NATIONAL RURAL HEALTH ALLIANCE INC.

Dr Stephen P King
Commissioner
Productivity Commission
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Dear Dr King

**Response to the Interim report on Inquiry into Human Services**

The National Rural Health Alliance (the Alliance) is pleased to provide comments on the Productivity Commission Preliminary Findings Report as it seeks to identify the scope for supporting greater user choice, competition and contestability into the delivery of a range of human services.

The Alliance supports the work the Commission is undertaking through this Inquiry and sees opportunities for the Commission to contribute to a greater understanding of the barriers to effective human services delivery in rural and remote Australia.

The Alliance notes that the Commission is examining human services delivery through the lens of user choice, competition and contestability. In its consideration of how these issues affect human services in rural and remote Australia, the first barrier that the Commission will need to consider is how the lack of access to human services impacts on communities in rural and remote Australia.

A key issue the Alliance would like to see the Commission consider is the extent to which solutions that suit a metropolitan setting adapt to a rural and remote setting where lack of workforce, cultural differences and distances complicate access on many levels.

It is also important that the Commission not simply use national data averages when analysing the issues of user choice, competition and contestability. Understanding access and equity issues in rural and remote Australia and how the lack of access impacts on choice and the delivery of human services is vital for the Commission to be able to assess the applicability of its possible policy solutions in those settings. The Alliance would suggest that small community case studies could be developed, making use of local data and community needs to inform how greater user choice, competition and contestability may contribute to better service delivery and development in those settings.

The nature of rural and remote service delivery constrains the extent to which issues of competition can be applied in those communities. Workforce, culture and distance are significant areas of consideration through which all policy interventions in remote Australia must be viewed.

The way in which contestability currently operates is also a significant concern for many operators of health and other human services. While this is discussed in greater detail in the attached comments on the Preliminary Report, the context in which service delivery occurs in rural and remote Australia is often at odds with current commissioning and contestability policies. Recruiting staff into rural and remote communities requires significant preparation and support and current contracting often does not recognise the way in which these constraints can impact the establishment and ongoing viability of services.

The Alliance also considers that the shift towards commissioning (as distinct from purchasing and procurement, which are different functions) has the capacity to improve access and choice for people in rural and remote areas. This is provided that the outcomes being focused on are about integrated models of care, building capacity and sustainable markets rather than on competitive tendering, which is likely to lead to greater disintegration, siloed approaches and lack of sustainability of services.

The Alliance recognises that these are complex issues and stands ready to support the Commission as it explores how to improve human services in rural and remote Australia.

Yours sincerely

David Butt
**Chief Executive Officer**
4 November 2016

**Attachment**

# Response to the Productivity Commission Inquiry into Human Services Interim Report

The National Rural Health Alliance (the Alliance) welcomes the opportunity to respond to the Interim Report of Stage 1 of the Productivity Commission Inquiry into Human Services.
The Alliance understands the lens through which the Productivity Commission is investigating this complex area is constrained to the issues of improving user choice, competition and contestability. Nevertheless, the Alliance believes that understanding the context in which rural and remote health provision is planned and delivered is important to ensure that the Productivity Commission is able to factor in the significant challenges that apply in this sector – particularly with regard to service delivery in rural and remote communities.

The Alliance notes that the Productivity Commission has identified six areas within the broad rubric of human services that it considers are potentially amenable to greater user choice, competition and/or contestability:

- Public dental health
- Public hospitals
- Specialist palliative care services
- Human Services in remote Indigenous communities
- Grant based family and community services
- Social housing

## Overview

The Alliance notes that the Interim Report references areas of major reform in both aged care and disability services and excludes these sectors from consideration at present on that basis. The Alliance is concerned that the Health Care Home implementation is not included in the general context for the provision of health services as implementation of this initiative has the potential to influence the nexus between public hospitals and the primary health care sector significantly.

The Alliance views this Inquiry as a significant opportunity for the Productivity Commission to consider vulnerable populations in rural and remote Australia who are generally poorly serviced with regard to all human services. Sadly, for many of those vulnerable groups, issues of access and equity with regard to required human services are foremost in their needs – significantly ahead of issues of greater competition.

