PRODUCTIVITY COMMISSION ISSUES PAPER

HUMAN SERVICES: IDENTIFYING SECTORS FOR REFORM

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The Commission is seeking participants' views on what constitutes improved human services. Do the concepts of quality, equity, efficiency, responsiveness and accountability cover the most important attributes of human services? If these are the most important attributes, how should they be measured or assessed?

Improved human services constitutes different outcomes for different people, and depends of what the client's current experience is of human services, and their level of disadvantage. The main concepts of quality, equity, efficiency, responsiveness and accountability are the important attributes for any person who receives a service whether it's from human services or other providers, however Access has been left out.

However, for disadvantaged people **ACCESS** is also critical, whether it be physical access, language access or just knowledge of the service available, for people of culturally diverse backgrounds, ie. LGBTI, indigenous, disabled, homeless etc. If this is not addressed people are not empowered to make choices of a provider, as they don't know what they don't know. Services may have high quality services, however keep access limited to a certain type of client that is easy to provide service for and not too complicated. For example, the client doesn't require interpreters so this keeps the cost down for the provider, allowing staff to see more clients, providers open limited hours, or no outreach service offered, or on line appointments for clients, these processes keep costs down and are not meeting fair and equitable principles for access to services.

I believe some government departments have moved from over monitoring and assessing providers to the extreme of no contact and very little measurements. I believe there is a middle ground and that is where the government should put resources into measurements and assessment and knowledge of the services that are being funded. Government can then be ensured that services are delivered in the way they say they will be delivered. i.e. % of CALD clients accessing a service, CALD clients receive the same quality of service as anybody else. This needs to be measured by visits, and feedback from client's not just raw data. This is an additional cost to government however, it is necessary to really measure service quality.

To measure outcomes is very difficult in human services and if done properly would be very expensive. For example providing settlement services, where the client may only need one visit to the agency to gain information and referral about their individual needs: how do you then measure that that service has assisted in the client's settlement? When is settlement completed? What constitutes successful outcomes in settlement? happiness? employment? Speaking english? school enrolment? buying a house? A lot of human service outcomes are completed over time, and then can change again with a life crisis, so to measure this would

require a longitudinal study of a client and their outcomes over that period. These outcomes can't be measured by one factor i.e. employment or i.e. housing. This is a difficult task and needs input from the grass roots providers and government.

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The Commission is seeking feedback on whether the factors presented in figure 2 reflect those that should be considered when identifying human services best suited to the increased application of competition, contestability and informed user choice.

Yes the factors identified in FIG 2 do reflect what should be considered when identifying's services that are best suited to increased competition, contestability and informed user choice.

Interestingly, within the scope of Consumer Directed Care (CDC) the user characteristics in FIG 2 are not necessarily common for CALD clients, but would be in elderly people that are competent, low need and high functioning with a healthy body and mind. However, in reality those clients currently needing services are often very frail, don't have family or carers that can actually negotiate the complexity of aged care system or residential care. A lot of our clients don't read or speak English, often don't have a computer or the ability to use the computer to access the required information. Hence, providers are now charging a fee to help elderly people to access the new MY AGED CARE and CDC. How is this equitable? What if you can't afford this service to assist you to access the services, to then decide who, what and where you want a service?

Access to user orientated information on price and quality is not being taken up by people who do not read or speak English. It is evident that some current providers are strongly encouraging their clients to stay with them for services. Some elderly people are too afraid and fearful they will lose their current service so go along with whatever they are told by the current provider.

Economies of scale and scope are critical for providers now being forced into an open market with for profit providers. Some providers are using cost to guide what and where they operate. Cost is driving the quality of services so if the cost to provide the service remains the same and the income to pay for the service is reduced providers will either charge the client a private fee or offer less service/ quality to the client.

The definition of case management is arguable, however current fees in aged care CDC do not pay for this, clients are still requesting this service, however they don't want to pay for it? They don't want to pay for admin? If the client does not want case management, however professional staff believe they require case management, what happens to the quality and outcomes for the client?

The current CDC and NDIS now allows families/ sole traders to set up business and provide the service they may have been doing in the past, so now they can be paid to do this. Is this reasonable? Where are the checks and measures for this service? Yes, we have service standards how are these family members going to be measured against standards?

Will these sole providers be measured against the same criteria as agencies with staff who are qualified professionals?

Consumer choice for some people is very good and a welcome option and process. However, if you are frail aged, part dementia, speak no English, do not know the current aged care system, don't have the capacity or energy to do the research, children are working and cannot be bothered this is not something that comes easily. These clients are likely to remain with their existing service provider…….. So one size does not fit all.

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The Commission is seeking participants' view on which human services have the greatest scope of improved outcomes from the increased application of competition, contestability and user choice. Where possible, this should be supported by evidence from performance indicators and other information to show the extent to which:

- ***current and expected future outcomes – measured in terms of service quality, efficiency, equity, accountability and responsiveness – are below best practice***
- ***Competition, contestability and user choice do not exist under current policy settings, or are not as effective as they could be in meeting the goals of quality, equity, efficiency, accountability and responsiveness.***

The Commission welcomes participants' views on how best to improve performance data and information in the human services sector.

