Submission to the Productivity Commission Inquiry into Increased Competition, Contestability and User choices in Human Services

10/2/2017

Health and Human Services

in

Regional and Remote Australia

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

Good health and wellbeing for rural and remote Australia

www.ruralhealth.org.au twitter.com/NRHAlliance facebook.com/NRHAlliance (02) 6285 4660 nrha@ruralhealth.org.au

Health and Human Services in Regional and Remote Australia

The National Rural Health Alliance (the Alliance) welcomes the opportunity to provide comments and suggestions in response to the Productivity Commission Study Report *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*.

The Alliance is comprised of 39 national member organisations. We are committed to improving the health and wellbeing of all people living in regional and remote Australia[1]. Our members include consumer groups, representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses, midwives, allied health professionals, dentists, optometrists, paramedics and health service managers) and health service providers. A full list of members is at Attachment A.

The Alliance will not refer in detail to issues raised in our original submission to the Commission on this issue, but will offer general and specific comments on the way in which the focus and approach to the issues identified for consideration has developed.

General comments

The Alliance is pleased to see a focus on the issues relating to the commissioning of family and community services rather than to the services themselves. The Alliance considers that one of the best returns on investment for governments comes from addressing these issues, which have resulted in at times piecemeal and poorly applied policy interventions that have failed to address regional and remote community and government needs.

The Alliance notes that the issue of contestability has been reduced as a focus in this report. Contestability in rural and remote communities is a complex and difficult issue. In small remote communities, contestability is simply not an issue, as at best a single provider is committed to delivering services locally. Contestability becomes an issue when it results in changes to service providers – in remote Aboriginal and Torres Strait Islander communities the basis for successful service delivery is the strength of the relationships built up and maintained over time – changes in providers can result in serious dislocation of relationships and can undermine progress achieved and must be managed very carefully.

An issue that emerges as pertinent to all six areas under consideration by the Commission is that of the coordination of services. The Alliance notes a recent comment by the Minister for Indigenous Affairs, Senator the Hon Nigel Scullion, that the Government commissioned the *Solutions that work: What the evidence and our people tell us* report to advise on what works and what doesn't. The Report found that, with reference to Aboriginal and Torres Strait Islander policy, solutions need to be Indigenous-led and better coordinated.

> "Unfortunately the *Solutions that Work* report confirmed what I see as I go from community to community – a myriad of support services delivered by different agencies

[1] Throughout this submission, references to remoteness are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. In the submission, references to "regional areas" mean Inner plus Outer regional; and references to "remote areas" mean Remote plus Very remote.

> and not -for-profit organisations but with little coordination between them to make sure families are properly supported in times of great distress. The effect is that people fall between the cracks," Minister Scullion said.

Minister Scullion's comments are relevant throughout smaller regional and remote communities. Coordination is an issue for the delivery of all human services in regional and remote Australia. If we are to make the most effective and efficient use of scarce funding across the range of human services, we need to find ways to integrate and link services and people more effectively.

The Alliance believes that there is an Australian service model that is capable of delivering services that are well coordinated and are appropriate to their community

A model for the delivery of integrated human services in small regional and remote communities

The Multipurpose Service (MPS) is a model of health and aged care service delivery that developed to address the need for access to health and aged care in small regional and remote communities in Australia.

The MPS model provides pooled funding from the Commonwealth and State/Territory governments to enable a small number of hospital beds and residential aged care places in communities that would otherwise not be financially viable for either of those services operating on a stand-alone basis. The MPS is also a base for the delivery of health and aged care services into the home, community services such as Meals on Wheels, specialist, dental and allied health visiting professionals and other services that to date have focused on supporting local health and aged care.

They are a central hub in their community. And they are the obvious place to look to find a way to improve access to human services in small communities.

The MPS is existing local infrastructure that people already respect, use and value. Looking at how its' role can be expanded to support the delivery of broader local human services in smaller communities is the obvious place to start for providing a more integrated base for the delivery of human services for smaller communities and for their coordination.

