Response to the Productivity Commission's Reforms to Human Services: Issues Paper, December 2016

24 February 2017

Background

The following paper provides the Aboriginal Medical Services Alliance Northern Territory (AMSANT) response to the *Reforms to Human Services: Productivity Commission Issues Paper, December 2016* [1].

This response should be considered alongside our November 2016 *Response to The Productivity Commission's Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform - Preliminary Findings Report*, in which we:

- rejected competition, contestability and user choice as a primary means of improving outcomes for people who use services in remote Aboriginal communities;

- instead, urged an approach based on the evidence of what we know works, and the views and experience of Aboriginal people, communities and organisations; and

- identified three major ways that increased competition as a primary means of reform risks worse outcomes through undermining the effectiveness of individual services; service integration at a local and regional level; and effective health system planning.

We stand by those conclusions and the evidence that supports them.

We agree that there is a need for reform of the way services are funded and delivered in many remote Aboriginal communities. AMSANT, working in partnership with Australian and Northern Territory Governments and other agencies such as the Northern Territory Primary Health Network (NT PHN), through forums such as the Northern Territory Aboriginal Health Forum (NTAHF), has a long history of working constructively to address these. AMSANT is also a member of the Aboriginal Peak Organisations NT (APO NT) alliance that has become a key partner and collaborator with government and other stakeholders in working to address the reform of human service provision to the Aboriginal community. We urge the Commission to recognise these existing collaborative structures and processes as the way forward in building an effective health and human services system in the Northern Territory, especially for remote Aboriginal communities.

The *Issues Paper* makes a large number of 'requests for information' (RFIs) in its chapter on *Human services in remote Indigenous communities*. Our response focuses on those RFIs that we believe are most likely to be of use to the Commission, emphasising the evidence in regard to each one and practical ways the Commission can ensure that any reforms lead to better service delivery in remote Aboriginal communities and better health outcomes for those living in these areas.

The current model of service provision

RFI 32: Strategies to address the challenges of recruiting, training and retaining staff

The most important strategy for addressing the challenges of recruiting, training and retaining staff is the sustainable resourcing of Aboriginal community controlled health services (ACCHSs).

ACCHSs are the largest employer industry of Aboriginal and Torres Strait Islander people within Australia (3265 FTE during 2014-15) [2, 3].

ACCHSs significantly outperform non-Indigenous organisations delivering health services to Aboriginal communities in the employment of Aboriginal staff with 57% Aboriginal and Torres Strait Islander staff for ACCHSs to 37% for mainstream government and non-government agencies. Over half (54%) of senior managers and supervisors in ACCHSs are Aboriginal, compared to just 10% in mainstream organisations [2]. See Figure 1.

ACCHSs also provide a career pathway and skills development for Aboriginal people including for people with little formal education but with strong cultural skills and community knowledge – something that is especially important in remote areas [4].

Given these facts, tendering or commissioning processes for services in remote Aboriginal and Torres Strait Islander communities should:

* recognise the superior record of Aboriginal community-controlled organisations in employing and developing Aboriginal staff;

* weight any assessment processes accordingly, such that they preference Aboriginal organisations and take into account a respondent's capacity for employment, training and retention of Aboriginal people; and

* ensure that where there is not an existing Aboriginal organisation with the capacity to deliver the service, that weighting and preference is given to applications from partnerships developed in accordance with the APO NT NGO Partnership Principles.

RFI 32: Ways service delivery could be adapted to better meet the needs and preferences of Indigenous Australians living in remote communities (for example, how service delivery could better respond to the higher mobility of Indigenous Australians).

Lack of cultural security of services for Aboriginal people remains a significant barrier to service access, particularly in remote areas where traditional culture may be strong and English a second language. Addressing these barriers is a challenge for all organisations in these communities, but a challenge in which local Aboriginal community-controlled organisations have a significant advantage.

ACCHSs have been found to have better cultural security than mainstream primary care services, resulting in improved patient satisfaction and higher rates of adherence to treatment [5].

Adapting evidence-based service delivery to local social and cultural environments is a challenge for all organisations delivering services in remote Aboriginal Australia. Through their structures of governance, including in particular their elected community boards, ACCHSs are uniquely well-placed to meet this challenge [6]. It is particularly clear from our experience that a relationship of trust with, and deep knowledge of, the local community and its particular needs and wishes are essential in delivering culturally secure services; such relationships and knowledge can only be built up over many years.

