Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform

Productivity Commission Preliminary Findings

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1. Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Productivity Commission on their preliminary findings on *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* (hereafter referred to as the Preliminary Report).

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

In the submission by the AHHA to the Productivity Commission Issues Paper on *Human Services: Identifying Sectors for Reform*, some general principles were outlined as necessary pre-conditions when examining the scope for effective increased competition in human services in the health sector. Given the importance of these principles in assessing any proposed change to market conditions in the delivery of healthcare services, they are reiterated here:

- Increased competition can only be realised with appropriate **transparency**. This includes transparency related to both individual health practitioners and provider groups with respect to:
  - Appropriate alternatives for the provision of needed healthcare
  - Pricing practices and costs
  - Health outcomes achieved
  - Quality of healthcare provided across appropriate dimensions
  - Prospective delays in receiving treatment

- Increased competition can only be realised with appropriate consumer **health literacy**. This includes:
  - Access to relevant authoritative health information
  - The individual having the capacity to understand and act appropriately with this information, and noting that this will be different for different people and in different circumstances
  - The existence of an appropriate principal-agent relationship between the patient and their healthcare provider with expert guidance to properly enable **informed consumer choice**

- Relevant individual healthcare **data is portable** to enable alternative healthcare practitioners and providers to feasibly provide a competitive alternative. Characteristics of portable data include:
  - Data structures are compatible across vendor applications and use common clinical coding systems
  - Individual health data is maintained in real time
  - Appropriate safeguards are in place to ensure patient confidentiality and health care data security

- The varying **context** in which otherwise similar healthcare is needed means that a change in competition settings will not always work the same way in different settings eg what is feasible in urban settings may not be feasible in non-urban settings implying the need for regionally tailored approaches to competition settings

- There is currently a wide recognition within the health sector of the importance of **integrated healthcare** in achieving better health outcomes, and better use of resources and competition policy should not create perverse or short-term incentives that work against this objective

- Individually short-term rational decisions should not be at the expense of long-term **sustainable health outcomes** or broader **whole-of-system technical efficiency**

- **Funding mechanisms** influence what healthcare services are provided and where they can be provided

- Any increase in competition should not cause an increase in **health inequalities** through perverse incentives or otherwise unintended consequences

- The impact of entrenched professional cultures that prevents clinically safe **expanded scope of practice** consistent with inter-disciplinary competencies must be addressed

The Commission has expressed a view that reform could offer the greatest improvements in outcomes for people who use, inter alia, public hospitals, specialist palliative care, public dental services, services in remote Indigenous communities, and grant-based community services. While the Commission provides insights into opportunities for greater competition, contestability and informed user choice, it provides very scant evidence regarding the potential impact on individual or population health outcomes or service delivery outcomes, as these are defined in the Commonwealth Government's Health Performance Accountability Framework. While it contemplates reforms which might address criteria specified in the Report on Government Services Health Framework, notably efficiency, it overlooks aspects of the criterion related to effectiveness and pays minimal attention to the equity criterion.[1]

Selection of Priority Areas

While a framework for identifying services best suited to reform is provided at Figure 2[2], it is not clear how the Commission applied this framework in its review process in order to identify the six priority areas selected. In its next report on this Inquiry, the Commission should provide a detailed explanation of its analysis, not only of scope for improvement which has to some extent been examined in this Preliminary Report, but also of the factors influencing the potential benefits, and the potential costs of greater competition, contestability and user choice. In particular, it must address in detail matters related to government stewardship at all levels.

Government Stewardship

The AHHA supports the concept that well-designed reform, underpinned by strong government stewardship, could improve service quality, accessibility and consumer choice. However, the Preliminary Report does little to articulate how government stewardship would be strengthened, and implemented within a private sector where its policy levers, and its capacity to provide stewardship, are limited. Exemplifying this is: the limited control it has been able to exert over the private health sector regarding provision of data for health statistical collections, acknowledged as critical for improving the effectiveness of human services provision[3]; and regarding the use of a national

[1] See http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/PAF~PAF-Section-4.
[2] Page 12.
[3] Page 2.

electronic health record (notwithstanding substantial government investment in electronic health record infrastructure).

