Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the Productivity Commission's Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform.

1. Introduction

The Central Australian Aboriginal Congress (Congress) welcomes the opportunity to contribute to the Preliminary Findings Report for *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* (the Report) and is providing feedback on Chapter 7: *Human services in remote Indigenous communities*. Congress is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people living in and nearby Alice Springs each year.

2. The unique nature of service delivery in remote Aboriginal communities: Addressing the challenges

The Report acknowledges the challenges of service delivery in rural and remote areas, particularly for Aboriginal communities, and the ongoing impact this has on health outcomes. Vast distances and sparse populations means that not all services can be delivered to all parts of Australia. Conditions in remote Australia are not conducive to an effective competitive market in human services and meet the classic economic textbook definition of an environment conducive to market failure.

Under such conditions, it is much better to ensure outcomes are being achieved by the delivery of core services through large, regional ACCHSs that have sufficient economies of scale to provide a broad range of core services. The move to regionalised delivery of primary health care under Aboriginal community control has been an agreed objective of the Northern Territory and Australian Governments, and the community controlled health sector, for some years[1]. Under this model, accountability for outcomes can be assured through appropriate Key Performance Indicators and not through the threat of competition from a different provider if outcomes are not achieved.

This is especially the case as there is a need to provide much greater funding certainty in rural and remote areas in order to attract and retain professional staff that will simply not come or leave if a service has to be tendered for every few years in the spirit of competition. A quality professional workforce is key to the provision of quality services. Congress has repeatedly experienced the problem encountered when short term funding leads to loss of professional staff.[2]

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As noted in the Commission's Report, these challenges are compounded by: responsibilities for essential services provision that are split across levels of government and government departments; multiple and inconsistent funding streams; and multiple short-term, ad hoc program funding. These conditions reinforce fragmentation, duplication and poor coordination of services.

The Report also acknowledges that while there have been improvements in some indicators for Aboriginal people e.g. childhood mortality, there is still a long way to go before many health and well-being indicators match those of non-Aboriginal Australians. For instance, Aboriginal people experience a disease burden that is 2.3 times higher than non-Aboriginal people, while in the Northern Territory, with the largest number of remote communities and highest proportion of Aboriginal people, the burden of disease is three times higher.[3, 4,5]

As also noted in the Report, the nature and situation of Aboriginal people in living remote areas, particularly around language, culture and mobility requires that providers are able to meet their specific needs. This means they have to be culturally appropriate, and engaged with the community if they are to be acceptable to, and therefore used by, the populations they are seeking to serve.

Congress therefore agrees with the Report's view that '…service models that work in other parts of the country will not necessarily work in remote Indigenous communities [p126].' Congress also agrees with the Report's comment that '…introducing competition where there are at best one or two providers, is unlikely to be the most effective model for improving service outcomes for users.'

In principle, Congress supports the following key structural goals identified in the Commission's Report that seek to address the issues outlined and underpin better services [p129]:

- Better coordination and service integration
- More stable policy settings
- Greater community control and engagement

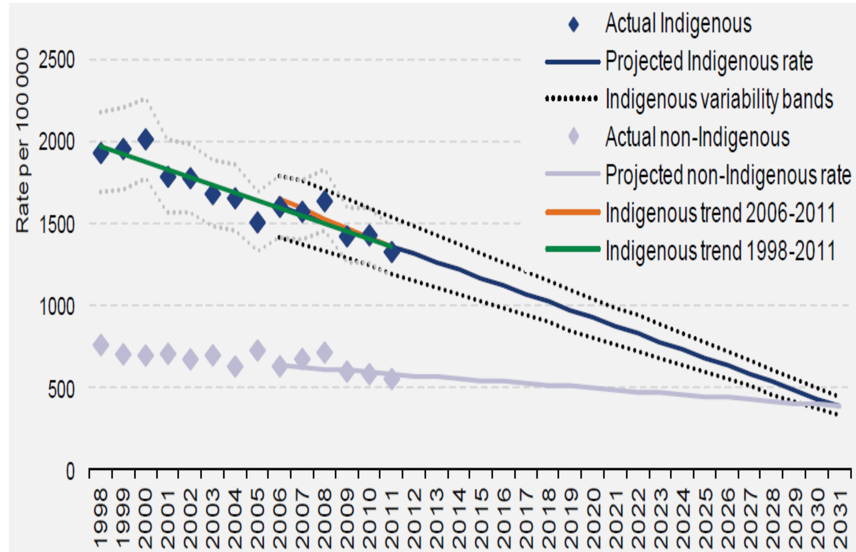
However, despite the issues documented in Chapter 7 in the Report remote Indigenous communities are still identified as one of the six priority areas "where introducing greater competition, contestability and informed user choice could improve outcomes for people who use human services, and the community as a whole" [p2]. While reform is needed, prioritising user choice and encouraging competition in service delivery is both unrealistic and unlikely to improve health outcomes in remote areas.

