



The Royal Australasian
College of Physicians

RACP Submission February 2017:
Productivity Commission Issues Paper
– Reforms to Human Services

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide its comments on the Productivity Commission Issues Paper on Reforms to Human Services. The RACP is the largest specialist medical college in Australasia and trains, educates and advocates on behalf of more than 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. Thus we have a unique perspective to provide based on the experience of our members in the frontline of at least three of the sectors identified by the Issues Paper, namely public hospital services, end of life care, and the provision of human services in remote Indigenous communities.

The RACP believes that, until further detail on proposed reforms is provided, it is premature to endorse any particular models for introducing greater competition, contestability and user choice in each of these sectors. Thus, rather than setting out a detailed blueprint of the kinds of measures that we might like to see put in place, this submission highlights some of the complexities and complications that should be expected if greater user choice, competition and contestability were to be introduced to these three sectors, and potential measures that could help address or ameliorate these.

We have also noted some recent, highly nuanced findings from the economic literature on hospital competition to assist the Commission in considering and learning from the experience of other jurisdictions in implementing pro-competitive reforms in human services sectors. We hope that the Commission will take into account the matters we have highlighted in this submission and we look forward to examining the Commission's more detailed proposals arising from the inquiry as they emerge.

1. Public hospital services

1.1 Complications and complexities associated with user choice

Overall, the RACP consider greater user choice in the public hospital sector to be a positive goal. But at the same time there needs to be consideration of the numerous complexities and complications associated with enhanced 'user choice' of public hospital services. These complexities and complications, which are outlined below, need to be appropriately managed before greater user choice can be either a reality or a driver of improvements in the quality of healthcare.

Diversity and variation in care

Public hospital services meet a diversity of needs through services such as acute in-patient care, and out-patient services, whether provided through out-patient clinics or Emergency Departments. The number of choices and access points is also contingent on the patient's location, whether this is in a metropolitan, regional, rural, or remote setting. This significant variability in services provided would create marked difficulties in tailoring a 'one size fits all' approach for policy reforms.

Adding to the complexity in design considerations, the Australian Commission on Safety and Quality in Healthcare has documented the marked variation in the volumes of a number of services being offered by health service providers through its *Atlas of Healthcare Variation* reports. More variability is introduced by jurisdictional differences resulting in different rules and regulations for accessing hospital services. For instance, in regions adjacent to State borders major issues arise from differing legal frameworks, especially around allocating accountability for decision-making on behalf of patients not deemed competent, and delays arise in relation to the best management of patients who no longer need medical care in acute public hospitals but are awaiting housing decisions.

Patient demand for user choice

The extent to which patients demand greater choice of options is worth further exploration so that reforms can be targeted where they are most likely to yield patient benefit or satisfy unmet demands. Guidance can be obtained from the experience of other jurisdictions which have tried to implement greater user choice. For instance, a scoping review conducted to evaluate recent UK National Health Service (NHS) reforms to promote user choice in the 2000s concluded that the greatest demand for increased choice comes from patients facing elective surgical procedures who currently obtain poor service at their local hospitals.¹ Beyond this particular case, demand for enhanced user choice was not high amongst those patients surveyed.

Geographical and quality constraints on user choice

In designing user choice enhancements, policymakers must be aware of the most significant underlying constraints on choice. Geographical factors are one such constraint, with reviews of past UK NHS reforms concluding that patients tend to prefer the local, and convenient to access, public hospitals. This tendency is more marked among older patients though not confined to them.² Having chronically poor health or typically travelling to the local hospital by bus were also associated with 'loyalty' to the local hospital.³

Perceived clinical quality also clearly matters in constraining patient choice, as UK patient surveys have found that quality exerts the largest influence on choice of hospital, though those without formal educational qualifications placed less weight on this.

¹ Fotaki M. Patient Choice and the Organisation and Delivery of Health Services: Scoping review. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO). December 2005.

² Harding A, Sanders F, Lara AM, et al. Patient Choice for Older People in English NHS Primary Care: Theory and Practice. ISRN Family Medicine. 2014; 742676.

³ Burge P, Devlin A, Appleby J, et al. Understanding Patients' Choices at the Point of Referral. RAND Technical Report 2006.