In considering the introduction of competition for human services in the healthcare sector, there are also important lessons to be gained from the implementation of the National Disability Insurance Scheme. Early insights from the seven National Disability Insurance Scheme trial sites suggest that it could take more than a decade for markets to mature to a substantially revised policy, funding and consumer controlled setting.[4] There is also a recognition that that this may never occur within some rural and remote areas, with an associated need for ongoing direct government intervention.[5]

These findings reinforce that the provision of healthcare services is a complex mix of quality and safety standards, funding arrangements, rational behaviour by self-motivated non-government operators, varying operational environments, and groups with differing special needs, with this all occurring in an environment with a high degree of information asymmetry and often sub-optimal capacity for consumers to make truly informed choices. The AHHA supports moves to improve the efficiency of the health system, but careful policy design is essential to ensure that changes occur within a strategic policy framework that considers broader system impacts.

AHHA Recommendations

AHHA proposes the following measures should underpin the provision of all health-related services in the public sector, whether delivered by government-owned and controlled agencies or outsourced to the not-for-profit or private sector via competitive and contestable arrangements:

1. To improve **health outcomes** – apply a values based health care model to achieve the best outcomes at the lowest cost
2. To improve **quality** – all services providing publicly funded care must be accredited and report clinical quality indicators
3. To improve **equity** – funding must be based on a universal health care principle
4. To improve **efficiency** – apply a funding model that is measurable by health outcome indicators and that applies risk adjusted funding that supports service delivery to populations that have access issues
5. To improve **accountability and responsiveness** – ensure public reporting of the health outcome indicators

[4] Easton S. 2015. CEO's Lessons From the NDIS: Scaling Individualised Services. The Mandarin (accessed 10 October 2016).

[5] Kerr-Smith E. 2015. Annie's Story, and Getting the NDIS Right. The Mandarin (accessed 10 October 2016).

2. Proposal to Introduce Competition into Public Hospital Services

The Preliminary Finding 4.1 has four points on greater user choice and contestability in public hospital services which are addressed separately below.

However, a general observation on the Preliminary Report is that the Commission reports international examples of choice and information provision in relation to public hospital services but does not provide citations for these examples.[6] It would be helpful if citations were made available to facilitate review of the Commission's proposals.

One such article (Larsson *et* al 2012[7]) describes the impact of publication of disease registries on clinical decision-making by specialists and on associated health outcomes for patients. It does not distinguish between whether clinical services were provided in public or private operated facilities, and improvements in decision-making and outcomes were significantly influenced by competitive performance amongst clinicians - a scenario which could equally be replicated in a single institution or across a public provider system. The competitive pressure was driven by data and transparency, rather than contracting, purchasing or funding arrangements.

The Commission must also ensure that recommendations intended to improve technical or allocative efficiency in part of the care system do not occur at the expense of other parts of the system.[8] A realistic whole-of-system assessment must be made of any proposals. One pertinent example in the context of hospital care is the recognised importance of coordinated care beyond the hospital walls.

Matching the Practices of Better-Performing Hospitals

The Preliminary Report notes that while Australian hospitals are generally performing well, there is scope to improve outcomes for patients and to lower costs by benchmarking against better performing hospitals. A key element to facilitate such improved outcomes is transparency of clinically meaningful and consumer relevant hospital performance indicators being available in a timely manner.

From a consumer perspective, this may facilitate pressure on underperforming hospitals to improve practices. However, for many consumers there is no practical alternative public hospital that can be selected (eg if the nearest geographic alternative would involve an unreasonable travel burden). In those local markets where there is a viable public hospital alternative, a key issue for system managers would then become the even greater challenge of managing demand for hospital services across the network. This currently manifests in waiting lists and waiting times, and if consumers gravitated towards public hospitals that are seen to be better performing, this could increase congestion at these sites and lower their efficiency.

It is also noted that there are already some mechanisms in place that provide incentives for public hospitals to work towards more efficient levels of operational performance. Standardised pricing provided through the Activity Based Funding framework for clinically similar episodes of care is one such example. The steady decrease in the National Efficient Price over recent years is evidence of the positive impact this has had on system performance. The report on healthcare variation in Australia similarly highlights the significant variation in admission rates for selected conditions at a meso level

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6 For example, see Box 4, page 18.

7 The example cited re public performance reporting in Sweden appears to be drawn from an article by Larsson et al 2012 (Larsson S, Lawyer P, Garellick G, Lindahl B and Lundström M. 2012. Use Of 13 Disease Registries in 5 Countries Demonstrates the Potential to Use Outcome Data to Improve Health Care's Value. *Health Affairs*, 31(1), pp 220-226.)

