
Australian Government

Department of Health
and Aged Care

# Australian Government response to the Evaluation of Outreach Programs Report

## Introduction

The Australian Government funds a number of health outreach programs to address the high need for health services in areas of market failure, particularly in rural and remote areas. These programs are delivered by mostly the same fund holder in each state and territory.

| | Program | Target population | Locations* | Fundholders |
|---|---|---|---|---|
| 1 | Medical Outreach Indigenous Chronic Disease Program (MOICDP) | First Nations | MM1 – MM7 | NSW Rural Doctors Network<br>SA Rural Doctors Workforce Agency<br>NT PHN<br>NT Department of Health<br>Rural Workforce Agency Victoria<br>Rural Health West<br>CheckUP<br>TAZREACH, Tas Department of Health<br>Rural Health Tasmania |
| 2 | Eye and Ear Surgical Support Scheme (EESS) | First Nations | MM3 – MM7 | |
| 3 | Healthy Ears – Better Hearing Better Listening (HEBHBL) | First Nations | MM2 – MM7 | |
| 4 | Visiting Optometrists Scheme (VOS) | Whole of population* | MM2 – MM7 | |
| 5 | Rural Health Outreach Fund (RHOF) | Communities in rural and remote Australia | MM3 – MM7 | |
| 6 | Heart of Australia (HoA) | Communities in rural and remote Queensland | Queensland | Heart of Australia |

**Modified Monash (MM) Model*

These outreach programs aim to improve access to primary health care and specialist services for those living in rural and remote areas. While targeted populations who receive services through these programs are varied, the MOICDP, EESS and HEBHBL programs are specific to First Nations people. The VOS program serves all Australians, but 40 per cent of program funding is quarantined to fund services to First Nations people.

To reach this aim, the key objectives of the programs are to:

- identify health issues in regional, rural, and remote locations through improved collaborative needs assessment and health activity planning;
- provide tailored services in areas of market failure, particularly in regional, rural and remote Australia, who do not have ready access; and
- increase access to a range of health services to the targeted populations living in regional, rural and remote locations to meet community health needs.

These programs contribute to the reduction of the burden on the health system and improve quality of life for people by increasing access to a range of health services, especially for chronic diseases.

These programs also support the implementation of the National Agreement on Closing the Gap by providing services to First Nations Australians specifically. Chronic diseases are the leading causes of illness, disability and death, and are estimated to be responsible for 70% of the health gap in the First Nations people.[1] The MOICDP, EESS, HEBHBL and VOS outreach services aim at closing the health gap by treating and managing chronic diseases for First Nations Australians in regional, rural and remote locations.

## Background to the Evaluation

In 2019, the Department of Health and Aged Care (the Department) engaged Health Policy Analysis Pty Ltd (HPA) to evaluate the six outreach programs. The review report was submitted to the Department in late 2022.

The purpose of the evaluation was to assess:

1. outcomes of the programs to inform future policy direction;
2. service delivery, efficiency, effectiveness and appropriateness of the outreach programs, and the extent to which activities were coordinated across the programs;
3. whether the programs were achieving their objectives to determine if changes were required.

A set of key evaluation questions were designed to guide the evaluation and to capture feedback and insights from stakeholders. The key questions were:

1. How well are each of the outreach programs being delivered?
2. How effective are each of the outreach programs in achieving their intended outcomes?
3. How efficient and cost-effective are each of the outreach programs?
4. To what extent are the outreach activities coordinated across the outreach programs?

As a result of extensive stakeholder engagement, HPA consulted with 69 stakeholder organisations across Australia. These included fund holders, service providers, the National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates, Primary Health Networks, state health departments, an Aboriginal workforce group, hospitals, Australian Government Department of Health and Aged Care staff, a range of workforce organisations, and Community Grants Hub Funding Arrangement Managers.

The evaluation report comprises of three volumes, 39 recommendations and a number of further long-term recommendations and system level observations to consider.

