

## Submission Response

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### Productivity Commission Study Report– Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform

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16 February 2016

The Aboriginal Health Council of Western Australia (AHCWA) welcomes the opportunity to provide a brief submission to the Productivity's Commission's Study Report - Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform. This written submission confirms our previous written submission in regards to the Productivity Commission's Preliminary Findings Report. We understand that it may have been difficult for the Commission to consider our previous submission, given that it was provided past the date required for feedback. As such, we make very similar points again below.

**Note:** we have chosen to do our submission in response to quotes in the Study Report as it is that document rather than the Issues Paper which contains the Commission's most detailed rationales. It is those detailed rationales which we believe show the Commission is heading in the wrong direction with this inquiry, and which are therefore skewing some of the questions in the Issues Paper.

#### 1. SUMMARY

We would like to reiterate the central importance of ACCHSs to provide holistic, spiritually and culturally appropriate comprehensive primary health care services that address many barriers to access associated with most of the mainstream primary health sector. In line with our previous submission, AHCWA still holds that existing, high-functioning ACCHSs should be exempted from the proposal to impose alternative providers or contestable processes. If a particular ACCHS is demonstrably working well, it should be considered a 'preferred provider' without the need to frequently re-tender.

The fragmented service delivery in some remote Aboriginal communities could be tackled through bundling of services not generally considered to be part of the health sector (but which are certainly some of the social determinants of health), and delivering a larger range of outcomes through Australia's existing ACCHSs.

#### 2. KEY FACTS ABOUT OUR SECTOR

The Australian Aboriginal Community Controlled Health Services (ACCHSs) Sector has been operating for over 45 years.

Currently, the Sector nationally sees almost 350,000 clients annually<sup>1</sup>, who benefit collectively from approximately 3 million episodes of care each year.<sup>2</sup>

The Sector currently has almost 7,000 FTE<sup>3</sup> employees nationally, approximately 55% of which are Aboriginal and / or Torres Strait Islanders<sup>4</sup>. Collectively then, we are one of Australia's biggest, if not the biggest, employer of Aboriginal and / or Torres Strait Islander persons.

### 3. KEY STATEMENTS FROM THE STUDY REPORT

#### Key Quote 1:

*“Competition between multiple service providers is not always possible or desirable. As an alternative, where there would be net benefits, governments can seek to mimic competitive pressures through contestable arrangements to select providers, or to replace a poor provider with better performers.” (page 8)*

#### Response:

As stated in our previous submission, we want to note that as part of other consultative processes AHCWA has frequently made written submissions in which we have observed that a ‘fly-in, fly-out’ (FIFO) / ‘drive-in, drive-out’ (DIDO) approach to service delivery into remote Aboriginal communities is simply not working. This is perhaps most acutely borne out by the current crisis in Aboriginal youth suicides and self-harm incidents in WA.

As currently advised, it is AHCWA’s view that either:

- forcing multiple service providers upon remote Aboriginal communities who already have access to a high-functioning ACCHS; or, alternatively
- potentially displacing ‘one-stop-shop’ ACCHSs delivering quality care as the sole providers in particular remote Aboriginal communities,

would increase the percentage of services delivered FIFO / DIDO by large, non-Aboriginal organisations. To some extent this has already happened with the widely-criticised first phase of funding under the Federal Government’s Indigenous Advancement Strategy (IAS). It is a trend that should be resisted with future IAS allocations, and in other government funding processes.

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<sup>1</sup> Page vi, Australian Institute of Health and Welfare 2016. Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171. Canberra: AIHW.

<sup>2</sup> Page vi, Australian Institute of Health and Welfare 2016. Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171. Canberra: AIHW.

<sup>3</sup> Page 13, Australian Institute of Health and Welfare 2016. Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171. Canberra: AIHW.

<sup>4</sup> Page 13, Australian Institute of Health and Welfare 2016. Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171. Canberra: AIHW.

Key Quote 2:

*“A contestable market (including one with a single active provider), with a credible threat of replacement, can enable the better performing service providers to expand their service offering and keep current providers on their toes.” (page 8)*

Response:

The ACCHS Sector already has processes that deliver ‘the credible threat of replacement’ that keep each ACCHS ‘on their toes’; the Board will regularly be up for election, with the members voting also being frequent users of that service. 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, with a high chance of ensuring that the ACCHSs maintain both clinical and cultural standards and protocols.

Key Quote 3:

*“Service providers face barriers to effective service provision, such as a lack of and difficulty in accessing infrastructure, and difficulty recruiting and retaining staff. The challenges of remoteness can make the cost of providing services in remote Australia several times the cost in urban areas.” (page 26)*

Response:

We agree, although it should be noted that having ACCHSs as the main health service provider does allow for training of local Aboriginal people for roles such as an Aboriginal Health Worker. This addresses some of the barriers raised above, whilst also building sustainable work skillsets in the local community.