8 The care system is a broader view of the many sectors that interact in the delivery of care to individuals and across the life course. This includes community, primary, specialists, acute, aged, disability, dental and palliative care systems.

(the then Medicare Locals).[9] Service level agreements between state and territory governments and their local health networks is another mechanism for targeted improvements by public hospitals.

The Commission must also be cautious to recognise the variety of constraints that different public hospitals can face that can make average levels of performance difficult to achieve. The age of a facility, difficulties attracting and retaining the medical and related workforce, and the special needs of particular groups within the catchment of a public hospital can all create circumstances that justify variation in performance. Deviation from a benchmark does not unambiguously point to sub-standard performance.

Overall, greater transparency around clinically meaningful and consumer relevant hospital performance indicators available in a timely manner could provide incentives to public hospitals to change practices and facilitate some improved consumer choice. However, this also raises system issues that go beyond the performance of individual establishments.

Greater User Choice in Public Hospital Services

Preliminary Finding 4.1 states that, "greater user choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians." Australians are currently not prevented from attending a public hospital of their choice, though absent performance indicators as discussed above, this choice will often be based primarily on access convenience (in terms of travel time and waiting lists). However, if competition in the provision of public hospital services by private providers was introduced as appears to be alluded to in this finding, then this raises a larger set of issues than simply providing more consumer choice.

If the private sector was able to compete for the offer of services to public patients, governments would likely require some mechanism for demand management with what is an open ended commitment to the provision of public hospital services. Currently this is managed through existing public hospital system capacity. If the capacity for public hospital services was expanded this could generate a supplier-induced demand effect, as would be observed for example through a diminishing of waiting lists.

It is also likely that private providers would not be willing to take on more complex cases due to the clinical and financial risk associated with these patients. Such risk-averse selection of patients by private providers would then impact on the types of patients public hospitals are left to treat. If private hospitals are enabled to provide care for public patients, then they should also be required to deliver the entire episode of care, including after care and managing complications. Currently many complications of privately delivered care are picked up by public hospitals. While this makes the private system appear to have good outcomes (eg low length of stay and readmission rates), the flow on impact to public hospitals and rehabilitation mask the real outcomes.

The Commission has made this preliminary finding in the belief that greater choice in public hospital services could disproportionately benefit disadvantaged groups relative to others, presumably referring to those with private health insurance. While improved equity of access for disadvantaged groups is an appropriate objective, this would appear to be a proposal with system implications beyond this specific goal. The Commission should also not lose sight of the practical decision making processes public patients would use nor the broader impact on public hospitals from likely private sector responses.

[9] Australian Commission on Safety and Quality in Health Care (ACSQHC) and Australian Institute of Health and Welfare. Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study. Sydney: ACSQHC, 2014.

Access to Useful Consumer-Orientated Information

The provision of useful consumer-orientated information on services complemented by support in making decisions by referring practitioners is supported. This would require the timely availability of clinically meaningful and consumer relevant hospital performance indicators as discussed above, but also relies on the fundamental agency relationship between a patient and their treating medical professional. It also requires a level of health literacy which will vary with different patients and in different circumstances. In practical terms, useful consumer-orientated information will not be the same for all patients. While more information and better information is preferable to less, the Commission should be cautious in the utility of this proposal for all patients in and in different circumstances.

More Contestable Approaches to Commissioning Services

While mechanisms to improve the operational performance of public hospitals are important, for the reasons discussed above, changes in the delivery of some public hospital services may not lead to an optimal overall system outcome. Responsibility for testing contestable approaches to the commissioning of public hospital services should be at jurisdictional level given that states and territories have responsibility for these services. State and territory governments in consultation with their local health networks will also be better placed to determine the local capacity to respond to a move towards contestability for defined services and to structure such an approach so as to minimise any negative externalities and to account for local workforce constraints.

The Preliminary Report raises the prospect of introducing a mechanism to "replace the management team (or board of the local health network) rather than switch to a non-government provider" as a mechanism to implement contestability within public hospitals.[10] These mechanisms are already in place across many of Australia's hospital networks, and have been exercised from time to time. However it should be noted that this could not be unilaterally imposed by the Commonwealth as it would usurp state and territory authority over public hospitals and local health networks.

