5. Delivering disability services

Although the majority of Indigenous Australians live in major cities and inner regional areas, a much higher proportion of the Indigenous population resides in outer regional, remote and very remote areas than is the case for the non-Indigenous population. While a number of the issues that need to be considered when delivering disability services to Indigenous Australians apply in all geographic areas, there is a set of specific issues that relates to providing services in regional, remote and very remote areas. This chapter discusses key issues involved in delivering disability services to Indigenous people and possible delivery models. Several possible models and approaches to service delivery are discussed and, drawing upon the existing evidence base, where it exists, the advantages and disadvantages of different models are outlined.

Implications of the nature of Indigenous disability for service delivery

While there are many similarities in the nature of disability experienced by Indigenous and non-Indigenous Australians, there are some distinctive aspects of disability in the Indigenous population which have important implications for the delivery of services. Key features of disability in the Indigenous population are:

- a significantly higher rate of disability in the Indigenous population, especially after adjusting for age
- impairment tends to occurs in earlier age groups for the Indigenous population
- Indigenous people with a disability are relatively more likely to have an intellectual disability than are non-Indigenous people with a disability
- there is a higher incidence of complex needs and issues which span health, disability and other issues; an example is substance abuse combined with cognitive impairment[1]
- many Indigenous people with a disability are themselves caring for one or more other persons with a disability[2]

1 Wilkes et al. (2010) report that Indigenous men are over four times, and Indigenous women over three times, more likely to be hospitalised for mental disorders attributable to psychoactive substance misuse than their non-Indigenous counterparts.

2 According to the 2008 NATSISS, about half of Indigenous people with a disability were caring for somebody else with a disability.

- cultural differences in perceptions of disability and of identification as having a disability amongst some groups of Indigenous Australians.

There are also a number of interactions between these factors. For example, when combined with substance abuse, intellectual disabilities are often associated with behaviours that are challenging from a service provider perspective. Furthermore, the impact of disability on a person's ability to function is determined by the interaction between the physical nature of their disability and the physical, economic and social environment within which they live. There are clear differences between the environment in which the Indigenous population with a disability live and that of the non-Indigenous population and these can have important implications for the impact of disability on people's lives as well as the nature of service needs.

One set of differences relate to geographic remoteness. Some of the implications for services arising from geographic remoteness are:

- low population density, which can provide a number of challenges to service delivery, making it more expensive than in cities and larger towns
- difficulties in attracting and retaining a professional skilled workforce
- distance from key infrastructure, such as hospitals
- often a lack of physical infrastructure or poor-quality infrastructure e.g. roads, suitable buildings
- harsh climatic conditions and inaccessibility due to weather events for extended periods of time.

Writing about a Northern Territory community, Senior (2000: 10) notes:

> The physical environment of the community is limiting to people with disabilities. The roads are dirt and deeply corrugated causing great difficulties for those in wheelchairs or who are unsteady on their feet. In the wet season the roads are often flooded and always boggy. Moving around the community can be very difficult. Transport is also a problem for members of the community. Very few people have cars and public transport is limited.

There are a range of factors that need to be taken into account when delivering services to Indigenous Australians. As there is a great deal of diversity within the Indigenous community, the following issues will apply to a differing extent to particular individuals, groups or communities.

- The nature of family, family networks, and the ways in which informal care is provided.

- Mistrust of government services arising from negative past experiences, or simply an individual's feeling that government services are not for them.
- Higher rates of low income and economic deprivation.
- Relatively low levels of education and associated low levels of literacy and numeracy. In some communities, English is not the first language spoken.
- Cultural differences in the way in which disability is perceived, understood and responded to, and the ways in which it impacts on people's lives.[3]
- Being over-represented in the criminal and juvenile justice systems, and in the care and protection system, both as parents and children.

Current disability service delivery models and systems in States and Territories

A variety of disability service delivery models are currently operating in Australia.[4] The key features of the system in each State and Territory in 2012 are summarised here and in Fisher et al. (2010). There are differences in the extent of individual support packages (ISPs) and consumer control over how their support package is allocated. Nonetheless, there appears to be a trend towards individualised funding models with some jurisdictions having had individualised funding models and consumers having had much more say in the services they access for a significant period of time (in the case of Western Australia since 1988), while others are trialling ISPs and consumer choice (e.g. South Australia).

