Submission to the Productivity Commission Inquiry into Introducing Competition and Informed User Choice into Human Services

3 August 2016

Introduction

Thank you for the opportunity to provide a submission to the Productivity Commission's inquiry to examine the application of competition and user choice to services within the human services sector and develop policy options to improve outcomes.

The Aboriginal Medical Services Alliance NT (AMSANT) is the peak body for Aboriginal community controlled health services (ACCHSs) in the NT. Our members are located right across the NT from Darwin to the most remote areas. ACCHSs provide comprehensive primary health care in an integrated, holistic, culturally secure framework which combines a population health approach with primary health care service delivery.

We note that the terms of reference identifies the need to increase efficiency and effectiveness, timeliness, affordability, quality and cost-effectiveness of human services.

We also note that the inquiry is to occur in two parts and that this submission addresses the first round objective to deliver an initial study report identifying services within the human services sector that are best suited to the introduction of greater competition, contestability and user choice.

Key messages

1. Our submission seeks to provide the Commission with an understanding of why the Aboriginal community controlled health service (ACCHS) sector is *not* suited to the introduction of greater competition, contestability and user choice.

The reasons for this are complex, addressing issues encompassing the location, demographics and aspirations of Aboriginal communities; the features of ACCHSs and the particular requirements of delivering comprehensive primary heath care (CPHC) to Aboriginal people including the need for culturally competent service delivery and Aboriginal leadership; and the effectiveness of the quality assurance and continuous quality improvement (CQI) framework that Aboriginal CPHC operates within that already delivers the improved outcomes that the government is seeking to obtain through the mechanisms of competition and contestability.

2. Certain health related human services delivered by ACCHSs as part of comprehensive primary health care (CPHC) *are* currently subject to competition and contestability, leading to numerous instances of such services being delivered by external NGO, private sector and government agencies resulting in less efficient, less effective and less cost-effective outcomes.

3. ACCHSs should be the preferred providers of CPHC services to Aboriginal communities.

4. Funding for services comprising Aboriginal CPHC should be consolidated and allocated through a single funding agreement between ACCHSs and the Commonwealth Department of Health.

5. Quality assurance and CQI frameworks provide an alternative and in many ways superior methodology for achieving the kinds of improved outcomes that government seeks through introducing competition and contestability.

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6. Improving outcomes for Aboriginal clients of human services as well as benefits to the broader community, particularly in remote areas, can be achieved by increasing the delivery of such services by Aboriginal controlled organisations based on quality assurance measures.

7. Government investment in human services can be used to support the development of new Aboriginal controlled service providers by configuring procurement processes to support appropriate partnerships with non-Indigenous NGOs as outlined in the APO NT NGO Partnership Principles.

1. The Aboriginal community controlled health services sector is not suited to a competition and contestability regime.

User choice

The issues paper notes the recommendation of the *Competition Policy Review* that government should "put user choice at the heart of human services delivery as users are best placed to make choices about the services they need".

Aboriginal community controlled health services have resulted from the determined actions of Aboriginal communities to develop and control their own health services. As such ACCHSs are an ultimate example of 'informed user choice'. This also means they are uniquely placed to deliver culturally competent primary health care.

The ACCHSs model has been recognised as the preferred model of Aboriginal primary health care delivery by both the NT and Commonwealth governments under the Pathways to Community Control model endorsed by the NT Aboriginal health Forum (NTAHF 2009). The Forum is a high level jurisdictional health planning body comprising both governments, AMSANT and the NT Primary Health Network.

It is also the case that regional and remote areas are not well serviced by alternative PHC providers, particularly GPs. In most areas of the NT outside the main centres there are no private practice general practitioners – all general practitioners are employed through the Aboriginal PHC sector (either community controlled or government services). There are also no private providers operating in the areas of allied health or counselling outside urban areas.

It should be noted that Aboriginal controlled organisations in general, delivering a wide range of community and human services, are also expressions of 'informed user choice'.

Any consideration of introducing further user choice or competition and contestability for such Aboriginal controlled delivery of services would need to take into account of the costs and benefits of such an approach, as outlined below.

Comprehensive Primary Health Care

The model of comprehensive primary health care developed and delivered by ACCHSs extends the scope of services and activities normally provided as part of PHC to include services relating to alcohol, tobacco and other drugs, early childhood development and family support, aged and disability, and mental health and social and emotional well being; as well as the provision of health promotion and illness prevention programs, involvement in research, policy and planning; and cross-sectoral collaboration and advocacy to promote public health and community development outcomes.

The scope of these services and activities, provided through multi-disciplinary teams, is most optimally provided through regionally based services that have the service populations and economies of scale to provide the full suite of core CPHC services. This requires long term planning and investment, in the manner required for hospitals and other substantial health infrastructure. Currently the NT has a large Aboriginal PHC sector with only a small minority of Aboriginal people (largely residing in Darwin and to a lesser extent in Alice Springs) choosing to use private general practice. Of note, Danila Dilba (the ACCHS servicing the Darwin region) is rapidly expanding with episodes of care almost doubling from 2009/10 to 2014/15. This large service now provides care to most of the Aboriginal population in Darwin, despite the plethora of private general practices operating in Darwin (Danila DIlba Annual Report 2014-5).

