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Steve Turner
Productivity Commission
Level 12, 530 Collins Street
Melbourne VIC 3000, Australia

Dear Mr. Turner

RE: Submission to the Productivity Commission's Inquiry into Human Services: Reforms to Human Services

Please find attached our submission to the Inquiry into Human Services: Reforms to Human Services. This submission responds directly to the Terms of Reference for the Inquiry, with an emphasis on equitable access to human services by Aboriginal people and those factors necessary to enable Aboriginal people to exercise informed choice and control over the care they receive.

Thank you for your consideration of the matters raised in this submission.

Yours sincerely

Trevor Pearce
Acting Chief Executive Officer
VACCHO

Submission to the Productivity Commission's Inquiry into Human Services: Reforms to Human Services

Please note: In this submission the word "Aboriginal" refers to both Aboriginal and Torres Strait Islander People. Direct reference to Torres Strait Islander people and the word "Indigenous" have been used where these are part of a title or direct quote.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) was established in 1996. VACCHO is the peak body for Aboriginal health and wellbeing and also represents Aboriginal community controlled organisations (ACCOs) in Victoria. The role of VACCHO is to build the capacity of our members and to advocate for issues on their behalf. Advocacy is carried out with a range of private, community and government agencies, at state and national levels, on all issues related to Aboriginal health.

Nationally, VACCHO represents the community controlled Health sector through its affiliation and membership on the board of the National Aboriginal Community Controlled health Organisation (NACCHO). State and Federal Governments formally recognise VACCHO as the peak representative organisation on Aboriginal health and wellbeing in Victoria. VACCHO's vision is that Aboriginal people will have a high quality of health and wellbeing, enabling individuals and communities to reach their full potential in life. This will be achieved through the philosophy of community control.

VACCHO and our members welcome the opportunity to respond to the "Reforms to Human Services: Productivity Commission Issues Paper". This submission responds directly to the Terms of Reference for the Inquiry, with an emphasis on equitable access to human services by Aboriginal people and those factors necessary to enable Aboriginal people to exercise informed choice and control over the care they receive. Responses to specific requests for information are incorporated where appropriate.

Unless stated otherwise, the responses below are relevant to all 6 of the identified areas for reform.

VACCHO has concerns that the inquiry has a focus on services for remote Indigenous communities but does not acknowledge the extent to which these issues are shared by Aboriginal people in rural or urban locations.

The Overcoming Indigenous Disadvantage Report 2016 demonstrates that outcomes generally worsen as remoteness increases, but are nevertheless much poorer for Aboriginal people in rural and urban areas compared to the non-Indigenous population.[1] It is important to note that Aboriginal communities in Australia are heterogeneous and their cultural needs are diverse. In addition, the human services covered by the inquiry comprise the mainstream health system (hospitals, dental services, palliative care) and many of the social determinants of health (e.g. housing, family and community services) which have an impact on all Aboriginal communities, irrespective of location.

Our input is drawn from the experience and expertise of VACCHO membership in Victoria. Our Member ACCOs have a cooperative membership structure and offer a range of services to their local communities, including but not limited to primary health services. Other services vary across the members but will often include housing, justice, child and family, social and emotional wellbeing, aged care and disability services and may be affected. As such Member ACCOs have a core role in addressing the social determinants of health. NACCHO uses the term ACCHOs (Aboriginal Community Controlled Health Organisations) which includes VACCHO Member ACCOs.

1. ***The roles and responsibilities of consumers, service providers (including the private sector, government agencies and the not-for-profit sector) and governments in the delivery of human services***

1.1. Roles and responsibilities of Aboriginal organisations

ACCOs have a proud history as sustainable, grassroots organisations that assist in building community capacity for self-determination.

Indigenous peoples have the right to self-determination. Under the *United Nations Declaration on the Rights of Indigenous Peoples* this includes the right to "freely determine their political status and freely pursue their economic, social and cultural development" and to "autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions."[2]

Community Control is a practical expression of self-determination, which is supported by the Turnbull Government and reflected in the governance and service models of the Member ACCOs. The Board of Directors have direct responsibilities and accountability to their communities.

In accordance with these rights, VACCHO believes that each Aboriginal community needs its own community based, locally owned, culturally appropriate and adequately resourced primary health care facility. NACCHO outlines the difference in Aboriginal and western understandings of health:

> The Aboriginal understanding of health is holistic and includes land, the physical body, clan, relationships and lore, it is the social, emotional and cultural wellbeing of the whole community, not just the individual.[3]

Accordingly, notions about the roles and responsibilities of individual consumers and service providers must be considered in a cultural context and cannot be translated directly from western models and concepts.

Specialist providers in the Aboriginal community-controlled sector are often small, and serve the needs of dispersed, disadvantaged Aboriginal communities.

1.1. Roles and responsibilities of the Commonwealth Government

The Commonwealth has unique responsibilities in relation to Aboriginal people. For example, the Statement of Intent to Close the Gap commits the Commonwealth to work together to achieve equality in health status and life expectancy between Aboriginal people and non-Indigenous Australians by 2030. This includes the recognition that specific measures are needed to improve Aboriginal peoples' access to health services, and that Aboriginal peoples must be actively involved in the design, delivery and control of these services. [4] Key commitments include:

- Ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gaps in health standards by 2018.
- Ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.
- Working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.
- Building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.
- Supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.
- Respecting and promoting the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality. [5]

See **Attachment A** for a copy of the Statement. State and Commonwealth governments also made commitments to work in partnership on "Closing the Gap" through a series of agreements at the Council of Australian Governments (COAG). The overarching National Indigenous Reform Agreement (NIRA) sets out the policy principles, objectives, performance indicators and specific steps governments are taking to meet the Closing the Gap targets.

