CATHOLIC HEALTH
Australia

Human Service Inquiry
Productivity Commission
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Submission to the Human Services Inquiry – Identifying Sectors for Reform

Dear Commissioner,

Thank you for the opportunity to contribute to the first stage of the Commission's inquiry into introducing competition and informed choice in human services.

We note that the purpose of the first stage of the inquiry, and the associated issues paper that was circulated, is to identify human services that are best suited to the introduction of greater competition, contestability and user choice.

Catholic Health Australia is strongly of the view that both hospitals and aged care are services where greater competition and consumer choice and control has the potential to significantly benefit consumers and taxpayers.

This letter separately addresses issues relating to hospital and aged care services.

Hospital and health services

Health expenditure in Australia in the financial year just ended is likely to have been around $175bn representing just under 10% of GDP – with expenditure on hospitals (public and private) accounting for around 40% of that total at close to $67bn[1].

The Productivity Commission in the Supplement to its 2009 Research Report, *Public and Private Hospitals*[2], estimated that the average output of individual hospitals across both sectors was around 10% below best practice. In monetary terms, if best practice could be realised, this would mean nearly $7bn annually in either reduced hospital expenditure for the same number of services (or an increase of around 1.4 million cases treated each year for the same level of expenditure).

At a time of constraint in government revenues and increasing future demand for health services, it is very important that our health system operates as efficiently as possible.

[1] Australian Institute of Health and Welfare, Health expenditure Australia 2013–14, Supplementary Tables, Table A6 multiplied by an indexation factor of 6.6% and 6.2% respectively based on the average increase of the preceding 5 years Ibid Table A7.
[2] Productivity Commission 2010, *Public and Private Hospitals: Multivariate Analysis*, Supplement to Research Report, Canberra

Whilst there are many reasons why such a theoretical saving may not be achievable in the real world, particularly if we are concerned to ensure continued equity of access to services by all Australians, the quantum of savings available from even a modest improvement in efficiency make a compelling case for an investigation by the Productivity Commission into the benefits and costs of applying greater competition, contestability and informed user choice across the hospital sector.

CHA considers it vitally important however to ensure that consideration of any proposals to increase efficiency must also take into account the impact on the most vulnerable and disadvantaged – particularly in their ability to be able to access high quality health services regardless of their financial means. More broadly, any investigation will also need to consider the impact on those services where a more collaborative approach across services approach is required – such as in the management of chronic disease or health conditions where there is a need to develop long term relationships of trust, such as in the provision of mental health services or culturally appropriate services to indigenous or other minority groups.

The maximisation of the potential gains from increasing the application of competition and contestability would also require a number of structural issues to be addressed, including competitive neutrality between public and private providers. We also need to recognise the constraints to increasing competition and contestability in many regional and remote areas of the country – although over time some of these may be addressed by changing technologies.

The ability for consumers to make informed choices about health services is a worthwhile goal in itself.

Informed consumer choice is currently constrained by a number of factors including:

- lack of meaningful information as to comparative provider outcomes;
- lack of information about potential treatment options, including the potential out of pocket costs depending on the option taken; and
- role of 3rd party funders in limiting consumer choice (eg being treated by the nominated public hospital doctor if a public patient or, if a private patient, whether a particular provider has a contract with the patient's health fund which minimises additional out of pocket costs).

This submission will now address several of the above issues in relation to hospitals in more detail. It should also be kept in mind that, at this stage, a proposal in this submission for an area to be examined by the Productivity Commission does not necessarily mean that CHA proposes that area should be subject to greater competition, contestability or informed user choice. Rather it means that CHA considers it worthwhile to examine the potential positives – as well as negatives – from applying greater competition and contestability to the nominated area.

Hospital governance and funding

The provision of hospital services in Australia takes place in the context of a complex funding and regulatory framework.

Most public hospitals are owned and operated by state and territory governments. Additionally a number of public hospitals are owned and operated by non-government entities including members of Catholic Health Australia on contract to state governments. Public hospitals are funded jointly by State/Territory governments and the Commonwealth – with the respective funding shares determined by agreements of the Council of Australian Governments. The funding of individual public hospitals and health services, including the Commonwealth component, is determined by State/Territory governments and set out in service agreements with hospitals and health services.