Linking the MPS more formally with local government and the Primary Health Network and supporting better coordination of local services will provide better return on investment by reducing duplication and ensuring visiting services are better targeted. They should also develop collaborative and cooperative links with local Aboriginal Health Services. The most crucial role is that of coordination. It is the step most commonly missing at present.

Coordination will be the glue that enable the delivery of a health care home style of service in remote communities supported by Nurse Practitioners or a Bush Nurse. It will assist in retaining remote staff. And it will assist in ensuring small communities can provide integrated services that are more responsive to user needs, giving greater choice.

At the heart of the delivery of human services is the concept of supporting vulnerable individuals and families to participate fully in their community to the mutual benefit of all. The key question with regard to the administration of human services under such arrangements is whether the policy embeds the right to support with reciprocity: that is when concepts of rights, self-determination and mutual obligation mesh together constructively, the community receives the best outcome – including the best return on investment.

The Alliance strongly supports government activity that supports and realises the socio-economic potential that exists in regional and remote communities.

Trends and drivers of need

The Alliance notes the analysis undertaken by the Commission into the forces at work currently in the delivery of human services. For the 7 million people living outside the major cities, access to human services can be highly variable. Much of that variability is due to the impact of the drivers that have been identified by the Commission.

A key issue that needs to be front of mind in considering human service delivery in regional and remote communities is access to information and telecommunication. This will be explored below in greater detail and must not be underestimated: if an individual lives in a community where they cannot undertake internet banking or send email due to poor coverage and slow speeds, expecting these same individuals to make use of portals such as MyGov and MyAgedCare is unrealistic.

Multiple and complex needs

The Alliance has a long-standing interest in the broader causes of poor health outcomes including access to social housing, lower income levels in regional and remote communities and the way in which complex health needs impact on the range of human services an individual and the carer and family may need to access. The Alliance believes that it is not possible to consider these issues separately due to the way in which each affects the impact of the others.

For example, poor access to social housing, and the current poor quality of much social housing stock in remote communities, leads to overcrowding, which in turn is reflected in poor hygiene, poor school attendance of children, higher levels of illness in children and adults and in long term poor health outcomes and poor compliance with treatment.

For this reason, examination of the health status of people in remote communities in particular, can be indicative of the broad level of unmet social need as well as the level of unmet health need. Similarly, the lesson for policy makers is that it is unrealistic to expect to see improvement in health outcomes in those communities without addressing the underlying causes of those poor health outcomes.

The prevalence of chronic diseases, particularly of people with multiple chronic diseases, is significantly higher outside the major cities. Some key facts comparing the prevalence of chronic diseases outside the major cities with major city prevalence:

- There are 10% fewer people with no chronic disease outside the major cities;
- There are similar numbers of people with one chronic disease;
- There are around 20% more people with two chronic diseases outside the major cities;
- There are around 50% more people with three or more chronic diseases in Inner regional communities; and
- There are around 30% more people with three or more chronic diseases in Outer regional communities[2].

At least some of the reasons for the differences above is due to the different age structure of regional and remote communities and that people with more complex care needs in remote communities move into regional centres as they age and need better access to care and social services. This is supported by mortality data that shows that the number of people who die with multiple chronic diseases is 20-30% higher in regional Australia than in major cities and lower in remote areas.

These data reflect the lack of access to appropriate human services in remote communities. The question not answered is to what extent is it more efficient to deliver those services closer to the individual in a rural or remote community. Within the context of a discussion on greater user choice, the exploration of the broad economics of human service delivery in remote communities needs thorough consideration.

The delivery of services closer to the individual in need will lead to the generation of jobs and educational opportunities that at present do not exist and which need to be factored into the economic cost benefit analysis underpinning discussion of potential efficiencies. To what extent is the most efficient choice to offer a user of human services in a remote community the option of going to a major centre for diagnosis or treatment or staying locally and 'taking their chances' the most cost effective option, and how acceptable this is, should be a matter for community discussion and consideration.

