Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Response to the Productivity Commission's Reforms to Human Services Issues Paper

Who we are

Central Australian Aboriginal Congress (Congress) is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people living in and nearby Alice Springs each year including five remote communities; Amoonguna, Ntaria (and Wallace Rockhole), Ltyente Apurte (Santa Teresa), Utju (Areyonga) and Mutitjulu.

Background

This submission responds to the requests for information contained in the Productivity Commission's *Reforms to Human Services Issues Paper* of December 2016[1]. It builds upon Congress' earlier submission to the Productivity Commission's report *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*[2].

In our earlier submission, we expressed in principle support for the structural goals identified in the Commission's Report [p129] of better coordination and service integration; more stable policy settings; and greater community control and engagement. However, on the basis of both the evidence and our long experience in delivering services in remote Aboriginal communities, we concluded that:

> *prioritising user choice and encouraging competition in service delivery is both unrealistic and unlikely to improve health outcomes in remote areas.*

Instead, we outlined a history of achievement in the first decade of this century which showed that the Northern Territory, alone of all jurisdictions, was on track to meet Close the Gap targets in life expectancy. These gains were founded on collaborative planning and the allocation of resources according to need to existing health service providers. However, when government policy shifted to encourage greater competition in tendering, the use of multiple service providers (many of them mainstream, non-Aboriginal organisations) increased, and improvements in health outcomes ceased. On this basis, we strongly recommended that remote Aboriginal health services were one area where competitive funding in service delivery will not improve outcomes for Aboriginal people.

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Aboriginal health in Aboriginal hands.

This view was supported by both the evidence and the experience of many other service delivery organisations who made submissions to the Productivity Commission. It was also supported by the Australian Senate's Finance and Public Administration References Committee inquiry into the *Commonwealth Indigenous Advancement Strategy tendering processes*[3] which described in detail the negative effects of that program's emphasis on competitive tendering.

Many of the arguments against increased competition – for example, how it leads to a system marked by fragmentation, duplication and inefficiency – were reflected in the Commission's own *Preliminary Report*[4]. However despite documenting such issues, that report identified remote Aboriginal communities as one of the six priority areas "where introducing greater competition, contestability and informed user choice could improve outcomes for people who use human services and the community as a whole" [p2].

We wish to place on record here our continued opposition to the blanket imposition of policies that encourage greater competition and contestability in the delivery of health and community services to remote Aboriginal and Torres Strait Islander communities. In our context, the evidence is in: these are failed policies. While reform is needed, prioritising user choice and encouraging competition is both unrealistic and will not improve health outcomes in remote areas.

About this submission

We nevertheless acknowledge that the Productivity Commission is seeking more information in its current *Issues Paper* on important topics such as remote area service delivery challenges; the strengths and weaknesses of the current service delivery model and the experience of Aboriginal people and service providers within it; ways to improve the effectiveness of services; and how to improve commissioning arrangements. In recognition of this – and because it is critically important that any reforms assist Aboriginal people in remote areas to live longer and healthier lives – we present this current submission.

Note that Congress, as a provider of comprehensive primary health care services, addresses not just clinical issues but also the social determinants of health, for example, through providing services supporting early childhood development, through advocacy for healthy public policy (e.g. appropriate alcohol controls) and through employing and training a local, Aboriginal workforce. Thus, while we focus our response on Section 9 relating to *Human services in remote Indigenous communities*, there is much in our response which is also applicable to the broader questions in the Commission's *Issues Paper*.

General points

The key points that we would like the Commission to take into account in recommending reforms are as follows; evidence for these points is found throughout the rest of our submission.

1. **Commissioning for health and wellbeing services to remote Aboriginal communities should explicitly recognise Aboriginal Community Controlled Health Services (ACCHSs) as preferred providers.** This is due to a range of inter-linked structural advantages they have in delivering services and hence improved health and wellbeing outcomes compared to non-Indigenous services (government or private). These advantages include:

- **a comprehensive model of primary health care** with a focus on clinical services to address the existing burden of health and on prevention and population health initiatives, including through addressing the social determinants of health.

- **the provision of responsive, evidence-based care.** The ACCHS sector in the Northern Territory has a practice of Continuous Quality Improvement (CQI) built up over decades of service-delivery and collaboration with other providers and government. This makes ACCHSs such as Congress leading centres for evidence-based innovation and responsiveness to population and service needs, and important sites for developing the future evidence and research base.

- **culturally secure services:** ACCHSs are able to provide their effective evidence-based care within a culturally secure setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong historical relationships with the communities that they serve.

- **better access, based on community engagement and trust:** a strong practice of community engagement founded on strong relationships with the community, in turn based on a sense of ownership and history (many ACCHSs such as Congress have been serving their communities for many decades). Aboriginal people consistently prefer to use ACCHS over mainstream services giving them a strong advantage in addressing access issues.

- **Aboriginal governance**: individuals and communities are encouraged and enabled to participate in decisions on service delivery, including though formal governing Boards.

- **an Aboriginal workforce**: community-controlled services are significantly better at attracting, training and retaining Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity building in the Aboriginal community.

- **integrated services**: ACCHSs such as Congress are single health service providers of a range of services, allowing for multidisciplinary teams to provide effective integrated care, and to support complex patients with multiple health and social needs.

- **high levels of accountability:** ACCHS are highly accountable to their funders through robust data collection and a reporting regime which is above the requirements of mainstream health and wellbeing services.