The Alliance will not comment on the potential for greater user choice, contestability and competition in the delivery of specialist palliative care services or human services in remote Indigenous communities, other than in broad terms as these issues are the purview of other organisations that are better placed to offer detailed, considered comments.
With regard to specialist palliative care services, the Alliance notes that palliative care services in rural and remote communities need considerable additional support, including through the use of innovative technology to provide fast, efficient support to the network of community

nurses that undertake home based palliative care services at present. The delivery of palliative care services in rural and remote communities is subject to the same workforce issues that constrain all other specialist services. The Alliance would strongly support actions that provide better access to palliative care services throughout rural and remote communities as well as better professional support for existing providers.

Similarly, the Alliance strongly supports the delivery of culturally safe, community led human services in rural and remote Indigenous communities. The current community led health and human service providers in Indigenous communities have a history of understanding and providing the wide range of services needed in their local community, combining health, aged care and the wide range of human services in a culturally appropriate, culturally safe environment. The Alliance's Indigenous health members will be responding to these issues and the Alliance supports their advocacy.

## Contestability

One issue that is of great concern to the Alliance and its members is the way in which tendering and procurement regarding human services is undertaken at present.

For many small community organisations, success in securing a tender to provide services is a source of employment within the community. It may also require the recruitment of specialist staff to deliver those services, which can result in significant investment throughout the community in supporting incoming staff and their families. In many cases the contracts for those staff are for only 18 months to 30 months due to Government contracting periods.

At present, at or near (and sometimes even after) the conclusion of the contract period, the organisation may be required to re-bid to continue delivering that service. The impact of the current timing is that gearing up a new service may take 6-12 months and by the time it is fully operational, it is time to retender. But staff need security of tenure and if the re-bid process is left until late in the contract, staff will leave for greater certainty of tenure. The service then falls over or has to be wound down, and the community expectations that had been built up as the service was implemented and reached full operational potential is lost and may never be re-gained

We need to find a better way of commissioning services as the current process severely compromises the delivery of ongoing human services in rural and remote communities. Ideally, there would be contracts of at least three years' duration, with evaluation at two years and notification then as to whether there will be an extension at the end of the contract for a further 3 years, or a requirement to re-tender, with any re-tendering process completed and announced at least six months prior to the end of the contract. There should be automatic extension of contracts to enable this 6-month period of notification of conclusion of the contract to be achieved.

This 6-month period would enable hand over of services where that is happening and management of community expectations. Such a change over period would also enable opportunities for staff to seek employment with the incoming tenderer or seek local alternative employment, thus reducing dislocation that can have a severe impact in small communities.

Further, the recent shift away from 'purchasing' services to commissioning services, which are different functions, requires that providers have a clear understanding of the community needs and are able to target the required services to meet these needs. Commissioning brings focus to local need and goes someway to improving access to required services as well as building local capacity and sustainability of local services. Models of commissioning must have local needs at the forefront and as such commissioned services will differ across communities as needs, existing services and health outcomes vary. The Alliance supports this model of health service delivery and believes that it will be beneficial for all communities including in rural and remote Australia.

## Data

The Alliance notes the extent to which the Productivity Commission has made use of data in its consideration of the issues facing each area identified for reform.

In considering the use of data as it relates to human services in rural and remote Australia, it is important to look beyond national averages. There is considerable variation between states and between communities. The Alliance believes that the Productivity Commission should be fully aware of the degree of variation across both jurisdictions and remoteness categories to ensure that it is able to consider the complex interactions in the delivery of human services.

In recent times both the ABS and the AIHW have released key health data by small geographic area (either Local Government Area or Primary Health Network). The specificity of this data allows better targeting to ensure that health planning meets local needs.

With regard to Australia's current data holdings, policy makers have data on health outcomes and data on system outcomes, but very little data links the two and also considers the impact of remoteness. This makes effective modelling of the impact of potential systemic changes difficult: and particularly difficult to consider the way in which systemic change may impact across rural and remote communities.