Professionalism

Increased professionalism is a growing feature across the delivery of human services nationally. In regional and remote communities, the growth of professionalism offers significant opportunities for current and future local employment growth. With access to appropriate education and training, growing local expertise to deliver professional human services, particularly in family and community services, child care, paramedical, health support and aged care should become the way of the future.

Smaller regional and remote communities currently rely primarily on external recruitment of health care professionals, including medical, allied health, paramedical and support workers. With regionally based universities now expanding their footprint to include smaller regional centres, the prospect of being able to train closer to home, with the possibility of training placements in local communities, seeking employment in the human services sector becomes more attractive to people who would previously have set aside these ambitions to remain within their community.

---

[2] These data are drawn from crude rates that have not been age standardised. Source: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012014-15?OpenDocument

Universities need to be supported by a vibrant Technical and Further Education sector that offers increased access to quality education and training to enhance the growth in the human services workforce.

A further question for consideration is to what extent a range of support positions within the human services sector could be appropriate for training through an accredited apprenticeship system enabling portability of qualifications across the human services sector and offering a new supported stream of training and education to build the local workforce.

Workforce changes

Among the workforce issues in the report, the Alliance is pleased that the Commission includes consideration of the role of volunteers and carers in supporting the delivery of human services, and particularly in regional and remote communities. As the Report acknowledges, the number of carers and volunteers is reducing, and this will have a long-term impact on the delivery of human services, and especially health services, in regional and remote communities.

The changes in the workforce generally and the professionalisation of the human services workforce are closely intertwined. Further, as new organisational players and funding schemes enter the scene, such as the National Disability Insurance Scheme (NDIS), they will also require access to a professional workforce supported by continuing professional development and training. Unless the changing workforce needs are planned for appropriately, there is a real risk that the competing priorities will exacerbate existing workforce shortages significantly. In particular, there is a significant risk that the aged care workforce may be poached by the NDIS as it expands into regional and remote communities.

There is an urgent need to develop a comprehensive rural human services workforce plan that supports comprehensive planning and education to meet the growth in need.

Such a workforce plan also needs to include consideration of current areas of workforce mal-distribution and how such mal-distribution is to be addressed.

Planning for the future workforce needs of communities should also consider the changing nature of the expectations of professionals providing health and other human services. For example, very few new doctors considering rural or remote practice are willing to buy into a general practice. This has resulted in development of different models of practice where an external community organisation, such as the local council or another not for profit or for profit organisation taking on the role of owning and managing the infrastructure, while the practitioner operates in a ‘walk in- walk out’ basis. For small communities, the cost of this form of operation may be considerable.

Technology

One of the most significant areas of need in regional and remote Australia is for better access to technology – including better access to high quality, fast internet services. The Alliance recently responded on this issue to the Productivity Commission inquiry into the Telecommunication Universal Service Obligation (TUSO), noting that the draft report acknowledges two key issues that are of significant concern to Alliance members and people living in rural and remote Australia:

> *While NBN infrastructure will deliver a high quality voice service over fixed-line and fixed wireless networks, there is question about the adequacy of NBN services as a baseline service in pockets of the satellite footprint, particularly given the high dependency on the network in areas where there is no mobile coverage (affecting up to 90,000 premises).*
>
> *The extent that there are any remaining availability, accessibility or affordability gaps once the NBN roll-out is complete, current policies and existing policy setting suggest that these are likely to be small and concentrated, and amenable to specific social programs rather than large scale government interventions such as the TUSO.*

In today's human service delivery, internet access is almost mandatory, which places people in smaller regional and remote communities at a distinct disadvantage.

Generally, there are greater vulnerabilities and challenges facing people living in regional and remote Australia. Poor access to adequate and affordable digital services only serves to deepen these vulnerabilities and challenges.

The Alliance believes that cost, access and proficiency are key issues in improving the delivery of first class health and human services in regional and remote Australia. The delivery of high quality telecommunication services offers potential gains for regional and remote communities in terms of improved access to education, health and business opportunities: but if the services available do not provide the quality and reliability required, such potential gains may be significantly diminished.