Competitive processes that bring in new or outside, non-Aboriginal organisations will undermine the delivery of services that meet the cultural needs of the communities they serve. Tendering or commissioning processes for services in remote Aboriginal and Torres Strait Islander communities should therefore:

- recognise the inherent advantage of Aboriginal community-controlled organisations in delivering culturally secure practice that is adapted to better meet the needs and preferences of Indigenous Australians living in remote communities;

- weight any assessment processes accordingly, such that they preference Aboriginal community-controlled organisations, and require respondents to describe resourced structures and processes for local Aboriginal community input into / governance of services; and

- ensure that where there is not an existing Aboriginal organisation with the capacity to deliver the service, that weighting and preference is given to applications from partnerships developed in accordance with the APO NT NGO Partnership Principles.

Evaluating reforms to increase competition and user choice

RFI 34: Whether the reforms have increased the effectiveness of service delivery in remote Indigenous communities, particularly the responsiveness of services to the needs and preferences of users and the quality of services

Recent government reform based on contestability and open competitive grant rounds have been shown to be significantly flawed, and have undermined the effectiveness of service delivery in remote communities and the trust of Aboriginal communities and organisations in the capacity of government to implement such reforms.

While the move towards contestability and increased competition in the funding of services to Aboriginal communities has been gathering pace for some years [4] the Commonwealth Indigenous Advancement Strategy (IAS) announced in 2014, consolidated $4.8 billion under a single program, a large proportion of which was to be disbursed through an open competitive grant funding process [7]. Two significant inquiries into the IAS have now been completed, coming to similarly negative conclusions about the implementation of the Strategy.

The Senate Finance and Public Administration References Committee Inquiry into the Indigenous Advancement Strategy tendering process [8] heard that the process was poorly designed, failed to consult and engage Aboriginal and Torres Strait Islander communities, and lacked an evidence-base. In relation to funding through competitive tender, the IAS disadvantaged Aboriginal and Torres Strait Islander organisations, did not recognise the enhanced outcomes from Aboriginal led service delivery, and failed to distribute resources effectively to meet regional or local needs.

The Australian National Audit Office (ANAO) audit of the IAS [7] found that it was inadequately planned and not effectively implemented, and that in relation to the competitive grant process, the Department of Prime Minister and Cabinet did not:

- assess applications consistent with its own guidelines and public statements;

- meet its obligations under the Commonwealth Grants Rules and Guidelines;

- keep records of key decisions; or

- establish performance targets for all funded projects.

These in-depth reviews of government reforms intended to increase competition call into question government capacity to develop and run effective, fair and transparent competitive grant processes. They also outline the key risks in terms of poorer outcomes and opportunity costs of foregoing the clear benefits of Aboriginal-led service delivery.

RFI 34: Lessons from the implementation of these reforms, particularly where arrangements needed to be tailored to the circumstances of remote communities

1. **The need for sustained, collaborative planning processes** over the long-term to direct resources to where they can do the most good and to build integrated, stable, evidence-based health systems that meet the needs of remote Aboriginal communities. This is in line with the Recommendation 1 of the Senate Inquiry [9], which stated that:

   future tender rounds are not blanket competitive processes and are underpinned by robust service planning and needs mapping (page vii).

   In the Northern Territory, the NTAHF is the established structure for such collaborative planning processes and should be supported to carry out this role in any reforms.

2. **Competitive tendering processes need to take account of all issues affecting service effectiveness,** including by giving a weighting to Aboriginal community controlled organisations in recognition of the evidence of their greater effectiveness (see response to RFI 36 below for details). This approach was recommended by the Senate Inquiry:

   Recommendation 3: ... that future selection criteria and funding guidelines should give weighting to the contribution and effectiveness of Aboriginal and Torres Strait Islander organisations to provide to their community beyond the service they are directly contracted to provide (page vii).

3. **Non-Indigenous organisations contracted to deliver services must meet a set of Partnership Principles** to ensure that they are able to work with other service providers including Aboriginal organisations, and that plans are in place to build capacity of Aboriginal organisations and transition such services to more effective structures of Aboriginal control (see Attachment 1: *APONT Partnership Principles for non-Aboriginal NGOs*; and response to RFI 36 below for details).