While the GP Superclinic and Health Home models provide some features of CPHC, they do not approach the level of integrated service delivery and community participation and engagement that the CPHC model provides.

Additional benefits of ACCHSs

The Aboriginal community controlled model of delivering CPHC services provides a number of significant additional benefits that are not provided through government, not-for-profit and private sector providers. These benefits considerably add to the cost-effectiveness of investment in ACCHSs, both in terms of the quality of service provision as well as in relation to broader health and health-related outcomes.

- The ACCHSs model engages the community in the governance of ACCHSs and contributes to community and individual self-reliance, participation and control. These factors are known to have positive health and community wellbeing outcomes. Canadian research has found the community-controlled model is associated with improved psychological wellbeing and reduced hospitalisation rates for Indigenous people.
- ACCHSs contribute to improving the performance of the broader health system in meeting the needs of Aboriginal people, through partnerships with other health professionals, organisations and government, and advocating on behalf of Aboriginal communities to inform health policies.
- The ACCHS sector is the largest employer of Aboriginal people in Australia, and provides training pathways in a range of management, administrative and health careers.
- ACCHSs increase Aboriginal peoples' access to primary health care, including among hard-to-reach populations such as those with mental illness. Multiple studies describe a preference among Aboriginal peoples for ACCHS-delivered care, suggesting this is because it is flexible and responsive, culturally appropriate and delivered by trusted staff in a safe setting.

Introducing competition or contestability that contemplates the transfer of the provision of services normally provided by ACCHSs, to government, not-for-profit or private sector providers, would see these additional benefits and positive outcomes foregone.

Quality assurance and continuous quality improvement (CQI)

A further feature of the ACCHS sector that is threatened by the introduction of competition and contestability is its focus on quality assurance and continuous quality improvement (CQI). Quality assurance and CQI frameworks are designed to achieve improved efficiency and effectiveness, timeliness, affordability, quality and cost-effectiveness of health services.

The ACCHSs sector has been a leader in the development of quality assurance and CQI frameworks for PHC service delivery, being early adopters of electronic health records and patient information systems, and co-developers with government in developing standard clinical treatment guidelines, key performance indicators (KPIs) to measure health service performance and CQI processes to drive improved health service performance and health outcomes.

These frameworks, based on collaborative processes and requiring long-term planning and investment in partnership with government, are greatly put at risk by competition and contestability principles given that the levels of sophistication in CQI/system development and accountability systems has taken decades of collaborative work to achieve – with this degree of collaboration likely to be undermined by competition. Quality assurance and CQI provide an alternative and in many ways superior methodology for achieving the kinds of improvement that government seeks through introducing competition and contestability.

As a comparison, the GP sector, as a private sector provider of PHC, lags the ACCHSs sector in their capacity to use electronic health records to drive developments in KPI and CQI systems to measure performance or improvement. In contrast to the Aboriginal PHC sector, which reports on two compulsory sets of indicators, the private GP sector undertakes no compulsory universal reporting on indicators, thus making it difficult to ascertain what is required in order to lift performance across the board or in some regions where outcomes are particularly poor.

2. Case studies of negative outcomes of competition and contestability in Aboriginal health-related services.

Despite the evidence of the effectiveness of CPHC delivered through ACCHSs, a number of the core services of CPHC continue to be funded through siloed programs, often through open competitive tendering processes, with the result that these Aboriginal-specific services are often provided by multiple non-ACCHS providers. Case studies of such service provision provides evidence of the negative outcomes that can result.

AOD, mental health and social and emotional wellbeing services

Aboriginal AOD, mental health and social and emotional wellbeing (SEWB) services are core CPHC services, usually delivered by ACCHSs through multi-disciplinary teams using holistic, culturally responsive approaches. However funding for these services has been provided through multiple, siloed programs funded variously through the Commonwealth Department of Health, Department of Social Services and the Department of the Prime Minister and Cabinet (DPM&C).

In the past couple of years Aboriginal AOD and SEWB funding has been transferred from the Department of Health to DPM&C and put to open tender under the Indigenous Advancement Strategy (IAS). Before this change there had already been the introduction of an increasing number of non-Indigenous not-for-profit providers competing and in some instances taking service funding from ACCHSs (and other Aboriginal service providers). The IAS increased the number of ACCHSs' programs previously funded through siloed, ongoing grants that have been opened to competitive tendering.

Existing services of ACCHSs that were opened to competitive tender under the IAS included a broad range of core primary health care services including SEWB services currently funded under Bringing Them Home/Stolen Generations funding streams as well as Indigenous AOD services.

In the case of the Bringing Them Home/Stolen Generations funding streams, the transfer breached the original intention and commitment of the funding to provide vital mental health services

delivered by community controlled health services for the types of intergenerational mental health conditions associated with the forced removal of children.

