Australian Government

Productivity Commission

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

Productivity Commission
Preliminary Findings Report

September 2016

This preliminary findings report has been prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

Opportunity for further comment

The purpose of this report is to seek feedback from participants on the Commission's preliminary findings, and any further issues that should be considered before the public release of the study report in November 2016. The Commission welcomes further written comment on the preliminary findings in this report, and will undertake consultations and hold roundtables to facilitate feedback from participants to inform the preparation of the study report. Interested parties are welcome to put forward services they consider should be recommended for reform in the second part of the inquiry. The due date for submissions is 27 October 2016.

Further information on how to provide a submission is provided on the inquiry website: www.pc.gov.au/inquiries/current/human-services/make-submission#lodge

Terms of reference

PRODUCTIVITY COMMISSION INQUIRY INTO INTRODUCING COMPETITION AND INFORMED USER CHOICE INTO HUMAN SERVICES

I, Scott Morrison, Treasurer, pursuant to Parts 2, 3 and 4 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission undertake an inquiry into Australia's human services, including health, education, and community services, with a focus on innovative ways to improve outcomes through introducing the principles of competition and informed user choice whilst maintaining or improving quality of service.

Background

The Australian Government is committed to working in partnership with State and Territory Governments and non-government service providers to ensure that all Australians can access timely, affordable and high-quality human services, which are appropriate to their needs, and are delivered in a cost-effective manner.

The human services sector plays a vital role in the wellbeing of the Australian population. It covers a diverse range of services, including health, education and community services, for example job services, social housing, prisons, aged care and disability services. There are some features that are common across the range of services and models of service provision, while other features are unique in nature. Complexity arises from differences in the characteristics of the services, and of the individuals receiving the services, the objectives sought, and the jurisdiction and market in which the services are being supplied.

While governments have made progress in introducing competition, contestability and user choice to human services provision, the efficiency and effectiveness of the delivery of services within the sector varies significantly between jurisdictions. Service delivery frameworks in the human services sector that are inefficient and/or ineffective can result in significant costs to the economy and individuals, including poorer outcomes and reduced productivity.

Australia's human services sector is facing significant challenges, including increasing demand for services due to the ageing population, the effect of technology and cost increases associated with new and more complex service provision demands. Finding innovative ways to improve the efficiency and cost effectiveness of the human services sector, and to target services to those most in need, will help ensure that high quality service provision is affordable for all Australians and leads to improved outcomes for the economy and individuals.

Scope of the inquiry

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

The Commission is to undertake the inquiry in two stages.

1. The first stage will deliver an initial study report identifying services within the human services sector that are best suited to the introduction of greater competition, contestability and user choice. The Commission will examine:

   (a) the current level, nature and future trends in demand for each major area of service delivery;

   (b) the current supply arrangements and future trends, including the scope for diversity in provision and informed user choice, alternative pricing and funding models, and the potential for contestability in supply by government, not-for-profit and private sector providers;

   (c) the effectiveness of previous reforms intended to introduce greater competition and user choice, and the pathway taken to achieve those reforms, through investigating:

      (i) case studies of existing practices and trials in Australian jurisdictions; and

      (ii) international examples of best practice.

2. In the second stage, the Commission will undertake a more extensive examination and provide an inquiry report making recommendations on how to introduce greater competition, contestability and user choice to the services that were identified above.

   (a) In providing its recommendations, the Commission's report should identify the steps required to implement recommended reforms.

   (b) In developing policy options to introduce principles of competition and informed user choice in the provision of human services, the Commission will have particular regard, where relevant, to:

      (i) the roles and responsibilities of consumers within the human service sector, and the service or services being considered;

      (ii) the factors affecting consumer use of services and preferences for different models of service delivery, noting the particular challenges facing consumers with complex and chronic needs and/or reduced capacity to make informed choices;

      (iii) the role of the government generally, and as a commissioner, provider and regulator, in the delivery of human services;

(iv) the role of government agencies in designing policy, commissioning and, in some cases, delivering human services in a client-centred way that encourages innovation, focusses on outcomes and builds efficiency and collaboration;

(v) the role of private sector and not-for-profit providers;

(vi) the benefits and costs of applying competition principles in the provision of human services, including improving competitive neutrality between government, private and not-for-profit service providers;

(vii) how best to promote innovation and improvements in the quality, range and funding of human services;

(viii) the challenges facing the provision of human services in rural and remote areas, small regional cities and emerging markets;

(ix) the need to improve Indigenous outcomes; and

(x) the development of systems that allow the performance of any new arrangements to be evaluated rigorously and to encourage continuous learning.

Process

The Commission is to undertake appropriate public consultation processes including holding hearings, inviting public submissions, and releasing issues papers to the public.

The Commission will publish the initial study report within six months of receiving these Terms of Reference. The report will set out the findings from case studies and international experiences and identify which services within the human services sector are best suited to the application of competition, contestability and informed user choice principles.

The final inquiry report, including policy recommendations and a path and process to ensure sustainable, efficient and effective reform, will be provided within 18 months of receiving these Terms of Reference.

S. MORRISON
Treasurer

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Contents

Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal community controlled health organisation
AIHW	Australian Institute of Health and Welfare
CAPDS	Child and Adult Public Dental Schedule
CDBS	Child Dental Benefits Schedule
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
GP	General Practitioner
NDIS	National Disability Insurance Scheme
NSQHSS	National Safety and Quality Health Service Standards
PCOC	Palliative Care Outcomes Collaboration
VET	Vocational Education and Training

OVERVIEW

Key points

- Greater competition, contestability and informed user choice could improve outcomes in many, *but not all*, human services.

- The Commission's preliminary finding is that there are six priority areas where introducing greater competition, contestability and informed user choice could improve outcomes for people who use human services, and the community as a whole.

  – The Commission's view is that reform could offer the greatest improvements in outcomes for people who use social housing, public hospitals, specialist palliative care, public dental services, services in remote Indigenous communities, and grant-based family and community services.

  – Well-designed reform, underpinned by strong government stewardship, could improve the quality of services, increase access to services, and help people have a greater say over the services they use and who provides them.

  – The purpose of this report is to seek participant feedback on the Commission's findings before the public release of its study report in November 2016.

- Introducing greater competition, contestability and informed user choice can improve the effectiveness of human services.

  – Informed user choice puts users at the heart of service delivery and recognises that, in general, the service user is best-placed to make decisions about the services that meet their needs and preferences.

  – Competition between service providers can drive innovation and create incentives for providers to be more responsive to the needs and preferences of users. Creating contestable arrangements amongst providers can achieve many of the benefits of effective competition.

  – For some services, and in some settings, direct government provision of services will be the best way to improve the wellbeing of individuals and families.

- Access to high-quality human services, such as health and education, underpins economic and social participation.

  – The enhanced equity and social cohesion this delivers improves community welfare.

- Government stewardship is critical. This includes ensuring human services meet standards of quality, suitability and accessibility, giving people the support they need to make choices, ensuring that appropriate consumer safeguards are in place, and encouraging and adopting ongoing improvements to service provision.

- High quality data are central to improving the effectiveness of human services.

  – User-oriented information allows people to make choices about the services they want.

  – Data improves the transparency of service provision, making it easier for users to access the services they need, and increases accountability to those who fund the services.

  – Governments are better able to identify community needs and expectations, and make funding and policy decisions that are more likely to achieve intended outcomes.

Overview

1   Introduction

High-quality human services, such as health and education, underpin economic and social participation. Access to high-quality human services contributes to the wellbeing of individuals and the welfare of the community as a whole. Community welfare is enhanced by the social cohesion and equity benefits of people having access to a minimum level of human services, regardless of their means or circumstances.

Everyone accesses human services during their lifetime. Many people draw on human services in a reasonably predictable pattern of use. Others will require transitional support to assist with a short-term crisis. Some will have multiple and complex needs and require access to several coordinated services, potentially for long periods. For example, about 28 000 people who accessed specialist homelessness services in 2015 also required access to mental health, drug and alcohol, or disability services. Of these, about 6000 people accessed two of these services, and a small number drew support from all three. Services to support people who have complex needs will generally be more successful at achieving intended outcomes if they are coordinated around the needs of users and their families.

The design of systems to deliver human services is a complex task. Every level of government is involved in funding or delivering human services. Non-government providers include unpaid informal carers, sole traders, mission-driven organisations that rely on volunteers and donations, and for-profit entities that have a footprint over multiple jurisdictions and service areas. The people that are served are diverse in their needs, preferences and capabilities, including their capability to exercise informed choice. Data systems have the potential, if used effectively and cooperatively, to better target services to diverse users.

Public and private expenditure on human services is significant — almost $300 billion in 2013-14 (figure 1) — with demand projected to grow as people live longer, incomes grow and technological breakthroughs increase the range and number of services available to users. Expenditure provides an indication of costs but does not measure the benefits of human services to an individual or to the community — the social and economic benefits when a person at risk of homelessness, for example, finds their way to stable accommodation, better health care and, ultimately, fulfilling employment.

The Commission's task

The Commission has been asked to examine whether the efficiency and effectiveness of human services could be improved by introducing greater competition, contestability and informed user choice. The terms of reference request that the inquiry be undertaken in two parts: the first is to identify services that are best suited to reform by introducing greater competition, contestability or informed user choice. For the services identified as best suited, the second part is to make reform recommendations that help to ensure all Australians have timely and affordable access to high-quality services that are appropriate to their needs, and that those services are delivered in a cost-effective manner. The final inquiry report will be submitted to the Australian Government in October 2017.

Figure 1   **Expenditure on human services**
$ billion, 2013-14
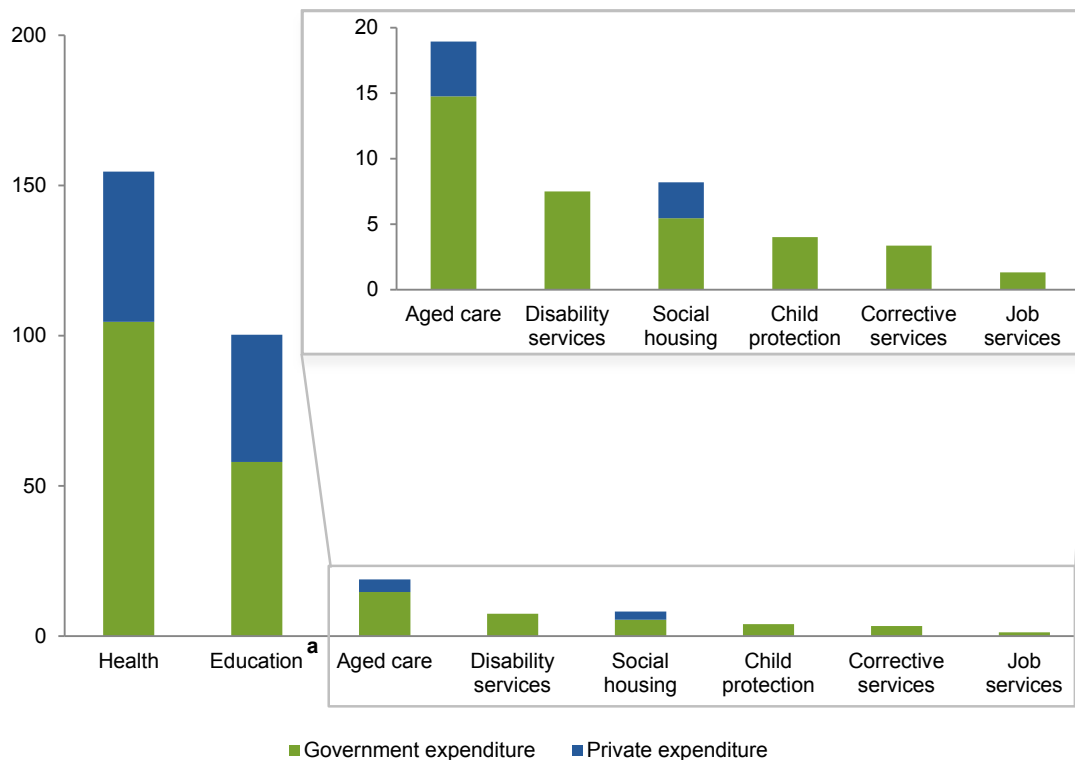
a Private expenditure on education is based on ABS Government Financial data and may include some government payments to private individuals that are spent on education services and are also included as government expenditure on education.

The introduction of greater competition, contestability and user choice will not be the best reform option for all human services. This preliminary findings report sets out the Commission's framework for identifying those services that could be suited to this type of reform, and its initial findings as to which services should be carried forward to the second part of the inquiry.

The purpose of this report is to seek feedback from participants on the Commission's findings, and any further issues that should be considered before the public release of the study report in November 2016. The Commission welcomes further written comment on the preliminary findings in this report, and will undertake consultations and hold roundtables to facilitate feedback from participants to inform the preparation of the study report. Interested parties are welcome to put forward services they consider should be recommended for reform in the second part of the inquiry. The due date for submissions is 27 October 2016.

The scope of this inquiry

The terms of reference for this inquiry do not define 'human services', or provide a definitive list of which human services are within scope. Instead, the terms of reference list examples of human services — health, education, community services, job services, social housing, prisons, aged care and disability services — that serve as a guide to the scope of the inquiry. Potential reform to existing government 'back-office' systems that support the delivery of human services, such as payments systems, is beyond the scope of this inquiry.

2 Roles for government in the provision of human services

Governments take an active role in the funding, provision and stewardship of human services. This recognises that markets, as price and quality-setting forums, often struggle to deliver an appropriate level or distribution of these services across the community. The level of funding assistance from governments to service users varies — up to 100 per cent of the cost of provision for some services and for some users — as can the way the funding flows to service providers and users.

The nature of funding flows from governments — who receives the funding, when and on what basis — is a significant driver of outcomes from the provision of human services. Some services are funded through payments to suppliers, while for others funding is placed in the hands of the consumer. Funding can be based on meeting outcomes agreed between governments and providers, or on the basis of activity. Careful design is needed to ensure the incentives of providers and users are aligned; and that government objectives are met. Care is needed, for example, to avoid overconsumption of services that are 'free' to users.

Governments have a stewardship role

Governments' stewardship role in the delivery of human services is broader than overseeing the 'market'. Stewardship encompasses almost every aspect of system design, including identifying policy priorities and intended outcomes, designing models of service provision, and ensuring that services meet standards of quality, accessibility and suitability

for users. Some recipients of human services can be vulnerable, with decisions often being taken at a time of stress. The need to ensure the development and implementation of appropriate consumer safeguards is an important aspect of the stewardship role and will be a key focus for the Commission in the second part of this inquiry.

With governments' involvement in the provision of human services comes the expectation from the community that those services meet a minimum standard. If governments do not adequately discharge their stewardship function, the effects can be damaging to service users, providers and governments. Australia's recent experience with the VET FEE-HELP scheme demonstrates what can happen when governments fail to discharge their stewardship role well (box 1).

Box 1   Vocational education and training reforms

Reforms to the vocational education and training (VET) sector illustrate the potential for damaging effects on service users, government budgets and the reputation of an entire sector if governments introduce policy changes without adequate safeguards.

In 2009 the Australian Government introduced the VET FEE-HELP system of income-contingent loans for higher-level VET courses. Initially these loans were only available to students undertaking education and training through VET providers that had credit transfer arrangements with a higher education institution. In 2012, the Australian Government expanded the scheme so students undertaking courses at other VET providers could access VET FEE-HELP loans. The number of approved providers doubled between 2012 and 2014 to reach nearly 250, but no requirements were put in place for providers to demonstrate that they were delivering high-quality education. While consumer choice was expanded, the Australian Government did not fully anticipate the market stewardship issues that would emerge.

The number of students accessing VET FEE-HELP increased almost fivefold from 2012 to 2015, mainly due to a substantial increase in the number of full-fee paying students enrolled at private training providers and accessing loans. Combined with a lack of accessible information, the weakening of price signals from the removal of upfront costs contributed to large increases in average tuition fees — which more than doubled for students eligible for VET FEE-HELP.

Some private providers aggressively marketed their courses, emphasising to students that they would not have to pay upfront, and in some cases offering inducements (such as 'free' laptops). Under the influence of high-pressure marketing, thousands of students signed up for courses that they had little prospect of completing. Even among those who did complete their qualifications, many were unlikely to have considerably increased their employment prospects or potential earnings.

Individuals were left with large debts that many are unlikely to ever repay, and the Australian Government incurred a large fiscal liability. The Australian Government has since tightened the criteria for education providers accessing government funding, with the intention of weeding out low-quality providers. Better oversight of providers and tighter controls on service users' access to government funds would have had administrative costs, but could have helped avoid other costs that ended up being much larger.

Stewardship of human services also includes evaluating outcomes to identify effective practices, and making ongoing improvements to policies and programs to disseminate

innovations and improve service outcomes. This aspect of stewardship is challenging. The ability to accurately define and measure outcomes varies significantly across the different human services. These difficulties mean that models of service provision and programs for evaluation need to be carefully designed and appropriately resourced.

Several submissions revealed a tension between the value of funding not-for-profit organisations to pursue a positive (but often broad and unmeasurable) social mission, and funding models that are primarily focused on providing services to improve the wellbeing of individuals and their families. These participants argued that using not-for-profit providers delivers additional social capital, pointing to the community focus of such organisations, their sense of mission, and the use of volunteers to support service delivery. Some participants were concerned that service models that draw on competitive pressures threaten the ability of not-for-profit providers to generate these broader benefits.

The Commission agrees that not-for-profit organisations can provide social capital. In its 2011 inquiry into *Disability Care and Support,* the Commission recognised the benefits to social capital that can accrue through, for example, the fundraising and volunteering activities undertaken by (often small) not-for-profit community organisations. Similar conclusions were reached in the Commission's 2010 report on the *Contribution of the Not-for-Profit Sector* which found that not-for-profit providers can deliver benefits to the community that extend beyond the direct benefits to the recipients of human services.

The Commission considers that maximising community welfare from the provision of human services does not depend on adopting one type of model or favouring one type of service provider. Additional benefits — such as those potentially offered by not-for profit organisations — should be considered, but not at the expense of improving outcomes for individuals and their families.

3   Competition, contestability and user choice

Informed user choice places users at the heart of human services delivery. With some exceptions, the user of the service is best-placed to make choices about the services that match their needs and preferences. Putting this power into their hands lets individuals exercise greater control over their own lives and can generate incentives for service providers to be more responsive to users' needs. Competition between multiple service providers for the custom of users can drive innovation and efficiencies. Competition and user choice are already common across a range of human services including general practitioners (GPs) and private dental services, and childcare centres. More competition and user choice is being introduced in other human services, such as disability services.

It will not always be the case that users are well-placed to make decisions on their own behalf. People vary enormously in their ability to make informed choices about the services they need or want, as does the level of assistance and user-oriented information needed to support user choice. Not everyone can, is willing to, or should exercise choice.

The very young or those with severe cognitive impairment, for example, may not be well-placed to make decisions There are also circumstances when a user's agency is explicitly removed, such as being placed under a court order to attend drug rehabilitation.

Competition between multiple service providers is not always possible or desirable. As an alternative, where there would be net benefits, governments can seek to mimic competitive pressures through contestable arrangements to select providers. These providers could be from within government (ideally separated from the commissioning body) or from outside government, with contractual arrangements specifying the terms under which the service should be provided. A contestable market (including one with a single provider), with the credible threat of replacement, can enable the better performing service providers to expand their service offering and keep current providers on their toes. Under the right conditions, contestability can deliver some, or even many of, the benefits of effective competition.

Competition, contestability and informed user choice can be part of a system that encourages providers (and governments) to be more effective at achieving outcomes for service users by improving service quality, using innovative delivery models (box 2), expanding access so more people get the support they need, and reducing the costs to governments and users who pay for those services. Competition, contestability and user choice do not have to be applied simultaneously. User choice can be introduced where services are commissioned using contestable processes to select multiple providers. Competition to provide a service may be used when there are sufficient suppliers, while contestability can be used for the same service where competition would be ineffective due, for example, to thin markets in regional and remote areas.

The introduction of greater competition, contestability and user choice may not always be the best approach to reform. One size does not fit all and redesigning the provision of human services needs to account for a range of features, including: the rationale for government involvement; the outcomes the services are intended to achieve; the nature of the services and the dynamics of the markets in which the services are provided; the characteristics and capabilities of users; and the diversity in purpose, size, scale and scope of providers. Not all of these features are clear cut or measurable, and all change over time. Further, reforms may raise or lower government expenditure on the provision of human services and different design options will have different fiscal implications for government.