Recommendations by general practitioners also have an impact on choice though significantly, only negative recommendations against particular hospitals, and not positive recommendations in favour of specific ones.⁴

Equity implications

These considerations generate concerns about the possible equity implications of enhancing user choice, insofar as they indicate that patients of higher socioeconomic status may be relatively more advantaged in exercising choice than others as they are more able to afford the costs associated with accessing information and traveling further to a hospital provider in order to receive treatment sooner, as well as potentially being better cognisant of and equipped to interpret whatever quality indicators are available.

The early evidence from studies looking at the impacts of the UK NHS reforms so far however suggest that increased patient choice and competition have not led to a reduction in patient equity and have facilitated the slightly more rapid growth of elective inpatient admissions over time in more socioeconomically deprived areas⁵. The equity implications of user choice in healthcare are by no means a settled question though, especially in Australia where a disproportionate number of public hospitals are located in the more affluent major cities, which means that populations in these cities have more effective 'user choice' than those in less affluent rural and remote areas. Therefore, in the event that user choice reforms are implemented in Australia, we strongly recommend that the impacts on equitable access to hospital services should be regularly monitored and reviewed.

Patients with complex care needs

One area where enhanced user choice could make a difference is in addressing the current inadequate coordination of medical services and its specific implications for patients with complex care needs and/or reduced capacity. Typically multiple providers serve these patients, each taking responsibility for providing a segment of the care required by the patient. Currently there is little in the way of consistent and effective use of tools to ensure coordination of service provision, and there are few incentives for time-poor practitioners or resource-limited service providers to provide integrated care. There is also often poor understanding by service providers of the capability of other providers in providing components of care, and how their service models function. We recommend that the Commission make it a priority to tailor user choice reforms in a way that enhances the patient experience and the coordination and quality of care for those with complex and chronic care needs. The challenge is how to enhance the prospects for better integrated care while increasing competition, contestability and user choice. While the two objectives are not mutually exclusive, neither are they easy to reconcile.

Choice of hospital versus choice of practitioner

There are different levels at which user choice may be exercised. One is the choice of hospital where the focus is on reducing unnecessary barriers including supporting patients being able to make more informed choices. While this may create some complications (which are discussed in the next section) it is to some degree already a reality, especially for those with private health insurance and for those in urban areas.

In addition, there is the idea of patient choice of specialist at public hospitals. There are more significant implementation hurdles associated with this choice. In particular, medical services in public hospitals are organised on a team basis, with specific rules determining the specialist under whom a patient is admitted. These rules and protocols are designed to ensure that the workload is equitable, manageable, and provides good patient care. Introducing patient choice at the specialist level would therefore have significant potentially negative implications for teamwork and workload

⁴ Burge P, Devlin A, Appleby J, et al. Understanding Patients' Choices at the Point of Referral. RAND Technical Report 2006

⁵ Cookson R, Laudicella M, Li Donni P. Does hospital competition harm equity? Evidence from the English National Health Service. *Journal of Health Economics*. 2013;32: 410– 422

allocation at public hospitals. There may also be implications for the relative attractiveness of continuing to hold private health insurance.

1.2 Managing the consequences of increased contestability/competition

Increased competition and contestability is not desired for its own sake, but as a means of spurring performance improvements in the provision of public hospital services. Given this, particular care must be taken in managing the consequences of enhanced contestability and competition in the hospitals sector, as it is the **net benefits** of these changes which ultimately matter. Accordingly this section highlights a number of potential consequences and concerns, based on the experience and perspectives of our members, who are on the frontline of service provision in public hospitals.