3. A history of achievement

The structural areas for change identified in the Commission's Report will not be addressed by encouraging competition. In fact, the health improvements that were achieved in the Northern Territory (NT) during the early years of this century came about through collaborative planning, and through it the allocation of resources according to need to existing health service providers. The NT was able to utilise these strategies, the antithesis to competitive resource allocation processes, to greatly improve the health system and its outcomes for Aboriginal people, with much of the thinking that led to these reforms coming from within the ACCHS sector in the NT, led by the Aboriginal Medical Services Alliance Northern Territory (AMSANT).

The following table from the Council of Australian Governments Indigenous Reform Council report shows a more than 30% decline in all-cause mortality for Aboriginal people and that the NT was on track to Close the Life Expectancy Gap by 2031[6]:

Figure A.6 Death rates per 100 000 standard population, 1998–2031, Northern Territory

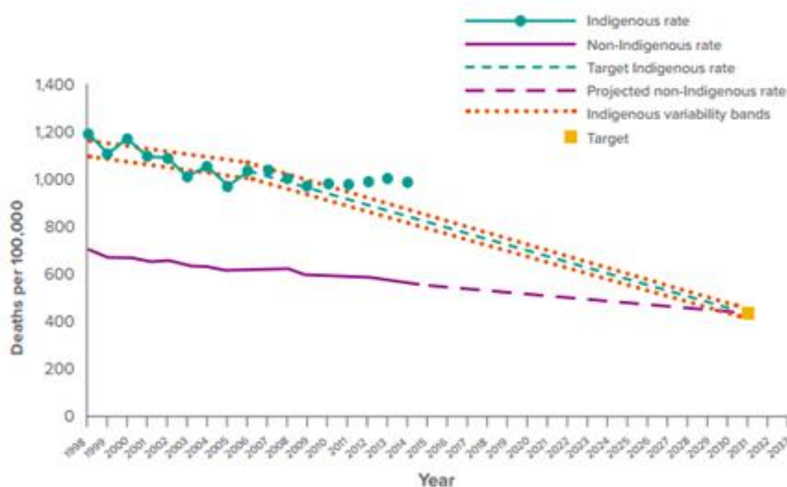


Source: ABS and AIHW—see Appendix D.

In this period, other key drivers of health outcomes (such as educational attainment, average income, employment and overcrowding) did not change in the Northern Territory, as outlined in the same COAG report. Instead those positive changes came from health system improvements including improved access to primary health care supported by a needs-based, collaborative planning process that was able to allocate new resources to where they were needed most. This meant the average per capita funding increased from $700 per person in 1999[7] to more than $3000 per person in 2013.

Significantly, competitive tendering was not part of this process. However, since 2009, as the policy model shifted to encourage competitive tendering, the use of private non-Aboriginal community controlled providers, and mainstreaming, these improvements have ceased, as shown in the next graph. The improvement has not only stopped in the NT but also in other jurisdictions. Congress believes that this is strong circumstantial evidence, supported by the on-ground experience of many health professionals and Aboriginal people, that competitive tendering is ineffective and inefficient compared with collaborative needs based planning and allocation of resources.

FIGURE 11: Overall mortality rates by Indigenous status: NSW, Qld, WA, SA and the NT combined 1998-2031



Source: ABS and AIHW analysis of National Mortality Database

4. How did the NT get resource allocation right and what lessons can the Productivity Commission learn from this?

In the 1990s it was clear that there was a need for a completely new funding model that was based on both pooled grant funding as well as access to Medicare and the PBS. This was one of the key outcomes sought in the transfer of responsibility for Aboriginal health from the former Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health in 1995.[8]

The need for this reform was made evident by the reality that funding levels were not based on need, with little or no coordination between governments, leading to large inequality between regions of the Northern Territory in access to health services. For example, in Central Australia there was one area where the Commonwealth spent nothing on primary health care and the NT spent only $347 per person. This contrasted with another area where they both spent their maximum amount leading to more than $2000 per head.

To address this, at the suggestion of AMSANT, the Commonwealth government agreed to a new Integrated Funding model as part of a new program known as the Primary Health Care Access Program (PHCAP). This required the pooling of all Commonwealth and Territory grant funds as well as access to MBS and PBS. Under the PHCAP the NT was divided up into 21 health zones based on geographic, cultural and social affiliations. Major planning studies were then undertaken which provided data on these 5 criteria in each zone:

- pooled per capita Primary Health Care funding
- population/staffing ratios for GPs, nurse and Aboriginal health practitioners
- existing health infrastructure for clinics and staff housing
- capacity to benefit i.e. through effective Aboriginal leadership and community control
- core functions of Primary Health Care.

A key part of these reforms (led by the NT Aboriginal Health Forum – the collaborative planning forum for both governments and the community controlled sector) was the development of a set of agreed "core primary health care services." These provided the basis for a more rational approach to needs based funding, by specifying the core activities of Aboriginal primary health care practice including a range of clinical services, support services, social and preventative programs and policy and advocacy functions[9]. There have been 3 iterations of the core primary health care services model with the most recent and comprehensive version produced in 2011 in which there are five service domains[10] :

1. Clinical Services
2. Health Promotion
3. Corporate Services and Information
4. Advocacy, Knowledge, Research, Policy and Planning
5. Community Engagement, Control and Cultural Safety

Defining core services has been important to ensure access to evidence based services and programs according to need drives the allocation of resources, and delivering on the obligation of government to ensure all of its citizens' right to health are realised.