Data availability and use

Increased availability and use of human services data is necessary to realise the potential benefits from greater competition, contestability and user choice. To make informed choices, users need to understand the range of services that are available to them. Providers require data to analyse and improve their services. Governments need data to identify community needs and expectations, the demand for services and gaps in service provision. Better data can be used to target services more accurately to the people who need and

would benefit from them most. Program design, monitoring and evaluation rely on high-quality data. Governments might better use these data to tailor and improve the programs that are used to deliver services, helping to ensure that the effectiveness of human service provision improves over time. Effective data collection and analysis are not costless. The Commission's Inquiry into *Data Availability and Use* will examine these types of issues.

Box 2   Telehealth and telecare services: an example of innovative delivery models

Telehealth and telecare services are facilitating innovative models of service delivery. Using sensors and communication devices, providers are able to evaluate the status of a person's health through their vital signs, and check and respond to emergencies — all while the person remains in their own home.

Innovative service models such as these have the potential to facilitate service provision and increase the benefits from greater competition, contestability and user choice in regional areas, particularly as internet access improves.

- Innovative service delivery models are being used for medical consultations in remote areas and to assist people with disabilities. For example, the not-for-profit telecommunications company Jeenee Mobile has tailored smart phone apps to allow people with a disability to live more independently.

- In a 12-month trial, the CSIRO partnered with not-for-profit organisations, local health districts and for-profit telecommunications companies to evaluate the effectiveness of home monitoring services for elderly patients with chronic disease. Results from the trial in urban and regional areas found that users were less likely to visit a general practitioner or be admitted to hospital, and users reported improvements in their quality of life and understanding of their condition.

Many, but not all services, are suited to greater competition, contestability and user choice

Non-government provision has been a feature of many human services for a long time. Non-government provision has increased in some sectors since the mid-1990s, including schools, vocational education and training, residential aged care, employment services and childcare. In many cases, increased non-government provision has been accompanied by greater access, with users having choice over the service they receive, who provides it or perhaps both. Participants pointed to the benefits of this, for individuals and the community as a whole.

The government and non-government provision of human services has also involved instances of controversy or failure. Many participants expressed concern about service provision being subject to greater competition and contestability, and, to a lesser extent, user choice. The reasons for participants' concern included that:

- competition, contestability and user choice risks bidding down the cost of delivery and will lead to a reduction in the quality of services — especially where for-profit providers are involved

- the users of human services are among the most disadvantaged in the community with vulnerabilities arising from very low incomes, mental or physical illness, frailties due to older age, low numeracy and literacy skills, or a lack of access to the resources and support needed to exercise informed choice

- some providers of human services have taken advantage of vulnerable people (and poor government stewardship), exposing weaknesses in the system and undermining confidence that competition, contestability and user choice can be beneficial to users, and to the community more broadly

- not-for-profit, community-based organisations are better-placed to provide human services — they are closer to the communities they serve and, because they are mission (rather than profit) driven, will reinvest any surplus back into services to support less profitable areas. However, they are disadvantaged by the time- and resource-consuming administrative processes used to commission services

- introducing greater contestability creates incentives for providers to focus their attention on tender applications and for governments to focus on contract management rather than on 'what works' for those in need of support.

Each of these concerns is legitimate but may be minimised or removed by designing appropriate systems to provide human services. Even with these concerns, measures to empower service users and increase competitive pressures could lead to better outcomes for some service users and communities. The question is when is it possible to design service delivery models that capture one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice. The NSW Disability Council explains this in the context of the National Disability Insurance Scheme (NDIS):

> Choice is empowering and can facilitate greater independence and improve overall quality of life, particularly for people with disability that may have been denied choice and opportunities for self-determination.

A strong theme in submissions was the need to consider how reforms to introduce greater competition, contestability and user choice could contribute to the effectiveness of the service. Effectiveness is best considered in the context of human services as an overarching concept, incorporating the attributes of quality, equity, efficiency, accountability and responsiveness to determine whether the service is achieving its intended outcomes. Introducing greater competition, contestability or user choice might not improve all of these attributes at the same rate, or in equal measure, for all service users. Many, but not

all, human services are suited to this type of reform and options that *generally* offer improvements across this range of attributes will be examined in the inquiry report.

4   The Commission's framework

To assist with its task, the Commission developed a three-stage framework in its issues paper to ensure a consistent approach to assessing the suitability of each service for competition, contestability and user choice reform (figure 2). It involves three steps:

- Assessing whether there is scope for changes in policy settings to increase the wellbeing of the community as a whole by improving the provision of human services.

- Examining whether the characteristics of the service user, the service itself and the supply environment mean that improvements in service provision could be achieved by introducing greater competition, contestability and user choice.

- Identifying potential costs associated with introducing greater competition, contestability and user choice, including costs to users and providers, and the costs of government stewardship.

Services identified as best suited to reform

The Commission's assessment of the services presented in table 1 takes into account evidence from a range of sources including contributions from participants, overseas experience, research undertaken by others and Commission analysis. Case studies from Australia and overseas have been used to inform the assessment of suitability for reform.

In identifying services, the Commission had regard to a number of factors, including:

- the extent to which services are already subject to competition, contestability or user choice (examples here include the provision of GP services)

- whether reforms to introduce greater competition, contestability or user choice are proposed, or are underway (examples here include disability services, mental health services and vocational education and training)

- whether improved outcomes could be better delivered by reforms other than greater competition, contestability or user choice (examples here include school education).

For a number of the services considered by the Commission, competition, contestability or user choice reform could improve service provision for users, and benefit the community as a whole. The services identified reflect the Commission's preliminary view of where well-designed reform could offer the greatest improvements in community wellbeing. The assessment has identified six priority areas:

- social housing

- public hospital services

- specialist palliative care

- public dental services

- human services in remote Indigenous communities

- grant-based family and community services.

Figure 2   Identifying services best suited to reform
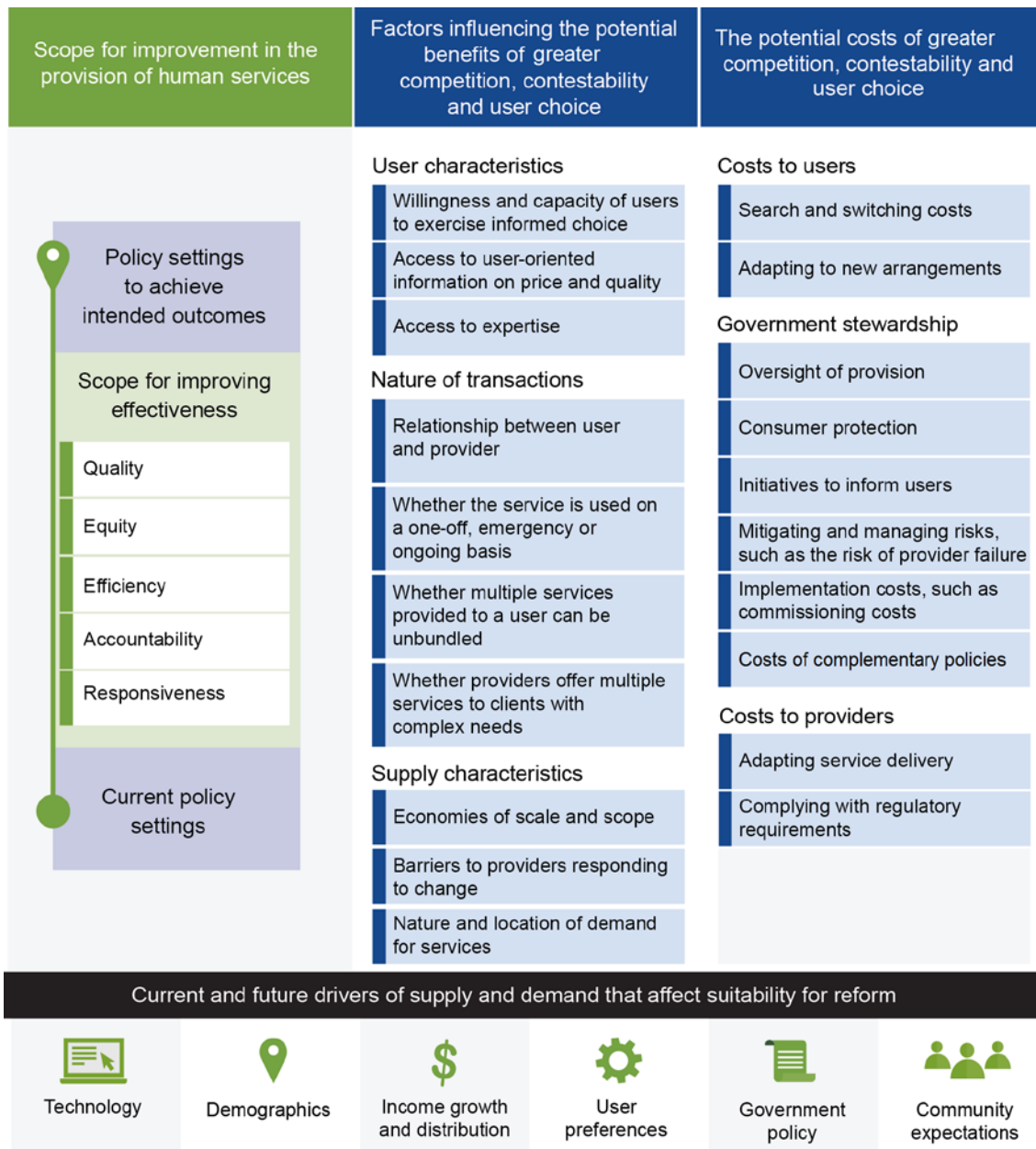
These priority areas are diverse — in the type and number of users and providers, the settings and circumstances under which services are provided, their reform history, the

current application of competition, contestability and user choice, and the level of expenditure contributed by governments and users. The policy design challenge in each will be unique.

Table 1   Services assessed in this study[a]
In alphabetical order

Alcohol and drug services	Family support services and out of home care	Mental health services
Allied health services	General practitioners (GPs)	**Public dental services**
Child and family health services	**Grant-based family and community services[b]**	**Public hospital services**
Community health services	Higher education	Primary and secondary schooling
Corrective services	Home-based aged care	Primary health networks
Disability employment services	Homelessness services	Residential aged care
Disability support services	**Human services in remote Indigenous communities**	**Specialist palliative care**
Early childhood education and care	Job services	**Social housing**
Emergency payments	Maternity services	Vocational education and training

a Services in bold are those identified by the Commission as best suited for reform. **b** Includes alcohol and other drugs services, community-based mental health services, family support services and out of home care, and homelessness services.

The importance of ongoing reform and evaluation

There are six priority areas for reform identified in this report. These reflect the Commission's preliminary views on the highest priorities for the Commission's current task. However, many other services could also benefit from reform. For example, there is considerable scope to improve outcomes by promoting competition, contestability and user choice in the provision of residential aged care services. The Commission's inquiry into the aged care sector in 2011 made recommendations, such as replacing the system of discrete care packages across home-based and residential care with a single integrated and flexible system of care entitlements. If implemented, these reforms would improve outcomes for users of residential aged care services, and the community as a whole.

Reforms are underway to introduce greater competition, contestability or user choice to other services included in the scope of this inquiry. For example, in home-based aged care, reforms are being implemented to offer greater choice for service users. Other areas, such as the NDIS and early childhood education and care, are also under reform. All warrant continued scrutiny and evaluation to ensure the potential net benefits of those reforms are captured.

The Australian Government has also committed to reforming the provision of mental health services, including making the delivery of mental health services more contestable, evidence-based and person-centred. The Commission supports the intention of these important reforms, but notes that it is too early to evaluate their effectiveness.

5   Services identified for reform

Social housing

Shelter is a basic human need. Housing assistance provides a safety net for those that are experiencing homelessness, or who face high barriers to sustaining a tenancy in the private rental market, and plays an important role in increasing their quality of life. About 400 000 households live in social housing. Recipients of social housing support, who are also likely to access a number of other human services (box 3), have reported through the National Social Housing Survey that they are in better health, are better able to improve their employment situation and have better access to the services and supports they need once settled in stable accommodation.

Box 3   Characteristics of social housing tenants

Compared with the general population, tenants of social housing are more likely to be female, Indigenous, Australian-born, from single-person households and to have a disability. Tenants are likely to access a number of other human services, most commonly health and medical services (two thirds of all tenants), and mental health services (one fifth of all tenants).

Three out of four working-age social housing tenants who are in receipt of an income support payment (such as Newstart Allowance or Youth Allowance Job Seeker) have severe or significant barriers to employment. Employment participation rates are low — nationally in June 2013, about 10 per cent of working-age public housing tenants in receipt of an income support payment were employed, compared to 20 per cent for other working-age recipients of an income support payment.

Over time, there has been a shift in the demographics of people receiving support through the social housing system — from working families to recipients of income support who have additional barriers to entering the private housing market. This, combined with the long-lived nature of housing assets, has resulted in a growing mismatch between the characteristics of the social housing stock and those receiving support. It has also resulted in funding pressures on the system. The disconnect between the level of subsidy social housing tenants receive and that received by tenants in the private rental market through the Commonwealth Rent Assistance payment has also increased over time.

Making judgments on the number of households assisted through the social housing system depends on a range of factors, and international evidence suggests that there is no 'right' level of social housing. The level of social housing needed will depend on interactions with

broader government policy, including the level of income support provided, the objectives of the state and territory governments that have responsibility for the policy area, and the amount of affordable housing available for people to rent in the private market.

Most social housing is provided by government entities

Government entities manage four out of five social housing properties, with the remainder managed by not-for-profit community housing organisations. About 20 per cent of social housing managed by governments (public housing) is not in an acceptable condition, property underutilisation is high, and prospective tenants face long waiting times before they receive housing (figure 3). Limited data on tenant outcomes restrict the ability of governments to monitor service providers and make informed decisions about which providers — including both government and non-government providers — would be best-placed to manage social housing.

Figure 3   Indicators of public and community housing, 2014[a]
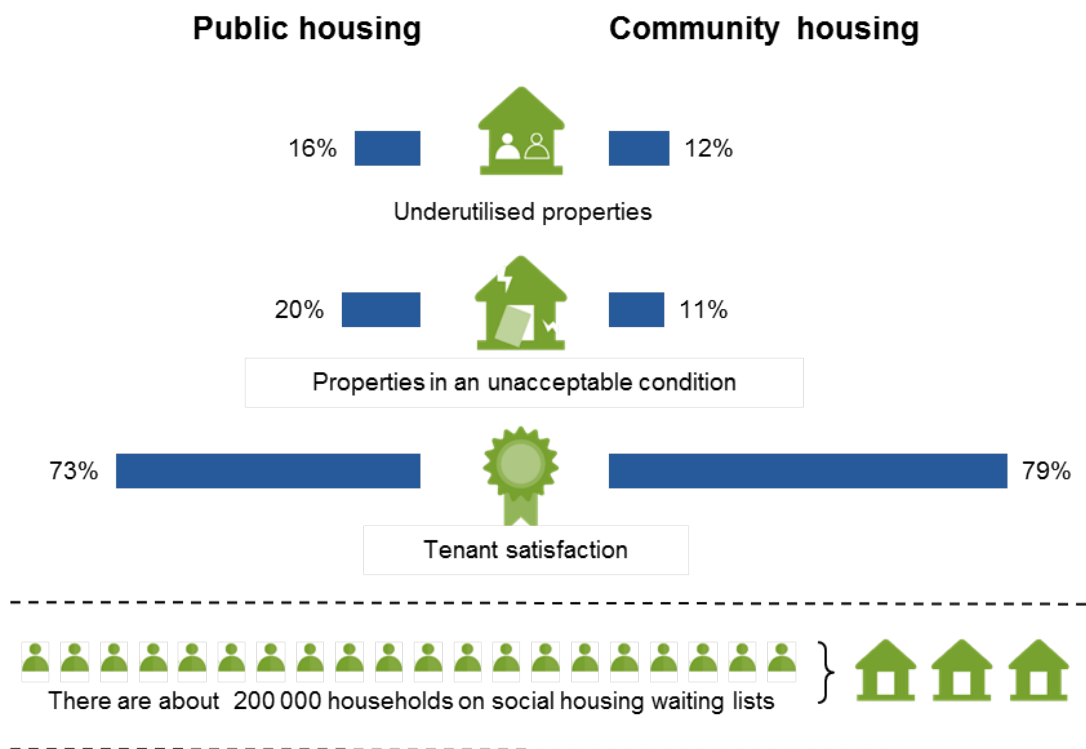
Public housing   **Community housing**

16%   Underutilised properties   12%

20%   Properties in an unacceptable condition   11%

73%   Tenant satisfaction   79%

There are about 200 000 households on social housing waiting lists

a Underutilisation refers to the percentage of properties that have at least two more bedrooms than the number of tenants living in them. Tenant satisfaction is the percentage of people who reported being satisfied or very satisfied with their housing. A property is considered to be in an unacceptable condition if it does not have working facilities for washing people, washing clothes, preparing food, and sewerage or has more than two major structural issues.

Offering more choice to social housing tenants

The current social housing system limits the ability of tenants to choose the home they would like to live in. Once applicants reach the top of the social housing waiting list, they are generally allocated an available home based on their preference for the area in which they would like to be housed and their broad characteristics. The suitability of an allocated property can be a question of timing and luck. Tenants cannot 'hold out' for a preferred property, because those that reject two (or sometimes one) offers of housing are relegated to the back of an already long waiting list, and often must take what is offered.

Many people who enter social housing are likely to be capable of exercising choice over their housing options — although some may need additional support to be able to exercise informed choice and maintain a tenancy. Efforts to improve users' choice of home have led to a range of benefits overseas. Tenants are more likely to stay in the same area, invest in the local community, and have stable accommodation. Data collected from choice-based systems has been used to identify the housing characteristics that tenants prefer, and to target areas of high demand and need.

Under the current social housing system, demand for social housing far outstrips supply, limiting the properties available for prospective tenants to choose from. Approaches have been implemented overseas that provide a choice of home, even where there are supply constraints. Reform options could also be explored in Australia to address supply constraints and increase the housing options available for prospective social housing tenants.

PRELIMINARY FINDING 3.1

Introducing greater competition, contestability and user choice could improve the effectiveness of the social housing system in meeting tenant needs.

- There is substantial room for improvement in the current social housing system. There are long waiting lists, poorly maintained and underutilised properties, and a lack of information available to allow governments to select and monitor the performance of service providers.

- Four out of five social housing properties are managed by government entities, yet there are a large number of housing providers — both not-for-profit and for-profit — that could perform this service. Community housing providers outperform public providers on some indicators, including tenant satisfaction and property maintenance.

- There are currently not enough social housing properties to meet demand, limiting the housing choices available to social housing tenants. Nonetheless, approaches implemented internationally allow social housing tenants greater choice of home. Reform options could be explored in Australia to address supply constraints and increase the housing options available for prospective social housing tenants.

Public hospital services

The term 'public hospital services' refers to healthcare that (mostly public) hospitals provide to public patients. This covers many different types of care and can be provided in a range of settings, including specialised units in large hospitals, outpatient clinics, day-procedure centres, and hospital-in-the-home care. Almost 60 per cent of expenditure is on admitted services, with the vast majority of this being acute care to cure a condition, alleviate symptoms or manage childbirth. Even a small percentage improvement in outcomes from public hospital services, including quality, could deliver significant benefits in aggregate, given the scale of service provision.

There is scope to improve outcomes for patients

On average, Australian public hospitals perform well against those in comparable countries in terms of health outcomes and costs. Nevertheless, there is scope to improve. Equitable access is an ongoing concern for some groups, particularly those in remote areas. Moreover, benchmarking within Australia suggests that many public hospitals could increase their service quality and efficiency by matching best practice among their domestic peers. There are many policy levers that governments already use to improve patient outcomes, including quality standards and professional training requirements. Greater contestability and user choice could place indirect pressure on hospitals, as part of a broader suite of reforms, to improve outcomes.

User choice could be greater

The good health outcomes that Australia generally achieves compared to other countries indicate that, from a clinical perspective, public hospitals are typically responsive to the needs of patients. However, public patients are often given little or no choice over who treats them and where. Overseas experience indicates that, when hospital patients are able to plan services in advance and access useful information to compare providers (doctors and hospitals), user choice can lead to improved service quality and efficiency (box 4).

As was the case overseas, potential reforms to introduce greater user choice in Australia would need to be supported by user-oriented information. Without it, low levels of health literacy would reduce the willingness and ability of public patients to make informed choices. Providing greater choice at the point where individuals are referred to a specialist by their GP might be another way of supporting choice for people with low levels of health literacy. This is broadly the model that has existed in England (although not the rest of the United Kingdom) since 2006.