Indigenous specific AOD services are vital in reducing alcohol and other drug related harms. Evidence now clearly demonstrates the value of providing such services as part of CPHC, through a combination of medical care, focused psychological strategies and social and cultural support in a similar manner that patients with other complex chronic conditions, such as diabetes, require.

The increasing take-over of service funding by NGOs has led to perverse and negative outcomes. For example, a remote community in Central Australia of about 400 people was being serviced by 16 separate NGOs delivering SEWB-related programs. These were mostly on a fly-in-fly-out and drive-in-drive-out basis. There was little in the way of communication or coordination with the local ACCHS, with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc.

The resulting fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients is totally counter to the improved outcomes sought by this inquiry and yet this was the result of government policy to introduce greater competition and contestability into service delivery.

Services for children

The plethora of uncoordinated fragmented serviced delivery has been noted many times. In 2010, more than 1,000 programs and services for children under 15 years of age were identified across the NT. They were characterised by multiple funding sources, lack of overall coherence, and a lack of rigorous evaluation. The NT Government inquiry into youth suicide also noted the lack of coordination, duplication and gaps in services for at risk young people. We believe that the trend for poor coordination, fragmentation and duplication is likely to be getting worse with the increase in services now put out too tender.

3. Consolidation of core CPHC funding under the Department of Health

With these case studies in mind, AMSANT is strongly of the view that programs that comprise core services of Aboriginal CPHC, including mental health, social and emotional well being and AOD services, should be consolidated and managed within the health portfolio, and allocated through a single funding agreement between ACCHSs and the Department of Health. Approval of ongoing funding should be based on achievement against quality assurance and CQI measures as occurs with current PHC funding through the Department.

The transfer of these programs to DPMC breaches the integrity of the comprehensive PHC model and runs counter to three decades of collaborative work on the development of Aboriginal CPHC under the NTAHF. The programs are now managed by DPMC staff who have little understanding of the Aboriginal primary health care context of these programs.

Moreover, the shift also opens up these programs to a competitive tendering process that is likely to result in the inefficient fragmentation and lack of coordination of services through multiple providers servicing small remote and regional populations.

4. Competition and contestability in the provision of Indigenous-specific human services

Worse investment outcomes

As the above case studies show, introduction of competition and contestability is not a panacea and in the case of Aboriginal services the likely result is worse service outcomes. These trends have seen an increased presence of mainstream NGOs and private sector providers in Indigenous-specific service delivery and development work in Aboriginal communities in the NT, contributing to fragmentation and duplication of service delivery, lack of coordination with Aboriginal organisations, and compromised outcomes for clients.

At a broader level the impacts have included the gradual erosion, undermining and loss of Aboriginal controlled service organisations and a lack of genuine capacity development outcomes that might have resulted if investment had been directed towards Aboriginal service providers.

Poor cost-benefit analysis

Such negative outcomes of increased competition and contestability are the result of poor cost-benefit analysis in the planning of service delivery. Large NGOs, private sector providers and government entities can appear superficially attractive options. They have the resources and capacity to draw up complex tender documents under tight timeframes and offer economies of scale that might appear attractive in cost terms.

However, these organisations also come with additional unacknowledged costs. They often lack community links, cultural knowledge and long-term commitment and capacity to deliver programs to Aboriginal people in an optimal, culturally safe manner. They also lack capacity to develop and retain an effective Aboriginal workforce. The considerable additional benefits of having Aboriginal organisations employing local Aboriginal people to deliver services to their communities are not usually factored into open competitive tendering processes.

Applying competition and contestability to Aboriginal specific areas of service delivery, such as Aboriginal primary health care, Aboriginal legal services and activities based on Aboriginal land, such as rangers programs, is inherently counter-productive. The Aboriginal controlled organisations delivering these services are not only best suited for doing so, but provide the priority outcomes that the Government is seeking in terms of sustainable Aboriginal employment as well as experience and engagement in governance and management, and the development of community self-reliance and responsibility.

Investing in Aboriginal capacity

Government investment in human services would be better placed in supporting and funding Aboriginal organisations as service providers based on quality assurance in governance, management and service delivery outcomes. In other words, effective accountability, not contestability should be applied.

Local Aboriginal organisations should always be regarded as the first priority for delivering services to Aboriginal communities.

However, where there are currently insufficient Aboriginal organisations or Aboriginal capacity to deliver specific services or programs, we believe that better outcomes can be achieved through an approach that seeks to leverage government investment to develop additional Aboriginal capacity and new Aboriginal service delivery organisations through appropriate partnerships with non-Indigenous NGOs, supported by government procurement processes.

The Aboriginal Peak Organisations NT (APO NT), of which AMSANT is a member, has developed the NGO Partnership Principles in collaboration with mainstream NGOs working in the Aboriginal service delivery space in the Northern Territory. The Principles seek to harness the goodwill, experience and resources of NGOs towards actively supporting and helping to build Aboriginal organisational and service delivery capacity.

Government investment in human services can be used to support the development of new Aboriginal controlled service providers by configuring procurement processes to support appropriate partnerships with non-Indigenous NGOs as outlined in the APO NT NGO Partnership Principles.