Unravelling appropriate and efficient healthcare collaboration

It has been increasingly recognised that the ideal of integrated patient-centred care requires greater collaboration and co-ordination between healthcare providers and agencies and this is not best delivered by competition which locks patients into fragmented, siloed, disconnected care services. Co-creating and co-designing systems of care around the expressed needs of local populations requires a sharing of ideas and collective action by different healthcare stakeholders. This has been the approach taken by many successful multi-site, multi-disciplinary quality improvement collaborations over recent decades, and is the same approach as that frequently articulated within new models of integrated primary-secondary care. Concrete examples of effective collaborations where rather than competing, public and private hospitals have formed partnerships to share costs which would otherwise be prohibitive include Joondalup Health Campus in WA, the new Royal Adelaide Hospital in SA and the new Sunshine Coast University Hospitals in Queensland. Another type of example is where a single tertiary hospital in a capital city, such as the Sir Charles Gairdner Hospital in Perth and the Royal Brisbane and Women's Hospital, serves as the state-wide referral centre or centre of excellence for a particular condition (in these cases for pituitary surgery and thyroid cancer respectively). Thus, rather than every hospital attempting to deliver every possible service in competition with its neighbours, each should develop its own strengths and niche, and should develop cross-referral and transfer procedures for access to specialised services that one or the other does not offer. Increased competition and contestability is to some extent antithetical to these collaborative approaches and to the maintenance of clinical centres of excellence and therefore appropriate exemptions should be carved out within any pro-competitive frameworks which are developed to ensure that these arrangements are not hampered.

Placing teaching hospitals at a competitive disadvantage

The vast majority of medical training occurs in public teaching hospitals; from undergraduate teaching through to pre-vocational medical training and into specialist training. However, the necessity of combining effective education with clinical care, if not appropriately recognised in hospital accounting and compensation systems, would be manifested in increased costs of performing simple procedures in these hospitals. Accordingly (absent special recognition) these hospitals would be penalised in a healthcare system that placed too great an emphasis on efficiency. Fortunately, the special role of teaching hospitals is recognised by the Independent Hospital Pricing Authority (IHPA), which is currently investigating the best means of compensating appropriately the value of teaching, training and research provided by these hospitals. It is important that the Commission is aware of this body of work and aware that it is still a work in progress, and that moreover Commonwealth funding only accounts for part of the funding of public hospitals. This means that public hospitals which perform these essential teaching and training functions may not have their contributions recognised and would not be able to compete on a 'level playing field' with other hospitals. In economic terms, teaching hospitals provide a positive externality to the rest of the healthcare system and increased and unregulated competition could risk unravelling this.

'Cherry picking'

'Cherry picking' is a well-documented phenomenon which occurs where competition between public sector providers and for-profit providers has been introduced, resulting in the non-government

providers ‘cherry picking’ the most profitable parts of the market and leaving the incumbent public sector providers with those groups who are costlier to serve. In the context of the hospital sector, cherry picking can occur if private or for-profit providers are not willing to take on more complex cases due to the clinical and financial risk associated with these patients, thus leaving public hospitals (or hospitals not managed by private or for profit providers) as the only providers to treat these patients. This in turn results in public hospitals assuming a higher cost burden than before and leaves them looking even less efficient compared to the pre-competition period.

Unfortunately cherry picking is not just a theoretical concern; it has been robustly documented as one side effect of recent changes to the UK NHS system. In particular, a recent study established that where UK public hospitals competed with other public hospitals in a similar locality this generated improvements in productivity, but where the primary competition for these public came from local private hospitals, not only did these improvements not occur but the public providers were left with a more costly case-mix of patients and recorded increases in post-surgical length of stay.⁶ Cherry picking can be avoided with appropriate provisions such as ensuring that even non-government providers meet some minimum community service standards and therefore cannot simply ‘cherry pick’ the most profitable patients. Alternatively, payment models could be weighted in a manner that recognises the higher cost of managing patients with chronic and complex conditions.

There are different kinds of ‘pro-competitive’ reform

The theoretical economic literature on competition in healthcare provides a more nuanced view of its costs and benefits than does the simple mantra that more competition is always better. In particular, we direct the Commission’s attention to the many rigorous theoretical models of hospital competition. These conclude that while increased competition can improve clinical outcomes, this is only if the prices of hospital services are appropriately fixed or regulated⁷; and that reductions in quality can result (such as for instance an increase in mortality) if providers are allowed to compete on price.⁸

It has been argued that the conflicting results of studies of NHS reforms may reflect the different kinds of reform that were introduced in different time periods⁹:

- The so-called ‘internal market’ reforms to the NHS introduced in the 1990s created a set of buyers, funded by central government (‘fundholders’), who were free to purchase healthcare for their populations from both public and private sector providers. In other words, not only did these reforms pit public sector providers against non-government providers but also introduced an element of price-based competition because it was possible for private providers to secure a contract from fundholders by effectively underbidding government providers. While this period of reform saw some improvements in waiting times, it also led to reductions in ‘unobserved quality’ (i.e. indicators of quality of care that were not being actively monitored by government performance data but which were measured in later studies).¹⁰
- The NHS reforms of the 1990s were reversed by later governments but a new phase of pro-competitive NHS reforms was introduced from the 2000s which were arguably an improvement on the ‘internal market’ reforms because of two important features. Firstly prices for elective care were set centrally using a prospective payment system (similar to how prices are determined under Activity Based Funding by IHPA), which effectively meant that there were limits placed on ‘price competition’, which, as the theoretical literature

⁶ Cooper Z, Gibbons S, Jones S, McGuire A. Does Competition Improve Public Hospitals’ Efficiency? Evidence from a Quasi-Experiment in the English National Health Service. CEP Discussion Paper 2012.

⁷ Gaynor M. What Do We Know About Competition and Quality in Health Care Markets? CMPO Working Paper Series No. 06/1512006; Brekke KR, Cellini R, Siciliani L, Straume OR. Competition and quality in health care markets: A differential game approach, *Journal of Health Economics* 2010; 29(1): 508-523.

⁸ Gaynor M, Town RJ. Competition in health care markets. National Bureau of Economic Research (NBER), Working Paper 17208.

⁹ Cutler H. Competition in health and human services. 2012 Presentation, Centre for the Health Economy. Macquarie University.

¹⁰ Propper C. 2012, Competition, incentives and the English NHS, *Health Economics*. 2012;21:33-40

previously cited suggests, prevents hospital competition from degenerating into a 'race to the bottom'. Secondly there was a greater effort placed on improving the availability of data on quality and other attributes of care.¹¹ The reforms of the 2000s involved providing patients undergoing elective surgery with the choice of four to five hospitals (including one private hospital) and information on the quality, timeliness and distance to care of the various hospitals on offer. It is also worth noting that these reforms were accompanied by other measures such as greater autonomy to managers of high performing hospitals and substantial growth in the health budget. These additional elements may also have aided the move to enhanced user choice. These more nuanced reforms to the NHS have generally yielded better results including improvements in hospital mortality rates and other indicators of clinical quality¹².

Lack of excess capacity in the hospital sector

While it is tempting to subscribe to the ideal of public hospitals striving against one another to attract more users, this ignores the reality of the current constraints they face which means that the more attractive public hospitals may simply find themselves overloaded, leading to increased congestion in these hospitals. Long waiting lists for elective procedures, extended waiting times for access to Emergency Departments, and the postponement of planned elective surgeries on account of unplanned emergency admissions, are all clear evidence of insufficient capacity in some public hospitals, which infers that these hospitals would struggle to provide an effective service for the larger numbers of patients they might attract if they were encouraged to compete for patient with neighbouring hospitals. Part of this lack of excess capacity is due to specific constraints, including infrastructure. For instance, rural and regional public hospitals experience problems with retaining an adequate workforce with, at times, competition between public and private sector providers. These issues would need to be resolved before increased competition could generate optimal outcomes.

1.3 Public reporting of hospital performance data

In healthcare, asymmetry of information between patient and provider puts the former at a disadvantage in deciding the value and worth of health services. While we strongly welcome the move towards full disclosure of potential benefits and harms of different care options to patients to support and drive shared decision-making, there will still be many instances in which the best informed patient will find it difficult to distinguish between high-value and low-value care. Despite the proliferation of websites reporting various metrics of healthcare performance such as MyHospital in Australia or NHS Choices in the UK, nuanced data at the level of individual providers or specialty groups are still to be developed. In any event, evidence suggests that the public may have trouble understanding and making healthcare decisions using such data and may distrust their findings¹³. Therefore, as a precondition to this approach being successful, the information reported must be timely, clinically meaningful and consumer relevant. It also requires an increased level of health literacy among the general population.

The argument that transparency pushes up standards is still subject to considerable debate¹⁴. There is some tentative evidence of benefits associated with better information and public reporting

¹¹ Propper C. 2012, Competition, incentives and the English NHS, Health Economics. 2012;21:33-40

¹² Cooper Z, Gibbons S, Jones S, McGuire A, Does hospital competition save lives? Evidence from the English NHS patient choice reforms, The Economic Journal. 2011; 121: 228-260; Bloom N, Propper C, Seiler S, et al. The Impact of Competition on Management Quality: Evidence from Public Hospitals. CEP Discussion Paper No 983 2010; Gaynor M, Propper C, Seiler S. Free to Choose? Reform, Choice, and Consideration Sets in the English National Health Service. American Economic Review. 2016; 106(11): 3521-57.