3 However, as noted earlier, there is relatively little qualitative research on this issue and very little if any quantitative research.

4 As part of the National Disability Agreement (NDA), the Commonwealth, State and Territory governments have agreed that a priority is to increase the access of Indigenous Australians to disability services. The National Disability Agreement National Indigenous Access Framework has been agreed to by Commonwealth, State and Territory governments. The framework is available from http://www.dprwg.gov.au/research-development/publications/national-indigenous-access-framework (accessed 27 November 2012).

Disability service models operating in Australia

New South Wales

The funding model in New South Wales is for a wide range of community support and specialist care provided directly by Ageing, Disability and Home Care (ADHC) or through the Home Care Service of New South Wales, a statutory authority. ADHC also funds 900 local governments and non-government organisations (NGOs) to provide services.

In terms of the degree of individual control, New South Wales is in the formative stages of self-directed support. Some pilots with small numbers of people include:

- The Attendant Care Program – direct payment model
- Community Participation – self managed model
- Family Assistance Fund
- My Plan, My Choice – Early Start
- My Plan, My Choice – Older Carers program
- Life Choices and Active Ageing – self-managed model
- Extended family support
- Younger People in Residential Aged Care (YPIRAC) Program

Intermediaries are commonly used. ADHC currently offers two models of individual funding: the first where a portable funding package is held by the service provider, which provides or buys disability support for the person; the second involves the person or family receiving a direct payment to purchase disability support from the open market, including service providers.

An Indigenous specific program called Services Our Way (SOW) is a demonstration project commenced in 2010–11. It is available to Aboriginal people (in the trial area) with a diagnosed intellectual or physical disability, including Acquired Brain Injury and Multiple Sclerosis. SOW is based on an ISP with the funds held by the agency. The program is delivered by Aboriginal Support Specialists. It should also be noted that an ADHC Aboriginal Advisory Committee was established in June 2011.

As far as rural/remote specific programs are concerned, the rural and remote working group was formed in 2010. Remote videoconferencing facilities have been developed.

Victoria

The funding model in Victoria is a mix of ISPs (to service provider or financial intermediary or through a direct payment) and block funding through the Community Sector Investment Fund. The Department of Human Services offers specialist disability services including short-term supports (such as respite services, behaviour supports, case management and therapy), and ongoing supports (such as ISPs and shared supported accommodation). It should be noted that the demand for ISPs exceeds supply. A report on the effectiveness of individualised funding has been published (Victorian Auditor-General's Office 2011).

The degree of individual control is indicated by the *Victorian State Disability Plan 2002–12* which emphasises individual needs and choices (since the time of this research, the *Victorian State Disability Plan 2013–16* has been released). In 2010–11, around 700–800 people had an ISP, receiving 19 per cent of annual total disability funding. People on an ISP can use any combination of direct payments, a financial intermediary service, and/or a registered disability service provider. ISPs are approved regionally, but once obtained, funding can be moved to another region. If the participant moves interstate, funding moves with them for a 12 month period. Participants can buy services delivered just to them or buy group-based services. Facilitators are available to help people to develop a personal plan for their needs and goals, and a funding proposal, but the person with disability or a supporter may take on this role if they wish. The regional office assesses the funding proposal, which must be reviewed at least every three years. Funding cannot be used to employ staff directly, unless as part of the Direct Employment Project Trial and with departmental approval, or employed by a service provider. Family members (not living in same dwelling) may be employed if they meet these criteria.

The Indigenous specific programs operating in Victoria are the Closing the Gap project, and the Disability Services Cultural and Linguistic Diversity Strategy.

Queensland

Funding for disability services in Queensland is a mix of block funding, targeted funding, individual funding, and hybrid funding models. Specialist disability services are delivered by Disability Services Queensland and the non-government service providers funded by it. The Growing Stronger program of reform (2007–11) aimed to build a better specialist disability service system, shifting from an input-funding focus to funding for output-based service provision

(Disability Services Queensland 2007). In July 2011, program structures (Post School Services, Family Support Program and Adult Lifestyle Support Program) were discontinued in favour of individualised assessments of needs.

