Response to The Productivity Commission's *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform - Preliminary Findings Report*

4th November 2016

Summary

1. AMSANT commends the Productivity Commission's preliminary report in documenting the challenges facing service delivery in remote Aboriginal communities, and for identifying three important ways forward (better coordination and service integration; more stable policy settings; and greater community control and engagement).

2. However, AMSANT firmly rejects the conclusion of the Productivity Commission's preliminary report that greater competition, contestability and user choice will improve outcomes for people who use services in remote Aboriginal communities.

3. AMSANT urges the Productivity Commission to avoid a repetition of recent Government policy failures in Aboriginal funding processes, by recommending an approach that prioritises the evidence of what we know works, and the views and experience of Aboriginal people, communities and organisations.

4. From the experience of our sector, and from a large and growing evidence base, it is clear that increased competition is not the answer to improved outcomes in remote communities in Aboriginal Australia. Contrary to the conclusions contained in the Productivity Commission's Preliminary Report, increased competition in this context would lead to worse outcomes through undermining:

    - *the effectiveness of individual services*, by failing to recognise the advantages of Aboriginal community controlled organisations and simultaneously advantaging non-Indigenous organisations in competitive tendering processes,

    - *service integration at a local and regional level*, by creating complex service delivery environments with multiple providers, and promoting a culture of competition rather than cooperation, and

    - *effective health system planning*, by damaging the collaborative relationships and knowledge that has been built up over many years, and replacing them with a health system characterised by fragmented services that are not based on evidence or on an understanding of the needs of the Aboriginal community.

5. AMSANT therefore asks that remote Aboriginal service delivery be excluded from any further consideration for the introduction of measures aimed at greater competition, contestability and user choice, as such measures will not improve outcomes for people who use services in remote Aboriginal communities.

Introduction

The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) would like to thank the Productivity Commission for the opportunity to comment on the *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform - Preliminary Findings Report* [1].

As the Commission is aware, AMSANT is the peak body for Aboriginal community-controlled health service (ACCHSs) sector in the Northern Territory which has played a pivotal role in addressing the burden of ill health carried by Aboriginal people. It is from the perspective of our sector's long history of representing the needs of Aboriginal communities, and working alongside government to meet those needs, that we provide the following brief comments on the Commission's preliminary findings in relation to the introduction of greater competition, contestability and user choice to services in remote Indigenous communities. Our comments build on and reiterate some of the issues we raised in our original submission to the Productivity Commission [2].

Ways forward

We commend the Productivity Commission's preliminary report in documenting the challenges facing service delivery in remote Aboriginal communities, including:

- market failure (that is, very few or no private sector providers),
- the complex and fragmented nature of funding arrangements,
- uncertainty of funding streams and large administrative burden,
- lack of service coordination and integration,
- barriers to access such as distance, a mobile population and cultural safety, and
- non-Aboriginal organisations and staff that are inexperienced in the delivery of effective services in cross cultural environments.

We also commend the Commission for identifying three important ways forward:

- better coordination and service integration,
- more stable policy settings, and
- greater community control and engagement.

AMSANT supports these as key issues to drive improved service delivery and outcomes in remote Aboriginal communities. However, it is unfortunate that the Commission's Report goes on to conclude that:

> *introducing greater competition, contestability and informed user choice could improve outcomes for people who use ... services in remote Indigenous communities (page 2).*

The Report offers no evidence that greater competition will help address the issues it has identified as ways forward. In fact the analysis the Report provides suggests exactly the opposite – that greater competition will exacerbate the problems it has identified and undermine what progress has been made.

Why more competition is not the answer

In this brief submission, we do not intend to recapitulate all the arguments we have already made in our original submission to the Productivity Commission. Instead we re-present the most important reasons why increased competition will not lead to better outcomes for remote Aboriginal communities and indeed, is likely to lead to worse outcomes.

We believe that any way forward must be based on two key and interconnected factors:

- the evidence-base of what we know works, and specifically what we know works in remote Aboriginal service delivery, and
- the views and experience of Aboriginal people, communities and organisations that have been working for many years in these areas and have significant achievements to their credit.