The most common planned (elective) surgical procedures in Australian public hospitals include cataract surgery, removal of skin cancers and knee replacements. Overall, public hospitals account for about one-third of elective surgical admissions but almost 50 per cent for patients in the most disadvantaged quintile (figure 4). Thus, greater choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

Box 4   Overseas examples of choice and information provision

In England, patients referred to a specialist by their GP have a legal right to choose the hospital or clinic and consultant-led team they attend. They can access a useful website to compare alternatives, and use an online booking service when they have chosen. Quantitative studies have found that following these reforms:

- consumers sought out better-performing providers — hospitals with lower pre-reform mortality rates and waiting times had a greater increase in elective patients post-reform than those with higher mortality rates and waiting times. Among people seeking a coronary artery bypass graft, choices made by sicker patients were more sensitive to reported mortality rates

- hospitals in more competitive locations improved service quality the most — death rates for patients admitted after a heart attack fell the most in hospitals that had more nearby competitors. Hospitals located in more competitive areas also had larger declines in mortality from other causes and lower lengths of stay for elective surgery.

Studies of other countries — including Canada, Sweden and the United States — have also found benefits following the public release of information on service quality. For example, the adoption of public performance reporting in Sweden was followed by a decline in the share of patients requiring an artificial hip repair or replacement to among the lowest rates in the world.

Figure 4   **Elective surgery by sector and socioeconomic status of patient, 2014-15**
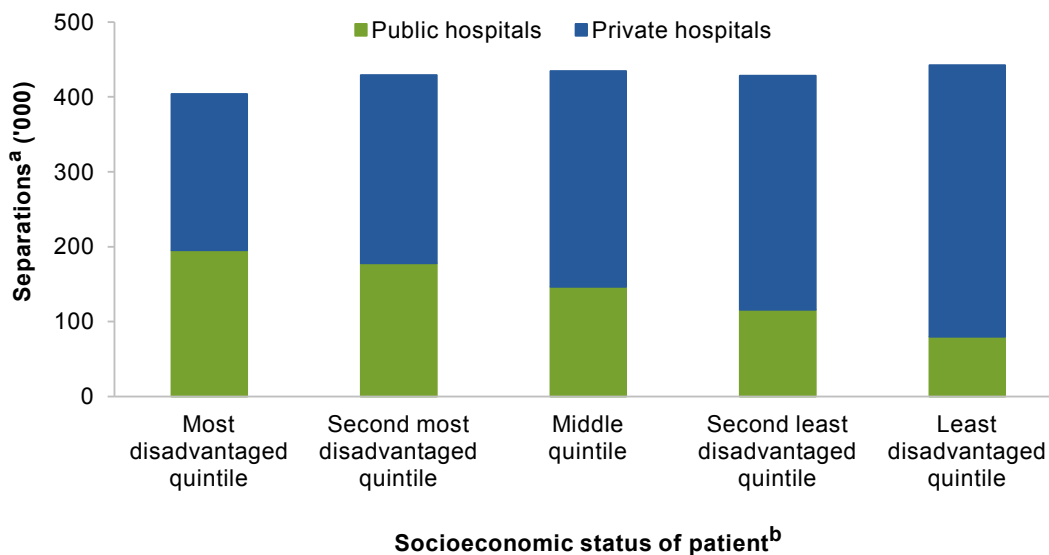
a A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). **b** Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a patient resided. The index summarises population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

More contestable approaches to commissioning public hospital services

In most cases, services are provided by state and territory governments through local health networks. These networks regularly renegotiate service agreements with their government and this could be used as an opportunity to test more contestable approaches to commissioning services. Such a reform should not be taken lightly — public hospitals and the services they provide are very heterogeneous, with many submarkets, and there are complex links between public hospitals and the rest of the health system, including private patients and private hospitals. There have been difficulties in the past commissioning non-government providers and the lessons from these attempts should not be forgotten. Workforce issues can also pose particular challenges to changing providers. As a result, it may be more feasible to implement contestability as a more transparent mechanism to replace an underperforming public hospital's management team (or board of the local health network), rather than switch to a non-government provider. Another option is to focus on introducing greater contestability for a subset of services.

PRELIMINARY FINDING 4.1

Introducing greater user choice and contestability in public hospital services could, as part of a wider range of reforms, lead to better outcomes for patients.

- Australian hospitals generally perform well against those in other countries. There is still scope for many to improve outcomes for patients, and to lower costs, by matching the practices of better-performing hospitals within Australia.

- Greater user choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

- Other countries have shown that user choice can benefit patients when they have access to useful consumer-oriented information on services and referring practitioners support them in making decisions.

- There is an opportunity for state and territory governments to test more contestable approaches to commissioning services when they regularly renegotiate service agreements with local health networks. More transparent arrangements for replacing senior management of government-operated hospitals (or local health network boards) in cases of underperformance could also increase contestability. This would not require switching to a non-government provider.

Specialist palliative care

Specialist palliative care refers to medical care that focuses on relieving the symptoms of a life-limiting illness, rather than treating the underlying causes of that illness.[1] It is provided to patients whose physical, social, emotional and spiritual needs exceed the capabilities of primary care providers. This covers both inpatient care provided to patients admitted to a hospital or a standalone palliative care facility, and community-based care provided in the home or in a residential aged care facility. In 2015, more than 40 000 people across Australia accessed specialist palliative care services.

Management of symptoms, including relief from pain, and support provided by social workers, counsellors and volunteers, can make a significant difference to the wellbeing of patients and their families at a time of high stress.

There is scope to improve outcomes

Australia's palliative care services are well-regarded internationally and, on at least some measures, patient outcomes have improved over recent years. Yet there remains scope for improvement. The range and quality of services available varies across jurisdictions, and between urban and non-urban areas. Indigenous Australians, and people from culturally and linguistically diverse backgrounds are likely to be underserviced, as are people suffering illnesses other than cancer even though they have many of the same palliative care needs.

A lack of comprehensive, publicly available national data about expenditure, patient activity and patient outcomes hampers accountability. Coordinating services, determining costs of care, appropriately allocating funding and evaluating measures designed to improve service provision are all made more difficult by the lack of adequate data.

Increasing user choice about the setting, timing and availability of care

The development of a chronic life-limiting illness is emotionally taxing and psychologically distressing for patients, carers and loved ones. In this environment, making choices about palliative care arrangements may be difficult.

Much has been made of survey findings that consistently show that most people would prefer to receive care and die comfortably at home, yet most palliative care patients die in hospital. The reality is more complex than this and, as death approaches, a person's preferred place of death can change. Palliative care patients can become concerned about the effect that the caring task has on their loved ones and may choose to use inpatient

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[1] The focus of palliative care is on providing support to people with life-limiting illnesses, not to hasten or postpone death. Assisted suicide and euthanasia are not considered part of palliative care and are not examined as part of this inquiry.

services closer to the end of life. These changing preferences highlight the importance of user choice as to the setting, time and availability of care.

The characteristics of users can pose challenges to implementing user choice for palliative care patients. While patients with cancer tend to have fairly predictable disease trajectories, often with full cognitive and communicative capacity until close to death, other patients have less predictable trajectories of deterioration in cognitive and physical functioning. While some patients receive months of palliative care and repeated episodes of care, others may have no contact with specialist palliative care services until their last days of life. This limits the ability of some patients (and their families) to plan ahead and express preferences for care.

The inability of users to express preferences directly would, to some extent, be addressed if carers, relatives and medical professionals were well informed about user preferences and engaged in discussions about palliative care from the early stages of illness. Taboos about discussing death can prevent this from happening. Patients often rely on medical professionals to initiate conversations about palliative care, many of whom are inadequately trained about, and intimidated by, holding such conversations.

Greater user choice between providers would need better supports

Greater user choice between providers raises additional challenges. As with other forms of healthcare, patients receiving specialist palliative care services can have difficulty judging the quality of services available to them. Palliative care does not involve a single transaction of a well-defined service and making like-for-like comparisons between providers is difficult.

Information asymmetry between palliative care users and providers could be lessened through the provision of high-quality, consumer-oriented information about the availability and quality of services. While some information on patient outcomes is currently available, it is not provider-specific and is not designed to be consumer-oriented.

Introducing greater competition or contestability

There is substantial variation in the quality of palliative care services across Australia. Despite this, there has been little focus on whether better service models exist. In these circumstances, introducing greater competition, contestability and user choice could improve outcomes. The preferred reform option may vary across regions.

Introducing greater user choice through contestability or competition would require careful design to ensure that the interests of patients and their families are well served. Special measures for consumer protection may be needed given the vulnerability of many palliative care users and the potential magnitude of harm should a service provider act without due care. Arrangements would need to be in place to ensure continuity of care

between providers. More extensive data collection and improved monitoring and benchmarking of provider performance would also be required. Introducing greater contestability could, however, make providers more accountable for their performance and spur the innovation required to lift patient outcomes among poor performers.

PRELIMINARY FINDING 5.1

Placing greater emphasis on user choice could help to better satisfy patient preferences regarding the setting, timing and availability of palliative care.

- The quality of specialist palliative care services is highly variable, there are concerns about patients not being able to access services and there is limited performance reporting, particularly in community settings.

- There is little evidence that service providers are being held to account for relatively low service quality. Introducing greater contestability could make providers more accountable for their performance and spur the innovation required to lift patient outcomes among the poor performers.

- The potential to increase user choice through greater competition between providers or through more contestable arrangements would depend on market size and the ability to cost-effectively provide user-oriented information, among other things. The preferred reform option will likely vary across regions.

Public dental services

Publicly-funded dental services play an important role in improving access to care for people who face financial and other barriers. In 2013-14, public dental services accounted for about 14 per cent ($1.2 billion) of Australian expenditure on dental care. Of those people (aged 5 and over) who saw a dental professional in 2013, about 84 per cent visited a private practice at their last visit, while most of the remaining 16 per cent last visited a public (including school) practice.

There is scope to improve outcomes

Most public dental services are provided in clinics (and dental hospitals in some jurisdictions) operated by state and territory governments. While users can sometimes choose between different public dental clinics, there can be few of these located close to a patient's residence compared to private dental practices that could potentially provide the service. Access outside major cities is also a concern, particularly for Indigenous Australians, many of whom live in regional and remote areas.

The continuity of care that public clinics provide can be an issue because patients may be treated by a different person each time. Without continuity of care, users could be discouraged from maintaining a favourable visiting pattern, which can eventually lead to more extensive remedial care being required. People from low socioeconomic

backgrounds, who are the predominant users of public dental services, are more likely to have an unfavourable visiting pattern. For some people, an extended period on a waiting list means that a potentially preventive or restorative treatment becomes an emergency case. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14.

A further concern is the lack of published evidence on the efficiency of public dental services. This is symptomatic of a lack of accountability to those who fund public dental services (governments and users through co-payments). It is also evident in the lack of performance reporting on service quality and patient outcomes.

Competition, contestability and user choice could be greater

The most appropriate approach to introducing greater competition, contestability and user choice could vary between regions due to differences in characteristics of the population and geographic dispersion of dental professionals.

Service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics. This could facilitate the development of more flexible and responsive service models. Innovative service delivery may be particularly important in remote areas, which have less than half the number of dental professionals per person than major cities.

More competition and choice could involve using delivery mechanisms that allow users to choose between competing private dental practices. Such mechanisms are already used to some extent in all jurisdictions and this has shown that private dental practices can supply good quality services to public patients.

As part of any shift to more choice in the provision of public dental services, governments would need to ensure that they support disadvantaged groups to choose a dentist, possibly through a combination of information provision and person-to-person advice.

PRELIMINARY FINDING 6.1

Introducing greater competition, contestability and user choice in public dental services could lead to better outcomes for patients and the wider community.

- Users could benefit from having greater choice over the timing and location of treatment. Greater continuity of care may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary.

- The uncontested provision of services in government-operated clinics results in limited responsiveness to user needs and preferences. Minimal public performance reporting limits accountability to those who fund services.

- Service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics. More competition and choice could involve using delivery mechanisms that allow users to choose between competing private dental practices.

Human services in remote Indigenous communities

About 85 per cent of Australia is classified as remote or very remote — the physical distance to the nearest town or service centre can be in the hundreds of kilometres. A lack of transport infrastructure, coupled with extreme seasonal conditions, makes travelling those distances uncomfortable and time-consuming at best or impossible at worst. Just over 2 per cent of Australia's population, including about one fifth of Indigenous Australians, live in remote areas.

Physical isolation underpins many of the challenges to providing high-quality human services to the over 1000 discrete Indigenous communities in remote areas. The cost of providing services in remote Australia can be several times the cost in urban areas due to long distances and travel times, and the lack of scale (more than three quarters of the remote Indigenous communities have a population under 50). Only 36 per cent of remote Indigenous households, for example, have an internet connection (compared to 73 per cent of remote non-Indigenous households). Service providers also face barriers such as difficulty accessing infrastructure, and recruiting and retaining staff.

The remoteness of Indigenous communities is a major reason why these communities typically cannot access the range of human services that are provided elsewhere, but it is not the only reason. Indigenous Australians living in these communities may also interact with services differently to other Australians. One area of significant difference is language. About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared to 2 per cent for Indigenous Australians living in non-remote areas. Another area of difference is culture. Indigenous Australians tend to relocate more frequently than other Australians, which can lead to significant variability in the level and nature of demand for services in communities and can be challenging for providers to respond to. The Australian Government's 2014 Mental Health Review found that Indigenous Australians had poorer access to mental health services, in part because services designed for the broader population are not culturally appropriate. The NDIS trial in the Barkly region also identified the importance of providing services in a culturally appropriate way, including through building relationships and trust, and providing tailored information to those accessing support.

Outcomes in remote Indigenous communities are not meeting expectations

Indigenous Australians living in remote communities are more likely to experience poor outcomes than other Australians, including Indigenous Australians living in non-remote areas (figure 5).

The Commission's early investigations suggest that current arrangements for purchasing and delivering human services are not fully meeting the needs and preferences of Indigenous Australians living in remote communities. Responsibility for service provision is split across governments and departments, and funding is delivered through numerous programs. Problems arise from a lack of coordination across services, including

duplication in some areas, gaps in others, and unclear lines of responsibility across and within governments for identifying and achieving the intended outcomes for people who are receiving the services.

Figure 5 **Outcomes for Indigenous Australians, by remoteness**
Per cent of Indigenous Australians, 2012-13
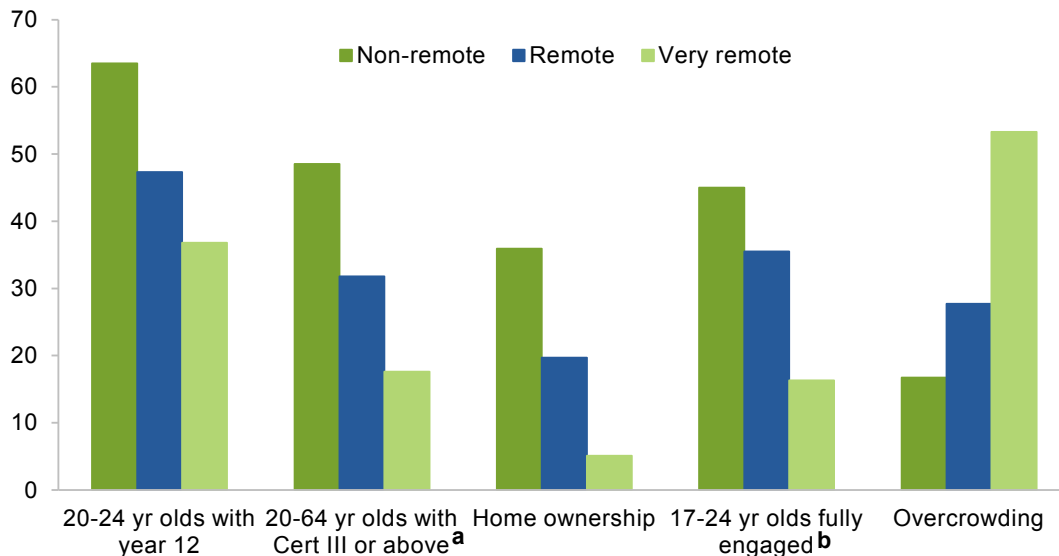
a Includes current students. **b** Fully engaged in post-school education, training and/or employment.

In its submission to this inquiry, the Aboriginal Medical Services Alliance NT gave the example of a remote community in Central Australia where around 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. The Alliance described what happens on the ground.

> There was little in the way of communication or coordination with the local ACCHS [Aboriginal Community Controlled Health Service], with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The resulting fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients is totally counter to the improved outcomes sought by this inquiry.

A way forward

There are many economic and social factors that drive outcomes in remote Indigenous communities. The nature of service provision and the characteristics of users mean that the service models that work in other parts of the country will not necessarily work in remote Indigenous communities. For example, introducing greater competition, when there are at best one or two providers, is unlikely to be the most effective model for improving service outcomes for users. This also suggests that governments may need to be more flexible in

their approach to service models and providers, to allow for better ways of working and achieving governments' intended outcomes.

Expectations of a quick fix are unrealistic. More promising, given the issues with current service delivery arrangements used by governments, is the scope to improve outcomes over the long term through better design and implementation of policies to purchase services in remote Indigenous communities. Many services are (at least nominally) contestable, but the arrangements are not delivering the benefits of contestability to the communities themselves, or to governments and service providers. Many of the ideas discussed in the next section on grant-based family and community services also apply to services to remote Indigenous communities. Outcomes should be defined holistically, rather than being narrow and program-driven. Better service provision could involve better coordination, place-based service models, increased community voice in service design and delivery, and stable policy settings.

PRELIMINARY FINDING 7.1

Current arrangements for purchasing and delivering human services are not fully meeting the needs and preferences of Indigenous Australians living in remote communities.

- Improving the quality of services and providing services in a more culturally appropriate way could improve outcomes for Indigenous Australians living in remote communities.

- Better coordination of services to address people's needs could overcome some of the problems that arise from service fragmentation.

- Place-based service models and greater community voice in service design and delivery could lead to services that are more responsive to the needs of people in these communities.

- More stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving the wellbeing of Indigenous Australians living in remote communities.

Grant-based family and community services

Family and community services offer a range of supports to build people's capacity and resilience. Examples include services for people experiencing homelessness, alcohol and other drug abuse, and family and domestic violence. While often grouped under the banner 'community services', government-funded services generally focus on improving outcomes through the provision of specific services for individuals and families, rather than being directed to community-level projects. Hundreds of thousands of people receive these services every year for a variety of reasons and with diverse needs — some need emergency relief, while others have multiple, ongoing and complex needs.

Providers of family and community services are similarly diverse. Some services are provided directly by governments, but the majority are provided by mission-driven not-for-profit organisations. Providers vary in size. Many small organisations operate in a single location, often with the help of volunteers, and focus on a single service. Some larger organisations provide a range of services across many locations, and receive funding through numerous grants from several governments.

Government funding for family and community services runs to billions of dollars each year. At July 2016, the Australian Government Department of Social Services reported that it had about 7000 grant funding agreements in place for 'families and communities' programs, with a combined value of about $2.8 billion. Each state and territory government also allocates hundreds of millions of dollars (and billions in the larger states).

Flawed commissioning processes

Current approaches to commissioning family and community services constrain the ability of these services to meet the needs of many people. People outside of metropolitan areas, culturally and linguistically diverse groups and Indigenous Australians can face significant barriers to accessing family and community services that meet their needs. People who have multiple, ongoing and complex needs require coordinated assistance across several services, but are inadequately served when the system is fragmented and difficult to navigate.

Funding to deliver family and community services is usually contested through tender processes that entail at least a nominal threat of replacement by an alternate provider. In practice, commissioning processes are often flawed and do not consistently deliver the benefits from contestability that should flow to governments and providers and, importantly, they are not effective at delivering outcomes for users.

- There is generally a lack of an overarching framework based on improving outcomes for service users to inform service planning and determine how objectives should be achieved (figure 6). Governments need to undertake systematic analysis of community needs, gaps in service delivery and risks. Commissioning agencies need to specify policy priorities and the program outcomes that are consistent with achieving these objectives.

- Government engagement with service providers is inconsistent and does not always take advantage of providers' experience and expertise in program delivery. It is uncommon for providers to be invited to participate in the program design stage. Instead, programs are designed by government agencies that are often remote from the realities of 'what works' in family and community services, and the costs of providing effective services. Often what looks good on paper does not translate to the real world.

