of findings back to sites
- National site partner workshop
- Participant survey
- Internal analyst meetings
- Discussion and sharing of findings with HSCG

Analysis

- Participant feedback incorporated into the analysis
- Findings and analysis adjusted and elevated with every cycle of data collection and analysis
- Synthesis analysis across all data sets and findings from various analysis

PRIMARY DATA SETS:

- Project protocol
- Cycle 1 interim report
- Cycle 2 interim report
- Appendices with supporting materials (incl methodology and IAHP information)
- Internal working papers
- Collaborative reports

C 1.1 Evaluation brief

The Department of Health and Aged Care sought:

- the development of a highly innovative and sophisticated evaluation design
- a fit-for-purpose evaluation that adopted a systems level approach and emphasised highly participatory evaluation practices to maximise system learning
- active engagement with a wide range of stakeholders from within the health system, including communities and consumers and in other relevant sectors
- a design that met the evaluation objectives and addressed the KEQs
- an evaluation design that enabled the drawing of clear conclusions and identification of improvements from an evidenced-based perspective
- robust evidence useful at both the macro and micro levels to inform systemic change (and transform the system), including evidence from both:
    - a national systems level perspective to inform ongoing program implementation and policy design
    - local and regional levels to inform and bring about real change in improving the quality and effectiveness of health service delivery
- a design that ensured the community voice and consumer remained intrinsic to the evaluation, specifically that it:
    - enabled further engagement and capacity for dialogue and local action for Aboriginal and Torres Strait Islander communities
    - was culturally safe
    - facilitated community voices in determining the choice of data collection and analysis methods
- a design that enabled three-way ongoing learning between community, regional, and national levels.

In the evaluation brief, the department requested the use of specific methodological elements:

- a theory-based design that tested the existing program logic
- co-design and participatory evaluation practices
- systems approach that maximised system learning
- process learning (to document lessons learnt)
- rapid reflection and feedback loops
- a longitudinal time-series design, enabling comparisons across different contexts
- triangulation of mixed methods data to generate robust findings
- processes that incorporated Aboriginal and Torres Strait Islander culturally determined views on health and wellbeing.

Co-design was defined by the department as the:

> active involvement of stakeholders at national, regional and local levels, whose perspectives will collectively inform and shape the evaluation's methodology, including the key evaluation questions[1].

C 1.2 The evaluation purpose

The evaluation focused on the investment in Aboriginal and Torres Strait Islander PHC under the IAHP. This investment included funding for PHC services delivered by ACCHSs, AMSs, state and territory services, and mainstream services. The evaluation considered how the IAHP 'enabled, interacted and influenced' other parts of the PHC and wider health systems. The evaluation sought to examine how well the Australian Government's IAHP investment contributes to improving PHC systems (KEQ1 and 2), and whether these improvements, and the IAHP itself, translate into better health and wellbeing outcomes (KEQ3), for Aboriginal and Torres Strait Islander people.

The overall aim of the evaluation was to strengthen the appropriateness and effectiveness of comprehensive PHC systems for Aboriginal and Torres Strait Islander people and communities. The evaluation is to support informed policy, planning and decision-making that will enable improvements to be incorporated into the IAHP as it is implemented through practical, timely and evidence-based findings and recommendations.

Specifically, the evaluation was to:

- meet the accountability needs of the Australian Government
- provide timely information and evidence to support the continuous improvement of the IAHP to accelerate change in improving Aboriginal and Torres Strait Islander people's health and wellbeing and to meet the Closing the Gap targets
- inform the 2023 revision of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023
- facilitate the adaptive management and continuous improvement needs of PHC organisations and other key stakeholders across the service system
- ensure that Aboriginal and Torres Strait Islander communities are able to articulate their needs and aspirations
- contribute to real change in Aboriginal and Torres Strait Islander people's health and wellbeing through supporting improvements in the IAHP and its interaction with the PHC and the broader health system
- facilitate learning between the different levels of the health system – local, regional, state and territory, and national (Bailey et al., 2018, p. 37).

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[1] The Schedule, Contract, p.37.

There were three evaluation objectives:

1. To develop an improved understanding both of consumers (people who use and do not use PHC services) and of health care providers' perspectives and experiences of the health system in terms of what they value.
2. To evaluate the appropriateness and effectiveness of the Australian Government's investment in Aboriginal and Torres Strait Islander PHC considering the broader PHC system in a range of contexts.
    a. Understand and identify the enablers, barriers and changes required at different levels of the system, in order to improve health outcomes for Aboriginal and Torres Strait Islander people.
3. To support informed policy, planning and decision-making that will enable improvements to be incorporated into the IAHP as it is implemented through practical, timely and evidence-based findings and recommendations.
    a. Promote system learning and adaptation throughout the implementation of the evaluation.

A fourth evaluation objective to recommend an approach for monitoring and evaluation over the longer term was removed from the evaluation due to duplicative workstreams currently being undertaken within the department.

The premise of the methodological design was to bring together four (interdependent) diverse levels (settings) of the health system in its data collection approach, analysis, sense-making and reporting (i.e. bringing together findings from community yarning and engagement with staff from PHC organisations, state and territory representatives, and national stakeholders).

C 1.3 Ethical outlook

The evaluation design was grounded in the knowledges, values, experiences, and aspirations of Aboriginal and Torres Strait Islander people to ensure that culturally relevant evaluative conclusions were drawn. It emphasised accountability as essential to ensuring that decision-makers at various levels of the health system have evidence-based information that flags the significance of tracking resources, results, and liberties to identify what works, where improvement is needed, and what leverage points can make the most gains in more appropriately and effectively meeting the health needs of Aboriginal and Torres Strait Islander populations.

A transformative theoretical framework drove the methodological design, guiding principles and values, and engagement strategies. A transformative worldview functions where human rights and social justice are key principles (Cram & Mertens, 2016).

The methodological design and applied research approaches were underpinned by the imperative that evaluations conducted with Aboriginal and Torres Strait Islander nations must be culturally safe, useful, and directly relevant to the production of knowledge for societal progress, human health, and flourishing. Evaluation design must also produce innovations that have an impact as defined by Indigenous people (Bainbridge et al., 2015).

This imperative pushed for the need to implement an evaluation process that included meaningful place-based methods of engagement that value and build on Aboriginal and Torres Strait Islander expertise, existing community strengths, assets, and knowledge systems. It also warranted a need for methodological adaption and innovation to develop more suitable ways of doing research and evaluation in Aboriginal and Torres Strait Islander health.

C 1.4 Evaluation team and roles

The evaluation was undertaken by a consortium led by Allen + Clarke Consulting, University of Queensland (UQ), and Monaghan Dreaming. The evaluation leadership team comprised a team member from each organisation (Table C-1).

Table C-1: Evaluation leadership team

Name and organisation	Family affiliations	Role and responsibilities
Professor Roxanne Bainbridge, UQ	Gungarri, Kunja and Wadjalang	Principal Investigator. Evaluation intellectual and strategic leadership; leadership of evaluation design, planning, ethics, engagement, data tool development, analysis, and reporting.
Ned Hardie-Boys, Allen + Clarke Consulting	Pākehā, New Zealander	Project Lead. Overall evaluation leadership and responsibility.
Robert Monaghan, Monaghan Dreaming	Bundjalung, Gumbaynggir, Baryulgil	National Health Sector Engagement Lead. Indigenous leadership of the evaluation processes.

The evaluation had a commitment to embed Aboriginal and Torres Strait Islander leadership across all levels of the project, as well as having Indigenous and non-Indigenous evaluators and health service representatives in all team configurations at a site level.

All the Aboriginal and Torres Strait Islander team members had responsibility for leading engagement with site partners and community members, helping develop and review engagement and qualitative data generation tools, and analysis of qualitative data. In each site, an Aboriginal and Torres Strait Islander site lead partnered with non-Indigenous team members (referred to as ‘site buddies’) to undertake interviews and engage in workshops.

Except in one circumstance, yarns were led by the Aboriginal or Torres Strait Islander team member, sometimes supported by a site-based Aboriginal or Torres Strait Islander local evaluation coordinator (LEC).

The Principal Investigator and site leads shaped and influenced all aspects and stages of the evaluation. The use of participatory and grounded theory methods helped to centre Aboriginal and Torres Strait Islander voices, values, and knowledge, as well as to facilitate critical conversations within the evaluation team and with site partners about the short comings and harms of western knowledge systems and practices.

There was a commitment to work toward growing the Aboriginal and Torres Strait Islander team over the span of the evaluation. However, recruiting senior Aboriginal and Torres Strait Islander people with evaluation or research expertise was challenging as there is a shortage of Indigenous professionals in this field. At times this put additional pressure on the four Aboriginal members of the team[2] who bore the burden of explaining Indigenous world views and knowledge systems to the non-Indigenous team members and ensuring the evaluation had cultural integrity. It also meant that, at times, non-Indigenous team members had responsibility for aspects of the evaluation, for example conducting interviews and coding data, with limited overview from the Indigenous members of the team. Over the course of the evaluation, non-Indigenous team members got better at listening to guidance from their Aboriginal and Torres Strait Islander colleagues.

Aboriginal team members were operating both in contexts where they had family affiliation and in contexts where they did not, and therefore had to navigate cross-country differences, cultural differences, and, in some sites, language barriers.

Twelve non-Indigenous team members were based across three states in Australia and six were based in New Zealand. These members were a cohort of people with English, Scottish, New Zealand Pākehā, Māori, and Danish descent. All the non-Indigenous evaluation and research analysts had previous experience working in Indigenous contexts in partnership with Indigenous evaluators and researchers.

Together, the team had significant content and methodological expertise, including experience in the Australian health sector, Indigenous health, community engagement in Aboriginal and Torres Strait Islander contexts, public sector evaluation, qualitative and quantitative research methods, and project management. Collaboration within the evaluation team was built on an ‘all teach, all learn’ approach, where team members supported each other in learning and developing skills in various areas, such as site engagement, cultural safety, Indigenous worldviews, data collection, analytical methods, and evaluation approaches.

The evaluation team worked alongside a Health Sector Co-design Group (HSCG) to design the evaluation, and the HSCG continued to guide and support the implementation of the evaluation. Further information about the HSCG is included in section C 2.2 and **Appendix I: Members of Health Sector Co-design Group.**

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[2] The size of the team differed over the timeframe of the evaluation. These numbers are for Cycle 3, the final year of the evaluation. The four Aboriginal team members included two that were in the evaluation leadership team.

C 2 Evaluation design and planning

The evaluation was co-designed from October 2017 to May 2018. This involved establishing and working with the HSCG and engaging with state and territory stakeholders and community members.

This section outlines work undertaken between 2017 and 2018 to design and prepare for implementation of the evaluation.

The evaluation design phase included:

- review of literature and documents
- establishing the HSCG
- sector engagement
- developing an evaluation design.
- ethics approval
- establishing of sites.

C 2.1 Review of literature and documents

A literature review was conducted to provide up-to-date information on primary health care, health systems' thinking, system-level evaluation, and evaluation in the context of Aboriginal and Torres Strait Islander people's health.

Key messages from this review informed the evaluation design, including the following points on evaluation in the context of Aboriginal and Torres Strait Islander people's health.

- The need to follow a process of meaningful engagement with the individuals and communities involved that recognise, protect, and advance the rights, cultures, and traditions of Aboriginal and Torres Strait Islander people.
- The importance of methodological approaches that value and build on Aboriginal and Torres Strait Islander expertise, existing community strengths, assets, and knowledge systems.
- The value of participatory and collaborative processes with Aboriginal and Torres Strait Islander people that generate high-quality evidence, strengthen partnerships and Indigenous leadership in evaluation, build capacity, foster collaborative and continuous learning, and facilitate service improvement and local decision making.
- The need to respond appropriately to diversity within Indigenous communities, including the diverse health needs of Aboriginal and Torres Strait Islander people and communities, and the range of views about evaluation and concepts of 'success'.
- The need for customised and tailored approaches, for example, for those not using any health services, transient populations, children and youth, and incarcerated people.

- Some communities have less capacity or inclination to engage, including those that may have become cynical about the ability of governments to change, and where there is insufficient support for participation and capacity building.
- ACCHSs are diverse in location, governance, resources, and capacity, and thus may need different levels of support to engage.
- The value of place-based approaches, particularly where a high-level of engagement and trust is required to negotiate access to local-level data, to understand the context and together make sense of the data, and to create opportunities for adaptive management and service improvement.
- The need to avoid the long-standing pattern of deficit framing Indigenous people through data that problematises them, and a need to democratise data.

Literature also informed the development of specific methods for the evaluation (for example, the evaluation team's grounded theory approach to contribution analysis, Yarning methods, and the collaboratives).

C 2.2 Health sector co-design group

The HSCG was established in 2017, comprising individuals who brought expertise, experience, and perspectives from across the PHC system as well as expertise in evaluation and research with Aboriginal and Torres Strait Islander people.

The role of the HSCG was to:

- provide advice on the wider co-design and stakeholder engagement processes
- be engaged as co-designers in the evaluation design
- review and provide feedback on key deliverables
- advise the department and the Minister for Indigenous Health on the evaluation design
- continue to provide advice, guidance, and leadership in relation to implementation of the evaluation.

The membership of the HSCG was based on feedback provided from members of the Implementation Plan Advisory Group (IPAG), the Minister for Indigenous Health, the department, and input from the evaluation team. A deliberate effort was made not to seek representatives of agencies, but rather people who worked in different parts of the health system and who could contribute from that perspective.

The HSCG co-chairs were Dr Mark Wenitong, a senior medical advisor, and the Assistant Secretary, First Nations Health Division of the department.[3] Of the 22 HSCG members, 13 were Aboriginal and Torres Strait Islanders. The HSCG membership is outlined in **Appendix I: Members of Health Sector Co-design Group.**

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[3] Kate Thomann was co-chair until 2021 and the role was then taken up by Melinda Turner.

During the evaluation design phase, two meetings were held where HSCG members provided input into defining the evaluand (the ‘thing’ being evaluated) and gave feedback and advice on the evaluation design outputs. For example, at the first meeting (December 2017), HSCG members drew three ‘rich pictures’, each depicting different perspectives of the PHC system for Aboriginal and Torres Strait Islander people. Rich pictures are a soft systems methodological tool useful for framing, quickly generating, and understanding the evaluand.

Figure C-2 illustrates one of the pictures developed by the HSCG in which PHC was centred around people and their families. HSCG members then unpacked six interconnected aspects of wellbeing (safety, culture, community, empowerment, employment, and education). A second group of HSCG members structured their diagram around health and the IAHP funding system, and a third around the complexity of the provision of health care. This information, along with documentation and briefings with department staff, helped inform a description of the evaluand and the elements of the PHC system that would be in scope for the evaluation.

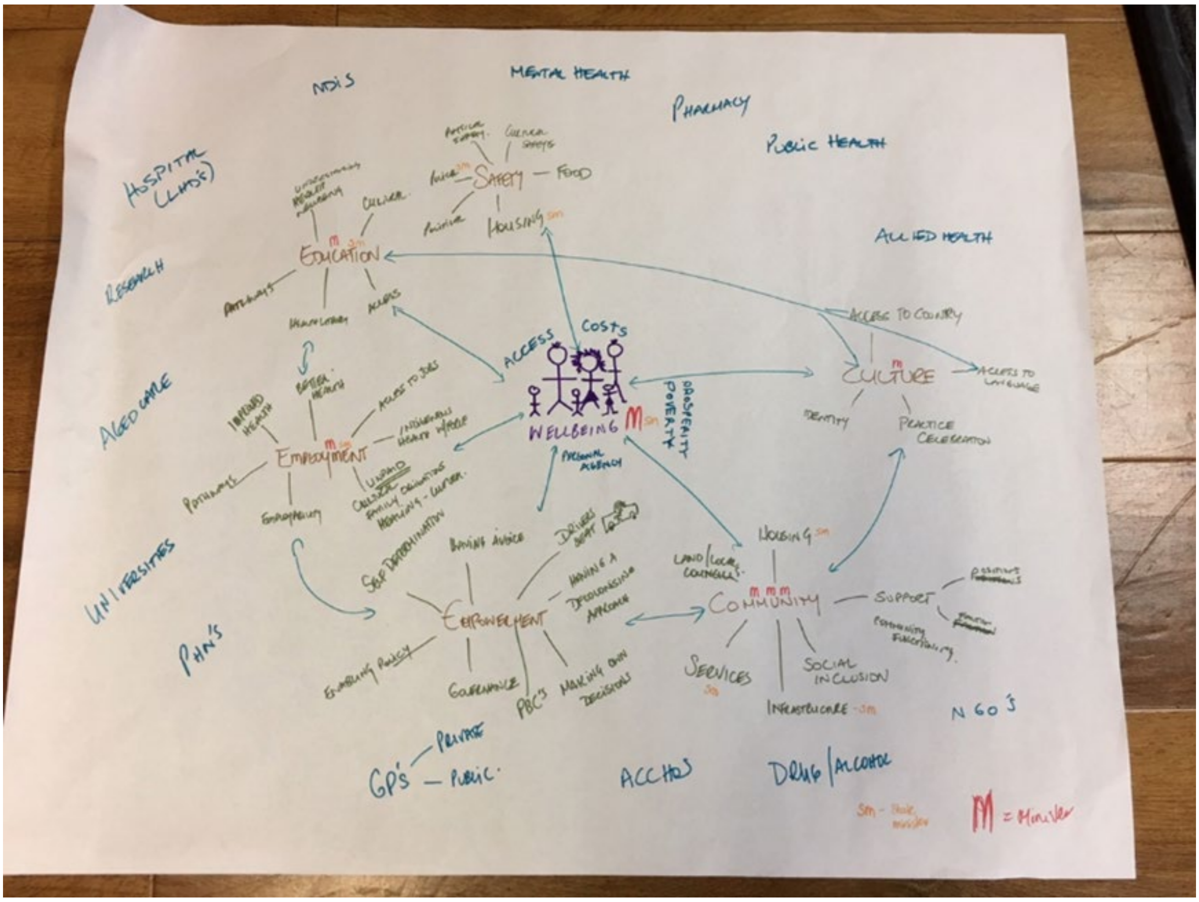

Figure C-2: Rich picture of PHC system for Aboriginal and Torres Strait Islander people

Over the evaluation timeframe, the HSCG met 10 times in Canberra, usually for 1.5-day meetings, as well as through numerous online meetings. The face-to-face meetings appeared approximately every 6 months and the group generally met online at least once in between these meetings. The HSCG members did not have roles in the implementation activities or access to raw data in any form.

C 2.3 Sector engagement

The evaluation design was the result of a multi-layered co-design process that involved participants from across the PHC system, including community members, health care providers, and state, territory, and national organisations. Five ethical principles provided the rationale for engaging community in the evaluation design and informed how this engagement occurred:

- Including and respecting diverse voices, values, and knowledge
- Building trustworthy and trusting relationships
- Ensuring equity of power and respecting self-determination
- Negotiating consent, accountabilities, resources, and governance
- Ensuring benefit and adopting a strengths-based approach.

Existing networks were used because of the time it takes to develop new relationships, trust, and rapport, and because the evaluation design and funding for implementing the evaluation had yet to be approved. Discussions were held with:

- members (formal and ex-officio) of the state and territory Health Partnership Forums and other key national organisations/agencies (103 people across 36 organisations or alliances).[4]
- members of community-based groups (about 40 people across six groups[5]) with whom the evaluation team had existing relationships.

The discussions were led by an Aboriginal engagement lead and two non-Indigenous evaluators.

The discussions identified the following information.

- There was an opportunity to make better use of existing data. Although data are reported into systems, not enough information is reported back to communities and services in a timely fashion.
- While data tells one story, narratives about people's experiences and aspirations are also vital. There was a need to look at measures beyond health service coverage and health status.
- It was important to look 'inwards' at the IAHP's policy and grant management processes and systems, as well as assessing service delivery and impacts for the Aboriginal and Torres Strait Islander population.

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[4] A list of organisations that participated in these engagements is included in the Monitoring and Evaluation Design Report (Bailey et al., 2018).

[5] The six community-based groups included members of the Aboriginal Staff Alliance, Australian Rural Health Education Network; Aboriginal and Torres Strait Islander students at the University of NSW; Aboriginal Community Controlled Health Services (ACCHS) community board members in WA (1 group) and NSW (2 groups); and a yarning session with users of a NSW ACCHS.

- Co-analysing the problems of the IAHP was key to co-designing the solutions, otherwise different conceptualisations of the problem would most likely result in disparate solutions.
- A whole-of-system and adaptable approach to the evaluation was needed, one that could respond to important emerging areas of inquiry.
- Strengths-based approaches were vital, ones that share and celebrate the success, strength, resilience, and capabilities of Aboriginal and Torres Strait Islander people and the innovations of health services in meeting their needs.

C 2.4 Evaluation design

The evaluation adopted a multi-phase iterative mixed method design, combining a variety of qualitative and quantitative methods of data generation and analysis. The design phase culminated in the development of a Monitoring and Evaluation Design Report (Bailey et al., 2018).

Three complementary strength-based methodologies underpinned the design:

1. A decolonising agenda to counter the dominance of Western knowledge by centring Aboriginal and Torres Strait Islander people's priorities and world views, understanding the situation from their position to provide culturally valid answers to the KEQs and make relevant, practical contributions to the health and wellbeing of Aboriginal and Torres Strait Islander people, as determined by Aboriginal and Torres Strait Islander people.
2. A highly collaborative, place-based, participatory action research (PAR) approach to achieve learning and change, based on 'All teach, All learn'.
3. A systems approach to identify, understand, and explain how the current health system works.

The design proposed engaging a wide range of stakeholders at different levels of the PHC system: local communities and providers, organisations at state, territory and national levels, and various groups of stakeholders in collaboratives to address cross-cutting themes.

The design involved implementing three PAR cycles at geographically based evaluation sites across Australia, and at state, territory, and national levels. It proposed that qualitative and quantitative data would be iteratively generated, analysed, and then discussed in facilitated emerging findings and 'collective action for change' workshops to encourage learning and evidence-informed change and answer the KEQs over a three-year period.

The implementation of a mixed methods design carried out in PAR cycles resembled a series of small separate studies, however, in reality, these were interdependent, and the various phases connected (Bainbridge et al., 2020a).

The value of this design lay primarily in its whole-of-system and deeply contextualised understanding and response, as it enabled engagement in different phases, sites, and settings to examine the IAHP and its interactions within the wider health system. The value of the design also lay in the highly participatory approach that has Aboriginal and Torres Strait Islander people's values, perspectives and experiences at its centre, which works well with Aboriginal and Torres Strait Islander ways of being and doing.

Identification of Aboriginal and Torres Strait Islander people's values was applied as criteria by which assessments would be made to answer the KEQs and draw conclusions on:

- What 'working well' looks like in diverse contexts, for example, for whom, under what conditions, achieved through what strategies and with what consequences (intended and unintended).
- Whether the 'difference' and the 'amount of difference' occurring is worthwhile.
- What are the 'best ways' of making faster progress.

The Australian Department of Health and Aged Care and the federal Minister for Indigenous Health at the time, the Hon. Ken Wyatt, approved the evaluation design in November 2018 and it moved into a four-year implementation period.[6]

A protocol for the evaluation was developed to provide a detailed plan for implementing the evaluation design (see Bainbridge et al., 2020). Key planning activities included obtaining ethics approval and establishing evaluation sites.

C 2.5 Ethics approval

Ethics approval processes were undertaken to ensure all the evaluation activities were in accordance with the ethical standards of the relevant institutional and national committees. These processes occurred in two stages with 13 different health research ethics committees (see overview in Table C-2). The first stage had a focus on site engagement, and the second stage on approval for data generation activities to answer the evaluation questions.

All individual participants involved in the evaluation provided informed consent.

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[6] Note that the evaluation period was extended to June 2023 because of the impact of the COVID-19 pandemic.

Table C-2: List of committees and approval reference numbers

Jurisdiction	Committee	Approval
National	Australian Institute of Aboriginal and Torres Strait Islander Studies	Reference E0205-20200929 1 February 2021
ACT	Australian Capital Territory Health	Reference 2020.ETH.00227 7 December 2020
NSW	Aboriginal Health & Medical Research Council	Reference 1736/20 22 January 2021
NT	Department of Health and Menzies School of Health Research	Reference 2020-3888 8 December 2020
NT	Central Australian Human Research Ethics Committee	Reference CA-20-3916 7 April 2021
Qld	Prince Charles Hospital	Reference 64665 20 October 2020
Qld	Darling Downs Hospital and Health Service	Reference HREA/2020/QTDD/72032 1 February 2021
Qld	Far North Queensland	Reference HREC/2020/ QCH/68938–1481 4 December 2020
SA	Aboriginal Health Research Ethics Committee	Reference 04-20-901 6 October 2020
Tas	Tasmanian Health and Medical Human Research Ethics Committee	Reference 23635 2 December 2020
Vic	St Vincent’s Hospital Melbourne	Reference HREC297/20 6 April 2021
WA	Western Australian Aboriginal Health Ethics Committee (including Pilbara Aboriginal Health Planning Forum)	Reference HREC1030 26 November 2020
National (Quantitative Data)	Central Queensland University Human Research Ethics Committee	Reference 0000022353, 27 April 2020 Reference 0000022739, 15 December 2020

C 2.6 Establishing evaluation sites

The evaluation design included establishing 20 evaluation sites as the primary unit for generating data and analysis. An evaluation site was defined as places where Aboriginal and Torres Strait Islander people live, work, and seek to receive (or not) PHC and other services. Two types of sites were envisioned: a general site, in which participation would be at a lower level of intensity, and an in-depth site, in which there would be an increased level of activity, such as a greater number of yarns or interviews with more people participating.

C 2.6.1 Site selection

The site selection process involved nine steps:

Step 1: Site selection criteria

The criteria for site selection were established and agreed as part of the approval of the M&E Design Report. The criteria stipulated that sites would cover a range of:[7]

- major city, inner regional, outer regional, remote, and very remote locations
- Aboriginal and Torres Strait Islander populations and population densities
- levels of the IAHP funding, including a site or sites that do not receive the IAHP funding
- programs or services targeting hard-to-reach groups, such as prisoners, that may or may not receive the IAHP funding
- models of PHC practice and care
- models of PHC governance and funding
- population groups, including across life stages (babies, childhood, young people, adults, and older people) and other groups such as people with disabilities, people with mental health challenges, LGBTQI+, prisoners/those in detention, transient people (including parkies/long grassers, young men, young people in home care/wards of state, at boarding school, and/or disengaged)
- those who regularly seek to participate in evaluation activity and those who do less so.

Step 2: Number of sites

The M&E Design Report recommended the inclusion of 24 sites, with a minimum of 16 sites. During contract negotiations for Phase 2 of the evaluation and taking into account the level of resourcing required for the site studies, a target of 20 sites was agreed, with a minimum of 16 sites. At least half of these sites were expected to be in-depth sites (with a higher-level intensity of engagement) and the remainder designated as general sites (with a lower-level intensity of engagement).

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[7] Site selection was not intended to produce a representative sample of sites; but a range of sites across these criteria.

Step 3: Site selection rationale and assumptions

The evaluation team identified the theoretical basis and assumptions underpinning the site selection criteria, which are set out below.

- The local context has a strong impact on how well the IAHP is being implemented and what difference it is making. Local contexts vary significantly. If the selected sites represent a variety of local contexts (i.e. contrasting sites), the analytical findings and conclusions are more likely to be replicable in other (non-study) sites with similar contexts, while also acknowledging that some sites may be outliers (unique in some way).
- To build up evidence from across the system, in particular to identify enablers and barriers to systems effectiveness, a degree of homogeneity across some sites (i.e. sites similar to each other) will strengthen the analysis.
- To meet the evaluation aims of facilitating learning and to accelerate change in improving health outcomes for Aboriginal and Torres Strait Islander people, sites will need to include a mix of those with relatively good health outcomes and those with relatively poor health outcomes.
- To learn how well the health system is working for Aboriginal and Torres Strait Islander people, the sites will need to include multiple and diverse stakeholder organisations.
- To reduce the potential for random variation in data analysed for the evaluation, sites will need to have a minimum Aboriginal and Torres Strait Islander population of around 1,500.
- To control the manageability of the site data analysis and engagement, each site will need to have no more than three Aboriginal Medical Services (AMSs) (community-controlled or state or territory managed), fall within the boundary of a single Primary Health Network (PHN) and local health district (or equivalent state government administered health district), and have a maximum Indigenous population of around 8,000.

Step 4: Distribution of sites across states and territories

The evaluation team proposed distributing the 20 sites across states and territories based on the distribution of the Aboriginal and Torres Strait Islander population, which was then adjusted to ensure adequate representation in jurisdictions with a lower total Indigenous population.

Step 5: Identification of potential sites

The evaluation team identified a non-exhaustive/-exclusive ‘long-list’ of potential sites informed by:

- the team’s knowledge of communities and services
- key selection criteria, including remoteness classification, proportion of population made up of Aboriginal and Torres Strait Islander people, and participation in other evaluation or research projects

- feedback received during state and territory engagements during Phase 1 of the evaluation.

Data were collated for each potential site on relevant statistical areas, remoteness classification, Australian Bureau of Statistics (ABS) Census population (total, Aboriginal and Torres Strait Islander and percentage Aboriginal and Torres Strait Islander), key stakeholder organisations, and involvement in previous evaluation and research projects.

Step 6: Consultation with Department of Health and Aged Care

The evaluation team consulted the department for specific advice on whether there were any factors that might affect the engagement of services and communities within the long-list of potential sites, including any sensitivities relating to specific communities or services, and any other known evaluation or research occurring that may present an added-burden for participation. Several issues were noted, and there was one potential site where members of the evaluation team considered that the issues raised were a basis for exclusion. This site was therefore excluded from the long list.

Step 7: Key stakeholder engagement

Activities undertaken as part of Step 7 took place over 3 months. First, the evaluation team sent a paper on site selection to NACCHO and invited feedback on the potential sites. The paper set out the site selection process; the selection rationale, assumptions and criteria; the proposed state and territory distribution of sites; and the potential sites for each state and territory. The paper indicated that the potential sites were presented as examples, and that alternative sites with similar characteristics might be suggested. It also identified preferences for, and benefits of, specific sites where these existed.

The long list of potential sites was subsequently sent by the department's Commonwealth Partnership Forums team to all state and territory Health Forums. The information included the site selection paper sent to NACCHO and an accompanying department briefing paper outlining recommendations and actions required. Health Forum members were asked to advise:

- on potential sites for their jurisdictions against the site selection criteria, including on site prioritisation and sensitivities, and to suggest alternative options if relevant
- whether they would like the evaluation team to present at one of their Health Forum meetings in 2019.

The site selection paper was considered by the HSCG. At that meeting:

- the evaluation team discussed the site selection process and provided an update in terms of the engagement with Health Forums
- HSCG members discussed their involvement in the site selection process and requested that they be provided with a copy of the accompanying department briefing paper

- HSCG members requested that the site selection process be documented so that the group could make an informed decision about whether it could endorse the process.

The evaluation team attended meetings of the Health Forums[8] in all states and territories. At each Health Forum meeting, the team provided a briefing on the evaluation, noted the written feedback received from members on site selection, requested further advice and guidance on site selection and/or sought agreement to preferred and back-up sites, and sought advice on how members wanted the evaluation team to initiate engagement with key stakeholders in the sites (for example, whether they were happy for the team to make initial contact with stakeholders, or whether they would prefer this to come from the department, state and territory health department, state and territory peak body, etc). The evaluation team paid particular attention to ensuring the perspectives of, and guidance from, the community-controlled Peak Bodies had been central to the selection process.

Step 8: Engagement with Primary Health Networks

The evaluation team attended the department's monthly PHN Chief Executive teleconference, providing a brief update on the evaluation and outlining a proposed process for engaging with PHNs on site selection. The proposed process was for the evaluation team to contact relevant PHNs only, and to do this on a one-on-one basis once the long list of potential sites had been refined following discussions with Health Forum members. Participants on the teleconference did not raise concerns with the process.

Step 9: Engagement with site stakeholders

The final step in the site selection process was to engage with key stakeholders within each site to invite them to participate in the evaluation and discuss and agree what participation meant. The engagement process was designed to provide transparent and detailed information to potential partners. Peak bodies emailed their affiliate members in selected sites to introduce the evaluation team and convey their support for the evaluation. The evaluation Project Lead followed up on these emails and contacted individual member organisations to invite them to meet with the evaluation team to discuss the project and the potential of being partners in the evaluation. The email contained a standardised invitation, a letter of support from the HSCG co-chairs, and an information sheet about the evaluation. All PHNs in selected sites were also contacted via email inviting them to meet with the evaluation team.

The evaluation Project Lead then followed up with the Aboriginal and Torres Strait Islander health services and PHNs in each site with a phone call or email to coordinate site meetings. Once a date was confirmed, a calendar invitation was sent to confirm the meeting, along with an 'Introductory Document' to the evaluation.

Evaluation team members then travelled to selected sites to meet with Aboriginal and Torres Strait Islander health services, PHNs, and, where possible, representatives from state and

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[8] All Health Forums include the state or territory Peak Body for ACCHSs, the state or territory health department, and the Department of Health and Aged Care. Some Health Forums also include members and/or observers from the National Indigenous Australians Agency and PHNs.

territory peak bodies, health departments, and offices of the department. The meetings were led by an Aboriginal team member, along with one or two other team members in attendance. The team used a PowerPoint presentation to keep the narrative of the evaluation consistent across sites. The presentation was facilitated as an interactive process to encourage conversation, better understand the site context, and elicit questions about the evaluation from potential site partners. In total, 20 sites were visited over a two-month period at the end of 2019.

Aboriginal and Torres Strait Islander health services' responses to the invitation to participate in the evaluation were diverse. They indicated varied reasons for wanting to participate in the evaluation, including:

- the opportunity to share their model of health care
- tell, and have their stories heard, by a wider audience
- access data to which they would not normally have access
- learn more about what their community values and how they experience the health system
- the potential to input into policy and decision-making.

Some site stakeholders also said they had low expectations of action or change occurring at a government level.

Many site stakeholders reported that they had limited capacity to resource a participatory-type evaluation. The evaluation team estimated that the involvement of the ACCHS staff would include:

- one 3-4 hour meeting per year to plan and review local co-design of the evaluation's implementation. This normally involved one or two staff, for example, the CEO, the health centre manager, or board members.
- one or two 3-hour meeting(s) per year to participate in collaborative interpretation and sense-making of the findings and identify actions (co-creation sessions). This normally involved the CEO, health centre manager, one or two board members and sometimes front-line health workers, for example, GPs and Aboriginal health workers.
- one 1-2 hour interview or yarning session per year for the CEO, health centre manager, one or two board members and sometimes front-line health workers.

Two Aboriginal and Torres Strait Islander health services declined the invitation to partner with the evaluation citing capacity reasons and/or other key organisational priorities.

Those organisations that expressed interest in participating in the evaluation were sent a draft Participation Agreement, an introduction to state and territory site evaluation leads, and proposed dates for a follow up planning workshop with all potential partners in their site.

Most sites agreed with the site boundaries as identified by the evaluation team. However, several site stakeholders provided a rationale for the modification of boundaries. The discussions around boundaries raised a broader question for the evaluation team: *To what* *extent is the purpose of the boundaries to identify a population and whether their needs are being met versus encompassing a service-provision area?*

Site engagement always included two or three Aboriginal evaluation team members. This strategy supported a consistent approach to the dissemination of information and messages about the evaluation, as well as forming relationships with potential key partners in sites.

The Aboriginal team members' knowledge of, and existing relationships within, the PHC sector enabled:

- 1-2 hour interviews with Aboriginal and Torres Strait Islander health services to be set-up and carried out within a short timeframe
- respectful connections to be made with each other, including through the Acknowledgement to Country, that '*immediately feels comfortable, establishes a trust and a respect for professional experiences, and face to face relationships for potential engagement – so powerful, so important'*.
- authentic connections with the professional and personal realities experienced by the Aboriginal and Torres Strait Islander people present in the initial meetings.

It was evident that the ACCHSs invested in the initial meeting with the evaluation team by bringing their key decision-makers to the table, with many committing considerable resources to the meeting. For example, one health service meeting included the board chair, the CEO, a finance officer, a program coordinator, and two other senior staff members. Another health service brought another key site partner to the meeting. The attendance of CEOs, senior managers, and board members is recorded below.

- Nineteen CEOs from 23 health services attended the initial meetings.[9] In the other four health services where the CEOs were not available, they asked their Chief Medical Officer (CMO) or Practice Manager to attend on the organisation's behalf. Reasons for CEOs who could not attend the initial meetings were attributed to health issues and previous commitments, and in one case unexplained.
- Some CEOs had their board chairs included in emails but board members were only present in two meetings with health services.
- Of the 19 CEOs who attended the consultation meetings, 13 were Aboriginal or Torres Strait Islander people, while the remaining six were non-Indigenous Australians. In the health services with non-Indigenous CEOs, all outlined a process for communicating the evaluation back to their organisational governance board. The CMOs were all non-Indigenous Australians who were clearly entrusted to represent the health service at the meeting with the evaluation team. Most PHNs included their CEO and other senior managers.

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[9] The evaluation team met with 23 health services across 18 sites.

Most of the initial meetings were on site. Meeting with stakeholders on site was considered important both in terms of starting a genuine relationship between the evaluation team and site organisations, and to understand a site's context.

C 2.6.2 Planning workshops with sites

A second engagement with sites was undertaken to discuss site boundaries, responsibilities of the evaluation team and site partners, data, and governance arrangements. The evaluation team was part way through site visits when a decision was made by the department, HSCG, and the evaluation team to pause the evaluation for 6 months (from end March 2020) due to the COVID-19 pandemic. The pause was put in place to reduce research and engagement burden on site partners who were focused on their COVID-19 preparations and response.

While on pause, the evaluation team continued to engage with potential site partners through regular phone contact and delivery of three webinars (with separate sessions for ACCHSs and PHNs) on the topics:

- Evaluation approach and benefits.
- Data sources and data sovereignty.
- Participation agreements and planning workshops.

The 90-minute webinars had approximately a 50% attendance rate from potential site partners, with slightly higher attendance from PHN representatives. Each webinar was recorded and circulated to partners who had expressed an interest but were unable to attend.

While the engagement process was drawn out by COVID-19, the evaluation team reflected that this enabled a genuine informed consent process and the establishment of good relationships with many services. When engagement activities with sites recommenced in October 2020, meetings were rescheduled to an online platform.

In total there were 17 sites, including 24 health service organisations and 13 PHNs, as illustrated in **Appendix A: Evaluation site descriptions and context**.

Distribution of the IAHP-funded ACCHSs in the 17 evaluation sites compared with the IAHP-funded ACCHSs not in the evaluation sites

The AIHW compared the IAHP-funded ACCHSs in the evaluation sites with the IAHP-funded ACCHSs not in the evaluation sites. This analysis found that, compared with the IAHP-funded ACCHSs not in the evaluation sites, ACCHSs in the evaluation sites were:

- more likely to be in major cities and in remote and very remote areas
- less likely to be in regional areas
- more likely to be larger organisations based on total number of clients and total number of staff FTE
- more likely to be located in South Australia, WA and Victoria (this is partly because one site in each of these states had three funded ACCHSs)
- less likely to be in NSW/ACT, NT and Queensland.

This analysis is provided in the separate AIHW report.

C 2.6.3 Local evaluation coordinators

The purpose of the local evaluation coordinator (LEC) role was to work alongside the evaluation site teams and assist with organising yarns, interviews, workshops and other communication. The intention was that LECs would be invited to join the evaluation team to assist with skills building for the evaluation. It was anticipated that the role would involve about 30 days of paid project work each year over 2.5 years.