In relation to the need for an evidence-based approach, we draw the Productivity Commission's attention in particular to the recent Senate Inquiry into the Indigenous Advancement Strategy (IAS) [3]. One of the features of the IAS was the delivery of the bulk of the funding through open competitive grants rounds. The Senate Inquiry was highly critical of the IAS in general, and its focus on competitive funding processes in particular, and concluded:

> *The committee questions the evidence base for the program design. While PM&C were able to identify the analysis done by the ANAO and the Department of Finance as the evidence underpinning the case for policy change to the service delivery of Indigenous programs, it did not articulate the evidence base for the development of the IAS as the means by which to address earlier policy failings in this area (page 61, emphasis added).*

The following three sections provide some of the key evidence and arguments that we believe the Productivity Commission must consider in the preparation of its final report. In short, these sections describe how increased competition in the delivery of services to remote Aboriginal communities will undermine:

- the effectiveness of individual services,
- service integration at a local and regional level, and
- planning for an effective health system.

Competition undermines effectiveness of Aboriginal organisations

The Senate Inquiry into the IAS found that one of the failings of moving to competitive tendering processes was that 'the model used did not recognise the enhanced outcomes of service delivery by Indigenous organisations' [3](page 21). In our original submission, we documented a number of these advantages, including

- contributing to community and individual self-reliance, engagement and control though participation in the governance of ACCHSs,

- durable and effective partnerships with other health professionals, organisations and government (see below),
- enhanced employment outcomes for Aboriginal people, and
- improved access to health services for Aboriginal people.

It is for these reasons that ACCHSs have been accepted by successive governments as the preferred, most effective way of delivering health outcomes [4, 5] and have gained significant support from non-government representative bodies such as the Australian Medical Association [6].

Attempts to assess the effectiveness of ACCHSs in comparison to mainstream primary health are difficult because ACCHSs' service population has significantly more complex health needs, and frequently live areas where private practice business models struggle and service access is a particular challenge. In addition, ACCHS provide a comprehensive model of care that goes far beyond what mainstream services provide. Nevertheless, the evidence points to ACCHSs as a highly effective model for addressing Aboriginal and Torres Strait Islander health, with:

> *... some studies showing that ACCHS are improving outcomes for Aboriginal people, and some showing that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload* [7].

In particular, ACCHSs contribute significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birth weight [8].

The key role of ACCHSs is supported by the fact that Aboriginal and Torres Strait Islander people show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes in large part because of their better capacity to deliver culturally safe care [9]. Indeed, ACCHSs are a profound expression of 'user choice'.

Further, ACCHSs have their own effective means of ensuring that they are meeting the needs of the communities they serve. First, they have the processes of community input, engagement and control which provide an ever-present conduit for user preferences and feedback into the delivery of services. Second are the processes of Continuous Quality Improvement (CQI), including formal accreditation processes and in-depth reporting against national and NT KPIs. These approaches, the development of which have been led by the ACCHS sector, are highly valuable in building and maintaining a high quality service system.

Last, ACCHS employ Aboriginal people at a significantly higher rate than other health services do. The latest figures show that ACCHOs employ 3,265 Aboriginal people nationally; even amongst services focusing solely on Aboriginal health, they employ over five times as many Aboriginal people as non-ACCHOs, with almost 60% of their staff being Aboriginal [10].

The evidence of the effectiveness of ACCHSs in comparison to mainstream services is thus very strong, whether reflected in better delivery of health services, improved outcomes, better cultural safety, better quality assurance processes and higher rates of employment

of Aboriginal people. Mainstream services are highly unlikely to be able to replicate these advantages, especially in remote areas in which they are likely to be inexperienced, and where they do not have the advantage of long-term relationships of trust and engagement with local Aboriginal communities. Under these circumstances, increased competition will profoundly undermine positive outcomes already being delivered in remote Aboriginal communities by Aboriginal organisations such as ACCHSs.