Kohen and Spandonide look at the way in which people in remote communities access telecommunication, noting that pre-paid services are the main source of access (1). They also note that charges are significantly higher in these communities, resulting in lower levels of access. With higher costs and poorer service quality, expecting the delivery of health services through apps and other mobile platforms will further disadvantage remote communities, particularly remote Aboriginal and Torres Strait Islander communities.

Lane et al undertook a case study of broadband access in rural Australia and their paper includes data on the limited availability of services, and greatly reduced download speeds, in rural and remote Australia (2). They indicate that the demand for data in rural and remote Australia is outstripping the capacity of current network services. While policies are in place to address these issues, Lane et al contend that the lag in delivery of those policies has resulted in efforts to address the inequality in service access being unsuccessful to date (2).

Lane indicates that affordability of broadband services decreases with remoteness as do the range of choices available to people seeking reliable, fast telecommunication and internet services with widely variable download speeds. They found that these limitations underlie significant dissatisfaction with the supply of broadband infrastructure in outer regional, remote and very remote households (2).

The need for improved telecommunication services in regional and remote Australia is urgent. If we are to address the need for greater professionalism and better access to information to empower human services users, then adequate and affordable technology and telecommunications must be available to meet the challenge. At present they do not.

Data availability and use

There is an urgent need for better access to data to support the development of policies and to plan for the delivery of human services throughout Australia, but particularly in regional and remote Australia.

In recognition of this need, the Alliance developed its *Little Book of Rural Health Numbers*, which was our attempt to bring together data from a myriad of providers into a single, accessible location. Of course, the maintenance and ongoing development of that project is now a significant issue for the Alliance.

The data needed to understand the level of community need for the wide range of human services is diverse and from multiple sources. One of the major issues with much data collected through surveys, rather than through Census, is that the survey population often under-samples, or simply does not sample, remote communities. As the Alliance found in its recent work looking at the health impact of food insecurity in regional and remote communities, the data available significantly understates the degree of the problem because of this methodological issue (3). The lack of data, or poor quality of data, results in policy developed that does not adequately describe the level of need. Issues that should be a priority are not identified because the data is simply not accurate. And as a result, the issues that urgently need attention are not addressed.

Timeliness of data is a further issue. Often the only data sets publicly available are up to five years old, which makes recognition of trends or changes difficult. Similarly, it is often difficult to find data that includes remoteness – for example employment data looks at major cities and the rest of the state/territory. This is particularly unhelpful if you are looking at trends in smaller remote communities and trying to explore linkages with health outcomes. Again, the lack of accurate data makes the recognition of areas facing significant issues difficult, as is accurate targeting of policy to address areas of specific need.

Finally, data needs to be local. National and jurisdictional data rarely provides the level of granularity required for local needs assessment, planning and decision-making. There is huge variation in access and outcomes for services between communities which may not be geographically far apart. Data on those variations at a local level is needed to enable local responses to different local results and their underlying causes.

The Alliance seeks a greater emphasis on the development and ongoing maintenance of accurate and timely human services data, which is available freely and which over time captures information on local variations between communities. This must be combined with a funded commitment and plan to address data weaknesses and gaps.

Increased integration of services

As the Commission recognises, the delivery of human services generally occurs within silos. This frequently results in users not being able to recognise services that may be of benefit to them. It also results in people "falling between the cracks".

The Alliance believes that the most important role in the delivery of human services generally, is that of a coordinator. Having someone who knows what services are available locally, can advocate for additional services and who is able to link people and services together is vital if we are to offer real user choice. With so many new competing services in aged care, disability care, community care and health care, users need help to negotiate their way to their best mix of services.

Additionally, coordinators in smaller regional and remote communities can help ensure that visiting services are linked to those who need them, issue reminders and in some circumstances link individuals to transport support to ensure visiting services are used effectively and efficiently.

Coordinators can also ensure that treatment and diagnostic information is made available appropriately and referrals are acted upon. For people having to travel significant distances to access diagnostic and treatment services, coordinators are vital. There are too many stories of people getting to a specialist service in town to be told their appointment has been moved or who were not aware that the tests would be over several days. Frequently they leave and return home.