LECs were appointed for 12 of the 24 Aboriginal and Torres Strait Islander health services. They were appointed by the ACCHS partner. In all cases, an existing employee picked up the evaluation work alongside their existing role.

In two sites where there was no designated LEC, community yarns did not take place. This indicates the importance of the designated LEC role in helping with the evaluation logistics. In other sites, the LECs helped to identify participants, organise catering, a venue for workshops, and photocopying. In some ACCHSs, the LECs also helped with transporting community participants to attend the yarns. LECs also shared community knowledge and understanding of context for the yarns and in some sites led interviews with community members.

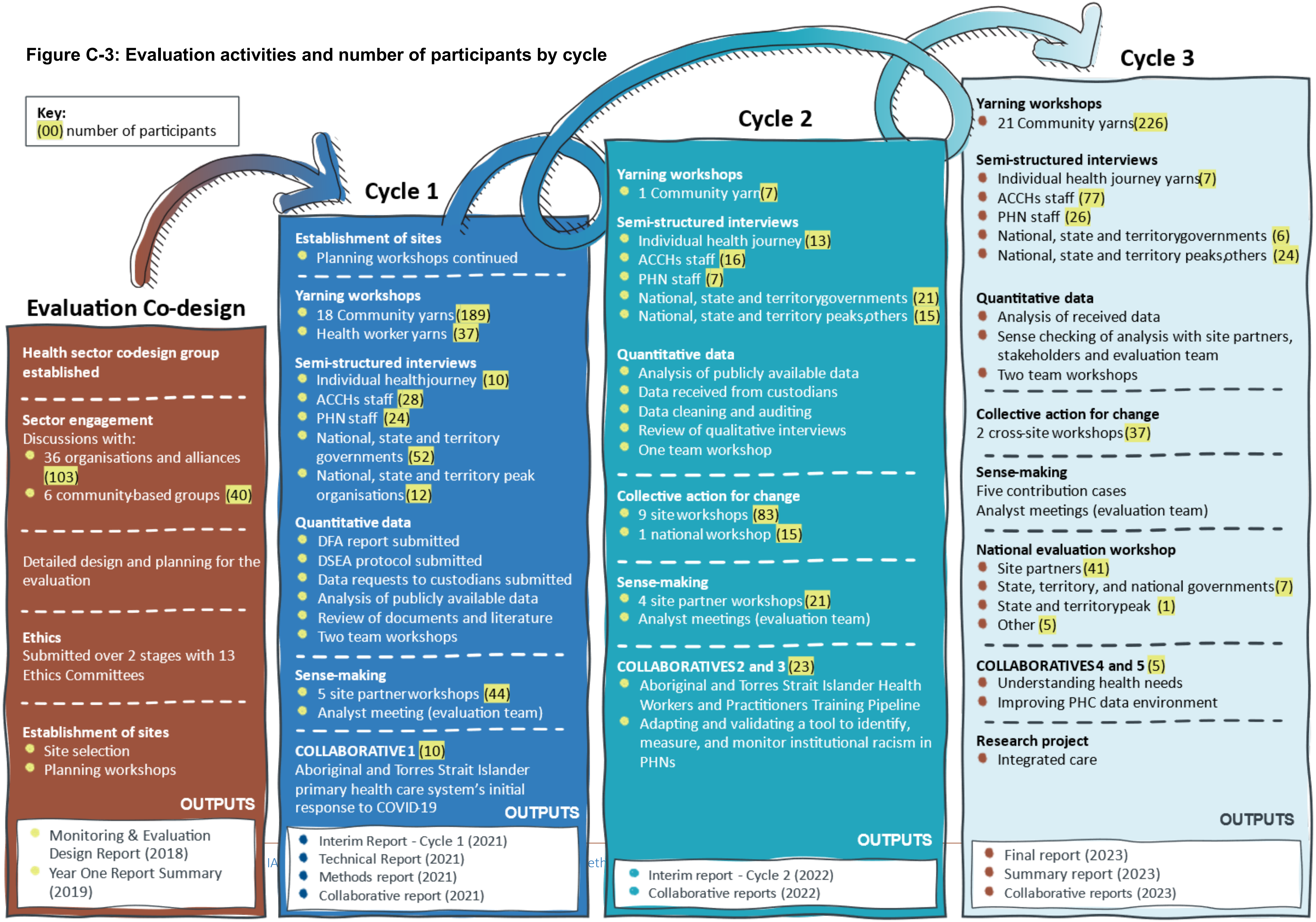
C 3 Evaluation implementation

This section documents the qualitative and quantitative methods, data collection, and analysis implemented from 2019 to 2023 to answer the KEQs. It includes a description of data generation and analysis methods for the yarns, interviews, focus groups, collective action for change (CA4C workshops), collaboratives, and secondary (quantitative data). Thirty-seven partners in 17 sites across Australia were engaged in the evaluation.

Note that the process of sense-making, data integration and synthesis across the different data sets and approaches to analysis is addressed in Section C 4.

Figure C-3 provides an overview of the evaluation activities and count of participants per cycle, including the evaluation co-design phase.

Figure C-3: Evaluation activities and number of participants by cycle



Key:
(00) number of participants

Evaluation Co-design

Health sector co-design group established

Sector engagement
Discussions with:
- 36 organisations and alliances (103)
- 6 community-based groups (40)

Detailed design and planning for the evaluation

Ethics
Submitted over 2 stages with 13 Ethics Committees

Establishment of sites
- Site selection
- Planning workshops

OUTPUTS
- Monitoring & Evaluation Design Report (2018)
- Year One Report Summary (2019)

Cycle 1

Establishment of sites
- Planning workshops continued

Yarning workshops
- 18 Community yarns (189)
- Health worker yarns (37)

Semi-structured interviews
- Individual health journey (10)
- ACCHs staff (28)
- PHN staff (24)
- National, state and territory governments (52)
- National, state and territory peak organisations (12)

Quantitative data
- DFA report submitted
- DSEA protocol submitted
- Data requests to custodians submitted
- Analysis of publicly available data
- Review of documents and literature
- Two team workshops

Sense-making
- 5 site partner workshops (44)
- Analyst meeting (evaluation team)

COLLABORATIVE 1 (10)
Aboriginal and Torres Strait Islander primary health care system's initial response to COVID-19

OUTPUTS
- Interim Report - Cycle 1 (2021)
- Technical Report (2021)
- Methods report (2021)
- Collaborative report (2021)

Cycle 2

Yarning workshops
- 1 Community yarn (7)

Semi-structured interviews
- Individual health journey (13)
- ACCHs staff (16)
- PHN staff (7)
- National, state and territory governments (21)
- National, state and territory peaks, others (15)

Quantitative data
- Analysis of publicly available data
- Data received from custodians
- Data cleaning and auditing
- Review of qualitative interviews
- One team workshop

Collective action for change
- 9 site workshops (83)
- 1 national workshop (15)

Sense-making
- 4 site partner workshops (21)
- Analyst meetings (evaluation team)

COLLABORATIVES 2 and 3 (23)
- Aboriginal and Torres Strait Islander Health Workers and Practitioners Training Pipeline
- Adapting and validating a tool to identify, measure, and monitor institutional racism in PHNs

OUTPUTS
- Interim report - Cycle 2 (2022)
- Collaborative reports (2022)

Cycle 3

Yarning workshops
- 21 Community yarns (226)

Semi-structured interviews
- Individual health journey yarns (7)
- ACCHs staff (77)
- PHN staff (26)
- National, state and territory governments (6)
- National, state and territory peaks, others (24)

Quantitative data
- Analysis of received data
- Sense checking of analysis with site partners, stakeholders and evaluation team
- Two team workshops

Collective action for change
2 cross-site workshops (37)

Sense-making
Five contribution cases
Analyst meetings (evaluation team)

National evaluation workshop
- Site partners (41)
- State, territory, and national governments (7)
- State and territory peak (1)
- Other (5)

COLLABORATIVES 4 and 5 (5)
- Understanding health needs
- Improving PHC data environment

Research project
- Integrated care

OUTPUTS
- Final report (2023)
- Summary report (2023)
- Collaborative reports (2023)

C 3.1 Overview of activities in each PAR cycle

C 3.1.1 Cycle 1

In Cycle 1, both qualitative and quantitative data were generated or collected. The focus was to generate a baseline description of what Aboriginal and Torres Strait Islander people value in health service design and delivery, and how people experience the health system; create site system maps and contextual descriptions; as well as gather a set of local and system level indicators and baseline data to plan, monitor, and measure change.

The main evaluation activities in Cycle 1 were:

- all of team data collection preparation sessions and workshops
- reflective and future focused community yarning workshops at 12 sites (section C 3.3.1.1)
- individual patient experience journey interviews at 6 sites (section C 3.3.1.2)
- reflective and future focused Aboriginal and Torres Strait Islander health service staff yarning workshops held with 44 health services staff at 12 sites (section C 3.3.1.3)
- semi-structured and KEQ based interviews with Aboriginal and Torres Strait Islander health service leadership staff across all sites (section C 3.3.1.3)
- semi-structured and KEQ based interviews with managerial staff from 13 PHNs (section C 3.3.1.3)
- semi-structured and KEQ based interviews with stakeholders from site, state and territory, and national organisations across all sites and jurisdictions (section C 3.3.1.5)
- five online emerging findings workshops (section C 4).

Cycle 1 data collection processes were disrupted by the COVID-19 pandemic that began to impact Australia in March-April 2020. Due to travel restrictions and concerns for vulnerable communities that were participating in the evaluation, the evaluation team was unable to hold community yarns workshops in all 17 sites. Moreover, the emerging findings workshops, which were planned with site partners towards the end of Cycle 1 in September 2021, were all held online over 5 days, split over 2 weeks.

Data analysis included the use of multiple methods appropriate to answering the respective evaluation question (elaborated in section C 3.4 and C 3.6).

- An adapted form of Schema analysis using tools from Situation Analysis was employed to analyse community, service staff, and patient experience data to address what is valued in service delivery and design.
- An inductive approach which enables patterns and theories to emerge from the data (adapted from grounded theory analysis) was used to analyse community and patient experience data to examine how people experience the health system.

- Content analysis was used to explore the site, state and territory, and national organisation interview data to explore the difference the IAHP was making to the PHC system.

Data were also gathered from the site partners on information systems and data extraction procedures to inform planning for Cycle 2 and 3. Data requests were submitted to data custodians for data sets identified through a data feasibility assessment (DFA) and a data specification extraction and analysis (DSEA). Publicly available quantitative data were collected from relevant organisations such as the Australian Institute of Health and Welfare (AIHW) and the department. These data were analysed at a state and territory level. Data on population, workforce, immunisations, Medical Benefits Schedule (MBS) items, National Key Performance Indicators (nKPI), and Online Services Report (OSR), were received from custodians mid-2021. Two internal team meetings were held during Cycle 1 to share and discuss the available quantitative data and emerging findings.

Data integration and reflection was undertaken in a series of facilitated workshops held over one week that included all evaluation team members. This enabled the team to test for interpretative resonance across evaluation team members. The emerging findings were then reported back to evaluation partners through a series of two-hour online workshops, to facilitate their input to interpretation and sense-making. Following the workshops, participants were surveyed to gauge the impact of the workshops and partners' preferences for future information sharing.

Public documents and existing literature were accessed and reviewed to see how the emerging findings related to other studies and to explore the 'so what' or significance of the findings.

Documents such as health service and PHN annual reports and other publicly available information (website information, brochures, and booklets) were gathered and administrated in NVivo[10] to provide contextual information for the site descriptions and to inform follow-up interviews with site-based participants.

C 3.1.2 Cycle 2

In Cycle 2, the evaluation built on foundational data generated in Cycle 1. The aim of this cycle of data generation was to build on the data gathered in Cycle 1, particularly in those areas where gaps, inconsistencies and a need for sense-checking had been identified. Where Cycle 1 focused on generating a baseline description of the IAHP, Cycle 2 focused on exploring the contribution of the IAHP. As with Cycle 1, engagement with site partners, community members and other evaluation participants was impacted by the COVID-19 pandemic. The majority of interviews and workshops were held online.

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[10] NVivo is a qualitative data analysis (QDA) computer software package from Lumivero (formerly by QSR International). NVivo helps qualitative researchers to organize, analyse and find insights in unstructured or qualitative data like interviews, open-ended survey responses, journal articles, social media and web content, where deep levels of analysis on small or large volumes of data are required (*Qualitative Data Analysis Software* | *NVivo*, n.d.).

The main evaluation activities in Cycle 2 are set out below.

- Collective Action for Change workshops across 8 sites and with the Department of Health and Aged Care. These involved mapping the health system in each site; discussing what is working well and challenges; and identifying what needs to change and (in some cases/sites) an action plan to drive change (described in section C 3.3.2).
- Interviews, workshops and analyses as part of three cross-cutting collaboratives. The collaboratives were on: (1) the Aboriginal and Torres Strait Islander PHC system's initial response to COVID-19; (2) the training pipeline for Aboriginal Health Workers and Health Practitioners; and (3) adapting and validating a tool to identify, measure and monitor institutional racism in PHNs (described in section C 3.3.5).
- Yarns and interviews with community members who access mainstream PHC services or who don't access PHC at all.
- Interviews with managers and staff from ACCHSs, AMSs and PHNs targeting specific information gaps.
- Interviews with stakeholders not engaged in Cycle 1, including from state and territory peak bodies for community-controlled health services and government health departments.
- Analysis of new data collected through interviews at site level.
- Analysis of routinely collected data sets at state, territory, and site levels.
- Analysis about the contribution of the IAHP to strengthening comprehensive PHC for Aboriginal and Torres Strait Islander people. This included re-analysis of Cycle 1 site partner interviews and was achieved through the development of 'contribution cases' to test the contribution of the IAHP to expected changes (see section C 4.3 for more detail on contribution case analysis).
- Four workshops with site partners to interpret and validate the emerging findings.
- Quantitative data on PIP, hospitalisation, perinatal, and mortality were received to inform the analysis of the IAHP's contribution to health outcomes (KEQ3). The cleaning and auditing of this data commenced during Cycle 2 and initial links between the IAHP and observed health outcomes measures were tested. Two internal findings meetings were held, discussing the quantitative data and initial observations with the wider evaluation team (see section C 4).

C 3.1.3 Cycle 3

The focus of data generation and analysis over Cycle 3 was informed by the findings from Cycle 2. For example, in Cycle 3, the evaluation generated more precise information on the burden of reporting and potential solutions were discussed with ACCHSs.

The primary focus of Cycle 3 was the collaborative development of specific actions and solutions to improve the IAHP. The evaluation team also tested, revised, and strengthened contribution cases through discussions with site partners and other subject experts over Cycle 3.

The main evaluation activities in Cycle 3 were:

- group yarns with hard-to-reach populations (such as recently incarcerated people).
- sense checking of findings on what people value about health service design and delivery through group yarns with community members.
- interviews with health service and PHN managerial staff focused on change needed to the IAHP and the wider system.
- interviews with mainstream PHC providers and other non-ACCHS stakeholders engaging with the IAHP-funding organisations.
- final interviews with site partners and stakeholders at state, territory, and national levels with a focus on changes needed to the IAHP and the wider system.
- strengthening of contribution cases through sense-checking interviews with health service partners, PHNs and others.
- facilitation of a contribution review panel providing feedback on the contribution cases and exploring nuances, gaps, and alternative explanations.
- revision and analysis of contribution cases and write up of an overarching contribution narrative.
- facilitating two cross-site collective action workshops on specific topics.
- completion of two collaboratives on: (1) identifying and piloting approaches to assessing health needs and indicators for health needs within the community; and (2) develop recommendations to improve the PHC data environment.
- completion of a sub-project that identifies what is needed for PHC organisations and health professionals to establish coherent integrated care models at funding, administrative/ governance, organisational, service delivery and clinical levels.
- facilitation of a national evaluation workshop for site partners in Melbourne to share and sense check the evaluation findings and recommendations and to promote learning across sites and levels of the health system.
- development of funding profiles for five site partner ACCHSs to demonstrate organisational capacity, funding and contracts, and burden of reporting (see section C 3.3.1.4).

With most COVID-19 restrictions being lifted during 2022, the majority of interviews and other site engagement activities were done in person. However, some sites were still impacted by COVID-19, which affected their capacity to engage in the evaluation and meant that some interviews and workshops were conducted online.

C 3.2 Preparation for data collection

Preparation for data generation was led by the Principal Investigator, an Aboriginal scholar, and included team workshops and the creation or adaptation of tools. The team workshops were attended by Aboriginal and non-Indigenous team members and included activities to ground the work in the core values, surface the teams' positionality, and learn through experiencing, doing, and practising.

In preparation for Cycle 1 data generation and collection activities, the evaluation team met for three days of workshops in February 2021.

Two online team meetings were held in January 2022 with the purpose of setting up processes and preparing for data collection of Cycle 2. For Cycle 3, a team preparation meeting was held in August 2022, reflecting on findings from Cycle 2 and getting clarity about what new data should be gathered and which issues, topics, and gaps would need to be explored in further depth.

The Principal Investigator led the development of the preparation workshops with input from other Aboriginal and Torres Strait Islander team members and support from non-Indigenous team members to develop activities and resources.

In other workshops, the evaluation team familiarised themselves with interview guides, reflected on strategies to address challenges in conducting interviews for the evaluation, practised interview skills, and was introduced to a tool to prompt reflections post-interview. The workshops concluded with information sharing about other activities being undertaken as part of the evaluation to ensure team members understood the interaction and dependencies of the evaluation components. Evaluation team members were further supported by the development of a Site Evaluation Handbook.

C 3.3 Qualitative data collection methods

C 3.3.1 Yarns and interviews

This section provides information about yarns and interviews conducted over the three cycles of the evaluation.

A note about language

The findings and recommendations in this evaluation report are shaped by the expertise of Aboriginal and Torres Strait Islander people. While this report refers to people who contributed to this evaluation process as 'participants', the evaluation team recognises that Aboriginal and Torres Strait Islander people are the knowledge holders for what will improve health outcomes for Aboriginal and Torres Strait Islander people. The use of 'participants' in this report is not intended to diminish the leadership and expertise of Aboriginal and Torres Strait Islander people within their communities and throughout this evaluation process.

The evaluation team drew from yarning as a methodology (Bessarab & Ng'Andu, 2010; Fredericks et al., 2011) to design and implement interviews and conversations with Aboriginal and Torres Strait Islander community members and staff from Aboriginal and Torres Strait Islander health services. Interviews and yarns were conducted through facilitated roundtable discussions that employed cultural protocols. The conversations did not hold to the deep sense of connection and grounding to the extent expected when implementing a yarning methodology. Yarning inherently centres Aboriginal and Torres Strait Islander values in the research process and facilitates participants as active voices for individuals, families, and communities' experiences, concerns, and needs (Bessarab & Ng'Andu, 2010; Fredericks et al., 2011). It is a valuable tool for generating data because it is a familiar process that supports cultural safety through its embedded elements of respect, protocol, and engagement with the extant relationships between participants (Bessarab & Ng'Andu, 2010; Fredericks et al., 2011). Fredericks et al. (2011) highlight the value of yarning beyond being a method of data generation in participatory action research because of its active and relational nature that considers participants as co-investigators, which can contribute to empowerment. The fluidity and interaction of the yarns generate rich description and draws together the shared experiences beyond the individual (Bessarab & Ng'Andu, 2010).

For the purpose of interviews with PHN managers, non-Indigenous health service staff, state and territory and national representatives, and other stakeholders, the evaluation team also drew on the method of semi-structured interviews (DeJonckheere & Vaughn, 2019), which is one of the most frequent qualitative data sources in health services research. This method consists of a dialogue between researcher and participant, typically guided by a flexible interview protocol shaped by the overarching evaluation questions and is supplemented by open-ended follow-up questions, probes and comments to explore responses further. The method allows the researcher to collect open-ended data, to explore participant thoughts, feelings, and beliefs about a particular topic and to delve deeply into specific issues and sometimes sensitive issues (DeJonckheere & Vaughn 2019). Qualitative researchers use semi-structured interviews to collect new data, expand the notion of concepts and definitions, as well as to explore participants' thoughts, beliefs and values about a particular topic.

This method of interviewing aligns well with the participatory research design and has many similarities with the yarning approach to interviewing. Appropriate ethical etiquettes and cultural safety procedures were adhered to in these interviews.

C 3.3.1.1 Aboriginal and Torres Strait Islander community yarns

Data to address the questions of (1) *what Aboriginal and Torres Strait Islander people value in health service design and delivery*, and (2) *how Aboriginal and Torres Strait Islander people experience the health system* was generated through a series of community and individual yarns held between March 2021 and November 2022. The approach emphasised yarning's fluidity and interaction to generate rich descriptions and draw together shared experiences creating deeper insights.

The community yarns were facilitated primarily in groups, varying from 3 - 20 participants. In a few cases a community yarn was done with only one participant.

In total, 452 community participants contributed to the evaluation, 422 in the group yarns and 30 in individual yarns. The evaluation team spoke with a diverse mix of community members.

417 of the community participants were Aboriginal and Torres Strait Islander and the ethnicity of the remaining participants were unknown. Sixteen people attending a community yarn were ACCHS board members. The geographic and demographic characteristics of the yarns and contributing knowledge-holders are shown in Table C-4.

Yarning workshops were also held with 44 health service staff in 12 of the 17 evaluation sites between March 2021 and August 2021, during Cycle 1. These workshops aimed to understand what Aboriginal and Torres Strait Islander people value in health service design and delivery and how they experience the health system (rationale 1 of objective 1) (Bainbridge et al., 2020) and drew on the dual experience of staff as both community members and health service staff.

Preparation for data generation was led by the Aboriginal Principal Investigator and included team workshops and the creation or adaptation of tools. The team workshops were attended by Aboriginal and non-Indigenous team members and included activities to ground the work in the core values, surface the teams' positionality, and learn through experiencing, doing, and practising. Yarning guides were developed for the community yarns and adapted from a Lowitja Institute patient journey mapping tool (Kelly et al., 2012) for the individual yarns by the Principal Investigator.

The evaluation team's Aboriginal site leads worked with LECs to organise the yarns to meet sites' contextual needs and circumstances. Yarns were primarily held on weekdays at an ACCHS site to provide a comfortable and familiar environment. The evaluation team greeted community knowledge holders (Moreton-Robinson, 2017; Whyman et al., 2022) contributing to the yarns, offered refreshments, and provided information sheets and consent forms tailored for each location. The team ensured everyone could provide informed consent and, if requested, provided assistance to read or clarify the contents of the forms. Yarning was undertaken either as a group or individually, depending on people's preferences. The LEC also recruited health service staff to participate in Aboriginal and Torres Strait Islander health worker yarns. The process of these yarns was the same as for community participants, and the same guide was used by facilitators.

Aboriginal site leads facilitated each yarn and were supported by a non-Indigenous team member. Cultural protocols and group agreements were established to support people's comfort and safety. The yarns lasted between one and two hours, allowing everyone to share their perspectives and experiences. Individual yarns were conducted by an Aboriginal team member whenever possible. Yarn contributors were compensated for their time with a $50 gift card from a local supermarket accessible to each location.

Community knowledge holders shared a combination of statements about what they valued in health service design and delivery, rich descriptions of their experiences of health care delivery that evidenced what is valued, and histories of health care systems and delivery over their lifetime. Through the yarning they identified relationships between system characteristics and experiences, explored divergence between individuals' experiences, and explained the influence of contextual differences. Whilst they shared this knowledge generously, many of the contributors expressed consultation fatigue and frustration that nothing changed despite their input into these processes over many years. As one elder stated:

> I think you know, we've heard that we're the most consulted mob around here, but nothing changes. You know, it just. They come next time saying, you still in the same place. That's soul-destroying, you know. And there's a lot of this and that words, reports, you know. You can't eat reports. You can't eat words. You can't make yourself well, you know. And often you get let down, because, you know, again.
>
> **Community member**

Data were generated over three cycles of site visits. In the third cycle, community knowledge-holders were also presented with a draft framework of what was valued in health service design and delivery to provide input to the framework.

The yarns were digitally recorded. The files were uploaded to a secure drive and transcribed verbatim. A member of the evaluation team undertook a quality assurance process to ensure the accuracy of the transcript before it was checked by the relevant Aboriginal site lead.

C 3.3.1.2 Individual patient journey yarns and interviews

In addition to the community yarns workshops, the evaluation team held individual interviews with community members. The purpose of the interviews was to hear and include the stories of people in 'hard-to-reach' groups or those with complex needs (further informing rationale 1 of objective 1).

A total of 30 participants contributed to individual patient experience journey interviews across 13 sites. Individual interviews were held onsite at the health services, and there was a balance of genders. Participants were primarily people with complex health needs who had experienced PHC and the broader health system, and variously understood how different system parts interact.

The LEC identified and invited potential participants to participate in the yarn or asked if they would prefer to participate in an individual interview at the community yarns workshops. One interview had two participants who were family members with a shared complex health experience. Participants were provided with an information sheet and informed consent form.

The individual interviews were conducted in a private room, and Aboriginal site leads conducted all except one. Participants in the interview conducted by a non-Indigenous, female team member were offered the chance to have an Aboriginal interviewer but chose not to accept. Participants were compensated for their time with a $50 gift card from a local supermarket accessible to the location.

The interviews lasted for approximately one hour and participants were offered refreshments. Interviews were recorded digitally. The file was uploaded to a secure drive and transcribed verbatim. A member of the evaluation team undertook a quality assurance process to ensure the accuracy of the transcript. A copy of the transcript was then sent to the participant if they elected to receive one, requesting them to respond within 2 weeks if they wanted to amend or withdraw any of their data.

Table C-3: Count and demographics of participants in community yarns and individual health journey yarns

Indigeneity	Age				Gender			Total
	18-24	25-54	Over 55	Not provided	Female	Male	Not provided	
Aboriginal and/or Torres Strait Islander	52	121	120	124	259	142	16	**417**
Not known or other	2	2	0	31	8	3	24	**35**
Total	**54**	**123**	**120**	**155**	**267**	**145**	**40**	**452**

Note: some people participated in more than one yarn at different stages of the evaluation and thus are counted more than once.

C 3.3.1.3 Interviews with site partner staff and other site-based representatives

Semi-structured interviews were undertaken with health service and PHN staff in Cycles 1-3. These focused on staff perspectives and experiences of the IAHP and how the IAHP works to support the delivery of comprehensive PHC and the operation of Aboriginal and Torres Strait Islander health care organisations. The interview questions were structured around the KEQs and included (where relevant) specific questions related to identified gaps, inconsistencies or nuances in need of further explanation. The health service staff included senior staff from 23 ACCHSs and one territory-run service, including chief executive officers (CEOs), practice managers, and public health medical officers. PHN staff included CEOs, senior executives, and commissioning managers for the IAHP funded initiatives.

In Cycle 3, these interviews also involved sense-checking of five contribution cases (elaborated further in **Appendix K: Cycle 3 findings**). Cycle 3 engagement focused on exploring in further depth what needs to change with the IAHP and the wider system and what potential improvements to the IAHP might look like.

Interviews with PHN staff focused on exploring processes and challenges in the mainstream system, as well as understanding the relationships between Aboriginal and Torres Strait Islander health services and mainstream service providers and commissioning organisations. Conversations with PHN staff also provided insights about the implementation of the IAHP funding into mainstream health services (for example through ITC and mental health funding).

Interviews took approximately one hour and were usually led by the evaluation site leads, with another evaluation team member attending. Interviews were recorded electronically, de-identified and uploaded to NVivo.

In total, 68 interviews with health service staff and 28 interviews with PHN staff were facilitated.

Table C-4 illustrates participation of people from health services, PHNs and participants from other site-based organisations (such as staff from mainstream health services, housing, correction, and family services agencies).

Table C-4: Count of participants included in sector engagement over Cycles 1-3

Sector engagement over three cycles	Total
Health service staff	140
PHN staff	71
Others	27
Total	**238**

Note: some people participated in more than one interview at different stages of the evaluation and thus are counted more than once.

C 3.3.1.4 Funding and reporting profiles

Cycle 1 findings identified that many health services were reliant on multiple funding sources, including the IAHP, and a related burden with multiple reports needing to be produced. In Cycle 3 the evaluation sought to provide evidence of the multiple funding sources and level of reporting required.

The evaluation team aimed to develop funding and reporting profiles for remote, regional and metro sites. Managers at six ACCHSs agreed to share information about funding and reporting with the evaluation team.

A one-page funding and reporting profile was developed for each service. This was populated with publicly available information (from the ACCHS website, annual report, and GrantConnect). The draft profile included contextual information as well as funding data.

The draft profiles were sent to the ACCHSs to check and to populate with additional or revised information where possible, including the number of funding contracts (by type of funding organisation) and the number of reports they had to produce, by frequency of reporting. Staff reported that checking and completing their profile took up to 8 hours of time.

Profiles were followed up with an interview with the ACCHS finance or contracts manager to reflect on their experiences and perspectives with reporting.

The final profiles were sent back to sites to use as a resource with their internal stakeholders (e.g. board members). For the purpose of the evaluation, each profile was anonymised and became an additional source of data related to funding and reporting.

C 3.3.1.5 State, territory, and national level interviews

Semi-structured interviews were undertaken with state, territory and national organisations in Cycles 1-3. A total of 48 interviews were facilitated.

The state, territory and national engagements aligned with the aim of creating multiple opportunities for Aboriginal and Torres Strait Islander people, and other key organisations and people as required, to come together and problem solve, analyse and interpret data, discuss emerging evaluation findings, and identify solutions and actions.

Engagement at this level also provided an opportunity to facilitate learning and action within and between the different levels of the health system. The aim of national engagement through PAR sessions, for example, was to engage national participants horizontally across divisional and departmental boundaries, and where possible, with other stakeholders across the health system.

Table C-5 shows the count and demographic information on participants that engaged in National, state and territory engagement interviews.

State and territory engagement

State and territory participants included staff from:

- peak bodies for Aboriginal and Torres Strait Islander community-controlled health services, including CEOs and deputy CEOs.
- state and territory government departments responsible for health. Typically, participants included senior staff in Aboriginal and Torres Strait Islander health policy or strategy divisions.
- state and territory offices of the Australian Government Department of Health and Aged Care.
- state and territory offices of the National Indigenous Australians Agency (NIAA).

The purpose of these interviews was to gain a jurisdictional-level perspective on how well the IAHP and the PHC system was working for Aboriginal and Torres Strait Islander people and identify state and territory-led solutions in response to emerging evaluation findings.

The evaluation engaged with state and territory-level stakeholders in all eight jurisdictions across the three evaluation cycles. The engagement took place in various ways, including as:

- key informants: participants were interviewed for their perspective on how well the IAHP and PHC system was working in their jurisdictions), and about specific contextual issues.
- members of the PAR/CA4C workshops to help interpret the emerging findings for sites in their state or territory and in identifying actions in response to the findings, including state and territory-led solutions.

In addition to engaging with state and territory participants in the above activities, the evaluation also communicated with participants to share information about the evaluation process and progress, and to disseminate annual evaluation reports.

Interviews took approximately one hour and were led by a senior member of the evaluation team with one or two other evaluation team members attending, including the Aboriginal National Engagement Lead. Interviews were recorded digitally, de-identified and uploaded into NVivo.

National engagement

Participants at a national level were interviewed for the same purpose and in the same way as state and territory engagement – to facilitate a national-level perspective on how well the IAHP and PHC system were working for Aboriginal and Torres Strait Islander people; to identify national-led solutions in response to emerging evaluation findings; and to bring emerging findings and learnings from site and state and territory engagement to interpretation sessions with national stakeholders responsible for the IAHP and comprehensive PHC policy, planning and program management.

National participants were people who had key information about the challenges, barriers, enablers, solutions tried to date, and other relevant experience and knowledge. Involvement at this level was key to identifying and actioning policy-led and other solutions in response to emerging evaluation findings. National participants included representatives of:

- the Australian Government Department of Health and Aged Care, focusing on staff in the First Nations Health Division who manage the policy settings for the IAHP and staff in other divisions with responsibilities for workforce and PHNs.
- the NIAA including staff responsible for strategic policy, health and wellbeing policy, and health and wellbeing programs.
- AIHW's Indigenous Group.
- the Department of Social Services (DSS) Community Grants Hub staff responsible for grants under the IAHP.
- four professional organisations representing sections of the Aboriginal and Torres Strait Islander health workforce: Australian Indigenous Doctors Association (AIDA), Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA), and National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP).
- the Aboriginal and Torres Strait Islander Health Faculty at the Royal Australian College of General Practitioners (RACGPs).
- representatives from the office of the National Rural Health Commissioner.

The interviews generated data to contribute to addressing primarily KEQ2 and 4 including:

- an understanding of health care providers' perspectives and experiences of the IAHP
- knowledge about how the IAHP works

- baseline knowledge of the situational context at varying levels of the health system – at state, territory and national levels
- identification of system-level and clinical indicators related to the IAHP funding and evaluation questions.

Table C-5: Count and demographics of state, territory and national participants

Participant type	Indigeneity			Total
	Aboriginal and / or Torres Strait Islander	Other	Not provided	
State and territory level				
Government	7	-	16	**23**
Peak body	10	3	3	**16**
Total	**17**	**3**	**19**	**39**
National level				
Government	9	25	22	**56**
Peak body	6	-	5	**11**
Other	-	1	-	**1**
Total	**15**	**26**	**27**	**68**

Note: some people participated in more than one interview at different stages of the evaluation and are counted more than once.

C 3.3.1.6 Continuing stakeholder engagement

In addition to the engagement through yarns, interviews and workshops, stakeholder engagement was an integral component of the evaluation at both the design and implementation phases. The evaluation leadership team and various team members were involved in engagement activities throughout the evaluation, including:

- attendance and presentation at HSCG meetings
- regular contact with the department
- engagement with data custodians
- engagement with site partners for the purpose of planning, data generation, collective action for change workshops, and sense-making
- miscellaneous and ad hoc engagement activities including presentations to various Australian and state and territory forums.

C 3.3.2 Collective action for change workshops

Collective action for change (CA4C) workshops were an important part of the PAR approach. The purpose of CA4C workshops was to bring data and findings back for discussion with site partners and other stakeholders, provide an opportunity to share knowledge and understanding between organisations and services, identify PHC implementation enablers and barriers, and to identify spheres of influence for change (to leverage strengths and overcome barriers).

Table C-6 illustrates a break down of the various collective action for change workshops and the count of participants.

Originally, the CA4C workshops were designed as one day face-to-face workshops held in each site. After the first face-to-face workshop, COVID-19 intervened, and workshop were reshaped to be online (typically 4-6 hours long). The much-reduced time recognised that many site participants were busy with the pandemic and sustaining active engagement in an online environment presented a challenge.

In total 10 CA4C site workshops were held in nine sites during Cycle 2, involving 83 participants. Two workshops were facilitated in one site. The second workshop was a follow up workshop requested by the site partner to explore and expand on the ideas surfaced in the first workshop. Only two of these workshops were held face-to-face. Workshop participants were identified by the site partners and included ACCHS staff, PHN staff, peak body representatives, and people working in various organisations and agencies intersecting with the PHC sector (for example, staff from family and community services, youth support groups, corrections, the local school, hospital, and council).

The participants were invited by the site partners or the evaluation team. The workshops were facilitated by an evaluation team member, with support from the relevant site evaluation team members.

Most workshops followed a similar format.[11] After introductions and scene setting, the emerging findings from Cycle 1 were summarised. Participants then engaged in a site system mapping exercise using Miro, an online tool. Each person was invited to think of their site as part of complex system, composed of multiple components, both tangible and intangible. These included people, resources, services, relationships, values, and perceptions. They were asked to view a map of their site and reflect on the various aspects of the system that contributed to the delivery of PHC for Aboriginal and Torres Strait Islander people.

From this exercise, participants were asked to reflect on what was working well (and not so well) within the site, and what needed to change. They were then asked to identify if these specific changes were within or outside their influence. The next step was a rapid prioritisation of things that needed to change and identifying actions and who might progress these. Within a week of each workshop a summary was sent from the evaluation team to all site participants.

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[11] Participants in one site had already identified priorities and so the CA4C workshop was adapted to their needs.

The evaluators noted that most participants were engaged, and feedback was positive. Some participants said there were advantages with the online platform, such as being able to see everyone on a screen. All the workshops included robust discussions.

Challenging aspects for the evaluation team included getting site participants to attend because some services were short staffed because of COVID-19 lockdowns. Once participants got to the action planning part of the workshop, and particularly who would take actions forward, there was often silence. Thus, some workshops did not result in clear actions or accountability about who would take responsibility for the next step. Following up on actions and maintaining momentum was also challenging. All participants reiterated how understaffed and overworked they were, especially because of the pandemic.

A short report on each workshop, including a summary of the discussion, was sent to participants in each workshop.

C 3.3.3 National CA4C workshop

One CA4C workshop was held at the national level, with 15 department staff attending. The workshop was facilitated by the Principal Investigator, Project Lead, National Engagement Lead, a site evaluation lead, and another (non-Indigenous) evaluation team member. It was held in person in Canberra.

The purpose of the workshop was to support informed policy, planning, and decision-making that could enable improvements to the IAHP and support wider system learning and adaptation. It was expected that this would be achieved through:

- building collective knowledge of the comprehensive PHC system, including sharing the experiences of the health system for Aboriginal and Torres Strait Islander people, and its impact and consequences for people
- understanding the current commitments for comprehensive PHC system change and reform, including barriers, enablers, and intervention points for change and collective role(s) in facilitating change processes
- affirming commitments for action to strengthen comprehensive PHC systems for Aboriginal and Torres Strait Islander people and communities.

Participants were encouraged to reflect on, and discuss, the Cycle 1 interim findings. A short report on the workshop, including a summary of the discussion, was subsequently sent to the department.

Bringing emerging findings and learnings from site and national level engagement to interpretation (co-creation) sessions in the PAR workshops helped to facilitate conversations about the barriers and enablers relating to the implementation of the IAHP and wider PHC policies and programs.

C 3.3.4 Cross-site CA4C workshops

In Cycle 3, two cross-site CA4C workshops were held: one on partnerships, networks and alliances, and another on funding.

The purpose of the partnerships CA4C workshop was to hear stories on how and why partnerships have been formed, discuss the impact of partnerships on organisations and the people they serve, explore the effect of government policy and the call for profound change in the way governments partner with Aboriginal and Torres Strait Islander people, and reflect on possible recommendations to government on how future partnership can be best supported.

All site partners were invited to attend the two-hour online workshop. In total there were 18 attendees, 7 from ACCHSs and 11 from PHNs, plus 5 people from the evaluation team, including the Principal Investigator.

Prior to the workshop, participants were sent a background briefing paper to set the scene. A summary of emergent evaluation findings relating to partnerships was included, along with links to current health reforms and policy.

The workshop included presentations by partners in four sites of innovative partnership arrangements, and breakout discussions with participants.

The purpose of the funding CA4C workshop was to hear stories on how the current funding arrangements were working, discuss the impact of funding arrangements on organisations and the people they serve, explore the effect of government policy and the call for profound change in the way governments fund PHC, and reflect on possible recommendations to government on how future funding can be best supported, with a particular focus on the IAHP.

The workshop was proceeded by the circulation of a brief paper that focused on funding issues impacting on Aboriginal and Torres Strait Islander people’s health.

The workshop had 20 participants, 11 from ACCHSs, 8 from PHNs, 1 from a hospital service, as well as 5 people from the evaluation team, including the Principal Investigator.

The workshop consisted of four broad areas for discussion, each of which was introduced by members of the evaluation team.