The Alliance believes it is important to consider how changes in one area of human service provision may impact upon others. As an example, we would expect that improved access to quality social housing would have a positive impact on health and wellbeing and it is important to ensure that in advocating improvements in social housing, data is collected to enable the broad impact of changes in health and social status to be evaluated.

The delivery of human services is an area where there are currently significant gaps in the data, making assessment of the impact of change in those services difficult to assess. As an example, the Alliance is aware that recent changes in social security policy has resulted in an increase in the number of women and children reporting to medical centres in Central Australia unable to afford to buy food. But there is no formal reporting procedure or data collection that links this outcome to that change in policy. The Alliance believes it is imperative that any changes in human service provision and service delivery must include data collection that is sensitive to the early detection of potentially negative outcomes.

## Stewardship

Stewardship is a term that is not well understood by the general public. Should this term be used in discussing this report, there is a need for support and information on exactly what is meant by the term. This is an issue impacting across Australia rather than being specific to rural and remote communities. It should be noted however, that often rural and remote communities can have lower health literacy than their urban counterparts thus exacerbating the situation.

There should be careful consideration of how the concept of stewardship may change the nature of the tripartite relationship between governments, people and the health service provider and how this can and should be communicated. This is an area in which the general public have a great interest but of which there is little public discussion of issues such as expectations, roles and responsibilities.

Setting out clear expectations of the standards and timelines in which health service delivery will occur and the roles and responsibilities of each participant in the exchange has great potential for increasing patient empowerment and establishing minimum service standards nationally. However, the potential success of such arrangements is dependent upon the level of health literacy and health self-efficacy of the most vulnerable sector of the population; and in Australia the evidence is that the level of both health literacy and health self-efficacy of the most vulnerable sectors of the population is very low. Johnson reports that an Australian Bureau of Statistics assessment of health literacy in 2008 found that …

> *…59 per cent of the Australian population aged 15 to 74 years did not achieve an adequate health literacy skill level to meet the complex demands of everyday life and work in a knowledge-based economy. Although low levels of health literacy is (sic) disproportionate in certain demographic groups, such as the elderly, people from non-English speaking backgrounds (in an English speaking society), and people with low general literacy, low levels of health literacy affects all segments of the population.* (1)

As health literacy affects an individual's ability to understand their diagnosis, options for treatment and indeed provide informed consent (1), the low levels of health literacy in vulnerable populations compromise the potential improvements in patient outcomes that underpin the drive for more effective and efficient health services. And they also affect the ability of health service providers to adapt to change, as Johnson reports that there are also low levels of health literacy in some health providers which makes clear communication of health information more complex (1). Poor health literacy in health providers may manifest as an inability to convey information meaningfully.

Poor health literacy also makes the attainment of health self-efficacy more difficult. Health self-efficacy is the ability to understand and respond to the need for health mediated behaviour modification by making the required changes – for example give up smoking, modify drinking patterns or lose weight (2).

Supporting vulnerable populations to improve their health literacy and health self-efficacy is potentially a highly effective means of addressing a range of pressures on the health system and should be considered in the way in which a stewardship role is communicated and discussed in the broad context.

## Social determinants of health

The Alliance believes that every aspect of our social environment has the ability to effect health outcomes, the ability to participate, and to lead contributing lives. Issues such as housing, employment, education and justice underpin the sense of wellbeing in rural and remote communities and therefore affects the way in which health is mediated in that community.

The Alliance also considers the Productivity Commission should consider the potential productivity gains and opportunities for economic growth by improving the health and wellbeing of people living in rural and remote Australia. There are considerable disparities – and a greater burden of disease on a per capita basis – for rural and remote residents when compared to metropolitan residents, leading to a significant drain on the economy. Even by halving those disparities (not even achieving the same outcomes as for metropolitan residents) there would be significant gains in participation and productivity, and consequent increased growth in the Australian economy.

The Alliance is pleased to see the Productivity Commission engage in such a broad examination of human services, as it is only through such engagement and making the linkages throughout society that we are able to see the health and wellbeing outcomes that come from enacting good social, health and economic policies.