Integration of services across the range of human services also requires careful coordination. Knowing that an individual needs insulin but does not have access to a refrigerator for storage means treatment for diabetes may be compromised. Being able to coordinate the need for cool store with social housing or with another community support service is vital to support that individual to manage their diabetes more effectively. If that individual is homeless, being able to refer them to emergency housing or other support services is also vital.

The Alliance sees the need for dedicated coordination positions to improve integration of human services in small regional and remote communities. Coordinators will support and enhance user choices in the delivery of human services.

Meeting consumer preferences

Establishing realistic consumer preferences that can be met in regional and remote communities is vitally important, particularly in the context of rapidly changing human services delivery. The impact of the National Disability Insurance Scheme (NDIS) and the expectation of consumers that they will be able to access flexible services tailored to their specific needs, with similar expectations raised in the aged care sector, is producing a range of significant issues for service providers in regional and remote communities.

Recent feedback received with regard to the aged care sector indicates that consumers, and particularly their carers, are not well informed, and are not being served well by the existing internet based information and portals. Consumers are demanding better information that is not internet based and better access to advocacy to enable better outcomes for themselves.

Aged care providers also indicate that the current expectations of consumers and particularly their carers are not realistic. The introduction of means testing has resulted in aged care consumers refusing to accept the offer of Level 1 and 2 home care packages, which are means

tested, and waiting until their level of need is reassessed as level 3 or 4, which are not means tested. Further, as consumers consider their need for residential care, they are not realistic in their expectations as to which services are provided in the base package and which services are available for additional funding.

The Alliance believes there is an urgent need to assess the information available to consumers and develop new materials that better meet consumer needs, including establishing realistic expectations for the level of services available in smaller regional and remote communities.

Social housing

In regional and remote Australia, the need for access to appropriate, quality social housing, whether Government owned or community owned, is vital. Enabling people who live in smaller regional and remote communities to maintain a basic level of health and hygiene can depend on their access to appropriately maintained social housing. There has been a move by some State/Territory governments to encourage remote Aboriginal communities to combine into larger "hub" communities, but these messages are not necessarily being well received in those smaller communities who see these hubs as increasing the range of social issues to which their community may be exposed[3].

Access to community social housing may also have significant waiting times – for example in Katherine in the NT the waiting time exceeds five years, with few if any options for those waiting to access this support[4]. The Commission report also notes waiting times of up to ten years in some remote NSW communities.

Access to appropriate shelter is vital to develop and maintain good health and wellbeing. Indeed, recent research published in the Medical Journal of Australia indicates that one of the risk factors for high rates of hospitalisation in Aboriginal and Torres Strait Islander children is poor housing due to overcrowding, poor access to clean water and sanitation and social disadvantage[5].

The Alliance would support actions to improve the accountability of providers of social housing together with steps to improve the access to emergency housing in smaller regional and remote communities.

Public hospital services

As the Commission notes, the public hospital system in Australia is an area where even a small improvement in outcomes could generate significant savings. The Commission also suggests

[3] http://architectureau.com/articles/remote-indigenous-settlements/
[4] https://theconversation.com/refugees-in-their-own-land-how-indigenous-people-are-still-homeless-in-modern-australia-55183
[5] http://www.abc.net.au/news/2017-01-30/indigenous-child-health-icus-research-uq/8218928

that this is an area where greater user choice as to who treats them and where can lead to improved service quality and efficiency.

This statement ignites a potentially significant tension due to a basic user choice that already exists in the public hospital system.

Below is a statement from the Department of Health Fact Sheet on Private Health Insurance:

> *Under Medicare you can be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital. You can choose to be treated as a public patient, even if you are privately insured.*
>
> *As a public patient, you cannot choose your own doctor and you may not have a choice about when you are admitted to hospital.*

One of the cornerstones of the Australian health care system has been that if you elect to be a public patient you do not get to choose who treats you or where (or when) you are treated. If you wish to do that, you either pay for care and treatment yourself or take out private health insurance.