In its submission to the first stage of this inquiry, the Commonwealth Department of Prime Minister and Cabinet (Indigenous Affairs Group) also recognise the unique role of governments in relation to Aboriginal people. Noting that governments have a role in cultivating service provision that serves the particular needs of Aboriginal people, they point further to the real value of consultation with Aboriginal service users and providers.[6]

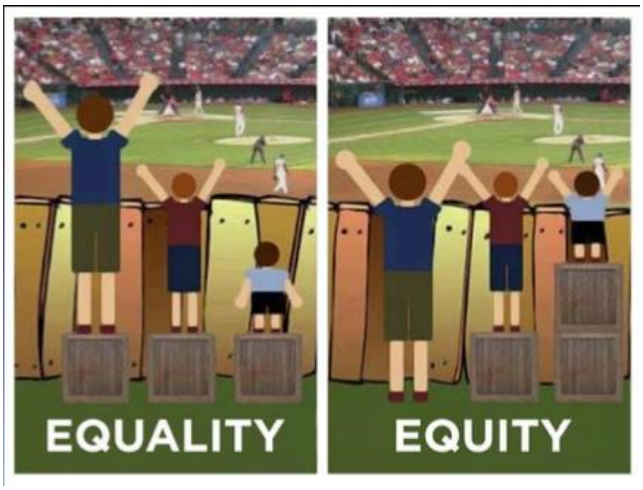
VACCHO is concerned that a 'one size fits all' approach to competition, contestability and user choice in human services will undermine formal commitments and specific measures to achieve health and other outcomes for Aboriginal peoples.

Five years ago the Productivity Commission warned that the proposed National Disability Insurance Scheme (NDIS) may not deliver adequate care and support to Aboriginal people with a disability. The report also flagged the possibility that it may be necessary to block fund some

service providers to support Aboriginal people with a disability if they were to have an increased likelihood of overcoming the additional barriers associated with social and economic disadvantage and address the higher incidence of disability and the disproportionately low numbers of people engaged with disability services than the non-Aboriginal population.[7] However, special measures of this type, to ensure equity of access by Aboriginal people, have not been introduced.

This inquiry recognises 'equity' is one of the components of effectiveness.[8] However VACCHO is concerned about the view that "equity of access to services might be achieved by providing the services to all members of the community on the same terms" [9] and notes that equity of access must include the capacity to overcome obstacles to access in order to achieve fairness. Equity of outcomes will not be achieved without governments assuming responsibility for equity of access.

It is important to understand the difference between equity and equality. The following illustration makes this difference clear:



In 2005, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Commissioner Tom Calma, pointed to the limits of formal 'equality' in achieving equity in primary health care:

> An equitable distribution of primary health care and an equal standard of health infrastructure should not be measured in terms of formal equality - that is that the same per capita resources are being devoted to Aboriginal and Torres Strait Islander and non-Indigenous health. It should be expected that greater per capita resources would need to be devoted to Aboriginal and Torres Strait Islander health …. Significant investment in Aboriginal and Torres Strait Islander health is required to re-balance decades of under-investment. Also, until health and life expectation equality is achieved, Aboriginal and Torres Strait Islander peoples will have greater health care needs than the non-Indigenous population.[10]

VACCHO agrees with the Australian Council of Social Service (ACOSS) that it is unlikely that the expansion of competition policy or the reform of contestability arrangements "will be effective in isolation to address the underlying disadvantage inequality already experienced by Aboriginal and Torres Strait Islander peoples (whether they live in urban, regional or remote communities)".[11] ACOSS argue for a more comprehensive approach to achieving equality of outcomes rather than simply ensuring access to services. [12] VACCHO agrees with this but further notes, as detailed below, equity of access to services itself requires special measures and cannot be achieved by offering the 'same' service to all people.

In addition, partnership approaches to the delivery of care to Aboriginal Victorians must ensure equity between partners. Where Aboriginal Community Controlled Health Organisations are partnered with mainstream organisations to deliver state-funded services, ACCHOs should play a central role as the experts in culturally appropriate care. Contract and partnership arrangements should ensure that roles and responsibilities of each partner are clear and that resourcing is commensurate to those roles and responsibilities. Where competitive tendering processes are employed, preference should be given to applicants with a strong history of equitable partnerships with the community controlled sector. There are many principles available to guide what this standard should be.[13] Government stewardship has a responsibility to actively support, monitor and uphold this standard.

2. *The factors affecting consumers' use of services and their preferences for models of service delivery, noting the challenges facing consumers with complex and chronic needs, or reduced capacity to make informed choices*

1.2. Factors affecting consumers' use of services and their preferences for models of service delivery

There is a preference among Aboriginal people for Aboriginal organisations.[14] ACCOs are the dominant choice of Aboriginal people in all geographical areas in which they are located, and many Aboriginal people travel considerable distance to access them, often passing by mainstream services to do so.[15] Aboriginal people are more likely to seek health and community services from a provider that offers cultural safety, and understands the multi-layered concept of Aboriginal health. On the other hand, Aboriginal people may delay seeking medical advice if these services are not available to them.[16]

NACCHO points to the role of ACCHOs in supporting equity of access, arguing further that the concepts of quality, efficiency, responsiveness and accountability are all actively reflected in their routine service provision to Aboriginal people. [17]

> Four A Barriers – Availability, Affordability, Cultural Acceptability and Appropriateness (to health need) are directly addressed and access enhanced by a range of ACCHO services that are rarely if ever provided by mainstream primary health care services.[18]

A review of the evidence by the Aboriginal Health and Medical Research Council of NSW found that the community controlled model has been associated with improved health outcomes for Aboriginal people in international studies.[19] While equivalent studies have not been undertaken in Australia, the available literature supports the view that ACCOs contribute to positive health and wellbeing for Aboriginal peoples. This is likely due to self-determination and community empowerment, improved healthcare seeking rates and improved mental health and wellbeing.[20] In addition to direct service provision, ACCOs also contribute to improving the performance of the broader health system through partnerships and advocacy. [21] AMSANT agree the evidence of effectiveness compared to mainstream services is 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."[22]

Any understanding of user choice must take into account the unique cultural, social and health needs of Aboriginal people and the right to choose an Aboriginal organisation. The National Disability Insurance Scheme emphasises choice and control for individual. While it is legislated to take culture into account, it has no investment in the viability and sustainability of organisations, which has implications for the capacity of Member ACCOs to offer their unique service model (with demonstrated benefits) and/or a culturally safe service.

