

A case study in the use of evidence in a changing political context: an Aboriginal and Torres Strait Islander health service re-examines practice models, governance and financing

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Abstract. This paper examines the response of a regional body, the Institute for Urban Indigenous Health (IUIH), coordinating Aboriginal community controlled health organisations (ACCHOs) in south-east Queensland, to research evidence as they prioritise and plan services in response to internal economic and organisational factors, as well as external policy change. An event-based analysis of a quarterly management meeting of the IUIH allowed an exploration of how the IUIH uses a range of evidence to respond to the challenges faced within the Aboriginal community controlled health sector. The study identified three distinct but interconnected processes: (1) identifying evidence for change; (2) exploring and reframing this evidence; and (3) the application of this evidence at different levels of policy and practice. These processes were evident in each of the three major agendas addressed during the meeting, namely navigating current political change, reforming the ACCHO business model and reframing the available evidence for advocacy. The result has been the emergence of a new service delivery model, in which evidence supports accountability, change management, self-sufficiency and attempts to redefine community control.

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Setting

Recent political changes at federal and state levels have reintroduced a degree of uncertainty to the policy direction, resourcing and delivery of Aboriginal and Torres Strait Islander health services in Australia. Since being elected in September 2013, the Liberal–National Federal Government has split policy and funding responsibilities across two departments, with strategic policy functions relocated into the Department of Prime Minister and Cabinet.¹ This notably includes responsibility for the health performance framework, health expenditure analysis and life expectancy modelling. The Office for Aboriginal and Torres Strait Islander Health (OATSIH) has been dissolved, with the Department of Health retaining responsibility for the funding of health services under the newly created Indigenous Health Service Delivery Division. Following a review, Medicare Locals will be replaced by Primary Health Networks from 1 July 2015.^{2,3} At a state level, the Queensland Government continues to implement reforms and funding cuts, with implications for service delivery and the health workforce. Through the process of

determining contestability, the Queensland Government intends to test the market in order to determine whether the current Aboriginal community controlled health organisation (ACCHO) providers deliver health services most competitively, with the option of opening up the delivery of health services to Aboriginal and Torres Strait Islanders to other providers if this is not the case.⁴ Within Queensland Health, there has been a review of the Indigenous workforce and their roles, with questions around optimal integration of these staff into programs. All these come at a time when new service delivery models, such as the Institute for Urban Indigenous Health (IUIH) Model of Care, are already evolving, driven by the Closing the Gap commitment, mainstream health developments and reforms initiated within ACCHOs in response to these changes.

Objectives

This case study examines the use of evidence in a recently established organisation, namely the IUIH (a partnership between the Aboriginal and Torres Strait Islander Community Health

Service Brisbane, Kalwun Health Service, Yulu-Burri-Ba Aboriginal Corporation for Community Health and Kambu Medical Centre), in negotiating these uncertain times. Created in late 2008 in response to Closing the Gap,^{5,6} the IUIH is an innovative community controlled regional body leading planning, development and coordination for Aboriginal and Torres Strait Islander health services in south-east Queensland. This event-based analysis is structured around the observation of a quarterly management meeting of the IUIH held in October 2013, and explores how the IUIH uses a range of evidence to respond to the challenges faced by the sector through a regional vision, shared systems and processes, and self-regulation.

Setting, participants and methods

With the informed consent of participants, three independent researchers from the University of Queensland and the University of New South Wales observed, recorded and analysed the issues covered at a routine quarterly meeting of the IUIH. Day 1 consisted of a senior management team meeting, which focused on strategic planning and governance reforms. Day 2 consisted of the lead clinicians group meeting and focused on: clinical reforms; presenting and discussing data; and shared learning concerning best practice, technologies and performance frameworks. We examined conversation and debate, language and discourse and the materials presented. The case study is part of a broader research project examining the uptake of research evidence in Indigenous health policy and therefore focused on the use of evidence by the IUIH.

Ethics approval

The 'Uptake of evidence to policy: the Indigenous burden of disease case study' (Project no. 201001442) has National Health and Medical Research Council ethics approval.

Outcomes

In terms of the use of evidence, three distinct but interconnected processes were discernible at the meeting: (1) identifying evidence for change; (2) exploring and reframing this evidence; and (3) applying the evidence at different levels of policy and practice. These processes were evident in the three major agendas that emerged during the meeting, namely navigating current political change, reforming the ACCHO business model and reframing the evidence for advocacy.