- Adequacy of current health funding to meet the Closing the Gap policy objective.
- Priority investments in health for Closing the Gap.
- What does co-design look like when it comes to purchasing services for Aboriginal and Torres Strait Islander people, including those using mainstream services?
- What needs to change with the IAHP funding?

A report of the discussion for both cross-site workshops was disseminated to all site partners and state and territory peak bodies.

Table C-6: Count of CA4C workshops and participants who attended across three cycles of data collection.

Cycle	Number of workshops by type	Number of participants
2	10 site workshops	83
	1 national workshop	15
3	2 cross-site workshops	37
Total	**13 workshops**	**135**

Note: some people participated in more than one workshop at different stages of the evaluation and are counted more than once.

C 3.3.5 Cross-cutting collaboratives

Five cross-cutting collaboratives were undertaken as part of the evaluation. The collaboratives were intended to focus on system-level issues and bring together groups of stakeholders to problem solve and identify actions to address a common issue.

The need for collaboratives arose through the analysis of data and information gathered through the 17 site studies and the state, territory, and national engagements. The collaboratives also emerged from stakeholders expressing a strong interest in working on a specific issue that aligned with the evaluation aims, objectives, and questions. The selection criteria for deciding the topics of the five collaboratives included:

- alignment with the evaluation brief (contribution to the evaluation’s aims, objectives, and questions)
- value-add for the evaluation (focus on gaps in knowledge and avoid duplication)
- alignment to the IAHP (contribution to testing the IAHP theory of change and outcomes across the levels in the IAHP program logic and relationship between the topic and the IAHP)
- addressing a gap in current knowledge (potential to add to the current body of research and evaluation)
- influence for learning and change (potential to influence change at a system level (national or local), including contributing evidence to current reforms)
- strength of opinion (importance and usefulness of a topic to the evaluation site partners and other stakeholders).
- an approach to data collection, which aimed to lessen the burden on participants, particularly health service providers who were overloaded with the impact from COVID-19.[12]

The evaluation team applied the selection criteria to a list of potential collaborative topics. As a result of this assessment, five collaborative topics were identified.

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[12] Note that this selection criteria was added post-COVID and indicated how the evaluation adapted its engagement approach according to circumstances.

Cross-cutting collaboratives functioned alongside the collective, cyclic action that occurred across the broader evaluation. As such, the methodology aligned with the broader multi-phased, emergent, and mixed methods design of the evaluation.

A total of 38 participants took part in the collaboratives. These participants were a mix of ACCHS and PHN staff, government officials, and academics. Over half of the participants were Aboriginal and Torres Strait Islander people. Table C-7 shows a break-down of the number of participants in the collaboratives, in terms of Indigeneity and profession.

Table C-7: Count of participants in collaboratives (by setting and indigeneity)

	Indigeneity			Total
	Aboriginal and Torres Strait Islander	Other	Not provided	
Aboriginal health service staff	10	3	-	**13**
PHN staff	3	-	6	**9**
Government (including government agencies)	5	4	-	**9**
Other (i.e. university)	6	1	-	**7**
Total	**24**	**8**	**6**	**38**

Note: some people participated in more than one yarn at different stages of the evaluation and thus are counted more than once.

C 3.3.5.1 Collaborative 1: COVID-19

The first collaborative involved a deep dive into the initial response to COVID-19. It sought to understand how well the Aboriginal and Torres Strait Islander PHC system responded to the COVID-19 pandemic and to consider which features of the response should be maintained or extended. This was a point-in-time review of the initial months of the pandemic and excludes the COVID-19 vaccine roll-out. The review was undertaken between June and August 2021. The response to the COVID-19 pandemic in Australia and internationally has been unprecedented and has had a significant impact on the health sector and people's health and wellbeing.

The methodology for this collaborative sat within the broader mixed methods design for the evaluation. The following methods and data sources were used:

- Document analysis and targeted literature search and review.
- Qualitative data gathered in semi-structured stakeholder interviews.

Interview participants were primarily, members of the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 (the Advisory Group). Purposive sampling was used to identify stakeholders who could provide perspectives from Australian, state and territory governments, and from the community-controlled sector. The timeframe and stakeholder availability necessitated a targeted approach. Participation was opt-in based on an invitation sent out through the Advisory Group secretariat, and follow-up invitations to target members who offered a range of perspectives on the Aboriginal and Torres Strait Islander PHC system response to COVID-19. The collaborative was relatively small in size with low participant numbers due to the demands of the COVID-19 pandemic response at the time (see Table C-8).

The findings were interpreted with the limited sample in mind. Nonetheless, in combination with the extensive documents and literature review, the collaborative provided important insights that contributed to COVID-19 response and recovery planning and broader agendas for strengthening comprehensive PHC. The collaborative report was shared with participants in November 2021, notably, as the Omicron variant was spreading rapidly, and the response had shifted focus to the vaccine rollout. The Department of Health and Aged Care elected not to disseminate this report.

Table C-8: Count of participants in Collaborative 1, by setting and indigeneity

Perspective	Number of interviews	Number of Aboriginal or Torres Strait Islander participants
Community-controlled sector	6	3
Australian Government Department of Health and Aged Care	2	1
State or territory health department	2	2
Total	**10**	**6**

C 3.3.5.2 Collaborative 2: Aboriginal and Torres Strait Islander Health Workers and Practitioners Training Pipeline

A critical realist approach (Danermark, 2019) was used to research the context, structure, and mechanisms that influence training pipelines, and support the development of solutions to address workforce demand. Multiple data sources and analytic methods were used, including secondary analysis of site, state and territory, and national interview data from Cycle 1 of the evaluation. An environmental scan was undertaken to inform mapping of training pipelines, and a synthesis of existing literature drew on the large body of work already undertaken. Sampling supported the identification of relevant stakeholders beyond the health sector for interview. Sense-making was undertaken during meetings of the evaluation team members and with stakeholders.

This cross-cutting collaborative utilised:

- interviews with community members, site partners, state and national participants.
- an environment scan of government, registered training organisations, and other stakeholders' websites.
- interviews and discussions with the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP); NSW Department of Education; WA Department of Training and Workforce Development; and SA Department of Innovation and Skills.

C 3.3.5.3 Collaborative 3: Adapting and validating a tool to identify, measure and monitor institutional racism in PHNs

This collaborative adopted the definition of institutional racism developed by the Queensland Aboriginal and Islander Health Council and Queensland Health for regulatory changes to support health equity.

Figure C-4: Definition of Institutional Racism (Queensland Aboriginal and Islander Health Council & State of Queensland (Queensland Health), 2021, p. 26)

What is institutional racism?

For the purpose of the proposed Regulation, institutional racism is defined as ways in which racist beliefs, attitudes or values have arisen within or are built into the operations, legislation and/or policies of an institution in such a way that discriminates against, controls or oppresses, directly or indirectly, a certain group of people to limit their rights; causing and/or contributing to inherited disadvantage.

Identification of tool: A review of the literature established the current understanding and approaches to identifying and addressing institutional racism. Consultations were undertaken to assess the suitability of an existing tool for adaptation to the PHN context. The consultations also considered the different roles of PHNs compared to state-level health organisations and the nature of institutional racism in PHNs' organisational processes. A policy scan identified the boundaries and restrictions from legislation and operational guidelines on PHN operations including the ability to undertake transformation. Site partners engaged through online webinars that provided information on the tool. A recording of the webinar is available to site partners via online registration on an ongoing basis.

Adaptation: An expert working group of Aboriginal and Torres Strait Islander academics and health system leaders with expertise and experience relevant to institutional racism was assembled to undertake the adaptation of the tool (Table C-9). This adaptation occurred during a one-day workshop held in May 2022 in Gimuy (Cairns), with some group members participating via online conferencing. A non-Indigenous evaluation team member facilitated the workshop. The workshop was supported by Mr Adrian Marrie one of the authors of the original tool and its South Australian adaptation. In addition, one of the expert working group members for the modified tool (Dr Chris Bourke), led the South Australian adaptation of the original tool.

Table C-9: Expert working group members

Expert working group		
Leeroy Bilney Tullawon Health Service	Dallas Leon West Queensland PHN	Sarina Solar Evaluation team
Dr Chris Bourke CSIRO	Pauline Nolan Murray PHN	Prof James Ward Poche Centre University of Queensland
Rebecca Colbung South-West Aboriginal Medical Service	Francis Nona University of Queensland	Dr Mark Wenitong Lowitja Institute
Ali Drummond CATSINaM	Prof Yin Paradies Deakin University	Adrian Marrie Bukal Consultancy Services
Dr Summer May Finlay University of Wollongong	Dr Carmen Parter Poche Centre University of Queensland	Prof Roxanne Bainbridge Evaluation team

The adaptation of the tool followed that of the South Australian (Health Performance Council & Government of South Australia, 2019). The foundational concepts of institutional racism were familiarised with the experts before they co-designed the adaptation through group discussion. Due to time limitations, some wording and scoring of criteria and sub-criteria were not completed during the workshop. These were completed by two non-Indigenous evaluation team members and Mr Marrie using notes and a transcript from the workshop. A prototype tool was then shared with the expert working group for feedback.

Validation: The prototype tool was shared with site partners (ACCHSs, PHNs) to provide feedback to validate the tool. Participants considered the content, wording, and weighting of criteria and sub-criteria scores. Feedback was provided during two online workshops and individual correspondence or discussion with the evaluation team. Consolidated feedback and potential amendments were then circulated to the expert working group for consideration and agreement.

The evaluation team used the adapted and validated tool to examine the nature of institutional racism in PHNs. The tool comprised of a scoring system against five key organisational indicators based on both theoretical (Hamilton & Ture, 1992) and empirical (Came, 2014) studies of institutional racism. The indicators are:

1. participation in governance
2. policy implementation
3. service delivery and partnerships
4. recruitment and employment
5. financial accountability and reporting.

Applying the tool involved an in-depth document analysis, that required scanning through and identifying all publicly available documents and website materials related to the indicators from each PHNs. The evaluation team then allocated a score and summary for each PHN indicating how they performed in relation to the five key organisational indicators.

The results were shared back with PHNs through individual feedback sessions. This work contributed to addressing KEQ1 and 4 of the evaluation. For KEQ1, it contributed to identifying how PHC systems were oriented to Aboriginal and Torres Strait Islander cultures and accountable for Aboriginal and Torres Strait Islander involvement in system design, planning and decisions about the delivery of PHC. For KEQ4 it contributed to how greater progress can be made to achieve system reform.

C 3.3.5.4 Collaborative 4: Understanding health needs

Multiple methods to identify conceptualisations of health needs were used from the literature and primary qualitative data collected across the evaluation. A workshop with site partners was held for sense-checking and identification of recommendations to operationalise health needs assessment (HNA) for Aboriginal and Torres Strait Islander people. The literature review used a hermeneutic process (Boell & Cecez-Kecmanovic, 2014; Greenhalgh et al., 2017) to build on understanding from existing systematic reviews of health needs analysis processes (Bucci, 2022; Langham et al., 2019; Ravaghi et al., 2023) with Aboriginal and Torres Strait Islander perspectives and voices consistent with the decolonising approach of the evaluation (Bainbridge et al., 2020a).

An analysis of the qualitative evaluation data collected to date was then conducted. The data came from 217 sources. Sources included 69 consumer yarns (collective or individual), 42 interviews with health service managers, 19 yarns with health workers and other service staff, 31 interviews with PHN staff, 10 interviews with peak bodies, 23 interviews with government staff (state, territory, and Australian governments), and 23 workshops with combined attendees. Data were coded using a hybrid method of initial deductive coding to identify any data that related to health needs in terms of conceptualisation, identification, measurement, or HNA processes. The evaluation team then used inductive and relational coding to support an abductive analytic process (Timmermans & Tavory, 2012). Initial findings were discussed between the evaluation team, then workshopped with 47 site partners and stakeholders for sense-checking and developing recommendations.

C 3.3.5.5 Collaborative 5: Improving the PHC data environment

Multiple methods were used to identify and examine issues and potential solutions relating to the PHC data environment from evaluation data and literature. Data from interviews which had already been conducted across the three evaluation cycles was analysed. This involved coding of 168 data sources to identify references to the data ecosystem, beyond discussion of reporting burden and issues specific to the IAHP data ecosystem. The sources analysed included 68 semi-structured interviews with ACCHS managers and staff, 28 semi-structured interviews with PHN managers and staff, 20 semi-structured interviews with peak bodies, 28 semi-structured interviews with government staff (state, territory, and Australian governments) and 24 workshops with combined attendees (including, for example, CA4C workshops and sense-making workshops). Data were extracted from 98 sources and coded using a hybrid method of initial deductive coding to identify any data related to current limitations and constraints with the PHC data environment as well as any potential solutions or recommendations for addressing them. Inductive and relational coding was then utilised to support an abductive analytic process (Timmermans & Tavory, 2012).

Semi-structured interviews were held with staff from the AIHW and NIAA. These interviews focused on discussion of potential improvements to the PHC data environment within the context of current PHC data reforms, including the development of the National Primary Health Care Data Collection.

A process analysis, building on the initial Design Specification Extraction Assessment (DSEA) (Doran et al., 2020) was conducted to examine the use of current PHC and related datasets to evaluate the IAHP. The experience of limitations of routinely collected datasets relevant to Indigenous health were examined to determine how they reflect issues in the PHC data environment more broadly. Finally, a rapid review of recent (2021-2022) research in Aboriginal and Torres Strait Islander health that utilised PHC or related datasets was undertaken to identify the reported strengths and limitations of utilising this data to develop evidence.

C 3.3.6 Integrated care project

As part of the evaluation, a research project in Cycle 3 focused on the design of the care processes and the identification of elements needed to support integrated care models that are valued by Aboriginal and Torres Strait Islander people in comprehensive PHC. This included developing a framework that reflects the identified foundations, principles, processes and elements of value-based integrated care for Aboriginal and Torres Strait Islander people. The definition of integrated care was '*an organising principle for care delivery with the aim of achieving improved patient care and system efficiencies through better coordination of services'*.

The aim of this project was to build understanding of integrated care as a significant concept in designing and delivering care across the primary, secondary and tertiary care systems for Aboriginal and Torres Strait Islander people.

The objectives of the project were to:

1. Produce a value-based framework for integrated care for Aboriginal and Torres Strait Islander people.
2. Develop policy/funding and practice/operational lessons for the implementation of value-based integrated care in Aboriginal and Torres Strait Islander comprehensive primary health care (PHC).

In support of these objectives, the project would:

1. Reflect outcomes that matter for Aboriginal and Torres Strait Islander people and communities (be values-based).
2. Assess integrated care processes and practices at the client, health service and regional level, including:
    - identify current organisational models and universal domains for integrated care that are adaptable across contexts

- identify the key characteristics that enable integrated care processes and practices that lead to positive patient experiences and care outcomes
  - describe the effectiveness of the models, including identifying where the best evidence lies
  - identify implementation lessons at policy and practice levels
  - use international best practice evidence to fill gaps in current local practice.

The framework and implementation considerations identified through this project may be used to inform the design of integrated care processes and pathways in comprehensive PHC that are valued by Aboriginal and Torres Strait Islander people.

C 3.3.6.1 Data sources

Evidence was synthesised across three data sources:

1. Existing research literature on integrated care was reviewed to understand the key domains and characteristics of integrated care.
2. Existing evidence generated through community engagement in the IAHP evaluation on what people value about health service design and delivery and on how they experience the health system was synthesised to ensure the development of an integrated care framework reflects what is important to Aboriginal and Torres Strait Islander people. This data source comprised of transcripts and notes from yarns and interviews with 452 community members.
3. Existing evidence relevant to integrated care generated through interviews with service providers and PHNs through the IAHP evaluation. This data source comprised of transcripts and notes from interviews with 140 health service staff (who were primarily working in ACCHSs) and 71 PHN staff.

These latter two data sources were used to understand convergence and divergence with the findings of the literature review.

C 3.3.6.2 Method for the literature review of integrated care

The literature review involved an umbrella review to synthesise evidence from multiple existing reviews. The umbrella review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2015).

The review provides the most up-to-date evidence on the components of integrated health care. Peer-reviewed literature was searched for relevant documents. An accredited university librarian helped identify the databases and search strings to identify papers from the peer-reviewed literature. The librarian also conducted an exploratory and final search and provided an overview of the search strings and results as of 21 March 2023 (see Integrated Care report, Appendix B). The exploratory search with Indigenous nations in its search terms yielded only one review paper of relevance, so the search was expanded to include the general population.

C 3.3.6.3 Inclusion/exclusion criteria

Eligible publications required:

- Publication between 2000 and 2023.
- Publication in English.
- A focus on understanding and reporting on the elements of integrated health care in high-income countries with an Indigenous population, including Canada, Australia, New Zealand and the United States (CANZUS).
- A focus on integrated care as a holistic concept to align with Aboriginal and Torres Strait Islander people's understanding of health.

Ineligible publications included those focused on individual health issues, such as diabetes, mental health.

C 3.3.6.4 Data extraction

Included reviews were conceptually mined for the following components: author, publication year, title, brief description, aim, study design, number of papers included in the review, findings and implications. The characteristics and elements of integrated care relevant to the research were also extracted.

C 3.3.6.5 Search results

In total, 969 references were identified. Publications were excluded if they: (1) were duplicates (n=360); or (2) did not pertain to the inclusion/exclusion criteria in the abstract of journal articles (n=562). In all, 922 references were excluded, leaving 47 references for full-text assessment. Out of 47 full-text articles, 38 were excluded because they were: (1) not in scope (n = 26); (2) wrong setting (n = 11); and (3) wrong design (n=1). The final analysis and synthesis included 9 review publications. See Appendix C for PRISMA flow chart which records the literature search process.

Of the 9 reviews:

- one focused on whether integrated care is effective or culturally appropriate for Indigenous populations in the United States (Lewis et al., 2018)
- one explored integrated care with a population health focus (Burdett et al., 2021)
- one centred on organisational strategies for integrated care to bridge the gap between biomedical doctors and other disciplinary practitioners (Chung et al., 2012)
- one explored the education needs of the integrated care workforce (Howarth et al., 2006)
- one identified the barriers to, and facilitators of, integrating primary and specialist health care (Kozlowska et al., 2018)
- one focused on the transformation of PHC to a more holistic integrated model (Miller et al., 2018)

- one explored governance models for integrated care (Nicholson et al., 2013)
- one sought to make existing care coordination theoretical frameworks more accessible (Peterson et al., 2019)
- one examined the nature of health systems integration strategies (Saunders & Carter, 2017).

C 3.3.6.6 Summary of findings

Many of the features of integrated care identified in the literature review align with what Aboriginal and Torres Strait Islander people value in health care and are designed to address some of the issues that contribute to poor experiences of the heath system. This includes features of health care integration at a local level such as adapting care to context, focusing on holistic approaches to care, and taking a population and preventive health approach. This also includes features of integrated care that operate at professional and organisational levels, including the need for multidisciplinary team-based approaches to health care and the need to ensure coordination or care and continuity of care across health care settings, particularly from primary to specialist care.

Other features of integrated care identified in the literature function at a health system level, including the integration of information and communication systems and funding and payment systems to enable and incentivise the delivery of integrated care.

Based on the literature review and evaluation findings, a set of domains and associated principles or outcomes was developed to inform an integrated care framework for Aboriginal and Torres Strait Islander people. Many of the principles/outcomes identified relate to the need to partner with and empower local communities to be partners in health care. Other outcomes relate to adapting models of care to be more responsive to Aboriginal and Torres Strait Islander people's holistic health care needs. Notably, the model of Aboriginal and Torres Strait Islander community-controlled comprehensive PHC is aligned to an integrated model of care. Finally, other outcomes relate to creating an enabling environment for integrated care.

The literature review identified limited guidance on how to implement integrated care in practice. However, lessons for the implementation of integrated care and actions required at different levels of the health care system to create the enabling environment for integrated care were identified from the literature.

Managing the changes required at multiple levels of the health system to transition to integrated care can be complex and it can take time. The research report concluded by noting that the current ambition in PHC policy frameworks is matched by the aspirations of many of the ACCHSs and PHNs that partnered in the evaluation.

C 3.4 Qualitative methods of analysis

Different analytic methods were applied to different types of data and according to purpose and usage. The following indicates the analytic methods used for the various qualitative data generated.

All primary qualitative data were confidential to the evaluation team. As part of the secure storage of all notes and transcripts from the group yarns, interviews, and workshops, the interview recordings and transcripts were allocated a code along with the removal of identifying individual and site details. The code was only available to nominated analytical members of the evaluation team, who needed to (1) analyse the qualitative data in relation to the context and (2) ensure the reported analysis and findings does not lead to the reidentification of individuals or adversely impact on services and other organisations. When de-identified, all data were loaded into NVivo for coding. Miro board was also used as an analytical tool, being specifically useful for system mapping exercises, high-level analysis, visualisation and online collaboration.[13]

C 3.4.1 Grounded theory analysis

An inductive grounded theory methodology inspired the overarching analytical approach. Grounded theory is a systems method of analysis, designed to explore and understand the nature and occurrence of complex social phenomenon (Bainbridge et al., 2019). The approach ensures that the values, preferences and priorities of participants are reflected and ground the evaluation, captures Indigenous voices, and makes transparent the process of development and model generation from verbatim concepts. It also ensures that explanations are developed ‘from the ground up’ and not based on a priori assumptions.

This approach was used to identify codes and categories, with memos used to capture important insights. Constant comparative methods enabled exploration of issues to establish points of consensus and dissent and to saturate categories. Throughout the analytic process questions were asked like, what power is in this situation and under what specific conditions is it enabled/enacted? How is it manifested, by whom, when, where, how, with what consequences (and for whom or what)? And with what intensity? (Flyvbjerg, 2001).

Data segments in the initial coding were larger than normal for grounded theory, representing incident, foci, or discursive junctions.

C 3.4.2 Situational analysis

Analysis of community yarns and interviews with ACCHS staff members was undertaken predominantly using situational analysis, a relational form of grounded theory (Clarke et al., 2017). Situational analysis grounds the analysis in the broader situation of the inquiry, centres on social processes, incorporates non-human actors, manages complexity, and seeks

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[13] Miro is a digital whiteboard that makes it easy to collaborate online with others. The software allows you to create notes and designs, move things around, and communicate through embedded video calls or online chats. With the evaluation team working from different locations, Miro provided a successful way to communicate, share findings and collaborate during the analysis process.

differences or absent positions within the data. Situational analysis is an optimal method to understand the ecology of what Aboriginal and Torres Strait Islander people value in health service delivery and design because of the inseparability of knowledge from the socio-cultural, historical, and political situations in which it is created.

Data generated from the Aboriginal and Torres Strait Islander community yarns, patient experience journey interviews and Indigenous ACCHS staff member yarns were used to address the question of '*what Aboriginal and Torres Strait Islander people value in terms of health service design and delivery'*. The community yarns and patient experience journey interviews were the primary data sources, whilst data from the staff member yarns were used to provide explanatory or confirmatory power to the analysis.

To address the research question, it was important to analyse the data from the community yarns and patient journey experience interviews beyond a descriptive laundry list of what people liked or disliked in terms of service delivery and design. The data generated included people's explicit statements of what they valued, the use of rich experiential narrative that provides context, and interactive dialogue that creates meaning from the evidence being shared within the yarn.

Data were familiarised through a close reading of the transcripts, listening to the recording, and discussions at weekly team meetings. The transcript was then uploaded into NVivo to facilitate analysis. Data were initially inductively coded using an adapted Schema analysis (Rapport et al., 2019). This approach was appropriate for the research question because it supports identifying key elements of the data before interpretation of those elements occurs (Rapport et al., 2019). Each transcript was coded in larger fragments (or 'chunks') reflecting segments or incidents rather than individual lines. Data interrogation was conducted by asking, 'what does this tell us about what the community values in primary health service design or delivery?' This approach supported the summative nature of Schema analysis and ensured that the codes generated were neutral statements of what is valued. This position of neutrality distinguishes this analysis to examine what is valued from what is experienced in health service design and delivery.

Coding was done by a non-Indigenous team member and checked with the Aboriginal site coordinators and discussed during weekly meetings. This process was an adapted form of developing group or meta-schemas. Codes from each group yarn were visualised to provide feedback to contributing knowledge-holders in group yarns in Cycle 1. The codes were written as shorter labels using more accessible language in consultation with the Aboriginal site coordinators and organised to reflect some of the initial relationships identified between them in the data.

Situational analysis analytic mapping tools were then employed to progress the analysis. Situational analysis focuses on mapping relational ecologies and positional analysis to examine complexity, power relations, and specify differences using cartographic tools to map the elements of a situation and prompt the analyst to reflect on the nature of the relationship between the elements (Clarke et al., 2017). Data were analysed using social worlds maps, positional maps (Clarke et al., 2017) and abductive processes of revisiting the phenomenon, defamiliarization, and alternative casing (Timmermans & Tavory, 2012) to refine the codes into concepts. During this part of the analytic process questions were asked like, 'what are the conditions in which this is enabled/enacted?', 'what are the mechanisms of power in this situation? And 'how does this manifest and under what conditions?' (Flyvbjerg, 2001). Further coding and mapping were undertaken to examine and capture the relational nature of the concepts and develop them into a framework. The relational analysis goes beyond traditional cause-effect or process maps and provides a systematic, coherent, and provocative way to understand the situation and its complexity (Moreton-Robinson, 2017) The analysis also considered any divergence between sites and the dynamic nature of the health system.

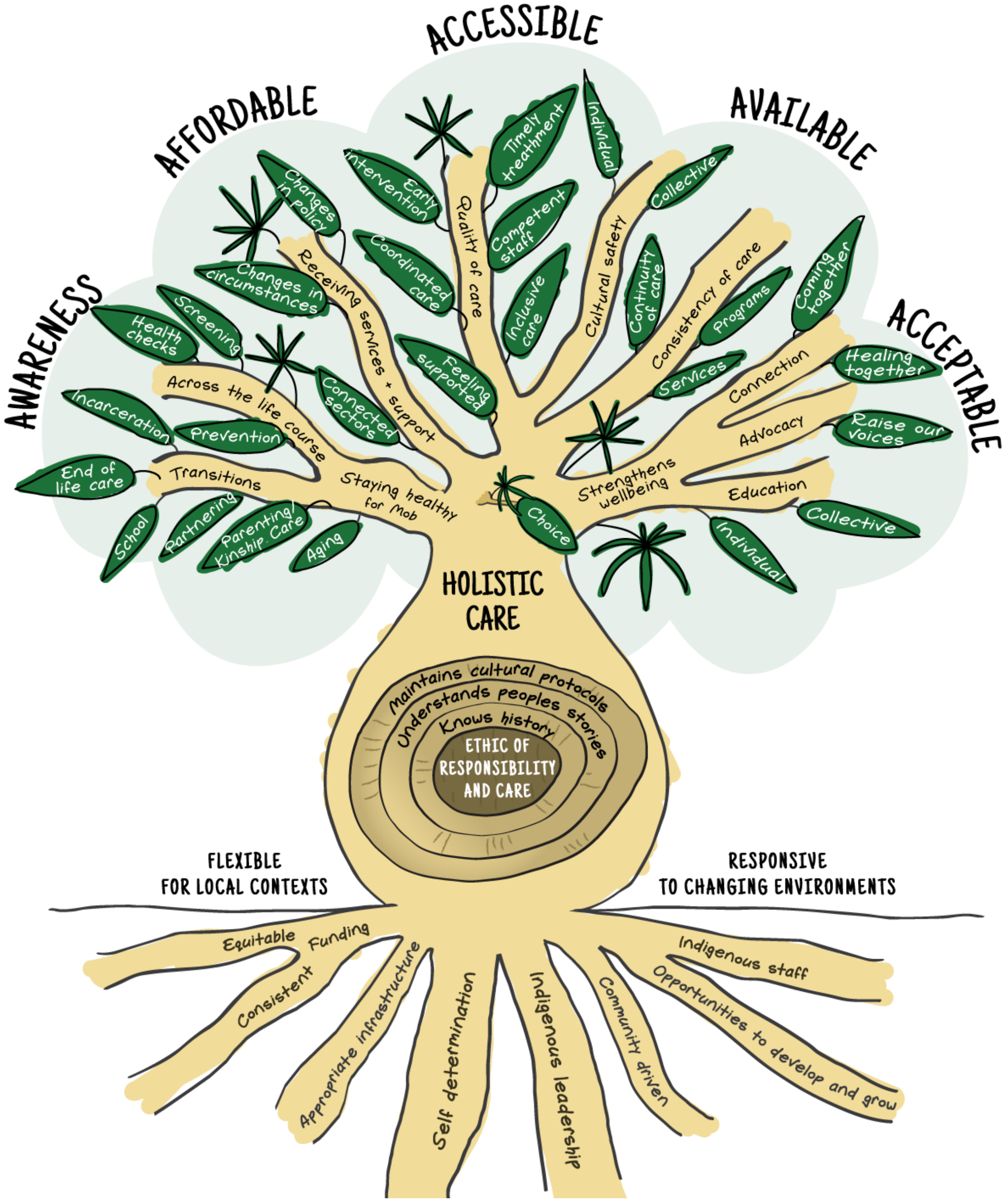
C 3.4.3 The Babuny model – using system mapping and explanatory metaphors

The framework of what Aboriginal and Torres Strait Islander people value in health service design and delivery is visualised using the pictorial conceptual metaphor (Fredericks et al 2015) of a tree. Metaphor is consistent with Indigenous epistemologies, provides greater explanatory value of relationships between concepts than box and arrow diagrams, and is a way of sharing social knowledge (Moreton-Robinson 2017, p.16-18). Trees share several valuable characteristics consistent with primary health services. The framework uses the metaphor of the bottle tree, Brachychiton rupestris or Babuny. The bottle tree has medicinal properties (Thabet et al 2018) and specific characteristics (Reynolds et al., 2018) that reflect important elements of what Aboriginal and Torres Strait Islander people value in health service design and delivery. The framework is illustrated in Figure C-5, below.

A bottle tree represents a dynamic system connected to, and part of, place. It transforms its resources, such as water and nutrients, to create shelter and other resources. It supports the survival of other entities and creates growth and wellbeing of individuals and the landscape by returning resources to it. Similarly, Aboriginal and Torres Strait Islander knowledge-holders stated a good quality health service should connect to and be part of the communities it serves. Drawing on the resources available, a health service should provide spaces, programs, and services where individual and collective wellness is supported, creating stronger communities, and strengthening health determinants. The appropriateness of the tree metaphor for the framework was supported by community knowledge holders who provided feedback. Trees have always been places to access resources, shelter and gather, as one elder stated:

> And trees are good. I believe with trees. Trees can help you with birthing. They grow and they're grounding, and they help support you when you need them.
>
> **Aboriginal elder**

Figure C-5: Babuny framework, illustrating what Aboriginal and Torres Strait Islander participants value in health service design and delivery



Mapping the elements of what is valued in health service design and delivery and analysing their relationship identified the importance of the interaction and dependence between the elements. Western dominant approaches of categories and themes or system mapping did not reflect the nature of the relationships between the elements. Previous work by Indigenous scholars, Harfield et al. (2018) and Garvey et al. (Garvey, Anderson, Gall, Butler, Cunningham, et al., 2021; Garvey, Anderson, Gall, Butler, Whop, et al., 2021), conceptualised these types of relationships using metaphors of weaving to reflect the importance of interaction. Ongoing, reflective discussions between the Principal Investigator, the analyst, and an external Gungarri academic led to the explanatory metaphor used for the resultant framework.

The Babuny model provides a relational, summative, and inductive representation of what Aboriginal and Torres Strait Islander people value in PHC service design and delivery. The model was developed on the basis of data generated in Cycle 1 of the evaluation and tested and refined using abductive analytic cycles (Strübing, 2007), through further data generation and consultation with communities and site partners during subsequent cycles. The analyst engaged in ongoing dialogue with the Aboriginal site leads and the Principal Investigator and prioritised Aboriginal and Torres Strait Islander theories throughout this process to ensure that Aboriginal and Torres Strait Islander world views were embedded in the resultant framework.

C 3.4.4 Content analysis and top-line summaries

The evaluation team also applied a more deductive method of analysis – content analysis (Downe-Wambolt, 1992), which was guided by the interview guides and KEQs and aimed to produce top-line summaries.

Content analysis is a framework approach based on pre-set codes and analytical structure (e.g. developed from research questions or interview topics). This approach to analysis facilitates both descriptive and interpretive content, focussing on the subject and context whilst emphasising variation (Graneheim et al., 2017).

The evaluation analyst team used this method when analysing interviews with health service managers, PHN managers, state and territory and national organisations, and CA4C workshops.

This analysis process evolved primarily during Cycle 1 in response to the need to return summaries of top-line findings to participants and other stakeholders. It was undertaken by five non-Indigenous analysts, although three did the majority of the work. Interview transcripts were initially summarised using pre-organised templates created on the basis of the KEQs. Summaries were circulated to the site evaluation leads and other team members who had been present at the interviews, along with a copy of the full transcript for checking. Summaries and transcripts were then sent to participants and their feedback was later incorporated into the summaries and the analysis process.

The interviews and summaries of top-line findings were then analysed further, collating common themes, issues and targeted content associated with each evaluation question. As part of this process, headlines were developed for each interview, with relevant textual data (evidence and explanation) underneath. The headlines for all sites were then grouped together by evaluation question. Cross referencing occurred to track backward or forward from the data to the findings.

This method was helpful for developing presentations and engagement material for the collective action for change workshops and sense-making workshops with sites, where the evaluation team needed to share emerging findings and get participants involved in the sense-making process.

Moreover, content analysis and the use of top-line summaries were suitable for analysing the data generated through the various site-based and cross-site workshops, as these engagement activities often required a follow up summary report to be shared with participants. These reports were later integrated into the broader sense-making process and analysed in further depth from a more inductive approach (for example, through the contribution analysis – see section C 4.3).

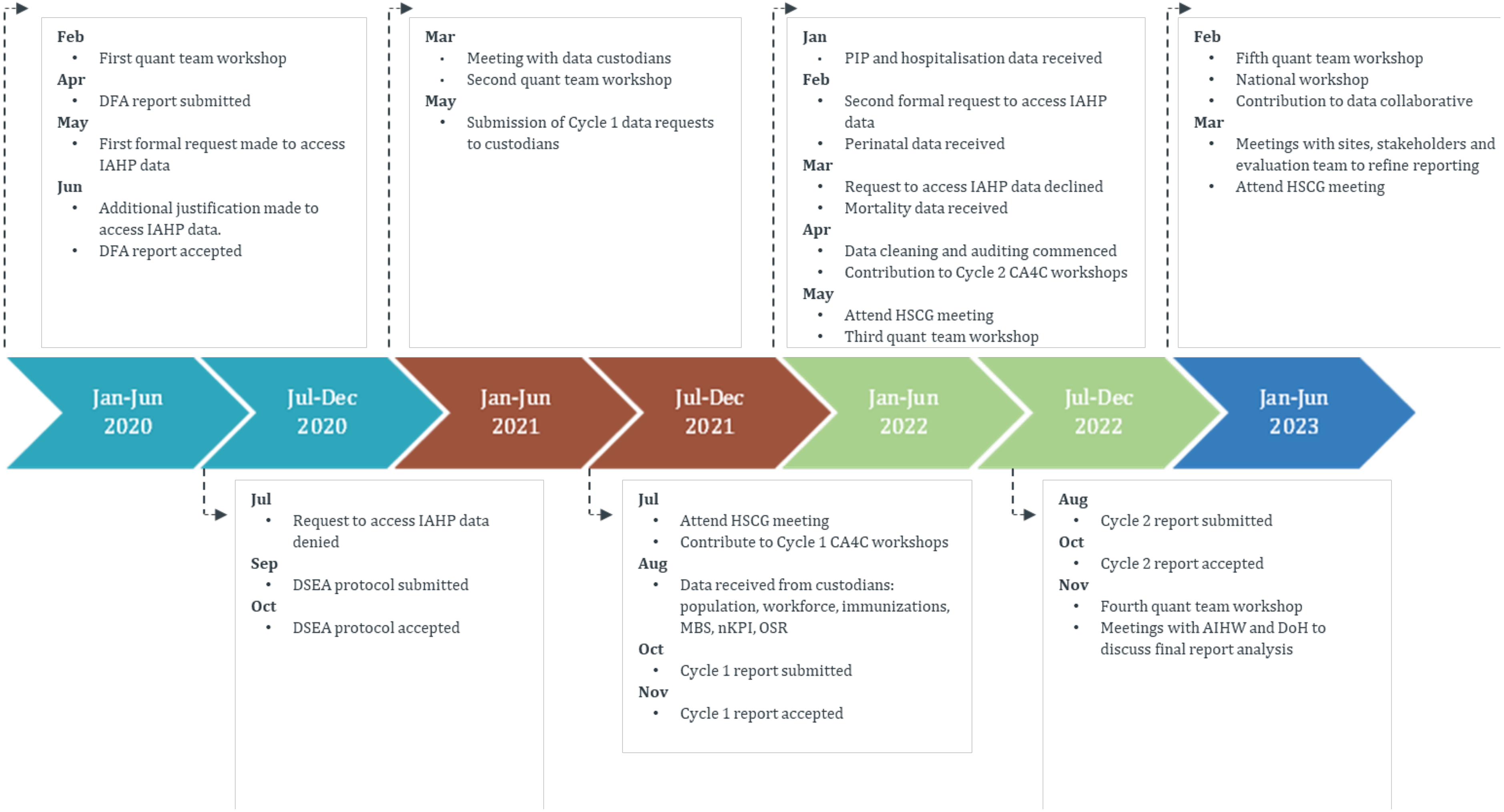
For the national workshop conducted in Cycle 3 (see section C 4.2.1), a graphic scriber was used to visually capture discussion headlines and summarise the meeting outcomes in a more engaging and easily accessible way.

C 3.5 Quantitative data collection methods

A multi-disciplinary quantitative project team, led by Prof Chris Doran from Central Queensland University, was subcontracted to support the evaluation by providing quantitative data analysis to inform the KEQs. This section provides an overview of the quantitative methods that contributed to Cycle 1 and Cycle 2 reporting, and provides additional analyses related to the Cycle 3 activities.

A summary of the key activities and milestones associated with the quantitative data analysis is shown in Figure C-6.