The Alliance notes that the Commission discusses greater access to information because "under current arrangements, public patients are often given little choice over their provider and limited information to compare alternatives". But under Medicare as it is currently configured, once you have elected to be treated as a public patient, you do not have the ability to choose your provider. Exploration of alternatives is something that must happen prior to electing to be treated as a public patient. If the individual wishes to have choice in their provider or in where they access the service, they have the option of either self funding their care and treatment or of using private health insurance.

Building user choice into the current configuration of Medicare comes with significant risks, including whether the concept of increased user choice, as suggested by the Commission, is compatible with Medicare.

Building in user choice may undermine the role of private health insurance and result in people choosing to no longer self-insure. This would result in significant additional expenditure to the public health purse. How greater user choice could be incorporated into public hospital services without compromising Medicare is difficult to conceive. Such changes will be highly contentious, in addition to requiring legislative change.

This is not to deny that there may be scope for greater efficiencies in the provision of public hospital services.

Perhaps a focus on centralised waiting lists (at the State or Territory level) may result in both greater efficiency and provide scope for user choice without compromising Medicare, as it may be possible to offer an individual on a consolidated public hospital waiting list a choice of public hospitals able to accommodate their needs. The Alliance notes that this will be a more feasible solution in larger centres than in smaller centres, but considers the concept worthy of consideration nevertheless.

Further, the Alliance considers the Multipurpose Service (MPS) as a potentially more suitable alternative in smaller regional and remote communities. The MPS offers other ways to deliver public hospital services that are both more flexible and potentially offer greater choices for people living in those communities – the choice of seeking hospital care close to home. They could also provide a 'step down' option for an individual recovering from major surgery in a larger centre who is not well enough to go home but is well enough to be supported in an MPS close to home.

The Alliance would support making better information available to patients on the outcomes being achieved at public hospitals, as a means of enabling consumer support improving the quality and efficiency of local public hospital services. This should be accompanied by consumer education programs to better inform consumers to enable them to make the best use of this information.

End-of-Life care

The Alliance will not comment extensively on this issue as Palliative Care Australia is best placed to comment on the range of issues relating to the national delivery palliative care services, including in rural and remote communities.

In smaller regional and remote communities, there will always be the issue of insufficient specialist resources which of necessity are spread thinly, supported by community nurses.

The Alliance is aware that the workforce issues facing the palliative care workforce are largely the same as the broad issues outlined above. The need for training and education close to the palliative care service, and to grow and train local support workers is indeed similar. The need for access to good telehealth and ongoing access to appropriate specialist care is also important to ensure people approaching the end of life are able to remain in their community with the appropriate care and support for themselves and their carers.

Where smaller local communities do not have access to a hospice, facilitating user choice is dependent on the ability of local health and nursing staff to either support the individual in their home, or provide appropriate hospital care.

Public dental services

As a member of the National Oral Health Alliance (NOHA), the Alliance is acutely aware of the current poor level of access to public dental services in regional and remote Australia. The Alliance believes strongly that oral health should be included in primary health care, with access to dental services considered a vital part of good basic health care, and funded accordingly.

In seeking data on the dental workforce, the Alliance found that the AIHW offers data that considers dental professions by remoteness, but that this data is now 5 years old. Interrogation of the Australian Health Practitioner Regulation Agency found considerable, newer data on the dental profession, including information on the rapid growth in numbers entering the profession in the last 5-10 years. This data, however, was not available by remoteness.

The Alliance notes that there is a considerable undersupply of dental practitioners – both public and private – in regional and remote communities.

Dental professionals (AIHW 2012)[6]	MC	IR	OR	R/VR	
Dentists	64	42	36	22	
Dental hygienists	5.8	2.7	2.8	1.7	
Dental therapists	3.4	4.3	5.6	4.5	
Dental prosthetists	5.6	6.4	3.2	0.5	
Oral health therapists	2.6	2.8	2.6	1.4	

The mal-distribution of supply results in poor dental health outcomes for people living outside the major cities.