Where a Member ACCO is not available, does not deliver the service in question or are not the first choice of an Aboriginal person, Aboriginal people maintain their right to cultural safety in accessing mainstream services. User choice for Aboriginal people is meaningless without this standard of service quality. ACCOs work with mainstream health providers to improve access, pathways, cultural safety and quality of health care for Aboriginal people, including advocating and supporting mainstream health services to be more accountable for Aboriginal health outcomes. VACCHO shares the concerns of ACOSS that competition and competitive tendering processes structure competition into such relationships which ought otherwise to be collaborative.[23] The Indigenous Advancement Strategy is one example of competitive tendering in which large mainstream organisations with economies of scale secured funds at the expense of local Aboriginal organisations with proven track records in delivering outcomes for people and communities.[24]

The Productivity Commission Issues Paper points out that, where user choice is not feasible or desirable, "there may be other options for empowering users – such as governments and providers taking greater consideration of user preferences in decision making".[25]

VACCHO recommends that all levels of government take into account the preferences of many Aboriginal people for community controlled organisations and ensure policies and programs support access to this choice. VACCHO challenges the finding by the Productivity Commission that social capital benefits are not exclusive to one type of provider[26] and asserts that the community controlled sector provides unique benefits that cannot be delivered by government, mainstream not for profit or for profit providers.

1.3. The challenges facing consumers with complex and chronic needs, or reduced capacity to make informed choices

Aboriginal people are more likely to present with complex and chronic needs. In addition, for many mainstream service providers, Aboriginal peoples' cultural needs increase the complexity of quality service delivery.

Individualised funding models require economies of scale to be financially viable. Member ACCOs in Victoria however are delivering to 'thin markets', supporting Aboriginal communities in small dispersed populations and high complexity of need, which means there are higher corresponding costs. In the absence of block funding there may be low incentives – or insufficient funding levels/profit margins- for non-Aboriginal providers to offer high quality and culturally safe services to these populations. For example, one ACCO staff member reported: "I have heard…that providers are not clamouring to pick up Aboriginal clients as they are considered to be difficult/ time consuming/hard work."[27]

VACCHO agrees with ACOSS that:

> Competition increases the risk of highly vulnerable clients 'falling through the cracks' due to the onus on the individual to navigate the market, and the fact that incentives are generally insufficient to engender sustained provider engagement with service users with complex needs.[28]

The Department of Prime Minister and Cabinet agree, noting that if "appropriate metrics for quality and appropriateness of services for Aboriginal and Torres Strait Islander clients are not in place (or if *inappropriate* metrics are in place)" then the specific needs of Aboriginal users may be overlooked by potential providers.[29]

Aboriginal organisations are accountable to their communities, which provides natural incentives to respond to complex or emerging need. However if Aboriginal organisations cannot establish financial viability under the pricing models available (see for e.g. the NDIS Price Guide) this leaves the market chronically under-serviced.

Aboriginal people will often depend on their local ACCO to support their access to mainstream services, or to fill gaps left by the mainstream sector, although ACCOs are rarely funded to do this kind of work.

Reforms in the areas of aged care and disability offer some cautionary learnings for future reform. For example, standardised 'one size fits all' assessment processes present barriers to access for Aboriginal people. Better outcomes would be achieved if Member ACCO's were funded to engage with communities and identify people who may be eligible, provide culturally safe assessment on-site wherever possible and support access to specialised assessment where required (e.g. by Aboriginal Health Workers attending appointments with them). The current assessment variability and lack of cultural safety, when combined with the increased reliance of assessment as an allocative mechanism for aged care and disability

services further disadvantages Aboriginal peoples' access to necessary services. Targeted strategies are needed to ensure cultural appropriateness of assessment tools and cultural safety of the assessment process are developed, implemented and outcomes monitored.

VACCHO interviewed staff in member ACCOs to inform the Aged Care Legislative Review. Comments included report on the Aged Care Assessment process: "Clients get confused with mainstream assessments. They don't understand the jargon used [and] need community workers to advocate for them."[30] Another staff member said "It's daunting to ring a government agency and a lot won't do it because it's too daunting. This will actually deter people getting support until it's critical and they need to go to hospital". [31] Another said:

> Workers accompany clients to assessments because the client "won't ask, won't say what the problems are to a stranger asking personal questions or don't want to be a burden but the worker knows what the problems are, they know e.g. the person is unsteady on their feet. The client is not disclosing enough to get what they need or are entitled to, especially if they've had dementia – they may even forget they've had contact. [32]

This places considerable demand on the capacity of the ACCOs to respond. As one member reported: "Community is used to coming to us when they need help in all areas of their lives and they are generally used to getting this help from a community organisation."[33] Another commented that "[our worker will] accompany the assessor if no other Aboriginal worker is available … or they won't open the door." [34]

Development and/or reorientation of business systems required to ensure viability under an 'individualised'/marketised' funding model has also been a major financial impost for small specialist providers of disability and aged care services such as ACCOs. These service providers play a vital role in ensuring availability of real choice of services to small, dispersed and culturally distinctive communities as well as communities in regional, rural and socially disadvantaged areas. In some instances, the demise of these service providers will deprive communities of their only available service provider, or at very least, their only culturally safe service provider and there will be no competitive pressure on mainstream providers to invest financially in culturally safe service models/practices to meet the needs of these communities.