The degree of individual control is limited in Queensland as block funding is the central approach. Some service providers do offer people control over their funding; however if a person receives funding directly, they must incorporate as an organisation and meet the requirements of a service provider. A small-scale program—the Self-Directed Support Pilot Program—involved 80 people over two years, and was directed at people without existing links to the community and without prior funding from Disability Services Queensland.

In terms of Indigenous specific programs there is an interpreter and translation assistance strategy. As far as rural/remote specific programs is concerned, Local Area Coordinators in rural and remote communities are employed to focus on strengthening individuals and communities with an emphasis on building natural and local supports.

South Australia

The funding model for South Australia is centred on Disability Services as the government service provider for people with disabilities. It provides supported accommodation, service coordination and specialist services. Services are also provided by non-government service providers. Individual funding is based on portable funding held by a service provider. While individual funding packages are common, they are not available across all service types.

The degree of personalisation is limited to a new approach to individualised funding, with a trial of 50 people that commenced in June 2010. Each participant was provided with a 'self-management facilitator', to help participants and their support network develop a personal plan. The participant (or proxy) may arrange and purchase services, decide what to buy but pay an organisation to manage the financial arrangements, or pay an organisation to arrange services and manage funds. The participant is helped in managing their funding through training, resource materials, an enquiry service, and their facilitator. Services must be purchased from organisations registered on the Disability Services Provider Panel, and participants must account for any use of funds, with quarterly and annual acquittals of the funding (and keep records of support and expenditure plans, receipts, invoices and relevant bank statements for seven years), with unspent money returned to the Department of Families and Communities after 12 months.

There is an Indigenous specific program through the Disability Services team of Aboriginal staff providing support for Aboriginal people with disability, their

families and carers. They provide Aboriginal workers if preferred, assist in finding and using disability services, and provide advocacy and help clients to secure support. In addition, there is a Cultural Inclusion Team that provides leadership on policy, community consultation, and regional planning for disability services to Aboriginal and Torres Strait Islander people with disability, their families and communities. This includes researching needs, trends and priorities; developing policy within the department and other government sectors; and improving contract outcomes with non-government service provision.

In terms of rural/remote specific programs, the Independent Living Centre's Mobile Unit Outreach Service is a free government service for people living in rural and remote South Australia.

Western Australia

Under the Western Australia funding model, individualised funding has been progressively implemented since 1988 and applies to all recipients of State government disability funding since 2005. The full range of individual funding approaches is applied, with portable funds held by providers, facilitators and direct funding to individuals and families. Block funding is rarely used to fund service providers. Direct funding is facilitated through the Local Area Coordination Program, with a network of Local Area Coordinators assisting individuals to plan, select and receive services. Applications for individualised funding go through a Combined Application Process, which prioritises and allocates funding. A significant proportion of services are provided by NGOs.

There is a high degree of consumer control in Western Australia compared to other States under shared management with coordination, administrative and financial functions undertaken by the intermediary organisation (including helping recruit, train and supervise the carer, and all the tasks associated with service delivery, including designing the support package). The Local Area Coordination Program also includes a capacity for self-directed funding through untied funding to cover low-cost, one-off, critical urgent needs (with a 16% uptake).

There is an Indigenous specific package, Getting Services Right, for Aboriginal people and their families in Western Australia, and an Aboriginal project officer within National Disability Services and within the Disabilities Services Commission policy branch. Regarding rural/remote specific programs, the Disabilities Services Commission has a country resource and consultancy team; and the Country Services Coordination Directorate has a remote area strategy.

Tasmania

The Tasmania funding model involves disability services primarily delivered by NGOs, with the government retaining the role of funder and regulator. To access services in Tasmania, clients are assessed and referred by Gateway Services who provide local area support. Self-directed support in Tasmania is delivered principally through ISPs, where funds are portable and held by a service provider. Under the ISP, the person with a disability applies for a number of support hours up to 34 hours per week to receive personal care and respite assistance. The hours are allocated to the person and the funding contract is made with the non-government service provider. The Tasmanian Government does not directly fund the person: it enters into a three-way contract with both the person and the service provider. People may cash out their allocation (based on funds equivalent to the weekly allocation of hours) to purchase personal support while on holiday and to buy authorised respite services. There is some trialling of direct funding through intermediary service providers. The Tasmanian Government has indicated that it plans to increase the use of self-directed support following a KPMG review of disability services in 2008 (KPMG 2009).