Figure C-6: Summary of key activities and milestones for the quantitative data analysis



Jan-Jun 2020

Feb
- First quant team workshop

Apr
- DFA report submitted

May
- First formal request made to access IAHP data

Jun
- Additional justification made to access IAHP data.
- DFA report accepted

Jul-Dec 2020

Jul
- Request to access IAHP data denied

Sep
- DSEA protocol submitted

Oct
- DSEA protocol accepted

Jan-Jun 2021

Mar
- Meeting with data custodians
- Second quant team workshop

May
- Submission of Cycle 1 data requests to custodians

Jul-Dec 2021

Jul
- Attend HSCG meeting
- Contribute to Cycle 1 CA4C workshops

Aug
- Data received from custodians: population, workforce, immunizations, MBS, nKPI, OSR

Oct
- Cycle 1 report submitted

Nov
- Cycle 1 report accepted

Jan-Jun 2022

Jan
- PIP and hospitalisation data received

Feb
- Second formal request to access IAHP data
- Perinatal data received

Mar
- Request to access IAHP data declined
- Mortality data received

Apr
- Data cleaning and auditing commenced
- Contribution to Cycle 2 CA4C workshops

May
- Attend HSCG meeting
- Third quant team workshop

Jul-Dec 2022

Aug
- Cycle 2 report submitted

Oct
- Cycle 2 report accepted

Nov
- Fourth quant team workshop
- Meetings with AIHW and DoH to discuss final report analysis

Jan-Jun 2023

Feb
- Fifth quant team workshop
- National workshop
- Contribution to data collaborative

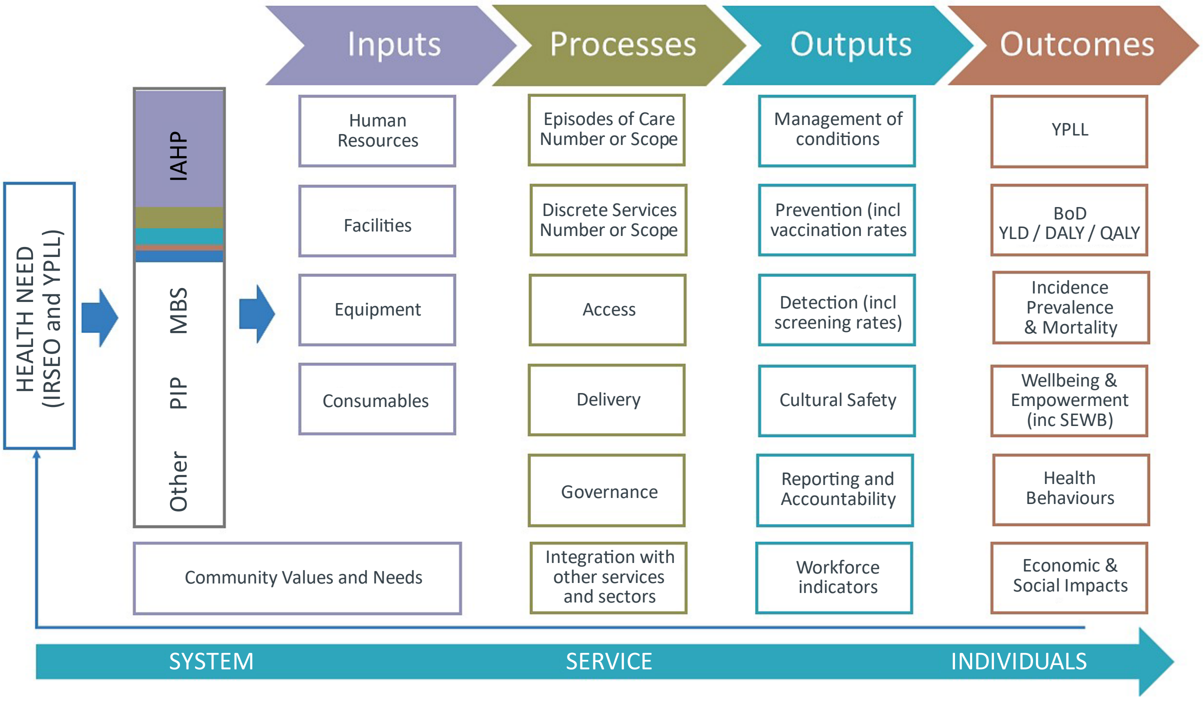
Mar
- Meetings with sites, stakeholders and evaluation team to refine reporting
- Attend HSCG meeting

C 3.5.1 Data feasibility assessment

The first task was to systematically determine which routinely collected data sets were suitable for use in the evaluation. This systematic assessment occurred through the data feasibility assessment (DFA).

A conceptual causal framework was developed to guide the DFA (Figure C-7). The framework operationalised the constructs and relationships from the IAHP logic model relevant to the evaluation. The framework was developed through the identification and mapping of key constructs, indicators, and assumptions inherent in the IAHP logic and funding models (**Appendix E: IAHP program theory and logic** and **Appendix F: IAHP Primary Health Care program**), the Health Performance Framework (HPF)[14] and the KEQs.

Figure C-7: DFA Conceptual Framework, V1.1



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[14] www.indigenoushpf.gov.au

An environmental scan was undertaken to identify and consider extant and in-development data sets. Five strategies were utilised to maximise the potential data sources identified, and to ensure the relevance and comparability of evaluation findings.

1. An examination of the evaluation documents, including materials provided by the department in relation to the IAHP.
2. Data sources used for the Aboriginal and Torres Strait Islander Health Performance Framework were captured.
3. A systematic interrogation of key data custodian sources was undertaken. This included the Australian Bureau of Statistics (ABS), the AIHW and the department.
4. A series of face-to-face and telephone meetings were conducted to identify any additional data sources that had not already been identified. This consultation was with representatives from the Department of Health and Aged Care (including the First Nations Health Division), the HSCG, the AIHW, the ABS, and other data experts. In addition to the identification of potential data sets, issues relating to the process, timeframes, costs, and security requirements of access were discussed.
5. Expert consultation was undertaken to draw on the knowledge and networks of the broader data assessment team to support data identification and quality assessment.

Five assessment criteria were developed and applied to each identified data source to determine fitness for purpose for use in the evaluation:

1. Relevance in addressing the five KEQs.
2. Relevance to Aboriginal or Torres Strait Islander people.
3. Geography.
4. Timeliness.
5. Demographic characteristics.

Based on these criteria, each dataset was given an overall rating as fit for purpose, not fit for purpose, or conditionally fit for purpose. Each dataset rated as fit for purpose was also assessed according to its accessibility for utilisation according to the following three categories: publicly available, available via special request from the data custodian, or accessible via secure access through a data platform.

A total of 79 data sources were identified. Data sources reported data relevant to measuring health status and outcomes (n=31), health system performance (n=29), and determinants of health (n=9), or a combination of these outcomes (n=10). Forty-seven data sources were assessed as fit for purpose unconditionally, and 32 were assessed as fit for purpose conditionally. Fourteen data sources were publicly available; 21 required a special request; and 2 sources (Indigenous Advancement Strategy and the National Indigenous Reform Agreement) required further investigation.

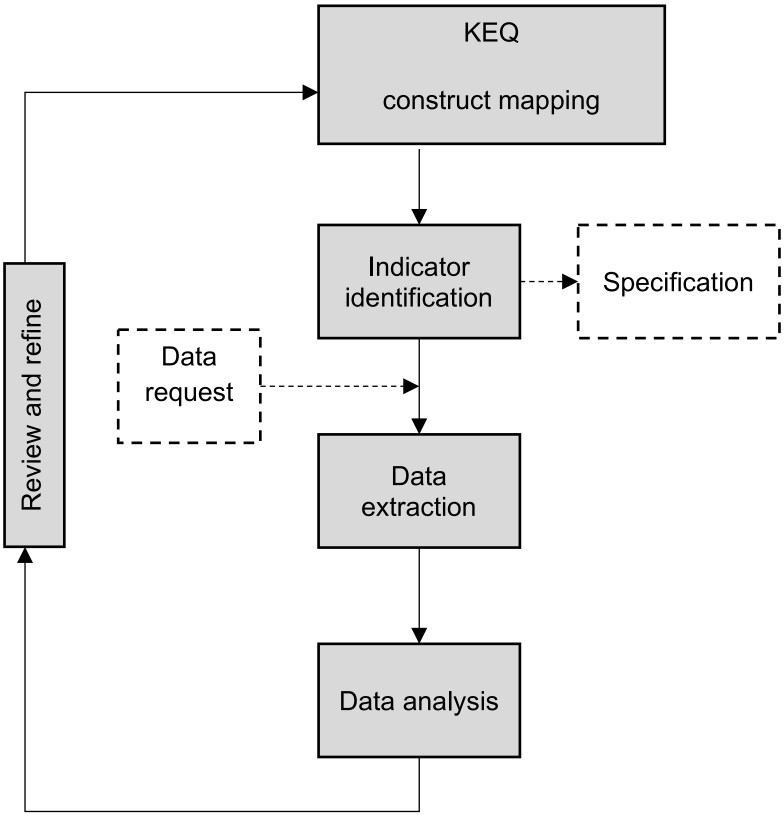
C 3.5.2 Data Specification Extraction and Analysis

Upon agreement of the initial set of data indicators and sources (the outcomes of the DFA), the evaluation team developed a data specification extraction and analysis (DSEA). The aims of this process were to:

- map the constructs to be operationalised as part of the analysis from the KEQs
- identify preliminary indicators to inform site engagement and co-design
- identify and commence data extraction of preliminary indicators
- to provide an initial data analysis plan to support ethics applications and co-design processes.

Figure C-8 provides an overview of this process with reference to the feedback loop involving review and refine to highlight the dynamic nature of this process. Given the substantive delays in obtaining the initial data request (see below), subsequent requests were considered as unfeasible, and a suggestion was made to utilise the available data in the best possible manner. This direction from the department resulted in the feedback loop being untenable, hence, the evaluation team were left with only one data request (as below).

Figure C-8: Overview of planned DSEA process



C 3.5.2.1 KEQ construct mapping

To support the identification of appropriate indicators and development of an analytic plan as part of a co-design process, a terminology audit was undertaken to examine the key and sub-evaluation questions for constructs that need to be defined and operationalised. In a concurrent process, graphical model representations of the analytical structure (i.e. stated or implied relationships between constructs) were developed for each question. The DSEA report provides a summary of the mapping exercise and terminology audit, noting the Graphical model formulations process.

C 3.5.2.2 PHC indicator identification

An initial evaluation of extant primary health care monitoring and reporting frameworks was undertaken. The evaluation considered the relevance of the indicators used in extant frameworks to the constructs identified in the KEQ construct mapping exercise, the consistency and comparability of the indicators used between frameworks, the appropriateness of the indicator for primary health care, and the consistency of the framework and indicators with principles of Indigenous Data Sovereignty. The frameworks examined were:

- the OSR and nKPIs due to their primacy in Aboriginal and Torres Strait Islander primary health care and alignment to broader health initiatives and health targets for Aboriginal and Torres Strait Islander people
- the Aboriginal and Torres Strait Islander HPF due to the alignment with key initiatives and targets relating to Aboriginal and Torres Strait Islander health
- the Productivity Commission Review of Services Framework for Primary Health Care
- AIHW Australia's Health indicators on PHC.

This process noted that existing frameworks for monitoring and evaluating primary health care draw on a range of data sources, often producing inconsistent findings for Aboriginal or Torres Strait Islander people due to differences in voluntary identification, collection methodologies, denominator data sources, and data cleaning. The DSEA noted a range of limitations of routinely collected data and problems associated with health outcome indicators including the capacity of primary health care services to influence the outcome, the delay between prevention activities and outcomes, and the level of sensitivity of the indicators to detect potential health gains.

C 3.5.2.3 Data extraction process

Several data sets identified by the DFA were considered pertinent and included: the Australian Childhood Immunisation Register, the Health Expenditure Database, the IAHP funding data; MBS data, nKPI data, National Health Workforce data, National Hospital Morbidity data, the National Perinatal Data Collection, OSR data, and the Practice Incentive Program Indigenous Health Incentive. An overview of the purpose, alignment with the HPF (if any), availability, variable specification, and extraction process is provided in the DSEA report. An example using nKPI data is replicated in Table C-10.

Table C-10: DSEA for nPKI data

DSEA for nPKI data	
Purpose	Data collected from the IAHP funded organisations to provide primary health services to Aboriginal and Torres Strait Islander people. Data collected under three categories: maternal and child health, preventative health, and chronic disease management.
Availability	Publicly available by Australian state and territory identifier on an annual basis through a range of media including publications, data cubes, summary tables published in electronic form, and statistics. Data by SA2 level is available by special request. Requires approval from individual ACCHSs for site-specific analysis.
HPF alignment	1-01-Low-birthweight; 3-18-Care-planning-for-chronic-diseases; 3-02-Immunisation; 2-22-Overweight-and-obesity; 3-05-Chronic-disease-management; 3-04-Early-detection-and-early-treatment; 2-21-Healthy-behaviours-during-pregnancy; 2-15-Tobacco-use; 3-01-Antenatal-care.
DSS	METeOR 715320: Indigenous primary health care NBEDS 2020-21.
Variable specification	The following variables will be extracted: Address – site name, postcode, Australian state and territory identifier; Child – fully immunised recorded indicator; Female – cervical screening indicator, hysterectomy indicator; Organisation – name type, organisation name; Person – absolute cardiovascular disease risk assessment result categories / recorded indicator, age, albumin/creatinine ratio (ACR) result, alcohol consumption status recorded indicator, AUDIT-C result, birthweight recorded indicator, blood pressure measurement result less than or equal to 130/80 mmHg indicator, blood pressure measurement result recorded indicator, body mass index / indicator, cardiovascular disease recorded indicator, chronic obstructive pulmonary disease recorded indicator, diabetes mellitus status, estimated glomerular filtration rate (eGFR) recorded indicator / result, glycosylated haemoglobin level / measurement, GP Management Plan (MBS Item 721) indicator, HDL cholesterol measurement result recorded indicator, Indigenous status, influenza immunisation indicator, MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715), microalbumin urine test result recorded indicator, regular client indicator, sex, smoking status recorded indicator, systolic blood pressure measurement result recorded indicator, Team Care Arrangement (MBS Item 723) indicator, tobacco smoking status, total cholesterol measurement result recorded indicator; Pregnancy – birth plurality, estimated duration of pregnancy at the first antenatal care visit, total completed weeks; Product of birth – birth status, birthweight; Service provider organisation – Australian state and territory identifier, day of operation, full-time equivalent staff (paid), number of service operation days (7 day period), number of service operation hours (24 hour period), number of service operation weeks (calendar year), standards assessment indicator, standards assessment level.
Extraction	SA2 level data will be requested from AIHW through a custom access request.

C 3.5.3 Ethical approval

Ethics approval for data access was obtained from the relevant ethics committees. Custom data requests were also made for eleven data sets from three data custodians as follows:

1. Department of Health and Aged Care (via a formal DRAP (Data Request Assessment Panel) process including completion of the five safes assessment template) to access:
    - IAHP funding data
    - MBS schedule data
    - National Health Workforces data
    - PIP data
    - Data recorded in the Australian Childhood Immunisation Register.
2. The Australian Institute of Health and Welfare to access:
    - National Perinatal Data Collection
    - National Hospital Morbidity
    - National Key Performance Indicator
    - Online Services Reports
3. Australian Bureau of Statistics to access:
    - Cause of death
    - Estimated Resident population.

A summary of data requested and received are provided in Table C-11.

C 3.5.4 Data access and limitations

Formal data requests to custodians were submitted in April – May 2021 following development of the DFA and DSEA plans. These datasets were intended to comprise the ‘first cut’ of available data, being the most established repositories of routinely collected data relevant to Indigenous health and the IAHP. The level of observation for initial analysis was evaluation site (ecological analysis). Findings from these analyses were intended to inform and justify subsequent, more specific data requests. Due to data related to health outcomes (hospitalisations, mortality, birthweights) not being received in full until March 2022, additional data requests were no longer feasible within project timeframes.

Limitations regarding the absence of individual-level or otherwise more detailed data would have likely been addressed by additional data requests. This applies broadly and is not specifically addressed against each dataset. The issues specified below pertain to the ecological analysis for which these datasets were originally intended. Limitations as they relate to each data source are included in Table C-11.

C 3.5.5 IAHP funding data requests

The IAHP data were requested directly from the department as it was not listed as a data source on the DRAP. The first formal request to access the IAHP funding was made in July 2020 through submission of a written request to the department using the Five Safes risk assessment template. The request to access the data were formally declined with the department expressing concerns over data accuracy. Based on recommendations from the department, a second formal request was made in February 2022. The evaluation team developed additional documentation to justify access to data which included the following statements: the IAHP funding data are needed to:

- directly answer evaluation questions, such as ‘what mix of initiatives is being funded by the IAHP?’, and ‘what does the investment in Indigenous PHC look like in practice (i.e., at sites, states and territories and at national levels of the system)?’
- contribute to the analysis of other questions to trace attribution of outcomes and changes to the IAHP, such as ‘what difference is the IAHP making to the PHC systems?’ (KEQ2), and ‘what difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?’ (KEQ3).

A scheduled meeting to discuss the data request with the department was cancelled and replaced with a meeting outlining the department’s position where it restated its concerns over quality of data pre-2018 and other reasons not specified. The department, however, agreed to provide higher-level data aggregated to the level of state and territory and national level for the period 2014-15 to 2020-21; and state and territory the IAHP grant funding data by program for the three-year financial period 2018-19 to 2020-21. A summary of these data is provided in Table C-11.

Table C-11: Summary of custom data requested, data received, and limitations of data sources

Dataset	Request method	Summary of data requested	Summary of data received	Limitations of data received
Custodian: the department				
IAHP Funding Data	Email with submission of Five Safes Assessment	The IAHP funding provided to sites over the period 2014- most recently available. Data requested conformed to 5 safes procedure and ethical clearance procedures.	• National IAHP grant funding data – 2014-15 to 2020-21 • State IAHP grant funding data – 2014-15 to 2020-21 (noting that NSW/ACT combined) • State IAHP grant funding data, by program – 2018-19 to 2020-21	No site level data received. State level data only for 3 years.
MBS data	Data request assessment panel (DRAP) form, incorporating the Five Safes Assessment	Data requested by SA3 and evaluation site for financial years 2012-13 to 2019-20 or most recently available: • Geographical area • Health assessments (items 704, 706, 708, 710, 715) • Services provided on behalf of a medical practitioner (item 10987) • Allied health services (items 81300, 81305, 81310, 81315, 81320, 81325, 81330, 81335, 81340, 81345, 81350, 81355, 81360) • Covid services (items 92004, 92011, 92016, 92023, 93048, 93061, 93200, 93202) • Chronic disease and complex care needs management and review (items 721, 723, 732; 900). • Service integration such as case conferencing (items 735, 747, 739, 750, 743, 758).	Data provided by SA3 and evaluation Site for financial years 2012-13 through 2019-20: • Estimated Indigenous Services • Estimated Indigenous Patients • Estimated Benefit Paid for allocated by: ◦ Broad Type of Service: Non-referred GP attendances; Sex; Age group; MBS Item Group; Allied health services; Chronic disease and complex care needs; management and review; Covid services; Health assessments; Service integration and case conferencing; Services provided on behalf of a medical practitioner	Estimated Indigenous Patients produces counts exceeding that of the Indigenous Estimated Population for multiple Sites. This led to reliance on Estimated Indigenous Services variable and no confidence in calculations of service coverage (for example the difference between ERP and Estimated Indigenous Patients).

Dataset	Request method	Summary of data requested	Summary of data received	Limitations of data received
		- By Group of Broad Type of Service (BTOS) using categories related to Unreferred Attendances and split Indigenous and non-Indigenous. - Indigenous status of client using the multivariate Indigenous identifier. - Sex of client. - Age of client (5-year groups, 0-4, 5-9, up to 85+).		
National Health Workforce data	DRAP	Data requested by SA3 and evaluation site for financial years 2012-13 to 2019-20 or most recently available Profession, Employment, Role, Area and Setting, Years in the workforce, Hours worked Indigenous status of health worker or practitioner (if available)	Data provided by SA3 and evaluation site by calendar years 2013 through 2019 inclusive: Total headcounts provided for profiles defined by categorical variables: PROFESSION_CODE, REGISTERED_FLAG, WORK_STATUS_A, INDIGENOUS_STATUS_AUS, SEX, Age_G, JOB1_ROLE, JOB1_AREA, JOB1_SETTING, Average_Weekly_Hrs, PROF_DIV.	JOB1_SETTING variable used to identify workforce in Aboriginal health services. Approximately 2% of records have uninterpretable numerical codes in place of text descriptions.
PIP data		Data requested by financial year, 2012-13 (or earliest year relative to PIP redesign and/or continuity of data requested) through 2019-20 or most recently available: Number of patients enrolled Number of payments received Sign-on payment Patient registration payment Tier 1 and tier 2 outcomes payment Organisation Type: if available ACCHS and / or others	Data received by SA2, SA3 and evaluation site for calendar years 2012 through 2020 inclusive: Number of payments for Practice sign-on Patient sign-on Tier 1 and Tier 2 outcomes payment	None

Dataset	Request method	Summary of data requested	Summary of data received	Limitations of data received
Australian Childhood Immunisations Register		Data requested by SA3 and evaluation site for financial years 2012-13 to 2019-20 or most recently available • Fully vaccinated at 1 year (numerator, denominator) • Fully vaccinated at 2 years (numerator, denominator) • Indigenous status of client	Data received by SA2 and SA3 and age group for calendar quarters Q3 2017 through Q2 2021 inclusive. • Counts and percentages provided for DTP, Polio, HIB, Hepatitis, MMR, Pneumonia, MenC, Varicella and Fully Immunised	No data prior to 2017. This Restricted availability for time-series analyses over the full time period of IAHP implementation.
Custodian: AIHW				
National Perinatal Data Collection			Data received by financial years 2012-13 through 2018-19 inclusive: • Liveborn babies of Indigenous mothers • Number of antenatal visits • Smoking status • Birthweight category (low, normal, high)	High number of suppressed values at discretion of custodian due to small counts or 'concerns about the quality of the data'. Birthweight data suppression at 44.6% for Sites, 68.5% for SA3. Financial years 2012-13 and 2013-14 combined with counts presented in aggregate. Data unable to be used as originally proposed for analysis.
National Hospital Morbidity data	Email with submission of data shell	Data requested by SA3 and evaluation site for financial years 2012-13 to 2019-20 • Hospital separations from the National Hospital Morbidity Database (NHMD) with any reported ICD-10-AM diagnosis, • Hospital separation by specified cause codes	Admitted patient and non-admitted emergency department number of hospitalisations by SA3 and evaluation site for financial years 2012-13 through 2019-20. Allocated by custom diagnosis groupings and Potentially Preventable Hospitalisations.	Known issue with hospitalisations for one site that may affect other areas broadly. SA2 in one site changed codes (but not name or geography) between the 2011 and 2016 versions of the ASGS. This

Dataset	Request method	Summary of data requested	Summary of data received	Limitations of data received
		- Potentially preventable hospitalisation categories as per National Health care Agreement: PI 18-Selected potentially preventable hospitalisations, 2018		change was nod back coded by AIHW- empty cells were provided until 2017 when their database switched to the 2016 ASGS. This meant there were only 3 data points for this site.
nKPI data	Email with submission of data shell	All nKPI data for relevant sites.	Data for half-yearly reporting periods June 2017 through June 2020 inclusive, by consenting Site partner organisations, aggregated to Site level for the following variables: - Maternal and child health, preventative health and chronic disease management. - Numerators and denominators for nKPI, formatted in line with publicly available reporting by AIHW.	Pre-2017 data not available. Three sites show patient populations greater than the relevant Indigenous ERP. Inability to estimate non-serviced population or service coverage by subtracting from ERP precludes more advanced analyses of health service activity. Unavailability of data prior to June 2017 precludes analyses of corresponding time periods for other health data (MBS, Immunisations, Workforce, Hospitalisations).
OSR data	Email with submission of data shell	All OSR data for relevant sites.	Subset of OSR based on advice from custodian, considering changes to OSR reporting over time. Counts for episodes of care, client contacts, client totals, FTE staff, vacant FTE staff, unpaid FTE staff by	OSR elements are relatively simple and provide limited information for analysis.

Dataset	Request method	Summary of data requested	Summary of data received	Limitations of data received
			evaluation site, including number of organisations in the site aggregate.	
Custodian: ABS				
Cause of death	Request to Department of Justice and Attorney General	Cause of death Unit Record Files by Jurisdiction for 2010-2017	Cause of Death Unit Record File for reference years 2010 through 2012 (inclusive) and 2015 through 2017 (inclusive) Selected ICD10 groupings	Known delayed time in collating mortality data in Australia. Latest reference year 2017. Reference years 2013, 2014 not available. Actual year of death fit-for-purpose up to 2015-16. Missing years precludes analyses of corresponding time periods for other health data (MBS, Immunisations, Workforce, Hospitalisations).
Estimated Resident population			Indigenous estimated resident populations count by sex and age, SA2, SA3 for 2011 and 2016.	Indigenous ERP available only for Census years at these levels of geography. Cells with ERP < 3 suppressed.

C 3.5.6 Publicly available data

Custom data requests to access routinely collected data at both state and site level had not been provided to the evaluation team in time for Cycle 1 reporting. In the absence of this data, publicly available data were retrieved from online resources to develop and test an analytic framework and reporting approach that could be applied at the state and territory level, and then utilised when site level data were available.

Data sources

Table C-12 provides an overview of the publicly available data sources used, including reporting period available, type of analysis, and limitations. The main data sources and their uses are set out below.

- The AIHW Health Performance Framework reports for 2017 and 2020 provided information related to morbidity through reported hospitalisation rates and mortality through reported rates.
- The department's Health Workforce data tool provided information related to workforce.
- Services Australia online reporting was used to provide information related to Indigenous health utilisation through MBS.
- The AIHW nKPI reporting (2021) was used to provide information related to primary care activity through nKPI data.
- Australian Government GrantConnect was used to provide information related to the IAHP funding.

Table C-12: Summary of publicly available data sources

Construct	Measure	Data Source	Times	Available
Morbidity	Hospitalisation rate	Health Performance Framework	Financial years 2011-2015 (T1), Financial years 2015-2017 (T2)	ACT, NSW, NT, Qld, SA, Tas, Vic, WA
Mortality	Mortality rate	Health Performance Framework	2011-2015, 2014-2018	NSW, NT, Qld, SA, WA
Health Workforce	Number of persons	Health Workforce Data Tool	2013 through 2019 annual	ACT, NSW, NT, Qld, SA, Tas, Vic, WA
Indigenous health utilisation	MBS (Indigenous items)– count, rate, benefit paid	Services Australia online reporting	FY 2012-13 through FY 2019-20	ACT, NSW, NT, Qld, SA, Tas, Vic, WA
Primary care activity	nKPI	AIHW nKPI reporting 2021	July 2017 through Dec 2020	NSW/ACT, NT, Qld, SA, Vic/Tas, WA
Expenditure	IAHP funding	Grant Connect	Jan 2018 through Dec 2021	NSW/ACT, NT, Qld, SA, Vic/Tas, WA

Data quality and limitations

The quality of the publicly available data used in this analysis is reduced by a number of factors. These include that data:

- came from multiple sources
- had been published in different formats
- were from different reporting periods
- were sourced from different jurisdictions
- were often summary statistics.

For all datasets, data were generally not available below the level of state and territory, limiting the number of observations to a maximum of eight and as few as five for some measures. For some tables (for example, hospitalisation rate), statistics were flagged with a warning that the standard error is above a given threshold, for example 50%, and were considered unreliable for analysis. Several observations were reduced to ‘not-published’ or ‘n.p.’ in the data, commonly used to indicate a low count. Often a single point-estimate (for example, crude rate, age-standardised rate, or numerator) was provided with no measure of spread (for example, standard deviation). A summary of data quality limitations is summarised in Table C-13.

Table C-13: Summary of data quality issues for publicly available data sources

Data Source	Data quality issues
Health Performance Framework	• Cell suppression ('n.p') for small numbers • Data points were published to one decimal place and no difference could be detected where an indicator changed by less than 0.05. For these reasons, robust statistical tests were not applicable • Data not available for ACT, Tas, Vic (mortality data). • Time periods overlap
Health Workforce Data Tool	• Small cells randomised. Noticeable for ACT and Tas
Services Australia online reporting	• Rate per 100,000 for total population, not Indigenous population
AIHW nKPI reporting 2021	• Aggregation for NSW/ACT and Vic/Tas
Grant Connect	• Type of grants funded doesn't line up well with the IAHP funding streams • ABNs may not line up with title of PHN / ACCHS • Title of PHN / ACCHS also may have changed over time / Head office of PHN / ACCHS may not line up with sites • Information on variations to grant awards is limited • Missing some key grants-funding through PHNs and through NT (and other jurisdictional) government services. • The department's historical grant data were from 2013-14 to 2016-17, however, the format was different from 2017 onwards data as there's no program group column to separate the IAHP funding

C 3.6 Quantitative methods of analysis

Sites were categorised as major cities, inner regional, outer regional, remote and very remote, based on the Australian Statistical Geography Standard (ASGS) Remoteness Structure (ARIA+) for the geographical areas nominated by the sites as the areas within their catchment of interest to them for this evaluation. Remote and very remote were combined due to small numbers of sites in each category. As the catchment areas for some sites included more than one ARIA+ category, sites were assigned based on the remoteness category of the residential mesh blocks in their catchment. Most sites were wholly contained in one or two remoteness categories and were assigned to the category of the majority of mesh blocks. One site included 3 remoteness categories and was categorised as remote.

C 3.6.1 Using qualitative data to map priorities

To inform KEQ1, the team first reviewed qualitative interviews and surveyed data to identify service and system characteristics that were deemed to be consistent with Aboriginal and Torres Strait Islander values and priorities for health care. These values and priorities were mapped to measures available in datasets (Table C-14).

Table C-14: Values and priorities mapped to measures

Value/priority	Measures
Receiving care from Indigenous staff	Proportion of staff at SA3 who were Indigenous
Having a mix of staff that were male and female	Proportion of staff at SA3 who were female (all workers, and Indigenous sub-group analysis)
Receiving care from experienced staff	As no detailed data were available in any data source related to experience of clinical staff, the following proxy measures were used: • Age was used as a proxy for experience in the profession, with staff 45 years or over assumed to have more experience. Measures examined included the proportion of staff at SA3 who were >45 (all workers, and Indigenous sub-group analysis) • Variety of other ages- Proportion of staff in other age groups • Continuity of employment. Proportion of Indigenous staff with continuity of employment (who can be tracked over multiple consecutive years)
Care of the elder	Number of workers (per 1000 Aboriginal and Torres Strait Islander residents) working in the job area ‘residential aged care facility’
Access to a variety of care	Number of workers (per 1000 Aboriginal and Torres Strait Islander residents) working in the following job areas: Aboriginal Health Services; Community drug and alcohol; Community mental health; Hospital; Private Practice; Allied Health

Data to inform the measures outlined in the table came from two sources: Health Workforce Data and OSR data.

Health workforce data were obtained from 2013 to 2020 by site and by SA3. Data included details of health care staff working throughout Australia in a range of settings including Aboriginal health organisations, hospitals, and private practice. Counts of staff by age group, sex, and profession (medical practitioners, nurses and midwives and some allied health professions) were available. Staff who were recorded as not working in the profession in Australia were excluded, but (unless otherwise specified) retained those listed as on leave for 3 months or more and those with unknown work status/non-respondent. Data for 2020 were only available for medical practitioners and were not used. Health workforce data does not include all health professionals (for example, audiologists). The available allied health professions were: Aboriginal and Torres Strait Islander health practice; Chinese medicine; Chiropractic; Dental practitioners; Medical radiation practitioners; Occupational therapy; Optometry; Osteopathy; Paramedical practitioners (2019 only); Pharmacy; Physiotherapy; Podiatry; and Psychology.

OSR data were obtained from organisations receiving the IAHP funding by site. OSR data included total counts of paid staff, unpaid staff, and vacant positions. Publicly available OSR data by state and territory was also downloaded as the publicly available data included an additional year of data.

C 3.6.1.1 Analysis of priorities (values)

Care from Indigenous staff

From the health workforce data, proportions of staff that were Indigenous were calculated for participating sites and the rest of Australia from 2013 to 2019. Changes over time in the odds of a worker being Indigenous was modelled using a logistic mixed model, with a random intercept for site to account for the repeated measures.

Care from staff with a mix of genders

From the health workforce data, proportions of female staff were calculated by dividing the number of female staff by the total number of staff after excluding 37 staff with unknown sex (<0.01% of staff). Data on gender were not available and male/female sex were used instead. Proportions over time were reported. Change over time in the odds of staff being female was modelled using a logistic mixed model, with a random intercept for site to account for the repeated measures. Change was modelled for (1) participating sites only and (2) Australia. In this analysis, only staff listed as clinicians were included. The assumption was that gender of staff in administrative, educational, and other roles was less important than the gender of clinicians.

Care by experienced clinical staff- aged 45 years and older

Change over time in the odds of staff being aged ≥45 years was modelled using a logistic mixed model, with a random intercept. Change was modelled for staff at Aboriginal Health Organisations and non-Aboriginal health organisations at the level of participating sites and across Australia, and for Indigenous and non-Indigenous staff at participating sites and across Australia. Analysis was limited to staff with clinical job roles.

Care by experienced clinical staff- Continuity of staff

From the OSR data, the number of vacant full-time equivalents (FTEs) for health and other positions at participating sites from 30 June 2015 to 30 June 2020 were reported. The proportion of staff that were retained each year for Aboriginal health organisations within each site was also estimated using the health workforce data. Some assumptions needed to be made because individual-level data were not available and age was only available in 5-year age groups, meaning it was not possible to know whether staff moved from one age group to another from one year to another. Two assumptions were made, and results compared (1) Pessimistic assumption - staff did not move from one age group to another in subsequent years; (2) Optimistic assumption - staff moved up one age group to maximise the estimates of retention.

C 3.6.2 Data on IAHP funding

To inform KEQ2, the analysis focused on total the IAHP funding, the components of the IAHP funding, changes in the IAHP funding over time, and the relationships between changes in staffing and level of activity at Aboriginal health organisations. A summary of the approach is outlined in Table C-15.

Table C-15: Summary of approach for KEQ2

Outcome	Data set	Measures	Analysis	Estimates
IAHP funding	Provided by Department of Health and Aged Care	Total funding over time (nationally and by state and territory)	Change over time	Inflation adjusted IAHP funding (2014-15 to 2020-21)
IAHP funding by program	Provided by Department of Health and Aged Care	Funding by program (nationally)	Descriptive	Proportion of inflation adjusted IAHP funding allocated to each program (2018-19 to 2020-21)
IAHP funding by program	Provided by Department of Health and Aged Care	Funding by program (state and territory)	Descriptive	Proportion of inflation adjusted IAHP funding allocated to each program (2020-21)
IAHP funding by service	GrantConnect	Funding per service with multi-year grants averaged over length of grant	Descriptive	Funding by service (2020-21)
IAHP funding per client (and population)	Provided by Department of Health and Aged Care, OSR, ABS	Funding per client and population (nationally and by state and territory)	Change over time	Change in relative funding (2014-15 to 2020-21)
IAHP funding and the number of staff	GrantConnect, OSR	IAHP funding per staff member working at organisations that receive IAHP funding (nationally and by state and territory)	Change over time	Change in relative funding and staff (2014-15 to 2020-21)

Data on the IAHP funding (to inform primarily KEQ2) came from several sources:

- Data on the IAHP funding from 2014-15 to 2020-21 at the national, state and territory levels were provided by the department.

- The number of clients, contacts with clients, and staffing levels at organisations receiving the IAHP funding by state and territory were drawn from OSR data provided by the department.
- ERP counts of Aboriginal and Torres Strait Islander people for each state and territory were obtained for each calendar year from ABS.
- Publicly available data on all grants awarded by the Australian Government from 2018-19 to 2020-21 to the sites and services participating in this evaluation were extracted from the GrantConnect system.

C 3.6.2.1 Analysis of IAHP funding data

IAHP funding (2014-15 to 2020-21)

Total funding over time was reported for Australia and by state and territory. Funding was reported both for dollars not adjusted for CPI and for dollars adjusted for CPI using the ABS health index, with the Consumer Price Index (CPI) for each financial year calculated by averaging index across the relevant four quarters (ABS (2023). 6401.0 Consumer Price Index, Australia, Canberra, ABS). Dollars are expressed as constant 2019-20 to allow for comparison with the latest (at time of writing) AIHW health expenditure data.

C 3.6.3 Data on health care outcomes

To answer KEQ, proxies for Aboriginal and Torres Strait Islander people receiving appropriate health care to maintain good health and wellbeing were used. Three questions were explored:

1. ***What proportion of clients are receiving 715 health assessments, and did the proportion vary between sites and over time?*** A 715 health assessment is a comprehensive assessment of a patients physical, psychological, and social functioning that aims to detect, diagnose, and intervene on common and treatable conditions that cause morbidity and early mortality. A 715 health assessment can be conducted by any general practice or Aboriginal health service, and is recommended as an annual check for all Aboriginal and Torres Strait Islander people. Completion of 715 health assessments is a nKPI for Aboriginal primary health care services. The evaluation team's working assumption was that widespread use of the 715 health assessment leads to appropriate follow-up care (tests and other services) and the conduct of this follow-up care results in better health outcomes.
2. ***How are risk factors, health service use and health outcomes among Aboriginal and Torres Strait Islander people attending Aboriginal health services associated with each other and 715 health assessments?*** The evaluation team examined how nKPIs clustered within services and how they related to 715 health assessments.
3. ***What are the risk factors, health outcomes, and health service use among Aboriginal and Torres Strait Islander people attending Aboriginal health services?*** The evaluation team considered the prevalence and trends of risk factors across the life course including in the perinatal period, middle life, and late life.

Data used to analyse these questions came from three sources:

- nKPI data covering three domains of indicators of service activity and client health, including maternal and child health, preventive health, and chronic disease management
- MBS data regarding the number of services for MBS health assessments (items 704, 706, 708, 710, and 715 combined)
- ERP data.

C 3.6.3.1 Analytical process

For all analyses, data from 2020 onwards were excluded to remove the effect of the COVID-19 pandemic on health service utilisation. nKPI and MBS data were treated separately, as nKPI data included regular clients of Aboriginal health services receiving the IAHP funding, whereas MBS data included all Aboriginal and Torres Strait Islander residents living with the geographical areas nominated by evaluation sites as geographical areas in their catchment areas and geographical areas of interest to them for this evaluation.

1. ***What proportion of clients are receiving 715 health assessments, and did the proportion vary between sites and over time?***

The proportions each year of clients of participating health services receiving 715 health assessments were graphed and median, mean, minimum, and maximum values reported. To assess changes over time, the proportion of completed 715 health assessments at each service over time was modelled using a logistic mixed model, with a random intercept for service to account for the repeated measures. This was performed separately for clients aged 0-4 years and clients aged 25 years or more, in accordance with nKPI reporting. From these analyses, the odds of regular patients receiving 715 health assessments over time was obtained. An odds ratio (OR) greater than 1 indicated that likelihood of clients receiving 715 health assessments increased over time (on average), and an OR less than 1 indicated that the likelihood decreased over time. To explore variation across the services, for each nKPI the proportion of the total variance explained by clustering within services was also estimated. The trend over time in the likelihood of people living within the geographical areas identified as the sites for this evaluation receiving a 715 health assessment as recorded in the MBS by site were estimated using a univariate logistic mixed model, with a random intercept for site. The denominator was estimated from extrapolated ERP data (as described above).

2. ***How are risk factors, health service use and health outcomes among Aboriginal and Torres Strait Islander people attending Aboriginal health services associated with each other and 715 health assessments?***

To examine correlations between nKPIs, two methods of variable clustering were performed- Hierarchical clustering and Principal Components analysis. Outcomes between the two methods were then compared to determine if there was agreement.

Hierarchical clustering

Hierarchical clustering was used to explore which nKPIs were most similar to each other. Hierarchical clustering is an iterative procedure, which starts by treating each data point as its own cluster. Then step-by-step, each cluster is merged with the cluster most similar to it to form a larger cluster, until all clusters are merged. A dendrogram is produced, which visually represents the hierarchical clustering. Hierarchical clustering was performed with all of the nKPIs listed in Table C-16 using the varclus package in R, and a Spearman correlation > 0.4 was chosen as the cut-point for identifying clusters.

Principal Components Analysis

Principal Components Analysis (PCA) was used to reduce the dimensionality of the data set by clustering items into a smaller set of uncorrelated variables (the principal components (PCs)).

The nKPIs (proportions of clients) each year at each site were used to form the PCs. Principal component scores were then created for each service for each year and each principal component. Services which did not have complete data for each of the included nKPIs for at least 1 year were not included in the main PCA. Associations between 715 health assessments for clients aged 25 and over and the principal component scores were then explored. The principal component scores were regressed on the proportion of clients with completed 715 health assessments in the same year using a linear mixed effects model with a random intercept for service. Lagged 715 health assessments (that is, health assessments in the previous year) were also explored to see if the relationships between health assessments and principal component scores were different for health assessments in the same year and health assessments in the preceding year. The PCA analyses were performed using the R package prcomp. Finally, sensitivity analyses were undertaken following imputation of the missing nKPI data using the R package mice.