This position is consistent with the Senate Inquiry's[5] recommendation 3 which states 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.*

2. **Reforms must recognise that collaborative, needs-based planning and resourcing processes are essential to make population-level gains in health and wellbeing.** Such processes must involve all major resource streams, and involve both levels of government, the ACCHS sector, and other key players such as Primary Health Networks. Reforms must recognise that:

    - **the recent policy emphasis on competition and contestability in the Northern Territory has stalled health gains** by frequently undermining Aboriginal organisations and favoring mainstream NGOs which are unable to duplicate the advantages of ACCHSs in service delivery (see point 1 above).

    - **competitive tendering has also led to a fragmented and disjointed service system and a lack of Aboriginal input and leadership into service delivery**. Mainstream NGOs do not have strong links with the community or other local service providers, nor do they have the long-term commitment required for sustainable and effective service provision.

    - **the commissioning cycle should therefore include collaborative needs-based planning, a focus on outcomes that contribute to closing the gap and direct/select tendering to ACCHSs.** Open competition should only occur in the absence of an Aboriginal community-controlled health service provider/s.

    - **all health and wellbeing services in remote communities should be preferentially transitioned to Aboriginal community control,** including through extending the reach of existing services where they so desire. Adequate supports for such organisations may need to be provided.

    These positions are supported by the recommendations of the Senate Inquiry into the Indigenous Advancement Strategy, namely:

    > *Recommendation 1: … that future tender rounds are not blanket competitive processes and are underpinned by robust service planning and needs mapping*

    and

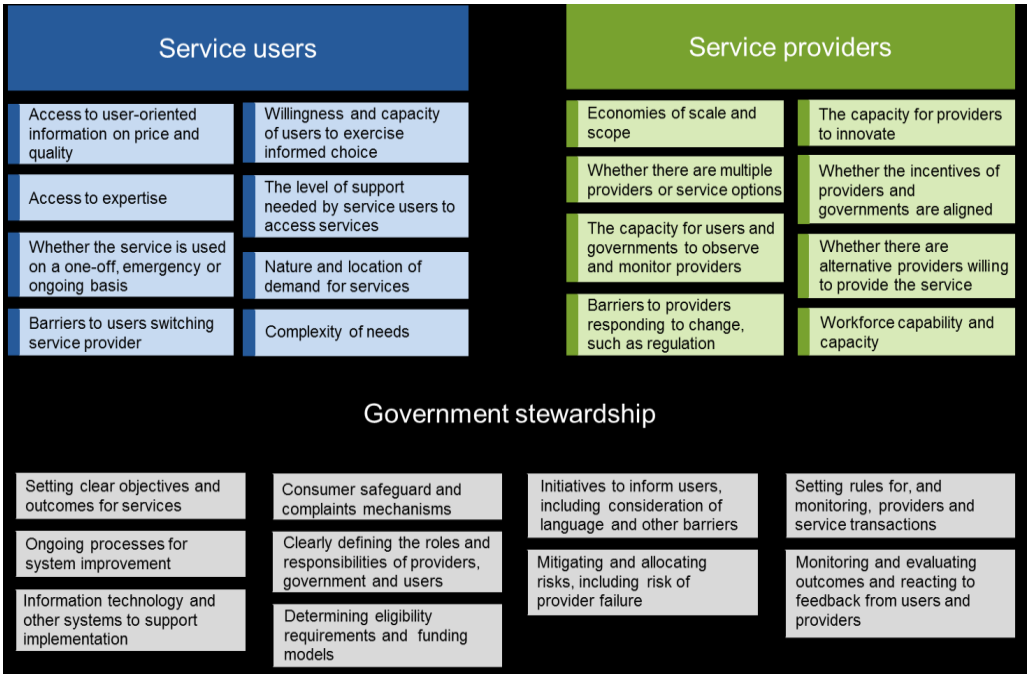
    > *Recommendation 2: … that future tendering processes should be planned strategically, with a clear sense of service gaps and community need based on consultation with local services and communities.*

Response to specific questions

1. Tailoring reform options

REQUEST FOR INFORMATION 1

The Commission is seeking feedback from participants on whether figure 1 reflects the characteristics that should be taken into account when designing reforms to service provision for the six priority areas considered in this inquiry. What other characteristics should the Commission consider?



Primary health care services need to be acceptable and affordable to be accessible to Aboriginal people (see 4.4.3 for further detail). Access to primary health care services is vital for health outcomes. It is therefore recommended that under 'Service providers' include 'Community Acceptability' and 'Affordable'.

Human services in remote Indigenous communities

2. The current model of service provision

REQUEST FOR INFORMATION 32

The Commission is seeking information on service delivery challenges in remote Indigenous communities, including:

- **how service providers could overcome the challenges associated with distance such as the high cost of service provision and difficulties accessing infrastructure (for example through the use of technology)**
- **examples of the costs faced by service providers in remote areas and how they differ to those for similar services in regional and urban areas (cost data would be particularly welcome)**
- **strategies to address the challenges of recruiting, training and retaining staff**
- **ways service delivery could be adapted to better meet the needs and preferences of Indigenous Australians living in remote communities (for example, how service delivery could better respond to the higher mobility of Indigenous Australians).**

2.1. Supporting the uptake of technology

For health services, technology such as Telehealth is making primary and specialist care more accessible to people in rural and remote areas. Technological innovations are improving the range of services that can be provided without requiring patients to travel a long distance. [6] Despite this, the

uptake of telehealth in rural and remote communities has been slow and is yet to achieve its full potential with consultations comprising less than 1 per cent of total consultations..[7,8,9]

To increase the uptake of technologies such as telehealth, in rural and remote areas Congress advocates for:

- An audit to assess the current IT infrastructure in remote communities to ensure it has sufficient capability to enable technological innovations to be used in all remote communities. Following the audit, there will need to a program to build the required infrastructure in all remote communities that currently do not have adequate high speed, IT infrastructure.