By being acutely aware of the interaction between the human services sector, health and the economy, and setting in place systems to describe and measure change accurately, robustly and sensitively, we are able to consider the most effective means of supporting positive change over the long term to support greater gains in national productivity, economic growth and human capital.

But we must also have in place means of identifying unintended consequences quickly and be able to respond and mediate any negative outcomes. Reporting and analysis of changes at the system level are vital and need to be inherent in any changes made from this review.

In this context, governments must be prepared to step in and respond where there is market failure, including lack of providers or domination of a market by one or a few organisations where this pushes up prices at above market costs compared to other similar regions and services.

## Public dental services

Public dental services in rural and remote locations have not been well funded for too long and are now in urgent need of support. There is a significant mal-distribution of dental health services with areas of highest need also being the areas with the lowest access to the dental workforce – that is rural and remote communities and remote Aboriginal communities (3).

As Perera and Perera note in their commentary on the above article…

> *This is further compounded by the high burden of oral diseases, such as dental caries, missing teeth and poor perceived oral health status among rural and remote inhabitants overwhelmingly dominated by Indigenous Australians[2-4]. In addition, the majority of Australian dentists (82.5%) are private practitioners[5].*(4)

For a large percentage of residents in rural and remote Australia, access to public dental services is their only means of accessing dental care due to shortage of and high out of pocket costs associated with accessing private providers. The dental workforce data bears out such claims of a maldistribution showing significant differentials in access to dental professionals, worsening with remoteness.

Similarly, data on the dental and oral health outcomes shows a similar gradient, worsening with remoteness. These are considerable inequities in access and outcomes that need to be addressed. As a member of the National Oral Health Alliance (NOHA), the Alliance supports action to address these significant inequalities.

| **Dental professionals (AIHW 2012)** (5)<br>Full-time equivalent per 100,000 | **MC** | **IR** | **OR** | **R/VR** | |
|---|---|---|---|---|---|
| Dentists | 64 | 42 | 36 | 22 | |
| Dental hygienists | 5.8 | 2.7 | 2.8 | 1.7 | |
| Dental therapists | 3.4 | 4.3 | 5.6 | 4.5 | |
| Dental prosthetists | 5.6 | 6.4 | 3.2 | 0.5 | |
| Oral health therapists | 2.6 | 2.8 | 2.6 | 1.4 | |

The Productivity Commission analysis focuses on choice not access. While choice is not unimportant, it is secondary when a significant proportion of the population simply cannot access regular oral health care. There is an urgent need to address the deficiencies in dental health access (both public and private) in rural and remote Australia.

Some of the population with access to public dental services have Health Care Cards (HCCs) and are eligible for public dental services. However, such services are severely under-funded relative to the need. The Alliance believes that in the current context, exercising choice for this group at present is simply choosing which unsatisfactorily long queue you should join. For those not eligible for HCCs but on lower than average incomes, it is well documented that cost is the crucial barrier that prevents people accessing private dental services. Choice in this current context equates to choosing which service you cannot afford.

A significant case can be made for urgent policy action to address the severe maldistribution of both public and private dental services and professionals across the non-metropolitan areas of Australia to improve access. But it should be recognised that rural Australia is under-serviced by private dentists too. Increasing choice will not solve the lack of dental services unless extra funding is injected into oral health care, focussing on addressing the worst areas of maldistribution as a priority.

The Child Dental Benefit Scheme (CDBS) has successfully utilised the private dental network as well as public services and made care more accessible. However, CDBS is not yet a mature system. Promotion of the scheme to families has been extremely limited, so it is not at all well known. As a result, take-up of the program, although growing, is only at 30% of potentially eligible users.

There are still problems in using the CDBS funding most efficiently so that government and the community can be assured money is spent where it is needed and not unnecessarily. The service model, however, provides a good example of how to make the best use of both public and private service delivery to reach those most in need.

In May 2016, the Government announced its intention to close the CDBS and fund the states to run their own systems of public adult and children's oral health care. This action is not supported by key stakeholders, including the Alliance and the National Oral Health Alliance (NOHA), who believe that a national system is crucial to address issues of equity across jurisdictions. At present, legislation to enact this decision has not been presented to Parliament.