Increasing user choice and community voice

RFI 35: Whether and why Indigenous organisations (such as ACCHOs) have been successful at achieving intended outcomes for people living in remote communities

Evidence comparing mainstream and ACCHS services is relatively rare [10]; and in addition such comparisons must take account of the fact that ACCHSs' service costs will be higher than most mainstream services as they service communities with more serious and complex health needs; frequently operate in rural or remote areas; and provide a wider range of comprehensive PHC services than mainstream agencies [11]. Nevertheless, what evidence there is shows that ACCHSs:

• *provide greater health benefits compared with mainstream primary care* [10], with overseas evidence suggesting the consistent long-term investments in community control significantly lower the rates of illness in Indigenous communities [12]

• *provide improved access to health services* measured by higher rates of Aboriginal use of primary care services [10]

- *demonstrate better cultural security than mainstream primary care services*, resulting in improved patient satisfaction and higher rates of adherence to treatment [5]

- *are more likely to be committed to processes of clinical governance and evidence based medicine* as the foundations of effective health care [10]

- *employ more Aboriginal people* than mainstream services [3]

- *provide a setting for the development of skills and a career path for Aboriginal people* including for those with little formal training [4]

- *are instrumental in developing and supporting innovative models of care*, including through partnering with mainstream providers [5].

Increasing the benefits of contestability

RFI 36: How processes for commissioning services could be changed to improve the quality, equity, efficiency, accountability and responsiveness of services

1. **Recognise that contestability and competitive tendering are not the best model for delivering services to Aboriginal communities**. As detailed in AMSANT's previous submission, the ACCHSs sector in the NT has demonstrated that an alternative model based on collaborative needs based planning, supporting a comprehensive, evidence-based Aboriginal community controlled service model incorporating effective quality assurance and CQI frameworks produces superior outcomes to alternative government, NGO or private provider models based on competitive tendering.

2. **Where competitive tendering processes are required, they must take account of all issues affecting service effectiveness.** In particular, this means ensuring that all those tendering for the provision of health and wellbeing services in remote Aboriginal communities must meet the same requirements expected of ACCHSs (e.g. resourced processes of quality improvement, formal and resourced processes for Aboriginal community governance and engagement, resourced strategies for implementing and monitoring cultural security, employment of local Aboriginal people, resourced engagement with other service providers).

   All tender responses should be assessed against at least the following elements, with a significant weighting given to Aboriginal community controlled organisations in recognition of the evidence of their greater effectiveness:

   - demonstrated capacity and resourced processes for Aboriginal community engagement and governance;

   - demonstrated capacity and experience in delivering culturally secure care in the specific region where services are to be delivered, and a resourced plan for how this is to be implemented and monitored;

   - demonstrated capacity and resourced plan for recruiting, retaining and training Aboriginal staff;

   - demonstrated capacity and plans for a resourced process of collaboration with existing service providers in the local region and beyond, including written statements of support from Aboriginal community-controlled services and peak bodies; and

   - demonstrated capacity and resourced plans for developing, implementing and monitoring CQI processes.

3. **Non-Indigenous organisations contracted to deliver services should be required to meet the APO NT NGO Partnership Principles,** as recently adopted by the NT PHN [13]. These principles are intended to ensure that non-Aboriginal service providers take realistic account of capacity issues in service delivery (their own, and that of other service organisations); that identify and work in genuine partnership with existing Aboriginal organisations rather than in competition with them; that they support and promote existing practice; and that they commit to the principles of community control as exemplifying best practice and consequently agree to develop a transition process for their services to Aboriginal community control as part of their practice. See Attachment 1 for details.

4. **Government should provide sustainable, block funding direct to Aboriginal community-controlled organisations as best practice in tendering**, rather than through intermediary government or non-government agencies which will inevitably lead to increased administration costs and less resources for service delivery.

RFI 36: The drivers behind the high levels of service fragmentation observed in remote communities, particularly in cases where the number of services and providers are very high relative to the population

The principle driver of the high levels of fragmentation seen recently in remote Aboriginal service delivery in the Northern Territory is the move to greater competition and contestability and the undermining of comprehensive needs based planning processes such as those established under the NTAHF, which could assess needs at a jurisdictional level and strategically allocate resources on that basis.

This is consistent with the experience of the introduction of competition into health care systems internationally. A recent review of international evidence trends suggested that increased competition (as well as reducing clinical outcomes, reducing access, and decreasing collaboration) led to greater fragmentation of the service system [14].