- the recognition of a number of telehealth services as Medicare Benefits Schedule (MBS) items, and to allow salaried health professionals to claim these items within rural and remote services.[10]

- MBS items to support point-of-care (POC) pathology testing. POC testing provides onsite, rapid pathology results and diagnostics leading to timely initiation of appropriate therapy and/or facilitation of linkages to care and referral. For example, time from HbA1c sampling to follow up consultation in remote settings has been reduced from 24 days to same day consultation with the doctor.[11] POC testing is particularly useful in remote areas that do not have easy access to a laboratory and is simple enough to be used in remote primary care clinics. This is improving the management of both chronic and acute conditions and is an effective screening tool in standard consultations.

2.2. Rural workforce

The foundation for a sustainable, workforce in rural and remote areas requires access to adequate pre-school, primary and secondary education and includes local training opportunities. Once this foundation is laid, specific training in health disciplines must be both culturally secure for the trainees, and result in skilled, competent professionals who are enabled to make a contribution to the health of their communities. Support should be given to ACCHSs and other primary health care agencies to employ and train clinicians locally.

Furthermore, professional training options, such as post graduate courses, should be increased in rural and remote areas. The current lack of training places means that many trainees in clinical psychology for example, leave the Northern Territory to attend training in the metropolitan areas and do not return.

Recruitment and retention of health professionals, particularly doctors and clinical psychologists, remains a challenge in rural and remote areas. There is still a need to address workforce maldistribution, through a combination of incentives to practice in remote areas, for example, the geographic restriction of provider numbers and rural loadings on MBS items.[12]

2.3. Working with mobility

The mobility of Aboriginal people in remote Central Australia can seriously impact service provision including continuity of care and availability of resources to meet need, especially for organisations

not well connected with the local community and other local Aboriginal organisations. For example, cultural business can bring large numbers of people into some remote communities for short periods of time, potentially affecting clinic and other services capacity and resources. Critical to managing such issues are strong links to and cultural knowledge of the community, allowing services to:

- predict events that may create movement of people across communities (e.g. ceremony, Sorry Business, local sporting events, etc);
- share information and plan collaboratively with other providers and agencies including existing local Aboriginal organisations such as regional councils, Land Councils, housing associations, and other health and social care providers;
- implement modified services to take account of temporary population shifts for example through increasing local clinic staff to accommodate population increases; ensuring clients who are traveling have sufficient medications and prescriptions; and sharing health and related data as appropriate.

The uptake of My Health Records and shared clinical data arrangements across clinical services will also allow for better continuity of care, and reduce duplication or gaps in service provision.

REQUEST FOR INFORMATION 33

The Commission is seeking information on the current service delivery model for human services in remote Indigenous communities, including:

- **areas where outcomes for users are not being met (for example, particular programs, services, communities or user groups), the drivers behind this, and how they could be addressed through reforms to the way services are provided**
- **areas where arrangements are currently working well and do not require major change, the drivers behind this, and how similar arrangements could be applied in other areas**
- **whether services are well-targeted in terms of both the type and mix of services provided and the eligibility criteria that determine who can access the services. The experience of implementation of reforms to increase greater choice and competition.**

There is overwhelming evidence to support the use of ACCHS as the most effective platform for the delivery of health services to remote communities and hence achieve health and wellbeing outcomes (see 4.4 for further detail). Compromising the effectiveness of ACCHS is the current shift from needs-based planning to open competitive tendering. Additionally, multiple, short term funding streams for individual programs creates uncertainty, numerous reporting regimes and is problematic in attracting and retaining staff (see 4.4.7).

3. Evaluating reforms to increase competition and user choice

REQUEST FOR INFORMATION 34

The Commission is seeking information on the experience of users, providers and governments with the implementation of reforms to introduce greater user choice and competition, such as disability support services, including:

- **whether Indigenous Australians in remote communities where these reforms have been implemented have access to a variety of service options and providers**
- **whether the reforms have increased the effectiveness of service delivery in remote Indigenous communities, particularly the responsiveness of services to the needs and preferences of users and the quality of services**
- **the experience of new providers entering the market and existing providers transitioning to the new arrangements**
- **lessons from the implementation of these reforms, particularly where arrangements needed to be tailored to the circumstances of remote communities**
- **whether similar reforms would be feasible (and desirable) for other services and why.**