A recent study by Carlisle et al has found that in Queensland, Aboriginal and Torres Strait Islander people were three times more likely to require hospitalisation due to oral health issues than non-Indigenous Queenslanders. They further found that in regional and remote areas, there was a three-fold increased risk of hospitalisation of children aged up to 14 years due to poor oral health (4).

In addition, Dudko et al have found that place of residence, and particularly the distance that has to be travelled to access dental care, has a strong influence on the rate of hospitalisation for oral health issues (5). They found the rate of hospitalisation increased 'markedly' with increasing distance to access a dental service. They also found that of the 4.7 million people eligible for public dental services nationally, 10% were on waiting lists, with wait times as long as 24 months to see a public dental service in some jurisdictions (5).

Dudko et al went on the conclude that enabling private dental providers to deliver subsidised dental health care would be one means of reducing waiting times and enabling better access to subsidised dental care. They also noted that increasing access in small regional and remote communities should be included in any changed program framework as a safeguard to protecting access for those communities.

An issue that Dudko et al do not consider is the current mal-distribution of the dental workforce, which will obviously need to be addressed to enable improvements in access to both private and public dental services outside the major cities.

The Alliance suggests that the Productivity Commission liaise with the Australian Health Practitioner Regulation Agency to ensure that analysis of registration of dentists and other health practitioners includes discussion of the workforce distribution by remoteness areas.

[6] Dental: AIHW 2014. Dental workforce 2012. National health workforce series no. 7. Cat. no. HWL 53. Canberra: AIHW. http://www.aihw.gov.au/publication-detail/?id=60129545961

Human services in remote Indigenous communities

The Alliance will not comment extensively on this issue as several of our member organisations, including the National Aboriginal Community Controlled Health Organisations (NACCHO) are best placed to comment on the range of issues relating to the national delivery of culturally appropriate and culturally safe health and community services, including in rural and remote communities.

The model of integrated health care offered through the Aboriginal Health Services nationally has grown and evolved to meet the very diverse needs of communities in different cultural and physical environments. There are many features of these services that serve as a model for the delivery of human services in other small communities. Indeed, there are many similarities between Aboriginal Health Services and some of the Multipurpose Services that currently support the health and aged care needs of many small regional and remote communities.

In examining the enablers and barriers to effective primary health care delivery in Aboriginal communities, Gibson et al identified five key issues the affected service acceptance and delivery (6):

1. Design attributes: essential elements to consider during the design of a chronic disease intervention in order to provide a solid foundation for successful implementation and sustainability. These include community engagement, the policy and funding environment, leadership, staff approach to change and sufficient resourcing.

2. Chronic diseases workforce: workforce issues include difficulties recruiting and retaining staff, unsuitable workforce training and development, lack of dedicated chronic disease positions with clear roles and responsibilities, excluding Indigenous Health Workers from decision-making, and the need to support staff well-being.

3. Patient/provider partnerships: the role of the service provider extends beyond their professional and technical skills. The valued qualities of a chronic disease health worker include being understanding, supportive and empowering, being able to communicate sensitively and allowing patients to be partners in their care.

4. Clinical care pathways: poorly performing electronic support systems and vague referral pathways are barriers to a service provider’s ability to deliver comprehensive chronic disease care.

5. Access: access to chronic diseases care is facilitated by providing consistent services and coordinated care, embedding culturally safe work practices (for example, by employing local Indigenous people and providing care in Indigenous spaces and being influenced by patient perspectives related to beliefs and experiences regarding health care and family support.

These five key issues reflect the issues raised previously and demonstrate the importance of developing and implementing local solutions through engaging the local health sector

expertise. They also apply more broadly than in chronic diseases alone, including in the delivery of aged care services in small remote communities.

Commissioning family and community services

Improving the commission of family and community services is an issue of great interest to Alliance members.

The Alliance agrees that there is scope to improve the equity underpinning these services through more effective understanding of local community needs. Further, by undertaking a more thorough needs based planning exercise, the capacity of local communities can be considered in the approach developed to manage the issues identified.

