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?

- The five dimensions may address some of the direct service qualities, but certainly are not the summation of what constitutes the most important attributes of human services. Human services are a product of social norms that encouraged people to choose a career in the human service sector over other careers in government or business.

  The human service sector attributes are shaped by the practice frameworks, which are first formed during tertiary education and show maturation over the years with hopefully, effective performance management and leadership of the sector. The human service sector is not merely a commodity and is fundamentally about human interaction that impacts on the wellbeing of people (e.g. patients, students and clients). The human service is more than just an exchange of a service for a fee, but consists of human interaction that is purpose driven. Therefore, the five measures as described do not completely cover other aspects of service as it relates to outputs and outcomes. The interplay of areas of work such as lobbying for clients, additional services that staff and volunteers deliver without cost to the client or the community need to be considered as part of the overall framework. Ironically while government recognise the value of "volunteering" at the same time, there are economic drivers seeking to commodify such social interactions. In addition, the community development work that practitioners do in seeking to improve social outcomes is not covered by the framework being proposed.

- While service *outputs* are generally easy to measure in terms of: hours, service events, and time on waiting lists; services *outcomes* are less tangible though not necessarily outside the scope of measurement. Outputs are activity based and outcomes are the affect of the activity. A useful way of considering measurement is as follows:
  - Quality can be measured by accreditation process which include external audits, benchmarking against other providers or using certain patient/student/client subject outcomes based on evidenced based measures. The current challenge to prove a service caused improvement is still rudimentary. Consider counselling where it is considered 87% of changes are due to factors outside of therapy and even within the therapy there are a number of factors that bring about change in a client's life.
  - The diagram below shows the complexity of measurement as it is applied to the provision of counselling services. See diagram Common Factors Model.

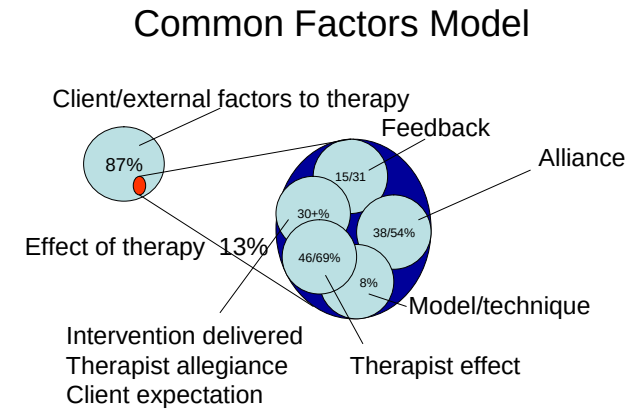

Diagram A. Source Duncan (2010).

- Equity is a complex issue. Issues of complexity are further compounded by the uneven distribution of services in Australia, especially in regional and remote areas and the fact that every time a government changes or department restructures service programs are discontinued, funding may be cut or shifted to other areas.
- Efficiency can be measured by the cost to deliver services. However, cost alone is not a sufficient measure of efficiency. A case in point is that a service in a regional area may be more expensive to run than in a metropolitan area, but may have a broader community and social benefit around whole of community health.
- Responsiveness can be measured. For example, in employment services a measure may include how long it takes a client to see a worker. However, in areas such as counselling service demand outstrips the supply of services, so people naturally go on waiting lists. The writer can site where quality practices were introduced regarding efficiencies of waiting list management, such as the use of one off counselling methodology, but this did not result in shortening of waiting lists.
- Accountability in the human service sector has increased over the decades with increased red tape. The risk with accountability is that often there are services which governments put out into the market place, but government takes on an arm's length approach. This distancing of Government can result in significant service failure e.g., the use of private companies in the prison system or outsourcing arrangements to deal with detention centres. In each of these cases there have been documented failures in quality outcomes.

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.

The various factors outlined in Figure 2, can assist in identifying those services that are best open to greater competition, such as whether a service is provided during a time of crisis such as emergency or disaster recovery. The inherent risk with these models is already being seen in the NDIS. For people who have family and friends to support them to make informed choices, the system has the potential to work well. However, for individuals without support or lacking perhaps certain capacities to engage in the consumer driven model, there is the potential for disadvantage at the point of engagement and in subsequent transactions. Historically, the mental health system reform of the last forty years has shown that those at risk of not having support or being able to engage in service systems may be open to abuse. For example: people with mental health living in accommodation settings such as boarding houses that are totally inappropriate for their housing. Such reforms may have compounding and unintended consequences. For example, some people have come into contact with police and have been criminalised as a result of psychotic episodes.

The Commission is seeking participants' views on which human services have the greatest scope for 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.

We challenge some of the assumptions associated with the need for further competition. There is an inherent assumption in the above statement that a market driven model will deliver the best outcomes; whilst failing to acknowledge that Australians live in a community not just an economic market. Does

the market alone drive better outputs and outcomes? There is evidence regulation has resulted in worst outcomes for so called consumers. Consider the following regarding electricity and competition:

> "Consumers will likely have to pay more than we thought they should," Paula Conboy, the head of the Australian Energy Regulator said on Friday of the challenge to her earlier decision to force through price cuts. A ruling on Friday by the Australian Competition Tribunal has put at risk cuts of up to $300 a household to the annual electricity bill which was imposed from mid-2015. The Australian Energy Regulator, an arm of the Australian Competition and Consumer Commission, has been told to conduct a further review of the planned spending by electricity companies. Since the power companies are monopolies, their prices and spending plans are subject to scrutiny and approval by the government.
> (Source: http://www.smh.com.au/business/energy/power-price-cuts-up-in-the-air-following-legal-challenge-20160225-gn3fmf.html, accessed 24 July 2016).