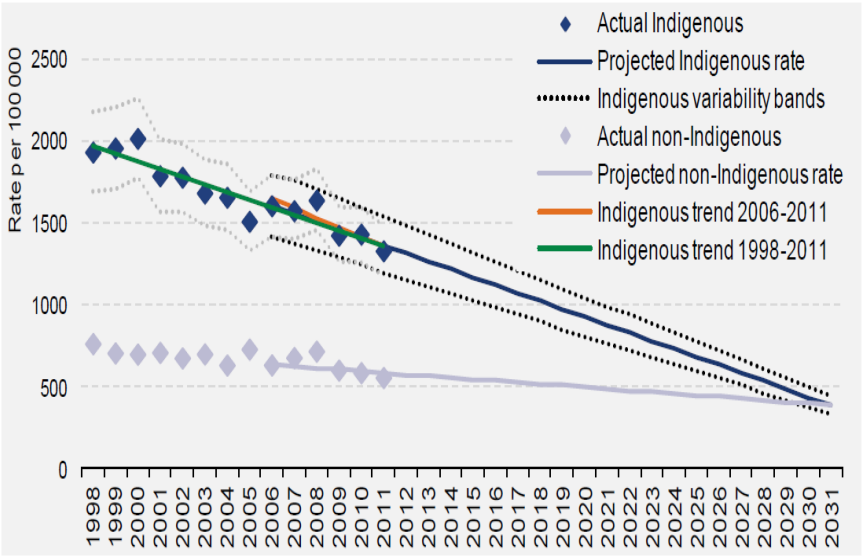
3.1. Successes of collaborative planning and support for community control (1990s to 2000s)

During the late 1990s and 2000s, the Northern Territory saw a successful response to the health and wellbeing needs of Aboriginal people through a system based on *collaborative needs based planning* and *transfer of services to Aboriginal community control* through a single provider at community or regional level.[13]

The collaborative needs-based planning which included the establishment and workings of the Northern Territory Aboriginal Health Forum contained challenges for all parties, both government and community controlled[14]. Nevertheless, the commitment to a cooperative approach and through it the allocation of resources according to need to existing health service providers improved the health system and its outcomes for Aboriginal people.

The following table from the Council of Australian Governments Indigenous Reform Council report in 2013 shows a more than 30% decline in all-cause mortality for Aboriginal people since the late 1990s, and that alone of all the jurisdictions, the Northern Territory was on track to meet its 'Close the Gap' Life Expectancy targets by 2031[15]:

Figure A.6 Death rates per 100 000 standard population, 1998–2031, Northern Territory



Source: ABS and AIHW—see Appendix D.

It is important to note that during this period, other key drivers of health outcomes such as educational attainment, average income, employment and overcrowding did not change in the Northern Territory[16] and that therefore the positive changes can be attributed to health system improvements including better access to primary health care supported by a planning process that was able to allocate new resources to where they were needed most. This resulted in the average per capita funding for primary health care increased from $700 per person in 1999 to more than $3000 per person in 2013. While the absolute increase in funding was important the priority allocation of new funds to the least funded communities and the enhancement of Aboriginal community control both made the health system more efficient.

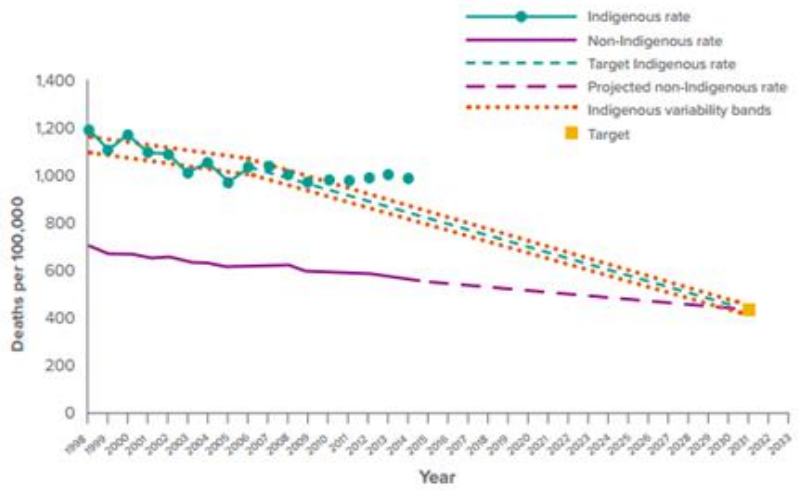
Evaluation of past efforts to improve service delivery to remote Aboriginal communities in the Northern Territory should also include the transfer of government-controlled services to Aboriginal community control on a regional basis, carried out in a number of locations in the Northern Territory in the late 1990s and 2000s. This process of 'transition to community control' has been evaluated in a recent publication, *The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples*[17]. Once again, this documented a number of challenges with the process of transition; however drawing on formal evaluations of these sites (Katherine West, Sunrise Health Service, and the Tiwi Islands), it also summarised the evidence for greatly improved services where services were moved to regional Aboriginal community control. These included:

- increased access to and improved quality of primary health services;
- improved delivery of culturally secure care;
- increased employment of local community members including Aboriginal Health Practitioners;
- a greater focus on public health, health promotion and prevention (including in relation to mental health and chronic disease); and
- improved community participation.

3.2. Recent shift towards competitive tendering (2009 onwards)

However, since 2009 the policy model shifted to emphasise competitive tendering and the increased use of mainstream non-Aboriginal community controlled providers, and these improvements have ceased, as shown in the next graph. The improvement has not only stopped in the Northern Territory but also in other jurisdictions. This is strong circumstantial evidence, supported by the on-ground experience of many health professionals and Aboriginal people, that open competitive tendering has contributed to a fragmented and disjointed service system that lacks Aboriginal input and leadership. It has facilitated the entry of numerous non-Aboriginal NGOs that do not have strong links with the community or other local service providers, have no history of successful service delivery in the challenging cross-cultural / infrastructure-poor environments of the Northern Territory, and no have no long-term commitment required for sustainable and effective service provision.