- Service providers that are funded on relatively short contracts (three years or less), face ongoing uncertainty about their future operations, and have to devote excessive resources to applying for further funding at the expense of delivering frontline services.

- Contract terms often limit providers' ability to develop flexible responses to the needs of service users. Although governments promote the virtues of innovation, when it comes to family and community services they often set highly prescriptive terms that are focused on managing funding flows, rather than on achieving outcomes for users. Some governments have experienced a loss of corporate knowledge of how these services work and instead have developed expertise in managing contracts. At the same time, they have created incentives for service providers to become experts in tender writing.

- The current approach to information collection, performance monitoring and reporting can create excessive burdens on service providers but does not deliver the information that is needed to understand how services contribute to achieving outcomes. Better access to data could contribute to governments and providers developing more effective programs and services, coordinating assistance for users with complex needs, and providing user-oriented information to support choice.

Figure 6   **Commissioning services to deliver outcomes**

- Identify policy objectives, outcomes, priorities and risks
- Assess demand, supply and service gaps
- Engage providers and consumers
- Formulate supply strategy

Community needs assessment and market analysis

Service design

- Develop outcome and performance frameworks
- Disseminate effective practices
- Stakeholder engagement

- Data collection evidence base
- Quality assurance
- Performance benchmarking
- Identify 'what works'

Monitoring and evaluation

Selecting providers and contracting

- Determine provider selection process
- Establish contract conditions and incentives

Better system design

The scope for improving the effectiveness of family and community services largely relates to the *way* they are commissioned by governments, rather than the use of contestable processes. Governments need to take a stronger stewardship role to design and coordinate a system of provision that is helped, rather than hampered, by shared interests across jurisdictions. They also need to develop an outcomes framework against which individual services could be planned, and their performance benchmarked and monitored.

PRELIMINARY FINDING 8.1

Improving the way governments select, fund, monitor and evaluate providers of family and community services could improve outcomes for the users of those services.

- Governments could deliver a better mix of services if they took a systematic approach to identifying what the community needs.

- Engagement with service providers and users at the policy design stage could increase the quality and efficiency of services.

- Contract arrangements that are focused on outcomes for service users could increase the incentives for service providers to deliver services that meet people's needs and provide more scope for innovation in service delivery.

- Better use of data could help service providers and governments identify and disseminate effective practices.

- Measures to support user choice and introduce greater competition between service providers could create incentives for providers to improve services in some areas.

1 The Commission's approach

1.1 What has the Commission been asked to do?

The *Competition Policy Review* recommended that governments should, wherever possible, put user choice at the heart of human services delivery as users are best placed to make choices about the services they need (Competition Policy Review 2015). In its response to the Review, the Australian Government committed to a Productivity Commission inquiry to examine policy options in the human services sector that incorporate the principles of competition, contestability and informed user choice. The inquiry terms of reference were received on 29 April 2016 and are provided at the front of this report.

In determining whether the efficiency and effectiveness of human services could be improved by introducing greater competition, contestability and informed user choice, the Commission was asked to examine:

- the current level and nature of demand for services, as well as future trends
- current supply arrangements for human services and future trends, including scope for user choice, diversity in provision, contestability, and alternative pricing and funding models
- the effectiveness of previous reforms intended to increase competition and user choice, both in Australia and internationally.

When making recommendations on reforms to the provision of human services, the Commission was asked to have regard to:

- the factors affecting consumer use of services and preferences for different models of service delivery, noting particular challenges for consumers with complex and chronic needs
- the roles and responsibilities of consumers, governments and providers
- arrangements to improve outcomes for rural, remote and Indigenous communities.

Conduct of the inquiry

The terms of reference for the inquiry request that it be undertaken in two parts: the first being the preparation of a study report to identify services that are best suited to reform by introducing greater competition, contestability or informed user choice. The study report will be publicly released in November 2016.

For the services identified as best suited, the second part is to make reform recommendations that help to ensure all Australians have timely and affordable access to high-quality services that are appropriate to their needs, and that those services are delivered in a cost-effective manner. The final inquiry report will be submitted to the Australian Government in October 2017.

To date, the Commission's consultation process has included:

- publication of the receipt of the terms of reference in print and social media

- the release of an issues paper on 16 June 2016 to assist interested parties to prepare submissions. In response, 290 submissions were received from the Australian, and state and territory governments, service providers and their peak bodies, unions, consumer advocates, academics and individuals

- consultations with the Australian, state and territory governments, service providers and their peak bodies, unions, consumer advocates and academics

- the release of this preliminary findings report.

The Productivity Commission thanks all participants for their contributions to the study through consultations and written submissions. There will be further opportunities to participate over the course of the inquiry through consultations, roundtables, submissions and public hearings.

The purpose of the preliminary findings report

The introduction of greater competition, contestability and user choice will not be the best reform option for all human services. This preliminary findings report sets out the Commission's framework for identifying those services that could be suited to this type of reform, and its initial findings as to which services should be carried forward to the second part of the inquiry.

The purpose of this report is to seek feedback from participants on the Commission's findings, and any further issues that should be considered before the public release of the study report in November 2016. The Commission welcomes further written comment on the preliminary findings in this report, and will undertake consultations and hold roundtables to facilitate feedback from participants to inform the preparation of the study report. Interested parties are welcome to put forward services they consider should be recommended for reform in the second part of the inquiry. The due date for submissions is 27 October 2016.

Which human services are within the scope of this inquiry?

The terms of reference for this inquiry do not define 'human services', or provide a definitive list of which human services are within scope. Instead, the terms of reference

lists examples of human services — health, education, community services, job services, social housing, prisons, aged care and disability services — that serve as a guide to the scope of the inquiry. Potential reform to existing government 'back office' systems that support the delivery of human services, such as payments systems, is beyond the scope of this inquiry.

1.2 Roles for government in the provision of human services

Governments take an active role in the funding, provision and stewardship of human services. This recognises that markets, as price and quality-setting forums, often struggle to deliver an appropriate level or distribution of these services across the community. Access to high-quality human services contributes to the wellbeing of individuals and the welfare of the community as a whole. Community welfare is enhanced by the social cohesion and equity benefits of people having access to a minimum level of human services, regardless of their means or circumstances.

The level of funding assistance from governments to service users varies — up to 100 per cent of the cost of provision for some services and for some users — as can the way the funding flows to service providers and users. The nature of funding flows from governments — who receives the funding, when and on what basis — is a significant driver of outcomes from the provision of human services. Some services are funded through payments to suppliers, while for others funding is placed in the hands of the consumer. Funding can be based on meeting outcomes agreed between governments and providers, or on the basis of activity. Careful design is needed to ensure the incentives of providers and users are aligned; and that government objectives are met. Care is needed, for example, to avoid overconsumption of services that are 'free' to users.

The design of systems to deliver human services is a complex task. Every level of government is involved in funding or delivering human services. Non-government providers include unpaid informal carers, sole traders, mission-driven organisations that rely on volunteers and donations, and for-profit entities that have a footprint over multiple jurisdictions and service areas. The people that are served are diverse in their needs, preferences and capabilities, including their capability to exercise informed choice. Data systems have the potential, if used effectively and cooperatively, to better target services to diverse users.

Governments have a stewardship role

Governments' stewardship role in the delivery of human services is broader than overseeing the 'market'. Stewardship encompasses almost every aspect of system design, including identifying policy priorities and intended outcomes, designing models of service provision, and ensuring that services meet standards of quality, accessibility and suitability

for users. Some recipients of human services can be vulnerable, with decisions often being taken at a time of stress. The need to ensure the development and implementation of appropriate consumer safeguards is an important aspect of the stewardship role and will be a key focus for the Commission in the second part of this inquiry.

With governments' involvement in the provision of human services comes the expectation from the community that those services meet a minimum standard. If governments do not adequately discharge their stewardship function, the effects can be damaging to service users, providers and governments. Australia's recent experience with the VET FEE-HELP scheme demonstrates what can happen when governments fail to discharge their stewardship role well (box 1.1).

Box 1.1   Vocational education and training reforms

Reforms to the vocational education and training (VET) sector illustrate the potential for damaging effects on service users, government budgets and the reputation of an entire sector if governments introduce policy changes without adequate safeguards.

In 2009 the Australian Government introduced the VET FEE-HELP system of income-contingent loans for higher-level VET courses. Initially these loans were only available to students undertaking education and training through VET providers that had credit transfer arrangements with a higher education institution. In 2012, the Australian Government expanded the scheme so students undertaking courses at other VET providers could access VET FEE-HELP loans. The number of approved providers doubled between 2012 and 2014 to reach nearly 250, but no requirements were put in place for providers to demonstrate that they were delivering high-quality education. While consumer choice was expanded, the Australian Government did not fully anticipate the market stewardship issues that would emerge.

The number of students accessing VET FEE-HELP increased almost fivefold from 2012 to 2015, mainly due to a substantial increase in the number of full-fee paying students enrolled at private training providers and accessing loans. Combined with a lack of accessible information, the weakening of price signals from the removal of upfront costs contributed to large increases in average tuition fees — which more than doubled for students eligible for VET FEE-HELP.

Some private providers aggressively marketed their courses, emphasising to students that they would not have to pay upfront, and in some cases offering inducements (such as 'free' laptops). Under the influence of high-pressure marketing thousands of students signed up for courses that they had little prospect of completing. Even among those who did complete their qualifications, many were unlikely to have considerably increased their employment prospects or potential earnings.

Individuals were left with large debts that many are unlikely to ever repay, and the Australian Government incurred a large fiscal liability. The Australian Government has since tightened the criteria for education providers accessing government funding, with the intention of weeding out low-quality providers. Better oversight of providers and tighter controls on service users' access to government funds would have had administrative costs, but could have helped avoid other costs that ended up being much larger.

Sources: Australian Government (2016a); DET (2015); NCVER (2015); Senate Standing Committees on Education and Employment (2015).

Stewardship of human services also includes evaluating outcomes to identify effective practices, and making ongoing improvements to policies and programs to disseminate innovations and improve service outcomes. This aspect of stewardship is challenging. The ability to accurately define and measure outcomes varies significantly across the different human services. These difficulties mean that models of service delivery and programs for evaluation need to be carefully designed and appropriately resourced.

Governments' objective should be to improve outcomes for users

Several submissions revealed a tension between the value of funding not-for-profit organisations to pursue a positive (but often broad and unmeasurable) social mission, and funding models that are primarily focused on providing services to improve the wellbeing of individuals and their families. These participants argued that using not-for-profit providers delivers additional social capital, pointing to the community focus of such organisations, their sense of mission, and the use of volunteers to support service delivery. (Brotherhood of St Laurence, sub. 286; CCA, sub. 193; Catholic Social Services Victoria, sub. 272; Jesuit Social Services, sub. 284; GSANZ, sub. 282; St Vincent de Paul Society National Council, sub. 285). Some participants were concerned that service models that draw on competitive pressures threaten the ability of not-for-profit providers to generate these broader benefits. For example, Jesuit Social Services (sub. 284, p. 14) noted that:

> Not-for-profit organisations generally have long histories of engaging with their local communities and have developed a strong reputation as a valued part of the community … The combined investment of time and goodwill by staff, volunteers, local community and business striving towards shared community goals is a highly valuable resource. This could easily be lost by increasing competition, as for-profit providers push out established not-for-profit organisations.

The Commission agrees that not-for-profit organisations can provide social capital. In its 2011 inquiry into *Disability Care and Support,* the Commission recognised the benefits to social capital that can accrue through, for example, the fundraising and volunteering activities undertaken by (often small) not-for-profit community organisations. Similar conclusions were reached in the Commission's 2010 report on the *Contribution of the Not-for-Profit Sector* which found that not-for-profit providers can deliver benefits to the community that extend beyond the direct benefits to the recipients of human services.

The Commission considers that maximising community welfare from the provision of human services does not depend on adopting one type of model or favouring one type of service provider. Additional benefits — such as those potentially offered by not-for profit organisations — should be considered, but not at the expense of improving outcomes for individuals and their families.

1.3   Competition, contestability and user choice

The task in this inquiry is to apply the principles of competition, contestability and user choice to the provision of human services to determine if and when these policy options

could improve outcomes for users, and the community more broadly (box 1.2). Human services are a large part of the economy and improvements in service provision could lead to significant benefits.

Box 1.2   Competition, contestability and informed user choice

Competition

Competition involves government and/or non-government providers of a service (or substitute services) striving against one another to attract service users. If competition is effective, service providers will attempt to attract users by reducing the price they charge, improving the quality of their service, offering new and innovative services, or otherwise tailoring their services to better meet the needs of users. Where competition is introduced in markets for human services, it is often done through individual entitlements (such as vouchers for Medicare-funded GP services or individual budgets under the National Disability Insurance Scheme) where users are able to choose from a range of providers, based on their preferences.

Contestability

Contestable markets are those where there are no substantial barriers preventing a provider that is not currently supplying services to users from doing so now or in the future. Contestability in human services refers to a provider of human services, or the management team of that provider, facing a credible threat of replacement if they underperform. This could include the threat of replacing the management of a public provider with another public management team. For this reason, contestability does not necessarily require the outsourcing of publicly provided services to the non-government sector.

There are several criteria that must be satisfied for contestability to deliver the benefits of effective competition. These include: ongoing performance monitoring of providers; alternative providers or management teams that pose a credible threat of replacing an incumbent; and a mechanism to replace underperforming providers or management teams.

Informed user choice

Someone, whether the user, the provider or a third-party such as a regulator, must decide which services a particular user receives. Informed user choice models empower consumers of human services to be actively involved in decisions about the services they use. There are many types of user choice. Users can directly make decisions about the services that they receive (for example, a person with a disability deciding which services best support their needs) and which organisation will provide services to them (for example, deciding between different residential aged care facilities). The user's choice may be assisted or facilitated through an agent or intermediary who is tasked with implementing the user's preferences. In other cases, organisations or governments take the needs and preferences of the user into account when making decisions on the user's behalf. A default option (with appropriate protections) may be used where a user does not wish, or is unable, to make choices on their own behalf. To support informed user choice, governments may need to facilitate the flow of information about services to the user and provide support to users to help them understand and act on that information.

There are also circumstances when a user's agency is explicitly removed, such as being placed under a court order to attend drug rehabilitation.

Sources: Baumol (1982); Competition Policy Review (2014, 2015); Davidson (2011); Sturgess (2015).

Choice can be empowering for users

Informed user choice places users at the heart of human services delivery. With some exceptions, the user of the service is best-placed to make choices about the services that match their needs and preferences. Putting this power into their hands lets individuals exercise greater control over their own lives and can generate incentives for service providers to be more responsive to users' needs. User choice may also improve interpersonal relations and increase community integration (Neely-Barnes 2005). Competition and user choice are already common across a range of human services including GP and private dental services, and childcare centres. More competition and user choice is being introduced in other human services, such as disability services.

Several participants, such as Brotherhood of St Laurence (sub. 286), Catholic Social Services Australia (sub. 272), and the Benevolent Society (sub. 129), highlighted the benefits of user choice. For example, Catholic Social Services Australia (sub. 272, p. 23) stated:

> Catholic social services joins the current consensus that, other things being equal, the ability to exercise choice is a positive – among other things, it respects the dignity of the service user; it adds to the quality of the service as received by allowing citizen preference to be factored in to the selection; and it can help the service user over time to develop confidence and capability in engaging with others.

It will not always be the case that users are best-placed to make decisions on their own behalf (ACMHN, sub. 4; HOPE Community Services, sub. 204; Municipal Association of Victoria, sub. 256; PeakCare Queensland, sub. 128). People vary enormously in their ability to make informed choices about the services they need or want, as does the level of assistance and user-oriented information needed to support user choice. Not everyone can, is willing to, or should exercise choice. The very young or those with severe cognitive impairment, for example, may not be well-placed to make decisions; and just about everyone struggles to understand mobile phone plans.

People can only exercise user choice if they have information that is timely, accurate and in a format that users can easily understand and use. Without the user-oriented information needed to compare alternatives, choice can make users dissatisfied, overwhelmed, and confused about the implications of their choices (Hibbard and Peters 2003).

Competition and contestability can drive improvements in outcomes

Competition between multiple service providers for the custom of users can drive innovation and efficiencies. As an alternative, where there would be net benefits, governments can seek to mimic competitive pressures through contestable arrangements — ensuring that providers of human services face a credible threat of replacement. A contestable market (including one with a single provider), with the credible threat of replacement, can enable the better performing service providers to expand their service

offering and keep current providers on their toes. Under the right conditions, where there would be net benefits, contestability can deliver some, or even many of, the benefits of effective competition (Sturgess 2012).

The term contestability is used widely in the context of commissioning arrangements used by governments to select service providers. These providers could be from within government (ideally separated from the commissioning body) or from outside government, with contractual arrangements specifying the terms under which the service should be provided. Commissioning is a broad concept, and contestability can be introduced in several stages of the commissioning process, including when governments engage, select, monitor and evaluate service providers (chapter 8).

Competition, contestability and user choice can be part of a system that encourages providers (and governments) to be more effective at achieving outcomes for service users by improving service quality, using innovative service models, expanding access so more people get the support they need, and reducing the costs to government and users who pay for those services. Many service providers are intrinsically motivated to improve their services, but may not be rewarded for better performance. In some cases, regulatory and funding arrangements effectively discourage innovation by prescribing how service providers must deliver their services to receive funding. Systems that recognise and reward approaches that are more effective in achieving service outcomes have the potential to deliver higher-quality, more responsive and more accessible services.

Competition, contestability and informed user choice do not have to be applied simultaneously. User choice can be introduced where contestable processes are used by governments to select multiple service providers. Competition to provide a service may be used when there are sufficient suppliers while contestability can be used for the same service where competition would be ineffective due, for example, to thin markets in regional and remote areas.

Many, but not all, services are suited to greater competition, contestability and user choice

The introduction of greater competition, contestability and user choice may not always be the best approach to reform. One size does not fit all and redesigning the provision of human services needs to account for a range of features, including: the rationale for government involvement; the outcomes the services are intended to achieve; the nature of the services and the dynamics of the markets in which the services are provided; the characteristics and capabilities of users; and the diversity in purpose, size, scale and scope of providers. Not all of these features are clear cut or measurable, and all change over time. Further, reforms may raise or lower government expenditure on the provision of human services and different design options will have different fiscal implications for governments.

In addition, the benefits of introducing greater competitive pressures need to be weighed against the costs. Greater competition could lead to some service providers contracting or withdrawing from the market, or changing the way they deliver services, leading to a loss of connection for some service users (ASU, sub. 85; FECCA, sub. 25). This connection is important for relationships that are based on trust between the person providing the service and the person receiving it. Redesigning the provision of human services can involve adjustment costs for service users, governments and providers. If policy design is not done well, it can have significant costs for consumers and taxpayers (box 1.1).

The government and non-government provision of human services has involved instances of controversy or failure. Many participants expressed concern about the provision of human services being subject to greater competition and contestability, and, to a lesser extent, user choice. The reasons for participants' concern included that:

- competition, contestability and user choice risks bidding down the cost of delivery and will lead to a reduction in the quality of services — especially where for-profit providers are involved (ACTU, sub. 100; ASU, sub. 85; Illawarra Forum, sub. 238; St Vincent de Paul Society National Council, sub. 285; YFCC sub. 90)

- the users of human services are among the most disadvantaged in the community with vulnerabilities arising from very low incomes, mental or physical illness, frailties due to older age, low numeracy and literacy skills, or a lack of access to the resources and support needed to exercise informed choice (ACMHN, sub. 4; ACOSS, sub. 73; Brotherhood of St Laurence, sub. 286; NSW Meals On Wheels Association, sub. 7; St Vincent de Paul Society National Council, sub. 285)

- some providers of human services have taken advantage of vulnerable people (and poor government stewardship), exposing weaknesses in the system and undermining confidence that competition, contestability and user choice can be beneficial to users, and to the community more broadly (ACTU, sub. 100; AEU, sub. 224; McAuley Community Services for Women, sub. 241)

- not-for-profit, community-based organisations are better-placed to provide human services — they are closer to the communities they serve and, because they are mission (rather than profit) driven, will reinvest any surplus back into services to support less profitable areas. However, they are disadvantaged by the time- and resource-consuming administrative processes used to commission services (ACOSS, sub. 73; ACTU, sub. 100; ASU, sub. 85; Brotherhood of St Laurence, sub. 286; CSSA, sub. 226; St Vincent de Paul Society National Council, sub. 285)

- markets rely on perfect information and rational, self-maximising participants to work effectively, and these conditions do not hold for the provision of human services (Aged Care Crisis, sub. 273; Combined Pensioners and Superannuants Association, sub. 121)

- building a relationship of trust between the service provider and user is paramount and reforms may damage the continuity of this relationship (United Voice, sub. 237)

- introducing greater contestability creates incentives for providers to focus their attention on tender applications and for governments to focus on contract management rather than on 'what works' for those in need of support (ASU, sub. 85).