In the NDIS trial site of Barwon, Wathaurong Aboriginal Cooperative contributed an estimated 15 hours of un-funded work per person to facilitate Aboriginal peoples' initial access to the scheme. In addition, given the thin market, low economies of scale, complexity of needs of people supported and Wathaurong's commitment to holistic and culturally appropriate service provision, the organisation continues to run at a loss for the NDIS services it provides to community and has to subsidise this work through other areas of its business. Another member has had to invest significant funds upfront to prepare for delivery under NDIS and may not recoup those costs through the available 'market' for these services.

Informed user choice will only contribute to the development of responsive and appropriate markets where users are sufficiently empowered to actively shape the service response, placing pressure on providers to understand and meet their needs.[35] Aboriginal people, in

contrast, are often deeply disempowered, especially in mainstream settings, and face unique and complex barriers to access. Chronic under-servicing is the consequence when Aboriginal people are unable to navigate the service system to their benefit. For example, the Productivity Commission points out that, in addition to reluctance arising from cultural difference and negative experiences with mainstream services, some Aboriginal people may wish to engage but be constrained by a lack of knowledge about the requirements (e.g. paperwork and personal information) or lack confidence or understanding of their rights and entitlements.[36] In addition, for some services, there is a lack of user-oriented information that would enable users to make choices. This includes information on the level of cultural competency demonstrated by mainstream services, information which is of vital importance to Aboriginal people as consumers but not effectively monitored, let alone publically available. In addition, for Aboriginal people, informed user choice requires the choice of an Aboriginal organisation. If the market does not provide, the safety net of block grant funding and other measures is required.[37]

VACCHO does not believe that, without special measures to provide a safety net, marketisation will provide for the needs of Aboriginal people or that they will be in a position as individual consumers to shape how those needs are met.

It is important to recognise that informed user choice and consumer directed culture is not dependent on individualised budgets. Consumer directed culture can be developed within block funded service delivery by ensuring assessments include two-way communication that identify client and carer needs, strengths and goals, through client and community involvement in continuous improvement and evaluation processes, and in staff training.

VACCHO agrees with The Federation of Ethnic Communities Council of Australia (FECCA) that

> Consumers should be a core consideration when designing and delivering a service rather than an after-thought. They need to be involved in the design of a system, rather than placed into a pre-designed system, to ensure that it will work. A diverse cohort of consumers, representative of the ultimate cohort of users, should be included in the co-design process.[38]

This is consistent with evidence based approaches in working with Aboriginal communities, that is, that Aboriginal people must have a say in matters that affect them. VACCHO is encouraged that the Productivity Commission Issues Paper recognises the need for users to be involved in service design processes[39] and asks that attention be paid through this process to the specific contributions of Aboriginal people.

VACCHO agrees with NACCHO that governments should work towards a long term and holistic funding model for ACCOS as the providers of culturally appropriate primary health care services with funding for the social determinants of health across the range of human services. This provides sufficient security and economies of scale to enable ACCOs to respond holistically to complex and chronic needs through a unique range of health and social wellbeing services.[40] While it is acknowledged that block funding does not create the same

financial incentives to respond to users' needs as user-directed funding can,[41] government could do much better in the establishment and monitoring of KPIs, quality benchmarks and the evaluation of outcomes to ensure enhanced accountability to Aboriginal communities and service users.[42]

To support users to exercise informed choice where individual entitlement schemes are introduced, ACCOs should be funded to facilitate equitable access to quality. This should include funding for cultural support officers, outreach, culturally safe assessment, planning and reviews as well as support coordination and system navigation. Investment is also needed in community engagement and awareness strategies that ensure Aboriginal people understand their rights and entitlements. A block funding model such as the NDIS Information, Linkages and Capacity Building (ILC) Grants provides an example of how this could be delivered, but needs to be targeted to Aboriginal communities and available to every ACCO to adequately address the gap in service access. Other options include weighted funding packages and/or funding for items within the packages that recognise the unique needs of Aboriginal people, which may partially alleviate the funding pressures on organisations who already have the incentives to assist.

Treating Aboriginal people as though they are 'the same' as everyone else will simply not achieve equity of outcomes. For example, the table below shows data from the *Report on Government Services 2017* indicating that Aboriginal people are significantly less likely than the general population to have accessed an Aged Care assessment.

Aged Care Assessments (rate per 1000 target population)[43]

Year	Aboriginal and Torres Strait Islander	All Users
2012-13	23.1	52.3
2013-14	21.9	50.8
2014-15	22.1	48

There is also a widespread lack of understanding among the Aboriginal community of the aged care reforms and the impact this will have on aged care services.[44]

3. The benefits and costs of promoting competition in the provision of human services

As noted above, smaller specialist providers are unable to compete with the economies of scale available to large providers, including but not limited to for profit providers. At the same time, there are insufficient requirements, or even incentives, for large providers to respond holistically to the complex needs of Aboriginal people and limited capacity for cultural safety without the active support of an Aboriginal organisation.