Northern Territory

The Northern Territory funding model is undergoing major reform. Most disability services are provided through block funding to service providers, and ISPs are only used if block-funded services not available. The NGO sector is the major provider of services but is not reaching remote areas. In terms of individual control, at the time of the KPMG review of disability services (KPMG 2009), only around 10 per cent of funding was allocated to people through Individual Community Support Packages (ICSPs) based on individual assessments. The main role of ICSPs was to 'fill gaps in the Northern Territory Disability Service system with small and tailored packages'. ICSPs include the capacity for direct funding, paid and acquitted quarterly, and overseen by Disability Case Coordinators and Case Managers (with arrangements through Local Area Coordination now abandoned). The client has administrative responsibility for purchasing, managing expenditure, and accounting; they have substantial flexibility in purchasing from mainstream providers and from friends and neighbours as carers. Direct payments account for less than half of ICSPs.

Australian Capital Territory

In the Australian Capital Territory people with disability are required to register their interest to receive services or to change the type or level of services they receive. Funding is allocated through ISPs, allowing individuals to choose the

type of service and support they receive; however block funding of service providers remains important. While an agreed total level of funding is allocated to an agency for a specific individual, the service agency pools the funds with block funds and may allocate them to other individuals.

In terms of individual control, there is a small level of self-directed support through ISPs which are based on individual assessment, and generally occur through a service provider. This can take the form of individually tiered funding (brokered funding), individualised funding (direct funding), and individual grants (small non-recurrent allocations for a specific period, but with considerable flexibility about how they are acquitted). Local area coordination is provided through two community sector sites, rather than by government.

Indigenous specific programs are provided through several avenues. Aboriginal and Torres Strait Islander Services is part of the Office for Children, Youth and Family Support and aims to provide culturally appropriate services. Carers ACT Indigenous Carer Program provides assistance on request for counselling, information and advice, service referrals, case management, social support in general, and education and training. Disability ACT is developing a Draft Policy Framework for Aboriginal and Torres Strait Islander People with a Disability and Their Families (Disability ACT 2011).

The context of service delivery

Remote communities

It is widely recognised that a lack of access to services and infrastructure are important contributors to the high levels of disadvantage experienced in many remote Indigenous communities. The situation is clearly described in a recent Council of Australian Governments (COAG) report as a mixture of patchy service delivery, ad hoc and short-term programs, poor coordination, and confusion over roles and responsibilities. Complications have been exacerbated by Indigenous specific programs being added, often to replace missing mainstream services and/or without any relationship to community development priorities (COAG 2008).

Services in remote Indigenous communities are jointly funded by State and Territory governments and the Commonwealth Government and are often delivered by NGOs. Over the period 1990–2004, Commonwealth funding was provided to Indigenous community organisations largely via the Aboriginal and Torres Strait Islander Commission (ATSIC) and subsequently by Aboriginal and Torres Strait Islander Services (ATSIS). Since 2004, many Indigenous community

organisations have continued to receive funding to provide services. NGOs from outside remote communities have increasingly been funded by government to provide services to remote communities. The main types of organisations funded by governments to deliver services in remote areas are community councils/corporations, regional service providers, and specialised service providers. Many of the organisations are relatively small and very few specialise in a single area of service delivery (Office of Evaluation and Audit (Indigenous Programs) 2009). The most developed community services tend to be in the area of primary health care (Mason 2006).

Historically, Community Development Employment Projects (CDEP) organisations have delivered a range of services in remotes communities. As of the 1 July 2013, the CDEP scheme was replaced by the Remote Jobs and Communities Program, combining four programs currently providing employment and participation services and community development in remote Australia (see Department of Social Services 2013). These are existing CDEP providers, Job Services Australia, Disability Employment Services, and the Indigenous Employment Program.

There are a number of features of Indigenous communities in remote and very remote areas of Australia which make delivering services difficult and expensive. These include small populations, low population density, long distances, extreme seasonal variation in weather, insufficient accessible and affordable transport, physical isolation, and poor-quality infrastructure. Other challenges are related to the characteristics of the Indigenous population and the negative experiences that many Indigenous people have had in their interactions with government agencies. These have been discussed in Chapter 1.