Along with the development of these core services has been the corresponding development of core primary health care indicators that enable each service to continually monitor and improve their services, and maintain accountability through reporting to their communities and to funding bodies

This planned, collaborative approach to the application of funding resources to support sustainable, comprehensive primary health care delivered significant improvements in health outcomes for Aboriginal people in the Northern Territory[11,12,13]. Competition played little or no part in delivering these achievements, indeed the increasing emphasis on competitive tendering processes was one of the factor that has stalled further progress.

5. **Can competition address the needed reforms?**

The Productivity Commission Report identified three issues that needed to be addressed for improved service delivery and outcomes in remote Indigenous Australia: better coordination and service integration; more stable policy settings; and greater community control and engagement.

The question remains: can an increase in competitive tendering and user choice in remote Aboriginal service delivery address these issues?

- **Better coordination and service integration**

As we have seen in the Northern Territory in more recent years, competitive tendering encourages fragmentation of service delivery with multiple providers servicing small remote and regional populations, with no incentive to collaborate with local services, particularly with those who also contest for funds. There is good evidence that multiple providers to the one patient harms patient outcomes compared with multidisciplinary care within a single provider.[14]

The Commission's Report suggests tendering for bundled services, coordinated through central management, as a way forward. Even if this were the case, competitive tendering cannot achieve the outcomes required in remote communities while the focus is on the most efficient and cost-

effective delivery of services, rather than meeting local health needs. It undermines integration by promoting service platform instability, as organisations have to regularly re-tender to deliver services and may be replaced by new organisations which can, on paper at least, promise better outcomes for less money.

Competitive tendering undermines the ACCHS service model, which already provides comprehensive and effective services that are coordinated and designed to address local need. These issues have also been identified in the recent Senate Inquiry into the Commonwealth Indigenous Advancement Strategy[15], which raised the need for service planning and needs mapping while raising serious doubts about blanket competitive processes.

- **More stable policy settings**

Competitive funding undermines stable policy settings. For example, Congress exists within a relatively stable core-funding environment, which is linked to its ability to provide continuous comprehensive services and address health inequalities.[16] This is comparable to State-run services where disinvestments, alongside the shifting responsibility between State and Commonwealth services, have reduced accessibility and availability of comprehensive primary health care services.

This stable, long term funding model is vitally important for the recruitment and retention of professional staff who are essential to the delivery of quality primary health care services. The uncertainty created by tendering processes at 3 year intervals for example, often means the loss of key staff and all of the experience and expertise they have gained in Aboriginal health.

- **Greater community control and engagement**

Open markets cannot deliver the community-controlled services needed to help address the gross inequity in health outcomes between Aboriginal people and non-Aboriginal people, particularly in remote areas. Competition for funding generally favours larger, frequently non-Aboriginal NGOs that have the capacity and resources to tender for large or multiple projects, superficially appearing to reduce overall costs. Large non-Aboriginal NGOs do not have strong links with the community or other local service providers, nor do they have the long-term commitment required for sustainable and effective service provision. They also do not have the cultural knowledge and long-term capacity to employ and retain the appropriate Aboriginal workforce required to undertake community work.

6. Supporting ACCHSs: the most effective path to better outcomes

Rather than increasing competition, improved outcomes could be better delivered by reforms that enhance the uptake of the Aboriginal community-controlled service model. ACCHSs such as Congress deliver care that is community-led, designed according to local needs and co-ordinated both within the model and with external providers. The core services are based on need and designed to make the greatest contribution to Closing the Gap in health outcomes. Services across the spectrum of care, including regular clinical, maternal and child health, chronic disease management and other services, and also early childhood, family support, alcohol and other drug treatment, aged and disability care. ACCHSs have also adopted innovations in e-health to promote continuity of care and coordination across both ACCHSs and mainstream services.[17]

Where ACCHSs exist, the community prefers to and does use them. This is because they provide appropriate and affordable services that are culturally acceptable to Aboriginal communities, are of a high standard that is either equal or better than mainstream general practice, and consistently improve performance on best-practice care indicators.[18] Services and programs have a strong evidence-base, and ACCHSs including Congress, have developed their own research programs. ACCHSs are driven to improve, innovate and become more efficient and responsive to need through a robust quality improvement framework. This is above that which is required or undertaken by private primary care service providers.

7. Recommendations

Congress recommends that the Productivity Commission:

1. Clearly identifies that remote Aboriginal health services as one area where competitive funding in service delivery will not improve outcomes for Aboriginal people and therefore decides not to examine this sector from the perspective of enhancing competition.

2. Recommends the return to the successful pathway to improved health services and outcomes in remote Aboriginal communities, based on the sustainable, long-term resourcing of comprehensive models of primary health care under Aboriginal community control with system-level, supported by collaborative needs based planning rather than competition.

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