Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform - Preliminary findings report

1 As a private citizen I am loth to make a submission on this report because I find myself (I'm in good company, certainly) in a wasteland that lies between the ideologues with their simple mantras and the technocrats whose reams of data are beyond comprehension. I am neither an ideologue nor a technocrat.

However, as a private citizen, I am a consumer of human services and am disturbed that the findings in this preliminary report appear to be more concerned with the costs of supplying of human services than with the outcomes for consumers and those near to them. This is despite observations about stewardship in the report (p 5; my highlighting).

Governments' stewardship role in the delivery of human services is broader than overseeing the 'market'. Stewardship encompasses almost every aspect of system design, including identifying policy priorities and intended outcomes, designing models of service provision, and ensuring that services meet standards of quality, accessibility and suitability for users. Some recipients of human services can be vulnerable, with decisions often being taken at a time of stress. The need to ensure the development and implementation of appropriate consumer safeguards is an important aspect of the stewardship role and will be a key focus for the Commission in the second part of this inquiry.

Perhaps the Commission will focus more on consumer needs and outcomes and the role of governments in service-delivery in the second part of its enquiry. While recognising the problem of data (particularly on private and not-for-profit operations) I'd hope that this second part will (as set out in the terms of reference, p v) actually

examine the application of competition and user choice to services within the human services sector and develop policy options to improve….the sector's efficiency and effectiveness and help to ensure all Australians can access timely, affordable and high quality services, which are appropriate to their needs, and are delivered in a cost-effective manner.

2 While I cannot disagree with what appear to be the key findings in this report (p 8; my highlighting) I am disappointed that there is so little analysis in this preliminary report that might enable us to find evidence that actually supports (or refutes) the findings that

The introduction of greater competition, contestability and user choice may not always be the best approach to reform. One size does not fit all and redesigning the provision of human services needs to account for a range of features, including: the rationale for government involvement; the outcomes the services are intended to achieve; the nature of the services and the dynamics of the markets in which the services are provided; the characteristics and

capabilities of users; and the diversity in purpose, size, scale and scope of providers. Not all of these features are clear cut or measurable, and all change over time.

Also, I do wonder about the logic that may lead the Commission to draw general conclusions based on a scoping studies of just six of the sectors listed in Table 1 (p 13) and Table 1.1 (p 46). How and why were just these six sectors selected? Are these six sectors broadly really representative of the whole human services sector?

3 On the six sectors reported in the preliminary findings I want to offer my main remarks on just one sector, public hospital services. However I cannot refrain from making comments on specialised Palliative Care services, specifically as applied to end-of-life and usually elderly situations.

Now that I've passed my biblical three-score-years-and-ten, I've witnessed enough drawn-out deaths to make me more scared of dying than of being dead! The medicalisation of death (like the medicalisation of maternity), has had costs as well as benefits to patients and community. Surely we could do end-of-life palliative care better?

As far as I can see end-of-life palliative care happens mainly in hospitals where medical and ancillary staff deal well with difficult situations. Although the processes seem to be prolonged, palliative care in hospitals does appear to be handled professionally and with compassion.

However, my gut feeling is that hospitalisation of end-of-life palliative care is overly expensive in terms of costs per national weighted activity units (NWAUs), may be affected by the beliefs of third parties (such as of religious who put the sanctity of life over common humanity) and can involve too many relocations of patients.

I don't have answers as to where specialised palliative care services might best be managed. I doubt that palliative care at home (including nursing homes, probably) is desirable for most patients or for those around them. Perhaps Australia should be funding community stand-alone hospices (as in the United Kingdom and European countries)?

4 Turning to the public hospital sector, firstly I wonder how this preliminary report helps at all when it does not look first at the whole-of-hospital sector (including provision of specialist palliative care) before looking at any bits of the hospital sector separately.

I appreciate that the preliminary report avoids framing its analyses in terms of public v private and for-profit v not-for-profit (because these are for discussion in the second stage of the Commission's inquiry (pp v-vi)), and that this limits what the report can usefully say about any particular part of the hospital sector.