In response to the concerns regarding the lack of access to services and poor coordination of services in remote communities, a number of government initiatives are being implemented which aim to improve service delivery in these communities. One initiative being implemented is the National Partnership Agreement on Remote Service Delivery (NPARSD), a place-based approach, which involves the designation of 29 priority communities or locations. It is designed to both improve the range and standard of services delivered, and to improve community engagement and development. The 29 priority communities are spread across New South Wales, Queensland, South Australia, Western Australia and the Northern Territory, and will be the focus of targeted improvements in government service delivery.

These are among the larger communities in remote areas of Australia and provide a good guide as to the number of people who may be eligible for the NDIS in

this community type. Population projections for 2026 have been undertaken for these communities by the Centre for Aboriginal Economic Policy Research (CAEPR), and this analysis is presented below.[5]

Cost of providing services according to Indigenous status and geographic remoteness

The costs of providing many services increase with geographic remoteness. The Commonwealth Grants Commission (CGC) provides estimates of how the costs per employee vary according to geographic remoteness for police, schools and general services. The CGC estimate of the remoteness cost gradient of providing government services is shown in Fig. 5.1. It is clear that the relative cost per employee increases sharply with remoteness. The cost-remoteness gradient is steepest for police, followed by schools and then general services. In remote areas the cost per employee of providing policing is over 1.5 times that in a highly accessible area, whereas the costs of providing general services in very remote areas is just under 1.2 times the cost in highly accessible areas.

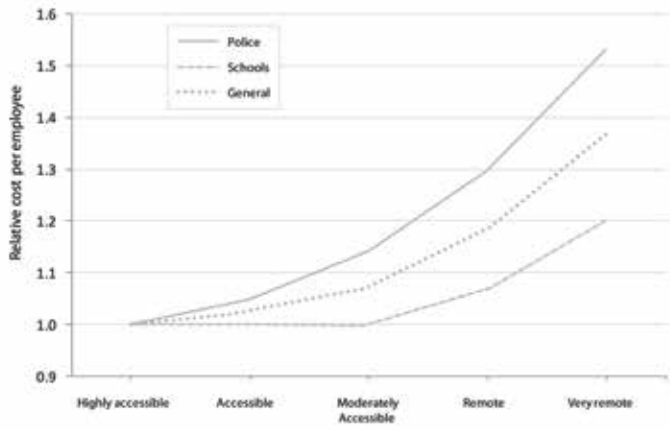

Fig. 5.1 Remoteness cost gradient for government services, Australia, 2012

Source: CGC 2012: Fig. 5.4

5 In late 2009, CAEPR was commissioned by FaHCSIA to undertake population projections for the 29 NPARSD communities. Details of the method used to produce the population projections are provided in Appendix 1 (projection scenario 4 has been used).

Even after the additional costs associated with geographic isolation are taken into account, the CGC finds that on average more is spent on Indigenous people than on comparable non-Indigenous people. CGC estimates indicate that on average, States/Territories spend four times as much on welfare and housing services for Indigenous people as they spend on non-Indigenous people with the same remoteness and other socio-demographic attributes (Table 5.1).

Table 5.1 Estimated average spending on comparable Indigenous and non-Indigenous people, Australia, 2012[a]

Service	Average spending per Indigenous person ($)	Average spending on comparable non-Indigenous people ($)	Ratio
Schools education	5 375	3 206	1.7
Post school education	667	237	2.8
Admitted patients	2 836	1 089	2.6
Community health	1 914	842	2.3
Welfare and housing	5 995	1 379	4.3
Services to communities	1 448	789	1.8
Justice services	4 988	713	7.0
Other	4 101	4 101	1.0
Total	27 325	12 356	2.2

a. The average spending on non-Indigenous people weighted by the socio-demographic mix of the Indigenous population.

Source: CGC 2012: Table 5.5

Estimating current and projected demand for NDIS in NPARSD locations

As discussed above, the 29 priority communities identified under NPARSD provide a useful basis for examining how the NDIS may impact in some remote communities. Using existing data sets, it is not possible to estimate reliably the rate of disability for the NPARSD communities (see Chapter 2). Therefore, in order to produce indicative estimates of the level of disability in the NPARSD communities, the following rough calculation is used. Based upon the Productivity Commission Report, the estimated Tier 3 NDIS population is 410 000, which is 2.12 per cent of the Australian population aged 65 years and under in 2010. This NDIS coverage rate is then multiplied by 2.5, our best estimation of the relative difference in the rate of disability between Indigenous and non-Indigenous Australians (see Chapter 2). The estimated Indigenous NDIS coverage rate is therefore 5.3 per cent, which is applied to the estimated Indigenous population aged 0–64 years in the 29 communities, as well as the projected 2026 population.