## Government Response

The Australian Government welcomes the findings of the evaluation and acknowledges the importance of programs that reduce the difference in service access between Australians living in metropolitan and rural and remote Australia.

[1] AIHW 2023, Aboriginal and Torres Strait Islander Health Performance Framework, Section 3.05 Chronic Disease Management. https://www.indigenoushpf.gov.au/measures/3-05-chronic-disease-management. Accessed 3 August 2023.

The Government will consider the report and action recommendations as part of any decisions about the future of each program and future funding arrangements.

## Recommendations for initial action

To improve the programs, the Government will consider recommendations for initial actions, especially in the areas in relation to program design, stakeholder engagement, program management, funding indexation and a range of other factors between and across programs.

The Department plans to undertake a phased approach, informed by consultation with key stakeholders following the release of the report, including:

- Phase 1: Update the Service Delivery Standards (program guidelines) to ensure consistency between and across programs. Key stakeholders will be invited to provide input into these updates and these consultations will also inform planning for future funding for the outreach programs.
- Phase 2: Consider broader changes to the outreach programs.

| | **Recommendations for initial action** |
|---|---|
| 1. | **Recommendation 1:** The Department to review the governance and funding arrangements for HoA with a view to strengthen the overall coordination and integration of regional and local outreach service planning and delivery across Queensland. |
| 2. | **Recommendation 2:** Remove variation in the annual service plan approval process and establish a consistent approach across all programs by enabling the advisory forum in each jurisdiction to approve annual service plans for the RHOF. |
| 3. | **Recommendation 3:** Existing fundholders should be retained across all jurisdictions, while supporting the establishment or continued support of regional governance models that enable decisions regarding service planning, funding and delivery to be progressively devolved. This will build the capacity for regionally-responsive models that provide outreach to surrounding local communities. |
| 4. | **Recommendation 4:** Encourage fundholders to maintain a single advisory forum that oversees the needs and service planning functions for all outreach programs. Where multiple outreach fundholders exist in a jurisdiction, the fundholders could be encouraged to establish a shared Advisory Forum and coordinate needs assessment and service planning processes to avoid duplication and streamline reporting to the Department. These arrangements could be extended to include other organisations involved in improving access to health services (for example, PHNs), where appropriate. |
| 5. | **Recommendation 5:** To strengthen the role of the Aboriginal and Torres Strait Islander health sector in the governance of outreach programs, require fundholders to invite the National Aboriginal Community Controlled Health Organisation affiliate organisations (or their nominee) to co-chair the advisory forum. |
| 6. | **Recommendation 6**: Require fundholders to provide the Department and the National Aboriginal Community Controlled Health Organisation with their planned needs assessment and service planning processes for each period, including how and when they will engage with local communities and other key stakeholders and to what extent the process will be coordinated with other fundholders to avoid duplication and streamline reporting to the Department. |
| 7. | **Recommendation 7:** Fundholders to make the following publicly available:<br>• The planned needs assessment and service planning process before for each planning period, including the nature and timing of opportunities for local communities and other key stakeholders to provide input into the process and key contacts for feedback.<br>• The outcomes of the needs assessment and the service plan before the commencement of each the service period, including details of the services and communities to receive the services. |

8. **Recommendation 11:** The Department to engage with fundholders, and NACCHO and its affiliates, directly and more actively in creating opportunities for it to share and learn from each other and provide information and feedback on their performance and the future directions for the programs, including annual plenary planning forums, online communities of practice, regular performance feedback and national events to 'showcase' service innovations.

9. **Recommendation 12:** To improve transparency and support the objectives in the Closing the Gap Agreement, the Department to consult with the National Aboriginal Community Controlled Health Organisation and its affiliates prior to finalising funding allocations for Aboriginal and Torres Strait Islander Australians under the MOICDP, VOS, HEBHBL, EESS outreach programs.