Improved outcomes are not synonymous with competition, contestability and user choice. Competition often drives the price for services down and this leads to lower quality services, this is evident in services that have been tendered. Competition has always existed in most service sectors, whether it be through applications or tenders, the main difference now is the private providers can enter the market, some departments only accept consortiums which forces agencies to work together and also larger catchment areas, which assists larger providers to scale up and become a monopoly in the market.

Performance data needs to include more than figures, to get the true satisfaction of clients they need to be interviewed or a process for feedback, this is costly but a more accurate measure of performance.

Data needs to be user friendly for providers and the government. Providers should be consulted in the development of data for the services that they are providing. The data needs to be provided back to the agencies and it needs to speak to other data systems to assist providers in their own planning. Currently, agencies have several data bases from different departments so resources are spent on inputting data and often the agency does not have access to the results of this data.

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Participants are invited to submit case studies of where policy settings have applied the principles of competition, contestability and user choice to the provision of a specific

human service. Such case studies could describe an existing example or past policy trial in Australia or overseas. Participants should include information on the:

- ***pathway taken to achieve the reform***
- ***Effectiveness of the policy in achieving best-practice outcomes for quality, equality, efficiency, responsiveness and accountability.***
- ***Applicability of the case study to the provision of human services in Australia if it is an overseas example.***

CASE STUDY - RTOS

We are very concerned that private RTO's are not delivering comprehensive training as demanded by the standards (Australian Skills and Qualifications Authority). There is anecdotal evidence of some providers delivering Certificate 4 in Aged Care courses in 6 weeks, a course that is otherwise delivered by TAFE's over 6 months including a fieldwork placement.

This has been a huge issue and of particular concern to us as many new arrivals (both migrant and humanitarian) are attracted to aged care certificate courses. There has been excessive variability in course requirements, evidence of short cuts in the delivery of curriculum and poor regulation and confusion brought about by the sheer number of courses being offered by private providers. We are also concerned that there are questionable assessment procedures and that students are not assessed for basic literacy skills pre-enrolment.

We are also aware that many service providers will not even consider job applicants who hold qualifications from particular providers. As a consequence, those students/former students have been severely disadvantaged and they are also no longer eligible for further training. This practise should be stopped immediately and is very difficult for the student who is now unemployed with a certificate that does not help them with employment.

This is an issue for us (and our clients) on two levels. First, as a Settlement Service we have many clients who are newly arrived and who undertake Aged Care Certificate courses after completing their English language studies. To some extent we are reassured that clients will follow on their English language studies with AMES and undertake a certificate course also with AMES, but this may not always be the case. Some clients anxious to find work and yet whose literacy is not really at a level to undertake formal study may be offered a place with an RTO whose course is of a questionable standard and whose Certificate will be regarded by potential employers in the aged care sector as next to useless.

Then, on the other hand as an aged care service provider ourselves, we are very concerned that only fully qualified and competent staff are delivering services to our elderly clients. This poor training practise is creating another level of unemployed people who have a certificate and yet are still unemployed and some don't understand why they are unemployed, they are the victims of a very unethical and unprofessional service.

We welcome the increased activity of the Australian Skills and Qualifications Authority (ASQA) in this area, in seeking to ensure compliance with standards. Monitoring RTOs needs to be more thorough and should include interviews with those current and past students for their feedback.

There is a strong argument that this demonstrates that competitiveness, contestability and an increase in choice does not equal an increase in quality. Indeed, in the example of RTO's it has led to a reduction in standards. Applied to the human services sector the same risk exists. Some competition is not a bad thing……..a totally open market for some services is likely to lead to poor outcomes.

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The Commission is seeking information on which human services have these characteristics:

- **service recipients are willing and able to make decisions on their own behalf and, if not, another party could do so in the best interest of the recipient**
- **user-oriented, timely and accurate information to compare services and providers can be made available to users so they are able to exercise informed choice or, if not, this could be cost-effectively addressed**
- **service recipients (on their decision makers) have sufficient expertise to compare alternative services and providers or, if not, this barrier could be overcome**
- **outcomes experienced by a service recipient and their family and friends in past transactions can inform which service and provider they choose in the future.**

It is my understanding that there are some services currently available as a consumer choice scenario, Job Active, CDC and NDIS, and some health services.

For people to navigate the human services systems, pricing and then compare services to then decide which service to use, takes time and expertise in understanding complex systems. Very few people have time for this and it is evident that in aged care a lot of people hand this over to families to do. Intelligent family members, (sometimes working in the sector) find this service system decision process stressful, complex and time consuming.

It would be interesting to find out how many clients have actually changed providers in the current sectors? And how easy was this process? And for what reason did the client change provider? Because the funding will be based on client numbers providers will try to keep clients as much as possible and put clients off in regard to changing to a provider. Also for the disadvantaged person do they have the confidence to change providers? Stand up and say I am not happy? For elderly CALD this would be a rare occurrence, for refugees that are unemployed this would be a rare occurrence.