3. *What are the risk factors, health outcomes, and health service use among Aboriginal and Torres Strait Islander people attending Aboriginal health services?*

The nKPI data were used to explore protective/risk factors, health outcomes and health service use for the perinatal period, middle life and later life (see Table C-16). For included nKPIs by life stage). The trajectories of the nKPIs were modelled over time, using a mixed effects logistic regression model, with a random intercept for site. The odds ratio (OR), the change in the odds of a client having the nKPI outcome in one year, compared to the previous year, was reported, with the corresponding 95% confidence interval. The proportion of variance explained by site differences was also reported, along with summary measures of the site proportions by reporting period (mean, median, minimum, maximum, and range). The proportions over time were graphed for each site, as well as the proportion for all sites combined. Graphs stratified by the remoteness of the site were also created.

Table C-16: nKPIs used to explore protective/risk factors, health outcomes, and health service use for the perinatal period, middle life and later life

Life stage	nKPI
Perinatal period	• Birthweight recorded • Birthweight result (normal) • Smoking status of women who gave birth in the previous 12 months (non-smoker) • Antenatal visit timing (<13 weeks)
Middle life	• Smoking status recorded (11+ years) • Smoking status non-smoker/ex-smoker (11+ years) • Alcohol consumption recorded • Low-risk AUDIT-C score (<4 in males and <3 in females) • BMI overweight/obese • Cervical screening (previous 5 years)
Later life	• Vaccinated against influenza (over 50 years) • Vaccinated against influenza (COPD patients) • Vaccinated against influenza (type 2 diabetics) • CVD risk factors recorded • Low CVD risk • eGFR recorded (for CVD patients) • eGFR recorded (for type 2 diabetics) • Normal eGFR result (CVD patients) • Normal ACR result (type 2 diabetes) • Blood pressure recorded (type 2 diabetes) • Normal blood pressure (type 2 diabetes) • HbA1c test recorded (within previous 6 months) • HbA1c normal (type 2 diabetes)

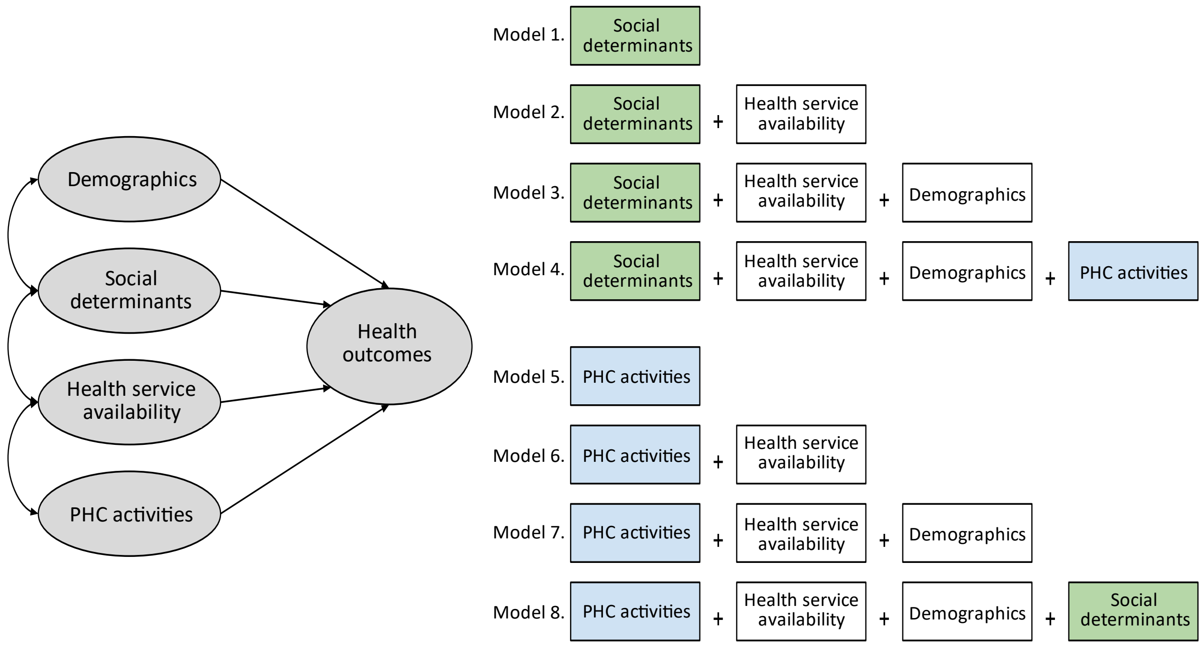
C 3.6.3.2 Multilinear regression analysis

The purpose of this analysis was to quantify the relative contributions of social determinants and primary health care on health outcomes for Aboriginal and Torres Strait Islander persons in Australia, controlling for demographic confounders.

Multiple linear regression was used to model health outcomes as a function of demographics, socio-economics, health service availability, and primary health care activity for geographic areas (i.e. ecological study) at two discrete time points (cross-sectional design), and for changes between time points (difference in differences analysis).

The effects of social determinants and primary health care were examined via the distributions of standardised regression coefficients and semipartial correlations produced for each explanatory variable across a series of hierarchical regression models in which social determinants or primary health care variables were introduced in either the first or last block. That is, models incorporating social determinants in the first block added primary health care variables in the last block and vice versa, producing a range of statistics from the simple bivariate case to those increasingly controlling for other variables. The general analytical approach is visualised in Figure C-9. In this example, five estimates for each statistic (regression coefficient, correlations) for PHC activities and social determinants with respect to the outcome variable are produced.

Figure C-9: General analytical approach using hierarchical multiple regression



Health outcomes and health service variables were expressed as the per-capita rate of incidence, occurrence or activity for each SA3. Rates were converted to standardised scores (Z) centred on the national estimate for each variable.

$$Z_{ij} = \frac{R_{ij} - R_P}{\sqrt{\frac{R_P(1 - R_P)}{n_i}}} \qquad \textit{for all } i \textit{ in available SA3s, for all } j \textit{ in Tracer Conditions}$$

Where:
R_P = Total population rate (all SA3s)
n_i = SA3 population

Where a construct had multiple component measures (for example, diagnoses for different health conditions), a composite score was computed as the sum of all component Z-scores for each SA3. This approach is based on the Stouffer method for meta-analysis but omits the denominator (typically the number of studies under meta-analysis; the number of components in this case) so as to preserve the information of any SA3 with zero counts. Omitting the denominator was a computational convenience based on the way some datasets were structured with a zero count resulting in the absence of a record for that SA3, which would underestimate the denominator when data were grouped or aggregated.

Data

Several data sources were used.

- Indigenous Estimated Resident Population (ERP): by age, sex, and SA3 for 2011 and 2016 were provided by the ABS. Indigenous ERP is not computed outside of Census years.
- Socio-economic Indexes for Areas (SEIFA): are computed from Census data for Census years. The four indexes reflect different socio-economic aspects and are generated using principal components analysis (PCA). PCA scores are used to rank areas on each index. Typically, high scores on an index represent relative advantage, and low scores represent relative disadvantage. SEIFA data are publicly available from the ABS website. Brief descriptions of each index is summarised in Table C-17.

Table C-17: Summaries for SEIFA indexes

Index	Description
Index of Education and Occupation (IEO)	Reflects the educational and occupational level of communities. Low scores indicate relatively lower education and occupation status of people in the area
Index of Economic Resources (IER)	Summarises variables relate to income and wealth, excluding education and occupation, to index the financial aspects of relative socioeconomic advantage and disadvantage
Index of Relative Socio-economic Advantage and Disadvantage (IRSAD)	Relates to the economic and social conditions of people and households. Low scores reflect relative disadvantage and high scores reflect relative advantage
Index of Relative Socio-economic Disadvantage (IRSD)	Summarises information related to the economic and social conditions of people and households and measures only relative disadvantage. Scores on this index range from most- to least-disadvantaged, unlike other indexes which range from relative disadvantage to advantage

- Indigenous Relative Socioeconomic Outcomes (IRSEO): Data for the IRSEO was available by SA2 for 2016 and converted to the mean decile across SA3s for use in this analysis. IRSEO attempts to account for the incomplete measure of wellbeing represented by socioeconomic status; particularly those that affect Indigenous people disproportionately even within areas of similar disadvantage as defined by other scales such as SEIFA.
- Remoteness: based on the Accessibility and Remoteness Index of Australia (ARIA+), classified into five remoteness categories.
- Health outcomes
    - Morbidity (hospitalisations): data from the National Hospital Morbidity Dataset (NHMD) were provided by the AIHW for hospitalisations with principal diagnoses in 16 categories of health conditions of interest to primary care.
    - Mortality: unit record file cause of death (URF-COD) data were provided by the ABS by calendar reference years 2010 through 2012 and 2015 through 2017.
    - Birthweight: categorical birthweight (low, normal, high) data from the National Perinatal Data Collection for liveborn babies of Indigenous mothers were provided by the AIHW by financial years 2012/13 through 2018/19.
- Health service availability
    - Healthdirect: Location data for health services were extracted from the “Find a health service” feature on healthdirect website (healthdirect.gov.au), using web-scraping algorithms. The locations of general practices, hospitals, emergency

    departments, pharmacies, dentists, psychology and counselling services were geocoded to SA3.

- Primary care activity
    - Medicare Benefits Schedule (MBS): data were provided by the department for the number of MBS services for non-referred GP attendances by SA3 and financial year from 2012/13 through 2019/20.
    - Childhood immunisations: data from the Australian Immunisations Register (AIR) were provided by the department for diptheria (DTP), polio, haemophilus influenzae type B (Hib), hepatitis, measles-mumps-rubella (MMR), pneumonia, meningococcal C (MenC) and varicella, by SA3 (2011 ASGS) and calendar quarter from March 2014 (quarter ending) through December 2020.
    - Practice Incentive Program– Indigenous Health Incentive (PIP-IHI): data for the number of payments by practice type and SA3 for calendar years from 2012 to 2020 were provided by the department.

Observation period

Time 1 and Time 2 periods reflected Census years 2011 and 2016, respectively, as closely as possible within the constraints of the available data. This was due to the unavailability of population data outside of those years and, given the study motivation, to ensure the best possible estimates for the effects of social determinants (SEIFA and IRSEO indexes are based on Census data). Per-capita rates were calculated in two-year periods for each timepoint, denominated by twice the ERP for 2011 and 2016 for T1 and T2 respectively.

Both timepoints could not be accommodated by all datasets. Notably, mortality outcomes could not be temporally aligned with GP attendance data from the MBS at T1, with deaths preceding MBS activity. Mortality models incorporated GP attendances as an explanatory variable at T2 only. Similarly, immunisations data were available from 2014 onwards and were incorporated in T2 models only. It was considered that effects of GP attendances and vaccinations should be seen as preventative activities; it made no sense to associate them with outcomes that preceded the activity. Emergency presentations were available for T2 only. The IRSEO was available for T2 only, due to earlier versions only being published under the Indigenous Areas geography and not the ASGS. Healthdirect data were retrieved in September 2021 and incorporated only in T2 models on the assumption of relevance to 2016 and later. This assumption could not be justified for T1 periods.

Table C-18: Observation periods

Variable type	Variable	Period	
		T1	**T2**
Outcome	Hospitalisations	FY 2012/13– 2013/14	FY 2017/18– 2018/19
	Mortality	2011-2012	2015-2016
	Birthweight	FY 2012/13– 2013/14	FY 2016/17– 2017/18
	ED	-	FY 2017/18– 2018/19
	PPH	FY 2012/13– 2013/14	FY 2017/18– 2018/19
Explanatory	SEIFA	2011	2016
	IRSEO	-	2016
	Remoteness	2011	2016
	Service availability	-	2021
	PIP-IHI	2011-2012 and 2012-2013 (for mortality and hospitalisation/birthweight models, respectively)	2015-2016 and 2017-2018 (for mortality and hospitalisation models, respectively), 2016-2017 for birthweight models.
	GP attendances (MBS)	FY 2012/13– 2013/14	FY 2014/15– 2015/16 and FY 2017/18– 2018/19 (for mortality and hospitalisation models, respectively), FY 2016/17-2017/18 for birthweight models.
	Immunisations	-	2015-2016 and FY 2017/18– 2018/19 (for mortality and hospitalisation models, respectively), FY 2016/17-2017/18 for birthweight models.

C 3.6.3.3 Hierarchical clustering of rates for conditions of interest to primary health care

Comorbidity could not be analysed due to the area-level aggregation of hospitalisations data. Hierarchical clustering was applied to examine any ecological relationship between health conditions.

Hospitalisation and mortality rates for each health condition by SA3 were converted to Z-scores at two time points per the method outlined in the SA3 regressions. Hierarchical clustering was applied at each time point to examine relationships between health conditions. Spearman's correlation with a threshold of .75 was used to define the clusters. Clusters therefore indicate that SA3s that rank higher on a given health condition for hospitalisation or mortality are more likely to have higher ranks on other conditions within the cluster.

C 3.6.3.4 A 'traffic light' framework

Analyses conducted with publicly available data aimed to answer KEQ 3: "What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?" and KEQ3.1 "to what extent are the IAHP initiatives changing people's lives for the better in terms of health and wellbeing outcomes?".

Analysis of publicly available data aimed to synthesise data into a single framework so data could be compared, appraised, and communicated at a high level, acknowledging the limitations of the available data. The analytical approach for publicly available data was motivated by two questions:

1. In which direction did an indicator measurement change over time?
2. How strong is the evidence for that change?

A custom 'traffic light' framework based on the indicators' observed changes over time was developed (Figure C-10). The traditional green-amber-red format was purposely avoided so as not to imply good or bad associations with observed changes at this descriptive stage and given the limitations of the data.

Figure C-10: Traffic light framework for observed changes

● **Observed decreased**

● **No observed change**

● **Observed increased**

Where data were published as an unbroken time series (for example, annual), the first traffic light reflected the direction of the regression coefficient (slope) for the time series. A second light was assigned based on the statistical significance (0.05) for the regression coefficient (slope) of the time series to indicate the strength of evidence for the observed change (see Figure C-11). Where data were published in discrete time 1-time 2 statistics, the first traffic light was assigned according to the sign (increase/decrease) of the difference (t2-t1). Where data were suppressed ('n.p.') due to small counts, it was assumed that an 'n.p.' referred to a smaller value than any published numerical value, and an imputation was made that a change in the relevant direction had been observed. If data for both timepoints were suppressed, it was assumed that no change was observed. The strength of evidence for change was then appraised with two additional lights. The first indicated that an individual observed change was larger than one-tenth of the largest observed absolute change across all observations (i.e., states and territories) for that indicator. The second indicated whether the time 2 observation was greater than 2% of the associated time 1 observation (see Figure C-12).

Figure C-11: Traffic light framework for observed change and evidence (regression coefficient)

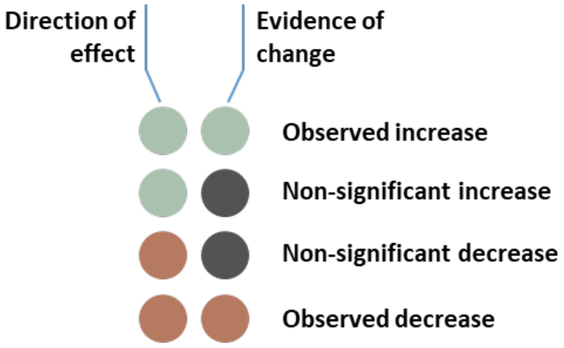
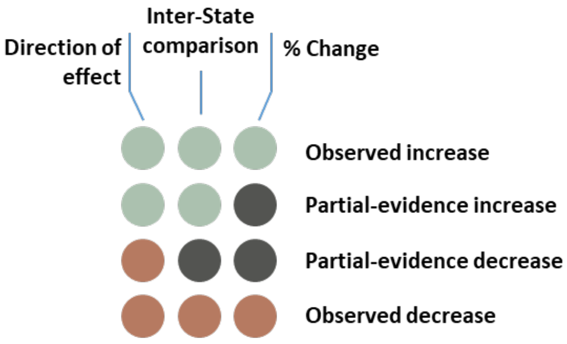


Figure C-12: Traffic light framework for observed change and evidence (T1-T2 comparison)



Morbidity. A T1-T2 analysis was conducted. Hospitalisation rates for 11 key disease groups (as principal diagnosis) were analysed as health outcomes, as categorised by the Health Performance Framework. Tier 1 variables included: Acute rheumatic fever and congestive heart failure (ARF/CHF); Malignant neoplasms (cancer); Diseases of the circulatory system (circulatory); Dental problems (dental); Diabetes mellitus (diabetes); Diseases of the ear and mastoid process (ears); Diseases of the eye and adnexa (eyes); Hypertensive disease (hypertensive); Chronic kidney disease excluding dialysis (kidneys); Mental health related conditions (mental); Diseases of the respiratory system (respiratory). Tier 2 and Tier 3 variables included: Injury and poisoning with first reported external cause of assault (assaults); Principal diagnosis related to alcohol use (alcohol); Discharge from hospital at own risk excluding dialysis; mental and behavioural disorders (early discharge any diagnosis); Potentially preventable hospitalisations (PPH); Hospitalisations with a procedure.

Mortality. A T1– T2 analysis was conducted. Mortality rates for 22 cause groups were analysed as health outcomes. These groups were taken from the Health Performance Framework reporting and in some cases are not mutually exclusive.

Morbidity-Mortality. A basic analysis for a meaningful subset morbidity-mortality pairings was conducted for states and territories that had available data (NSW, NT, Qld, SA, WA). A simple correlation approach was applied using only the direction of observed changes (first traffic light). Positive relationships were noted where both mortality and morbidity increased or decreased together for a given jurisdiction (up-up or down-down). Negative relationships were noted where inverse directions were observed (up-down, down-up). Independence of mortality and morbidity was noted where one or both indicators had not changed over time. An overall summary effect was then calculated from the proportion of positive, negative, or independent relationships observed, normalised from -1 to +1.

Health workforce in Indigenous health services. A trend analysis was undertaken. Workforce data from the Health Workforce Data Tool was retrieved for the number of Indigenous Health Practitioners (IHP), Medical Practitioners and Nurses/Midwives employed in Aboriginal Medical Services. The number of Indigenous persons and total persons employed in these roles was analysed. Data for the ACT and Tasmania had been perturbed due to small cell counts, resulting in nonsensical data and no serious analysis could be undertaken.

Health service utilisation. A trend analysis was undertaken using MBS data from the Services Australia online data repository. No Indigenous identification is available from this repository. Only items that are specific to Aboriginal and Torres Strait Islander persons were used for this analysis (see following list). The published population rate per 100,000 persons used the population for all Australians in calculation and not the Indigenous population.

- 228-Aboriginal and Torres Strait Islander people's health assessment (non-VR GPs)
- 715-Aboriginal and Torres Strait Islander people's health assessment
- 81300-Follow-up Allied Health-Aboriginal and Torres Strait Islander Health Service
- 81305-Follow-up Allied Health-Diabetes Education Service
- 81310-Follow-up Allied Health-Audiology Service
- 81315-Follow-up Allied Health-Exercise Physiology Service
- 81320-Follow-up Allied Health-Dietetics Service
- 81325-Follow-up Allied Health-Mental Health Service
- 81330-Follow-up Allied Health-Occupational Therapy Service
- 81335-Follow-up Allied Health-Physiotherapy Service
- 81340-Follow-up Allied Health-Podiatry Service
- 81345-Follow-up Allied Health-Chiropractic Service
- 81350-Follow-up Allied Health-Osteopathy Service
- 81355-Follow-up Allied Health-Psychology Service
- 81360-Follow-up Allied Health-Speech Pathology Service
- 10987-Follow-up for health assessment
- 10988-Immunisation
- 10989-Wound management
- 10997-Monitoring and support for person with a Chronic Disease Care Plan
- 10950-Chronic and complex care-Aboriginal and Torres Strait Islander Health Service
- 12325-Bilateral retinal photography to assess diabetic retinopathy.

Primary care activity. Publicly available nKPI data were retrieved from the AIHW website. Each indicator is reported as the percentage of regular patients who meet that indicator's criteria. To improve interpretability for analysis, indicators were transformed to be positively directed, that is, a higher percentage equates to a favourable interpretation. For example, indicator PI12: Body Mass Index Classified as Overweight or Obese was transformed to its complement (100% minus percentage reported). Indicators that are reported in ordinal categories were assigned an index weight and transformed into a single indicator score by multiplying the weight by the reported proportion and summing over the resulting values. Each indicator and the transformation applied is outlined in detail in the Cycle 1 technical companion document.

C 3.6.3.5 In-depth cases studies

Quantitative analyses for Cycle 1 of the evaluation utilised publicly available data at the state and territory level, and a custom analytical framework to examine high-level effects of health service activity on hospitalisations and mortality. Quantitative analysis for Cycle 2 applied the same methods to the requested site-level data to:

1. examine associations between nKPIs and hospitalisations
2. conduct in-depth case studies using diabetes nKPIs and MBS chronic care and hospitalisations to mitigate some limitations of the data.

For the first analysis (associations between nKPIs and hospitalisations), data for the nKPI were provided at the site level. Where a site contained more than one reporting organisation, the data were aggregated. Data for hospitalisations were requested using a combination of diagnoses (ICD-10) informed by the publicly available data (Health Performance Framework) and the National Guide to a Preventative Health Assessment for Aboriginal and Torres Strait Islander People (National Aboriginal Community Controlled Health Organisation & The Royal Australian College of General Practitioners, 2018). Together these are considered to comprise conditions of interest to Indigenous primary health care and were organised in 16 categories: Alcohol and drug use; Alzheimer’s and dementia; Acute rheumatic fever and rheumatic heart disease (ARF/RHD); Cancer; Circulatory health; Chronic kidney disease; Depression and suicide; Diabetes; Eyes and ears; Lifestyle factors; Mental disorders; Mental health-related hospitalisations; Older adults (falls and osteoporosis); Oral health; Respiratory health; Sexually transmissible infections and blood-borne diseases (STI/blood-borne). The same method of scoring nKPI across sites and associating with changes in hospitalisation rates developed in Cycle 1 was applied. For each health condition group, rates of principal diagnosis[15], additional diagnosis[16], and any diagnosis were computed.

Case study 1 – linking diabetes nKPIs and hospitalisations

For this case study, the analysis was restricted to diabetes-related performance indicators in the nKPI and hospitalisations for a principal diagnosis of diabetes. This restriction was made to mitigate the limitation of the breadth of primary care activity and hospitalisations covered by the nKPIs, and the health conditions being coded in hospitalisation data. The nKPI has five items with an explicit focus on diabetes. That is, these indicators are denominated by the

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[15] The diagnosis established after study to be chiefly responsible for occasioning a patient's service event or episode. (https://meteor.aihw.gov.au/content/433351)

[16] A condition or complaint either coexisting with the principal diagnosis or arising during a service event or episode. (https://meteor.aihw.gov.au/content/641014)

number of diabetes patients attending the health service (Table C-19). The correlation between each diabetes-related KPI and the 2017-2020 three-year hospitalisation rate for all sites was analysed. No other correlates or confounders were accounted for.

Table C-19: Diabetes-related nKPIs

Diabetes-related nKPIs	
PI05	HbA1c measurement result recorded within the previous 6 and 12 months—Type 2 diabetes
PI07	MBS General Practitioner Management Plan (item 721)—Type 2 diabetes
PI08	MBS Team Care Arrangement (item 723)—Type 2 diabetes
PI15	Immunised against influenza—clients with Type 2 diabetes
PI18	Kidney function test—clients with Type 2 diabetes
PI23	Blood pressure recorded—clients with Type 2 diabetes

Case study 2 – Linking MBC Chronic Care items and hospitalisations

For this case study, the analysis was restricted to relevant MBS items and hospitalisations for a principal diagnosis of diabetes. This restriction was made to mitigate the impact of the inclusion of hospitalisations for persons who were not provided care reported in the nKPI (for example, not a regular patient of a reporting health service). The MBS Item Group ‘Chronic disease and complex care needs management and review’ includes four activities: GPMP (item 721), TCA (item 723), GPMP review (item 732) and Domiciliary Medication Management Review (item 900). This analysis circumvents the flaw in limiting factor 2. The denominator for site MBS activity is the geographical site population, as it is for the hospitalisation rate, unlike the nKPI items which are denominated by regular patients of the reporting health service.

C 4 Sense-making, integration, and analytical synthesis

Data integration is inherent in the multi-phase mixed method design. Data integration consisted of: (1) merging - combining quantitative and qualitative data; (2) explaining - for example findings from interviews/yarns/PAR cycles were used to explain findings from analysis of nKPI and OSR data; and (3) building the responses to the KEQs by using one kind of data to expand the other (DeCuir-Gunby & Schutz, 2017).

The process of sense-making and analysis took place fluidly throughout the three PAR cycles. It was an integral part of iteratively presenting and discussing the evaluation purpose, design, and emerging findings internally amongst team members and externally with site partners, key participants, and other stakeholders involved the evaluation.

More deliberate segments of sense-making also took place during the three PAR cycles and leading to the completion of the two interim reports (1 and 2) and the final report at the end of Cycle 3. Findings from all data sets – quantitative and qualitative – were discussed and analysed collaboratively within the evaluation team in relation to each KEQ. Abductive analysis (Graneheim et al., 2017) was utilised as part of this process to draw meaning from the patterns of convergence and divergence within the data, as well as supporting the transferability of findings between contexts.

This section details the interpretation and sense-making activities that occurred continuously throughout the evaluation process. In addition to regular team meetings and ad hoc discussions, two activities were held to support focused and inclusive interpretation and sense-making:

- Integration and reflection workshops with evaluation team members
- Interpretation and sense-making workshops with evaluation partners.

These activities occurred as part of the data generation activities through the interaction of the evaluation team and participants. Integration and interpretation were embedded in the analytic process, and the use of memoing[17] and detailed analytical notes provided a record of how this had evolved.

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[17] In grounded theory, memoing is one of the most important processes to develop and enrich the analysis and theory building. A memo is the written record of the researcher's thinking. It is an analytical strategy that facilitates the researcher to develop clear concepts and valid arguments from the data.

C 4.1 Integration and reflection workshops for team members

The first integration and reflection activity was a week-long series of integration and reflection workshops for the evaluation team. These were held between August and September 2021, as part of Cycle 1. Another integration and reflection workshop was held in December 2022 as part of Cycle 2. Because of COVID-19 travel restrictions, the Cycle 1 workshops were held online, however, the Cycle 2 workshop was in-person.

The integration and reflection workshops were structured around the KEQs. An introductory session provided the evaluation team with an opportunity to come together, reflect on and amend the group agreement, and be provided with an overview of how each session would work. This included a clarification of the purpose, format, roles people would play, and the structured process for input and discussion.

Each workshop followed a format of discussing and integrating the key findings from the analysis of each data source relevant to that KEQ. A description and discussion on the context for sites was then provided to facilitate the team's shared understanding and contribute to the links between data sets and streams of analysis.

Two analyst and data integration team meetings were also held in July and August 2022, towards the end of Cycle 2. The purpose of these meetings was to:

- ensure alignment of findings across all analysts – identify shared themes and connections
- identify and discuss gaps in the data – again identify any common themes
- define the key priorities (and what was not a priority) for Cycle 3
- agree to a process for developing materials/training site teams.

The meeting in August 2022 included the site evaluation leads, and the key purpose was to ensure clarity on Cycle 3 data collection and alignment for the reminder of the project. The evaluation leadership team also met monthly with the quantitative data team during 2022 to discuss findings from quantitative analysis and make connections to the qualitative evidence.

At the final stages of the evaluation, the findings from each activity (for example, yarns, interviews, collaboratives, and quantitative data analysis) were written up as separate working papers to inform the Final Report.

With an evaluand as complex as the IAHP, it is difficult to provide cut and dried evaluative judgements. Rather, the evaluation team's intention was to provide defensible answers to the KEQs and develop a robust contribution narrative that described the ways the IAHP was associated with specific outcomes and where opportunities and barriers for change occur.

C 4.2 Interpretation and sense-making workshops with site partners

The second activity was designed to share the structured findings from the integration and reflection workshops with site partners (including health service and PHN staff, and state and territory peak bodies for community-controlled health services). These workshops were referred to as 'emerging findings workshops'.

A two-hour online workshop was developed by the site evaluation leads and the Project Lead. The workshop was repeated over five days at different times of the day to provide as much opportunity as possible for site partners to attend. The initial workshops were held between 15 and 21 September 2021, towards the end of Cycle 1. All sites had at least one site partner attend a workshop. Staff from 12 (of 13) PHNs were in attendance. Over half (13 of 24) of the health service partners participated. In total, 43 people attended a workshop, with between 5 and 12 participants at each session.

A second series of emerging findings workshops were held between 19 and 22 July 2022, towards the end of Cycle 2. A total of 21 site partners participated in a workshop. Following each series of emerging findings workshops (Cycle 1 and Cycle 2) an edited video of the workshop was sent to all site partners to view in their own time to ensure that all partners had the opportunity to hear and provide feedback on the emerging findings.

Invitations were emailed to potential participants. Registrations were completed online, and participants were sent a link to join the online workshop. The workshops were facilitated by the National Engagement Lead, the site evaluation leads, the Principal Investigator, and the Project Lead. Other evaluation team members contributed as required to provide additional information or clarification of findings. The findings were broken into smaller components for presentation and, following each section, participants were invited to provide input. Participants were prompted to reflect and consider whether the findings were consistent with their own experiences or understanding, if there were divergent or surprising findings, and whether any findings had particular sensitivities that needed to be considered. A facilitated discussion allowed the consideration of contextual influences for sites and jurisdictions.

The workshops had several purposes. They were an opportunity for site partners to check the evaluation team's interpretation of findings, connect with other evaluation partners across sites, learn and share knowledge, and consider what the findings mean for policy and practice. Workshop attendees and evaluation team members were invited to reflect on (1) the emerging findings content, and (2) the process used to bring site partners together.

The workshop discussions challenged participants to consider if the findings were consistent with their own experiences or data within the project and identify any divergent or unexpected findings that needed to be considered. Integration of the findings for each KEQ was through a facilitated discussion to identify the significance or importance of the findings for that KEQ and what those findings meant for how the IAHP needs to better enable the PHC system to work for Aboriginal and Torres Strait Islander people.

The process of taking the findings back to sites and discussing these with participants was a key part of the PAR design of the evaluation and essential to ensure that analytical assumptions and evaluative claims were relevant to the lived reality of people impacted by the evaluation and the IAHP.

C 4.2.1 The national workshop

A two-day national workshop was held in February 2023 after Cycle 3 data collection had been completed. The workshop has three aims:

1. **Facilitate participatory analysis**: Share the evaluation findings and check how they resonated with evaluation partners to inform further interpretation and explanation-building.
2. **Co-design implementable action**: Discuss the significance of the evaluation findings for the IAHP and broader policy settings and identify potential improvements and solutions to craft the evaluation's recommendations.
3. **Support learning and evaluation use**: Share and showcase promising practices in the design and delivery of PHC services to facilitate learning across evaluation partners.

54 participants attended the workshop. The majority of participants were from site partner ACCHSs and PHNs, and a small number of participants were from state, territory, and national organisations.

The workshop contributed to:

- A more robust and credible evaluation through a continuation of participatory processes.
- Direct sharing of experiences and ideas from site partners (ACCHSs, AMSs and PHNs) to state, territory and national level decision-makers and policy-makers (and vice-versa).
- Stronger connections and networks developed across health services and PHNs for ongoing sharing of ideas and practice, and with staff from state, territory and national organisations.

The workshop included six sessions covering different topics and discussions points. The sessions include:

1. **A session on what people value for their health and wellbeing.**

   The session focused on what communities value and need to support their health and well-being. The session also provided a synopsis of what good quality care looks like for Aboriginal and Torres Strait Islander people.

2. **A session on improving the implementation of the IAHP.**

   The session focused on building on the strengths of the IAHP to identity how its implementation should be improved to better meet the effective, accessible, coordinated and culturally safe care that is valued by Aboriginal and Torres Strait Islander people. The session also sowed the seeds for recommendations on improvements to the way the IAHP is implemented.

3. **A session on the IAHP's contribution to improving people's health and wellbeing.**

   The session focused on what difference the IAHP makes to people's health and wellbeing. It draws largely from an analysis of publicly available quantitative datasets. The session will strengthen the analysis by bringing local meaning to the findings and help determine the future focus of and investment in the IAHP.

4. **A session on the IAHP's interactions with the broader health system.**

   The session focused on the broader contributions of the IAHP and the strength of its interactions with the rest of the health system. The session also supported the cocreation of recommendations that strengthen system alignment and coherence.

5. **A session on the IAHPs support of Aboriginal and Torres Strait Islander health needs**.

   The session focused on co-creating recommendations on how the IAHP could best support the health needs beyond disease response.

6. **A session on framing the future state of the IAHP.**

   The session focused on the IAHP's role in countering system-wide issues identified in the evaluation. This includes consideration of the intent of the IAHP, particularly within the context of policies and frameworks such as Closing the Gap, and how the IAHP can be successfully implemented. The session will support the framing of recommendations on the future state of the IAHP, building on the strengths of the program and the opportunities ahead.

The workshop involved presentations from the evaluation team and site partner participants as well as an interactive session discussing the quantitative data and process of analysis. The recommendations were discussed and workshopped by participants and feedback was incorporated into the drafting of the evaluation recommendations and report.

A Melbourne-based graphic artist live recorded key points and concept from each workshop session and the following discussions. The live virtual recordings were displayed on a large screen during workshop breaks and sometimes while discussions unfolded (see **Appendix L: National evaluation workshop**). These graphic recordings captured the key themes and responses from audience, and the six 'session' recordings were shared with participants after the workshop.

The visual graphic notes served as a more accessible and engaging way to approach to collect meeting minutes and share these with site partners.

C 4.3 Data integration - Contribution analysis

Several of the evaluation questions had a specific focus on the IAHP's contribution. The evaluators drew on contribution analysis (Mayne, 2008). Contribution analysis seeks to establish a credible association between an intervention and an observed result that will withstand scrutiny and critique; or, inversely, to discount such an association (Mayne, 2008). The aim is to reduce uncertainty about the contribution an intervention is making to observed results through an increased understanding of why results occurred (or did not occur), and the roles played by the intervention and other influencing factors. The method addresses cause and effect by demonstrating contribution rather than proving causality. It is well suited for examining complicated policies:

> Contribution analysis works well for understanding and interpreting results in complex systems where a variety of factors and variables interact dynamically within the interconnected and interdependent parts of the open system (Mayne, 2008; Nunns et al., 2019)

Evaluative explanations and judgements about the IAHP's contribution have been made across a range of data sets and several layers of analysis, which have allowed for an in-depth assessment of the different contexts the IAHP is mobilised in, the variety between these as well as rival explanations.

C 4.3.1 A grounded theory approach to contribution analysis

A grounded theory approach to contribution analysis was applied to purposefully generate narrative data about the contribution of the IAHP to strengthen comprehensive PHC for Aboriginal and Torres Strait Islander people. Adopting a grounded theory approach meant that the evaluation team was able to analyse the IAHP's contribution in a way that:

- legitimises the experiences of Aboriginal and Torres Strait Islander people as a valid source of knowledge
- facilitates the development of theory directly interpreted from the words expressed by Aboriginal and Torres Strait Islander people
- considers the influence of contextual social processes and structures
- recognises the diversity of experience
- assumes regard for the relational aspects of the evaluation.

Grounded theory as an analytic method has much to offer in thinking about decolonising methodology[18] and it addresses many Indigenous critiques of Western research and

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[18] Decolonising methodologies are not about rejecting all theory, research, or Western knowledge. Rather, they are about centring Indigenous concerns and world views and then coming to know and understand theory and research from our own perspectives and for our own purposes (Smith, 2021, p. 39). This decolonising (emancipatory) movement advocates building a body of knowledge that has relevance, practical application and vision for Indigenous people.

evaluation approaches. Grounded theory avoids treating the evaluation phenomena (the IAHP) in isolation from the broader historical, socio-economic, cultural, and political systems in which it occurs. Grounded theory is a method that can connect these domains and develop theoretical arguments about an intervention that are grounded in the experiences of the people involved. Grounded theory is also a strengths-based approach that inherently focuses on the strengths of a situation and speaks to Indigenous aspirations, self-determination, values, and nation-building.

Used in the context of evaluation and contribution analysis, grounded theory adds a systematic, rigorous approach to evaluative reasoning, because it produces an analytical method centred on accountability, participants' voices, and expertise, as well as careful investigation of context, locality, and complexity.

C 4.3.2 Steps in the contribution analysis

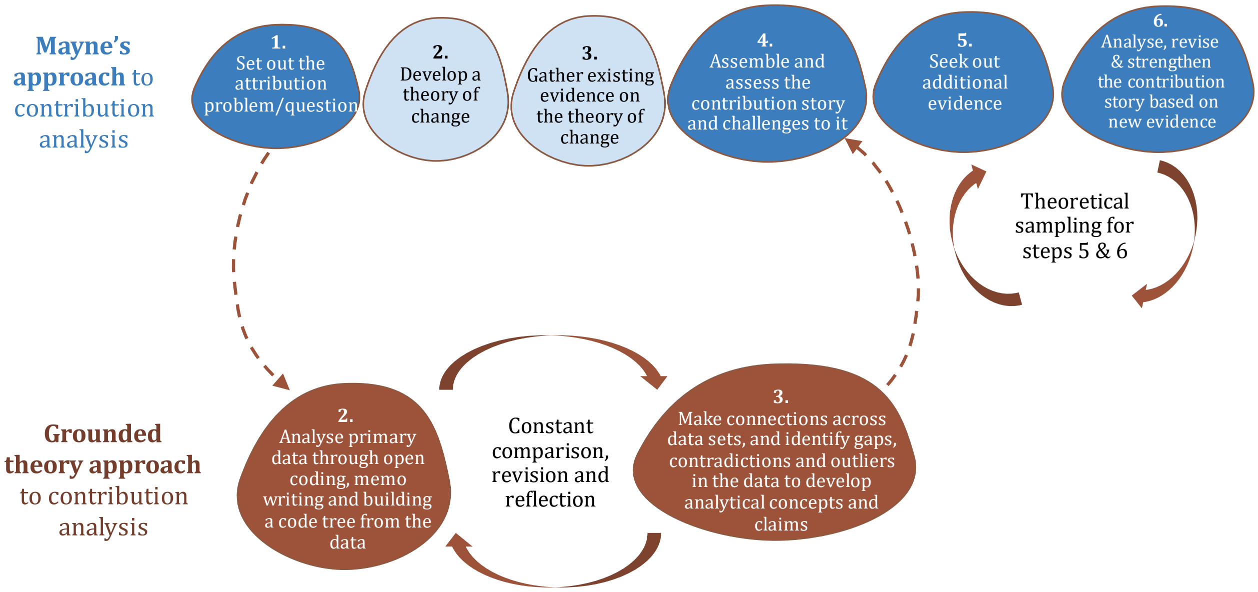
Figure C-13 illustrates the process of analysis and how a grounded theory approach was used to undertake contribution analysis. The evaluation team applied a similar step-by-step process to Mayne's six steps of contribution analysis.