Each of these concerns is legitimate but may be minimised or removed by designing appropriate systems to provide human services. Even with these concerns, measures to empower service users and increase competitive pressures could lead to better outcomes for some service users and communities. The question is when is it possible to design service delivery models that capture one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice. The NSW Disability Council (sub 118, p. 2) explains this in the context of the National Disability Insurance Scheme (NDIS):

> Choice is empowering and can facilitate greater independence and improve overall quality of life, particularly for people with disability that may have been denied choice and opportunities for self-determination.

That is the Commission's task in this inquiry — to determine the circumstances where the outcomes for the users of human services and the community as a whole could be improved by the introduction of greater competition, contestability and informed user choice in the provision of those services. In this study, improving outcomes draws on a set of attributes — quality, equity, efficiency, accountability and responsiveness (box 1.3). A strong theme in submissions was the need to consider how reforms to introduce greater competition, contestability and user choice could contribute to the effectiveness of the service. Some considered effectiveness as an aspect of quality, based on Davidson's (2011) conceptualisation (CPSA, sub. 121), while others considered effectiveness as an overarching attribute — a critical indicator as to whether interventions by governments are improving outcomes (NSW Government, sub. 122).

In the Commission's view, effectiveness is best considered in the context of human services as an overarching concept, incorporating the attributes of quality, equity, efficiency, accountability and responsiveness to determine whether the service is achieving its intended outcomes. Introducing greater competition, contestability or user choice might not improve all of these attributes at the same rate, or in equal measure, for all service users. Many, but not all, human services are suited to this type of reform and options that *generally* offer improvements across this range of attributes will be examined in the inquiry report.

1.4   The Commission's framework

To assist with its task, the Commission developed a three-stage framework in its issues paper to ensure a consistent approach to assessing the suitability of each service for competition, contestability and user choice reform (figure 1.1). The framework is flexible enough to take into account the vastly different dimensions of each human service, including the characteristics of users and providers, the circumstances under which

services are provided, and the complex needs of some users who may require access to a range of services. The factors considered by the Commission in its framework can vary over time in response to a range of drivers of supply and demand (chapter 2).

Figure 1.1   Identifying services best suited to reform

Quality

The concept of 'quality' in human services is open to interpretation and there is no single agreed measure of quality in any human service. One measure might be the effect that the service has on the user's quality of life, such as the reduction in pain from medical treatment, or the improvement in literacy from school education. These effects can be difficult to measure and proxies might be used instead, including service outputs (such as the number of students completing a particular year at school). For many human services the way the service has been delivered might also be an important aspect of service quality. Intangibles, such as courtesy and cultural sensitivity, might influence users' views of service quality. Service providers, users and governments might regard measures of inputs (such as the number of staff or their qualifications) as indicators of service quality.

Equity

The meaning of 'equity' can vary. Davidson (2015, p. 193) defined it as occurring when services are 'accessible to all people who need them'. A key challenge when considering equity issues is balancing community expectations about the quality of the service that should be equitably accessed and how (and by whom) those services should be funded. Equity of access to services might be achieved by providing the same service to all members of the community on the same terms. For example, all Australian citizens are entitled to access emergency hospital care when they need it. Equity of access might not lead to equity of outcomes from human services. Some people have greater need than others, and achieving similar outcomes might require allocating more resources to serve people who face the biggest challenges.

Efficiency

Economic efficiency is a measure of how well inputs are combined to produce outputs. It has several dimensions. Increasing *technical* efficiency can be achieved by producing more outputs without increasing inputs, or by producing the same outputs with fewer inputs. Increasing *allocative* efficiency can be achieved by determining the level of social resources that should be devoted to human services and then producing the combination of human services that the community values most, given those resources. Improving *dynamic* efficiency is achieved by continually improving technical efficiency (including through innovation in service delivery) and allocative efficiency (by adjusting the combination of human services that are delivered as preferences change).

Accountability and responsiveness

Responsiveness refers to how well an individual or organisation reacts to things. Le Grand (2007) identified being responsive to the needs and wants of service users as an essential element of respecting people as deliberative and purposeful agents.

Although responsiveness is desirable, there are some qualifications to this attribute. Service users generally do not pay the full costs of human services so being solely responsive to their wishes could place an unreasonable burden on taxpayers and the broader community.

Accountability is responsiveness to the concerns of the people who fund human services (taxpayers and service users). Taxpayers are also users of human services, and their interests will often overlap. Beneficial human services require that these two attributes — responsiveness and accountability — are balanced.

Scope for improvement

The first stage of the Commission's assessment considers whether there is scope for changes in policy settings to increase the wellbeing of the community as a whole by improving the provision of human services. All else equal, the benefits of reform would be greatest where current policy settings lead to outcomes that are typically well below best practice, and where current policy settings limit competition, contestability and user choice.

Factors influencing the potential benefits of reform

The second stage of the assessment examines whether the characteristics of the service user, the service itself and the supply environment mean that improvements in service provision could be achieved by introducing greater competition, contestability and user choice.

The potential benefits of user choice will be higher for services where there is the potential for the accurate, timely, cost-effective and reliable provision of user-oriented information. The potential benefits will also depend on whether users have the willingness and capacity to absorb the available information and make choices, or have access to another party (such as a family member or independent expert) that can assist the user to make choices that are in his or her best interests. The collection and provision of fit-for-purpose information is also an important prerequisite for the introduction of greater competition and contestability so that governments are better able to develop sound reform options and understand how they affect outcomes for users and the community as a whole.

The way in which service providers and users interact will also affect the case for reform. For example, it will be more difficult to exercise user choice where providers offer 'outreach' services by seeking out people, such as rough sleepers, who they consider need support, where the service is provided to a person only once, or where services are provided to clients during a crisis or emotionally difficult time (NSW Treasury, sub. 122; Vision Australia, sub. 28).

To be effective at achieving outcomes, it may be desirable for one service provider to offer multiple services to clients — people experiencing homelessness may also seek support for drug addiction, for example, and it may make sense to access these services from the one provider. The extent to which service provision should be bundled very much depends on the needs (and capabilities) of the user and the nature of the specific services being provided.

The potential costs of reform

The third stage of the assessment considers the potential costs of introducing greater competition, contestability and user choice. This assessment considers costs to service

users, governments and service providers, and includes both one-off adjustment costs and ongoing costs. Importantly, the costs depend on the model of reform and are considered in general terms at this stage of the inquiry.

Both service providers and users are likely to face upfront costs in adjusting to changes in regulatory arrangements and the way services are provided. Importantly, to benefit from greater competition and choice, service users (or their decision makers) will need to become more active in selecting the services they receive, and may incur costs where they choose to switch providers. Providers will face costs where new regulations impose compliance requirements — such as requirements to provide more information to users and governments.

Governments will face costs associated with their stewardship role. In particular, governments will need to establish and oversee frameworks to inform and protect service users, and to monitor service providers. This could include changes to general consumer protection laws, or the establishment of new bodies if more tailored safeguard arrangements are needed. Different service models will also have different fiscal implications for the government. For example, governments can find it more difficult to control total expenditure for a demand-driven scheme than when using grants-based funding.

Governments also face risks associated with being a 'provider of last resort' if, for example, a provider goes into bankruptcy or liquidation (NT DTF, sub. 261). In such cases, governments may need to step in and take over an underperforming or failing provider, or set up arrangements for a 'provider of last resort' as part of the reform process.

The list of factors included in figure 1.1 is not exhaustive. Other factors, such as the allocation of costs and risks between government and non-government providers, vary depending on which reform option is pursued, and will be considered in the second part of the inquiry. The Commission will also consider other, broader reforms that may need to be undertaken to enable the implementation of its recommendations to introduce greater competition, contestability and user choice in the identified services.

1.5 Services best suited to reform

The Commission's assessment of the services presented in table 1.1 takes into account evidence from a range of sources including contributions from participants, overseas experience, research undertaken by others and Commission analysis. Case studies from Australia and overseas have been used to inform the assessment of suitability for reform.

In identifying services, the Commission had regard to a number of factors, including:

- the extent to which services are already subject to competition, contestability or user choice (examples here include the provision of general practitioner services)

- whether reforms to introduce greater competition, contestability or user choice are proposed, or are underway (examples here include disability services, mental health services and vocational education and training)

- whether improved outcomes could be better delivered by reforms other than greater contestability, competition or user choice (examples here include school education).

For a number of the services considered by the Commission, competition, contestability or user choice reform could improve service provision for users, and benefit the community as a whole. The services identified reflect the Commission's preliminary view of where well-designed reform could offer the greatest improvements in community wellbeing. The assessment has identified six priority areas:

- social housing

- public hospital services

- specialist palliative care

- public dental services

- human services in remote Indigenous communities

- grant-based family and community services.

The reasons underpinning the inclusion of these services are outlined in chapters 3 to 8.

Table 1.1   **Services assessed in this study[a]**
In alphabetical order

Alcohol and drug services	Family support services and out of home care	Mental health services
Allied health services	General practitioners (GPs)	**Public dental services**
Child and family health services	**Grant-based family and community services[b]**	**Public hospital services**
Community health services	Higher education	Primary and secondary schooling
Corrective services	Home-based aged care	Primary health networks
Disability employment services	Homelessness services	Residential aged care
Disability support services	**Human services in remote Indigenous communities**	**Specialist palliative care**
Early childhood education and care	Job services	**Social housing**
Emergency payments	Maternity services	Vocational education and training

a Services in bold are those identified by the Commission as best suited for reform. **b** Includes alcohol and other drugs services, community-based mental health services, family support services and out of home care, and homelessness services.

These priority areas are diverse — in the type and number of users and providers; the settings and circumstances under which services are provided; their reform history; the current application of competition, contestability and user choice; and the level of expenditure contributed by governments and users. The policy design challenge in each will be unique.

The importance of ongoing reform and evaluation

There are six priority areas for reform identified in this report. These reflect the Commission's preliminary views on the highest priorities for the Commission's current task. However, many other services could also benefit from reform. For example, there is considerable scope to improve outcomes by promoting competition, contestability and user choice in the provision of residential aged care services. The Commission's inquiry into the aged care sector in 2011 made recommendations, such as replacing the system of discrete care packages across home-based and residential care with a single integrated and flexible system of care entitlements. If implemented, these reforms would improve outcomes for users of residential aged care services, and the community as a whole.

Reforms are underway to introduce greater competition, contestability or user choice to other services included in the scope of this inquiry. For example, in home-based aged care, reforms are being implemented to offer greater choice for service users. Other areas, such as the NDIS and early childhood education and care, are also under reform. All warrant continued scrutiny and evaluation to ensure the potential net benefits of those reforms are captured.

The Australian Government has also committed to reforming the provision of mental health services, including making the delivery of mental health services more contestable, evidence-based and person-centred (Australian Government 2015b). The Commission supports the intention of these important reforms, but notes that it is too early to evaluate their effectiveness.

2   Trends and drivers

2.1   A snapshot of human services

High-quality human services, such as health and education, underpin economic and social participation. Access to high-quality human services contributes to the wellbeing of individuals and the welfare of the community as a whole. Community welfare is enhanced by the social cohesion and equity benefits of people having access to a minimum level of human services, regardless of their means or circumstances.

The types of human service provided, and the way in which they are delivered, has evolved over time. In Australia, disability services, aged care and many family and community services were originally provided by volunteer and charitable organisations (APSC 2013; Kendig and Duckett 2001; Phillips 2008). Specialist occupations have emerged to respond to social issues, such as drug and alcohol counselling, family support workers and disability services workers (Victorian Government 2011). Human services have operated in a constant state of change over many years (VCOSS 2015), and the sector will continue to evolve to reflect changes in technology, demographics, income growth and distribution, user preferences, government policy and community expectations.

The users of human services

Everyone accesses human services during their lifetime but the circumstances and the settings in which those services will be needed vary enormously. The users of human services are diverse, in their needs, preferences and their capabilities (including their capability to exercise informed choice). Some people will need intense, professional support, potentially for long periods, while others will need transitional support to assist them with a short-term crisis. The system for funding, providing and stewarding human services needs to cater for this diversity, noting that, as the Australian population grows and preferences and technology change, so too will the demands placed on that system.

Many people have little difficulty engaging the services they need

Many people draw on human services in a reasonably predictable pattern of service use. For these people, their main interaction with the human services system will be through the childcare or education system, and occasional visits to a general practitioner (GP) or hospital. These users generally have a good understanding of the system, have time to plan their service use and compare alternatives, and have little difficulty in engaging with

providers to meet their needs — coordinating services to meet their needs is relatively straightforward (NZ PC 2015).

Some people have multiple and complex needs

While most human services users have relatively straight forward needs, some will have multiple and complex needs and require access to several coordinated services, potentially for long periods. For example, about 28 000 people who accessed specialist homelessness services in 2015 also required access to mental health, drug and alcohol, or disability services. Of these, about 6000 people accessed two of these services, and a small number required support from all three (AIHW 2016m). Services to support people with complex needs will generally be more successful at achieving intended outcomes if they are coordinated around the needs of users and their families.

Different cultural groups may need different types of services

A user's cultural background influences how they use and engage with the human services sector. These differences should be accounted for in the way that services are provided. Health services for Indigenous Australians, for example, will be less effective at achieving intended outcomes if they are not tailored to the needs of particular communities (Bainbridge et al. 2015). Similarly, cultural norms influence how recently arrived immigrants use certain human services. For example, the National Mental Health Commission (2014) noted that the response of the Australian mental health system can be inappropriate for migrants and refugees due to culturally different approaches to treating mental illness.

Linguistic diversity means that certain users can have difficulty in accessing information including about what services are available, how to access them and how to select a preferred provider. This can be the case for many Indigenous Australians who speak traditional languages, particularly in remote areas where more than half of Indigenous people speak an Australian Indigenous language (chapter 7) (ABS 2016e). Language and cultural barriers can also impede the ability of recently arrived immigrants to access information and make informed decisions in human services such as social housing (Wiesel, Easthope and Liu 2011).

Some groups require greater support than others

Differences in a user's background can affect which human services they require, and are an important consideration for the introduction of greater competition, contestability and user choice. Recognising these different needs is critical to meeting the community's expectation of equitable access to human services, and to generating equitable outcomes.

- Many Indigenous Australians have the same human service needs as non-Indigenous Australians. However, some Indigenous Australians have different and complex human

service needs, and consequently use some human services more intensely. For example, Indigenous Australians have four times the rate of hospitalisations for chronic conditions, almost two times the rate of disability and about six times the use of social housing as non-Indigenous Australians (SCRGSP 2014). (Data gaps impede comparisons of need between Indigenous and non-Indigenous Australians for most other human services.)

- Permanent immigrants generally have lower human services needs, as most arrive when they are of working age (ABS 2014) and typically have higher levels of educational attainment. However, permanent immigrants arriving under Australia's Refugee and Humanitarian programme generally have greater needs, particularly during the initial months of their settlement in Australia. For example, humanitarian visa holders typically arrive with limited resources and limited or no English language skills (Refugee Council of Australia, sub. 271), and consequently have greater English language and education needs (PC 2016a).

- Temporary immigrants arriving to work and study have lower human service needs, reflecting the fact that they are generally younger than permanent immigrants (ABS 2014) and are often required to be in good health before they are granted a visa. Temporary applicants also have limited access to most government services and are required to make provision for their own health insurance (DIBP 2016).

People in regional and remote areas can have difficulties accessing services

More than two-thirds of Australia's population lives in major cities, with the rest living in regional and remote areas that can be hundreds of kilometres from the nearest urban centre. Transport and communication networks can be poor, and access can be dependent on seasonal conditions. The physical distance, low population density, as well as difficulties attracting and retaining staff in regional and remote areas, can make the cost of service provision several times higher than in urban centres. Some services are simply not available outside urban centres.

For example, users of health services in regional and remote areas have access to fewer local medical specialists, making them more dependent on GPs (AHMAC 2012). Moreover, users in regional and remote areas cite greater difficulty in accessing hospital, general practice and dental services (ABS 2015b). These issues are particularly relevant for Indigenous Australians, who represent a higher proportion of the population in remote areas (ABS 2013b).

The providers of human services

Governments provide some human services directly, although non-government provision has been a feature of many human services for a long time. For the human services that governments provide, some are organised and delivered through departments and agencies

under the direction of a Minister, whereas others operate as statutory authorities with greater autonomy.

Non-government providers also differ in many ways, including their organisational structure (for example, unpaid informal carers, sole traders, mission-driven organisations that rely on volunteers and donations, and for-profit entities that have a footprint over multiple jurisdictions and service areas), the degree to which they rely on volunteer labour and donations, and the balance between profit, intrinsic or altruistic motivations. Informal carers are major contributors to the human services sector — an estimated 2.7 million family and friend carers provide almost 2 billion hours of care each year (Carers Australia, sub. 259).

Analysis undertaken by PwC (2016) shows that non-government providers accounted for an estimated 30 per cent of service provision in selected human services between 2012 and 2015.[1] Since the mid-1990s, there has been a trend toward non-government provision in many services, including schools, social housing and childcare (figure 2.1). Non-government providers are more prevalent in some services, for example, service provision in GP, allied health, optometry, job, community and aged care services. The evidence is mixed for other services, such as dental, and varies between jurisdictions.

Figure 2.1   Non-government provision of human services
Per cent of total
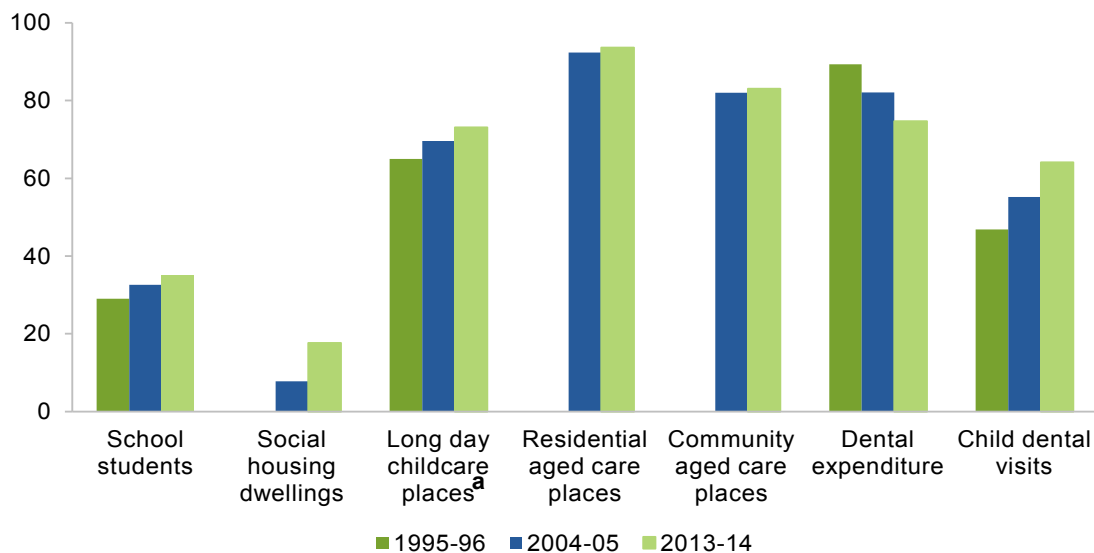
a Refers to for-profit providers in 1994, 2003 and 2012.
*Sources*: ABS (2016f); AIHW (2005, 2015e, 2015f; 2016); PC (2014); SCRGSP (2010, 2015).

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[1]   Includes health, education, aged care, disability services, social housing and services for Indigenous Australians and people who are unemployed.

The trend toward non-government provision will likely continue in some services. In particular, non-government provider participation in disability services will grow as the National Disability Insurance Scheme (NDIS) is rolled out — for example, the number of providers increased from 1350 to 1957 across seven trial sites in 2014-15 (NDIA 2015a). In many cases, increased non-government provision has been accompanied by greater access with users having choice over the service they receive, who provides it or perhaps both. Participants pointed to the benefits of this, for the individuals and the community as a whole.