ACOSS point to the limitations of competition policy to deliver outcomes in 'thin' markets. Where government providers are also unavailable, "market failure poses another challenge that could have considerable negative impacts".[45] These markets are not only thin in remote Aboriginal communities, but also in regional and urban settings. For example, for Aboriginal

people with disability the absolute number of Aboriginal people seeking a service might be low in any of these settings, even where they experience much higher incidence of disability than the general population.[46]

VACCHO agrees with ACOSS that the current focus on competition can obscure the lack of adequate funding for services and, in isolation, will not address funding inadequacy or accessibility issues.[47]

The Department of Prime Minister and Cabinet (PMC) report that in many Aboriginal service delivery settings (especially but not exclusively in remote settings) "markets are not sufficiently well-developed that competition principles are readily applicable".[48] In urban and well-serviced regional settings, they argue that "the story is different" because many Aboriginal people use the same services as non-Aboriginal Australians. This argument does not take into account the cultural safety, quality or effectiveness of the mainstream services for Aboriginal people, or the number of people who do not access services they need. For example, a study of 759 Victorian Aboriginal adults found that 29% had experienced racism in a health setting in the last 12 months.[49] In 2012-13, 30% of Aboriginal people reported they did not access a health service when they needed to.[50] The Aboriginal and Torres Strait Islander Health Performance Framework uses the higher levels of discharge against medical advice (which in major cities specifically is 2.6 times the rate of the non-Aboriginal population) as an indication of "significant issues in the responsiveness of hospitals to the needs and perceptions of Aboriginal and Torres Strait Islander peoples".[51] PMC do acknowledge that many urban Aboriginal people prefer to use community controlled primary health care and that "services will be more effective and provide better user outcomes where Indigenous-targeted or –adapted services are available".[52] Given this, VACCHO questions the basis for their finding that "market principles which can be usefully applied to mainstream services will affect Aboriginal and Torres Strait Islander populations in broadly similar senses"[53] and points in contrast to the 'thin markets' for high quality, culturally safe and effective services for Aboriginal people in all geographic locations.

The Central Australian Aboriginal Congress (Congress) likewise point out that competitive tendering undermines the ACCHS service model, which already provides comprehensive and effective services that are coordinated and designed to address local need. Open markets will simply not deliver the services needed to help address the gross inequity in health outcomes.[54] AMSANT agree, noting that the evidence put forward by the Productivity Commission about remote Aboriginal communities in the Preliminary Report suggest that "greater competition will exacerbate the problems it has identified and undermine what progress has been made".[55] This is supported by the Senate Inquiry into the IAS Tendering Process which found that competitive tendering processes may disadvantage Aboriginal organisations.[56] Further, as AMSANT point out, competitive tendering "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".[57]

VACCHO agrees with the Senate Inquiry into the IAS Tendering Process in its recommendation that future tender rounds "are not blanket competitive processes and are underpinned by robust service planning and needs mapping".[58] The Committee recommended furthermore

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.” [59]

In 2012, the Office of the Northern Territory Coordinator-General for Remote Services Report raised concerns about the levels of outsourcing to third party non-Indigenous not for profit organisations “who do not receive the level of scrutiny and accountability that might reasonably be expected of multi-million dollar, multi-year contracts”: [60]

> These third parties are not accountable to parliaments and too often are unaccountable to the communities in which they operate. Funds are being diverted to build the capital base and operational capacity of non-resident agencies rather than funding and building the skills and capabilities of local Aboriginal people and organisations.[61]

The Senate Inquiry into the IAS Tendering Process similarly highlighted concerns in the community about funds going to mainstream organisations.[62] In the Victorian context, there are multiple examples of mainstream organisations receiving funding for work in Aboriginal communities, and then seeking the goodwill and resources of the local ACCO to fulfil their commitments. Even where this work is brokered or subcontracted, the administrative fees that go to the mainstream organisation reduce the funds available to the ACCO to provide the service delivery on the ground and results in double handling by two agencies.

There are also examples of mainstream organisations passing on all responsibility to work with the Aboriginal community. That is, when an Aboriginal person exercises their choice and seeks support from a mainstream organisation, they are told they need to go to the Aboriginal organisation for assistance.

It is clear that government has a role to play in improving accountability to Aboriginal communities. One mechanism to assist would be a high quality Evaluation and Monitoring Framework based on appropriate and transparent benchmarks and the achievement of outcomes. This would include Key Performance Indicators, data collection systems, capacity to inform service delivery CQI, access to services CQI and outcome achievements. If Aboriginal communities are meaningfully involved in co-design of the solutions, then this increased accountability for outcomes can be effectively introduced. At the same time, outcomes focussed flexible funding and accountability mechanisms should always support self-determination. This includes involving Aboriginal people in the design and development of evaluation and monitoring and supporting community ownership of information and outcomes.

The Aboriginal Health Council of Western Australia point out that Aboriginal service users can also pressure Aboriginal community controlled health services for the changes they desire through elections to the boards of their local organisations. They note that “only local Aboriginal people can be members of those ACCHSs, so the connection between users of the service and the Board members is close. Thus, this type of accountability mechanism is strong”.[63]

Improved accountability by mainstream organisations is vital. This must include accountability for cultural competence which should be embedded in the operations of the organisation. KPIs should include cultural KPIs that demonstrate effective engagement with Aboriginal people. They should also demonstrate equitable partnerships with Aboriginal organisations, which are effectively funded by government to ensure resources are appropriate to role and the best outcomes for the community.

4. ***How best to promote innovation and improvements in the quality, range and funding of human services***

The Central Australian Aboriginal Congress provide an example of service planning innovation that led to measurable improvements in health outcomes for Aboriginal people. They argue that these health improvements did not come from competition, but through collaborative planning and, through this process, the allocation of resources according to need to existing health service providers. While this led to significant increases in per capita funding, it also achieved a massive 30% decline in all-cause mortality for Aboriginal people in the Northern Territory.[64] In 2009, when the policy shifted to encourage more competitive tendering, the use of private non-Aboriginal providers and mainstreaming, these improvements ceased.[65]

Improvements in the quality, range and funding of human services are better achieved by:

- Economies of scale through funding for holistic service models that encompass a broad range of human services
- Where individualised funding is introduced, include targeted funding for culturally significant items required to meet the needs of Aboriginal people (e.g. cultural support through the assessment process)
- Provide funding for the social determinants of health that take into account evidence about the systemic and structural factors producing ongoing disadvantage
- Provide funding on the basis of need, based on a cost benefit analysis and social insurance approach that recognises the long term economic benefits of effective intervention
- Collaborative needs based planning and allocation of resources
- Adequate resourcing and support to enable Aboriginal community participation in co-design of any reform to ensure it is effective in meeting the needs of service users
- An Evaluation and Monitoring Framework that is adopted by Commonwealth and State and Territory Governments and provides rigorous quality and outcome benchmarks based on empirical evidence about the needs and circumstances of Aboriginal people
- Accountability for outcomes through appropriate establishment and monitoring of KPIs

The sustainability of specialist service providers is integral to delivering services to special needs groups. If further family and community grants transition to an individualised funding model, there is a need to provide transition funding to support smaller specialist service providers to develop infrastructure and business systems which enable the administration of individual client budgets.