In 2013-14 the respective sources of the $45.7 billion expenditure on public hospitals were: State/Territory governments 54.2%, Commonwealth 36.8% (including 0.9% in private health insurance premium rebates paid to private patients treated in public hospitals), individuals 2.9%, private health insurance 2.1% and other 4% (including motor vehicle accident and workers compensation)[3].

Public patients do not pay to access hospitals at the time of use – their admission costs being met from State/Territory and Commonwealth general taxation revenue, including the Medicare Levy.

Any investigation in relation to increasing the application of competition principles will need to consider the respective roles of consumer and funder in a third party payer environment, where consumers do not face price signals and are not the only ones involved in selecting a provider or treatment option.

As the Commission notes in its Discussion paper, decisions about treatment are often made by others, including specialist doctors, who themselves may face other and different incentives to consumers, in recommending particular treatment options. CHA considers that the Commission will need to examine the incentives faced by other parties who also play a part in the decision-making processes about treatment and how these parties may respond to a more market based approach.

These include:

- Patient's GP
- Specialist doctor
- Public hospital (which allocates a treating doctor)
- Funders –particularly where they may have contracts with certain providers and not others, which then may flow onto the consumer out of pocket costs.

Public hospitals also derive revenue from the treatment of private patients – attracting benefits from private health insurers and also from the retention of a portion of the MBS rebate claimed by the hospital on behalf of treating medical practitioners exercising rights of private practice in the public hospital. CHA considers that the role of payment models at both Commonwealth and State/Territory level in influencing hospital behaviour needs to be examined.

Private hospitals are operated by a range of for profit and not-for-profit entities. Catholic Health Australia members treat between 25-30% of private health insurance admissions. Private hospitals earn revenue by charging for the treatment of private patients (mostly paid directly on behalf of those with private health insurance membership by the insurers through contracts with hospitals). Private hospitals also derive revenue from the treatment of uninsured individuals, veterans, motor vehicle accident and workers compensation payments as well as by limited contracting with State/Territory governments for the treatment of public patients.

In 2013-14 the respective sources of the $13.04 billion expenditure on private hospitals were: private health insurance 69.5% (of which 20.9% includes the Commonwealth's private health insurance rebate contribution), individuals 11.1%, DVA 7%, other 6.2% and State and Territory governments 3.9%.

[3] Australian Institute of Health and Welfare ibid.

Hospital payment systems and the potential to increase efficiency

Hospital payment systems have evolved over recent decades from systems that relied on historical block or daily payments to ones that more closely match payment to the number and average cost of actual services provided.

Under historical payment systems such as block funding or a daily payment for each day a patient is in hospital (per diem) and provided that they are able to earn sufficient revenue to meet their costs, hospitals have not faced strong financial incentives to increase efficiency. This is particularly the case where hospital managers could confidently expect any surplus to not stay with the hospitals and the even more likely prospect that last year's surplus would result in a reduced allocation in the following year.

Public hospitals have also often been required to give greater priority to meeting government policy objectives such minimising elective surgery waiting lists and emergency department waiting times.

The introduction in recent years of payment systems that are more reflective of the number and actual cost of services provided have generally been followed by lower costs in those systems where they have been adopted.

Victoria, as the first State to introduce to introduce Case-mix funding in 1993-94, consistently reports the lowest costs for the provision of public hospital services[4].

The wider adoption of Activity Based Funding by the Commonwealth in the contribution it makes to State/Territories for their public hospital services has further reinforced the trend to greater efficiency, with public hospital cost inflation of just 1% per weighted activity unity in the period from 2011-12 to 2013-14[5], as reported by the National Health Performance Authority in a paper released in April 2016.

The same paper notes the very large variation in average costs across Australian hospitals - with the cost per National Weighted Activity Unit varying from $3,000 to $6,100.

Similarly, the Grattan Institute has reported high variations in costs for particular procedures, such as hip replacements (ranging from $10,000-$25,000), which could not be readily explained by the usual reasons for cost variations.

The increasing application of techniques such as ABF, which have been followed by efficiency improvements, demonstrates that with the right incentives hospitals will respond accordingly.

One of the limitations of the ABF approach is that the payment of a single, administratively determined price across a jurisdiction works most powerfully to incentivise hospitals with above average cost structures to become more efficient and moved to the average as they will otherwise operate at a loss.

The price signals to those hospitals with costs below the average for a particular procedure are less powerful - although they still gain from any margin between the price they are paid and their own costs if they are allowed to retain their surpluses.