The size of the human services sector

There are many ways to measure the size of the human services sector including: government, private and total expenditure; the number of actual or eligible users; the number of providers; and the number of transactions (or the number of separations for some health services). Expenditure is often used to express the size of the human services sector as a whole (figure 2.2). By this metric, health and education were by far the largest human services in 2013-14, but expenditure on other human services, such as aged care, disability services and social housing, was also substantial.

Figure 2.2 **Expenditure on human services**
$ billion, 2013-14
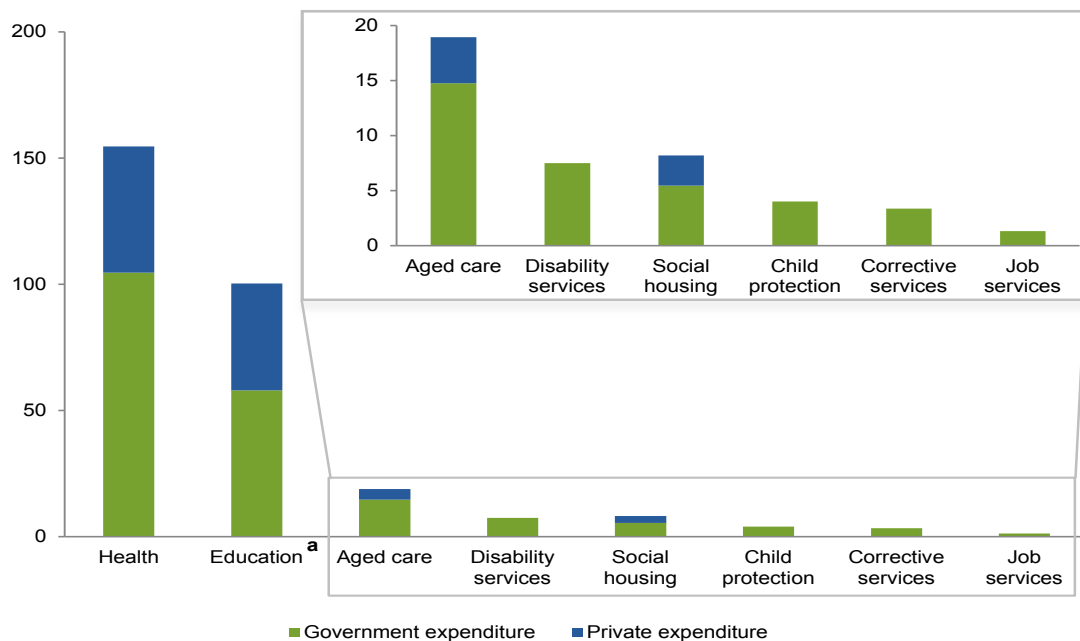
a Private expenditure on education is based on ABS Government Finance Statistics and may include some government payments to private individuals that are spent on education services and are also included as government expenditure on education.

Sources: ABS (2016a, 2016c); ACFA (2015); Australian Government (2014); SCRGSP (2015, 2016a).

Expenditure provides an indication of costs but does not measure the benefits of human services to an individual or to the community — the social and economic benefits when a person at risk of homelessness, for example, finds their way to stable accommodation, better health care and, ultimately, fulfilling employment. Expenditure will also underestimate the demand for services that are government subsidised and consequently have waiting lists to ration use, such as public hospital, social housing and public dental services.

2.2 Trends and drivers affecting human services

The dynamics at play in the human services sector are multifaceted — what services are needed, who demands those services, how they should be funded and provided, and who should provide them continues to change. Drivers of change in human services provision include increased demand, workforce trends, digital technologies and improved data availability, and a move toward tailored and integrated services (figure 2.3).

Figure 2.3   **Drivers of change in human services provision**
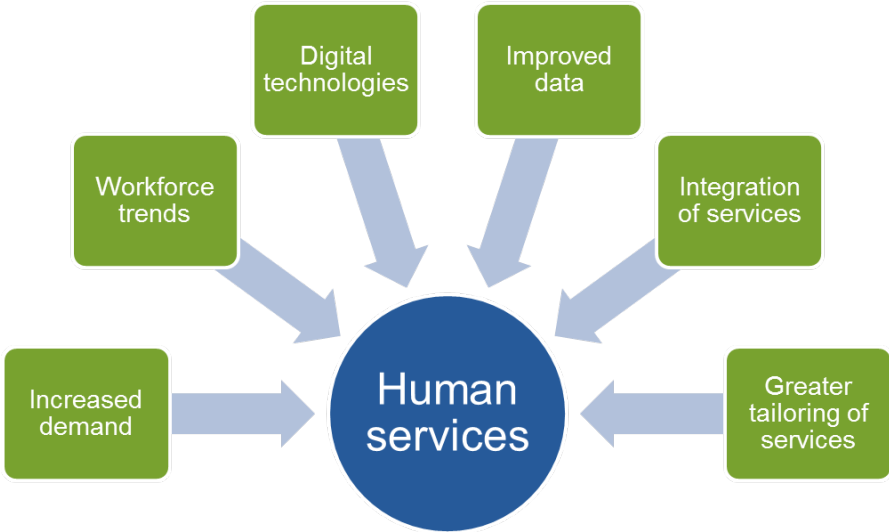
Demand for human services will continue to grow

Demand (as reflected by expenditure) is projected to grow across most human services, particularly health, disability services and aged care (figure 2.4 and Australian Government 2015a).

Figure 2.4   **Projected government expenditure on human services[a,b]**

Total growth in real expenditure per person, 2014-15 to 2024-25
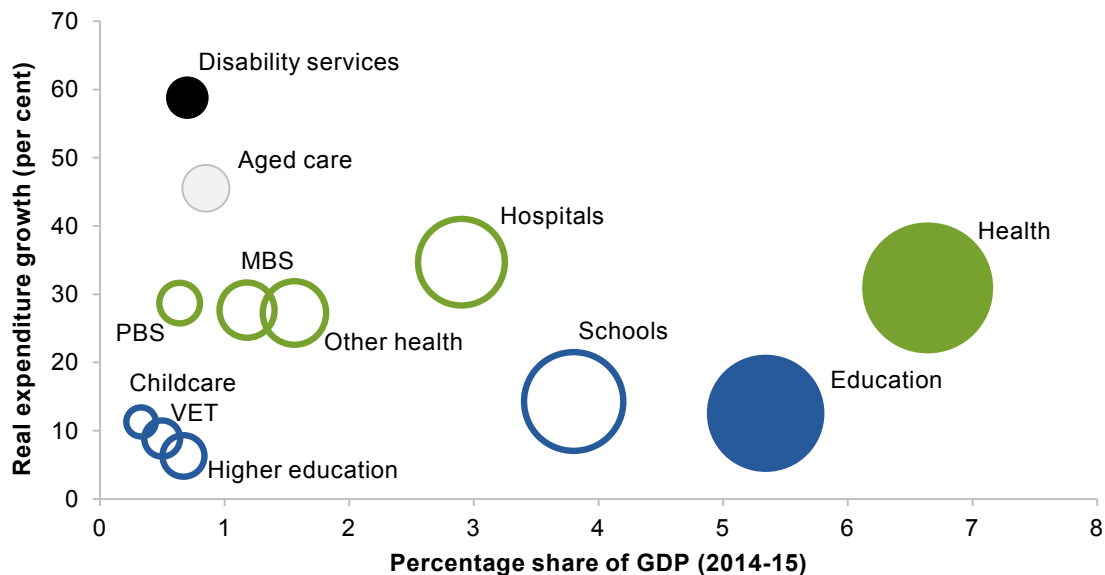
a The size of the bubble reflects the services' percentage share of GDP; unshaded bubbles are components of health and education. **b** MBS refers to the Medicare Benefits Schedule, PBS refers to the Pharmaceutical Benefits Scheme and VET refers to vocational education and training. Higher education excludes the cost of lending to students.

Source: Estimates based on PC (2013).


Reasons for greater demand generally reflect:

- *Population ageing* — The relationship between age and use of human services reflects an individual's consumption of education at a younger age, relatively low needs during their working life and higher health and aged care demand in retirement (figure 2.5). Population ageing, and its subsequent effects on human services demand, varies across Australia and will likely be more pronounced in regional and remote areas as the elderly represent a larger share of the population (NSW Government 2016d). The elderly also use services such as housing and dental more intensively, and demand for these services will grow with population ageing (ANZASND and ASSCID, sub. 200; AONSW 2013).

- *Chronic disease* — Changing lifestyles and population ageing are leading to an increased incidence of chronic disease. For example, the projected doubling of the number of people with dementia in 2050 (AIHW 2016g) and growth in other morbidities is expected to increase demand for palliative care services, including in age care settings and private homes (PC 2011a).

- *Income growth* — Higher incomes generally increase demand for more and higher quality human services, particularly health and care services generally. The distribution of income and the effect of business cycle fluctuations will also be important for

services targeted at those experiencing hardship. For example, demand for social housing might increase as more people become unemployed during a severe economic downturn, but demand can also be high during periods of strong economic growth accompanied by a rapid increase in housing costs (Select Committee on Social, Public and Affordable Housing 2014).

- *Changes in technology* — New technologies and medical breakthroughs have increased the number and range of services available to users, and demand can increase when new treatments are of higher quality (Australian Government 2015a). Technology is expanding the range of services able to assist those with a disability, particularly for people with intellectual and psychosocial disabilities where traditional services have had very little to offer (NDIS 2015).

The contribution of each of these factors, many of which are external to the human services sector, will vary across the different services. For example, in health services non-demographic factors are expected to account for about 80 per cent of the increase in expenditure, with population ageing accounting for about 10 per cent. In aged care, the effect of population ageing is a much larger factor (Australian Government 2015a). To meet the growth in demand for human services, governments will be required to collect additional taxes, find efficiencies within service provision or reduce their contribution to the cost of the service.

Figure 2.5   Use of human services by age[a,b]
Expenditure by all governments, 2011-12
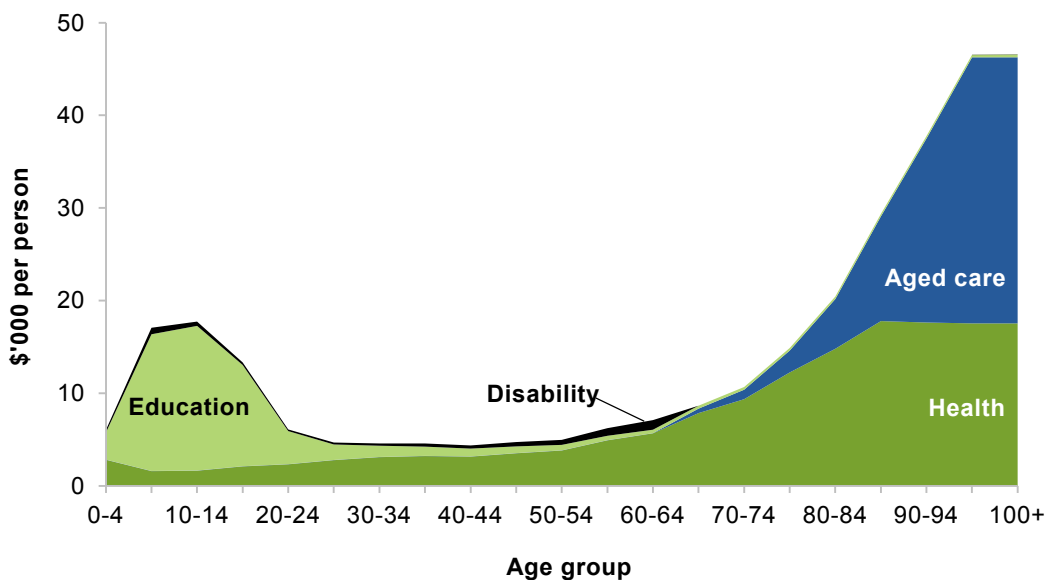
[a] Aged care refers to Australian Government expenditure only. [b] Excludes social housing, child protection, corrective and job services.

Source: Estimates based on PC (2013).

Trends in the human services workforce

High-quality human services rely heavily on the skills, experience and efforts of the human services workforce. Australia's formal human services workforce comprises a range of professionals who work in a structured manner on a paid basis. Over the past decade, the formal human services workforce has grown substantially. Health and education alone have accounted for more than a third of all employment growth in Australia (ABS 2016d). As noted above, volunteers and informal carers also contribute substantially to the care and wellbeing of many Australians.

Professionalisation of the workforce

Income growth, community expectations for higher-quality human services and the increasing government focus on delivering wellbeing outcomes (such as improved life expectancies) have led to an expansion of the formal human services workforce. In some services, these trends have led to the professionalisation of human services as paid qualified staff have replaced informal service providers. Examples of the trend toward professionalisation of the workforce include:

- *Childcare* — User preferences for early education rather than basic care services have driven growth in the formal childcare workforce. The Commission's inquiry into *Childcare and Early Childhood Learning* noted that providers increasingly needed to operate on a professional basis and take greater responsibility for organising and funding the professional development of their staff. Government policy decisions, such as the introduction of the National Quality Framework in 2008, have also contributed — the proportion of childcare workers with a certificate qualification or higher increased from 58 per cent in 2009 to 71 per cent in 2011 (ABS 2009, 2013a).

- *Family and community services* — Diverse and complex user needs, and greater worker responsibility for assessment and intervention activities, have driven the professionalisation of the family and community services workforce. In some situations, volunteer labour has been replaced with more qualified paid labour, and the workforce has become more qualified, as the proportion of social assistance workers with a post-school qualification increased from 58 per cent in 2006 to 66 per cent in 2011 (ABS 2009, 2013a). Professionalisation in family and community services goes beyond frontline staff, and has seen not-for-profit organisations recruit professionals to help them compete for grants-based family and community services (PC 2010).

Workforce changes

Greater demand for human services could give rise to workforce shortages in both formal and informal care. Amongst the formal workforce, shortages are recognised as a particular challenge in regional and remote areas, as a lack of professional development opportunities and accommodation options act as barriers to attracting and retaining appropriately qualified health professionals (Community Affairs References Committee 2012). Improved

matching of workforce qualifications with the complexity of the human service could partially address any workforce shortages.

The future availability of volunteers and informal carers could decline due to demographic factors such as population ageing, increased female workforce participation (CPSA sub. 121) and a decline in the rate of volunteering (ABS 2015b). Deloitte Access Economics (2015) has projected that the demand for informal carers will exceed supply over the next decade.

Technology is changing the way services are delivered

Human services are often relationship based and usually involve a person-to-person interaction. The quality of this interaction often drives the outcomes delivered. For people facing hardship, services often involve a degree of outreach and engagement that cannot be replicated via technology. Nonetheless, expanding internet coverage and increasing use of web-based technologies, smart phones and apps is starting to have a major influence on the options for delivering human services. Providers have been using these technologies to develop innovative service delivery models and improve their service offerings. For example, Better Caring (sub. 252) and Hireup have developed peer-to-peer platforms that allow users to manage their own care needs by engaging directly with service providers, who are also able to work flexibly.

Communication technologies will facilitate greater service delivery in regional and remote areas and can allow service providers to be more responsive to user needs. Services such as remote medical consultations and the School of the Air are already used in regional and remote areas (Northern Territory DTF, sub. 261), and greater use of telehealth and telecare will enable remote service delivery (box 2.1). For some human services, remote service delivery can increase the number of users a provider (or providers) can service. This may mean providers are better able to draw on economies of scale or scope and could allow for greater competition, contestability and user choice.

Digital communication technologies will not be the way of the future for all services, for all users, or in all locations. As noted above, some services are based on an outreach model where providers engage users, for example, services supporting rough sleepers. For some users communication technologies may improve access to services, but for others, models of service provision that rely on technology will reduce access and may, in fact, be isolating. Users who have difficulties using technology — such as the vision impaired (Vision Australia, sub. 28) or some people with low levels of literacy and numeracy (CQFCA, sub. 119) — or those who do not wish to use technology, would be disadvantaged by service provision models that rely too heavily on access to technology.

In the context of greater availability and use of digital communication technologies, the Commission's concurrent *Telecommunications Universal Service Obligation* inquiry is considering the future direction of a universal service obligation that provides ubiquitous access to standard telephone and payphone services. This includes consideration of

whether particular sections of the Australian community, for example, Indigenous Australians, people with a disability or people living in regional and remote areas, have different needs to which additional government intervention should be directed (PC 2016c).

Box 2.1   Telehealth and telecare services: an example of innovative delivery models

Telehealth and telecare services are facilitating innovative models of service delivery. Using sensors and communication devices, providers are able to evaluate the status of a person's health through their vital signs, and check and respond to emergencies — all while the person remains in their own home.

Innovative service models such as these have the potential to facilitate service provision and increase the benefits from greater competition, contestability and user choice in regional areas, particularly as internet access improves.

- Innovative service delivery models are being used for medical consultations in remote areas (Northern Territory DTF, sub. 261) and to assist people with disabilities. For example, the not-for-profit telecommunications company Jeenee Mobile has tailored smart phone apps to allow people with a disability to live more independently (NDS 2016).

- In a 12-month trial, the CSIRO partnered with not-for-profit organisations, local health districts and for-profit telecommunications companies to evaluate the effectiveness of home monitoring services for elderly patients with chronic disease. Results from the trial in urban and regional areas found that users were less likely to visit a GP or be admitted to hospital, and users reported improvements in their quality of life and understanding of their condition (Celler et al. 2016).

The responsiveness of the service, security and privacy concerns and the ability of the user to verify the service provider's credentials before using the service are added challenges (Knight and Hunter 2013). Similar to other sectors (PC 2015a), inflexible regulatory and contracting arrangements could impede innovative uses of technology, while consumer protections remain an important consideration.

Data availability and use

There has been substantial growth in the type and volume of data generated and collected, as well as the ability to draw insights from it. The future uses and applications of human services data are to some degree unknown — over time data will have uses and provide insights that have yet to be considered.

Increasing access to public data is a priority of the Australian Government, and some state and territory governments. The Commission has a concurrent inquiry into *Data Availability and Use* that, among other things, will make recommendations on how to increase the sharing and public release of public sector data, and how to standardise and integrate data to increase its usefulness. The Department of the Prime Minister and

Cabinet (2016) is leading several cross-agency projects to address barriers to data sharing and improve the dissemination of public sector data on the data.gov.au platform. Across jurisdictions, there is a move to improve real-time data on the outcomes and performance of government initiatives, including human services (COAG 2016a).

Improvements in the quality and availability of data

The development of better quality datasets underpins continuous improvement in the provision of human services. Governments need data to identify community needs and expectations, the demand for services and gaps in service provision. Better data can be used to target services more accurately to the people who need and would benefit from them most. Program design, monitoring and evaluation rely on quality data, all of which are important to improving the next round of decisions about which services to provide and fund so intended outcomes are more likely to be achieved.

Governments and providers collect a vast amount of administrative, program and survey data on human services. Currently, data are often fragmented and not comparable across users, providers or jurisdictions, particularly in health (AHCWA 2016 AHHA, sub. 134), and could be better used in education (PC 2016b). Data also tend to focus on service inputs, costs and the number of services provided (The Benevolent Society, sub. 129) rather than user outcomes. Others have suggested that the processes for accessing data can be complex (BSL 2016). Effective data collection and analysis are not costless. The collection of data can impose compliance burdens on users, providers (Hornagold, sub. 246) and governments.

The challenge is in ensuring that the right data are collected, and that the data used are fit for purpose. Governments and providers are examining ways to improve the use of data. For example, researchers are using linked data from the Sax Institute's *45 and Up Study* to predict which users are at risk of chronic disease, as well as identify treatment gaps. Similarly, the Australian Government (2015c) has funded longitudinal data collection to support an actuarial assessment of the lifetime liability of Australia's welfare system, which in turn could be used to tailor community and social services to try to prevent long-term dependence on income support.

Recent and upcoming trials of social impact bonds in Victoria, New South Wales, Queensland and South Australia provide an example of how governments can use data collection and analysis to change how services are delivered. The NSW Government (sub. 122) noted that data collection has been integral to their development of a social impact investment market, and that providers involved in social impact bonds have demonstrated a willingness to respond to data, and adjust their service provision accordingly.

Better use of data has the potential to improve service integration and prevent users from having to navigate service silos. For example, the NSW Data Analytics Centre has been established to facilitate data sharing between agencies and improve whole-of-government

decision making (NSW Government, sub. 122). Better use of data will present many opportunities, including better targeting of services to users most in need, improved evaluation and the development of preventative programs to stave off later traumas (Wareing 2013).

Technology and data have the potential to improve user choice

Transparent and accessible information and data on the quality, price and other characteristics of human services can play a key role in informing user choice (CSIA, sub. 192; Northern Territory DTF, sub. 261). Governments and providers are already using technology and performance data to help users make informed choices in human services. For example, the MySchool website provides contextual information, such as a school's geographic location, enrolment size and student demographics, to support user choice.