FIGURE 11: Overall mortality rates by Indigenous status: NSW, Qld, WA, SA and the NT combined 1998-2031



Source: ABS and AIHW analysis of National Mortality Database

This argument is supported by the Senate Inquiry into Commonwealth Indigenous Advancement Strategy[18] tendering processes in March 2016. The Inquiry highlighted the negative impact of the competitive tendering processes on service quality, efficiency and sustainability of services to Aboriginal people. It included the tendering process favoured larger mainstream organisations over smaller Aboriginal organisations that have fewer resources to make complex applications within short time frame, but that when it came to service delivery the tendering processes did not recognise the enhanced service delivery outcomes deliverable by Aboriginal organisations.

4. Increasing user choice and community voice

35. Request For Information

The commission is seeking information on ways to improve the effectiveness of human services provision in remote indigenous communities, including:

- **the scope for greater individual choice in remote Indigenous communities and whether there are particular services or user groups where greater individual choice would be feasible and desirable**
- **How governments can support users to make informed choices**
- **ways governments can improve how they engage with communities**
- **the scope for greater community-level involvement in service planning and in ensuring there are ongoing improvements in provision (for example, through co-design approaches where communities collaborate with government and providers to design services)**
- **how approaches to greater community-level involvement might be implemented (including the governance structures that would be required to support the proposed approach)**
- **what support communities (particularly smaller communities) would need in order to have a greater role in service planning (such as capacity building)**
- **how place-based approaches could be used to improve the effectiveness of service delivery in remote Indigenous communities (including examples of where place-based approaches have been successfully implemented in Australia and overseas)**

- **whether and why Indigenous organisations (such as ACCHOs) have been successful at achieving intended outcomes for people living in remote communities (information on governance arrangements, workforce capacity and capability, or the characteristics of the organisation, service or users that are most often associated with effective service provision would be welcome)**
- **factors that should be considered when balancing responsiveness of services to communities with accountability to those who fund the services.**

4.1. Scope and support for individual choice

A range of effective and quality services needs to be in place in remote Aboriginal communities before individual choice can be exercised; yet very few remote communities are ever likely to support such a range of 'competing' services that provide 'user choice'. As the Competition Policy review itself acknowledged:

> *… some markets will not have sufficient depth to support a number of providers including, for example, certain services in remote and regional areas. Ensuring access to services and maintaining and improving service quality in these cases increases the emphasis on well-designed benchmarking of services*[19]*.*

4.2. Government engagement and community

There is clear link between empowerment through community control and improving health outcomes.[20] Community controlled organisations are the infrastructure that supports and enables individuals in remote communities to engage in service delivery and inform decisions about the services they require.[21] For example, every Aboriginal person over the age of 18 years of age in the Congress catchment is eligible to become a Congress member. Membership is highly encouraged, free of charge and only members can vote in Board elections. Members can raise issues through the Board, through Congress staff or through a range of community engagement strategies including community consultations on new programs. This has provided community members with a sense of ownership over the service.[22] Investing in community-controlled organisations, will increase individual and community capability and capacity to make decisions about service delivery, as well as work with government.

A report by Flinders University found that Congress is a model for building into an organisation's governing structure the means for community participation in decision making and service planning – not just for Aboriginal people, but for community-based health services more generally.[23] Moreover, ACCHSs such as Congress have more mechanisms for accountability to the community and funders than that of mainstream primary care providers.

Governments can formally work with individuals and communities through organisations such as ACCHSs and through their peak, representative bodies e.g. National Aboriginal Community Controlled Health Organisation (NACCHO) and Aboriginal Medical Services Alliance Northern Territory (AMSANT). Forums such as the Northern Territory Aboriginal Health Forum (NTAHF) (see 4.3 below) facilitate collaboration between governments and community controlled organisations so that communities are involved in the planning and delivery of services through effective resource allocation.

4.3. Collaborative needs based planning in the Northern Territory – the Northern Territory Aboriginal Health Forum (NTAHF)

The NTAHF is the best example for joint planning and information sharing between government and Aboriginal communities for planning. Members of the Forum include:

1. AMSANT - representing the community controlled health sector
2. Commonwealth Departments of Health & Prime Minister and Cabinet
3. Northern Territory Department of Health
4. Northern Territory Primary Health Network.

The Forum seeks to increase the *effectiveness* of the health system, including through:

a) ensuring appropriate resource allocation
b) maximising Aboriginal community participation and control as a key element of sustainable, viable, effective and efficient health services
c) encouraging better service responsiveness to / appropriateness for Aboriginal people
d) promoting quality, evidence-based care
e) improving access for Aboriginal people to both mainstream and Aboriginal specific health services
f) increasing engagement of health services with Aboriginal communities and organisations.

Additionally, the Forum seeks to ensure that the social determinants of health are addressed through high level collaboration and advocacy outside the health system.

Collaborative needs-based planning through the Forum is supported by a set of agreed "core primary health care functions." These functions provide the basis for a rational approach to needs based funding, by specifying the core activities of Aboriginal primary health care practice including a range of clinical services, support services, social and preventative programs and policy and advocacy functions[24]. Funds are allocated effectively and equitably on the core services and programs needed in each health zone.