It is also emphasised that, as noted by the Commission and in submissions to this review process, the introduction of competition and contestability could lead to greater costs associated with tendering and contract management for providers and governments. There could also be a deleterious shift towards more short term thinking. The appropriate management of clinical governance and oversight of the quality of services would also need to be well understood. Clinical governance is different from contract management and meeting key performance indicators. The public system has invested in this capability and similar investments would need to be made in the private system.

Some functions performed by public hospitals eg pathology, imaging and pharmaceuticals are already in scope for competitive, contestable processes and the Commission could consider evaluation of these functions.

[10] See page 92.

3. Proposal to Introduce Competition into Specialist Palliative Care

The AHHA agrees that effort and investment is required for data development and reporting of specialist palliative care data. However given the Productivity Commission acknowledges the paucity of available data re quality of specialist palliative care and patient outcomes, it seems rash to claim that quality is highly variable, that there is relatively low service quality for which providers are not being held accountable and that these might be addressed by greater competition.[11]

Any proposals related to specialist palliative care will impact on highly vulnerable patients and their families. Therefore a high degree of caution must be exercised when considering changes to the market settings for palliative care. In particular, the AHHA urges the Commission to consider:

- The principle of user choice must be balanced with the knowledge that health literacy in Australia is low, services are fragmented and not well understood by many health professionals, let alone consumers, and that people who need specialised palliative care are most often physically and mentally compromised. There is a need for appropriate mechanisms to support consumer choice for palliative care.

- Specialist palliative care is much less accessible outside of urban settings and there is limited workforce to support the need, regardless of whether the setting is public or private.

- Assurance must be provided that neither secular nor non-secular palliative care is discriminated against (explicitly or tacitly)

- The Guidelines for a Palliative Approach in Residential Aged Care and the Guidelines for a Palliative Approach for Aged Care in the Community Setting are currently under review by the Commonwealth Department of Health and any recommendations may be pertinent to the work of the Commission.

- The strategic framework for provision of palliative care varies in each State and changes to this already fragmented system need to be carefully considered for knock on effects and pass the no disadvantage test prior to implementation.

[11] See Preliminary Finding 5.1, page 22.

4. Proposal to Introduce Competition into Public Dental Services

As noted in the Preliminary Findings Report, the majority of dental health care in Australia is privately funded and performed in private practice. While there may be scope to introduce greater competition, contestability and user choice in public dental services, this is unlikely to have a significant impact on the ability of Australians to access timely and affordable dental healthcare without appropriate funding and adequate availability of dental healthcare providers at the local level. This respectively reflects an absence of universal access to dental healthcare and limitations with respect to workforce and physical capacity.

Much of the unmet need for dental health care in Australia is due to a lack of funding (ie dental care is not part of Australian universal healthcare). This implies that introducing competition and contestability to public dental services would in isolation have perhaps only limited impact on meeting need, contributing to preventive health and avoiding potentially preventable hospitalisations. Furthermore, if public dental services were opened to private competition, there would be a need to ensure that the same quality and safety standards applied to all providers. In this context, the availability of private dental services may also be problematic - as an area becomes more remote there are less likely to be private providers servicing these markets.

The following comments are provided in relation to the proposals on the cost for competition and contestability with public dental services.

Scope to Improve Outcomes

The current fee-for-service funding model in Australian dentistry places the focus on throughput of patients rather than sustained oral health outcomes being achieved. The most effective way to address this concern is to have an agreed set of oral health outcome indicators and the necessary data collection processes to support assessment against this framework. As a first step in this regard, Dental Health Services Victoria is currently developing a set of oral health outcome indicators with the International Consortium for Health Outcomes Measurement (ICHOM).

The Preliminary Report also states that, “government-operated clinics limits responsiveness to user needs and preferences”. However, referring to South Australia as an example, dental funding is initially distributed based on the numbers of eligible people in a given area, and if public dental facilities are not available or reasonably accessible within that area, vouchers are then issued to eligible patients to access treatment from private providers. Furthermore, a range of programs targeted at sub-groups with identified high needs have been developed including for those living in aged care facilities, older people living in the community, Aboriginal and homeless people. There is also a fly-in-fly-out dental program for rural and remote areas where with neither public nor private providers.