Better use of technology and data will improve service transparency and allow users to compare service information based on characteristics that matter most to them. Following the trend toward greater user choice in home-based aged care and disability services, web platforms have emerged that allow users to share ratings and feedback about their experience (see, for example, Hireup). Similarly, NDIS participants have established forums on social media to share information and their experiences from exercising greater choice under the scheme (Disability Loop 2015).

The Australian Red Cross is supportive of technologies that support user choice:

> We are also supportive of mechanisms by which service users are encouraged to rate and comment on their own individual experience of providers. In the disability sector, Clickability provides a service similar to Trip Advisor, where users can publicly rate goods and services in real time. (sub. 203, p. 10)

However, these platforms present challenges, including whether users have access to information on all service providers in their area. In health, there is a suggestion that users may not have the technical expertise to review and comment on the clinical and technical aspects of the service provided (ADA 2016). Despite these limitations, St Vincent's Health Australia (sub. 207) supported greater provision of information and data to support user choice in hospitals (discussed further in chapter 4).

There is a push towards greater integration of human services

Human services have often been delivered in fragmented 'silos', and for many services, this remains the case. For many users of human services, this is unlikely to be an issue — they will access individual services as needed and are capable of navigating the human services system on their own. For those people in the community who are accessing several supports, a fragmented system can mean that those supports are offered in isolation with recipients required to contact, and explain their needs to, multiple service providers. Issues with fragmentation have been noted in a broad range of services, including mental

health (NMHC 2014), disability services (prior to the introduction of the NDIS) (PC 2011b), homelessness services (Northern Territory DTF, sub. 261), health care (Silver Chain, sub. 176) and job services (Centre for Policy Development, sub. 124).

Greater integration could improve service delivery

Greater integration, both within and across services, could result in higher-quality human services and better outcomes for users with multiple and complex needs. Greater integration can simplify access to human services, reduce duplication of services, allow for synergies in human services to be exploited and provide more holistic support to users for whom the effectiveness of services in one sector is dependent on services in other sectors (KPMG 2014; Mission Australia, sub. 277; NZ PC 2015). In palliative care, for example, a patient may access inpatient hospital care when an unexpected problem emerges and return home to receive care from specialist community-based providers. An integrated system of service provision would enable a seamless transition between different settings of care, with a patient's data and preferences travelling with them (chapter 5).

In light of the above benefits, governments are focusing on ways to improve integration across human services. The NSW Government (sub. 122) noted it is seeking to improve service integration and wrap-around services in community health and social housing. The Victorian Government has implemented Services Connect — a small scale trial of integrated human services delivery. Service providers and peak bodies such as the Community Services Industry Alliance (sub. 192), Mission Australia (sub. 277) and Silver Chain (sub. 176) also noted that they have sought to improve service integration.

Service integration has the potential to deliver better outcomes, particularly for people with complex needs who find it difficult to navigate the service system. Delivering integrated services requires a high degree of planning around the individual and systems for bringing services together effectively. The move to the NDIS represents one system for achieving this.

The costs and benefits of delivering highly integrated services can vary. The Social Policy Research Centre (2005, p. 3) noted that ' … the cost–benefit ratio of integration is not fixed, but will vary with the type and number of clientele, the extent and character of integration, and other factors that will enter into the planning decision'. Careful design is therefore needed to ensure that services are targeted to clients and circumstances where the benefits of integration outweigh the costs.

Competition, contestability and user choice reform can enhance integration

Several participants raised concerns that the introduction of greater competition, contestability and user choice could hinder the push towards integration (Inner South Community Health, sub. 244; CSIA, sub. 192; GSANZ sub. 282; MAV, sub. 256; Mission Australia, sub. 277; Uniting Church in Australia, sub. 173). These concerns reflect the

view that competition and contestability damage the collaboration needed for individuals and organisations to work together in order to achieve the best outcomes for users (Whiting, sub. 27; chapter 8).

Well designed and implemented systems can build the platform where integration and increased competition is delivered. For example, a greater focus on user outcomes in program and contracting design can promote integration, flexibility and innovation, relative to traditional contracts that are often prescriptive with regards to service inputs and processes (KPMG 2013; Northern Territory DTF, sub. 261; chapter 8). In other areas, providers have formally collaborated in order to achieve better outcomes for users (see for example the Transitional Housing Program in Kununurra discussed in chapter 7).

Tailoring services to meet consumer preferences

In human services, users are increasingly seeking more individualised services. For example, in aged care, baby boomers have higher expectations of exercising control over the services they receive and of receiving services tailored to their needs. Further, users are increasingly preferring to receive services at home rather than in a residential aged care facility (AIHW 2013b; PC 2011a, 2015c).

Several participants to this inquiry noted that services tailored to the needs of consumers are more effective and lead to better outcomes for users (CoHealth, sub. 240; FECCA, sub. 25; Mission Australia, sub. 277; Refugee Council of Australia, sub. 271). Tailored services can be particularly important for the economic and social participation of groups facing hardship (FECCA, sub. 25), and are important for user groups with diverse needs, such as Indigenous Australians and recent immigrants (section 2.1).

Many recent reforms to human services have sought to offer services more tailored to the needs of individual users. For example:

- The NDIS allows users to tailor a package of services to meet their needs, and in 2015 the Australian Government announced that people with complex mental health needs would have access to services tailored to their needs (Australian Government 2015b)

- The ACT Better Services reforms to human services included an objective to cater for more flexible and tailored services (ACT Government 2014)

- New South Wales is seeking to introduce personalised support plans for people in social housing (NSW Government 2016c).

While the tailoring of human services can improve user outcomes, it may not be appropriate to tailor services to all user needs. Individually tailored services can be costly and, because most users do not pay the full cost of human services, may place pressure on government budgets. As major funders of human services, governments should consider the degree to which greater tailoring and responsiveness places an unreasonable burden on taxpayers and the broader community (box 1.3).

The push towards individually tailored services will have implications for both service providers and governments. Service providers will need to adopt flexible approaches to allow them to meet the needs of individual clients. Governments will need to ensure that policy settings, such contracting and funding arrangements for non-government providers, are flexible enough to allow providers to respond to consumer preferences within constrained budgets.

3 Social housing

3.1 The social housing system

Shelter is a basic human need. Housing assistance provides a safety net for those that are experiencing homelessness, or who face high barriers to sustaining a tenancy in the private rental market, and plays an important role in increasing their quality of life. Different types of housing assistance are provided by government and non-government (including not-for-profit and for-profit) organisations (figure 3.1). In government expenditure terms, the two largest programs are the provision of social housing and Commonwealth Rent Assistance (CRA) (box 3.1).

Social housing covers both:

- public housing, which are properties managed by state government housing authorities, such as Housing SA or Housing NSW. Housing authorities are usually either government agencies or divisions within government departments. Governments also manage housing stock that is only allocated to Indigenous Australians, referred to as state-owned and managed Indigenous housing

- community housing, which is a mix of properties either owned by the provider, or managed by the provider but owned by the government. Currently all community housing providers are not-for-profit organisations. There are about 200 community housing providers of varying sizes registered under the national registration regime.
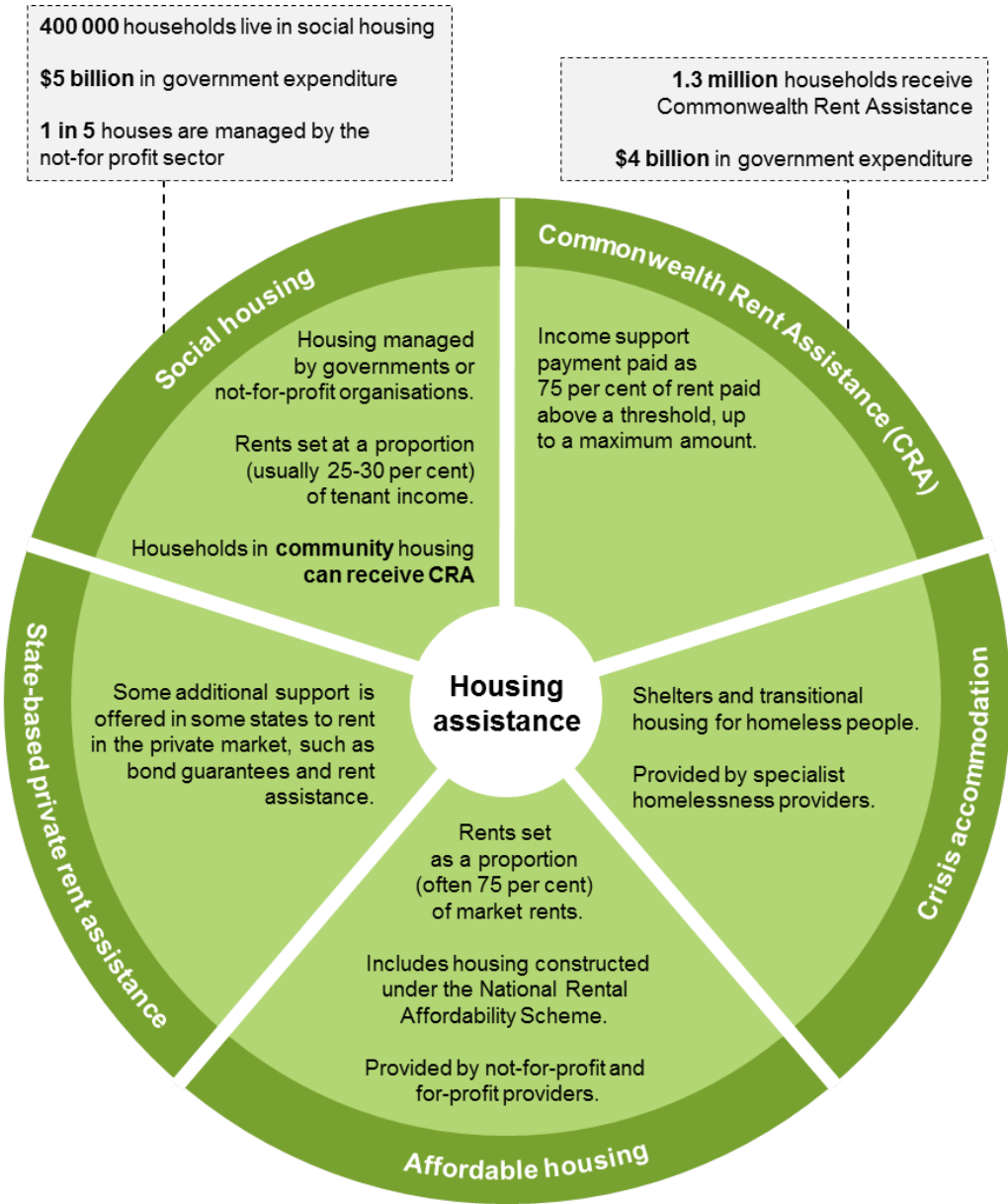
In addition, in some jurisdictions, such as Western Australia, a small number of people in need of social housing are housed in private rental homes (WA Housing Authority nd).

The Commission's focus is on social housing, as it is the aspect of housing assistance where, in the Commission's preliminary view, reform to introduce greater competition, contestability and user choice is most likely to be effective at delivering intended outcomes. User choice and competition is already a feature of aspects of housing assistance such as affordable housing and CRA. Crisis accommodation is delivered through the homelessness system, and will be considered as a grants-based family and community service along with other specialist homelessness services (chapter 8).

An assessment of social housing should consider not just people currently in social housing, but also those in need of social housing who are unable to access it. Access to social housing is rationed using waiting lists, of which there are usually two — one for general applicants and one for those in greatest need (such as those experiencing homelessness or at high risk of homelessness). There are a large number of people on these

waiting lists (section 3.2), and some people who are receiving other forms of housing support may be better suited to social housing. Jacobs et al. (2016, p. 12) note that the level of housing support received is determined more by housing tenure (such as if the tenant occupies a social rental property, a private rental property or is a home owner), rather than their need for assistance.

Figure 3.1   Housing assistance in Australia

400 000 households live in social housing

$5 billion in government expenditure

1 in 5 houses are managed by the not-for profit sector

1.3 million households receive Commonwealth Rent Assistance

$4 billion in government expenditure

Social housing

Housing managed by governments or not-for-profit organisations.

Rents set at a proportion (usually 25-30 per cent) of tenant income.

Households in **community** housing **can receive CRA**

Commonwealth Rent Assistance (CRA)

Income support payment paid as 75 per cent of rent paid above a threshold, up to a maximum amount.

State-based private rent assistance

Some additional support is offered in some states to rent in the private market, such as bond guarantees and rent assistance.

Housing assistance

Crisis accommodation

Shelters and transitional housing for homeless people.

Provided by specialist homelessness providers.

Rents set as a proportion (often 75 per cent) of market rents.

Includes housing constructed under the National Rental Affordability Scheme.

Provided by not-for-profit and for-profit providers.

Affordable housing

Sources: DSS (2016a); SCRGSP (2016a).

Commonwealth Rent Assistance (CRA) is an income support payment that aims to reduce the incidence of rental stress for people on low incomes. There is no universal measure of rental stress — what a household can afford to spend on rent will depend on its circumstances — although for statistical purposes the ABS has defined rental stress as more than 30 per cent of household income being spent on rent. CRA is paid at a rate of 75 cents for every dollar in rent above a rent threshold, up to a maximum amount.

In June 2015, the proportion of households in Australia in rental stress reduced from almost 70 per cent before receipt of CRA to just over 40 per cent after. CRA recipients tend to receive a lower overall level of assistance than public housing tenants, reflecting differences in location of the two types of tenants (in metropolitan areas, social housing tends to be located in suburbs close to the city centre, whereas CRA recipients tend to be more evenly spread) and a faster rate of growth in rents than the maximum CRA rate over the past decade.

Sources: ABS (2013c); AIHW (2016i); DSS (2016a); NSW FACS (2016a); PC (2015b); SCRGSP (2016a).

Making judgments on the number of households assisted through the social housing system depends on a range of factors, and international evidence suggests that there is no 'right' level of social housing. The level of social housing needed will depend on interactions with broader government policy, including the level of income support provided, the objectives of the state and territory governments that have responsibility for the policy area, and the amount of affordable housing available for people to rent in the private market. These interactions, and the interaction of social housing with other aspects of housing assistance, will be considered in the inquiry.

3.2　　Scope to improve outcomes

Recipients of social housing support have reported through the National Social Housing Survey that they are in better health, are able to improve their employment situation and have better access to the services and supports they need once settled in stable accommodation (AIHW 2014a). Nonetheless, there appears scope for improvement in the way social housing is delivered that could lead to better outcomes for tenants in the social housing system, as well as for people outside the system who are unable to access the support they need.

The focus of the social housing system has changed over time, and this has given rise to several issues. There has been a shift in the demographics of people receiving support through the social housing system — from working families to recipients of income support who have additional barriers to entering the private housing market (Groenhart and Burke 2014). In some jurisdictions, governments are increasingly using social housing to provide transitional support, rather than as a permanent destination for tenants (NSW FACS 2014b). These factors, combined with the long-lived nature of housing assets, have resulted in a growing mismatch between the characteristics of the social housing stock and those receiving support. It has also resulted in funding pressures on the system. In 1990,

nearly all state housing authorities were running an operating surplus, that is, income from rents and charges was more than sufficient to cover ongoing expenditure, including property maintenance (Hall and Berry 2004). By 2000 nearly all were in deficit, and the gap between what it costs to maintain a property and the rent paid by its occupants has continued to grow (SCRGSP 2000, 2016a). As housing authorities are expected to be financially viable, there is a tension between the affordability of housing for tenants, and the viability of the system (CHFV 2016). The disconnect between the level of subsidy social housing tenants receive and that received by tenants in the private rental market through CRA has also increased over time.

Quality

Due to these funding pressures and demographic changes, the quality of the service received by social housing tenants has deteriorated. Prospective tenants face long waiting times before they receive housing — in New South Wales, expected waiting times in 2013 were up to 10 years (and about a year for high-priority applicants) (AONSW 2013; SCRGSP 2016a). Once housed, the quality of the home received by the tenant can be poor: housing authorities have often taken a short-term view and deferred preventative maintenance, and about 20 per cent of properties are now not in an acceptable condition (figure 3.2; NT DTF sub. 261; VAGO 2012). Additional maintenance expenditure as part of the Australian Government's 2008 stimulus package has not alleviated deteriorating quality standards in public housing.

Equity

There are equity issues in the current housing system. People with the same income and characteristics (such as location and capacity to work) can receive vastly different rates of assistance depending on whether they are able to access social housing or rent in the private market. Households with a member with a disability and households in state owned and managed Indigenous housing have lower levels of satisfaction with their housing than for the public housing cohort as a whole (figure 3.3). This is likely to be in part because there are not enough houses modified to be suitable for a person with a disability. For example, in Tasmania there were about 4000 households in social housing with a member with a physical disability compared to about 1500 modified social housing properties (Tasmanian Audit Office 2016).

Efficiency

There is limited evidence available on the efficiency of social housing management in Australia. Pawson et al. (2015) noted that management costs for housing providers in Australia appear to be higher than those in the United Kingdom, although this may be partly explained by the larger scale of UK housing providers. Underutilisation of the social

housing stock is also high in Australia (figure 3.2). As noted above, there is a mismatch between the housing stock and tenant need — about half the people entering social housing in 2015 were single adults (AIHW 2016i) whereas the stock is largely designed for families. Housing NSW has estimated that underutilisation of properties in New South Wales led to a rent loss of about $25 million per year (AONSW 2013) — equivalent to the recurrent cost to government of providing public housing for about 3000 households.

Figure 3.2   **Indicators of public and community housing, 2014a**
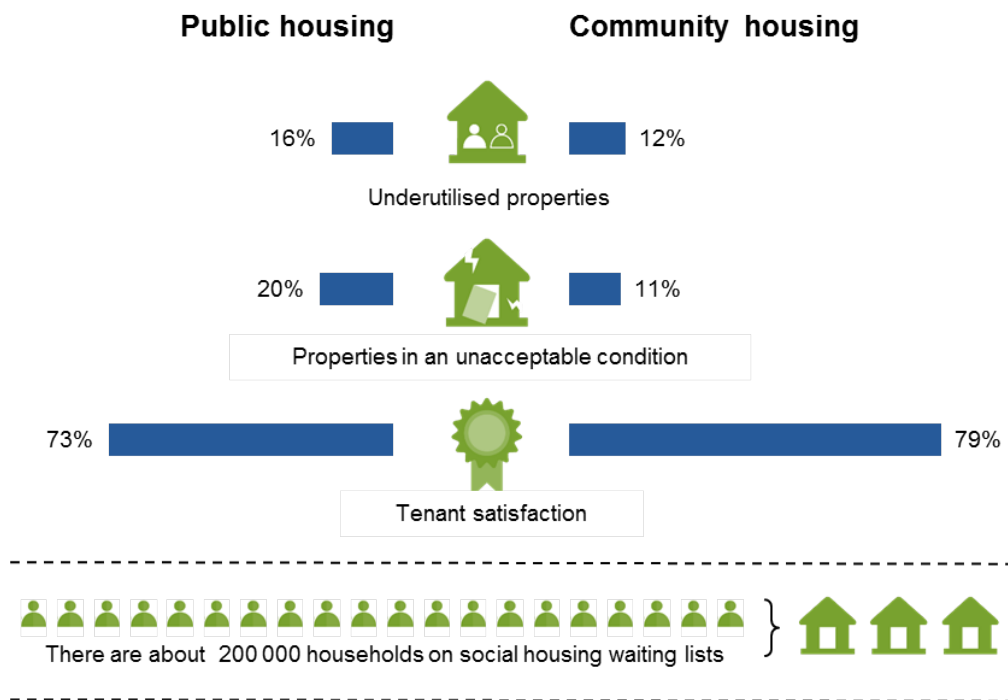
a Underutilisation refers to the percentage of properties that have at least two more bedrooms than the number of tenants living in them. Tenant satisfaction is the percentage of people who reported being satisfied or very satisfied with their housing. A property is considered to be in an unacceptable condition if it does not have working facilities for washing people, washing clothes, preparing food, and sewerage or has more than two major structural issues.

Source: SCRGSP (2016a).