In relation to Member ACCOs as providers of social housing, the quality and range of housing stock provided is limited by caveats imposed on some properties. Until these are lifted it impedes the capacity of the ACCOs to manage and upgrade housing stock for the best interests of the community. For example, the caveats can impact on transition out of social housing where they prevent sale of housing stock to current tenants. More broadly, involvement of Member ACCOs in delivery of social housing also supports innovative service delivery across a range of human services tailored around the broader needs of the individuals accessing housing support. A focus on tenant outcomes is built into the housing model, which generally includes services to help tenants maintain their tenancy and improve the health and/or education and employment outcomes of tenants.

5. The challenges facing the provision of human services in rural and remote areas, small regional cities and emerging markets, and the need to improve Indigenous outcomes

See sections above for many of the challenges facing the provision of human services to Aboriginal people in urban and regional areas. In fact, many of the challenges highlighted in the preliminary report regarding services in remote Aboriginal communities apply urban and regional areas. These include:

- Market failure (in this case very few providers able to engage effectively with the Aboriginal community and offer acceptable - culturally safe - standards of care)
- Barriers to access including distance, mobile populations and cultural safety
- The complex and fragmented nature of funding arrangements
- Uncertainty of funding streams and large administrative burden
- Lack of service coordination and integration
- Non-Aboriginal organisations and staff that are inexperienced in the delivery of effective services in cross-cultural environments.

As noted also above, implementation of disability and aged care reforms offer significant learnings.

In 2011, the Productivity Commission Inquiry into Disability Care and Support found that, Aboriginal people have a profound or severe core activity limitation at around 2.2 times the rate of non-Indigenous Australians, yet face significant barriers to accessing disability support services. These barriers suggest a purely market based service delivery system would not deliver adequate care and support to Aboriginal people with disability. Moreover, it may be necessary to block fund some service providers in order to overcome the additional barriers that Aboriginal people face.[66]

VACCHO agrees with the Productivity Commission that "reducing the 'disability gap' over the long-term is in the financial interest of the NDIS, but, more importantly, would also dramatically improve the opportunities and quality of life for Indigenous Australians".[67] Further, the identified causes of high rates of disability provide even more opportunities for effective, and cost effective, early intervention and prevention measures.[68] However, like the current inquiry, the NDIA has to date relatively focussed its attention on outcomes for Aboriginal people in remote areas, especially the trial site of Barkley, without equivalent

strategies to address comparable challenges in rural and urban settings. In addition, no block funding has been provided to address the challenges identified in this earlier inquiry.

VACCHO welcomes the focus on early intervention and prevention under the NDIS but cautions against rations or caps that limit support to people who did not receive early intervention, noting that there are both moral and financial incentives in responding to the needs of this group. There are similar incentives to actively support people with disability who do not meet the eligibility criteria of NDIS, and it is unlikely ILC funding will be adequate at current levels.[69] In Victoria, for example, if HACC funding for younger people is not continued, there is a significant cohort unlikely to transition into NDIS.

While NDIA have claimed positive outcomes in the rates of Aboriginal people accessing the scheme,[70] this does not take into account either the known or potentially hidden levels of over-representation of people living with disability in Aboriginal communities.[71] Crucially, the Scheme's current focus on transitioning people from existing disability services, which includes a cap on new clients coming into the scheme, does nothing to improve the chronic levels of under-servicing Aboriginal people have already been experiencing.

Where they are available, ACCOs are best positioned in Victoria to achieve strong outcomes for Aboriginal people. With strong networks into the communities they serve, the range of services they offer means that many Aboriginal people with disability will already be accessing them, even if not seeking support for their disability needs. For example, reviews of sample data provides strong support for the notion that people with disability are already accessing their local ACCO's primary health care services. VACCHO also anticipates there are high numbers of people with disability accessing family and community services, out of home care programs,[72] early childhood, tenancy support, justice programs, and employment programs and so on. Combined with targeted community engagement strategies, this existing infrastructure and relationship provides unique opportunities to better identify people with disability in the community and facilitate access to the support that they need.

Based on the feedback of members participating or preparing to participate as registered NDIS providers, VACCHO recommends against fixing price points to rely on narrow terms for the provision of service and economies of scale that can't be sustained by specialist providers. The current NDIS price points do not recognise the complexity or cultural needs of Aboriginal people accessing the scheme and as such leave this necessary work unfunded. ACCOs are highly motivated to do this work anyway, in response to identified community need, but many will be putting their other business areas or organisational viability at risk if they continue to carry the financial costs. A targeted flexibility in pricing models on the other hand will enable them to provide and be compensated for the unique social capital they are able to provide and broaden the scope of their support to target cultural and other needs not met by the mainstream model. This must go hand in hand with the introduction of funded options for cultural support (e.g. line items or registration groups). This could include, for example, funding for Aboriginal health workers to attend assessment and planning appointments, as well as cultural activities such as return to country and cultural healing programs. This could work through an active support model that is consistent with social insurance principles and

practice. More investment is also needed to support the development and validation of culturally appropriate assessment tools and frameworks for Aboriginal people with disability.[73]

There is also need a simplify claims, invoicing and engagement documentation. A precedent for this can be found in an adapted tool for Consumer Directed Care claiming that was developed and approved for use specifically by Aboriginal organisations in rural and remote locations, in response to the risks of market failure.