There have been three iterations of the core primary health care services model with the most recent and comprehensive version produced in 2011 in which there are five service domains[25] :

1. Clinical Services
2. Health Promotion
3. Corporate Services and Information
4. Advocacy, Knowledge, Research, Policy and Planning
5. Community Engagement, Control and Cultural Safety

Defining core services has been important to ensure access to evidence based services and programs according to need drives the allocation of resources, and delivers on the obligation of government to ensure all of its citizens' right to health are realised.

Along with the development of these core services has been the corresponding development of core primary health care indicators that enable each service to continually monitor and improve their services, and maintain accountability through reporting to their communities and to funding bodies.

While not without its challenges, this planned, collaborative approach to the application of funding resources to support sustainable, comprehensive primary health care has delivered significant improvements in health outcomes for Aboriginal people in the Northern Territory.[26,27,28] The Northern Territory and Commonwealth governments have shown great commitment to Aboriginal primary health care and to the Forum.

Furthermore the Northern Territory PHN has expressed appreciation for the collaborative, design-processes undertaken by the NTAHF which enabled it to allocate resources for Aboriginal people without recourse to an open competitive tendering process, particularly in Mental health and Drug and Alcohol treatment activities (attachment A). This includes its contribution to "strengthening the primary health care sector to ensure effective, coordinated, integrated and culturally appropriate Aboriginal and Torres Strait Islander health services responsive to community need."

A major risk to needs-based planning is that new funding is not necessarily being allocated under a core services approach or within the planning mechanism of the Forum (see 3.2).

4.4. The success of Aboriginal Community Controlled Services in health service delivery and health outcomes.

4.4.1. Effectiveness

Although they have a more complex and high needs population, ACCHSs are achieving health outcomes that are comparable or better than mainstream services.[29,30,31] Evidence points to improved health outcomes in mortality, sexual health, smoking cessation and cardiovascular programs, as well as maternal and child health outcomes, including birth weights, anaemia and immunisations.[32,33]

The effectiveness of ACCHSs is particularly clear in the Northern Territory where their comprehensive model of service delivery and advocacy for public health and system reform has been the foundation for much of the relative success in the Northern Territory in reducing mortality rates and 'closing the gap' in health between Aboriginal and non-Aboriginal communities.[34]

ACCHS are also cost effective. An economic evaluation of Danila Dilba Health Service in the Darwin region showed that in 2015-16 services were estimated to contribute $5.60 million in incremental benefits based on improved health outcomes for its clients in three areas, type 2 diabetes, chronic kidney disease and maternal and child health.[35] This is comprised of $0.43 million in avoided health and other financial costs, and $5.17 million in improved value of life.

4.4.2. Comprehensive, integrated primary care services that seek to address health inequities.

ACCHSs function within comprehensive primary health care service framework which aims to address health inequities and close the health gap between Aboriginal and non-Aboriginal people. This includes providing high quality, accessible, multidisciplinary clinical care as well as care that goes beyond the treatment of individual clients for discrete medical conditions.[36] ACCHSs are recognised as the best practice model for primary health care services for Aboriginal people in all the key national strategy documents including the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP).[37]

The ACCHS service model spans a range of curative, promotive, preventive and rehabilitative health care to individuals to make them well and keep them well, as well as action at a population level to address the broader underlying social determinants of ill health. Congress, for example, has expanded its role to include early childhood learning, nutrition, mental health including alcohol rehabilitation and family support as well as education and employment. Over half of Congress' clients have reported they received help from Congress staff with issues not directly related to health e.g. transport, housing, accessing benefits, job training and childcare.[38]

4.4.3. Access and choice

Primary health care is associated with a more equitable distribution of health outcomes in populations.[39] There is a demonstrated relationship between more or better primary care and improved health outcomes.[40] There continues to be sound evidence that supports the link between strong primary care activities such as prevention, early intervention and comprehensive care and improved health outcomes for Aboriginal people.[41, 42,43]

Effective primary care also reduces the reliance of more expensive acute care, particularly for chronic conditions.[44] A review of evidence shows that access to effective primary health care is strongly associated with the rates of hospitalisation for avoidable conditions i.e. admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services. Potentially Avoidable Hospitalisations (PAHs) are an indicator of accessible and effective primary health care.[45] There are higher rates of avoidable hospitalisation when there is:

- Poorer self-reported access to medical care
- Higher costs for the consumer
- Lower ratios of GPs to population
- Increasing socioeconomic disadvantage
- Lower numbers of GP consultations
- Greater remoteness.

Access to quality, culturally secure primary care services is therefore central to achieving longer term health improvements for Aboriginal people.[46] Evidence shows that there is a preference by Aboriginal people to attend ACCHSs, alongside increased patient satisfaction, adherence and compliance with treatment regimens.[47,48] Where ACCHSs exist, the community prefers to use them:

- According to the Aboriginal and Torres Strait Islander Health Performance Framework 2014 report, 73 per cent of Aboriginal Australians reported that they would prefer to go to an Aboriginal Medical Service or community clinic.[49]
- Between 1999 and 2013 the number of Aboriginal primary health-care services increased from 108 to 205.
- In the same period, the number of episodes of health care increased by 152% from 1.2 million to 3.1 million episodes.[50]
- Between 2009 and 2014, the number of Congress clients increased by 15 per cent, from 8600 to 10000.[51]
- Almost half of Congress clients rated the quality of services 4 out of 5, and 35 % gave a rating of 5 out of 5.[52]

4.4.4. Community engagement

There are clear links between community empowerment, overcoming disadvantage, and improving health outcomes.[53]As members of ACCHSs, individuals and communities are directly involved in the planning and delivery of services that are acceptable and used by communities. As noted above in 4.2, every Aboriginal person over the age of 18 years of age in the Congress catchment is eligible to become a member of Congress and community is consulted in the development and cultural security of programs.