Further, the same argument may be applied to where there is a difference in performance within hospitals. For example, one has only to consider the Queensland Public Hospital Commission of Inquiry, where poor clinical outcomes were due to poor management, lack of funding to hospitals e.g., patients had to go to a private hospital to use their equipment, lack of appropriately qualified medical officers and lack of integrity of certain individuals that caused systems not to be complied with as per the Commissioners comments. Competition alone won't improve service outcomes; this is a simplistic approach. (Source: http://www.parliament.qld.gov.au /documents/tableOffice/TabledPapers/2005/5105T5305.pdf, accessed 24 July 2016).

While there may be no **current policy setting** in respect to competition, contestability or user choice it is not correct to assume these don't currently exists in the human service sector. Notably, in the community sector it operates in an environment of competitive tendering. This has resulted in the number of smaller providers disappearing over the years, while large multi service providers have come into being. This has resulted in the erosion of many smaller specialist providers that often provide a service to the most disadvantaged.

In respect to **improved performance data and information** there is significant data collected by Government in relation to service delivery. The problem is not enough data. Rather, the reality is that there is poor understanding of metrics in the regulators e.g., when a government department want to use diagnostic tool for mental disorder to evaluate service effectiveness. Further, universities don't teach graduates generally about the need and use of metrics in the human service sector in respect to service improvement. Realistically improved service data and service information is faltering not because data isn't collected, but often it doesn't come back to service providers and then services providers generally aren't trained sufficiently to use the data.

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, equity, efficiency, responsiveness and accountability***

applicability of the case study to the provision of human services in Australia if it is an overseas example.

We refer the document *Making Public Service Markets Work* attachment. Fundamentally, some services such as waste management, school catering and similar service can be put into the market place with improved efficiency and costs. However, in drawing from the experience of the United Kingdom, it is evident that in more complex areas of service delivery there may be perverse

outcomes. A key example has included parking consumers due to their complexity and the potential cost of services that might result in a financial loss for the provider.
(Source: http://www.instituteforgovernment.org.uk/sites/default/files/publications/ Making_public_service_markets_work_final_0.pdf, accessed 24 July 2016)

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 (or 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.***

Many community service assist the public by practicing a "no wrong door" approach. Many providers have websites to enable people to access information. The provision of information about services generally exists by websites or call centres as well as community information directories.

In respect to service users comparing services, if mental health was taken as an example with early intervention services such as counselling people either can go to a website for information, contact a community service or their GP. The idea people will have sufficient knowledge to make informed choice is an interesting one. Counsellors, psychologist, psychiatrist, social workers and occupational therapists all can provide counselling and it would be possible to explain it on a website, but this is no different to what happens now.

Can past service experience inform future decisions regarding choice in the future? This is akin to suggesting that a person's experience with a dentist or doctor will help them choose more carefully in the future due to their past experience. Taking the example of mental health, certain professions such as psychology, psychiatry and occupational therapy - these are covered by the Health Practitioner Regulation National Law Act 2009; while other professionals such as counsellors and social workers are not covered by the Regulation Act. This means that consumers don't have any means of assessing the professional standing in these latter occupations apart from membership to a professional body. For these reasons, it could be argued that past experience doesn't guarantee the competence of the next provider when it comes to making informed choice.

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.

In services such as mental health, the ideal is that a service provides offers a range of workers for client choice: for example a female client may want a female carer rather than a male. Further, workers often need support due to the inherent risks of working in areas like domestic violence and in situations where there are isolated workers. Counselling is a service that can be one off, but ideally better outcomes are achieved for clients by engaging with the service over time. The service can be

provided remotely through the use of Skype. However, the challenge is finding a suitable location so that service users have privacy. The challenge of providing multiple services such as a worker providing general mental services as well as perhaps more specific areas like substance abuse, means a service provider needs to provide extensive staff training. In regional or remote areas, the turnover of staff can make it challenging to find workers able to work across a number of disciplines.

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 viable***

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.

Again taking mental health and counselling as a case example, there are already low cost providers such counsellor practitioners who are not psychologists working in the area of mental health. What might change is that workers will be more motivated to ensure they achieve a sufficient income since they are no longer earning a wage and be distracted from their current commitment to work in disadvantaged regions or with disadvantaged client groups.

The "worried well" might be better served rather than the disadvantaged or more challenging client groups. Certainly outreach work into regional or remote areas could suffer due to proving unprofitable.

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 users 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 user-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 costs faced by different types of providers, with different motivations and governance structures, when shifting to a more user-focused model of service provision.

The current level of compliance costs for not for profits can be around two percent of annual turnover and it would difficult to see how this would change with a consumer directed model. Under the NDIS with the development of individual invoicing this is an increase in cost that is ongoing and requires significant financial investment from an accounting perspective. Clients in the future may pay for the sessions they currently fail to turn up to or cancel late. Currently, there is extensive consumer law around professional service provision and it is questionable how much extra regulation would be

required. The consumer directed model might see more sole traders in the market place. This may include practitioners working in isolation or small practices, potentially resulting in increased risks for consumers as well as workers who will not be under the same scrutiny as those operating as part of an agency.

Further, private providers will be driven to make an income and potentially be less invested in disclosing poor practices. The fee for service model might mean that smaller providers cannot operate in the market place as is already happening in the NDIS. This could mean less choice especially in regional and remote regions. Alternately, large providers might initially come into the market with loss leaders to gain a market share and drive out small providers and when the business become unprofitable they will withdraw their service leaving a gap in service provision - again something already occurring with the NDIS.