Submission in response
to

The Australian Government Competition Policy Review: final report

May 2015

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.

Introduction

The National Rural Health Alliance (the Alliance) is the peak non-government organisation working in Australia for improved rural and remote health. It comprises 37 national organisations and is committed to better health and wellbeing for the more than 6.7 million people of rural and remote areas.

Members include consumer groups (such as the Country Women's Association of Australia, the Isolated Children's Parents' Association and Health Consumers of Rural and Remote Australia), representation from the Aboriginal and Torres Strait Islander health sector (AIDA, NACCHO and IAHA), health professional organisations (representing doctors, nurses, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and the Council of Ambulance Authorities). The full list of Member Bodies is attached.

Each of the Member Bodies is represented on Council of the Alliance, which guides and informs policy development and submissions. With such a broad representative base, the Alliance is in a unique position to provide input on the broader issues relating to health and wellbeing in rural and remote areas.

The Alliance welcomes the review of Australia's competition policy and agrees that there is merit is developing a set of principles that could be used across governments to guide policy development and implementation. The Alliance also agrees with the Review Panel that the application of these principles must meet a 'public interest' test.

The Alliance is also pleased to note that the Review Panel acknowledges that there are some circumstances where encouraging competition is not desirable because: the benefits do not outweigh the costs; and/or, the objectives of government policy can only be met by restricting competition. The Alliance believes that there are some aspects of health service delivery in rural and remote areas where encouraging competition is not desirable. Our views on the limits of competition policy in rural and remote areas, particularly in commissioning health services in rural and remote areas, are outlined below.

The limits of competition policy: delivering human services in rural and remote Australia

The Alliance works to improve the health of Australians living in rural and remote areas so they can live healthy lives and effectively participate in Australia's economy and society. One of the Alliance's central efforts is to help overcome the disadvantages that Australia's geography imposes on the provision of high quality, cost-effective health services to people in rural and remote areas.

The Alliance believes that 'major policy levers', including competition policy, should be used where they can to improve quality of life, business prospects and access to services in rural and remote areas. However it is impossible to ignore the issue of market failure, or the absence of markets altogether, when considering how competition principles might apply with respect to the delivery of health services in rural and remote Australia.

There is clear, longstanding evidence that the market for health service delivery is weak or non-existent in many parts of rural and remote Australia. Despite the existence of various programs designed to encourage more health professionals to practise in rural and remote areas, persistent workforce shortages remain in many places.

According to data from the Australian Institute of Health and Welfare, the number of full-time equivalent medical practitioners per head declines substantially the further you travel away from major cities. There are, for example, 405 medical practitioners per 100,000 people in major cities, but only 275 in inner regional areas, 250 in outer regional areas, and 249 in remote and very remote areas.[1] Similar trends are seen in the supply of dental health professionals and allied health professionals (who include physiotherapists, psychologists and optometrists).[2] The supply of nurses and midwives per head is lower in regional areas than major cities, but is slightly higher in remote and very remote areas.[3]

The Review Panel acknowledges that one of the central tenets of competition policy – the ability to choose between providers – does not always apply when it comes to delivering human services in rural and remote locations. If there are no providers in the area, or only one, then people cannot exercise choice. At best, many rural people have the option of choosing the only service provider in town, or going without.

The Alliance is keen to ensure that the unique circumstances of rural and remote Australia are given special consideration when developing policy in the human services area. In particular, policymakers need to be aware that in many parts of rural and remote Australia there is no realistic prospect of establishing a viable and sustainable market for service delivery. In these cases, the role of government must be different. Instead of investing time and resources into attempting to establish markets in areas where evidence points to a high likelihood of failure, governments should accept that it must take a more direct role in ensuring people have access to high-quality services.

The role of government in areas where there is no prospect of establishing a market can take various forms. It may include providing funding for salaried health professionals who are employed by government owned and operated health facilities. It may include providing subsidies and grants to private sector operators who are willing to set up practices in rural areas (for example medical and allied health professionals, or pharmacists), or making some services provided in rural areas eligible for government benefits (such as Medicare) where they are not if provided in city locations.

Encouraging service providers to relocate to rural and remote areas is only part of the challenge of establishing markets in these places. Once providers are there, governments need to take an active role in keeping them there. To improve the retention of health care and related service providers in rural areas, governments need to invest adequately in continuing

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[1] AIHW 2014.Medical Workforce 2012.National health workforce series no. 8. Cat. no. HWL 54. Canberra: AIHW.http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546076

[2] 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
Allied Health: AIHW 2013. Allied health workforce 2012.National health workforce series no. 5. Cat. no. HWL 51. Canberra: AIHW.
http://www.aihw.gov.au/publication-detail/?id=60129544591

[3] AIHW 2013. Nursing and midwifery workforce 2012.National Health Workforce Series no. 6. Cat. no. HWL 52. Canberra: AIHW.http://www.aihw.gov.au/publication-detail/?id=60129545333

professional development and training programs for these health professionals. Currently, there are many government programs and services in place that work along these lines. The Alliance is keen to ensure that these programs, where they are effective, are not jettisoned in the mistaken belief that they will not be needed under a market-based approach to service delivery.