Navigating political change

The senior management team meeting opened with an analysis of recent changes in government at the Federal and State levels, arguing that, as a result, ACCHOs needed to reposition themselves in the health sector. This policy analysis was framed as an opportunity to demonstrate how the IUIH model of care, which has been rolled out across south-east Queensland since 2009, places the sector at a competitive advantage. The IUIH has developed 'footprints', a graphic representation of coverage data, to identify areas of significant Indigenous populations and their access to services. Using population data from the 2011 census (see <http://www.abs.gov.au/websitedbs/censushome.nsf/home/data?opendocument&nvpos=200,ac-cessed 12 May 2014>) and

patient records from existing ACCHOs, the footprints provide the rationale for the rapid expansion of services in under-served areas and a denominator against which to track progress. Service coverage and utilisation has increased, with the number of community controlled clinics growing from five in 2008–09 to 13 in 2012–13, with the number of new patients increasing from 2000 to just over 6000 for the same time period.⁷ The initiative has been challenging, particularly for established ACCHOs, with pressure to shift from reactive, demand-driven health care to a pro-active population approach, with targets based on population data and progress monitored through shared IUIH systems and processes. Demonstrable health outcomes are now a focus: building on its internal data, IUIH has commissioned work to measure and communicate the impact of its services, including a cost-benefit analysis examining hospital admissions averted by the implementation of chronic disease management plans. Despite it being early days, the IUIH is confident these data can be used to demonstrate that the community controlled sector is a viable, competitive service provider.

Reforming the business model

Although not articulated in a single document, the IUIH model of care is referenced in reports, presentations and conversations (see www.iuih.org.au, accessed 12 May 2014), and underpins the clinical and governance reforms currently being implemented across south-east Queensland. It took 12 months to operationalise the model, to translate the theory into practice. The model continues to evolve and aims to ensure quality of care while optimising the use of Medical Benefits Scheme (MBS) item numbers designed to promote health screening and chronic disease care plans for Aboriginal and Torres Strait Islander clients. At the Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS), the number of health assessments and chronic disease care plans increased from 473 in 2011–12 to 861 in 2012–13 and from 77 in 2011–12 to 122 in 2012–13, respectively. Over a 12-month period, data from a cohort of 25 MATSICHS clients with diabetes found a reduction of 15% for HbA1c >10%, 23% for an 'obese' body mass index and 39% for microalbuminuria.⁸

Through its roll-out at 'greenfield' sites (i.e. new ACCHOs), the model has been tested and refined. It is informed by a general practice business model that realises efficiencies and maximises income, but delivers comprehensive primary health care in a culturally appropriate way. Matching the number and mix of staff to services has been easier in these contexts, where entrenched patterns do not need to be challenged. Translating the business model for the ACCHO context has led to changes in clinical governance issues, including quality of care, the volume of patients and time spent with them and workforce composition, particularly the role of Aboriginal health workers and community liaison officers. The model is starting to produce a surplus, which has generated opportunities to invest in additional services to extend coverage and the range of services provided, to include podiatry, dental and paediatric services, as well as transportation services not covered within MBS funding.

The collection and analysis of clinical data have been instrumental in refining the model and in providing the evidence base with which to justify reforms to 'brownfield'

sites (i.e. established ACCHOs). Evidence of the changes from monthly Continuous Quality Improvement meetings were reported to the senior management team at this quarterly meeting, and to the community and general public annually. An update of IUIH research projects was also presented, and included the results from an evaluation of community days and the Deadly Choices program.

The greatest challenge to the implementation of the IUIH model of care to date has been change management, with a tension between maintaining the independence of local community boards and the flexibility necessary to ensure consensus within the regional IUIH, where the board comprises representatives from each of the ACCHOs and four independent members appointed by them. The role of 'spearheads', introduced in 2011, has been critical to supporting the roll out and implementation of the model, although this again relies on each service accepting intervention from the IUIH. These IUIH staff are seconded to in-line positions in greenfield and brownfield sites, at the request of ACCHO boards, for up to 6 months to support CEOs, practice managers and staff through the implementation of the governance and clinical reforms.

Reframing the evidence for advocacy

The processes already discussed demonstrate evidence use in response to acute political change and in ongoing operations. It is evident IUIH is now exploring the interface between its clinical data and population data and the associated opportunities to influence policy and practice into the future.