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For specific human services, the Commission is seeking information on the nature of service transactions based on these characteristics:

- ***the nature of the relationship between the service user and the provider***
- ***whether the service is used on a one-off, emergency or ongoing basis***
- ***whether the service can be provided remotely***
- ***the extent to which services to an individual can be unbundled***

- ***whether there is a strong case for the provider to supply multiple services to an individual with complex needs.***

For most services it is evident that users prefer to know of or be recommended to a service, before they would just turn up at a service unless under an emergency situation, or monopoly where there is no choice. For the CALD communities, trust is essential in working with a service, and word of mouth is the best marketing strategy. We know that our clients trust us so they will use us and come back for repeated services. If the service is a one off or emergency service the situation may be different and maybe based on locality, and easy access as the criteria for deciding one service over another.

If a client requires several services it will depend if they are all related, as to whether they should be bundled services i.e. in health then it would be easier to receive these services from one provider or more importantly one location. However, the criteria for this would be level of service satisfaction as to whether the client wants all services from the same provider. If they are not happy with part of the service they may be happy to go to another provider for that one service in the bundle. If services are not related I question why they need to be bundled? Where the client has complex issues, then bundling would make common sense for the client, as easier to access. In the settlement sector there are complex case clients who we are funded for a 3 month period to receive intensive support via brokerage model and that works well. If the client is not considered complex then the services don't need to be bundled, allowing the client better choice. Some service sectors are still funded by a monopoly model, clients have no choice.

In complex situations with very high need clients bundled services could be beneficial and easier to access for the client. This should be a choice for the client or their carers to make.

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The Commission is seeking information on the supply characteristics of specific human services including:

- ***economies of scale and scope – in terms of costs and service quality – that may be lost by having a larger number of competing providers***
- ***the potential for service provision to be made more contestable because there is capability beyond an existing provider that could pose a credible threat to underperformance***
- ***whether there are barriers to providers responding to change, or new suppliers entering the market, that limit the scope for increased competition, contestability and user choice or, if they do, what could be done to address this***
- ***technological change that is making competition and user choice more variable***
- ***factors affecting the nature and location of demand, such as geographic dispersion of users, the distribution of demand among different types of users, particularly disadvantaged and vulnerable users, and anticipated future changes in demand.***

Economies of scale and scope do not equal quality and has been evidenced to be the opposite where the provider is so big they have lost the local knowledge and credibility and often don't connect with the local service sector. Place based services are more effective where the agency connects with the client and the local area and are familiar with the area and what goes on in the area. Also a large number of competing providers can be confusing for clients and the providers, this can happen with federal and state funding and sometimes different departments putting out funding but with the same outcomes as other departments funding. It can sometimes take time for providers to work out and link with all the providers in the same space and services that overlap.

Providers are generally very good at responding and adapting to change however, it takes time to change systems and processes and educate clients to new models of service and this needs to be recognised and realistic timelines set for implementation of major reforms. And in some cases providers should be resourced to educate and support clients into new service systems, as a recognised task that takes time.

Technological change does offer more choice for clients however, it assumes the clients have computers, internet and know how to navigate websites and read and write English, some people don't. Therefore the services are not accessible for all. i.e. CALD or refugees, homeless, people with a mental illness, frail aged etc

Human services should safeguard the interests of disadvantaged people that is one of the main reasons these services are provided. And yes increased competition can lead providers to focus on the lowest cost to be successful compared to quality of service. If the quality of service is not provided this cost transfers to other providers, as clients will then go in search for a better service or shop around for the most appropriate service. Clients should not have to shop around, the service should be high quality no matter where or what the service is.

The changes noted in government stewardship are very positive. Commissioning out to other providers for contract management is not always the best process as these agencies also have their own biases and are not always professional in negotiating and being flexible with contracted providers. Government takes a more considered approach and are not involved in any local politicking.

The shift away from block funding to consumer directed budgets and funding will mean that for some staff work will not be guaranteed and will then flow down to part time casual work for staff, with no guarantees of full time work. Marketing services direct to clients will become very common and fierce, as this is the only way providers will gain clients.

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For specific human services, the Commission is seeking information on:

- ***the costs that consumers would incur by becoming more active in selecting the services they receive, adapting to changes in how providers supply services, and switching services when a decision is made to do so***

- ***the regulatory arrangements and other initiatives that governments would have to modify or establish as part of their stewardship role, including to inform user about alternative services and providers, maintain service quality, protect consumers (especially disadvantaged or vulnerable users) from being exploited, and to fine-tune policies in response to any problems that emerge***
- ***how the compliance costs faced by service providers will be affected by changes in government stewardship, and the adjustment costs that providers will bear in order to shift to a more used-focused model of service provision***
- ***the extent to which such costs are one-off or an ongoing impost.***

The Commission welcomes information from participants on the cost faced by different types of providers, with different motivations and governance structures, when shifting to a more user-focused model of service provision.

Happy to discuss in more detail if required.