Many smaller regional and remote communities are deeply concerned at the long term viability of their communities and participating in the planning and in designing a local response will assist communities to be active participants in meeting local needs and setting in place desired outcomes and the measurements to assess their progress towards these outcomes.

One of the key issues in smaller communities is effective service coordination that ensures individuals do not get lost in the system. Another important issue is the development of effective relationships with service providers – that is relationships that include the consumer, their carers, general practitioner or local primary health provider and visiting health providers.

But key to maintaining these services, is that the funding pathway is managed well and does not work to undermine the effective delivery of health and human services – and there are many examples where at present, funding requirements do not deliver good outcomes for communities.

The Alliance supports longer term funding contracts between Government and providers, with commissioning or tendering undertaken well in advance of the expiry of the contract terms.

References

1. Kohen A, Spandonide B. Switching on the remote: a new perspective on accessibility in remote Australia. Learn Communities. 2016 Apr;(19):76–97.

2. Lane MS, Tiwari S, Alam K. The Supply and Use of Broadband in Rural Australia: An Explanatory Case Study of the Western Downs Region. Australas J Inf Syst [Internet]. 2016 Oct 17 [cited 2017 Jan 16];20(0). Available from: http://journal.acs.org.au/index.php/ajis/article/view/1202

3. National Rural Health Alliance. Food Security and Health in Rural and Remote Australia. Canberra: Rural Industries Research and Development Corporation; 2016 Oct.

4. Carlisle K, Larkins S, Croker F. Disparities in dental health of rural Australians: hospitalisation rates and utilisation of public dental services in three communities in North Queensland. Rural Remote Health [Internet]. 2017;17(3807). Available from: http://www.rrh.org.au/publishedarticles/article_print_3807.pdf

5. Dudko Y, Kruger E, Tennant M. A national analysis of dental waiting lists and point in time geographic access to subsidised dental care: can geographic access be improved by offering public dental care through priate dental clinics? Rural Remote Health [Internet]. 2017;17(3814). Available from: http://www.rrh.org.au/publishedarticles/article_print_3814.pdf

6. Gibson O, Lisy K, Davy C, Aromataris E, Kite E, Lockwood C, et al. Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: a systematic review. Implement Sci. 2015;10:71.

ATTACHMENT A

Member Bodies of the National Rural Health Alliance

National Rural Health Alliance - Member Body Organisations
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)
Australasian College of Health Service Management (rural members)
Australian College of Midwives (Rural and Remote Advisory Committee)
Australian College of Nursing - Rural Nursing and Midwifery Community of Interest
Australian College of Rural and Remote Medicine
Australian General Practice Network
Australian Healthcare and Hospitals Association
Allied Health Professions Australia Rural and Remote
Australian Indigenous Doctors' Association
Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
Australian Physiotherapy Association (Rural Members Network)
Australian Paediatric Society
Australian Psychological Society (Rural and Remote Psychology Interest Group)
Australian Rural Health Education Network
Council of Ambulance Authorities (Rural and Remote Group)
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CRANAplus
Country Women's Association of Australia
Exercise and Sports Science Australia (Rural and Remote Interest Group)
Federation of Rural Australian Medical Educators
Health Consumers of Rural and Remote Australia
Indigenous Allied Health Australia
Isolated Children's Parents' Association
National Aboriginal Community Controlled Health Organisation
National Aboriginal and Torres Strait Islander Health Worker Association
National Rural Health Student Network
Paramedics Australasia (Rural and Remote Special Interest Group)
Rural Special Interest Group of Pharmaceutical Society of Australia
RACGP Rural: The Royal Australian College of General Practitioners
Rural Doctors Association of Australia
Rural Dentists' Network of the Australian Dental Association
Royal Far West
Royal Flying Doctor Service
Rural Health Workforce Australia
Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
Rural Optometry Group of Optometry Australia
Rural Pharmacists Australia
Services for Australian Rural and Remote Allied Health
Speech Pathology Australia (Rural and Remote Member Community)