Contribution analysis is usually based on the existence of a theory of change for the intervention being examined. The theory of change is based on initial policy intentions, informed by a range of stakeholder views and information sources, including prior evaluations and research. A theory of change and program logic was developed by the department in 2015 (see Appendix E) as an internal tool to help bring about a shared vision for how the IAHP is supposed to work (Bailey et al., 2018). The department has acknowledged that the theory of change and program logic were developed with minimal stakeholder engagement and may not reflect a widely shared vision for, or accurate depiction of, the program or its place within the wider health system.

Mayne's six steps of contribution analysis is typically applied as a process of testing and checking an intervention logic and theory of change. However, in applying contribution analysis from a grounded theory approach, the evaluation team did not start with and focus on the IAHP theory of change. Rather, the focus of the analysis was on assessing the IAHP's contribution in relation to the qualities of good health care that Aboriginal and Torres Strait Islander health services were thriving to deliver, and community participants said they valued.

Thus, steps two and three of Mayne's (2008) approach to contribution analysis were modified to involve grounded theory coding and analysis of data collected during Cycle 1 and 2. A narrative process of theorising was used to analyse and reflect on 'what is going on' (based on interviews with stakeholders). This included identifying patterns, gaps, contradictions, and outliers from the data, to develop concepts. The contribution stories were created from detailed grounded theory coding, analysis and theoretical sampling, which outlined the line of reasoning and key evidence related to each claim about contribution.

Figure C-13 Approach to contribution analysis



As a **first step**, the evaluation team set out an overarching contribution (attribution) problem or question. In this context, the contribution analysis focused on the following questions:

How is the IAHP contributing to the PHC system and improving the health and wellbeing of Aboriginal and Torres Strait Islander people?

As a **second step**, the evaluation team analysed primary data through open coding of interviews with health service managers, PHN managers, and state, territory, and national participants collected through Cycle 1 site engagement. Three analysts were involved in this process and the coding was done over 6 months. New data were also collected during this time through Cycle 2 engagement and relevant data were coded and included in the contribution analysis. NVivo was used to organise and code all the interviews.

The coding was done using a grounded theory approach, building the coding system from the data. Small chunks of text were coded according to labels or categories that emerged from the data. The wording of these labels was taken from the text. These labels and categories worked as anchors that allowed key points, issues, and topics to be grouped and compared.

Part of grounded theory analysis is a negative case analysis, which meant looking for data that are inconsistent with the emerging patterns and discussing why this is and what other factors are relevant to the issue.

While coding, all analysts were recording their thoughts, reflections and relevant observations about the data sets and connection between these, through memo-writing, which worked as a process of analysing while coding and organising the data.

The **third step** of analysis involved developing contribution claims and concepts by identifying patterns, focal points, code clusters, and examining gaps, contradictions and outliers in the coded data. The online tool Miro was used to share and map out code clusters and draw connections between data sets and key concepts, issues, and emerging observations about contribution.

Throughout the coding process, fortnightly meetings were held where general patterns, emerging findings, and analytical questions were discussed. The iterative and comparative process of grounded theory analysis also meant that the evaluation team was constantly reflecting on the data, looking over the data several times, comparing and approaching it from different perspectives (e.g. by organising concepts in various ways). Early findings were also discussed with the wider evaluation team.

The **fourth step** involved assembling and assessing the contribution story and challenges to it. Contribution cases were drafted based on claims and concepts mapped out in Miro and identified the existence of an association between an IAHP intervention and observed changes / a change. Where an association was established, a contribution case was produced to sort the data narratively and flesh out the contextual background, implications, gaps, other influencing factors, and rival explanations.

Five contribution cases were developed. Each case was structured as:

- context
- contribution
- implications
- rival explanation/other factors.

A **fifth step** involved seeking out additional evidence to the five contribution cases. This was done through a process of returning the cases to site partners to discuss and sense-check their strength, accuracy and relevance. The purpose was to sense-check whether the contribution claims and observations between the IAHP and specific outcomes were reasonable and aligned with what people were experiencing in different sites. Table C-20 illustrates the two groups the evaluation team sense-checked the cases with (noting that the second stage of sense-checking the contribution cases with health sector academics and professionals was conducted as part of the sixth and final step of analysis).

Table C-20: Groups used for sense-checking

Group	Purpose
ACCHS, PHNs, community representatives, peak bodies	Sense-checking, gap filling and adding nuances
Health sector academics and professionals	Connect cases to wider health system context and explore alternative explanation and relevant literature

The cases were discussed with site evaluation leads to determine the best format for site engagement, where to take the cases, and who would be relevant to review them. Interview questions and facilitation guides were developed for each case, structuring an open conversation about the IAHP's contribution to a particular outcome. A diagram was also developed for each case to give an overview of the case and make it easier for participants to engage. The case and diagram were sent to participants before site visits.

The final **sixth step** of analysis involved analysing, revising and strengthening the contribution cases based on new evidence and beginning to develop and draft an overarching contribution story about the IAHP.

This was done firstly by revising and adding the five contribution cases to the feedback from interviews with site partners and other relevant data gathered from site visits (for example, reports, funding information and quantitative data). Then the cases were merged and two primary contribution cases (in the form of diagrams) were presented to a review panel of two health sector academics and professionals. The main outcome of this second stage of sense-checking with the review panel was added detail about observed associations between the IAHP, service delivery and changes in health outcomes. In addition, in-depth discussions about external influences increased the evaluation team's understanding of alternative explanations to the observed associations. More general issues of the contribution analysis and the methodological approach of a grounded theory approach were also discussed with the panel. The two primary contribution cases, including the feedback, input, and nuances added by site partners and the review panel, were collated into one overarching contribution narrative.

The step by step process of Mayne's contribution analysis, and particularly the final three steps of assembling and assessing contribution stories, seeking new evidence, and then revising and strengthening the stories based on this evidence, mirrors the iterative process of theoretical sampling applied in grounded theory, whereby the analyst jointly collects data, codes and analyses data to decide what data to collect next, and develops a theory as it emerges from the ground. This made it easy and effective to combine the two methods.

C 4.3.3 Integration of quantitative data in the contribution analysis

The contribution cases were shared with evaluation team members leading the quantitative data workstream early in the analysis process. Feedback and suggested input data were collected through regular contribution analysis meetings through Cycle 2 and 3. Quantitative data (for example on workforce, the IAHP funding contracts, nKPI reporting, and population) were then integrated into the cases to produce a comprehensive narrative about the IAHP's contribution in relation to the wider system in which it is implemented.

Once contribution cases had been checked and tested by site partner participants, the revised cases were again share with team members from the quantitative workstream to review these cases and add any evidence that would strengthen the evaluative claims the cases presented.

C 5 Strengths, limitations, and adaptations of the evaluation and methodology

This section discusses the strengths, limitations and adaptations that apply across the evaluation, including observations about data sources, the practical implementation of the evaluation design, sampling issues and the impacts of the broader health, social and political landscape over the duration of the evaluation. These observations are used as material for critical reflections about how the methodological design worked in practice, including challenges, benefits and creative ways of adapting to changing circumstances.

Specific observations associated with quantitative data sources and analysis are included in section C 3.5 and C 3.6.

C 5.1 Strengths of the methodology

Reflecting on the design and implementation of the evaluation there were significant strengths in the way it was approached and applied.

C 5.1.1 A cyclic and iterative approach to enrich the interpretation of data and facilitate quality improvement

The iterative and cyclic PAR processes were designed to ensure the values and experiences of Aboriginal and Torres Strait Islander people were central in interpreting and making sense of data, fostering effective partnerships and joint learning.

Continuing engagement with site partners allowed the evaluation team to collaborate locally to ensure the evaluation was shaped by what was important in the sites. Moreover, the participatory analytical processes which took place at the various sense-making workshops and interviews were particularly helpful in considering the evaluation's implications and ensuring that recommendations stayed relevant and meaningful to Aboriginal and Torres Strait Islander communities and health services.

The national co-design process with the HSCG provided rigour to the evaluation design process and the ongoing meetings with the group added strength to final processes of analysis and data integration and synthesis.

C 5.1.2 Centering Aboriginal and Torres Strait Islander stories and the importance of culture

The generation of data through yarns with Aboriginal and Torres Strait Islander people provided rich personal and narrative data on community members' needs and what they valued about health service design and delivery. The evaluation design recognised the centrality of culture to health outcomes and the specific expertise needed to work across diverse Aboriginal and Torres Strait Islander communities.

The co-design process created structured opportunities for input from Aboriginal and Torres Strait Islander health sector experts and community groups, as well as from others with expertise, responsibility and leadership roles at all levels of the health system.

Moreover, the qualitative data collection methods and analytical approaches supported Aboriginal and Torres Strait Islander voices and centred people's needs and aspirations. For example, the use of a grounded theory approach to analysis of the IAHP's contribution ensured that Aboriginal and Torres Strait Islander people's stories and experiences were set as a baseline for assessing the appropriateness and effectiveness of the IAHP.

C 5.1.3 Creating spaces for learning

The CA4C workshops, emerging findings workshops, and the cross-cutting engagement activities (like the collaboratives and the national workshop) were beneficial in creating opportunities for evaluation partners to create new relationships, share information, and learn from discussions with other PHC service providers and organisations.

Evaluation team members reflected that the most effective workshops were those that brought people from Aboriginal and Torres Strait Islander health services and PHNs together. This enabled conversations and learnings across different segments of the PHC system.

C 5.1.4 A diverse range of perspectives

The evaluation scale and mixed methods design allowed for issues to be explored in depth, and with a wide range of Aboriginal and Torres Strait Islander people. Particularly the place-based approach to data collection, using a multi-site approach, provided opportunities to examine how the IAHP has been implemented in different locations (urban, regional and remote), across organisational boundaries, and within different local settings (for example, geographic, economic, social and political) and population groups.

Health care systems, including primary care services, are increasingly understood to be components within complex social systems, composed of networks of interconnected components that influence each other, and the outcomes generated from such systems cannot be understood by looking at elements within the system in isolation (Ellis, 2013; Matheson et al., 2018; Pourbohloul & Kieny, 2011; van Olmen et al., 2012; Walton et al., 2011). An examination of multiple perspectives of health care and interactions across locations, demographics, organisations and levels of the health care system, provides a robust way of evaluating a complex system level initiative like the IAHP.

The cross-cutting collaboratives, site workshops and the networks developed during the evaluation also enabled additional perspectives, such as voices from particular Aboriginal and Torres Strait Islander advisory and advocacy groups, to be included.

C 5.1.5 A system-level focus

The evaluation took a systems approach that recognised health system complexity and accounted for the interactions between different forms of investment and multiple contextual influences. Sites included a range of communities and PHC service providers, including community-controlled and state and territory-operated Aboriginal and Torres Strait Islander health services, general practices, and other services in a range of different contexts. Thus, the evaluation gathered data at local, state, territory, and national levels, and the number of sites allowed a geographical spread across urban, regional, and remote areas.

Taking a systems approach was a valuable way to explore the influence of the IAHP on the wider health system. It was also a valuable way to identify unintended effects, understand how better to support the community-controlled sector, and to engage the resources of 'mainstream services' more effectively in accelerating progress.

The system-level findings from the evaluation were aligned with the objective of the IAHP and were designed with the IAHP theory of change and program logic in mind.

C 5.2 Limitations of the methodology

C 5.2.1 Sampling of qualitative data

The sampling of participants created natural limits to the evaluation focus and findings. Due to the reliance on ACCHSs to support the identification of community members for participation in the evaluation, the cohort of participants were generally people accessing PHC services through ACCHSs. While the sample did include some people who only accessed mainstream services and staff who work in mainstream PHC services, they were a minority. However, all participants reflected on their experiences of health care broadly and beyond the ACCHS settings, including experiences from accessing mainstream GPs, hospitals, and other specialist services.

There is limited information in the qualitative data from Aboriginal and Torres Strait Islander people that are not connected – or rarely connect – to the health system, either through ACCHSs or mainstream settings. This limits data to inform understanding of what more can be done to ensure equitable access to services based on the needs and aspirations of Aboriginal and Torres Strait Islander people that are not currently obtaining regular health care. The evaluation did, however, engage with a small number of marginalised and vulnerable cohorts of people, including people with disabilities and people who had recently been in prison.

There were no participants in the evaluation under the age of 18 years. However, issues related to health care for people aged under 18 years were examined and the evidence for this examination was based on information told by adults and young people (over the age of 18). There were over 50 participants in community yarns and interviews who were 18-24 years old.

C 5.2.2 Duration of the evaluation

This evaluation was conducted in two phases – design and implementation – and three implementation cycles over a period of 5-6 years. The duration of the evaluation – in combination with the shifting health, social and political landscape – created some challenges that required agility in evaluation approach and implementation.

The duration of the evaluation made it difficult to sustain active engagement with all site partners. The evaluation was affected by changes in staff in site partner organisations, the evaluation team, and the Department of Health and Aged Care. While staffing changes are not unexpected over this duration, this did require continuing investment in relationship building and understanding of the evaluation over the course of the evaluation.

Shifts in the health, social and political landscape resulted in changes to the IAHP within the evaluation period. In addition to the changes to the IAHP there were significant developments in the Aboriginal and Torres Strait Islander health system and the PHC system more generally. A new National Aboriginal and Torres Strait Islander Health Plan was finalised within the evaluation period. There were also changes to the National Agreement on Closing the Gap and the establishment of other review and reform processes, some with overlapping parameters, during the evaluation period.

C 5.2.3 Cultural safety

The nature and scope of the evaluation required advice and leadership from Aboriginal and Torres Strait Islander site partners and evaluation team members to guide safe participation and provide cultural supervision throughout the evaluation process. The limited number of Aboriginal and Torres Strait Islander people in the evaluation team resulted in these team members carrying a high cultural load and experienced strong reliance from non-Indigenous team members for cultural advice and guidance across the evaluation.

C 5.2.4 Coordination of local engagement

The evaluation team included a number of Local Evaluation Coordinators to build stronger connections between the evaluation team and the local communities in the evaluation sites. These roles were not used consistently across all evaluation sites which may have influenced the nature of engagement with communities and services at different evaluation sites.

C 5.2.5 Impacts associated with the COVID-19 pandemic

The duration of the evaluation included the period of the COVID-19 pandemic and associated public health measures. This influenced the ways of working across the evaluation and restricted travel to evaluation sites, for a period, to complete face-to-face engagement with site partners and community members**.** While some engagement moved to online platforms, this mode of engagement limited the delivery of the culturally-informed approaches to knowledge transfer contemplated in the evaluation methodology.

There were also indirect limitations due to the need for site partners to deliver an intensive health response within their communities, limiting engagement with the evaluation at key stages. This also impacted engagement from participants involved in the COVID-19 response at other levels of the system, including state, territory, and national level health sector participants.

C 5.3 Adaptations to the methodology

The cyclic mixed method design collecting qualitative and quantitative data over a long period of time required an adaptive approach that was responsive to changing circumstances. Several adaptions were made during the implementation of the evaluation in response to changing circumstances.

C 5.3.1 COVID-19 adaptations

The main adjustments were made in response to COVID-19, where engagement activities, such as emerging findings workshops and interviews, were frequently adapted to an online platform due to travel and gathering restrictions. Moreover, in relation to the selection of collaborative topics, additional criteria were added to minimise the need to engage with site partners because they were having to prioritise time on the COVID-19 response and many also experienced a shortage of staff.

C 5.3.2 Inclusion of patient experience journey interviews

Yarns with Aboriginal and Torres Strait Islander community members and health service staff were used to generate data on what is valued in health service design and delivery, and what ‘good’ health systems and service delivery looks like. To ensure a diverse range of perspectives, the yarning method was adapted to a patient experience journey interview. This provided an additional way to generate more in-depth information about the experiences of people in ‘hard-to-reach’ groups or those with complex needs.

C 5.3.3 Adapting the CA4C workshops

In seeking knowledge about the priorities for evaluation partners at different levels of the health system and how improvements for change could be created and actioned to meet their goals and aspirations, the plan was to facilitate regular participatory workshops for partners and other organisations to come together, share, and learn. However, the planned level of participation through workshops and networking forums was not feasible in the pandemic environment. Instead, the workshops were adapted to online workshops. In Cycle 3 these were further adapted to include participants from across the evaluation sites, rather than site-specific workshops.

C 5.3.4 Adapting the contribution analysis to suit a flexible and multi-programmed investment like the IAHP

A central part of the evaluation was to assess the contribution of the IAHP and the extent of this contribution. Based on Cycle 1 findings and information gathered about the IAHP, it was not possible to quantitatively follow the flow of money from the funder to specific activities (outputs) at a health service level, and to changes in the PHC system and the health and well-being of Aboriginal and Torres Strait Islander people (health outcomes). This was, primarily, limited by two factors: (1) the inability to source funding data at the health service or evaluation site level, and (2) had this data been available, the difficulty in attributing PHC Program funding data, which can be spent on a wide range of activities and supports, to specific health service interventions, particularly when the program represents one of many funding streams into a health service.

It was clear that the contribution analysis had to rely on qualitative data and a more narrative approach to assessing the IAHP's intervention was needed. Moreover, it was necessary to conduct the assessment of the IAHP in a way that was anchored in Aboriginal and Torres Strait Islander values and aspirations. To account for these requirements, the evaluation applied a grounded theory approach to contribution analysis, which drew on both quantitative and qualitative data, were grounded in community values, and involved the development of contribution cases that were built up and validated through a step-by-step method of testing and sense-checking with participants and a review panel.

C 5.3.5 Re-purposing of Objective 4

Objective 4 of the evaluation required the evaluation '*to recommend an approach for monitoring and evaluation over the longer term (5-10+ years). This is to include consideration of developing a future accountability framework that measures the public value and health outcomes of the Australian Government's Aboriginal and Torres Strait Islander-specific PHC investment'* (Bailey et al., 2018, p. 38).

In May 2022, the Department of Health and Aged Care decided that it was no longer appropriate or necessary for the evaluation to address Objective 4. The department indicated that there was other work progressing aligned to this objective.[19] As a result, work planned under Objective 4 was re-purposed and the department and the HSCG considered alternative work that:

1. Would be of value to the evaluation's health service partners and the Aboriginal and Torres Strait Islander comprehensive PHC sector.
2. Met a clearly identified purpose or purposes, and would be immediately useful and useable.
3. Could be delivered within the remaining evaluation timeline.
4. Would be aligned with and add value to what is already occurring.
5. Supported system learning, multi-directional accountability, and/or change.
6. Enacted principles of Indigenous Data Sovereignty and Indigenous Data Governance.

A decision was made to re-purpose Objective 4 to design a framework that incorporated the care processes and the identification of elements needed to support integrated care models that are valued by Aboriginal and Torres Strait Islander people in comprehensive PHC. This

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[19] This work included: (1) the development of an Accountability Framework as part of the National Aboriginal and Torres Strait Islander Health Plan 2021-2031; (2) work under Action 11 of the Closing the Gap Health Sector Strengthening Plan to rectifying the 'overburden of activity reporting to governments to allow the Aboriginal and Torres Strait Islander community-controlled health sector to focus on outcomes while maintaining accountability'; and (3) the development of the NACCHO Core Services and Outcomes Framework which outlines the foundations for community-controlled comprehensive PHC.

included developing a framework that reflects the identified foundations, principles, processes and elements of value-based integrated care for Aboriginal and Torres Strait Islander people.

APPENDIX D: KEY EVALUATION QUESTIONS

About Appendix D

Appendix D outlines the evaluation’s five key evaluation questions (KEQs) and their sub questions. It also indicates the primary section where the sub questions are addressed within the Final Report.

1. KEQ1: How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?
2. KEQ2: What difference is the IAHP making to the PHC system?
3. KEQ3: What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?
4. KEQ4: How can faster progress be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?
5. KEQ5: How well are the methodological approaches used in the evaluation achieving its aims?

KEQ1: How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?		
Question		**Main Report Location**
1.1	**What do Aboriginal and Torres Strait Islander people value in terms of health service design and delivery?**	**Section 4**
1.1.1	How well is the IAHP enabling PHC systems to meet Aboriginal and Torres Strait Islander people's holistic view of health, including their social and emotional wellbeing, and the social and cultural determinants of health?	
1.1.2	To what extent is the PHC service system, including IAHP-funded and mainstream services, oriented and/or becoming more oriented towards Aboriginal and Torres Strait Islander people's values and priorities?	
1.1.3	To what extent are PHC services accountable for the involvement of Aboriginal and Torres Strait Islander people and communities in the design, planning and decisions made about the delivery of PHC services?	
1.2	**How do Aboriginal and Torres Strait Islander people experience the health system?**	**Section 5**
1.2.1	To what extent is the IAHP contributing to the provision of culturally safe services for Aboriginal and Torres Strait Islander people across the PHC system?	
1.2.2	To what extent are Aboriginal and Torres Strait Islander people and communities enabled to manage their own health care?	
1.2.3	To what extent do Aboriginal and Torres Strait Islander people and communities have control over their own health care?	
1.3	**What is the coverage of PHC services for Aboriginal and Torres Strait Islander people?**	**Section 6**
1.3.1	Are the gaps (if any) due to geographical, demographic and/or other factors?	
1.3.2	To what extent are IAHP-funded and mainstream PHC organisations, and the health system providing services to Aboriginal and Torres Strait Islander people in different contexts, including hard to reach groups rather than just the more accessible populations?	
1.4	**Are some PHC services less accessible for some people?**	**Section 6**
1.4.1	To what extent does the IAHP support Aboriginal and Torres Strait Islander people to confidently access and navigate the PHC systems, including people in remote areas?	
1.4.2	Which cohorts do we know least about?	
1.4.3	Where is there unmet need?	
1.4.4	What are the implications of who is missing out on services and unmet need for the IAHP and the Implementation Plan in terms of policy, investment and practice?	

KEQ2: What difference is the IAHP making to the PHC system?		
Question		**Main Report Location**
2.1	**What mix of initiatives are being funded by the IAHP?**	**Section 3**
2.1.1	How is the investment in Indigenous PHC being implemented at different levels of the system?	
2.1.2	What does the investment in Indigenous PHC look like in practice (i.e. at sites, states and territories, and at national levels of the system)?	
2.1.3	How well are the governance and management processes across the system enabling the implementation of the IAHP?	
2.1.4	To what extent has the IAHP contributed to increasing the capacity of organisations to deliver coordinated and comprehensive care?	
2.1.5	To what extent are the funded the IAHP initiatives the right fit, for whom, and in what contexts?	
2.1.6	To what extent is the mix of initiatives under the IAHP right in terms of maximising the levers for health system improvements in health and wellbeing outcomes?	
2.2	**How well is knowledge and information used to inform and improve policy and practice?**	**Section 7**
2.2.1	To what extent has the IAHP contributed to the provision of adequate information systems and decision supports?	
2.3	**To what extent are PHC organisations accountable for addressing Aboriginal and Torres Strait Islander people's and communities' needs and values?**	**Section 6**
2.3.1	Where there is community input, to what extent does this result in improved health service design, planning and delivery?	
2.3.2	Is this improving over time?	
2.4	**To what extent is the IAHP enabling PHC services to be appropriately staffed and to support staff?**	**Section 7**
2.5	**How well is the IAHP working with the rest of the PHC systems and initiatives of other government agencies?**	**Section 7**
2.5.1	How well are the mainstream PHC systems working with the Indigenous PHC sector?	
2.5.2	To what extent is the communication of the IAHP priorities for health, internally (within the department) and across government and non-government agencies, supporting the provision of joined-up government policy and practice?	
2.5.3	What are the interactions (system dynamics), enablers, and barriers between the IAHP and other programs (including Commonwealth and State and territory government funded) (for example PHNs)?	
2.5.4	To what extent are the funded the IAHP initiatives supplementing other service delivery?	

KEQ3: What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?		
Question		**Main Report Location**
3.1	**To what extent are the IAHP initiatives changing people's lives for the better in terms of health and wellbeing outcomes?**	**Section 8**
3.1.1	How is this changing over time?	
3.1.2	How is the investment in comprehensive PHC and targeted investment (in areas such as child and maternal health, eye, ear and oral health, smoking, chronic disease, mental health, and alcohol and other drugs) making a difference in terms of outcomes?	
KEQ4: How can faster progress be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?		
4.1	**What, if anything, needs to change in the IAHP, the Implementation Plan, and in the broader policy settings and processes?**	**Section 9**
4.2	**What effective action can be taken to address the social and cultural determinants of health and environmental health?**	**Section 9**
4.3	**What needs to change at different levels of the health system (site, state and territory, and national)?**	**Section 9**
4.4	**What needs to change in other policy areas (for example education, employment, social security, housing, and food)?**	**Section 9**
4.5	**How can greater progress be made to achieve PHC system reform?**	**Section 9**
4.5.1	How can success be shared more broadly with the IAHP funded services, and across the PHC system, to celebrate and support learning?	
4.5.2	How can knowledge and information best be used across the IAHP to inform and improve policy and practice?	
4.5.3	How can the reach of PHC be extended to cover hard to reach groups (due to geography and/or population factors)?	
4.5.4	How can the overall system of the IAHP funding and grant-making processes be improved?	
KEQ5: How well are the methodological approaches used in the evaluation achieving its aims?		
There are no sub questions for KEQ5 and this key evaluation question is addressed in a separate report		

APPENDIX E: IAHP PROGRAM THEORY AND LOGIC

About Appendix E

Appendix E details the Department of Health and Aged Care’s theory of change and program logic for the IAHP.

This theory of change and program logic informed the evaluation design.

E 1.1 Situation

Aboriginal and Torres Strait Islander people experience significantly worse health outcomes than non-Aboriginal and Torres Strait Islander Australians. The IAHP aims to improve the health of all Aboriginal and Torres Strait Islander people through a variety of activities focused on local health needs, as well as targeted responses to particular health issues and activities across the life course.

The IAHP is implemented as part of a complex system. The First Nations Health Division (FNHD) in the department seeks to influence the system more broadly so that it works for the benefit of Aboriginal and Torres Strait Islander people.

E 1.2 Purpose of articulating a program theory for the IAHP

The IAHP theory of change and program logic is intended initially as an internal divisional tool to help bring about a shared vision of how the IAHP is supposed to work to achieve its objectives. The theory is intended to enable staff to see how their work links to the bigger picture of what the program is trying to achieve. It provides a tool to inform program implementation, refinement, and policy development to ensure that efforts are best directed to addressing needs and improving outcomes. It will also form the basis for identifying the FNHD's strategic evaluation priorities.

The theory of change and program logic will assist in evaluation design and scoping work, not just in terms of assessing the effectiveness of the IAHP at the service system or client levels, but also in terms of the FNHD's policy influence in the whole-of-department and government context. It is intended that sub-measures of the IAHP areas will map the overarching theory of change, and that a series of layered theories will be produced that will also help inform the design of future evaluations.

A longer-term goal is that the theory of change be used externally as a communication tool, for example, when working with other government agencies and stakeholders to bring about improvements in Aboriginal and Torres Strait Islander health policy, system, and services.

E 1.3 How to read this program theory

The program logic (Figure E-1) for the IAHP is an outcomes chain logic model. In other words, it focuses on results. The diagram reads from bottom to top, beginning by articulating the assumptions, context and external factors for the program. It is intended that each outcome statement (i.e., reading from left to right from the specific level of activity/outcome) should lead consequentially to the next, with each 'stream' eventually contributing to the three high level outcomes at the top and interacting with one another as they go.

The theory is divided into four streams:

1. Policy Framework, which is focused on how the elements of the various government systems at all jurisdictional levels work together to deliver evidence-based strategic outcomes.
2. System Level Enablers, which focuses on the key health system building blocks that the IAHP seeks to influence through the resources, inputs and activities that it supports.
3. Services System, which applies a systems lens to how the components of the health system work together, including planning, governance and integration.
4. Aboriginal and Torres Strait Islander people, which focuses on how Aboriginal and Torres Strait Islander communities and individuals interact with the various components of the health system.

E 1.4 Context

Improving the health and wellbeing of Aboriginal and Torres Strait Islander people underpins the Government's priorities of education, employment and safe communities.

COAG established a framework for tackling Aboriginal and Torres Strait Islander disadvantage with six targets (2008). Two of these targets relate directly to the health portfolio: to close the gap in life expectancy within a generation (by 2031), and to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five by 2018.

Progress is being made towards closing the gap in health outcomes. There has been a large reduction in deaths due to circulatory disease and a small but significant decrease in smoking rates. There have also been improvements in children being immunised and a reduction in infant deaths.

However, Aboriginal and Torres Strait Islander people still face a great number of health challenges and experience more illness, disability, and injury than other Australians. Aboriginal and Torres Strait Islander children born today can expect to live shorter lives than non-Aboriginal and Torres Strait Islander children-10.6 years shorter for males, and 9.5 years for females. Around two-thirds of the gap is due to long-term health problems.

The IAHP is implemented as part of a broader complex health system. The program will align with the implementation of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, which focuses on systematic service improvements and addressing geographic disparities. Program implementation will also align with broader health system effectiveness measures, such as electronic health records and the establishment of the PHNs and the planning and coordination opportunities they represent.

E 1.5 Key assumptions underlying the program theory

Major systems reform is needed to drive change so that the Australian health care system is appropriately oriented to the health needs of Aboriginal and Torres Strait Islander people. Concerted and long-term effort is needed across all levels of the health system to bring about the desired changes. The department, through the IAHP, can exercise significant leverage to this end.

At the service system level, there is wide variation in the local and regional context in which services operate including:

- the type of service delivery model (for example, community-controlled and mainstream)
- regional support arrangements
- the size and staffing configuration of the service
- the availability of other service providers
- demographic profile
- the types of activities being implemented (service mix)
- geography including degree of remoteness.

Aboriginal and Torres Strait Islander people exercise individual choice about where they access health care and may use Aboriginal and Torres Strait Islander specific primary health care organisations or mainstream health care (private general practice). However, the availability and choice of health care providers is more limited in remote areas.

Market failure makes it necessary for the Commonwealth to fund organisations to deliver health services to Aboriginal and Torres Strait Islander people, particularly in remote areas.

Access to comprehensive primary health care and prevention will improve health outcomes, lower the demand for acute care, and improve the cost effectiveness of health care (N.B: access is defined as the opportunity to have health care needs fulfilled). A comprehensive approach to primary health care takes into account the social determinants of health, health inequities, health promotion, illness prevention, treatment and care, community development, advocacy, rehabilitation, inter-sectoral action, and population health approaches (addressing the needs of the whole population, not just those who walk through the door).

Primary health care organisations should be the first point of contact and are well placed to support people through the health system and act as home points of care.

Aboriginal community-controlled health organisations are responsive to community needs through community-based boards.

There are varying levels of capacity among funded organisations to provide quality care. Significant policy and program effort needs to be put into driving systems improvements in a way that ensures effective risk management, but also harnesses intrinsic goodwill and motivations of staff. Over time this will drive culture change and greater accountability in Aboriginal and Torres Strait Islander communities for the operation of the health system.

The evidence base should continue to be built and shared as it informs policy and program decisions (for example, investment in the early years).

The effectiveness and efficiency of funded primary health care organisations will improve over time through the IAHP and its continued refinement in terms of design and implementation.

E 1.6 External factors that affect the success of the IAHP

There are a range of external factors that affect the success of the IAHP. Given that the main objective of the IAHP is to improve Aboriginal and Torres Strait Islander people's access to health care, the conceptual framework for this access is used as the basis for identifying relevant external factors. This encompasses the interface between health systems and populations.

The health system dimensions of access are: approachability, acceptability, availability and accommodation, affordability, and appropriateness. There are five corresponding abilities that populations need to interact with the system and generate access: the ability to perceive, to seek, to reach, to pay, and to engage.

Key external factors are both within the broader health system, such as workforce, as well as across the social determinants of health, such as education and employment. The influence of these external factors on the success of the IAHP emphasises the need for the Indigenous Health Division to engage with relevant policy areas across the department as well as government to ensure success.

E 1.7 Outcome and activity descriptions

The policy framework stream is focused on how the elements of the various government systems at all jurisdictional levels work together to deliver evidence-based strategic outcomes in collaboration with stakeholders and participants in the health system. Its success requires the following enablers to be present:

- A willingness by policy makers to work together and share information freely.
- Open communication between all participants.
- Long-term planning supported by robust funding and a willingness to allow initiatives to mature before enacting additional change.
- The IAHP provides the policy and funding foundations for Aboriginal and Torres Strait Islander health to identify priorities and provide authority for a comprehensive PHC approach that includes system integration and coordination between primary, secondary, and tertiary care. This informs the implementation of the IAHP and enables the following results and outcomes.

E 1.7.1 Short-term

IAHP priorities for health are communicated internally and across government and nongovernment agencies. The program priorities are the foundation for this stream, and it is critical that they are communicated to all stakeholders in the policy space.

Common understanding is reached as to how IAHP aligns with health and social objectives. This assumes that policy makers at all levels of government, as well as with non-government stakeholders, have a clear understanding of the interactions between the IAHP and the broader policy context. It also assumes that relevant agencies will examine their own initiatives and see how they align.

E 1.7.2 Medium-term

More aligned policy, program design, implementation, and accountability for Aboriginal and Torres Strait Islander health. This results in a more effective response that takes into account the varied factors and issues relating to the IAHP and to Aboriginal and Torres Strait Islander health more broadly (across government and non-government sectors). This outcome assumes that agencies' understanding of the IAHP will lead to government and non-government policy participants working together to align their approach to Aboriginal and Torres Strait Islander health and to coordinate policy development and program implementation.

Improved strategic alignment of data collection, monitoring and evaluation for system improvement. The assumption underlying this outcome is that aligned policy and programs will result in better data collection, monitoring, evaluation, and a willingness to accept responsibility for outcomes.

E 1.7.3 Long-term

IAHP has better understanding of needs, drivers, and policies affecting the Aboriginal and Torres Strait Islander health system, service, and local levels. This outcome relates to the improved use of data, not just in terms of planning, but also as it relates to continuous quality improvement and needs analysis.

Informed improvements to Aboriginal and Torres Strait Islander health policy, system, and services. This outcome assumes that as a consequence of holistic data being made available at various levels of the system, and reflective practice occurring, changes will occur that are based on the best available evidence.

E 1.8 System-level enablers

The system-level enablers represent the inputs and resources required for each of the health system building blocks based on the World Health Organization's 2007 health systems framework. The IAHP provides funding for a number of building blocks, while other divisions, such as the Health Workforce Division and the Pharmaceutical Benefits Division, support others (for example, the Workforce and Access to Medicines health system building blocks).

E 1.9 Service delivery

Through the IAHP, the Commonwealth funds organisations (including Aboriginal and Torres Strait Islander Community Controlled Organisations as well as other primary health care services) to provide culturally appropriate, comprehensive primary health care to address the health needs of Aboriginal and Torres Strait Islander people. This includes funding for infrastructure, such as capital works projects.

The IAHP also targets funding to influence the health system to respond to identified key priorities for Aboriginal and Torres Strait Islander health:

Table E-1: Key priorities

Priority	Measure/area of focus
Child and family health	Better Start to Life-New Directions and Australian Nurse Family Partnership Program
Chronic disease prevention, detection, and management	TIS Program
Northern Territory disadvantage	Northern Territory Remote Area Investment
High disease burden conditions- oral, hearing and vision health	Specialists and allied health
System integration	Funding contributor to the PHC networks

Through the IAHP, the Commonwealth also provides incentives and targeted funding to general practice to improve Aboriginal and Torres Strait Islander people's access to primary health care.

The IAHP funds the following system-level supports to improve system effectiveness, performance, and the quality and safety of care at the local, regional, and national level.

E 1.10 Information supports

Supports include funding guidelines, monitoring activity, data collections (for example national Key Performance Indicators), evaluation, and research.

E 1.11 Governance and leadership

Supports include the National Continuous Quality Improvement (CQI) Framework and Implementation Plan and funding to support sector governance/leadership capacity building (for example, NACCHO and affiliates).

The IAHP also contributes funding to PHNs to promote capacity building to enable system integration between primary, secondary, and tertiary care.

E 1.12 Service system

For the services system to work optimally, the following enablers are assumed to be present:

- Ongoing learning, including continuous quality improvement being embedded at all levels of the system.
- Leadership, governance, and commitment from system participants.
- A commitment to mobilising systems thinking.
- Shared understanding and accountability.
- Partnerships and collaboration (between health services and with Aboriginal and Torres Strait Islander communities and between government agencies).

E 1.12.1 Short-term

Community needs are incorporated in planning and decision making. This is a foundational element of planning, allowing community preferences and needs to be reflected in decision making at all levels.

Improved planning for Aboriginal and Torres Strait Islander population health (national, regional, and local). This outcome is critical for the system stream. It assumes that the approach being adopted by the IAHP will achieve improved planning outcomes to meet health and community needs.

E 1.12.2 Medium-term

Four streams of medium-term outcomes occur simultaneously.

Health services are appropriately staffed, and staff are supported. This outcome reflects the importance of staff with the right training and support being part of the system. It also speaks to the importance of retaining those staff over the longer term.

Comprehensive range of services provided. A well-planned and staffed service, with good systems in place, is in a position to provide a comprehensive range of primary health care services, including a population health approach.

Service providers are brought together through management and referral systems. This outcome assumes that appropriate planning will facilitate the links and communication channels that will underpin the requisite system improvements. It focuses on the system linking service providers, so that referrals can happen seamlessly, and patients are not subject to repeated questions.

Providers exchange technical and cultural information and jointly develop solutions. This outcome is driven by the collaboration of participants in the service system. It assumes that providers have the relevant skills required to deliver it.

The above streams of results contribute to the following outcomes.

Health and social services providers collaborate across the care continuum to deliver tailored services This outcome is focused on ensuring that the various available services, including ancillary (outreach, allied health and specialists) and non-health services, work effectively together to treat all client needs. It assumes that services have the capacity and resources to undertake the planning and collaboration required to deliver this outcome.

Health services are more accessible. This outcome assumes that effective planning will result in more optimal resource allocation leading to deployment of appropriate services that are made available, approachable, acceptable, and affordable for the target population groups.

Improved prevention, detection and treatment across the life course. This outcome is focused on ensuring that care is provided at every stage of a client's life, with a particular focus on prevention (including population health approaches) to deal with smaller issues before they turn into acute issues to be treated in a hospital setting.

Services are improved across the system and lessons are shared and used as part of service improvement. This outcome assumes that reflective practice, open communication, and free knowledge exchange will result in the sharing of lessons to inform improvements across the system.

Services are more effective in creating health and wellbeing. Services are synchronised and leveraged so that the various needs of individual clients can be addressed, and outcomes are improved.

Integrated service system is formalised to respond effectively to health needs. Once services are working well collectively, a more organised approach will ensure that the gains made in collaboration between the services are not lost over time and that improvement processes are embedded within the culture of all system participants to meet the health needs of clients and the target population.

E 1.13 Aboriginal and Torres Strait Islander people

This stream focuses on the experience of clients and communities within the health system. For the outcomes to be achieved, it is assumed that the following enablers are present:

- Open communication between services and clients.
- Services being part of communities, rather than just providing services to communities.
- Respectful understanding of client perspectives.

E 1.13.1 Short-term

Clients are more aware of services, and believe they are culturally safe. This outcome is focused on ensuring that clients know that the services they need are available, and that those services are available in ways that are culturally competent.

Clients access services. This leads to clients using the services that are on offer. It encompasses an ability to perceive the need for care, and the ability to seek, reach, pay for and engage with health care.

Clients receive quality, sensitive response to need. This leads to clients receiving culturally sensitive, appropriate quality health care to meet their health needs. It relies on the assumption that the care will be of a high quality.

E 1.13.2 Medium-term

Clients are motivated to take responsibility for health. This assumes that as their health improves and they see tangible outcomes, clients will take a greater part in driving further improvements, making informed decisions.