In relation to new areas of human service provision, VACCHO asks for significant caution in the introduction of any measures aimed at greater competition, contestability and informed user choice and the mandatory inclusion and adequate funding for special measures to mitigate the negative impacts on Aboriginal people in remote, rural and urban areas.

There is also a need for government stewardship to identify and address the impacts of individual and systemic inequities. For example, in relation to Aged Care, the Minister can intervene where widespread inequities are noted. However there is no criteria to indicate what constitutes an inequity in need of Ministerial address, nor any specification for the nature or scope of intervention to rectify the problem. More transparency and accountability to guide government stewardship in this area is required.

6. ***The evaluation of new arrangements and the need to encourage continuous learning.***

There have been too many examples of Aboriginal policy that disregards the evidence of 'what works'.[74] For example, the Senate Inquiry into the IAS Tendering Process found no articulation of the evidence base "for the development of the IAS as the means by which to address earlier policy failings in this area".[75] The Inquiry also found that the model for competitive tendering used for the IAS "did not recognise the enhanced outcomes of service delivery by Indigenous organisations".[76] VACCHO shares AMSANT's concerns that these mistakes will be repeated and endorses their recommendation for an alternative approach that "prioritises the evidence of what we know works, and the views and experience of Aboriginal people, communities and organisations."[77]

It is also important that the impact of any changes is closely monitored to ensure Aboriginal people, are not further disadvantaged, and the Governments' commitment to Close the gap can be achieved. This can only be successful by funding provided for formal and culturally appropriate evaluation. The current rollout of NDIS in rural and urban locations, for example, does little to suggest the Productivity Commission's earlier findings, and the findings of other key studies,[78] have been taken into account to ensure the outcomes for Aboriginal people with disability can meaningfully improve.

[1]Productivity Commission (2016a) *Overcoming Indigenous Disadvantage: Key Indicators 2016* Productivity Commission, Melbourne Available at http://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2016. See Overview p.9 on indicators worsening by remoteness. For a comparison with non-Aboriginal population by geographic location see for example educational outcomes and employment status Tables 4A.4.6 to Table 4A.4.99 and Table 4A.7.2; 4A.7.6-7, 4A.7.10; 4A.7.13. For another example see comparisons of coronary heart disease in Bradshaw PJ, Alfonso HS, Finn J, Owen J & Thompson PL 2011. A comparison of coronary heart disease event rates among urban Australian Aboriginal people and a matched non Aboriginal population. *Journal of Epidemiology and Community Health* 65:315–9.

[2] United Nations (2008). *United Nations Declaration on the Rights of Indigenous Peoples*. United Nations. Articles 3 and 4.

[3] National Aboriginal Community Controlled Health Organisation (2016) *NACCHO Submission to Inquiry into Human Services: Identifying Sectors for Reform*, Sub227 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p. 3.

[4] Close the Gap: Indigenous Health Equality Summit – Statement of Intent (2008) Available at https://www.humanrights.gov.au/publications/close-gap-indigenous-health-equality-summit-statement-intent

[5] Close the Gap (2008).

[6] Department of Prime Minister and Cabinet (2016) *Submission to the Productivity Commission Review of Human Services* Sub265 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p. 6.

[7] Productivity Commission (2011) *Disability Care and Support* Productivity Commission, Melbourne. p. 531

[8] Productivity Commission (2016b) *Reforms to Human Services: Productivity Commission Issues Paper*. Productivity Commission, Melbourne. p. 3.

[9] Productivity Commission (2016b), p. 3.

[10] Aboriginal and Torres Strait Islander Social Justice Commissioner (2005) *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission, Sydney. p.14.

[11] Australian Council of Social Service (2016) *ACOSS Response to Productivity Commission Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* Sub377 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p. 12.

[12] Australian Council of Social Service (2016), p. 12.

[13] See for example Australian Council of Social Service (2015) *Principles for a Partnership-centred Approach for Non-government Organisations (NGOs) Working with Aboriginal and Torres Strait Islander Organisations and Communities*, ACOSS, Sydney. Available at *http://www.acoss.org.au/principles-for-a-partnership-centred-approach/*

[14] Aboriginal Health and Medical Research Council (2015) *Aboriginal Communities Improving Aboriginal Health: An Evidence Review on the Contribution of Aboriginal Community Controlled Health Services to Improving Aboriginal Health*, AH&MRC, Sydney. p.4.

[15] National Aboriginal Community Controlled Health Organisations (2016), p. 7.

[16] National Aboriginal Community Controlled Health Organisations (2016), p. 12.

[17] National Aboriginal Community Controlled Health Organisations (2016), pp.7-9.

[18] National Aboriginal Community Controlled Health Organisations (2016), p.7.

[19] Aboriginal Health and Medical Research Council (2015), p.4, p.15.

[20] Aboriginal Health and Medical Research Council (2015), p.15.

[21] Aboriginal Health and Medical Research Council (2015), p.15.

[22] Aboriginal Medical Services Alliance Northern Territory (2016) *Response to the Productivity Commission's Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform – Preliminary Findings Report* Sub384 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne.p. 1, p. 5.

[23] Australian Council of Social Service (2016), p.3.

[24] Australian Council of Social Service (2016), p. 16; National Aboriginal Community Controlled Health Organisations (2016), p. 16; see also Senate Finance and Public Administration References Committee (2016) *Commonwealth Indigenous Advancement Strategy Tendering Processes* Parliament of Australia, Canberra, pp.21-24.