The estimates and projections presented in Table 5.2 show that for a number of the larger NPARSD communities there is a substantial number of Indigenous Australians who potentially fall under the remit of the NDIS. It is estimated that by 2026 there will be 2 755 people living in the NPARSD communities who would have significant and permanent disability and be eligible for the NDIS, ranging from 16 in Mossman Gorge to 255 in Maningrida.

The Productivity Commission cost estimates of their proposed scheme are based on an average individual package value of about $29 000 per annum.[6] Multiplying this by the relative cost ratio of 1.2 used by the CGC (2012) for remote Australia results in an estimated expenditure of about $35 000 per potential NDIS user in a remote community and rises to about $40 000 in very remote areas. To the extent that in these communities there is relatively little payment made for disability services, the introduction of the NDIS will potentially lead to a considerable inflow of funds into many of the large communities. For example, based on these projections it is estimated that by 2026 an additional $8.8 million per annum (in 2012 dollars) in NDIS funding will be coming into Maningrida.

The CGC also includes an additional estimate for higher average spending across a range of services for Indigenous compared to non-Indigenous users. This is in addition to differences based on socioeconomic status and remoteness of the area in which that service is provided. For community health, the ratio was 2.3 times higher for an Indigenous compared to a non-Indigenous person. For welfare and housing, it was 4.3 times as high. If these were also applied to services as part of the NDIS then it is quite possible that additional expenditure in some of the larger communities could be in the tens of millions of dollars.

6 This was derived by dividing the total estimated expenditure on the care and support component of the scheme ($1.184 billion) by the Tier 3 NDIS population (410 000).

Table 5.2 Potential NDIS demand in 29 priority communities, Australia, 2006–2026

Community	State	2006 estimate			2026 projection		
		Total	Aged 0–64 years	Potential NDIS demand	Total	Aged 0–64 years	Potential NDIS demand
Amata	SA	341	328	17	657	607	32
Angurugu	NT	1 013	990	52	1 958	1 823	97
Ardyaloon	WA	243	235	12	467	430	23
Aurukun	Qld	1 059	1 026	54	2 051	1 875	99
Beagle Bay	WA	1 059	1 026	54	2 051	1 875	99
Coen	Qld	239	232	12	466	427	23
Doomadgee	Qld	1 102	1 067	57	2 168	2 007	106
Fitzroy Crossing	WA	733	697	37	1 454	1 354	72
Galiwinku	NT	2 158	2 110	112	4 178	3 891	206
Gapuwiyak	NT	1 208	1 180	63	2 336	2 175	115
Gunbalanya	NT	1 141	1 116	59	2 243	2 111	112
Halls Creek	WA	1 092	1 047	56	2 145	1 994	106
Hermannsburg	NT	938	904	48	1 798	1 673	89
Hope Vale	Qld	797	772	41	1 543	1 411	75
Lajamanu	NT	735	711	38	1 427	1 337	71
Maningrida	NT	2 600	2 545	135	5 111	4 811	255
Milingimbi	NT	1 086	1 063	56	2 132	2 007	106
Mimili	SA	289	278	15	558	515	27
Mornington Island	Qld	1 028	995	53	2 026	1 875	99
Mossman Gorge	Qld	165	160	8	327	302	16
Nguiu	NT	1 463	1 432	76	2 875	2 706	143
Ngukurr	NT	1 055	1 021	54	2 043	1 914	101
Numbulwar	NT	713	697	37	1 381	1 286	68
Umbakumba	NT	434	424	22	839	782	41
Wadeye	NT	2 074	2 030	108	4 077	3 838	203
Walgett	NSW	1 220	1 174	62	2 429	2 220	118
Wilcannia	NSW	453	436	23	888	811	43
Yirrkala	NT	1 472	1 438	76	2 857	2 662	141
Yuendumu	NT	701	675	36	1 348	1 255	67
Total		28 612	27 808	1 474	55 832	51 971	2 755

Source: Customised calculations based on 2006 Census data, details given in Appendix 1

Primary health care system in remote communities

One of the best developed and the most extensive service system in remote communities is the primary health care system. The experience has been that standard mainstream services do not meet the needs of rural and remote communities (Humphreys and Wakerman 2008). This has led to a range of different and distinctive models for the delivery of services. Humphreys and Wakerman (2008) have developed a useful typology (reproduced in Table 5.3) for models for the delivery of primary health care in rural and remote communities.