RFI 36: What steps governments could take to improve coordination of both policy and service delivery (across the Australian, state and territory, and local governments, departments and programs)

1. **Comprehensive needs based planning processes involving multiple levels of government**, particularly at the Australian and state/territory levels. Collaborative, well-resourced and sustainable processes for health system planning have been identified as critical for health system effectiveness [15]. This role is played in the Northern Territory by the NTAHF which brings together the NT and Australian Governments, AMSANT (representing the community controlled health sector), and the NTPHN to work collaboratively on resource allocation; improving service responsiveness; quality, evidence-based care; improved access; and engagement of health services with Aboriginal communities.

2. **Engagement of Aboriginal peak bodies and governance structures in planning and program design, implementation, monitoring and evaluation.** Given the fact that large proportion of the 'health gap' between Aboriginal and non-Aboriginal Australia is due to the social determinants of health (poverty, housing, employment, education) as well as the delivery of health and wellbeing services themselves, engagement of other sectors is vital. In the Northern Territory, APONT (Aboriginal Peak Organisations Northern Territory) is an alliance between the Northern Land Council (NLC), Central Land Council (CLC), Aboriginal Medical Services Alliance Northern Territory (AMSANT), North Australian Aboriginal Justice Agency (NAAJA) and Central Australian Aboriginal Legal Aid Service (CAALAS) and provides an important point of engagement for all wider issues relating to the social determinants of health.

3. **Re-commitment to the establishment of regional primary health care organisations under Aboriginal community control.** As noted by the Productivity Commission report, services in many remote Aboriginal communities are fragmented and poorly integrated. During the 1990s and 2000s, government and the community-controlled sector worked to address these issues through the establishment of regional, Aboriginal community-controlled organisations, responsible for the delivery of all primary health care in a defined region and funded through sustainable bundled or pooled funding.

   This process of 'transition to community control' completed in the Katherine West, and Sunrise Health Service regions have been successful with formal evaluations of all three sites identifying a number of key improvements in primary health care delivery, including increased access; better quality care; improved acceptability of care to local community members; increased employment of Aboriginal people; improved focus on prevention; and improved community participation in health service design and delivery [11].

Figures

Figure 1: Number of FTE staff, by position type, type of organisation and Indigenous status, 1 June 2014 to 31 May 2015

Position type	ACCHO				Other			
	Indigenous	Non-Indigenous	TOTAL	% Indigenous	Indigenous	Non-Indigenous	TOTAL	% Indigenous
Aboriginal health worker	584	5	590	99%	207	3	210	99%
Aboriginal health practitioner	120	1	121	99%	40	1	42	97%
Doctor	35	373	409	9%	0	67	67	0%
Nurse/midwife	138	583	721	19%	18	376	395	5%
Allied health/medical specialist	15	124	139	11%	2	81	83	2%
Dental care	61	107	168	36%	5	15	20	26%
Social and emotional wellbeing	200	140	340	59%	15	85	100	15%
Other health	694	229	923	75%	80	48	128	63%
CEO/manager/supervisor	389	336	725	54%	20	191	211	10%
Administrative staff	775	512	1286	60%	166	168	334	50%
Driver/field officer	255	34	288	88%	54	8	61	88%
Total	**3265**	**2443**	**5708**	**57%**	**608**	**1043**	**1650**	**37%**

Note: Excludes visiting staff.
Source: AIHW analyses of OSR data collection, 2014-15. Available: http://www.aihw.gov.au/publication-detail/?id=60129554783&tab=3

Figure 2: Impacts on quality of healthcare through the introduction of competition, international trends

Component of quality	International evidence trends
Clinical outcomes	Data analyses, reviews and observational studies suggest reduced clinical outcomes
Access and equality	Data analyses and observational studies suggest reduced access
Costs and efficiency	Data analyses and observational studies suggest competition reduces costs for patients and commissioners
Satisfaction	There is little research, but a review suggests competition may improve satisfaction
Professionalism	Data analyses and observational studies suggest reduced staff stability, more stress and self-serving professional behaviour and role conflicts
System structure	Reviews and data analyses suggest competition may be associated with fragmentation and increased mergers

Source: The Health Foundation, *Evidence Scan: Competition in healthcare.* 2011, The Health Foundation: London

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