¹³ Scott IA, Ward M. Public reporting of hospital outcomes based on administrative data: Risks and opportunities. Med J Aust 2006; 184: 571-575.

¹⁴ Scott IA, Ward M. Public reporting of hospital outcomes based on administrative data: Risks and opportunities. Med J Aust 2006; 184: 571-575.

although it appears that this benefit is less driven by more careful consumer choice¹⁵ than by hospitals themselves being better motivated to increase their standards due to the publication of performance data.¹⁶

Notwithstanding all this, we are supportive of increased transparency around the quality and efficiency of hospitals and we note the work that the Australian Commission on Safety and Quality in Health Care has done in this area. We also support the collection and reporting of more nuanced data on the performance of individual hospitals. However this is subject to the caveat that the reported data on hospital performance needs to be adjusted to take account of the case-mix of each hospital and other factors beyond their control which may nonetheless influence their performance ratings, including the characterisation of their patient cohorts (such as measures of relative socioeconomic disadvantage). This is important to ensure that hospitals are not unfairly penalised if they take on a greater share of risky or more complex caseload. As highlighted earlier, not adjusting performance data to take account of caseload can also encourage hospitals to engage in 'cherry picking'.

There is the risk that a badly implemented or specified performance measurement framework would encourage hospitals to 'game' the system without necessarily improving their overall quality of care, for instance, by reducing their activity in unmeasured but equally important dimensions of care. Finally, a public reporting system should be supported by an adequately resourced and impartial complaints handling framework, because complaints (including, but not limited to, vexatious ones) could become even more reputation-damaging under such a system than they already are.

Given these complexities of implementation, while we support a fresh look at public reporting of hospital performance data, it would be premature to consider public reporting of performance at the **individual practitioner level** at this point in time.

¹⁵ Shekelle PG, Lim Y-W, Mattke S, Damberg. Does Public Release of Performance Results Improve Quality of Care? A systematic review. The Health Foundation 2008.

¹⁶ Fung C, Lim Y-W, Mattke S, et al. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of Internal Medicine*. 2008; 148: 111–23.

2. End of life care

2.1 Complementary measures and investments

This section looks at specific complementary measures which could be undertaken to enhance user choice in end of life care and facilitate the transition to an end of life care sector that is more receptive to the needs of patients and their carers.

Better integration to reduce unnecessary hospitalisation

Two elements in the 'bundle' of end of life care that should be better integrated into the coordination of care are general practitioners and residential aged care facilities (RACFs).

- General practitioners (GPs) should be more involved in discussion and decision-making, particularly by engaging their patients in conversations about prognosis, goals of care, preferred place of care, and advance care planning - whilst acknowledging uncertainties.
- RACFs, where a significant share of the terminally ill resides, should be better integrated into end of life care in a manner that reduces unnecessary hospitalisations. In this respect, it is worth looking at the Scandinavian model which assigns on-site practitioners or senior nurses to attend to simple cases to avoid unnecessary hospitalisation. RACFs, when considering sending patients to acute care facilities, could also take into account the end of life decisions which have already been made in advance. GPs could cooperate with RACFs, for instance, by providing a telephone consultation which could be itemised, either under the current relevant items, or as new MBS items. RACFs should also have systems in place to receive advance care plans and action them.

More generally there are some noteworthy private sector models that have been successful in facilitating the integration of end of life care across hospital, hospice and home, such as the Silver Chain group in Western Australia and the Macmillan model in the UK. For instance, the Macmillan Specialist Care at Home Model relies on a consultant-led multidisciplinary team, early referrals to the team during active treatment, routine advance care planning and home or community setting based clinical interventions with coordination and shared care.¹⁷ These merit a closer look for lessons on how to integrate care successfully. In investigating models for better integration of end of life care into the healthcare system, the Commission should also consider a role for a designated Navigator to advise and guide the integration of services for particular patients.