Table 5.3 Typology of 'innovative' rural and remote models for primary health care delivery

Context: rural-remote continuum	Primary health care model & examples	Main drivers for model
RURAL Larger, more closely settled communities	Discrete services: • 'Walk-in/walk-out' model • Viable models of General Practice • University Clinics	Population numbers usually sufficient to meet essential service requirements (some supports still needed to address workforce recruitment and retention)
	Integrated Services • shared care • Coordinated Care Trials • Public Health Service teams • multi-purpose services	Service integration resulting from pooled funding maximises efficiencies and access to locally available services. Single point of entry to the health system helps to coordinate patient care and reduces the need for travel
	Comprehensive Public Health Service services: • Aboriginal Controlled Community Health Services	Community participation, service flexibility to meet local circumstances, and access to services are critical components where few alternative ways of delivering appropriate care exist
REMOTE Small populations dispersed over vast areas	Outreach Services: • 'hub and spoke' models • visiting services • 'fly-in, fly-out' services • telehealth/telemedicine	Periodic outreach services (sometimes co-existing with other models) provide care to communities too small to support permanent local services

Source: Humphreys and Wakerman 2008: 6

While a number of innovative models have been developed and implemented, Humphreys and Wakerman (2008: 7) conclude that 'few have been evaluated in terms of their impact on health outcomes'. Barriers to the provision of health services to regional and remote communities which have been identified include:

- a funding focus on remunerating service providers rather than the needs of consumers which can result in supplier-induced demand
- workforce shortages
- inadequate health service performance monitoring and evaluation
- failure to organise care for chronic conditions
- failure to address prevention adequately
- lack of infrastructure, and
- failure to empower patients to participate in their care.

Many of these issues are directly applicable to the provision of disability services. A feature of health services in remote communities is that organisations typically provide a wider range of services than health services in urban areas. In rural and remote areas they often provide community-wide integrated health

services that can include mental health, oral health, community, and aged care and social services (see *The National Strategic Framework for Rural and Remote Health* between the Commonwealth, and State and the Northern Territory Governments by the Rural Health Standing Committee (Rural and Regional Health Australia 2012)).

Models for the delivery of family and relationship services in regional, rural and remote areas

An alternative typology of service provider models developed in the context of the delivery of family and relationship services in regional, rural and remote areas has been developed by Roufeil and Battye (2008). Table 5.4 provides an overview of common service provider models operating in regional, rural and remote Australia and their advantages and disadvantages. The authors note that there is limited published research comparing the effectiveness of different models, and have called for evaluations to be better funded and integrated into programs. In most cases, however, there is some evidence on how to maximise the efficacy of particular service models. Roufeil and Battye (2008) also state that while it is useful to consider different types of service models, it is important to keep in mind that the most critical requirement in rural, regional and remote communities is having strong, broad-based generalist services and that there are clear disadvantages in locating specialist services in such areas if there is not also a strong generalist workforce.

Table 5.4 Review of service provider models in regional, rural and remote areas of Australia

Model	Characteristics	Advantages	Disadvantages
Purchaser-provider	The purchaser is generally the government, which specifies the type, level, target groups and location of a service that is subsequently delivered by an auspice body (the provider); usually involves a fixed-term contract.	Provides an effective way to distribute finite funds. Potentially facilitates delivery of services by local people, as opposed to introducing new services to a town. It is preferable if purchaser and provider are able to be flexible with the specified service guidelines so that local needs can be accommodated.	Tender process fosters competition, not cooperation, between agencies. Tenders are skewed towards being granted on grounds of pricing, not on basis of local knowledge. Contract usually developed off-site and rarely reflects local needs (can be overcome by requiring tenderers to tailor service to meet local needs). Many providers are urban-based, with exogenous service delivery leading to loss of local trust, reduced local knowledge, diminished local capacity-building and reduced options for local cowmmunity development. Rigid adherence by purchaser to specified services and target groups limits ability of provider to implement flexible and holistic services to families.
Hub and spoke	A way of facilitating regionalisation and centralisation of services, such that services tend to be based in areas of greatest population density (hub) and provide services out to smaller centres (spokes). Can operate under a variety of funding models, including purchaser-provider.	Makes economic sense; works well when outreach services are regular, reliable, and adequately resourced, and have sufficient time to engage with local community.	Many outreach services are unreliable and susceptible to the vagaries of the weather, transport and availability of staff. Outsider providers often have little local knowledge and lack community trust. Managers are generally isolated from spokes, with little local knowledge.