10. **Recommendation 15:** Establish harmonised service delivery standards for the RHOF and the MOICDP to enable more flexible use of funding and better support local community health priorities. The service delivery standards should remove any inconsistencies by providing for the same level of coverage of the:

    - MM categories
    - Age of patients
    - Range of medical, allied health and nursing providers
    - Range of health conditions that can be addressed in meeting local priorities.

11. **Recommendation 17:** Ensure the service delivery standards for HEBHBL program, the provision under the VOS and EESS program are harmonised with those for the RHOF and the MOICDP to ensure consistent coverage of patient age groups and MM categories. While noting the variation in program objectives, alignment of age and location of patients may facilitate integration of services in supporting the broader eye and health needs of individuals in local communities

12. **Recommendation 19:** Review the current indexation of outreach programs with a view to applying a consistent approach across all programs with consideration given to existing approaches (for example MBS indexation, or the way the Independent Hospital Pricing Authority determines the hospital efficient price).

13. **Recommendation 20:** Review the range of planned service arrangements that require fundholders to seek approval from the Department (including alternative services arrangements where an underspend is anticipated) with a view to allow greater fundholder decision making capacity while strengthening reliance on fundholder accountability to ensure appropriate service provision and value for money

14. **Recommendation 23:** Simplify and harmonise guidance in the service delivery standards across all programs on the remuneration arrangements available for each workforce group and how they interact with funding support for transport, accommodation and food, including clarification of appropriate use of the Medicare Benefits Schedule and Workforce Support Payments to provide coverage of time:

    - travelling while away from usual practice
    - providing direct patient care
    - building local workforce capacity
    - engaging with local communities.

15. **Recommendation 25:** Extend the provision of funding for administration of the programs from 15% to 20%, with the requirement that 10% of the funding to be provided to extend financial support to host providers to coordinate and participate in face-to-face outreach visits, telehealth shared care arrangements, upskilling and education of their staff and enable community-led orientation and cultural awareness training.

16. **Recommendation 26:** Specify the requirement in the service delivery standards that a framework be applied to help guide the development of agreed local host and outreach provider arrangements in each community, including the number and nature of local staff involved, clinical equipment and facilities required, clinical referral protocols for ongoing treatment, risk management protocols and clinical governance arrangements.

17. **Recommendation 31:** Building on the momentum achieved through the COVID-19 pandemic, develop and monitor the implementation of a national program of shared care arrangements including local support for use of telehealth to broaden access and reliability of services, upskill the local workforce and support cost-effective continuity of care.

18. **Recommendation 37:** Allow fundholders to provide a consolidated:

    - needs assessment
    - annual service plan
    - narrative report.

    These documents would cover all the outreach programs. The single narrative report should include an explanation of factors contributing to any significant activity and/or budget variances within specific programs and identify planned mitigation strategies to bring the programs back on track.

## Recommendations for Future-thinking actions

The Australian Government notes recommendations 8, 9, 10, 13, 14, 16, 18, 21, 22 and 24. The recommendations go beyond the scope of the six programs and the evaluation to long term and significant program design elements that may be considered by Government in future program considerations.

1. **Recommendation 8:** The Department to review existing fundholder data information and reporting and design and establish a new standardised single national minimum data set, along with a streamlined data collection and reporting process, that:

a) covers all programs
b) reduces data burden on fundholders.
c) provides a sound basis for performance monitoring and feedback
d) enables consolidation of the data at the jurisdiction and national levels.

2. **Recommendation 9:** As part of the new standardised national minimum data set, the Department to establish and collect a small suite of key consumer facing key performance indicators (including outreach provider continuity, patient experiences, clinic utilisation, visit duration and unit costs) with data elements specified in the Australian institute of Health and Welfare metadata store to improve consistency and facilitate cross-jurisdictional comparisons.

3. **Recommendation 10:** To improve transparency and establish more robust data sharing arrangements that align with the National Agreement on Closing the Gap, the Department to provide key stakeholders groups, such as the National Aboriginal Community Controlled Health Organisation, its affiliates and the fundholders with regular and timely access to the national minimum dataset for the outreach programs.