More investment in training clinicians at all points in the care spectrum and provision of better information

Better coordinated and integrated end of life care presupposes that all healthcare professionals that could play a role in recognising the need for and providing end of life care services are appropriately trained in this area. Thus we recommend that more investment is needed to:

- Conduct more research on prognostication and the alerting symptoms and signs of the approach of end of life
- Train practitioners in identifying patients who are at risk of dying, applying relevant ethical and legal frameworks, as well as the best way to discuss, communicate with different parties and resolve conflicts should they arise
- Sensitise practitioners to the existence of different patient needs and values, cultural views and religious obligations.

The dearth of information that is currently available on end of life care should also be remedied. Thus we support the formulation and regular publication of key performance indicators by a relevant government agency to facilitate comparison of quality of death across sectors of the end of life space.

¹⁷ <http://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/specialist-care-at-home.html>, last accessed on 17/2/2017

More can also be done to optimise the provision of discharge information that the 'next' service provider in the end of life care chain requires. This task is currently often delegated to the most junior member of the team. Streamlining patient information, including through e-health records, will ensure that all health professionals involved in the care of the patient, whether in the public or private healthcare sector, have access to key information: discharge summaries, treatment and management plans (including information regarding substitute decision-maker appointments, advance care plans, goals-of-care plans, and resuscitation orders).

2.2 Special considerations for paediatric palliative care

Paediatric palliative care is a generally under-recognised area which merits more attention, particularly as the death of a child is relatively uncommon in developed countries which means that

- expectations from families and health professionals are high,
- discussing death and dying is avoided,
- skills in discussing death are difficult to acquire/maintain, and
- the community is often ill-equipped to support the family of a dying child

The care needs of these patients are also very variable due to the diverse range of life-limiting conditions that children can suffer from and variations in developmental/neurological status. The services involved in providing care to a child with a life limiting condition can be complex and generally straddles community and hospital care. Specialists in this area often experience difficulties in facilitating general practitioner care for this group of patients and this has been a challenge in providing good end of life care.¹⁸ In practice this means that paediatric palliative care specialists have to work with adult community palliative care providers to try and ensure the provision of appropriate care.

Parents have complex roles as care-givers and proxy decision makers and advance care planning is obviously a difficult issue for paediatric patients. Better support is required so decision-makers, parents, carers and the patient have a choice of location of care during the end of life. Parents often choose to care for their child at home but difficulties arise when support isn't accessible for the parents, the patient and also for the siblings, whose care can be inadvertently de-prioritised during this difficult period. Parents and carers need more and better information so that they can make choices which are right for their families. Greater flexibility in the system is also needed so that if it becomes too difficult for a patient to be cared for at home they can subsequently be moved to another location such as a hospice or hospital.

Further information and case studies on adult and paediatric end of life issues are available in the RACP's recent position statement - ['Improving Care at the End of Life: Our Roles and Responsibilities \(May 2016\)](#).

¹⁸ Written submission to RACP by Specialist Physician in Paediatric Palliative Care.

3. Human services in remote Indigenous communities

Our comments and recommendations in this section primarily apply to health services organisations in remote Indigenous communities because these are the service organisations which the experience of our members most qualifies us to comment on. This does not necessarily mean that our recommendations may not also be of broad applicability to other human services provided in these communities but we defer to the expertise of other organisations in commenting on non-health related human services.

We urge caution when thinking of applying a pro-competitive model to service delivery to remote Aboriginal and Torres Strait Islander communities. Indigenous Australians are a very vulnerable population with significant disparities in socioeconomic outcomes from the rest of Australia and they face unique challenges accessing care. Given the existing policy priorities to 'close the gap' in health outcomes with non-Indigenous Australians, any changes must not focus on generating cost savings but on improving the quality of service delivery and supporting good access to the necessary services. In addition, Aboriginal and Torres Strait Islander communities are far from homogenous, so taking what may work well in one setting and attempting to transfer the same model to another community may be ineffective, as the success of many programs is not only place-dependent but also time- and provider-dependent and the model might not be relevant to every community.