The Preliminary Report states that there is only minimal public performance reporting. While improvements to performance reporting can always be made, particularly with respect to a standardised outcomes framework, most jurisdictions collect data on patient dental treatment and dental health status with this data then used for internal decision making and shared with the Australian Research Centre for Population Oral Health at the University of Adelaide and the Australian Institute of Health and Welfare for analysis and publication.

Equity

The Preliminary Report statements on equity must be recognised in the context of how funding is provided for public dental health care, the socioeconomic distribution of need and access to oral healthcare, and the broader social determinants of health in which dental healthcare needs arise. By

policy construct, adults can typically only access public dental care if they are a concession card holder. The Productivity Commission is also reminded that person level characteristics cannot be inferred from spatially aggregated data and indexes.[12]

Efficiency and Accountability

While there are limited national efficiency and accountability measures published, the National Oral Health Plan has a set of key performance indicators that is being reported to health ministers. This should ideally be complemented by a broader suite of oral health outcome indicators. Comparisons of public and private access to dental services using currently available service data is also limited due to the absence of "per patient" level of data.

An example of the use of performance reporting is available from South Australia, where the cost effectiveness of their public dental services is routinely compared to the cost of delivering these services through the private sector with these reviews consistently finding that (for adults) it costs around 30 per cent more to provide a course of general dental care in the private sector than in the public sector. The primary reason for this cost difference is that private dentists consistently provide more treatment to the patient than would be provided by a public dentist. This is a clear example of how the availability of a private sector supply alternative does not necessarily lead to reduced costs or a more efficient allocation of limited health resources.

While this may be indicative of over-servicing by private providers, it is also possible the budget constraint within which public dental services operate imposes an intrinsic prioritisation of which services are provided to whom to gain the greatest marginal benefit. To the extent this latter explanation is true, this would represent a clear example of the guiding principle identified at the start of this submission where individually short term rational decisions (in this case, by private providers) should not be at the expense of long term sustainable health outcomes or broader whole of system efficiency (technical and allocative).

Such market behaviour of private dentists operating under a publicly funded dental program was evident in the now closed Medicare Chronic Disease Dental Program. In South Australia, many private providers "cherry picked" complex and lucrative treatment items of care up to the Scheme's $4,250 cap and then referred the patient back to the public dental sector for the more basic general dental care.

Responsiveness

The geographic accessibility of the private sector for dental services may not be matched by its socio-demographic accessibility. While income constraints is an obvious issue for many in need of dental care, factors related to the social determinants of health can also play a part. It should also be noted that in some rural areas, local private providers are unable to satisfy private demand and are unwilling to treat subsidised public patients.

Many public dental services provide significant preventive and health promotion programs aimed at preventing oral health disease rather than fixing it. Once people have a disease, some can be managed with preventive measures while others require restorative care.

[12] Inferring individual characteristics from aggregated data is the methodological error of ecological fallacy. This is initially discussed in: Robinson W S. 1950. Ecological Correlations and the Behavior of Individuals. American Sociological Review. Vol 15(3), pp 351-357.

Factors Influencing the Potential Benefits of Reform

User Characteristics

The Preliminary Report identifies that there is a disproportionate share of adult public dental health users from disadvantaged areas. Given that the eligibility for public dental health services is largely constrained to concession card holders, this is hardly surprising. Instead, consideration of the social determinants of health may provide a more powerful insight into understanding who is more likely to need access to public dental healthcare.

The Preliminary Report acknowledges that disadvantaged populations include hard to reach vulnerable communities. The challenge is to identify the most appropriate response to not only treating oral disease in these communities, but as importantly, providing effective preventive oral healthcare. The public sector has a major role in facilitating prevention through a range of health promotion programs, a role not within the scope of private providers who are instead focused on the provision of treatments. While evaluation of these programs is not comprehensive, there is evidence of positive impacts on oral health outcomes associated with these preventive health measures.[13]

Supply Characteristics

Models of care that propose alternative mixes of workforce components, such as being developed currently by Dental Health Services Victoria, may assist in achieving a more cost efficient workforce. Other innovations in service delivery models include teledentistry which is being used in the public dental sector in NSW, Victoria and Queensland. Teledentistry has the potential to improve access and reduce inequality in the provision of oral healthcare services.