Clients connected with all relevant services to meet needs. This outcome is about how clients will be referred to services that meet their needs, including the needs that might not be within the health system (such as social services). It assumes that the services clients need will be available and appropriate in their geographical area.

Clients implement personal health and wellbeing advice. This outcome focuses on clients adhering to the Health Plan they have developed with health professionals. It assumes that high-quality, culturally appropriate services will increase the likelihood of this outcome occurring, and that clients have the ability to engage actively in their health care.

E 1.13.3 Long-term

Improved client wellbeing enables increased participation. This outcome assumes that if a client is experiencing better health outcomes they will participate more meaningfully in a variety of areas, including but not limited to health, education and employment.

Communities value and maintain health supporting environments. As the health of communities consequentially improves, they will act to ensure that gains are embedded.

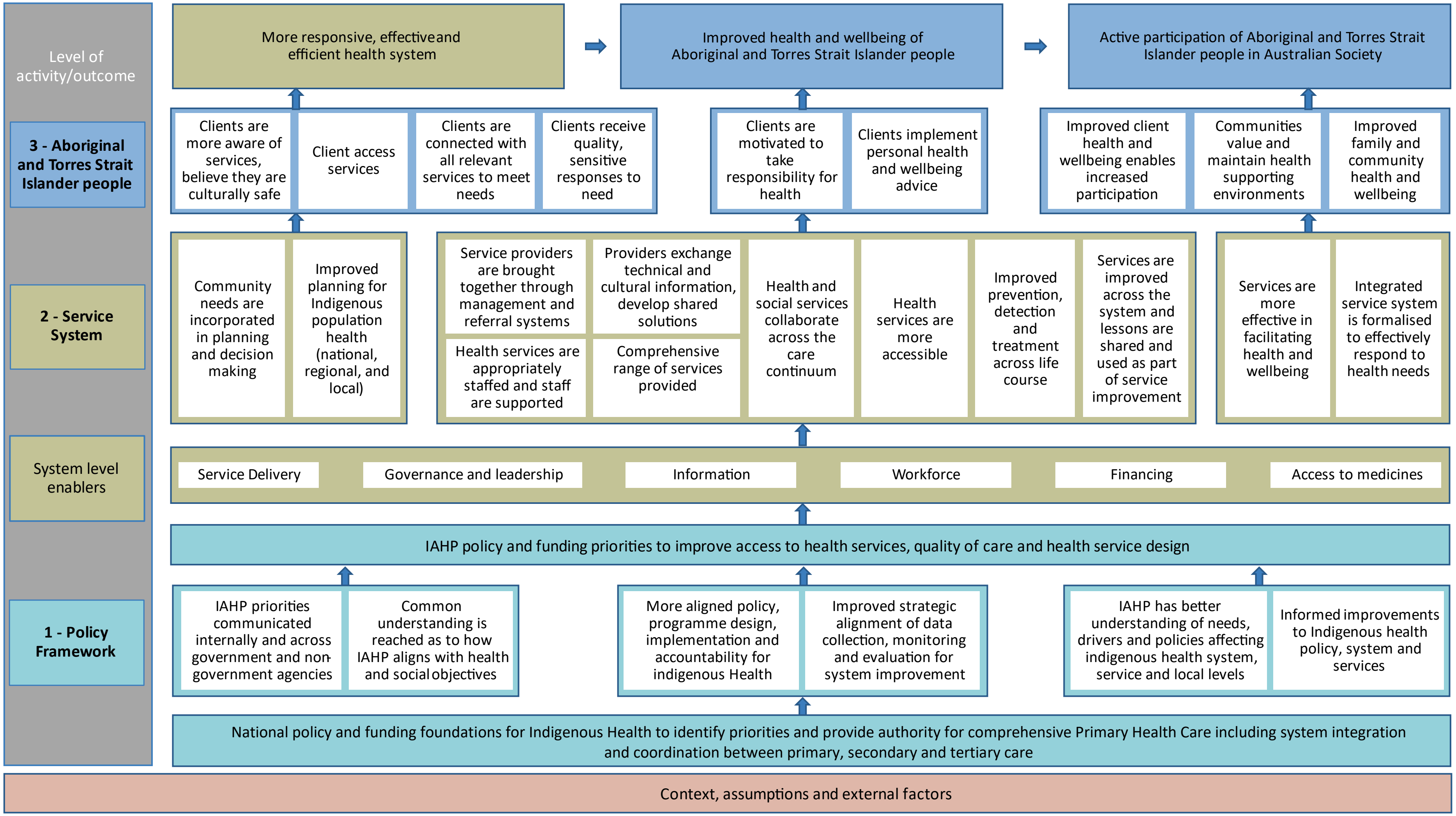
Improved family and community health and wellbeing. This outcome assumes that as a client's health improves it will, in turn, improve the lives of those around them through that person being able to participate and contribute more meaningfully in community life. It also assumes that by demonstrating the outcomes derived from health care services and healthy behaviours, others in the client's social network will be motivated to undertake similar action.

E 1.14 Overarching outcomes

All of the four streams contribute to the overarching outcomes of the IAHP:

- More responsive, effective and efficient health system.
- Improved health and wellbeing of Aboriginal and Torres Strait Islander people.
- Active participation of Aboriginal and Torres Strait Islander people in Australian society.

Figure E-1: IAHP Program logic



APPENDIX F: IAHP PRIMARY HEALTH CARE PROGRAM

About Appendix F

Appendix F details the aim, objectives, expected outcomes and funding eligibility under the IAHP PHC Program.

F 1 Aim of IAHP PHC Program

The aim of the IAHP PHC Program is to improve health outcomes for Aboriginal and Torres Strait Islander people through the following (Australian Department of Health, 2019c):

- the delivery of PHC services tailored to the needs of the Aboriginal and Torres Strait Islander community, including:
    - culturally-appropriate clinical services
    - a range of population health services
    - activities that support the delivery of essential clinical services
- improving access to antenatal care and child, maternal and family health services by Aboriginal and Torres Strait Islander children, their mothers, and families
- the prevention, detection, and management of chronic diseases
- investment in priority health areas in regions of high health need or population growth
- improving the clinical effectiveness of the health system and supporting sustainable, long term service reform delivery and improvement through Continuous Quality Improvement (CQI).

F 2 Objectives

Organisations funded under the program will:

- **Objective 1:** deliver a life-course approach to planning and delivery of comprehensive primary health care that maximises individual and population health, and mitigates preventable hospitalisations
- **Objective 2:** enable/assist clients, carers, and families to exercise choices related to their care, and encourage their participation in local service priority setting and planning, design, and evaluation
- **Objective 3:** deliver comprehensive multi-disciplinary, collaborative, team-based services in which culture and clinical best practice is central in the planning and delivery of culturally appropriate primary health care services to meet the health and wellbeing needs of individuals, families, and communities
- **Objective 4:** embed CQI and best practice clinical and organisational governance into their practices, supporting good health outcomes for clients and service sustainability.

F 3 Expected outcomes

The expected outcomes of the program are to:

- provide Aboriginal and Torres Strait Islander people with access to primary health care they need, when and where they need it
- continue to deliver culturally-appropriate primary health care services
- empower Aboriginal and Torres Strait Islander people to better manage their health conditions in the local community
- reduce preventable disease and hospitalisation among Aboriginal and Torres Strait Islanders.

F 4 Funding eligibility

Figures F1-F3 illustrate activities eligible for funding under the PHC theme. Figure F1 illustrates the types of activities included under Clinical Services. Figure F2 illustrates activities included under Population Health activities, and Figure F3 illustrates the types of activities that support service delivery. These figures are based on information in the PHC Program Grant Opportunity Guidelines (Australian Department of Health, 2019c).

Figure F-1: IAHP PHC Activity eligible for funding: Clinical Services

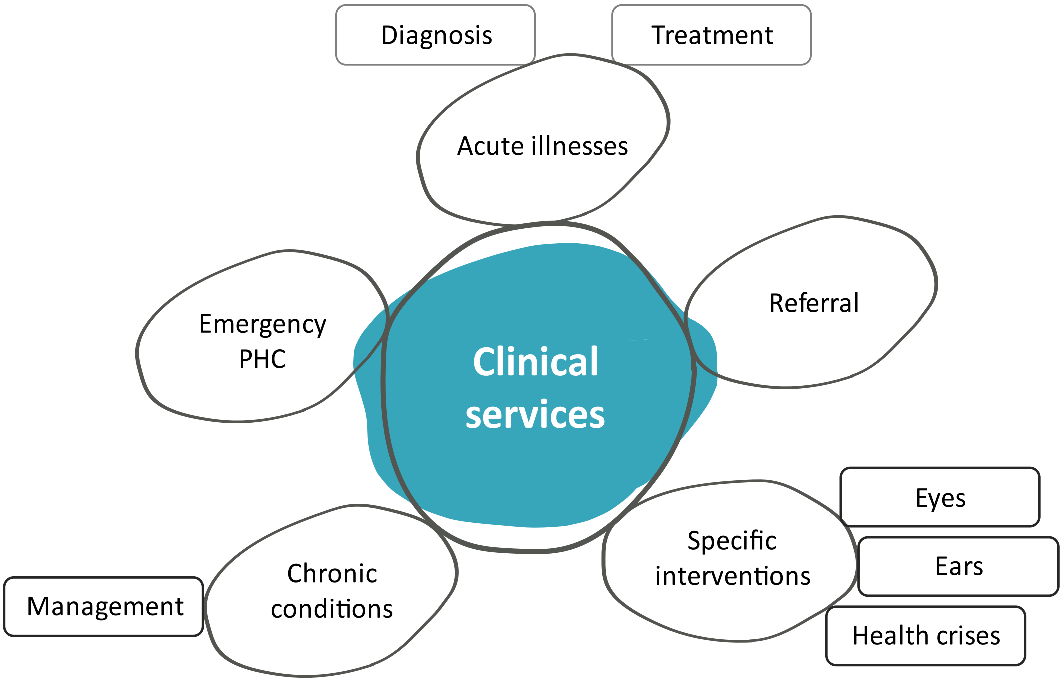


Figure F-2: IAHP PHC Activity eligible for funding: Population health programmes

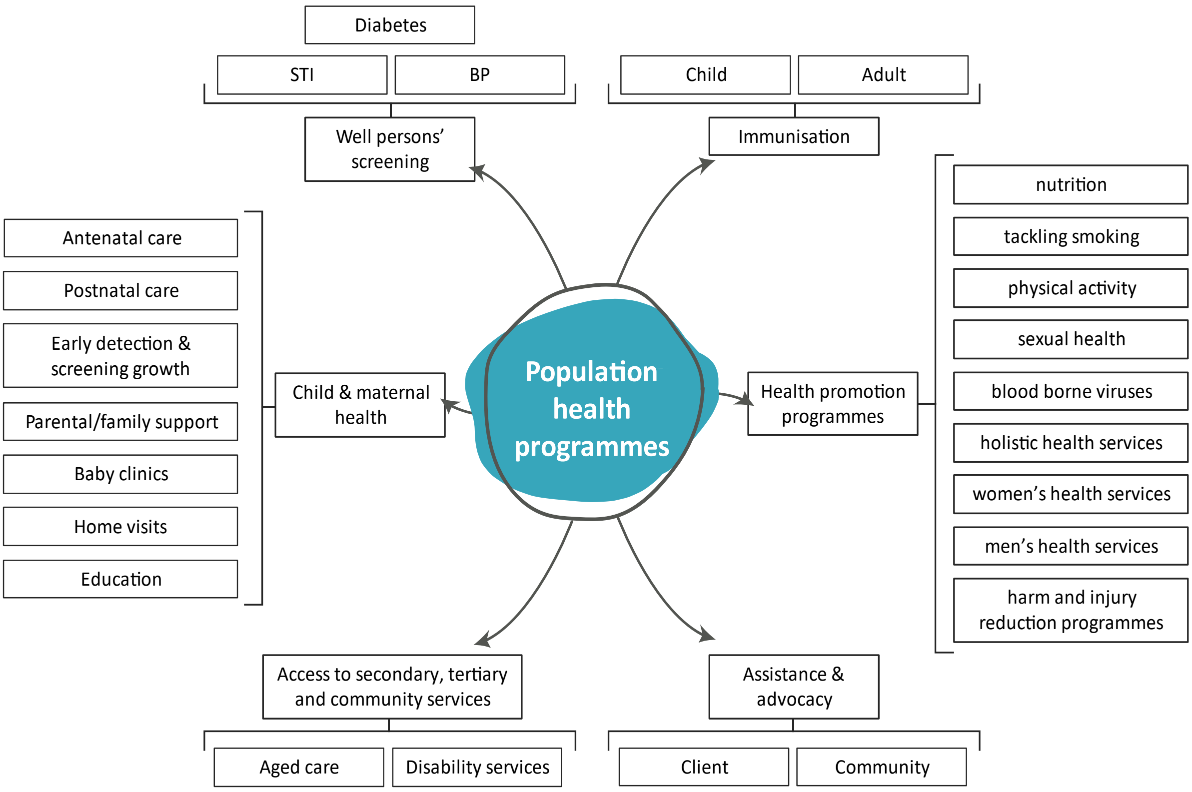
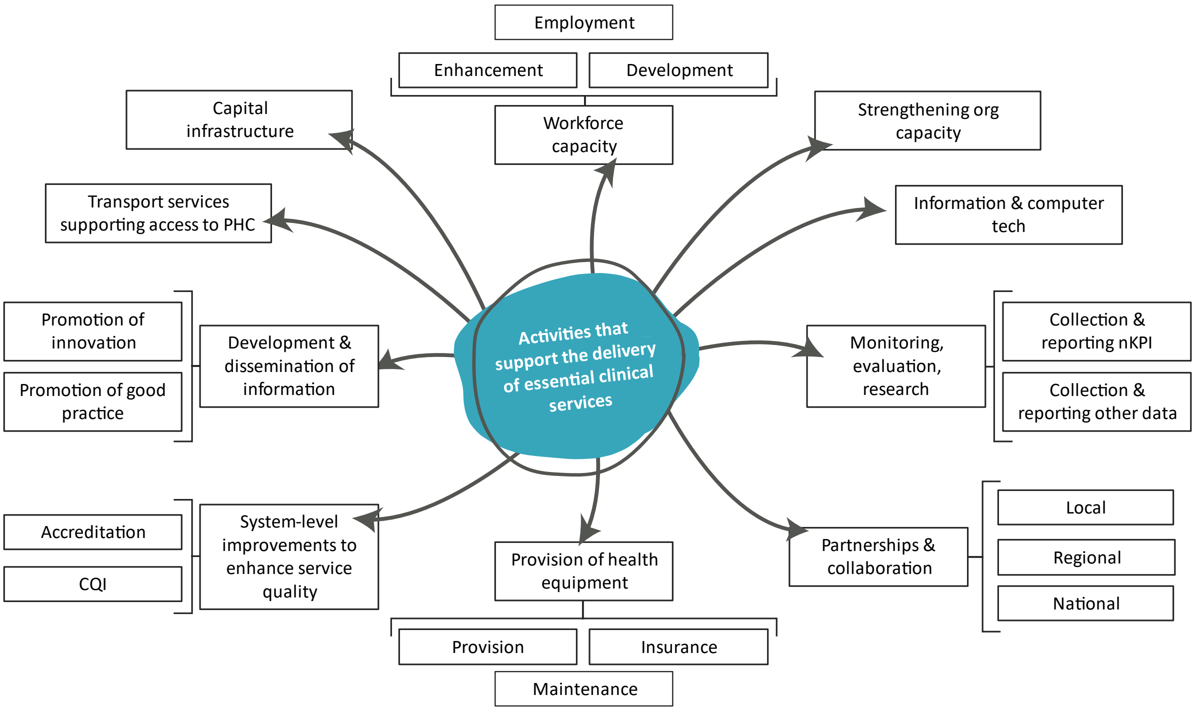


Figure F-3: IAHP PHC Activity eligible for funding: Support activities



APPENDIX G: IAHP FUNDING PROCESSES

About Appendix G

Appendix G details the IAHP’s funding processes, including:

- grant application and award processes
- definitions of grant opportunities
- variations in funding processes
- PHC funding model

G 1 Grant application and award processes

Most grant opportunities available under the IAHP are advertised via GrantConnect. The application process typically flows through five stages:

1. Submission of grant application and/or proposal.
2. Assessment of application/proposal against assessment criteria.
3. If successful, a grant is awarded, and a grant agreement is signed between the Department of Health and Aged Care and the grant recipient.
4. Grant recipients are to undertake the activity/initiative in line with the grant agreement and complete milestones and reporting requirements. The department generally makes payment, monitors progress, and collates reports.
5. The outcomes of the activity/program are evaluated, based on the information provided by grant recipients through various reporting materials.

Assessment of grant suitability or eligibility is assessed against specific criteria. The department will assess the performance of eligible organisations using information held by the department. This assessment will examine past value for money, compliance with the grant agreement, progress towards meeting grant activity milestones, quality, and performance concerns and any higher levels of monitoring put in place by the DSS (Australian Department of Health, 2019c).

Suitability is based on:

- How well an organisation's past performance meets the criteria using the following documentation:
    - performance reports
    - activity work plans and budgets
    - financial declarations
    - correspondence with the eligible organisation
    - other documentation held by the department as collected under current grant agreements.
- Whether an organisation's past performance continues to provide value with relevant money. When assessing the extent to which the project represents value with relevant money, the department consider:
    - the overall objective/s to be achieved in providing the grant
    - the relative value of the grant sought
    - the extent to which the geographic location matches identified priorities
    - the extent to which the evidence demonstrates that it will contribute to meeting the outcomes/objectives
    - how the grant activities will target groups or individuals.

The grant assessors are typically department staff. The assessors will review and make recommendations to a grant decision maker, who has the final say in terms of grant approval, funding amount, and the terms of condition. The assessors may seek additional information within the Commonwealth about an organisation and may also consider information about an organisation that is available through the normal course of business.

The assessors will recommend to the decision maker which organisations are suitable to receive a grant. The decision maker is the First Assistant Secretary in the First Nations Health Division. The decision maker decides which grants to approve, considering the advice of the assessors.

The decision maker will not approve funding if there is insufficient program funding available across relevant financial years for the grant. There is no appeal mechanism for decisions to approve or not approve a grant.

There are various types of grant opportunities that the department may undertake to award grants under the IAHP. These are (see box below for a definition of each of these types):

- Open competitive grant opportunity.
- Open non-competitive grant opportunity.
- Closed non-competitive grant opportunity.
- Demand driven grant opportunity.
- Targeted or restricted competitive grant opportunity.
- One-off and ad-hoc grants.
- Procurement.

In areas of limited market access or specialist requirements (such as high quality, comprehensive, culturally appropriate PHC), the department is expected to preference non-competitive rounds. The non-competitive rounds will assess past delivery of services, the maintenance of continuity of care and strong local knowledge.

Definitions of types of grant opportunity

The following definitions are from the Community Grants Hub website[1].

Grant

An arrangement for the provision of financial assistance by the Commonwealth or on behalf of the Commonwealth:

- under which relevant money or other Commonwealth Resource Fund money is to be paid to a grantee other than the Commonwealth
- which is intended to help address one or more of the Australian Government's policy outcomes while assisting the grantee achieve its objectives.

Open competitive grant opportunity

Have open and closed dates, with eligible applications being assessed against nominated selection criteria. The delegate [funder] may select to fund some or all applications.

Open non-competitive grant opportunity

Are open to the market for eligible organisations or individuals to apply. The delegate may select to fund all applications that meet eligibility and selection criteria. Typically, all eligible applications are funded.

Closed non-competitive grant opportunity

Applicants are invited by the entity [funder] to submit applications for a particular grant and the applications or proposals are not assessed against other applicants' submissions but assessed individually against other criteria. Typically, all eligible applications are funded.

Demand driven grant opportunity

Applications that satisfy stated eligibility criteria receive funding, up to the limit of available appropriations and subject to revision, suspension, or abolition of the grant opportunity.

Targeted or restricted competitive grant opportunity

Applications close on a specified date and applicants are assessed against selection criteria and ranked in order of merit.

One-off and ad-hoc grants

Grants determined on an ad hoc basis, usually by ministerial decision. These grants are generally not available to a range of grantees or on an ongoing basis.

Procurement

Encompasses the whole process of procuring goods and services. Procurement achieves policy objectives through the acquisition of goods and services for the Commonwealth's own use or for the use of third parties.

G 2 Variations in funding processes

The guidelines and criteria for application, assessment, and reporting varies depending on the specific funding stream, program, grant opportunity, and who the fundholder is. For example, most programs and activities funded through the targeted health activities funding stream (for example, ANFPP and the TIS program) each have their own application and assessment guidelines.

PHNs, which receive IAHP funding to manage the ITC program and the Aboriginal and Torres Strait Islander Mental Health Program, also operate under specific guidelines. PHNs are commissioned to provide service delivery arrangements in relationship with existing health service providers, including those delivered by the Aboriginal and Torres Strait Islander community-controlled health sector. PHNs are granted funding through open competitive funding rounds and the amount of funding allocated is determined by several factors, including population, rurality and socio-economic factors. The department may directly allocate additional funding to PHNs through non-application-based processes where the government determines that additional policy outcomes can best be achieved by PHNs.

PHN funding to health service providers should be based on a framework that includes needs assessment, market analyses, and clinical and consumer input, including through Clinical Councils and Community Advisory Committees. Their funding decisions must be transparent, defensible, well documented and made available to the Commonwealth upon request (Australian Department of Health, 2021). The process for undertaking a needs assessment is outlined in the PHN Needs Assessment Guide.

G 3 PHC Program funding model

A new funding model to allocate IAHP PHC Program funding was developed over 2017-2019. The model was implemented from 1 July 2020.[20]

The overarching purpose of the funding model is to distribute the PHC funding fairly and transparently based on activity levels, the cost of delivering services, and the relative health needs of locations. Some of the key characteristics of the new model are:

- $90 million additional investment over 2020 to 2023 to further support PHC and targeted to need.
- 3-year funding agreements for greater workforce continuity and planning.
- Annual indexation for all services.
- No service to lose funding-funding levels maintained in real terms.
- Streamlined grant application processes to reduce administrative burden.

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[20] The IAHP PHC Program Grant Opportunity Guidelines were updated in November 2019. Another updated version was published in 2020, outlining information for the IAHP Emerging Priorities Round Grant Opportunity.

The funding model uses the following approach to allocation of PHC Program funding as the cost of delivering PHC varies widely across Australia. The location of clinics and the health care needs of clients affects the cost-of-service delivery.

- **Activity:** This is calculated using client numbers and episodes of care as reported by organisations in the annual OSR.
- **Cost of service delivery:** The funding model uses the location of service delivery based on the Remoteness Structure component of the Australian Bureau of Statistics' Australian Statistical Geography Standard.
- **Health need:** The model calculates the impact of social determinants of health affecting the level of sickness and disadvantage experienced by communities. This is calculated using an estimate of the health care needs of clients based on the Indigenous Relative Socioeconomic Outcomes index (IRSEO), and a measure of Years of Potential Life Lost (YPLL) to adjust the amount of funding each service is calculated to receive (Australian Department of Health, 2019a).

In summary, the share of total IAHP PHC Program funding each organisation receives under the new funding allocation model depends on:

- the total number of clients
- episodes of care provided
- the relative remoteness of the service
- the health needs of Aboriginal and Torres Strait Islander Australians in the local area.

The number of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander clients are also considered under the funding model. Given the purpose of the IAHP is to provide Aboriginal and Torres Strait Islander people with access to comprehensive, culturally appropriate PHC across Australia, no more than 15% of an ACCHS's total number of clients and episodes of care will count towards the total in the funding model if delivered to non-Aboriginal and Torres Strait Islander people (Australian Department of Health, 2019b).

From 1 July 2020, funding has been distributed to eligible organisations which are the majority of ACCHSs delivering comprehensive PHC to Aboriginal and Torres Strait Islander communities. Eligible organisations did not need to submit a grant application. The department assessed suitability against the grant criteria.

IAHP PHC Program funding is allocated under three Grant Opportunity Guidelines:

6. PHC Funding Model (GO2884, closed non-competitive) – funding for 115 ACCHSs to deliver comprehensive primary health care, based on the IAHP PHC funding model.
7. PHC funding for organisations outside the PHC funding model (GO3199, closed non-competitive) – funding for 16 ACCHSs and 30 mainstream organisations (including state and territory government clinics) to deliver primary health care.
8. PHC Service Expansion Funding (GO4166 – targeted competitive) – funding for 24 ACCHSs and 3 mainstream organisations (excluding state and territory entities) to

expand access to comprehensive primary health care in regions of high health need and/or high population growth.

In response to a request from NACCHO, in March 2023 the Australian Government agreed to extend current IAHP PHC Program grant agreements for 12 months, to assist finalisation of the approach for 4 year rolling funding agreements for ACCHSs under the funding model. During the extension period, the Department of Health and Aged Care will continue working with NACCHO to settle the best approach for implementing the new 4 year rolling funding arrangements, including application of the existing IAHP PHC funding model. Longer term PHC funding arrangements aim to facilitate the transition to the Core Services and Outcomes Framework, which is currently being developed by NACCHO and the sector to more accurately reflect the range of services ACCHSs deliver.

APPENDIX H: ITC WORKER ROLES, SKILLS, AND QUALIFICATIONS

About Appendix H

Appendix H provides additional details regarding Integrated Team Care (ITC), and the roles, skills and qualifications of team members:

- Outreach worker
- Care coordinator
- Indigenous Health Project Officer (IHPO)

Table H-1: ITC roles, skills and qualifications

Position	Roles / responsibilities	Skills and qualifications required
Outreach worker	Practical assistance, including helping clients travel to medical appointments Community liaison-encourage community members to access health services Help with identifying barriers to health services Feedback regarding barriers, and in conjunction with IHPO, work to implement solutions to health services	No formal qualifications required (non-clinical role) Strong links with the community in which they work Effective communication skills Not required to be Aboriginal or Torres Strait Islander but strongly recommended
Care coordinator	Arrange the services in clients' care plans as per GP instructions Assist clients to participate in regular reviews by primary care providers Provide clinical care Provide feedback to GP about client's living environment when relevant to their care plan Ensure arrangements are in place for the client to get to appointments Transfer and update client's medical records Work with clients to build understanding of their condition so they adhere to treatment regimes and develop self-management skills Work collaboratively with services in their area to link clients with the services they need	Health worker qualification Good working knowledge of the health system, including referral pathways Ability to provide culturally appropriate care Advocate on behalf of Aboriginal and Torres Strait Islander clients Ability to work collaboratively with a range of health professionals, including GPs, specialists, nurses and allied health professionals Not required to be Aboriginal or Torres Strait Islander but recommended
Indigenous Health Project Officer (IHPO)	Policy and leadership Planning and needs assessment Assist with improving integration of care across region	Not specified Not required to be Aboriginal or Torres Strait Islander but recommended

APPENDIX I: MEMBERS OF HEALTH SECTOR CO-DESIGN GROUP

About Appendix I

Appendix I details the membership of the Health Sector Co-Design Group (HSCG) from 2017-2023

Table I-1: HSCG members

Name	Role and organisation	Term
Dr Mark Wenitong (Co-chair)	Strategic Advisor	2017-2023
Kate Thomann (Co-chair)	Assistant Secretary, First Nations Health Division, Department of Health and Aged Care	2017-2021
Melinda Turner (Co-chair)	Assistant Secretary, First Nations Health Division, Department of Health and Aged Care	2022-2023
Chris Bourke	Strategic Programs Director, Australian Health care and Hospitals Association	2019-2021
Karl Briscoe	Chief Executive Officer, National Aboriginal and Torres Strait Islander Health Worker Association	2017-2023
Dr Dawn Casey	Deputy Chief Executive Officer, NACCHO	2017-2023
Bob Davis	Chief Executive Officer, Maari Ma Health	2017-2018
Sandy Gillies	Chief Executive Officer, West Queensland PHN	2021-2023
Rob McPhee	Chief Executive Officer, Danila Dilba Health Service	2019-2023
Dr Janine Mohamed	Chief Executive Officer, Lowitja Institute	2017-2023
Professor Norm Sheehan	Director, Gnibi College of Indigenous Australian Peoples, Southern Cross University	2017-2019
Jessica Yamaguchi	Advisor, National Indigenous Australians Agency	2017-2023
Angela Young	Director Aboriginal and Torres Strait Islander Engagement, Children's Health Queensland	2017-2023
Dr Fadwa Al Yaman	Head, Indigenous and Children's Group, AIHW	2017-2023
Dr Fui Choong	Director, First Nations Health Division, Department of Health and Aged Care	2022-2023
Kim Grey	Senior Advisor, National Indigenous Australians Agency	2017-2023
Nicki Herriot	Chief Executive Officer, Northern Territory PHN	2018-2020
Dr Mike Mays	Director, First Nations Health Division, Department of Health and Aged Care	2019-2020
Dr Leanne Morton	Executive Manager, New England and Central Coast PHN	2017-2018
Dr Tomoko Sugiura	Director, First Nations Health Division, Department of Health and Aged Care	2021-2022
Karen Visser	Director, First Nations Health Division, Department of Health and Aged Care	2017-2018
Professor Jeanette Ward	Adjunct Professor, Nulungu Research Institute and Principal Consultant, Health Perspectives	2017-2023

APPENDIX J: IAHP PROGRAMS AND ACTIVITIES IN EACH EVALUATION SITE

About Appendix J

Appendix J provides additional information on the IAHP programs and activities run at each of the 17 evaluation sites

Table J-1: IAHP programs and activities in each evaluation site

Evaluation site	Programs and activities
Canberra, ACT	PHC Program, targeted health activities (including TIS program, ANFPP and Aboriginal and Torres Strait Islander Mental Health program), ITC program
South West Sydney, NSW	PHC Program, ITC program
South Coast, NSW	PHC Program, ITC program
Katherine East, NT	PHC Program, targeted health activities (including TIS program), ITC program, MOICDP, capital works
Central Australia, NT	PHC Program, targeted health activities (including TIS program, ANFPP, Eye Health, Ear Health, Alcohol and Other Drugs), ITC program, MOICDP, capital works
Torres Strait Islands	TIS program (Torres and Cape Health and Hospital Service receive PHC Program funding)
Mareeba-Atherton, Qld	PHC Program, ITC program
Charleville-Roma, Qld	PHC Program, ITC program
Brisbane, Qld	PHC Program, targeted health activities (including TIS program, ANFPP), ITC program, capital works, and data improvement, analysis, and reporting
North Adelaide, SA	PHC Program, targeted health activities (including TIS program, ANFPP), ITC program, capital works
Ceduna-Far West Coast, SA	PHC Program, targeted health activities (including Connected Beginnings program, sexual health), ITC program, capital works
Launceston, Tas	PHC Program, targeted health activities (including ear health, Connected Beginnings program), ITC program, capital works
North Melbourne, Vic	PHC Program, targeted health activities (including TIS program, ITC program, capital works
Echuca & Shepparton-Mooroopna, Vic	PHC Program, targeted health activities (including ANFPP), ITC program
Pilbara, WA	PHC Program, targeted health activities (including TIS program, sexual health), ITC program, capital works
Perth Northeast, WA	PHC Program, ITC program, capital works
Southwest, WA	PHC Program, ITC program, capital works

APPENDIX K: CYCLE 3 FINDINGS

About Appendix K

Appendix K summarises the data collection, analysis methods and findings in Cycle 3, including demonstrating how these have built on the methods and interim findings from Cycle 1 and 2.

K 1 Introduction to Cycle 3

The evaluation adopted a mixed-method design, combining qualitative and quantitative data and analyses with concurrent implementation of engagement activities to answer the evaluation questions over three participatory action research (PAR) cycles.

For further details about this methodology, see **Appendix C: Evaluation methodology** and the *IAHP Yarnes Project Protocol* (Bainbridge et al., 2020b).

This appendix includes an overview of the data collection methods, analytical methods and findings in Cycle 3. The overview is structured by key evaluation questions (KEQs) and demonstrates how the findings and methodological and analytical approaches evolved over the three PAR cycles.

K 1.1 Recap of Cycles 1 and 2

The focus of Cycle 1 was to generate a baseline understanding of what Aboriginal and Torres Strait Islander people value in health service design and delivery and how people are experiencing the health system. Cycle 1 also gathered baseline information about each site, the evaluation partner organisations and the local context of PHC in each site. The evaluation findings from this first data collection and analysis cycle were primarily descriptive, answering the *how* and *what* questions of the evaluation.

A full description of the Cycle 1 methods and findings are found in:

- *Evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander primary health care through the Indigenous Australians' Health Programme (the IAHP), Cycle 1 Interim Evaluation Report (26* November 2021).
- *Evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander primary health care through the Indigenous Australians' Health Programme (the IAHP) Cycle 1 - Companion Document 3, Technical Report (17 November 2021).*
- *Yarnes Cycle 1 Interim Evaluation Report Companion Document 2 - a description of the evaluation methodology and Cycle 1 methods (17 November 2021).*

The focus of Cycle 2 was to build on the data gathered in Cycle 1, particularly in those areas where gaps, inconsistencies and a need for sense-checking had been identified. Where Cycle 1 focused on generating a baseline description of the IAHP, Cycle 2 focused on exploring the contribution and difference the IAHP is making to the PHC system and the health and wellbeing of Aboriginal and Torres Strait Islander people.

A full description of the Cycle 2 methods and findings are found in:

- *Evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander primary health care through the Indigenous Australians' Health Programme, Interim Report – Cycle 2* (26 October 2022).

Both Cycle 1 and 2 data collection were disrupted by the COVID-19 pandemic, which first impacted Australia in March 2020. Due to COVID-19 travel restrictions and concerns for the vulnerable communities participating in the evaluation, the evaluation team could not hold community yarning workshops in all 17 sites during Cycle 1 and the emerging findings workshops planned at the end of Cycle 1 in September 2021 were all held online. Similarly, many Cycle 2 engagement activities were held online.

With many COVID-19 restrictions lifted during 2022, interviews and other site engagement activities were predominantly completed in-person for Cycle 3. However, some sites were still impacted by COVID-19 which affected their ability to engage in the evaluation and meant that some interviews and workshops were conducted online.

K 1.2 Cycle 3 – focus and purpose

The primary focus of Cycle 3 was engagement on potential changes and improvements to the IAHP and the PHC system, and the collaborative development of final recommendations to improve the IAHP. Building on Cycle 1 and 2 interview with health service staff, PHN staff and national, state and territory participants, which were primarily seeking to understand the implementation of IAHP, the interviews with the same type of participants in Cycle 3, focused on discussing 'what needs to change' and how faster progress can be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?

Cycle 3 was also used to gather further evidence on areas that were identified as 'gaps' during Cycle 1 and 2 and on areas that needed further exploration. For example, in Cycle 3, the evaluation generated more precise information on the burden of reporting (identified as an important issue during Cycle 1 and 2) and community yarns were conducted with young people and people in prison (hard to reach populations) – these groups were identified as missing during Cycle 1 and 2. The evaluation team also tested, revised, and strengthened five contribution cases through discussions with site partners over Cycle 3, which were part of the broader analysis and synthesising process. Moreover, the Babuny framework and the findings about what Aboriginal and Torres Strait Islander people value were taken back to discuss and sense-check with participants.

Cycle 3 also focused on analysing quantitative administrative data, particularly at the site level. These data were sourced through data requests in Cycle 1 and was provided by data custodians over Cycle 2. This involved the analysis of ten datasets including nKPI data, OSR data, MBS data, morbidity and mortality data, health workforce data, and funding data. Thus, many new findings were generated on the quantitative analysis in Cycle 3.

A full description of Cycle 3 methods and findings is found in:

- *Final report of the evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander primary health care through the Indigenous Australians' Health Programme* (June 2023).
- *Evaluation of the Australian Government's Investment in Aboriginal and Torres Strait Islander Primary Health Care through the Indigenous Australians' Health Programme: Quantitative Analytical Approach and Findings* (June 2023).
- **Appendix C: Evaluation methodology**.

K 2 KEQ1: How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?

A baseline understanding of what Aboriginal and Torres Strait Islander people value in the design and delivery of health services and how they experience the health system was developed during Cycle 1. During Cycles 2 and 3, this understanding was expanded and sense-checked with participants and in relation to Indigenous knowledge and research. Particularly the meaning and definitions of concepts like accessibility, holistic care, comprehensive care, self-determination and cultural safety were explored and discussed further with participants.

Cycle 1 data from community yarns also surfaced issues around access to comprehensive PHC, including, for example, issues of unmet needs, people missing out, hard-to-reach populations, and lack of choice for people in remote areas. Thus, the focus of Cycle 2 and 3 (primarily Cycle 3 due to COVID-19 restrictions during Cycle 2) was to target interviews with people and groups who could provide more evidence about these particular areas. For example, the evaluation noted that Aboriginal and Torres Strait Islander young people are a missing cohort regarding equitable, effective, accessible, acceptable, and appropriate health care, thus a specific focus in Cycle 3 was to facilitate yarns with young people.

Moreover, community yarns in Cycle 1 focused on people who access PHC through an ACCHS. Therefore, a focus of Cycle 2 and 3 was to talk with some people who accessed PHC through mainstream services (e.g. mainstream GPs and other non-Indigenous health services), as well as people who did not access (or had limited access to) health services.

In Cycle 1 and 2, the Babuny framework was developed and used as a metaphoric tool for describing the kind of health care that community participants value and need. The Babuny framework contributed to a deeper understanding of the stories from community yarns and allowed for the richness in their ideas and aspiration to be unpacked and described in a visual and symbolic manner. The Babuny framework was developed in collaboration between non-Indigenous and Indigenous evaluation team members. However, it was important to ensure that this metaphor resonated with participants. Thus, in Cycle 3, the values of health care were validated and explored by applying the Babuny framework as a way to share findings and explain analytical concepts.

In addition, the qualitative findings of community yarns were reviewed and applied as measures to analyse the quantitative datasets, adding further evidence to the narrative information about Aboriginal and Torres Strait Islander peoples' experiences and values of health care.

K 2.1 Cycle 3 data collection activities

- 21 community yarns, including yarns with young people and a yarn with a group of incarcerated men.
- Sense-checking of values through the Babuny framework (i.e. the framework was used as a tool to share analytical findings with community members to check for resonance and explore nuances between sites).

K 2.2 Cycle 3 analytical methods

- An inductive schema analytical approach was applied to analyse the community yarns.

K 2.3 Cycle 3 findings

The key findings of Cycle 3 in relation to KEQ1 were:

- The values and experiences highlighted from Cycle 1 data resonated with most participants and their feedback on the Babuny framework added further strength to the conceptualisation of this framework.
- Specific findings about young people's values and needs included that efforts to engage young people were frequently failing. Many ACCHS staff discussed the difficulties trying to engage this population. Young people described being reluctant to seek care and only accessing services when absolutely necessary given negative experiences.
- Aboriginal and Torres Strait Islander community members, ACCHS staff, and PHN staff were concerned about the unmet needs of prisoner populations and those leaving prisons. Some ACCHSs built connections with local prisons or correctional staff to ensure people were connected to health and social services on their release. Prisoners often have no access to culturally appropriate health care and experience delays in accessing the right support.

K 3 KEQ2: What difference is the IAHP making to the system?

In Cycle 1, evidence showed that ACCHSs depend on multiple streams of funding, including several streams of IAHP funding (e.g. PHC Program funding, targeted health activities funding, ITC and capital works funding). Reporting on multiple funding agreements, over and above the IAHP and across different funding organisations, was identified as a significant burden to health services.

Based on these findings, Cycle 2 and 3 explored the mix of funding that ACCHSs have available and how they manage multiple streams of funding and the reporting requirements associated with each contract. Interviews with operational managers and finance officers investigated the specific funding and reporting situation for site partner health services. In Cycle 3, further engagement with staff in six ACCHSs was used as a basis for developing detailed funding and reporting profiles for each organisation.