Funders, however, are still required to pay the administratively determined average price - even if the provider is able to achieve a lower cost and thus receive a substantial margin.

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[5] National Health Performance Authority, inFocus Hospital Performance, April 2016

In this situation, the application of greater competition and contestability may provide a further stimulus to efficiency gains – particularly if a potential competitor is able to use their industry knowledge to appropriately target high margin services.

If the Commission does decide to look at hospitals in more detail, consideration will need to be given to ways that competition and contestability will work.

Factors that will need to be considered could include:

- how the criteria for determining the purchase of services should be developed;
- who the purchaser is, including for public hospital services, whether it is appropriate for the purchaser and regulator to also provide hospital services;
- a range of competitive neutrality issues including, but not limited to:
    - cost of capital;
    - how administrative system overheads such as IT and IR frameworks are paid and accounted for (ie attributable to individual hospitals/health services or to head office?);
    - Tax treatment;
    - Employment arrangements;
    - Incentives for treatment of private patients in public hospitals;
    - Regulatory and licensing framework, including relative reporting and regulatory burden imposed on public and private sectors.

The ability for hospitals to operate at maximum efficiency can also be constrained by the way that other parts of the health system operate. Examples that fall into this category include the regulation of health professions – especially the existence of rigid professional boundaries that limit the ability of one health profession to be able to provide services in an area that has traditionally been the preserve of another health profession – even if the reasons for the original demarcations such as public safety and competency are no longer relevant. Many health professions have entry and training requirements that often have more to do with restriction of supply and protection of incomes than public safety and the provision of quality of care.

Similarly, hospitals that operate pharmacies on their premises have valuable infrastructure and highly skilled staff – yet they are often prevented from being able to be fully utilised by restrictive ownership and location rules.

Another significant issue that will need to be considered is where the boundaries should be drawn between those areas of hospital provided services where the application of competition and contestability may provide the community with a net benefit, as against those areas where competition is either impractical or the cost would be greater than any net benefit.

In particular, CHA is concerned to ensure that Australians living in rural and remote locations, indigenous communities and those suffering from socio-economic disadvantage are able to continue to access necessary care.

Any competition framework will also need to have regard to how services can best be delivered to consumers where continuity of care and the development of long-term relationships of trust are a vital component of appropriate care. This particularly applies to the provision of mental health services or culturally appropriate services to indigenous or other minority groups.

The design of a competition framework will also need to have regard for how those services, or bundles of services, that may be delivered to those with multiple, complex chronic conditions. A major criticism of current service provision for these groups has been the current high level of fragmentation or, in some cases, duplication of services. This can be alleviated in a more competitive environment by ensuring that the product that is the subject of competition is an integrated, bundled grouping of inter-related services, where that represents the most appropriate treatment model.

Provision of performance information for consumers

A consumer-driven health system requires consumers to have an informed knowledge of the performance of providers.

Performance reporting can be a powerful tool that:

- enables consumers to make informed choices when selecting a provider of health services (where such services exist);
- acts as a powerful incentive for all providers to lift their standards to the level of the best performance;
- provides strong accountability for the community at large, including funders, as to the performance of providers.

CHA believes this could be done through the progressive augmentation of the MyHospitals website with more detailed provider performance information including hospitals and clinicians – both medical as well as allied health providers.

In saying this, we also acknowledge that performance reporting needs to be appropriately risk-rated and designed in a way that minimises the risks of unintended consequences and gaming. CHA considers that performance reporting should only be linked to financial incentives and penalties where there is a strong evidence base and a clear link between with factors that the provider has control over.

Our priority needs to be on developing and rolling out robust, risk adjusted performance data that is collected in a consistent way with consistent definitions. There is still much work to be undertaken in Australia to reach this goal.

Dr Foster hospital guides in the UK and the US Department of Health and Human Services provide extensive information on the performance of hospitals and health care providers including on the results achieved by individual practitioners.

CHA considers that consumers should be empowered to make informed decisions in relation to their health care. Whilst consumers are given information about the treatment options they face, having access to provider performance data is also integral to informed decision-making.

Improved health literacy

Health literacy is a fundamental part of both preventive health and importantly is also a critical part of disease self-management for consumers in the event of ill health.

The level of community knowledge about health and well-being, including knowledge of infection control and hygiene (including the importance of hand washing and food hygiene) and lifestyle issues (including knowledge of healthy diet and exercise requirements) has an important influence on overall population health outcomes. In that respect health literacy can be seen as one of the social determinants of health.