Model	Characteristics	Advantages	Disadvantages
Collaborative models: interagency collaboration/ networking	Interagency collaboration spans informal networks (e.g. knowing who to talk to in order to reduce red tape) and formal networks (e.g. partnerships in service delivery using existing networks, referral protocols, case conferences, memoranda of understanding, co-location, and joint training).	Scarce resources can be maximised to produce the critical mass needed to sustain effective service delivery (e.g. *Bila Muuji Social and Emotional Wellbeing Initiative*). Fosters holistic approach to assisting families. Collaboration builds trust and a culture of reciprocity between providers and communities. Collaboration becomes increasingly important as remoteness increases. Although partnerships involve non-local educators, local agencies conducting the promotion/practical setup can help to ameliorate concerns about confidentiality (e.g. Lutheran Community Care's *Through Thick and Thin* program). Works best with active managerial support, time allocation, and strong leadership/role modelling.	Collaboration and effective networking challenges frontline staff, management and organisations; work overload often distracts from collaborative approach. Attitudes toward interagency collaboration at local level can be negatively influenced by competitive tendering processes.
Collaborative models: co-location	Sharing expensive infrastructure between agencies.	Useful for small agencies that would otherwise spend a high proportion of budget on infrastructure. Can be a valuable one-stop shop for clients (e.g. Early Years Centre in Nerang, Queensland).	Research evidence of efficacy of co-location is equivocal and co-location alone is probably insufficient to improve service delivery. Co-located agencies in small communities are vulnerable if one of the participating agencies closes. One-stop shops rarely overcome tyranny of distance for rural or remote communities.

Model	Characteristics	Advantages	Disadvantages
Collaborative models: fund blending	A type of collaborative model that involves one agency receiving funds from multiple sources to create a resource pool, with staff straddling various programs.	Potential to create a critical mass of resources that might otherwise be impossible to develop. Fosters mutual support between staff and decreases professional isolation. Most successful if multi-party agreements, including mechanisms for reporting, are established prior to model implementation.	Demanding and time-consuming for management and staff to report to several funding bodies. Being answerable to multiple funding bodies with inflexible program requirements can impact on agency sustainability in the long term.
Technology-based models	Spans a range of programs delivered by various technologies, including telephone, email counselling, chat rooms and videoconferencing. Often a mix of self-help and e-technology support.	Ease of access for clients in some regional, rural and remote communities. May facilitate service use in rural regions, due to increased anonymity of client. Appears to be useful for facilitating staff professional development, but evidence base still developing for delivery of many therapeutic programs. Some evidence supporting telephone delivery of non-structured services, and more structured services.	Access to cheap, reliable and efficient Internet service is highly variable across Australia. Need to develop evidence of efficacy of programs developed for face-to-face delivery when implemented via various technologies. Delivery of services using various technologies often requires staff to acquire new skills. It can take considerable time to train and support workers and develop appropriate usage policies that address the issue of confidentiality.
Pilot and seed funding	One-off funding for a specified service. This is not really a service model, but a funding stream. It is included here due to the high prevalence of services operating in an rural, remote and regional capacity.	Helps to establish a much needed service. Works best when there is a mechanism for ongoing funding to be readily available if the program is successful and the pilot funding accurately reflects the cost of running the service.	Communities highly suspicious of these funding arrangements, given the preponderance of rural, remote and regional services that are set up and then dismantled due to lack of funds, a situation that has eroded community trust in local agencies.

Source: Roufeil and Battye 2008: Table 1

This text taken from *Indigenous Australians and the National Disability Insurance Scheme*, CAEPR No. 34 Research Monograph, by N Biddle et al., published 2014 by ANU Press,
The Australian National University, Canberra, Australia.