Key Quote 4:

*“Informed user choice places users at the heart of human services delivery. With some exceptions, the user of the service is best-placed to make choices about the services that match their needs and preferences... User choice [through having alternative providers] can also generate powerful incentives for service providers to be more responsive to users’ needs.” (page 40)*

Response:

The WA ACCHSs Sector is committed to quality improvement for users as it is operated by local Aboriginal people who are also users themselves. Being artificially required to compete with (mostly culturally insensitive) mainstream primary health service providers has not been necessary for that to become our Sector’s way of operating. Continuous Quality Improvement (CQI) has in recent years been an explicit goal within the key primary health care funding agreements of AHCWA’s Member Services. Supporting that work at a service delivery level also has been made a specific aspect of the capacity building AHCWA is tasked to deliver to our Sector.

Whether in relation to the prospect of introducing additional service providers with the intention of stimulating innovation, or the prospect of having contestable access to a 'single-provider-sized' (for example) remote Aboriginal community, our Sector also says that we have another key way service users can pressure for the changes they desire: elections to the boards of their local ACCHS.

Key Quote 5:

*"Indigenous Australians living in these communities may also interact with services differently to other Australians, reflecting a combination of factors, including culture and past experiences with government services." (page 138)*

Response:

We agree, and it is why our Sector has set up so many ACCHSs clinics all around the country. Increasing competition or contestability in service providers could result in an increase in services from non-Aboriginal organisations that are ill-equipped to deal with these cultural factors, resulting in ineffective or inefficient services and no improvement in outcomes for these remote Aboriginal communities.

Key Quote 6:

*"About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared with 2 per cent of Indigenous Australians living in non-remote areas." (page 138)*

Response:

As stated in our previous submission, this factor lends further weight to the importance of ACCHSs. Those local languages are spoken by many of the Board members in the WA Sector, and of course the key staff like Aboriginal Health Workers in the relevant clinics.

Key Quote 7:

*"...Indigenous Australians had poorer access to mental health services, in part because services designed for the broader population were not culturally appropriate." (page 136)*

Response:

We agree, and this is why services that are constructed to cater for the Aboriginal population – like ACCHSs in particular – are required. All employees of ACCHSs are trained in cultural safety and it is one of the key aims of ACCHSs to provide a culturally appropriate service.

Key Quote 8:

*"Funding and responsibility for service provision and outcomes are split across governments, departments, programs and providers. Although this is also the case in human services*

*more generally, the negative effects of this are stark for remote communities with high levels of service fragmentation, and duplication in some areas and gaps in others.” (page 134)*

Response:

We agree, and across our Sector in WA our ACCHSs are seeking to deliver a wider and wider range of services [holistic health care being central to our model], such as allied health; social and emotional wellbeing; even things like transporting the deceased persons back to be buried on Country. AHCWA expects to have a role in supporting the WA Sector in moving toward an approach more like Victoria, where the equivalents of WA ACCHSs deliver services in the disability, aged care, and housing spaces.

Key Quote 9:

*“Alford (2014) gave an extreme case of one Aboriginal Community Controlled Health Organisation (ACCHO) with over 90 funding agreements, and an associated compliance burden of about 423 reports annually. Funding also tends to be short term and uncertain in nature. As a result, providers and governments spend considerable time and effort managing funding flows rather than focusing on delivering better outcomes.” (page 135)*

Response:

We agree, and the example referred to by Alford in the quote above is unfortunately not unique. We agree with the need to streamline reporting requirements and extend the length of service contracts to allow ACCHSs to operate more effectively and more efficiently.

Key Quote 10:

*“There is scope to improve outcomes over the long term through better design and implementation of policies to commission and deliver services in remote Indigenous communities.” (page 140)*

Response:

We agree. However, it is crucial that commissioning policies are constructed to reflect the evidence available. Too often this is not the case and the development of new policy does not address earlier policy failings, as shown in the Senate Inquiry into the IAS Tendering Process.

Key Quote 11:

*“Another way to increase the responsiveness of service providers is for governments to engage with communities to better understand their needs and take them into account in decision making.” (page 141)*

Response:

We agree, and this is central to the very idea of local-community-controlled Aboriginal health organisations.

Key Quote 11:

*“In Australia, the ACCHOs were raised by participants as an example of the positive effects of greater community control, and are significant service providers. ACCHOs have boards of management elected by the local community, and are widely used to access services where they are available.” (page 141)*

Response:

We agree. We trust the Commission’s final report will reflect the level of importance of ACCHOs by making a specific finding about their role, and by otherwise discussing their function in the Executive Summary of that final report.

*The Aboriginal Health Council of Western Australia advocates on behalf of 22 Aboriginal Community Controlled Health Services in Western Australia, to ensure that the health needs of the State’s communities are represented at all levels.*