In 2009, IUIH used the findings from the recently released Indigenous Burden of Disease (IBOD) study⁹ to substantiate urban disadvantage among Aboriginal and Torres Strait Islanders, and justify investing in urban, as well as remote, Indigenous health and its own creation. That focus has now shifted to demonstrating the local impact of the sector's contribution to Closing the Gap in south-east Queensland. Academics involved in the original IBOD study⁹ presented updated data at the meeting and modelled potential reductions in the gap from current IUIH program data at the request of senior management. The discussion explored the extent to which burden of disease processes could be localised and tracked to link IUIH activities to Closing the Gap targets, and the time frames within which these data would be useful.

Discussion

This brief case study examined the challenges faced by the Aboriginal community controlled health sector in this time of uncertainty and how the sector is using evidence to better position itself politically and with the community, now and into the future.

The centralisation of Indigenous policy within the Federal Government has had several implications, including the potential to dislocate Aboriginal health policy from national health policy and financing mechanisms, as was the case before 1995.¹⁰ The tensions between targeted services and mainstreaming options are not new,¹¹ and are recognised in the current National Aboriginal and Torres Strait Islander Health Plan 2013–2023.¹² Despite the new Federal Government's commitments to Indigenous health, it is unclear whether the Closing the

Gap targets and Health Plan will remain or, if they do, in what form.¹³ The restructuring and change in personnel has meant new relationships need to be cultivated and partners engaged. The IUIH places a high value on practical relationships of mutual benefit, but evolving evidence is needed to: (1) educate sceptical politicians; (2) demonstrate IUIH's return on investment; and (3) engage more strategically with State and Federal policy makers.

At the same time, the introduction of contestability reforms will place additional pressures on the sector to produce cost savings and quality improvements,⁴ but without regard to the intrinsic value of community control. In its quest for a sustainable business model, the sector is having to balance 'corporatisation' with its community-based ethos. ACCHOs were first established in the 1970s under the principle of self-determination, the desire for community ownership and control, and local level organisation and representation.^{14,15} Today there are over 150 services across Australia. Despite the philosophy of community control, service delivery models have traditionally been heavily reliant on government funding, and governance and accountability have been episodically problematic.^{11,16,17} Although there is a strong recognition in the community of the importance of community control, and, nationally, the National Aboriginal Community Controlled Health Organisation (NACCHO) estimates ~50% of Aboriginal and Torres Strait Islanders use ACCHOs,¹⁸ the IUIH is overt in its strategies to improve coverage in the region through community engagement, health assessments and culturally appropriate services.

The IUIH model of care confronts these issues in its business model, allowing the sector to assert its autonomy from government and exercise greater community control.

However, beyond its economic goals, the model aims to establish reliable demographic baselines against which to track increased utilisation of services, uptake of health assessments and chronic disease care plans, substantially improving coverage and quality of care. From 2011 to June 2013, the percentage of Aboriginal and Torres Strait Islanders in south-east Queensland accessing ACCHOs had increased from 14% to 30%. By June 2014, IUIH has a target of reaching 50% of the Aboriginal and Torres Strait Islander population in south-east Queensland through its member organisations. Monitoring the MBS profile of each clinic allows managers to chart patient journeys through the clinic(s), map human resource planning against case loads and optimise income. The income generated is being reinvested in extending services and innovating, for example in allied health services. A regional service delivery model for podiatry is being implemented, with IUIH employing podiatrists and members paying a fee for service. The intention is for costs to be recouped through effective referral processes following health assessments and enhanced primary care services. Over time, this will reduce the sector's reliance on grant funding. As of 30 June 2013, 6% of IUIH income was from non-grant funding, up 129% from 2011–12. For perhaps the first time, the sector finds itself in a position to be able to set and fund its own priorities. Yet, at the heart of the model is the patient, the patient's family and the community. For IUIH, reporting back to the community is a key accountability mechanism and an essential component of community governance.¹⁹

The generation and application of research evidence is integral to the work of the IUIH, which is exploring the interface between clinical and population data, and collecting clinical and economic data to demonstrate a return on investment. The result of this integration of evidence and practice is the emergence of a new service delivery model, in which evidence supports accountability, change management and self-sufficiency, and attempts to redefine community control.

Competing interests

CS developed an 'Eight Step Model of Care' which informed the IUIH model of care, and was involved in the formation of the IUIH. The remaining authors declare they have no competing interests.

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