Commissioning in rural and remote areas

The extent of commissioning in human services varies widely across sectors and jurisdictions. In some areas, for example mental health and employment services, governments routinely commission non-government organisations to provide services. In other areas, for example acute and primary care, governments have tended to play a more direct role by funding the establishment and provision of services, or providing benefits directly to patients who use health services.

Because of the difficulties of establishing viable markets in some rural and remote areas, commissioning services from private sector or non-government providers tends to happen less often in these areas than it does in major cities. If there is to be a shift in government policy to rely more on commissioning services, the Alliance believes that special consideration needs to be given to how, or if, it might work in rural and remote areas.

In rural and remote areas where there are likely to be a limited number of potential providers, there are additional risks associated with commissioning services. There is, for example, a considerable risk that commissioning bodies will relax their standards when selecting service providers if there are only a few potential options. If there is only one potential provider, it would be difficult for a commissioning body to deny a contract to a provider of inferior quality when the alternative would be no service delivery at all. The potential for standards to decline over time when there is only one provider in town is a very real one in rural and remote areas. Governments must pay special attention to this in areas where they are seeking to establish markets for delivering vital services, such as health care.

When faced with the typical situation of a relatively high cost of delivering services in rural and remote areas, providers may also be tempted to compromise on quality in order to save costs. This may take the form of supplying inexperienced staff, or curtailing expenditure on staff training, supervision or continuing professional development – resulting in diminished service quality and effectiveness in those areas.

To ensure that commissioning (where it is required and acceptable) has the best chance of working in rural and remote areas, governments need to ensure that additional resources are allocated to monitor the safety and quality of service delivery. Quality assurance systems that work in metropolitan areas will not necessarily work in rural areas. For example, additional investment may be required to support travel out to rural and remote locations to assess the quality of service delivery. Alternative models for complaints handling may also be needed in rural and remote areas where people may feel uncomfortable criticising service providers that they live and work alongside. For example, it may be necessary to fund assessors or complaints officers from communities outside the local area to ensure that people feel able to make complaints about services provided by local people.

Where commissioning services is possible in rural and remote areas, the government also needs to be cognisant of the challenges existing providers may have in transitioning to a market-based model. Currently, many public sector providers have limited experience operating in true market conditions. Public sector providers, for instance, make 'business'

decisions about workforce recruitment based on the knowledge that they have a fixed or set budget. They are not subjected to the same risks that many private sector operators are, and therefore require additional training and support (at least initially) to build the experience and business skills needed to succeed in this environment.

If there is a shift to commissioning in some rural areas, governments may need to provide additional support to public sector providers so that they are not forced out of the market in the early stages. This is particularly important because many public sector providers have years of valuable experience and detailed knowledge of the area in which they operate. Because there is a real risk that some private sector operators may come to the conclusion that they cannot sustain operations in rural markets, it is vital that governments support public sector providers to remain in operation in them. If they do not, rural people may be faced with the prospect of poorer access to care under a market model than they were when governments provided services directly.

Finally, governments need to be aware of the risks associated with establishing markets in some areas of human service delivery while continuing to also fund services directly. For example, in the area of health services for special needs children, state governments directly fund early intervention services for children with autism while the federal government has shifted to a competitive tendering model for similar services.

Some Alliance members have observed that in rural areas this has prompted some allied health professionals to resign from their positions in the public sector and set up private practices so that they can compete for federal government service delivery contracts. The result is that waiting times for public services have grown considerably as the workforce has not increased in size: it is the same providers working in both the public and private sectors.

Perversely, there is some anecdotal evidence that families in some rural areas have been putting pressure on health professionals to diagnose their children with conditions that meet the eligibility requirements for treatment under the federal government (privately commissioned) programs. They appear to be doing this because they know that this will maximise their chance of getting timely treatment for their children.

These examples serve as a reminder of the challenges of shifting to a market-based model where the market does not, and cannot, operate effectively.

If governments decide to pursue a greater number of market-based models for health service delivery in rural and remote areas, the Alliance stands ready and willing to assist in addressing its concerns about their design, implementation, management and appraisal.

ATTACHMENT

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (RRIG)	Exercise and Sports Science Australia (Rural and Remote Interest Group)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OA	Rural Optometry Group of Optometry Australia
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)