4.4.5. Aboriginal Workforce

The employment and training of Aboriginal Health Workers to work as 'cultural brokers' alongside non-Aboriginal doctors, as well as training Aboriginal people to be administrative staff, enhances the acceptability and accessibility of services to Aboriginal clients.[54] Aboriginal health professionals are better able to ensure culturally appropriate care in the services they deliver and improve the patient care.[55]An Aboriginal workforce is also another way to address the social determinants of health through increased training and employment. As an ACCHS, Congress provides education and training opportunities to Aboriginal people in the community including traineeship, cadetship and Aboriginal Health Practitioner training.

4.4.6. Continuous Quality Improvement and evidence-base.

ACCHSs drive improvements in the quality and safety of their services through Continuous Quality Improvement (CQI) practices, by achieving general practice standards and Australian Standards.[56] Quantitative data is used for local decision making and to report to funders using NT Aboriginal Health Key Performance Indicators (NTAHKPIs) and national KPIs (nKPIs). The submission of these data is compulsory and de-identified results are publically reported.

Congress CQI processes have in one year, for example, reduced rates of anaemia in children less than 5 years from 18 to 13 per cent in urban clinics, and from 13 to 2 per cent in a remote clinic. Improvements have been due to a collaborative effort by clinic staff including goal setting, outcome measures, evidenced-based clinical interventions, innovative organisational and practice change, and reviewing outcomes to see how they have worked.

Patient surveys also provide useful information on the patient experience that allows responsiveness to user needs.

The Congress CQI program also sits within the broader system of clinical governance which includes:

- The CQI Clinical governance committee which undertakes a root cause analysis of incidents and complaints, leads CQI priority areas and oversees the development and review of clinical policies and procedures essential for CQI.
- Staff credentialing and registration.
- Complaints, incidents and suggestions and CQI registers.
- Clinical audits.
- Development and review of the clinical information system (Communicare)
- Development of operational plans with appropriate KPIs for all programs and services.

Congress programs have a strong evidence base, and a research subcommittee of the Board that facilitates studies to be undertaken in our service area. New programs and innovations are also rigorously evaluated. A number of publications are available that validate ACCHS and Congress programs (see bibliography Appendix A).

4.4.7. Funding

Funding for ACCHSs is through a mix of block funding from Commonwealth and State/Territory Governments, MBS items and Pharmaceutical Benefits Scheme (PBS) items, as well as contracts for individual services and programs. Capitated block funding for the resident population provides for the range of comprehensive services that are responsive to community health needs and provides holistic, integrated services and programs, while MBS/PBS payments are a dynamic source of funding for services provided to both residents *and visitors* and for the many medications that are essential for health improvement. Services are free to clients as copayments will limit access to vital primary care services.

As noted above, accountability and responsiveness is managed through a rigorous reporting regime.

With this funding mix ACCHSs have greater capability to withstand changes in the fiscal and political environment that have seen State services narrow the breadth of their services.[57] However, multiple funding streams for individual programs creates uncertainty and instability[58] in the long-term retention of staff. Adding to this complexity are multiple different performance indicators, reporting systems and data bases and reporting requirements creating administrative burdens on clinical staff. A single funding stream, or bundled payment, would strengthen this model and allow for a degree of flexibility of services to address patient need. This need is supported by the Senate Inquiry into the IAS which recommended that:

> *where possible and appropriate, longer contracts be awarded to ensure stability so that organisations can plan and deliver sustainable services to their communities (Recommendation 4)* [59]

4.4.8. Balancing responsiveness of services to communities with accountability to those who fund the services.

As the Commonwealth Government develops its performance framework for primary health care, consideration should be given to transparency and comparison of CQI data between providers. This will increase accountability to both community and funders while creating a competitive environment between providers to improve outcomes.[60] Data comparisons will need to take into account population demographics that influence processes and outcome indicators (e.g. social disadvantage, age, disease prevalence) where clients will have poorer health outcomes and service usage compared to other populations.

The Commonwealth Government's current redesign of the Practice Incentive Program aims to support a data-driven, innovation-focused quality improvement model. Congress has provided in-principle support for a shift from volume-based health-care to a focus on value-based health care with incentives driving quality and innovation, rather than quantity.[61] Congress has been practising this approach for many years and supports the move to incentivise this type of systems approach to CQI rather than individual disease management.

5. Increasing the benefits of contestability

REQUEST FOR INFORMATION 36
The Commission is seeking information on ways to improve commissioning arrangements for human services in remote Indigenous communities, including:

- **how processes for commissioning services (including specification and measurement of outcomes and selection of providers) could be changed to improve the quality, equity, efficiency, accountability and responsiveness of services**
- **how commissioning arrangements could be adjusted to reduce the administrative burden on providers without jeopardising accountability to those who fund the services**
- **characteristics of remote Indigenous communities relevant to service commissioning that differ from elsewhere in Australia**
- **the drivers behind the high levels of service fragmentation observed in remote communities, particularly in cases where the number of services and providers are very high relative to the population**
- **what steps governments could take to improve coordination of both policy and service delivery (across the Australian, state and territory, and local governments, departments and programs)**
- **the potential for more integrated services to improve service effectiveness, including particular services that would benefit from integration, and the level of integration that would be suitable (for example, information sharing or merging of service providers)**
- **other approaches to improving the coordination of services (across governments, departments, programs and providers)**
- **the barriers to effective service coordination and how they might be overcome**