Health literacy is also about more than just being able to comprehend advice from a health practitioner about the clinical aspects of a health condition. It is also about consumers having the ability to apply that information in a meaningful way. As one example, there may be cultural or socioeconomic factors at work that act as barriers to being able to implement the advice from a health practitioner.

A health-literate community involves strong partnerships, communication and collaboration between consumers, carers, community as well as health practitioners and the wider society.

CHA proposes that health literacy, in common with the other social determinants of health, needs to be incorporated into the programs and policies of all other areas of policy – particularly within the health system but also within the education and welfare systems. CHA also supports health literacy being included as a core element of the national curriculum and that it is incorporated in national skills assessment across primary and secondary schools.

Aged Care

While it is the case that some tentative steps are being taken to introduce greater competition and consumer choice in aged care services, the transition to a consumer-driven market-based aged care system, as explained below, remains an aspiration. Further research and analysis is required to demonstrate to the primary funder, the Commonwealth Government, that the aspiration is achievable and affordable.

Scope for improvement in the provision of aged care services

Aged care is a major part of the Australian services economy. It currently provides services to 1.3 million Australians, employs some 360,000 people, generates annual revenues totally around $20 billion and comprises 0.9 per cent of GDP[6].

Commonwealth funding currently represents around 75 per cent of total sector revenues[7].

Aged care's role in the economy is expected to grow significantly due to structural ageing of Australia's population. As at 30 June 2015, 473,000 Australians were aged 85 and over. By 2055, the population aged 85 and over is projected to increase to 1.9 million, while the population aged 70 and over is expected to triple to 7 million. Currently, 38 per cent of people aged 70 and over are receiving Government subsidised aged care services, rising to 80 per cent of people aged 85 and over.

Even under the current rationing policies, it is estimated that aged care services will employ up to 830,000 people by 2050 and comprise 1.7 per cent of GDP[8].

Considered together with the likelihood that Commonwealth funding for care and support in aged care will always be a significant proportion of total sector revenues, the above metrics underline how critical it is that future policies and Commonwealth funding arrangements for the sector drive innovation and productivity improvement, as well as responsive quality services.

Under current policies, however, the contribution that competition and contestability in service delivery and consumer choice and control can bring to technical and allocative efficiency, responsiveness to consumer preferences and innovation is at the margins.

In most respects, aged care today still effectively operates as a Commonwealth Government out-sourced service, along with many of the controls in place that would apply if the Commonwealth, acting as a monopoly provider, directly owned and operated these services. As a result, the Commonwealth:

- determines the volume, type and distribution of services to be provided,
- determines care prices and service provider budgets for care services, and
- contracts with non-government service providers in perpetuity by allocating licences for residential places and home care packages.

Human services provided on this basis do not rate well when judged against the Le Grand desirable attributes for 'good' public services viz:

[6] ACFA 2016 Annual Report
[7] ACFA 2016 Annual Report
[8] 2015 Intergenerational Report

- There is excessive reliance on regulations and sanctions and associated 'red tape' to support **quality** in service outcomes and to protect consumer interests in a supply rationed system;
- There is reduced incentive and little flexibility for providers to be **responsive** to consumer preferences and needs in order to attract customers on the basis of quality and value. Through the balance of care ratios, the government is also effectively determining where consumers should live to receive aged care services.
- **Equity** in terms of timeliness of access to services is compromised by effective full occupancy and waiting lists and there are also inequities in terms of user contributions to care costs.
- **Efficiency** is compromised by the relative absence of competitive pricing pressures to motivate productivity improvements and innovation, and the need for excessive reliance on regulatory red tape to govern the system in lieu of market disciplines. The indexation of care prices based on minimum wage movements is also a blunt instrument for realising productivity improvements in a labour intensive sector.
- Because aged care services are so heavily regulated by government, **accountability** for the quality of services is often sheeted home to the government as much as to providers. As a consequence, the reputation of the whole sector, including in the labour market, is threatened by periodic sanctions activity.

The *Living Longer Living Better* Package

The 2013 *Living Longer Living Better* package made only a relatively modest contribution to increasing competition and consumer choice and control. The package:

- increased the overall service provision target ratio from 113 operational places per 1,000 people aged 70 and over to 125 by 2021-22 (though the actual operational provision ratio at June 2015 was still only 111.5),
- increased the opportunity for people to choose to remain at home by increasing the proportion of home care packages in the overall target from 22 per cent to 36 per cent, and
- introduced individual budgets for home care packages, but
- the overall supply of services remains capped, consumer choice between home care and residential care is constrained by the balance of care ratios and funding in residential care and home care continued to be allocated to providers.