On top of this, as noted by the Senate Inquiry, competitive tendering processes may actually *disadvantage* Aboriginal organisations:

> *The committee heard the view that the move to a competitive funding arrangement positioned small, Indigenous community-controlled organisations against well-resourced and experienced applicants, including large not for profit associations and the university sector. It was argued that this shift to a competitive funding process was a significant change that many Indigenous organisations were ill-equipped to deal with [11] (page 21).*

Large non-Indigenous organisations, experienced in such processes have the background and staff to produce convincing applications for funding, which is likely to hide their reduced capacity to deliver the results 'on the ground'. It was this factor which no doubt contributed to less than half of the organisations being funded through the IAS being Indigenous organisations, a fact that became an issue of significant public controversy and criticism.

Furthermore, as the Empowered Communities report points out, Aboriginal organisations have the motivation to solve entrenched problems because their leadership is accountable to communities, whilst mainstream NGOs have an interest in ongoing service delivery that can entrench problems. The Empowered Communities report sets out a vision where Aboriginal communities make decisions about their own future and become the senior partners with government in a supporting role. Key attributes include an increasing role for Aboriginal organisations in leadership and service delivery — as is occurring in the ACCHSs sector [17].

Competition undermines service integration

The heavy burden of disease and particularly the high prevalence of chronic disease in Aboriginal communities means that Aboriginal people often need to access multiple, different health services to get their needs met, including medical care, allied health care, specialist services, and hospital care. Effective care coordination is therefore a very significant enabler of effective health services [8].

Fragmentation and poorly coordinated care is increasingly being recognised as leading to suboptimal outcomes in the whole health system. The background paper to the Commonwealth's review of chronic disease management in primary health care as part of the Healthier Medicare Initiative [18] found that deficiencies in chronic disease care included a lack of monitoring quality in general practice, low rate of adherence to clinical guidelines, lack of consumer engagement in chronic disease care, lack of communication between health professionals, and less access to health care in rural and remote areas. The subsequent policy reform based on the review — Health Care Homes [19] — is a model

that remote ACCHSs are in effect already delivering through provision of coordinated multidisciplinary care within a comprehensive primary health care service.

There are a number of factors which support good service coordination: cultural security across the care spectrum, the involvement of local communities, and investment in coordination processes and support for staff [12]. ACCHSs play a significant role in facilitating care planning with 98% of ACCHSs providing care planning for their clients [13]. We also note an important systematic review of integration drawing on international evidence (including within Australia) which identified ten elements contributing to successful primary/secondary integration at a regional level, including: joint planning; integrated information communication technology; change management; shared clinical priorities; incentives; population focus; measurement – using data as a quality improvement tool; continuing professional development supporting joint working; patient/community engagement; and innovation [14].

It is unclear how competitive tendering processes can support any of these factors for success. Instead increased competition actually undermines them through creating complex, constantly changing service delivery environments with multiple providers of health services. It promotes a culture of competition rather than cooperation amongst providers, an emphasis on individual care rather than population health, and short-term outcomes rather than long-term gains in health.

Competition undermines planning for an effective health system

Collaborative, well-resourced and sustainable processes for health system planning are critical for health system effectiveness [15]. In the Northern Territory, the Northern Territory Aboriginal Health Forum (NTAHF) which brings together the NT and Australian Governments, with AMSANT (representing the community controlled health sector) and the NTPHN to work collaboratively on strategic resource allocation; Aboriginal community participation and control; better service responsiveness to Aboriginal people's needs; the provision of quality, evidence-based care; improved access to care for Aboriginal people; and increase engagement of health services with Aboriginal communities.

Such planning processes are critical to ensuring that investment in the health system is not wasted. Their success is demonstrated by the fact that in 2014, the Northern Territory was the only jurisdictions in the country to be on track to meet the target of 'Closing the life expectancy gap within a generation' [16]. A number of factors contributed to this success however, sustainable and collaborative needs-based planning through the NTAHF (plus increased primary health care funding directed through a well-organised network of ACCHSs) were critical.