Another focus in Cycle 3 was examining the contribution of the IAHP, which included assessing evaluation questions asking ‘to what extent’ IAHP is enabling or making a difference to something. In Cycle 2, all Cycle 1 interviews with health services, PHN and national, state and territory participants were re-analysed for the purpose of contribution analysis (that is examining the contribution of the IAHP to strengthening comprehensive PHC for Aboriginal and Torres Strait Islander people). The analysis took a grounded theory approach and interviews conducted in Cycle 2 were included in the analysis. Five contribution cases were written up, including an overarching contribution statement for each (i.e. a claim associating the IAHP with particular outcomes), a context description of this claim (e.g. funding details), evidence to back the claim, and a list of questions to explore the claim further (e.g. questions related to gaps, inconsistencies, missing information, or alternative explanations). During Cycle 3, these cases were taken back to site partners to be discussed, critiqued, and tested for resonance and alternative explanations.

In Cycle 3, funding data were analysed to gain a clearer understanding of the contribution of IAHP funding to health services’ capacity to deliver PHC services. In addition, health workforce data were analysed to illustrate a range of workforce challenges for the delivery of primary care to Aboriginal and Torres Strait Islander people across urban, regional, and remote locations.

K 3.1 Cycle 3 data collection activities:

- Targeted interviews with ACCHS CEOs, operational managers and finance officers to gather detailed funding information from six sites.
- Validating and strengthening of contribution cases through sense-checking interviews with health service staff, PHNs and others.
- Facilitating a contribution review panel workshop, where PHC sector professionals provided critique and feedback on the revised contribution cases and overall contribution narrative, exploring nuances, gaps, and alternative explanations.

- Analysing quantitative data on IAHP funding as a proportion of organisations' total revenue, and health workforce data from the OSR and National Health Workforce Dataset.

K 3.2 Cycle 3 analytical methods

- A grounded theory approach to coding and analysis of interviews.
- Collaborative analysis discussion throughout the review panel workshop.
- Revision and analysis of contribution cases according to feedback and write-up of overarching contribution narrative.
- Development of funding profiles for six site partner ACCHSs to demonstrate organisational capacity, funding and contracts, and burden of reporting.
- Descriptive statistical analysis of financial data for 23 ACCHS site partner organisations and health workforce data for 17 evaluation sites at SA3 level.

K 3.3 Cycle 3 findings

The key findings of Cycle 3 in relation to KEQ2 were:

- The extent of the IAHP's contribution to various outcomes was unpacked in further detail. For example, the association between capital works funding and the delivery of care was challenged in some sites, which either did not have access to this funding or did not view it as a main contributor to culturally appropriate care. Furthermore, it was made clear that the IAHP's contribution to, for example, health service organisations' capacity to deliver comprehensive cultural safe and holistic care, is highly dependent on broader systemic issues like workforce shortage, the training pipeline for Aboriginal and Torres Strait Islander health workers and practitioners, and access to other available funding sources (e.g. Medicare funding).
- The funding profiles demonstrated how ACCHSs administer their funding and the burden of this impact on their capacity depending on their size, location and workforce. It was made clear that there were significant differences in the weight of the burden of reporting and managing multiple funding streams depending on an organisation's size, maturity and workforce capacity.
- The analysis of financial data showed that total IAHP funding accounted for, on average, 35% of ACCHSs' total revenue in 2020-21. The analysis of health workforce data showed that there has been an increase in the health workforce across the evaluation sites. However, workforce shortages present significant challenges to the delivery of the IAHP, with acute shortages in some areas contributing to reduced primary care service delivery.

K 4 KEQ3: What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?

A custom traffic light approach was developed in Cycle 1 for analysis of publicly available data to examine high-level effects of health service activity on hospitalisations and mortality. Quantitative analysis for Cycle 2 applied the same methods to the requested site-level data to: (1) examine associations between nKPIs and hospitalisations, and (2) conduct in-depth case studies using diabetes nKPIs and MBS chronic care and hospitalisations to mitigate some limitations of the data.

Data cleaning and auditing of the received data from data custodians also commenced during Cycle 2 and continued on into Cycle 3.

The quantitative analysis in Cycle 3 involved two different analyses that addressed:

1. KEQ3 on what difference the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people.
2. The relative contributions of social determinants and primary care on health outcomes for Aboriginal and Torres Strait Islander people.

The analysis was restricted by the limited time periods for which data were available. Thus, the evaluation could not link data at the individual level, making it impossible to track the trajectory of care for patients over time. This also meant it was not possible to account for potential correlation over time due to repeated measures on the same person.

K 4.1 Cycle 3 data collection activities

Custom data received from 10 datasets from 3 data custodians (the Department of Health and Aged Care, AIHW, and ABS). The datasets were:

- MBS data
- National Health Workforce data
- PIP data
- Australian Childhood Immunisations Register
- National Perinatal data collection
- National Hospital Morbidity data
- nKPI data
- Online Service Report data
- Cause of death data
- Estimated Resident Population data

K 4.2 Cycle 3 analytical methods

Several analytic approaches were applied in Cycle 3 to complete the analysis of the quantitative data.

- A statistical analysis plan was made for the examination of the KEQs. To answer KEQ3, proxies for Aboriginal and Torres Strait Islander people receiving appropriate health care to maintain good health and wellbeing were used. Three questions were explored:
    1. What proportion of clients are receiving 715 health assessments, and did the proportion vary between sites and over time?
    2. How are risk factors, health service use and health outcomes among Aboriginal and Torres Strait Islander people attending Aboriginal health services associated with each other and 715 health assessments?
    3. What are the risk factors, health outcomes and health service use among Aboriginal and Torres Strait Islander people attending Aboriginal health services?
- Hierarchical clustering was used to explore which nKPIs were most similar to each other.
- Principal Components Analysis (PCA) was used to reduce the dimensionality of the data set by clustering items into a smaller set of uncorrelated variables (the principal components (PCs)).
- To investigate the relative contributions of social determinants and primary care on health outcomes, the following methods were applied:
    - Multiple linear regression was used to model health outcomes as a function of demographics, socio-economics, health service availability and PHC activity for geographic areas (i.e. ecological study) at two discrete time points (cross-sectional design), and for changes between time points (difference in differences analysis).

    - The effects of social determinants and PHC were examined via the distributions of standardised regression coefficients and semi-partial correlations produced for each explanatory variable across a series of hierarchical regression models in which social determinants or PHC variables were introduced in either the first or last block, That is, models incorporating social determinants in the first block added primary health care variables in the last block and vice versa, producing a range of statistics from the simple bivariate case to those increasingly controlling for other variables.

K 4.3 Cycle 3 findings

The key findings of Cycle 3 in relation to KEQ3 were:

- Higher levels of primary care activity were most often associated with increased tertiary care (hospitalisations). Similarly, higher rates of MBS chronic care activity were accompanied by higher rates of diabetes hospitalisation. Strong correlations between MBS chronic care activity and hospitalisation were associated with lower rates of mortality for diabetes.
- Within the evaluation sites, one-third of the nKPIs of protective/risk factors, health outcomes, and health service use showed improvement over time. There was significant variability in nKPIs within and between sites. Client nKPI outcomes tended to cluster within sites with scores on one measure systematically corresponding to scores on other measures.
- Within IAHP funded organisations in the evaluation site, more than half of adults and more than one-third of children had a health assessment. There was no clear evidence that this had changed over time. The proportion of *all* Aboriginal and Torres Strait Islander site residents who received a health assessment had increased over time.
- Of a set of primary care activity, demographic and socio-economic variables, being in the NT, remoteness and age were the most important variables for explaining differences in health outcomes within the evaluation sites. Changes in rates of GP attendance over time was the most important variable for explaining changes in health outcomes over time.
- Of the same set of variables, having greater economic resources and higher relative socio-economic outcomes were the most important variables in explaining lower morbidity and mortality. All of the socio-economic measures (education and occupation, economic resources, and socio-economic advantage and disadvantage) were positively associated with normal birthweight.

K 5 KEQ4: How can faster progress be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?

A focus of Cycle 3 was to explore and explain what needed to change and improve with regards to the IAHP and the PHC system. These discussions were also used as a basis for formulating the evaluation's recommendations.

Findings from KEQ1 and 2 laid the foundation for understanding how the IAHP is currently working on the ground and the main barriers and enablers for change. This foundation provided an indication of where the mechanisms for faster progress were located, and for identifying promising practice and potential improvements. These were a focus for engagements with site partners, and national, state and territory participants.

Collective Action for Change workshops and deeper engagement in selected sites were key features of Cycle 2. Ten Collective Action for Change workshops were held in Cycle 2 across 9 sites and one with the Department of Health and Aged Care. These workshops involved mapping the health system, discussing what is working well and the challenges, and identifying what needs to change and (in some cases/sites) an action plan to drive change. Evidence from these discussions provided important information in understanding barriers and enablers for faster progress to be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people (i.e. answering KEQ4).

K 5.1 Cycle 3 data collection activities

- Interviews with health service and PHN managerial staff focused on changes needed to the IAHP and the wider PHC system.
- Interviews with state, territory, and national stakeholders focused on changes needed to the IAHP and the wider PHC system.
- Interviews with mainstream PHC providers and other non-ACCHS stakeholders engaging with IAHP funded organisations.
- Facilitation of two cross-site collective action workshops on specific topics – one on funding and another on partnerships.
- Facilitation of a national evaluation workshop for site partners in Melbourne/Naarm to share and facilitate discussion around the evaluation findings and draft recommendations. The main purpose of this workshop was to promote learning across sites and partner organisations and to ensure an opportunity for site partners to contribute to the recommendations and the evaluation's conclusions regarding what needs to change.

K 5.2 Cycle 3 analytical methods

- Cluster coding based on high-level content analysis.
- Content analysis to produce summary reports for the CA4C workshops.
- Content analysis to pull out key messages to inform draft recommendations.
- Production of six summary infographics from the national evaluation workshop to visually demonstrate the discussion outcomes from each workshop session. These infographics where shared with site partners (see **Appendix L: National evaluation workshop**).

K 5.3 Cycle 3 findings

The key findings of Cycle 3 in relation to KEQ4 were:

- There is considerable reform occurring in the health system, including in response to the National Agreement on Closing the Gap Priority Reforms and the National Aboriginal and Torres Strait islander Health Plan. There are also recent and emergent experiences, including from the COVID-19 pandemic response and changes to IAHP commissioning processes, to build further improvements upon.
- There is a need to increase self-determination, autonomy, and responsiveness within the IAHP and the broader health system, including through strengthening governance, shared decision-making and accountability arrangements. To support effective partnerships, there is a need to improve processes for engaging Aboriginal and Torres Strait Islander health services and communities in program and service design, and to strengthen dedicated Aboriginal and Torres Strait Islander health policy capability within the Department of Health and Aged Care. Commissioning processes need to be adapted to enable partnerships, shared decision-making, and community-led responses.
- There is a need to scale up investment in the IAHP and Aboriginal and Torres Strait Islander PHC more broadly. Increased investment needs to take account of the cost of delivering comprehensive PHC to Aboriginal and Torres Strait Islander people and communities, health workforce requirements, and the current lack of investment applied to prevention and health promotion activities outside of clinical service delivery.
- There is a need to strengthen the integration of the IAHP with the health system and reduce system fragmentation through supporting integrated models of care, and building processes for information sharing and collaboration.
- There is a need to enhance the use of knowledge and information to better reflect what Aboriginal and Torres Strait Islander communities value about health care and their needs, to track and monitor outcomes, and to support decision-making and continuous quality improvement at all levels of the system.

K 6 Cross-cutting collaboratives 4 and 5

In Cycle 3, two collaboratives functioned alongside the participatory, cyclic action that occurred across the evaluation.

K 6.1 Data collection activities

Two collaboratives were completed during Cycle 3 on the following topics:

- Understanding health needs - identifying approaches to assessing health needs and indicators for health needs within the community.
- Improving PHC data environment - developing recommendations to improve the PHC data environment.

Each collaborative utilised a range of different methods, including stakeholder and expert interviews, re-coding of evaluation data, harvesting of document (e.g. policies, annual reports, strategies, and journal articles) and analysis, and in-depth literature reviews.

K 6.2 Collaborative 4 - analytical methods and findings

The challenges with current understanding and approaches to assessing health needs in the Australian PHC system were identified in the evaluation across different system levels. Collaborative 4 sought to understand what Aboriginal and Torres Strait Islander communities and health services identify as their health needs and whether the current policies and processes facilitated those needs being identified and met.

Multiple methods were used to identify conceptualisations of health needs from the literature and primary qualitative data collected across the evaluation. A workshop with site partners was held for sense checking and identifying recommendations to operationalise health needs assessment for Aboriginal and Torres Strait Islander peoples.

The literature review used a hermeneutic process to build on understandings from existing systematic reviews of health needs assessment (HNA) processes. A narrative synthesis of the literature was used to distil findings on (1) current conceptualisation and operationalisation of the concept of health and health needs in HNA, and (2) the alignment of these to Aboriginal and Torres Strait Islander conceptualisations and the principles of Indigenous Data Sovereignty and Indigenous Data Governance.

Based on the literature review the collaborative addressed issues about current understandings and approaches to health needs assessment. For example, the collaborative found that there is a lack of universal definition or conceptualisation of the critical constructs of health, health need, and community influence how HNAs are undertaken. The literature review also found that there is a tendency to exclude Aboriginal and Torres Strait Islander conceptualisations of health, health needs, and wellbeing, which reflects a form of systematic or institutionalised racism. Additionally, the literature review concluded that current approaches to primary care HNA fail to address the principles of Indigenous Data Sovereignty and Indigenous Data Governance, and as a result, perpetuate deficit portrayals of Aboriginal and Torres Strait Islander communities, undermine the principles of self-determination, and are inconsistent with the Closing the Gap Priority Reforms.

From the re-analysis of evaluation data, four key concepts were identified, which collectively reflect a higher order concept of the need for HNA processes to be consistent with principles of self-determination. The four key concepts were (1) the need to build health and wellbeing across the life course, (2) the need for places of connection, (3) the need for HNA processes to resource and utilise the cultural capital and domain expertise of ACCHSs, and (4) addressing the current fragmented and prescriptive funding for health promotion.

These findings indicate a further need to address the social determinants of health through joined up and multi-sectoral alliances.

K 6.3 Collaborative 5 - analytical methods and findings

Throughout the evaluation, participants strongly supported the need to improve the effectiveness of data collection and utility. Collaborative 5 aimed to identify outstanding challenges with the data environment and assess potential solutions in relation to current PHC data reform.

Data were extracted from 98 sources and coded using a hybrid method of initial deductive coding to identify any data related to current limitations and constraints with the PHC data environment and any potential solutions or recommendations for addressing them.

A process analysis, building on the initial Design Specification Extraction Assessment (DSEA), was also conducted to examine the use of current PHC and related datasets to evaluate the IAHP. The experience of limitations of routinely collected datasets relevant to Aboriginal and Torres Strait Islander health were examined to determine how they reflect issues in the PHC data environment more broadly. Moreover, a rapid research review was undertaken to situate the findings in relation to other studies of PHC data and knowledge of data environments.

Key findings from interviews with health service and PHN staff showed that:

- Data (the routinely collected custom data) is commonly homogenous, output-focused and, in some cases, culturally inappropriate.
- Data systems are fragmented and are often opaque and inaccessible.
- Data relationships are characterised by mistrust and require a balancing of different data needs and functions.
- Most ACCHSs are insufficiently resourced or supported to engage with the data environment.

Findings from the process analysis demonstrated that despite the large volumes of data generated through the daily activities of the PHC sector, the use of current data assets to undertake system level evaluation is impaired by: (1) a lack of meaningful outcome data, (2) data quality, (3) temporal influences, (4) comparability and non-inclusion of PHC data, (5) effect of cell suppression on small area analysis, and (6) data access.

The rapid scan of literature demonstrated that a key limitation of a number of studies was the inability to link to meaningful PHC data. This creates important gaps in understanding a person's health journey particularly when people reside in remote areas where PHC also provides emergency care functions.

This collaborative identified limitations of the data environment and assessed potential solutions in relation to current PHC data reform. The findings indicated that transformative change is required to create a PHC data environment that enables service providers to support the needs of their communities. These findings contributed to the final evaluation recommendations, for example, suggesting funding to build the capacity of community-controlled services to collect and use data.

K 7 Integrated care project

The project on integrated care aimed to build understanding of integrated care as a significant concept in designing and delivering care across the primary, secondary and tertiary care systems for Aboriginal and Torres Strait Islander people.

Integrated care is an organising principle for care delivery. Integrated care aims to contribute to improvements in population health, individual experiences of care, reduction in costs of care per capita, and better conditions for the health care workforce. The delivery of people-centred, coordinated, and integrated care features as an ambition in Australian primary health care (PHC) policies and reforms.

This project drew on evidence synthesised across three data sources:

4. A literature review of integrated care to understand its components.
5. A review of existing evidence generated through community engagement in the IAHP evaluation.
6. A review of evidence relevant to integrated care generated through interviews with service providers and PHNs through engagement in the IAHP evaluation.

Many of the features of integrated care identified in the literature review align with what Aboriginal and Torres Strait Islander people value in health care and are designed to address some of the issues that contribute to poor experiences of the heath system. This includes features of health care integration at a local level such as adapting care to context, focusing on holistic approaches to care, and taking a population and preventive health approach. This also includes features of integrated care that operate at professional and organisational levels, including the need for multidisciplinary team-based approaches to health care and the need to ensure coordination or care and continuity of care across health care settings, particularly from primary to specialist care.

Other features of integrated care identified in the literature function at a health system level, including the integration of information and communication systems and funding and payment systems to enable and incentivise the delivery of integrated care.

Based on the literature review and evaluation findings, a set of domains and associated principles or outcomes was developed to inform an integrated care framework for Aboriginal and Torres Strait Islander people. Many of the principles/outcomes identified relate to the need to partner with and empower local communities to be partners in health care. Other outcomes relate to adapting models of care to be more responsive to Aboriginal and Torres Strait Islander people's holistic health care needs. Notably, the model of Aboriginal and Torres Strait Islander community-controlled comprehensive PHC is aligned to an integrated model of care. Finally, other outcomes relate to creating an enabling environment for integrated care.

The literature review identified limited guidance on how to implement integrated care in practice. However, lessons for the implementation of integrated care and actions required at different levels of the health care system to create the enabling environment for integrated care were identified from the literature.

Managing the changes required at multiple levels of the health system to transition to integrated care can be complex and it can take time. This report on this research concluded by noting that the current ambition in PHC policy frameworks is matched by the aspirations of many of the ACCHSs and PHNs that partnered in the IAHP evaluation.

APPENDIX L: NATIONAL EVALUATION WORKSHOP

About Appendix L

The evaluation facilitated a two-day national workshop with site partners in February 2023 in Melbourne/Naarm.

The purpose of the workshop was to:

- **Facilitate participatory analysis:** Share emerging evaluation findings and check how they resonated with different participants to inform further interpretation and explanation-building.
- **Co-design potential solutions:** Discuss the significance of the emerging evaluation findings for the IAHP and broader policy settings and identify potential improvements and solutions to inform the evaluation recommendations.
- **Support learning and evaluation use:** Share and showcase promising practice in the design and delivery of PHC services to facilitate learning across participants at different levels of the health system.

A graphic artist and illustrator (Zahra Zainal) created live graphic recordings of each workshop session. Live graphic recording is a process of simplifying and amplifying spoken content into colourful illustrations, in real-time. This method served as a more accessible and engaging way to approach written minutes.

The graphic recordings were displayed on a large screen during the workshop, primarily during breaks but also while discussions and presentations unfolded. The graphic recordings captured the key themes and responses from the audience, and the six ‘session’ recordings/images were shared with participants after the workshop.

This appendix includes the images recorded during the workshop, which cover (1) What people value for their health and wellbeing; (2) Improving the implementation of the IAHP; (3) The IAHP’s contribution to improving people’s health and wellbeing; (4) The IAHP’s interactions with the broader health system; (5) The IAHP’s support of Aboriginal and Torres Strait Islander health needs; and (6) Framing the future state of the IAHP.

The images presented in this appendix are organised to align with the order of the workshop sessions.

Figure L-1: Graphic recording - what people value in health and wellbeing

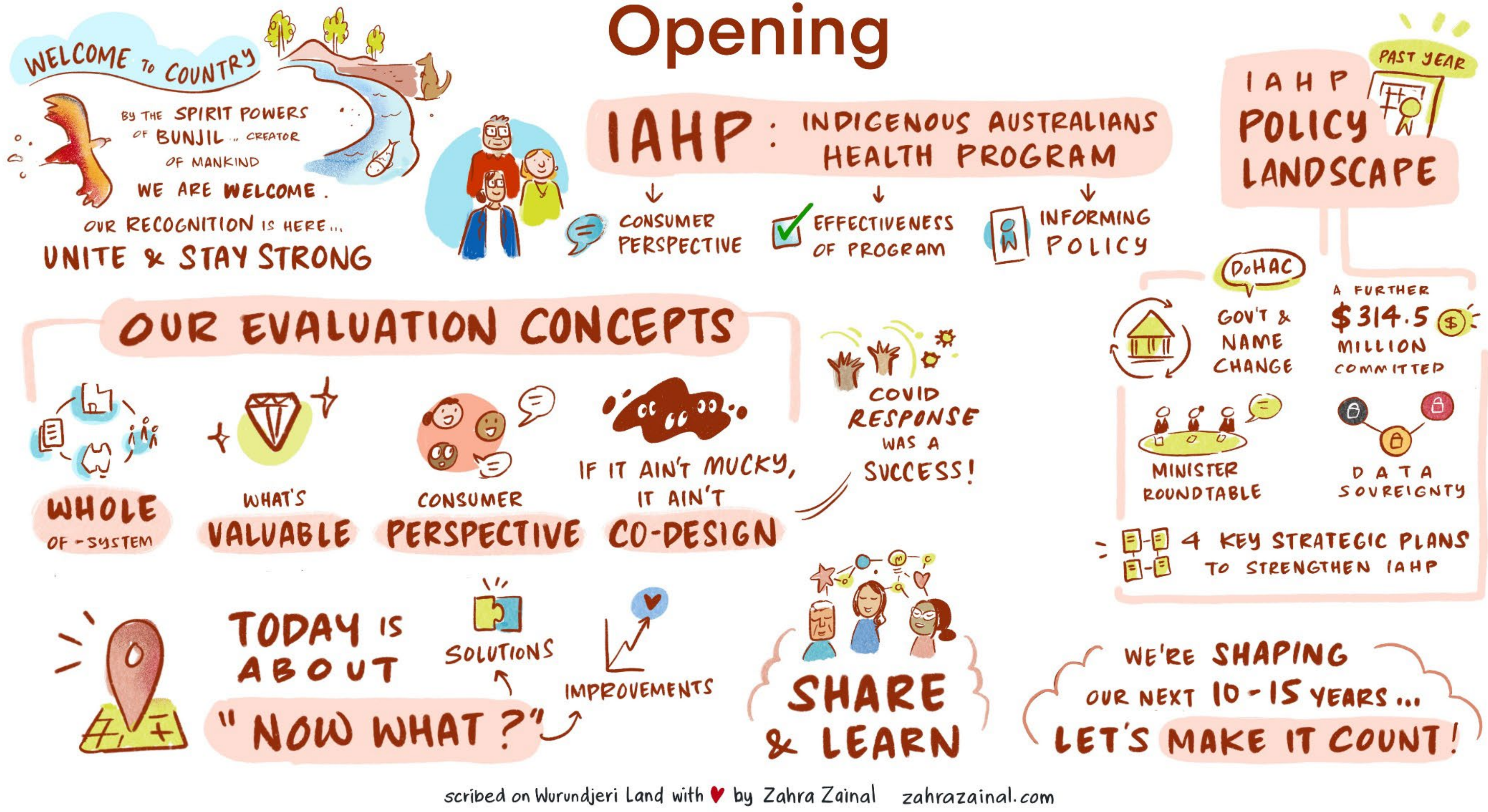


Figure L-2: Graphic recording - improving the implementation of the IAHP

Figure L-3: Graphic recording - the IAHP's contribution to improving people's health and wellbeing

Figure L-4: Graphic recording - the IAHP's interactions with the broader health system

Figure L-5: Graphic recording - the IAHP's support of Aboriginal and Torres Strait Islander health needs

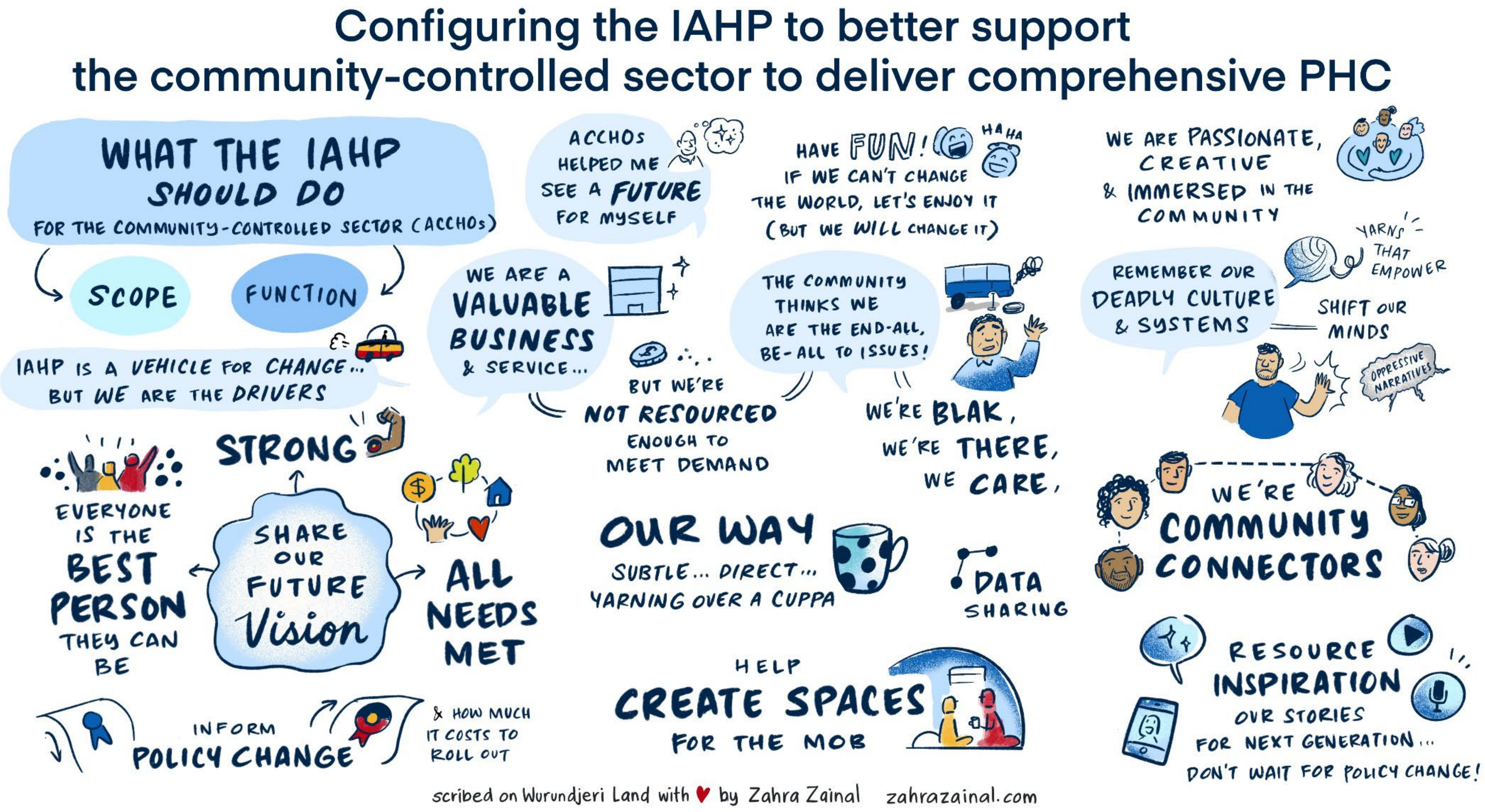


Figure L-6: Graphic recording - framing the future state of the IAHP (1)

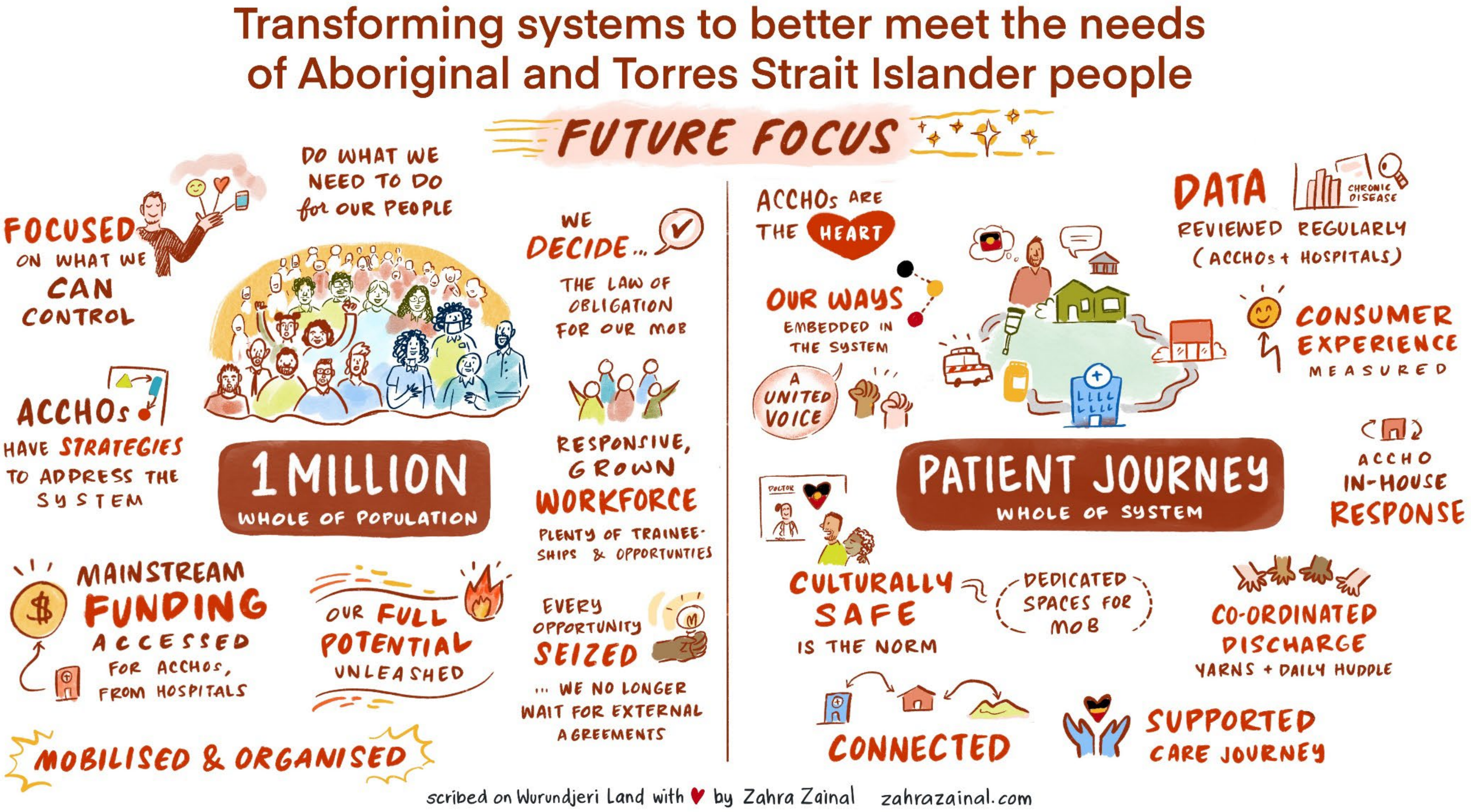
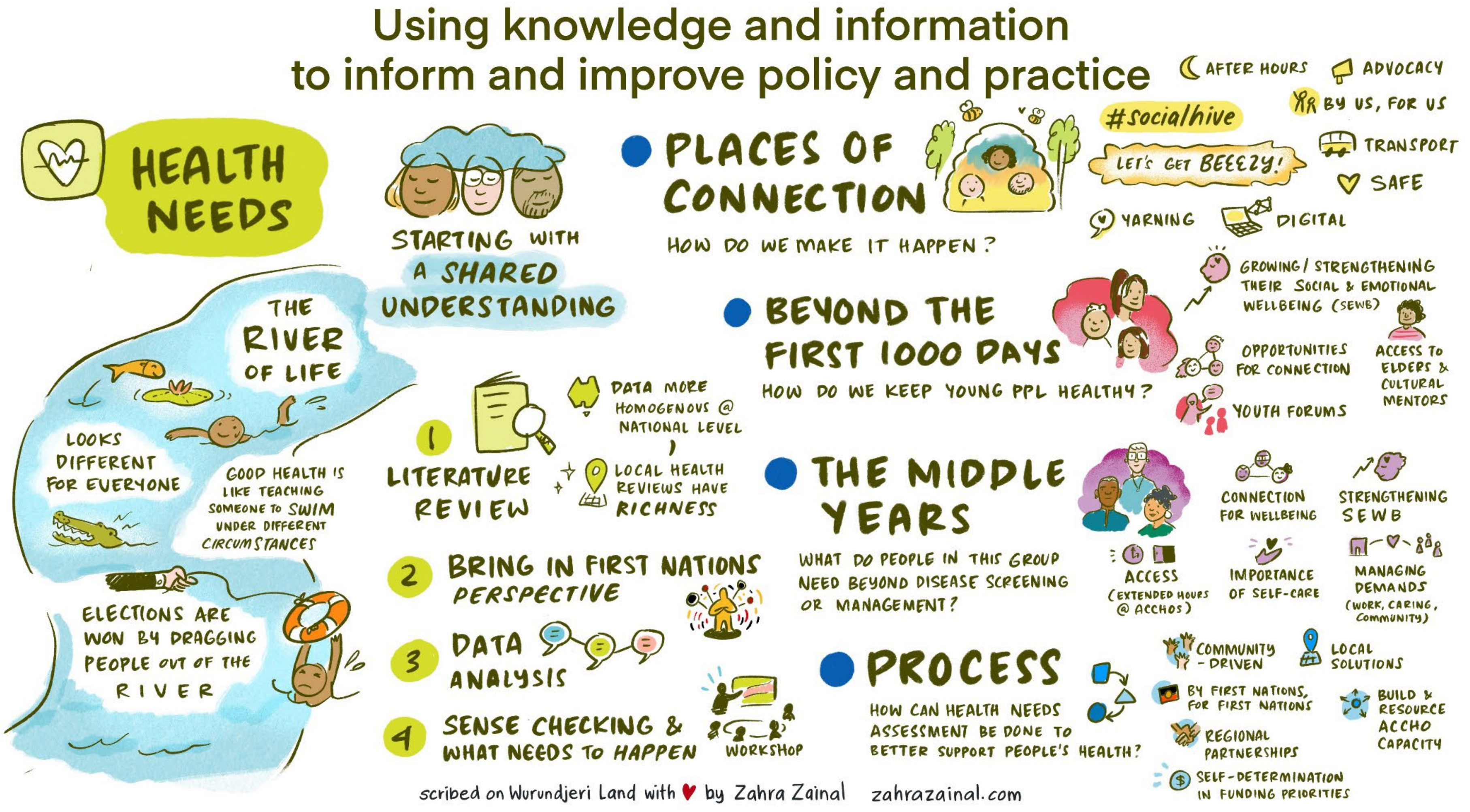


Figure L-7: Graphic recording - Graphic recording - framing the future state of the IAHP (2)



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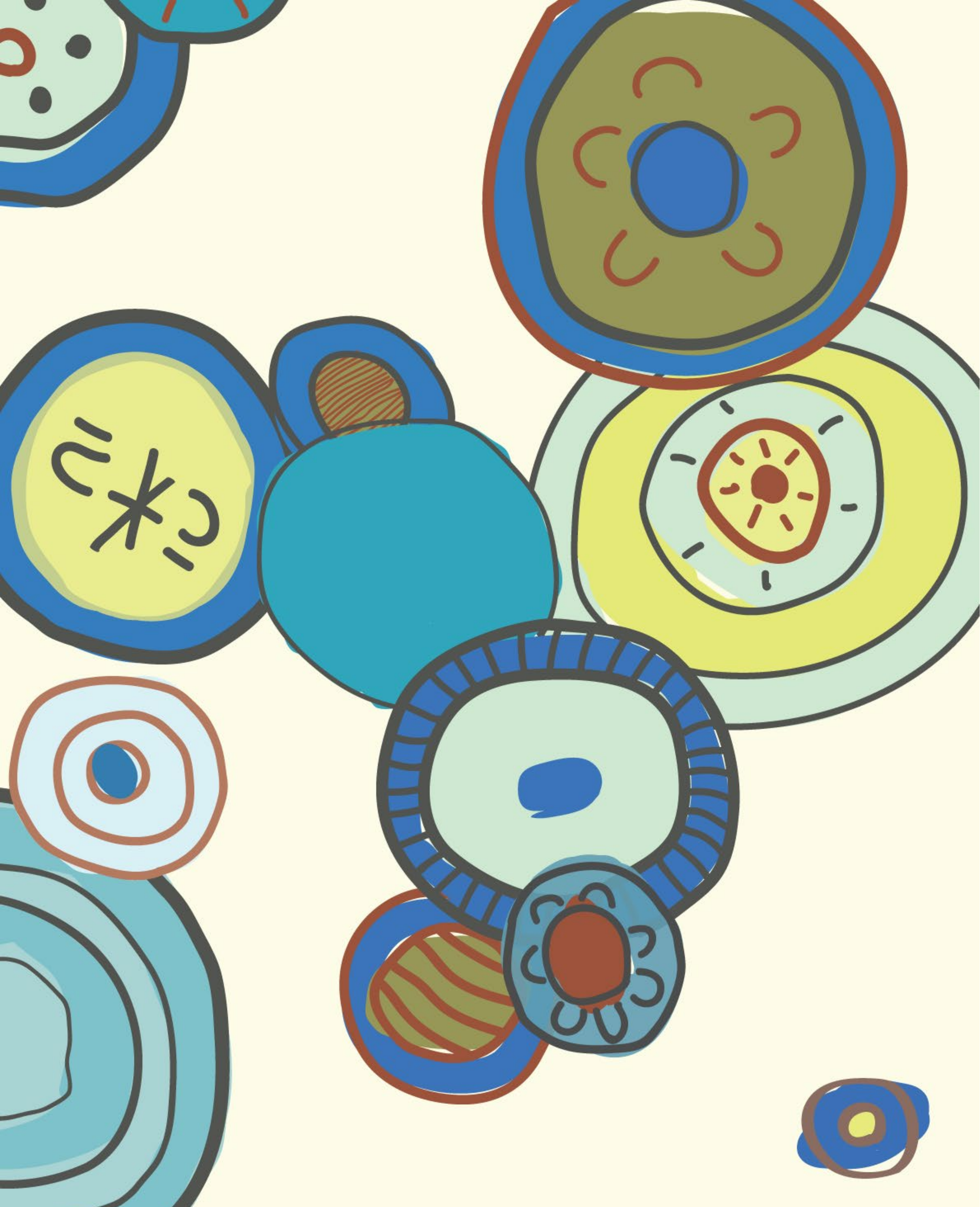

IAHP Yarnes

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Yarning • Action • Reflection • National • Evaluation • Systems