In fact, many of the more significant *Living Longer Living Better* package measures were aimed at improving sustainability by increasing prices and extending consumer contributions viz:

- introducing market-based accommodation prices across all residential care for non-supported residents,
- increasing the accommodation supplement for supported residents, largely funded by savings in accommodation costs that will be realised by more people being cared for at home with packages,
- introducing a combined assets and income test in residential care, and
- introducing an income tested fee in home care.

The policy change with the greatest potential to increase competition and consumer choice and control was not announced until the 2015-16 Budget ie the decision to introduce 'funding following the consumer' for home care packages from February 2017. But this will still operate within a regime of capped supply.

An alternative model

An alternative model for the delivery of aged care services based on a consumer-driven market approach needs to be developed and implemented, thereby engaging the discipline of greater competition and consumer choice and control.

Under such a model, the Commonwealth would no longer out-source aged care services by 'contracting' with non-government service providers. Instead,

- Commonwealth contributions (subsidies) would be directed to individuals to purchase aged care and support services.

- Commonwealth contributions would be based on individual assessed needs and means, and would be agnostic as to where an eligible person chooses to live. Accommodation options would be limited only by people's imaginations and local planning by-laws.

- The Commonwealth would no longer regulate the number, type, distribution and price of services. Instead service providers would compete on price, value and quality for customers.

- The government would also publish a reasonable market-informed price for **accommodation and everyday living** costs for low means consumers seeking residential care. Government would also contribute to the cost of the consumer's accommodation and living costs based on a reasonable market-informed price and each consumer's capacity to pay (based on total wealth).

- The government would also publish reasonable market-informed prices for **care and support** based on levels of need, and would continue to contribute to the cost of each consumer's care and support based on the reasonable market-informed price and each consumer's capacity to contribute.

Viewed in the context of how Australia's wider services sector operates, a service model based on competition and consumer choice and control is familiar territory. That is, individuals exercising choice in the purchase of services and service providers who compete for business based on price, value, convenience and quality.

However, there are a number of features of aged care services and consumers that distinguishes the sector from other service sectors which require additional policy responses. The key features are:

- the vulnerability of aged care consumers and the implications for engaging with informed choice to drive competition,
- the availability of services for those communities where there is insufficient market response, such as 'thin' markets due to isolation or the characteristics of certain special needs groups,
- the inevitable ongoing heavy reliance on taxpayer funding to subsidise care and support services for consumers (and accommodation costs for some), and
- the implementation risks of transitioning away from the current heavily regulated system.

These are discussed below.

Factors influencing the potential benefits of increased competition, contestability and user choice

Informed choice

There are concerns that the vulnerable nature of consumers in older age may mean that informed choice and control, a pre-condition for an efficiently operating market, will not be exercised effectively.

These are legitimate concerns, but they need to take into account a number of mitigating factors.

In particular, many consumers will have the support of family and friends, and in practice an effectively operating market does not require all consumers to engage in informed choice to influence provider responsiveness and behaviour.

Also, many of the decisions about aged care services relate to daily living considerations and sense of community and wellbeing in response to increasing frailty. Choices on matters such as these are generally more amenable to informed decision making by the public compared with, for example, medical procedures and treatments for diseases which also require expert clinical input.

Moreover, community expectations about service quality and responsiveness are increasing, especially (but not only) for the baby boomer generation. This will find expression not only in the aged care expectations of the baby boomer generation, but also that of their parents.

Nevertheless, more can and needs to be done by government to support informed consumer choice by publishing consumer experience data and regulating the publication of prices and their form in order to ensure that comparisons can be readily made by consumers. It is also likely that the introduction of greater choice will see an expansion of 'trip advisor' type arrangements and social media activity to support consumer choice and to act as a discipline on provider behaviour.

Looking forward, the knowledge in the community that there is a capacity to exercise choice will, of itself, stimulate consumer engagement, whereas the current system of limited supply and choice fosters a more passive approach to service expectations and consumer behaviour.