As an example of alternative service delivery models that the Productivity Commission may wish to examine, public dental care in Victoria is provided by several non-Government organisations (NGOs) within community health services that are linked into a broad range of multidisciplinary health services. Oral health is therefore integrated into general health care. The services are well coordinated and supported by Dental Health Services Victoria, so there is an overall system approach in place.

But other states do not have such a network of experienced multidisciplinary health services that could provide a base for the infrastructure needed to support dental services. Health NGOs are fewer and more specialised and focussed. Opening up existing funding to competition without existing infrastructure throughout the jurisdiction may be more difficult, although other health infrastructure, such as Multi-Purpose Services (MPSs), could be considered in this context.

The Alliance agrees that urgent policy action is needed to support better access to public dental services. However, the critical area of concern is of equity of access, which must come significantly before consideration of increasing user choice or competition.

## Public hospital services

Setting out to improve public hospital outcomes relating to all areas of hospital operation is a complex journey. In rural and remote communities, the nature of the choices available to health system users is significantly more limited than the choices available in larger regional centres and the major cities.

With access to private hospitals severely limited, the public hospital system in rural and remote Australia may be the only option available to address a range of health services, including emergency care, acute care, aged care, palliative care, maternity care (where available) and mental health care needs.

The missing discussion in the Interim Report is about patient centred care and how any transition to patient centred care in other areas of health will impact on the interface between primary health care and the public hospital service. The impact of the health care home transition on the interface between primary health care and public hospitals should also be considered carefully.

The role of Primary Health Networks also is a vital element within this context. PHNs have been established to plan and commission services which best meet the priority needs of their communities. This includes working with consumers, service providers, the government and NGO sectors, on local needs assessment and commission of joined-up, integrated services. In undertaking this role, it is essential that PHNs work with government service providers, and particularly with Local Hospital Networks (or their equivalents) on joint planning, opportunities for co-design, co-commissioning, co-provision and co-monitoring. This has the potential to drive significant change of models of care, including reducing avoidable hospitalisations, improving population health outcomes and taking the pressure off the hospital system.

It is possible to tackle reform of public hospitals using a multipronged approach that will enhance user choice considerably. But doing so in rural and remote Australia must support the range of services that local health infrastructure provides in rural and remote communities.

Recent work by the Grattan Institute has indicated that it is possible to identify communities that have high levels of potentially preventable hospitalisations and target the underlying causes of those hospitalisations. Addressing high rates of potentially preventable hospitalisations will generate a return on investment that can be directed to supporting further hospital reform.

The Alliance notes recent actions by the Baird Government in New South Wales, which is seeking to move some smaller public hospitals into a public/private partnership model. Five hospitals were identified and expressions of interest were sought to find a private operator who would take on the provision of public hospital services. One of the hospitals identified was the major regional hospital in Goulburn, but unfortunately the result of the call for expressions of interest was that no suitable private operator was identified.

Given Goulburn is a major rural centre, the lack of a suitable private operator is concerning. If a suitable operator is not possible in a major rural centre the applicability of private public partnerships in smaller rural and remote centres must be questioned. If the only way to fund public health services in rural and remote communities is through public only funding, it is vital to ensure that this funding is at a level appropriate to address the often complex needs of those communities.

For small rural and remote hospitals, having access to patients who elect to be treated as private patients in a public hospital may provide a small but significant funding boost that must be maintained for those hospitals to remain viable. But they also need to consider what other activities they could engage in to improve their viability while maintaining their vital community role.

The Alliance suggests that enlarging the network of Multi-Purpose Services (MPSs) is worth consideration, and that using the MPS infrastructure as a human services hub should be explored. This model would be similar to the Aboriginal Health Services model and has the same potential to provide a 'one stop shop' driven by local need at the heart of a small rural or remote community.

For rural and remote communities, the presence of a medical centre of any description is a source of civic pride and communities will engage positively with activities that seek to improve the sustainability of that service. The MPS model has community engagement at its heart. It is, therefore, already well placed to explore how it can serve its community better, working with jurisdictional local health networks and the Commonwealth supported Primary Health Networks.

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