5.1. Commissioning in remote Aboriginal communities

Commissioning for remote Northern Territory services should recognise ACCHS as the preferred provider for Aboriginal people. Outcomes of commissioning should address local needs identified through collaborative needs-based planning and more broadly contribute to Closing the Gap. Commissioning of services through the Primary Health Network (PHN) using both Aboriginal and mainstream funding should therefore be undertaken in collaboration with the NTAHF and prioritise:

1. *Direct tenders* to an identified provider e.g. an Aboriginal community controlled health service
2. *Select tenders* to a few identified providers e.g. a group of Aboriginal community controlled health services
3. *Open or competitive tender* to any provider that applies and fits the criteria as a last resort where no Aboriginal community controlled health providers exist.

For all health program and services where the major recipients are Aboriginal people, a direct tender to an Aboriginal community controlled health service will be the preferred option where one exists. Select and direct tendering of Aboriginal health services acknowledges these providers as models of best practice in Aboriginal health, as acknowledged by the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.[62]

This is also a key recommendation from the Senate Inquiry which recommended that any selection criteria and funding guidelines for IAS funding 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.

Aboriginal community controlled health services work because of their acceptance by the community through Aboriginal leadership and governance and a comprehensive holistic approach to primary health care with cultural security embedded throughout service delivery and very high levels of client access.

Assessment of service providers should be therefore weighted on the ability to:

- deliver culturally secure services to Aboriginal peoples, including a description of the proposed structures and processes to guarantee cultural security for Aboriginal clients and staff.
- provide local / regional Aboriginal governance, community representation and engagement in the design and delivery of appropriate services, including formal and informal processes and structures for governance and a demonstrated existing relationship with the local community
- provide employment of an Aboriginal workforce, including target numbers and training and employment strategy describing how to employ, retain and train local Aboriginal staff
- coordinate services with other services and programs, including evidence where possible of existing service relationships and their success, and letters of support from local / regional / jurisdictional Aboriginal organisations
- implement ongoing, professional CQI processes to measure achievement of improvement in health outcomes for Aboriginal people; this should include a requirement to report against all relevant KPIs (as required for ACCHSs)

Organisations responding to open tenders must provide verifiable evidence of meeting these criteria or being able to meet these criteria in the particular communities to be serviced: non-specific or generic statements about cultural security or community engagement should not be considered.

5.2. Service integration and coordination

Improving coordination between service providers could be better managed by commissioning for health outcomes beyond a single disease focus, with contracts that mandate for service cooperation to achieve joint goals. However, the true service integration is best achieved through a single comprehensive primary care provider with multidisciplinary teams supported by one clinical IT system, and driven by shared incentives e.g. one funding stream and single governance.[63] For example, Congress' co-located SEWB service, AOD and suicide prevention and physical health care model works as it operates under the one employer, which enables for example, the multidisciplinary team to be supported by a common clinical IT system and case coordinators.

6. Implementing reforms

REQUEST FOR INFORMATION 37
The Commission is seeking information on the implementation of reforms to human services in remote Indigenous communities, including:

- **barriers to and drivers of success of reform processes (including examples of previous reforms, their rationale and why they did or did not lead to improved outcomes)**
- **whether existing structures and organisations (including governments, providers and community organisations) could be used to minimise disruption and churn as a result of policy changes**
- **how evidence could be better gathered, shared and used to support service allocation, commissioning and delivery (by both governments and providers), including improvements to the conduct and use of program evaluations**
- **how recommendations could be adapted to communities with differing needs and characteristics**
- **complementary policy measures that would support the introduction of greater competition, contestability or user choice in remote communities (for example, the provision of culturally appropriate information to allow users to exercise informed choice)**
- **the costs and benefits of reform**
- **stewardship considerations when implementing reforms to services in remote Indigenous communities (for example, feedback and complaints mechanisms, and processes to make ongoing improvements to policies and programs).**

6.1. ACCHS lead in community-driven service delivery.

The ACCHS sector is growing with commitment from both Northern Territory and the Commonwealth Department of Health (DOH) to the pathway to community control. Smaller communities may engage through larger ACCHS and their peak bodies e.g. NACHHO and AMSANT. This allows for communities to be empowered and engaged in service delivery. This sector can inform the development and use of services in a number of ways:

- The NTAHF and governance structures of ACCHSs such as Congress can be used as models and implemented elsewhere.
- The Commonwealth DoH's development of a primary care performance framework would learn much from the ACCHS's CQI systems, data collection and reporting.
- A competitive environment can be achieved through the transparent use of data so all primary care providers compete against each other's outcome data.
- Commissioning for outcomes that take into account the complexity of Aboriginal populations and acknowledging that Aboriginal control over services is more likely to achieve the desired outcomes than open, competitive tendering.
- Closing the gap in Aboriginal health and well-being requires an ongoing whole-of-government commitment and agenda that addresses the social determinants of health including: housing, early childhood learning, education, employment and justice.

Appendix A

Publications supporting ACCHS and Congress effectiveness.

1. Aboriginal health in Aboriginal hands: Community-controlled Comprehensive Primary Health Care @ Central Australian Aboriginal Congress, Flinders University Southgate Institute for Health, Society & Equity
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