Moreover, community engagement is vitally important and has been demonstrated many times as a fundamental element of effective service delivery:

- community engagement can facilitate appropriate feedback to service providers on how to best design and structure services to meet the needs of the community¹⁹
- it has a positive impact on sociocultural outcomes such patient satisfaction and confidence in the service, which may in turn enhance adherence to treatment regime and thus improve clinical outcomes.

When aiming for increased user choice for Aboriginal and Torres Strait Islander people, it must be recognised that, for many, their current engagement and involvement in personal decisions around their health care is much less than for most non-Indigenous Australians. There are a range of reasons for this, including the Indigenous perspective of health often not being recognised within the western models of care that Australia tends towards, institutional racism, the lack of cultural competency and safety within healthcare organisations and from healthcare professionals, and the generational impacts of colonisation.

For people living in remote communities these are compounded by the increased costs and time associated with the 'tyranny of distance', issues associated with people having to leave their communities and land including the loss of family and social support, as well as language difficulties. These all combine to render the task of ensuring informed decision-making even more difficult. Informed decision-making presupposes educated decision-making, and patient education can be difficult where English is a third or fourth language, where there are literacy issues, or fundamentally different world views. Appropriate user education therefore requires a true engagement which is relationship-based, and which takes time to develop.

Unfortunately, there is a strongly warranted concern expressed by stakeholders that contracting-out services for Aboriginal and Torres Strait Islander people can result in disproportionate service provision by NINGOs (non-Indigenous NGOs) and/or mainstream services²⁰. The fundamental situation is that the organisation that can present the best bid (and NINGOs and mainstream organisations may well, more often than not, be more experienced and resourced to write bids), is

¹⁹ Stewart J, Lohoar S, Higgins D 2011. Effective practices for service delivery coordination in Indigenous communities. Resource Sheet 8. Produced by the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare and Melbourne: Australian Institute of Family Studies

²⁰ Senate Finance and Public Administration References Committee Report on Commonwealth Indigenous Advancement Strategy tendering processes March 2016.

not necessarily the organisation that can provide the most appropriate and effective service. Direct links with the community – and with services set up by and for Aboriginal people – have an inherent and proven advantage, and are of fundamental importance. For instance, the ability of Aboriginal community controlled health services to deal with the impact of social determinants and lower health literacy is due, in part, to the fact that they are significant providers of Aboriginal employment and training.²¹ Moreover, Indigenous staff will have an advantage due to their ability to provide culturally safe care together with pre-existing contacts, local knowledge, and trusted relationships, which can facilitate the linkage between Indigenous individuals and families with services and providers.²²

Thus we believe that there should be an important qualification to pro-competitive principles, namely that Aboriginal and Torres Strait Island organisations should be designated as preferred providers unless it can be clearly shown that some other arrangement can produce better results in terms of both access to, and quality and outcomes of services. In addition, employment of Aboriginal and Torres Strait Islander people in service delivery, or more generally, a commitment to upskilling an Indigenous workforce for long term service delivery should be one of the performance indicators used for selecting the best provider. This is because the limited evidence available strongly indicates that services set up and delivered by Indigenous people perform as well as if not better than more ‘mainstream’ services²³, particularly in crucial areas of health for the Indigenous population such as risk factor monitoring and management of hypertension and chronic disease. There is also evidence that access and service utilisation are significantly higher for community controlled health services delivering antenatal care than more mainstream services, which may result in health gains as evidenced by birth weights.²⁴ Finally, there is evidence that these community controlled health services can improve sociocultural outcomes such as patient satisfaction, confidence in the service, and adherence to treatment regimens.²⁵

Other issues which need to be considered include the significant loss of corporate memory and other impacts of the high levels of staff turnover in NGOs. Caution is also required in policy which results in the merging of providers, as this has not worked well in terms of regional councils in the Northern Territory.

Any reforms should also move to reduce the current reliance on locum staff in remote community healthcare. This impacts the service’s ability to maintain continuity of care for patients and to provide services such as health promotion aiming for longer-term lifestyle changes and preventive care. Staff engaged on a short-term basis are likely to have a far more limited understanding of local community needs and limited, if any, connections with the community and other providers. An alternative model may involve nursing and medical staff serving in rotating rosters, flying in and out for one to three months at a time. While initially this might seem costly, the experience of having the same staff alternate with each other over very long periods of time (up to 20 years) suggests that this model would be more cost-effective in the long run, and avoids staff burnout, while providing good long-term care.