Importantly, it would not be the case that a market based system based on competition and consumer choice would operate in isolation. Aged care would be expected to continue to operate within a quality assurance framework which includes approved provider arrangements, accreditation and an independent complaints scheme. However, quality assurance would no longer rely exclusively on regulation and a sanctions regime. Instead it would be complemented by competition and the exercise of consumer choice, the very discipline that the ACCC relies upon for the economy at large.

There will also be older people who find themselves in circumstances where they are less capable or unable to exercise choice, such as people with cognitive impairments with no family supports and certain special needs groups. Consequently, there would still be a need for supports such as advocacy services and homeless services dedicated to assisting those less well placed to access appropriate aged care.

However, the system would be based on the assumption that a sufficient number of people will be able to exercise informed choice if they are given the chance.

'Thin' markets

As is the case for the service economy generally, competition and choice is problematic in less populated areas, such as most parts of rural and remote Australia.

Accordingly, governments will need to continue to make special arrangements if they wish to ensure services are available in such areas. In aged care, this currently takes the form of paying higher prices (the viability supplement and providing capital grants) and pursing models such as Multi Purpose Services designed to realise economies of scale by combining various human services under one entity. Inevitably, choice of aged care service provider is not a realistic expectation where there are 'thin' markets, but contestability of provider could be introduced through time limited tendered contracts. These contracts could go beyond aged care to include related primary health and human services.

However, the constraints on competition, contestability and consumer choice and control in less populated areas should not drive policy for the regions where most Australians live.

The potential costs of increased competition, contestability and user choice

To operate efficiently in aged care, competition and choice will require the removal of the current caps on supply which dictate service volumes and types, and constrain consumer choice and competition.

This is best illustrated by the fact that average residential aged care occupancy continues to hover around 93 per cent, and that consumer choice to live at home or in a residential facility is determined by the government's allocation service volumes between the two service types.

However the move to a demand-driven system introduces financial risk for government, as the major funder of aged care and support, because the level of unmet need and demand is uncertain.

Accordingly, there is a need to undertake research and modelling to determine the level of unmet need for aged care services and the cost to government and individual consumers under a variety of scenarios.

The factors that modelling of affordability would need to take into account include:

- The impact on system costs if greater consumer choice results in a further shift from residential care to home care.
- The impact on demand of a more robust, consistent and tightly administered eligibility and assessment processes (gate keeping) through MyAgedCare, including the availability for the first time of accurate waiting lists.
- The impact on system costs and affordability for consumers under various consumer contribution scenarios, including taking into account all wealth and treating all wealth equally irrespective of the form it takes.
- The impact on system costs and affordability for consumers of a greater alignment of user contributions for people with the same care needs irrespective of where they choose to receive their care.
- Productivity gains that might accrue under the operation of a more competitive aged care services market.

- The impact on system costs of a greater emphasis on early intervention and reablement.

Modelling of unmet demand and costs should also take into account that the current forward estimates are based on the Government's provision target of 125 operational places per 1,000 people aged 70 and over by 2021-22, whereas the provision level as at June 2015 was only 111.5 operational places.

The Aged Care Roadmap

The Aged Care Roadmap[9] was prepared by Aged Care Sector Committee, following representations to the Government, in order to stimulate further reform towards the creation of a consumer-driven market-based aged care system, broadly in line with that envisaged in the Productivity Commission's 2011 Report *Caring for Older Australians*.

While the Roadmap sets out future reform directions and key steps towards a consumer-driven market based system, it does not provide a template for reform and is not Government policy.

At this stage, the Turnbull Government has indicated only that it is 'committed to delivering a plan to create a consumer-driven market approach to aged care, one which can also protect special needs groups and work in geographic areas where it is not always practical for providers to be on the ground' and that 'the Aged Care Sector Committee Roadmap for reform will guide the way'[10].

As a consequence, there is still a considerable amount of policy development and analysis required before aged care can successfully transition to a consumer-driven market-based system which allows the benefits of competition, contestability and greater consumer choice and control to accrue to consumers and taxpayers. Some of the issues were referred to earlier in this document.

Catholic Health Australia therefore submits that the Productivity Commission can play an important role through its human services inquiry in providing independent advice on the policies and reforms needed for this transition and to demonstrate that a consumer-driven market-based aged care system is achievable and affordable.

Catholic Health Australia
July 29th 2016

[9] Aged Care Roadmap, Aged Care Sector Committee, April 2016
[10] Statement issued by Susan Ley, Minister for Health and Aged Care, 6 May 2016.