The existence of the NTAHF is an essential consideration in considering any proposals to introduce increased competition in remote Aboriginal services. The NTAHF has been in existence for nearly twenty years and has its core a shared commitment to the model of Aboriginal community controlled comprehensive primary health care delivered through ACCHSs. This has been formalised in the Pathways to Community Control policy endorsed by the NTAHF [4]. This commits to the progressive transition of Aboriginal primary health care services to community control over time — a policy agenda that is diametrically opposed to increasing competition.

Increased competition will undermine the commitment, experience, knowledge and relationships built up over many years that are necessary to make these planning processes work, and lead towards a health system characterised by short-term, fragmented services that are not based on evidence, or on an understanding of the needs of the Aboriginal community.

Note that Senate Inquiry into the IAS made a strong statement about the failure of competitive funding processes in relation to health system planning with its first recommendation:

> *The committee recommends that future tender rounds are not blanket competitive processes and are underpinned by robust service planning and needs mapping* [3].

Notes

1. Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform - Preliminary Findings Report*. 2016, Commonwealth of Australia: Canberra.

2. AMSANT (Aboriginal Medical Services Alliance Northern Territory), *Submission to the Productivity Commission Inquiry into Introducing Competition and Informed User Choice into Human Services*. 2016, AMSANT: Darwin.

3. Finance and Public Administration References Committee of the Australian Senate, *Commonwealth Indigenous Advancement Strategy tendering processes*. 2016, Commonwealth of Australia: Canberra.

4. Northern Territory Aboriginal Health Forum, *Pathways to community control: an agenda to further promote Aboriginal community control in the provision of Primary Health Care Services*. 2008.

5. Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, D.o. Health, Editor. 2013, Commonwealth of Australia: Canberra.

6. Australian Medical Association. *Aboriginal and Torres Strait Islander Health - Position Statement*. 2015 2 November 2016]; Available from: https://ama.com.au/position-statement/aboriginal-and-torres-strait-islander-health-revised-2015.

7. Mackey P, Boxall M, and Partel K, *The relative effectiveness of Aboriginal Community Controlled Health Services compared with mainstream health service*, in *Deeble Institute Evidence Brief*. 2014, Deeble Institute for Health Policy Research; Australian Healthcare and Hospitals Association.

8. Dwyer J, Silburn K, and Wilson G, *National Strategies for Improving Indigenous Health and Health Care*. 2004, Commonwealth of Australia: Canberra.

9. Vos T, et al., *Assessing Cost-Effectiveness in Prevention (ACE–Prevention): Final Report*. 2010, ACE–Prevention Team: University of Queensland, Brisbane and Deakin University: Melbourne.

10. Australian Institute of Health and Welfare (AIHW), *Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15*. 2016, AIHW: Canberra.

11. Senate Finance and Public Administration References Committee, *Commonwealth Indigenous Advancement Strategy tendering processes*. 2016, Parliament of Australia: Canberra.

12. Stewart J, Lohoar S, and Higgins D, *Effective practices for service delivery coordination in Indigenous communities. Resource Sheet 8.* . 2011, Closing the Gap Clearinghouse: Australian Institute of Health and Welfare and Melbourne: Australian Institute of Family Studies.: Canberra.

13. Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AHMAC, Editor. 2015, Commonwealth of Australia: Canberra.

14. Nicholson C, Jackson C, and Marley J, *A governance model for integrated primary/secondary care for the health-reforming first world - results of a systematic review.* BMC Health Serv Res, 2013. **13**: p. 528.

15. World Health Organization, *Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action.* 2007, World Health Organization: Geneva.

16. COAG Reform Council, *Indigenous Reform 2011-12: Comparing performance across Australia*. 2013, COAG Reform Coucnil: Sydney.

17. Empowered Communities: Empowered Peoples Design report. At http://empoweredcommunities.org.au/about/report.aspx

18. How can Australia improve its primary health care system to better deal with chronic disease. Background paper. Mckinsey Company 2015.

19. Health Care Homes. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes#one.