[25] Productivity Commission (2016b), p. 6.
[26] Productivity Commission (2016b), p. 10.
[27] Interviews with Member ACCOs for Aged Care Legislative Review, VACCHO Transcript, November 2016.
[28] Australian Council of Social Service (2016), p. 2.
[29] Department of Prime Minister and Cabinet (2016), p. 4.
[30] Interviews with Member ACCOs for Aged Care Legislative Review, VACCHO Transcript, November 2016.
[31] Interviews with Member ACCOs for Aged Care Legislative Review, VACCHO Transcript, November 2016.
[32] Interviews with Member ACCOs for Aged Care Legislative Review, VACCHO Transcript, November 2016.
[33] Interviews with Member ACCOs for Aged Care Legislative Review, VACCHO Transcript, November 2016.
[34] Interviews with Member ACCOs for Aged Care Legislative Review, VACCHO Transcript, November 2016.
[35] Productivity Commission (2016b), p. 6.
[36] Productivity Commission (2011), pp. 539-40, 542.
[37] Productivity Commission (2011), p. 531.
[38] The Federation of Ethnic Communities Council of Australia 2016 *Submission to Productivity Commission Inquiry into Human Services: Identifying Sectors for Reform,* Sub25 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p.6.
[39] Productivity Commission (2016b), p.12.
[40] National Aboriginal Community Controlled Health Organisations (2016), p. 10, p. 12.
[41] Productivity Commission (2016b), p. 10.
[42] Australian National Audit Office (2017) *ANAO Report No.35 2016–17 Performance Report: Indigenous Advancement Strategy* Commonwealth of Australia, Canberra, pp. 57-61.
[43] Productivity Commission *Report on Government Services 2017* Productivity Commission, Melbourne. Table 14A.23 Aged Care Assessments.
[44] Victorian Aboriginal Community Controlled Health Organisation, National Aboriginal Community Controlled Health Organisation and Council of the Aged *Aboriginal and Torres Strait Islander Communities and Aged Care Reforms*. Unpublished Paper. p. 5.
[45] Australian Council of Social Service (2016), p. 12.
[46] Productivity Commission (2011) notes it is likely the estimated number of Indigenous people with a disability significantly underestimates the real figures, p. 537. See also N. Biddle, F. Al-Yaman, M. Gourley, M. Gray, J.R. Bray, B. Brady, L.A. Pham, E. Williams, M. Montaigne *Indigenous Australians and the National Disability Insurance Scheme* Australian National University Press, Canberra, p. 64, citing the 2008 NATSISS results showing nearly half of Indigenous Australians with severe or profound core activity limitations identified having problems accessing service providers.
[47] Australian Council of Social Service (2016), p. 1.
[48] Department of Prime Minister and Cabinet (2016), pp. 2-3.
[49] Kelaher, M, Ferdinand, A & Paradies, Y (2014), cited in Australian Health Ministers' Advisory Council (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AHMAC, Canberra. p. 142.
[50] Australian Health Ministers' Advisory Council (2015), p. 142.
[51] Australian Health Ministers' Advisory Council (2015), pp.146-7.
[52] Department of Prime Minister and Cabinet (2016), p. 3.
[53] Department of Prime Minister and Cabinet (2016), p. 3.
[54] Central Australian Aboriginal Congress (2016) *Submission to the Productivity Commission's Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*. Sub382 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne pp 5-6
[55] Aboriginal Medical Services Alliance Northern Territory (2016), p. 2.
[56] Senate Finance and Public Administration References Committee (2016), pp. 21-22; Aboriginal Medical Services Alliance Northern Territory (2016), p. 5.
[57] Aboriginal Medical Services Alliance Northern Territory (2016), p. 6.
[58] Senate Finance and Public Administration References Committee (2016), p. vii.
[59] Senate Finance and Public Administration References Committee (2016), p. vii.

[60] Olga Havnen (2012) *The Office of the Northern Territory Coordinator-General for Remote Services Report June 2011 to August 2012*, Northern Territory Government, Darwin. p. 5.
[61] Olga Havnen (2012), p. 5.
[62] Senate Finance and Public Administration References Committee (2016), pp. 21-22; p.61.
[63] Aboriginal Health Council of Western Australia *Submission Response. Productivity Commission Preliminary Findings Report – Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform.* Sub393 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p. 2.
[64] Central Australian Aboriginal Congress (2016), pp. 2-5.
[65] Central Australian Aboriginal Congress (2016), pp. 3-4.
[66] Productivity Commission (2011), p. 531.
[67] Productivity Commission (2011), p. 546.
[68] Productivity Commission (2011), p. 546.
[69] It is outside the scope of this submission to fully demonstrate the cost savings, but, as an example only, the data on imprisonment rates and recurrent costs for people with cognitive impairments in the criminal justice system makes a strong case for the economic benefits of ensuring adequate support.
[70] NDIA Staff Member, Personal Communication, October 2016.
[71] Reference for this? Productivity Commission on NMDS data?
[72] For the numbers of children with disability in out-of-home care, often without disability assessment or support, see for example Commission for Children and Young People (2016) '*Always Was, Always Will Be Koori Children': Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-Of-Home Care in Victoria* Commission for Children and Young People: Melbourne. p. 95.
[73] See for example Bohanna, I. Stephens, A. Wargent, R. Catherall, J. Timms, C. Graham, D. And Clough, A. (2013) *Assessment of acquired brain injury in Aboriginal and Torres Strait Islander Australians: Guidance for Disability Care Australia*, James Cook University, Cairns.
[74] Aboriginal Medical Services Alliance Northern Territory (2016), p. 1.
[75] Senate Finance and Public Administration References Committee (2016), p. 61.
[76] Senate Finance and Public Administration References Committee (2016), p. 21, p. 61.
[77] Aboriginal Medical Services Alliance Northern Territory (2016), p. 1.
[78] See for example Biddle et al (2014) and Bohanna et al (2013).