4. **Recommendation 13:** Fundholders to work with the NACCHO affiliates to identify further opportunities to progressively devolve outreach program funding for MOICDP, VOS, HEBHBL, EESS to regional Aboriginal Community Controlled Health Organisations, where robust governance and service capacity are in place.

5. **Recommendation 14:** The Department to explore ways to further integrate the VOS with funding support under the RHOF and the MOICDP for ophthalmologists and other eye health providers to enable more flexible use of eye health funding and better support local community eye health priorities, including review of existing enabling legislation for the Visiting Optometrists Scheme.

6. **Recommendation 16:** Extend the scope and coverage of the service delivery standards of the RHOF and the MOICDP to explicitly include dental health and to confirm coverage of eye and ear health services to clarify the scope for integration with services funded under other relevant outreach programs.

7. **Recommendation 18:** Review the current approaches to allocating funding to jurisdictions for the programs and explore alternative methods, including those that are responsive to both changes in demographics and the capacity of local service provision. For example, variations in Medicare Benefits

Schedule utilisation across rural and remote areas in each jurisdiction could provide a signal of local service capacity and align with the Workforce Incentives Program and other initiatives aimed at building the local workforce.

8. **Recommendation 21:** Encourage fundholders to extend existing collaborative arrangements with other fundholders to foster regional approaches to conducting needs assessment and service planning and establishing a shared 'regional master plan' that incorporates outreach, regional and local services.
9. **Recommendation 22:** Establish a greater focus on planning, monitoring and funding time spent by outreach providers in undertaking community engagement and relationship building and host provider teaching and training. These activities could be supported by incorporating specific plans guided by consultation with communities and budget allocations under the overall service plans.
10. **Recommendation 24:** Review the Medical Benefits Schedule and existing workforce support payment arrangements to create a simpler, more consistent and sustainable way to reimburse outreach providers. This may include exploring the feasibility of moving to blended payments.

## Recommendations with broader health system observations

The Australian Government notes broader system observations 1-8. The observations provide scope for both expansion of program objectives and its interactions with other programs, stakeholders and workforce policy and will be considered as part of any decisions about the future of each program and future funding arrangements.

**Broader system observation 1:** To strengthen consideration of health outreach as an enduring and responsive mechanism to improving service access in rural and remote communities, the Department could consult with officers from relevant portfolio areas to ensure further integration of the health outreach programs is achieved through future strategy development under the Stronger Rural Health Strategy and the National Agreement on Closing the Gap.

**Broader system observation 2:** Department could explore feasibility of revising funding arrangements to better support the sustainability of outreach providers and services by establishing processes for more predictable and reliable funding.

**Broader system observation 3:** The Department could consult with universities and health agencies responsibilities for medical, nursing and allied health student clinical placement programs to explore scope to further integrate students into outreach services, including arrangements to financially support students.

**Broader system observation 4:** The Department could encourage fundholders to engage with public and private health service agencies to identify and explore the potential to expand strategies to promote a workplace culture whereby participation in outreach is actively supported by the agency.

**Broad system observation 5:** The Department could encourage host services to further explore new workforce models and training pathways, such as the Certificate III in Allied Health Assistance, which seek to bolster and develop local capacity to better support the outreach programs.

**Broader system observation 6:** The Department to consider the feasibility of commissioning the assessment of service models to build an evidence base for innovations that represent value for money, with a view to provide support for the capital infrastructure required for such innovations through the establishment of an open and contestable national funding pool.

**Broad system observation 7:** The Department could commission a study on the long-term recurrent costs of transport for one day visits versus the provision of capital infrastructure that provides accommodation and support for longer stays by outreach providers, particularly in smaller and very remote communities. This may contribute to broader economic consideration of the financing of capital infrastructure in rural and remote communities.

**Broader system observation 8:** The Department may seek to investigate possible ways to further encourage fundholders to explore potentially cost-effective service innovations, recognising that existing arrangements allow fundholders to roll over unspent funds that may result from efficiencies generated from service innovations and invest them back into service expansion.