The Preliminary Report also notes that emergency care comprises a greater share of services provided to public dental patients and there is proportionately less preventive and restorative care provided by public clinics. This profile of services largely results from public dental services needing to respond to demand for emergency treatments. Meeting this urgent demand then leaves diminished resources to address the needs of non-emergency patients. This reflects the varying objectives of the public and private dental care systems.

In non-emergency public dental care, a balanced and targeted mix of preventive and restorative care is provided tailored to the individual's disease risk. The private sector is more likely to provide a basket of preventive services irrespective of the patient's disease risk, potentially leading to over-servicing.

While the Preliminary Report states that, "greater contestability of government-funded dental care could assist in the development of more flexible and responsive service models", such a position should not be applied globally, but instead be only selectively applied where local market conditions are such that the overall level of services provided to public patients would not be diminished and overall population oral health outcomes would not be compromised.

The Potential Costs of Reform

With the many program changes over the years and jurisdictional differences in public dental services offered, consumers are at risk of being confused or uninformed with any changes to public dental services and provider options. Anecdotal evidence suggests that many consumers are not aware of current services which they or their dependents may be eligible to receive. The guiding principles

[13] Petersen P and Kwan S. 2009. World Health Organization global oral health strategies for oral health promotion and disease prevention in the twenty-first century. Prävention und Gesundheitsförderung, 4(2), 100-104.

stated at the start of this submission are worth repeating with respect to the crucial importance of health literacy and truly informed consent.

There is a need for all service delivery organisations to be accredited against the National Safety and Quality Health Service Standards. While accreditation is not a guarantee of safety and quality in dental care, it is important that some form of quality measure is provided. The collection of standardised and meaningful data should also be made compulsory, and in particular, with health outcome indicators including clinical indicators.

Caution should be applied to extrapolation of the experience with the Child Dental Benefit Scheme which has only been reviewed on its administrative processes. A more comprehensive assessment of the public health benefits from public dental health schemes must take into account the outcomes achieved, including the value of preventative oral health interventions.

Finally, there is a barrier to more effective workforce reform as a result of dental therapists, dental hygienists and oral health therapists not being able to be issued their own provider number, and having to rely on dentists' provider numbers for the services they perform. While dentists have opposed provider numbers for these other clinicians, enabling the allocation of provider numbers to these clinicians would contribute to a greater use of the skills of the full dental workforce and enhance overall system capacity and flexibility.

5. Proposal to Introduce Competition into Remote Indigenous Communities

While some competitive and contestable service arrangements are already in place in remote Indigenous communities, both private and public funded service arrangements are often characterised by less capacity to deliver the full range of health services to meet community needs, and particularly, to provide these services on a regular basis.

The role of Aboriginal Community Controlled Health Organisations (ACCHOs) is vital in providing culturally appropriate care and in circumstances where private service provision will often not be feasible. ACCHOs must continue to be supported to fulfil this role and to develop Indigenous capacity within the healthcare sector.

There is also a role for NGOs to work in partnership with ACCHOs to complement available services, but these arrangements should be considered as supporting and complementary, not as a substitution for Indigenous-controlled, culturally appropriate services.

The AHHA agrees with Preliminary Finding 7.1 as it relates to Aboriginal and Torres Strait Islander people living in remote communities that identifies the importance of culturally appropriate care, the need to better coordinate service delivery and reduce fragmentation, greater community voice in service design and the importance of stable policy settings.

6. Proposal to Introduce Competition into Family and Community Services

The AHHA welcomes findings from the Productivity Commission with respect to the inconsistent and limited strategic engagement of government with service providers, the negative impact of short term contracts and uncertainty related to ongoing funding, the stifling of innovation and onerous reporting requirements.[14] The recommendations in Preliminary Finding 8.1 should be further developed to address these serious concerns that hamper community service provision.

As local markets adapt to new measures of competition or contestability, it is also important to recognise the value of existing social capital and local relationships between providers and clients and to preserve these where possible.[15] We note that the Productivity Commission has separately recognised the benefits of social capital to local communities.[16]

It is also emphasised that, as noted by the Commission and in submissions to this review process, the introduction of competition and contestability in family and community services could lead to greater costs for providers and governments associated with tendering and contract management. There could also be a deleterious shift towards more short term thinking.

[14] See pages 27 and 28.
[15] Kerr-Smith E. 2015. Annie's Story, and Getting the NDIS Right. The Mandarin (accessed 10 October 2016).
[16] See page 35.

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