Still, I'd have thought that any attempt to scope any part of the hospital sector would have proceeded from a rigorous analysis of what hospital services we as a

society want to be available generally before turning to questions both about how the whole-of-hospital sector is performing and then to how different parts (eg public and private) contribute.

On what the community wants of the whole-of-hospital sector I'd have thought that it is equal access to as wide a range of services as possible, *locally*. I stress 'locally' because when distance restricts access to services, outcomes may be poor and, in the case of unscheduled maternity and especially A&E services, life threatening.

5 I should say here that I am acutely conscious of the problems of isolation outside metropolitan areas. I live in a small cluster of people (<50,000), which is not well-off (Wingecarribee Shire sits in the worst quintile of NSW LGAs in terms of income-inequality) and in which its ageing component (half us are older than 46) is growing rapidly.

Bowral Public Hospital is a small regional hospital (94 beds), co-located with an even smaller private hospital (SHPH, 77 beds). It is at least an hour away from any 'large regional hospital' (Goulburn, which is a smallish hospital administered within a different Local Health Area 'silo') and further away still in time-terms from any Sydney large regional hospital.

While few of us understand how the public-private interface works locally, particularly as it affects us directly, data on My Hospitals website and in the Bowral Hospital operational plan 2014-8 suggests that between them the two hospitals do allow us to access locally a range of services that compares well with those offered by larger hospitals.

However that range of services comes at a price to governments. Costs per NWAU in this public hospital are inevitably higher than in metropolitan 'district' hospitals, which may be exacerbated by transfers of more profitable patients to the SHPH (a perhaps unintended effect of competition which cannot be assessed because so little private performance data is available publicly).

However, while the simplistic data on separations and NWAUs used in the Commission's preliminary report might appear to support arguments for moving patients away to larger hospitals, ambulance costs and patient transport costs between Bowral and Sydney are examples of other costs that need to be discounted against crude NWAU performance data.

Other costs also not factored at all into hospital performance data are the opportunity costs born almost entirely by patients and people close to them of moving patients out of their community. Moving patients out of their community isolates them from loved ones, carers and advocates, and their own medical advisers; unless it is critically necessary relocating patients should be regarded as hospital failures.

So while the simple data in this preliminary report might suggest reducing the capacity of this small regional hospital, in fact the capacity needs to be strengthened. If resources are under-used (eg in the case of theatres, it has been suggested) then admissions should be increased (especially of locals who

may currently have to go elsewhere, but including also patients from neighbouring shires).

However, enlarging the critical mass of this hospital would require capital infusions and human resources. For example, Accident and Emergency facilities need major renovations and they also need to be backed up by more patient beds and possibly more staff accommodation. These are not anticipated in the hospital operational plan 2014-18. Even the 15% increase in beds anticipated in that plan for identified needs remains unfunded!

As most of us will visit this hospital at some time in our lives, we do need to live in the hope that our visits will not be one-way.

6 In short, I am suggesting that the traumas of separating patients from their local community in non-metropolitan areas argue for keeping patients in their local hospital if at all possible, whether for planned procedures or for unscheduled admissions such as for maternity or A & E.

Removal of patients to specialised or 'higher-order' hospitals should be exceptions rather than a norm. And in these cases, the hospitals selected should be as reasonably accessible as possible to patients' support networks – central rather than other locations in Sydney, for example; the ACT for some cases, perhaps.

I recognise that localisation of the delivery of hospital services to the fullest extent possible puts pressure on government budgets, especially if an underlying principle for public funding is equal access to a defined minimum level of provision regardless of personal circumstances.

The matter is complicated by ideologically-driven debates about privatisation which often confuse funding and operation of infrastructure with the funding of service provision (which in many cases must involve contracting of private services to or though hospitals, public or private). It is a whole-of-hospital sector with which the community, if not the bean-counters, is concerned.

I hope the Commission will get to grips with these issues in the second stage of its inquiry.