²¹ Panaretto KS, Wenitong M, Button S, Ring I. Aboriginal community controlled health services: leading the way in primary care. *Med J Aust* 2014; 200 (11): 649-652

²² Flaxman S, Muir K & Oprea I 2009. Indigenous families and children: coordination and provision of services. FaHCSIA Occasional Paper no. 23, Canberra: Department of Families, Housing, Community Services and Indigenous Affairs

²³ Panaretto KS, Wenitong M, Button S, Ring I. Aboriginal community controlled health services: leading the way in primary care. *Med J Aust* 2014; 200 (11): 649-652.

²⁴ Jan S, Conaty S, Hecker R, Bartlett M, Delaney S, Capon T. ‘An holistic economic evaluation of an Aboriginal community-controlled midwifery programme in Western Sydney’. *Journal of Health Services Research and Policy* 2004; 9(1): 14-21

²⁵ Jan S, Conaty S, Hecker R, Bartlett M, Delaney S, Capon T. ‘An holistic economic evaluation of an Aboriginal community-controlled midwifery programme in Western Sydney’. *Journal of Health Services Research and Policy* 2004; 9(1): 14-21; Campbell S, Brown S. ‘Maternity care with the women’s business service at the Mildura Aboriginal Health Service’. *Australian and New Zealand Journal of Public Health* 2004; 28(4): 376-82; Aspin C, Brown N, Jowsey T, Yen L, Leeder S. ‘Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: a qualitative study’. *BMC Health Services Research* 2012; 12: 143.

Conclusion

Until further detail on proposed reforms is provided, it is premature to endorse any particular models for introducing greater competition, contestability and user choice in the human services sector. However it is clear that if these were to be introduced into public hospitals, a number of complexities would require addressing:

- The significant constraints on effective user choice due to socioeconomic factors and the complex care needs of some patients which, if unaccounted for, could lead to the exacerbation of inequities in access to healthcare.
- The complexities of managing workload allocation and teamwork in public hospitals which suggests that imposing 'choice of specialist' on the public hospital system (as opposed to other forms of user choice) would not be a viable approach.
- The importance of collaborative and cooperative arrangements in many healthcare contexts, particularly to facilitate better integrated care, which could be considered antithetical to a more competitive approach.
- The fact that the vast majority of clinical education occurs in public acute teaching hospitals, (which is still undercompensated under existing funding arrangements for this essential role) and that, absent special recognition, these hospitals would be penalised in a healthcare system that placed more emphasis on efficiency.
- The risk that under unconstrained competition, public hospital providers would end up caring for the most difficult to manage patients or potentially cutting back inappropriately on essential costs of care. The latter risk can be managed by ensuring that competition is on the basis of quality rather than price or cost.
- Ensuring that public reporting of hospital performance data does not induce public hospitals to simply cut back on dimensions of care that are not being appropriately measured or monitored.

On end of life care, the RACP recommends the following complementary measures which could enhance user choice in end of life care and facilitate the transition to a more responsive end of life care sector:

- Better integration of services to reduce unnecessary hospitalisation
- More investment in training of clinicians at all points in the care spectrum and provision of better information on quality of care in the end of life sector to facilitate patient/carer choice.

We also note that paediatric palliative care is a generally under-recognised area which merits more attention, particularly as the care needs of these patients are especially variable with special challenges for advance care planning.

The RACP is generally sceptical of the wider application of competition, contestability and user choice in the provision of human services (and particularly health services) in remote Indigenous communities because of the potential for adverse impacts of an already disadvantaged and vulnerable population who experience significant disparities in socioeconomic outcomes from the rest of Australia and particular existing barriers to accessing timely, appropriate care. Given the existing policy priorities to 'close the gap', changes must not focus on generating cost savings but on improving the quality of and access to service delivery. If any reforms are introduced for these communities, we strongly recommend that Aboriginal and Torres Strait Island health services organisations are designated as preferred providers unless it can be clearly shown that some other arrangement can produce better results in terms of both access to, and quality and outcomes of services. In addition, employment of Aboriginal and Torres Strait Islander people in service delivery, or more generally, a commitment to upskilling an Indigenous workforce for long term service delivery should be one of the performance indicators used for selecting the best provider.