Responsiveness and accountability

There is little user choice in social housing

The current social housing system limits the ability of tenants to choose the home they would like to live in. Once applicants reach the top of the social housing waiting list, they are generally allocated an available home based on their preference for the area (which may contain multiple suburbs) in which they would like to be housed and the characteristics of the household such as the number of people and need for a particular type

of housing due to a disability (NSW FACS 2016b; Victorian DHHS 2015b). Properties can be very different in their size, physical condition, and proximity to preferred amenities (Wiesel et al. 2004).

The suitability of an allocated property can be a question of timing and luck. Tenants cannot 'hold out' for a preferred property, because those that reject two (or sometimes one) offers of housing are relegated to the back of an already long waiting list, and often must take what is offered.

Figure 3.3   Tenant satisfaction

Per cent of tenants satisfied or very satisfied with their housing
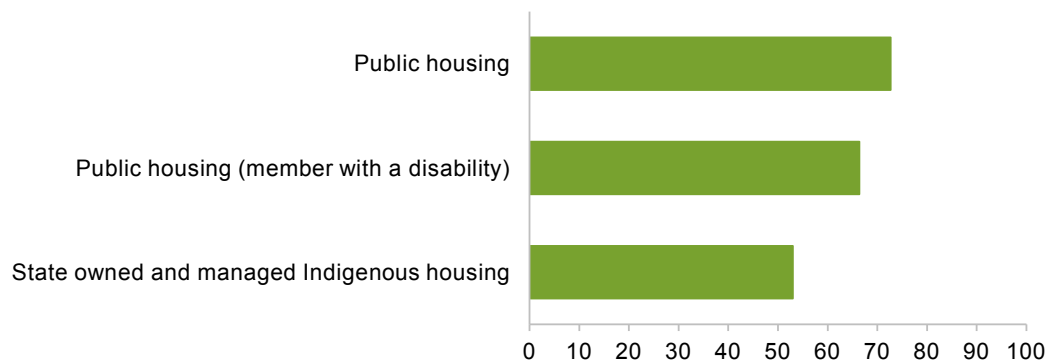
Source: SCRGSP (2016a).

Tenants able to access the private rental market via CRA (with additional government support in some states and territories) generally have greater choice over where they live than social housing tenants. However, some participants have argued that the level of support provided by CRA is inadequate, and not all recipients are able to maintain a private tenancy even with the support of CRA and other programs (Homelessness Australia, sub. 149; National Shelter, sub. 232). This includes recipients on very low incomes in high-rent areas, people who have difficulty accessing and retaining housing, and people who have particular requirements such as disability supports (National Shelter, sub. 232).

The limited scope for social housing tenants to choose their own home affects the responsiveness of the social housing system to meet the preferences of tenants, has flow-on effects on the quality and efficiency of the system (section 3.3), and can constrain the choices available to tenants in other parts of their lives.

> Lack of choice over where one lives, in turn constrains other life choices: about the range of jobs one can take, about the range of public services one can access, particularly schools, hospitals, public transport and food outlets. (Brotherhood of St Laurence, sub. 286, p. 19)

Participants to several studies and inquires have cited the need for, and benefits of, increased user choice in allocation of Australian social housing. In this inquiry, the NSW Federation of Housing Associations et al. (sub. 235) and National Shelter (sub. 232)

supported moves to increase user choice in social housing. Participants to a 2010 Victorian Legislative Council inquiry, including the Victorian Council of Social Services and the Brotherhood of St Laurence, supported increased choice within the allocation system (FCDC 2010). Similarly, participants responding to a 2015 NSW Government discussion paper stated that reform was needed to the allocation process to give people a greater say in their home (NSW FACS 2015).

There is little accountability for service providers

The majority of the social housing sector in Australia is publicly managed and not subject to contestable arrangements. There has been growth in the number of houses managed by the community housing sector, largely due to government transfers of the management of social housing to the sector (box 3.2). In some states (including South Australia and New South Wales) there are commitments for further transfers of housing stock. Properties have not been transferred to for-profit providers.

Box 3.2   **Better Housing Futures**

Better Housing Futures is the Tasmanian Government's program of transferring the management of public housing to the community housing sector. An initial pilot package of 500 properties was transferred in 2013 through a non-prescriptive tender process in which bidders were asked to provide ideas on what they may be able to achieve. Subsequently, a further three packages of properties totalling 3500 houses were transferred, using an open tender process to select providers and drawing on the lessons learned from the pilot transfer.

One of the key objectives of the Better Housing Futures scheme is community regeneration in disadvantaged areas and renewal of properties. Providers are required to undertake catch-up repairs to properties, and also to undertake place-based initiatives to improve community engagement and welfare. Targets for new property construction were also set for housing providers, which is expected to slow the decline in social housing property numbers in Tasmania.

An assessment framework that takes into account social and economic benefits is being developed. Tenants were provided with the choice of maintaining their tenancy with Housing Tasmania or switching to the new provider. The majority of tenants elected to switch to the community housing provider.

Sources: Housing Tasmania (2014); Pawson et al. (2013); Tasmanian Government (2015).

Limited data on tenant outcomes restrict the ability of governments to monitor service providers and make informed decisions about which providers — including both government and non-government providers — would be best-placed to manage social housing. The NSW Federation of Housing Associations et al. (sub. 235) noted that governments have focused on inputs and outputs, rather than the effect of housing on individuals. Pawson et al. (2015) noted that there is no means of measuring social housing tenants' economic reconnection outcomes, such as education and employment outcomes. The Victorian Auditor-General's Office (2012) has noted that the Victorian housing

authority lacked basic information to inform decision making. Similar issues have been noted in New South Wales (AONSW 2015a). Better data collection, and better use of existing data, could help address these concerns.

Improving the accountability of service providers could improve a range of attributes of social housing. For example, it could provide incentives for housing providers to improve the quality and efficiency of their services, stimulate innovation in housing management, and lead to improved outcomes for tenants over time.

While housing is a state and territory responsibility, the Australian Government funds social (and other affordable) housing through the National Affordable Housing Agreement. Participants to a Senate inquiry into affordable housing raised concerns that there was a lack of adequate accountability and transparency in how state and territory governments used Australian Government funding for housing (SERC 2015).

3.3 Factors influencing the potential benefits of reform

Whether reform to introduce greater competition, contestability and user choice is the best mechanism to address the issues highlighted in section 3.2 will depend on several factors, including the capacity of tenants to make decisions, the nature of transactions, and the nature of current and potential suppliers to the market.

Characteristics of users and transactions

Many people who enter social housing are likely to be capable of exercising choice over their housing options. Social housing tenants already state their preferences as to the areas in which they wish to live, and the capacity required to choose between specific properties is unlikely to be substantially different. Most aspects of a home that people value (such as the location and condition of the house) are observable prior to entering into a tenancy agreement. The ability for tenants in social housing to make decisions about their home is demonstrated by the experience of 'choice-based letting' overseas, which has been reported to have had substantial benefits, including improving the responsiveness, efficiency and quality of social housing (box 3.3).

Nonetheless, the capabilities of people that enter social housing vary (box 3.4), and some people will require additional support to be able to exercise informed choice (Marsh, Cowan and Cameron 2004; NT DTF, sub. 261). The type of support required will differ between individuals and groups, each of whom may face a different impediment to making informed choices (NT DTF, sub. 261). In some cases, tenants may require assistance with conduct that limits their ability to enter into and maintain a tenancy, such as sustaining amicable relations with neighbours. Some may require information on vacancies in a specific format (such as printed leaflets), while those who are unable to inspect properties or articulate preferences may require an agent to act on their behalf.

Box 3.3   User choice in social housing — international examples

Choice-based letting in the Netherlands and United Kingdom

Over the past two decades, most housing associations in the Netherlands have moved to a choice-based allocation process based on market principles. Known as the 'Delft model', available social housing properties are advertised in newspapers and online, along with eligibility requirements such as income level and household size. Eligible applicants bid for the listed property and are ranked against published selection criteria such as waiting time, applicant age and time spent in their current premises. The applicant with the highest ranking is offered the property, and the qualifications of the successful tenant are published so that unsuccessful tenants can check if the successful applicant indeed had a better application. A small number of people are directly allocated properties for social reasons, including health problems arising from to their housing situation, homelessness, catastrophic circumstances or clearance due to urban renewal. A similar allocation system exists in the United Kingdom, where local councils allocate their social housing properties using 'choice-based letting'.

Benefits of choice-based letting

Evaluations of choice-based letting in the United Kingdom found that 80 per cent of registered users preferred the choice-based system compared to more bureaucratic allocation models, despite the extra effort required by tenants to choose a property. Social housing tenants typically preferred choice as it gave them increased agency over their housing situation and resulted in a more open and transparent allocation process — both for successful and unsuccessful tenants.

When people are able to exercise more choice over where they live, they are more likely to stay in the same area, invest in the local community and have stable accommodation. For some tenants, a stable address and living conditions can improve their prospects of finding employment. The Commission has previously found that, among income support recipients, those that moved house were four to eight percentage points less likely to be employed than those that did not move. Priority applicants are most likely to benefit as they are more likely to be in unstable housing situations prior to entering social housing.

Choice-based letting can improve the efficiency and quality of the social housing system. For example, data collected through choice-based allocation systems have been used to identify the housing characteristics that tenants prefer, and to identify and target areas of high demand and need.

Sources: Brown and Lishman (2013); Brown and Yates (2015); Marsh et al. (2004); Ouwehand and van Daalen (2002); PC (2015b); Shelter (2014, 2015).

For many tenants, support to find a home will not be sufficient unless support is also provided to meet the other needs of the tenant and to help them sustain their tenancy (Jacobs et al. 2016). Most additional services accessed by social housing tenants (for example, for some tenants, mental health support) are provided separately from tenancy management services (NSWFHA et al., sub. 235). Where community housing providers offer additional services, they are generally aimed at community building or tenant education, such as social outings, community events, budgeting workshops and computer classes (NSWFHA et al., sub. 235). However, at times tenancy management can blur into tenancy support. Community housing providers aim to build close and trusting relationships with their tenants (NSWFHA et al., sub. 235), and the onsite housing manager can play a role in alerting support services to potential issues. The housing

community itself can be an important form of support for some tenants. Any reform would need to ensure that relevant support functions are available for social housing tenants.

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Box 3.4   **Characteristics of social housing tenants**

Compared to the general population, tenants of social housing are more likely to be female, Indigenous, Australian born, from single-person households and to have a disability. Tenants are likely to access a number of other human services, most commonly health and medical services (two-thirds of all tenants), and mental health services (one-fifth of all tenants).

Three out of four working-age social housing tenants who are in receipt of an income support payment (such as Newstart Allowance or Youth Allowance Job Seeker) have severe or significant barriers to employment. Employment participation rates are low — nationally in June 2013, about 10 per cent of working-age public housing tenants in receipt of an income support payment were employed, compared to 20 per cent for other working-age income support payment recipients. Social housing tenants tend to have higher employment rates and incomes than applicants for social housing, which may reflect the positive effect that a stable address and living arrangements can have on employment.

Sources: AIHW (2014a, 2015g, 2015h, 2015i); PC (2015b).

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Characteristics of supply

Under the current social housing system, demand for social housing far outstrips supply, limiting the properties available for prospective tenants to choose from. Many organisations point to a lack of investment in new properties as responsible for the shortage (ACOSS 2015; CHFV et al. 2014; TUV 2015). Waiting times for social housing are long, although the time spent on waiting lists can vary substantially. For example, a non-priority applicant seeking a two-bedroom home in Sydney can expect to wait anywhere from two to ten or more years, depending on the area they wish to live.

Absent other reforms, constraints on the supply of social housing would likely reduce the gains from user choice. However, some benefits would remain. Increasing user choice may allow applicants to better evaluate the trade-off between remaining on the social housing waiting list while a home that better suits their needs and preferences becomes available, or accepting a property in an area with a shorter waiting list. Approaches have been implemented overseas that provide a choice of home, even where there are supply constraints. In Toronto, Canada (where, like Australia, waiting times are long), choice-based letting led to a higher acceptance rate for offered homes, and a decrease in the length of time housing remained vacant (City of Toronto 2016; Cressman 2014).

Under the current social housing system in Australia, the supply and location of social housing are largely determined by government. Reform options could be explored to address supply constraints and increase the housing options available for prospective social housing tenants, so that they are better able to find a home that matches their specific needs. One way to achieve this is by making it easier for people to choose between social

housing and renting in the private rental market, for example, by offering a payment that provides a similar level of financial support regardless of which home they choose (SA Government, sub. 281). If such an approach were used, additional support, such as bond guarantees, may be needed to assist people to rent in the private market.

The management of social housing could be made more contestable, including where supply is constrained. Four out of five social housing properties are managed by government entities, yet there are a large number of housing providers that could provide this service (section 3.1). Allowing community housing providers to manage social housing appears to have had benefits, both in Australia and elsewhere (box 3.5). For-profit providers could introduce further contestability and choice. There are some examples of for-profit private landlords being involved in the provision of subsidised housing to people on a social housing waiting list.

- Western Australia is piloting the Social Housing Investment Program, which involves private landlords offering subsidised housing to people on the social housing waiting list (WA Housing Authority nd).

- Launch Housing operates a not-for-profit tenancy management service for private landlords that are willing to offer housing to low-income households at a below-market rate (Launch Housing 2016).

- In Toronto, Canada, private landlords are involved in the provision of housing with income-based rents — with the housing authority paying the difference between the subsidised rent and the market rent to the landlord (Housing Connections 2008).

Box 3.5 Benefits of transferring the management of public housing stock to community housing providers

There is evidence to suggest that there have been benefits from transferring the management of social housing to community housing providers. This evidence should be treated with caution, as community housing providers receive additional funding relative to public providers through Commonwealth Rent Assistance, are responsible for managing newer and more suitable properties, and because outcomes for tenants in social housing are not routinely monitored (section 3.2).

- Properties managed by community housing providers have a lower underutilisation rate, are better maintained and have higher tenant satisfaction (figure 3.1).

- Inquiry participants cited the benefits provided by community housing providers. The NT Department of Treasury and Finance (sub. 261) noted that community housing providers have better quality stock, provide more client-centric services and have greater tenant involvement. Similarly, Mission Australia (sub. 277) and the NSW Federation of Housing Associations et al. (sub. 235) stated that community housing providers have a more customer-focused approach to service delivery.

- In the United Kingdom, transfers of stock to community housing providers led to a more customer-focused approach, increased innovation, and greater tenant satisfaction (KPMG 2010).

Transferring the management of more properties to non-government providers could deliver more options for tenants who are offered a choice of housing provider. Where further transfers are considered, making the management of housing contestable would allow governments to select those providers best-placed to improve the management of social housing properties, and give incentives for providers to be responsive to tenant needs. Such a process would not preclude the management of properties remaining with the public provider, if they were best-placed to provide the service.

Economies of scale in tenancy management would need to be taken into account in any reforms to increase user choice and contestability to avoid a potential increase in the costs of tenancy management. Pawson et al. (2015) found that community housing providers are likely to have higher unit costs than the existing public providers, due in large part to the larger scale of public providers. The NT DTF (sub. 261) noted that community housing providers should be managing about 500 properties to achieve adequate scale.

3.4   The potential costs of reforms

The potential costs of greater application of competition, contestability and user choice would depend on the type and scale of reforms implemented. Increased user choice will involve costs to users of social housing in gathering information to make an informed choice. Social housing providers would need to supply applicants with information such as the properties that are available and how the allocation process will work, to enable informed choices at each stage of the process (Wiesel, Easthope and Liu 2011). Information may also need to be provided to allow prospective tenants to compare waiting times for properties, such as integrating social and public housing waiting lists into a single housing register, and standardising data (NSWFHA et al., sub. 235). There would also be costs involved in providing support for tenants that are less able to exercise choice or sustain a tenancy.

Reforms to introduce more effective contestability would have implementation costs for governments. Governments would need to procure and monitor providers to ensure that they are providing high-quality services to tenants. In addition to these costs, there would be a transfer of costs and risks from the public sector to the non-government sector.

Finally, changes to the social housing system, particularly any changes to CRA, would need to consider how the system interacts with other options for housing support.

PRELIMINARY FINDING 3.1

Introducing greater competition, contestability and user choice could improve the effectiveness of the social housing system in meeting tenant needs.

- There is substantial room for improvement in the current social housing system. There are long waiting lists, poorly maintained and underutilised properties, and a lack of information available to allow governments to select and monitor the performance of service providers.

- Four out of five social housing properties are managed by government entities, yet there are a large number of housing providers — both not-for-profit and for-profit — that could perform this service. Community housing providers outperform public providers on some indicators, including tenant satisfaction and property maintenance.

- There are currently not enough social housing properties to meet demand, limiting the housing choices available to social housing tenants. Nonetheless, approaches implemented internationally allow social housing tenants greater choice of home. Reform options could be explored in Australia to address supply constraints and increase the housing options available for prospective social housing tenants.
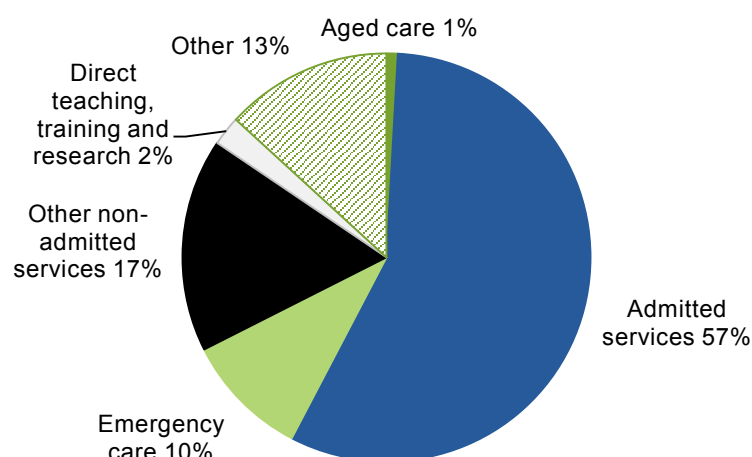
4   Public hospital services

4.1   Defining public hospital services

The term 'public hospital services' is used in this report to refer to healthcare that hospitals provide to public patients. Such services are almost always provided by public hospitals and so their characteristics and activity are used to describe services in this chapter. However, as detailed later, public hospitals also treat private patients. Moreover, a small proportion of public patients are treated in private hospitals.

Public hospital services cover many different types of healthcare and can be provided in a range of settings, including specialised units in large hospitals, outpatient clinics, day-procedure centres, and hospital-in-the-home care. However, almost 60 per cent of public hospital expenditure is on services where patients are admitted to hospital (figure 4.1). The vast majority of admitted services involve acute care, which aims to cure a condition, alleviate symptoms or manage childbirth. The remaining small proportion of admitted services involves sub-acute and non-acute care, such as rehabilitation.

Figure 4.1   **Public hospital expenditure by type of service, 2014-15[a]**

[a] Recurrent expenditure including depreciation.
Source: AIHW (2016d).

Among non-admitted services, emergency care is an important function that is almost exclusively provided by public hospitals. Other non-admitted services include care

provided in outpatient clinics where patients consult specialists or have diagnostic and other procedures.

This inquiry focuses on public hospital services. Some inquiry participants suggested that the Commission also consider the scope to reform private hospital services (for example, BUPA, sub. 258; Catholic Health Australia, sub. 236; Doctors Reform Society of Australia, sub. 144). However, various initiatives are currently in progress in this regard, including Australian Government consideration of issues raised in recent public consultations on private health insurance, steps taken by private insurers to better inform their clients about different hospitals and clinicians, and an industry working group report to the Australian Government on prostheses pricing arrangements for private patients. The Commission concluded that this inquiry could add more value by focusing on public hospital services where there is currently little contestability or user choice. The Commission is cognisant of the links between the public and private health systems and will take these into account where relevant.

4.2   Scope to improve outcomes

On average, Australian hospitals perform well against those in comparable countries in terms of quality, equity, efficiency, accountability and responsiveness (AIHW 2016a, 2016b, 2016c; Davis et al. 2014; St Vincent's Health Australia, sub. 207). Nevertheless, there is scope to improve. Equitable access is an ongoing concern for some groups, particularly those in remote areas. Public patients are offered little choice, which constrains responsiveness to user preferences. Benchmarking within Australia suggests that many public hospitals could increase their service quality and efficiency by matching best practice among their domestic peers.

There are numerous policy levers that governments already use to improve outcomes in public hospital services, including quality standards and professional training requirements. Greater contestability and user choice could place indirect pressure on hospitals, as part of a broader suite of reforms, to improve outcomes. Even a small percentage improvement in outcomes from public hospital services could deliver significant benefits in aggregate, given the scale of service provision.

Service quality

The share of the population receiving particular services in a hospital varies significantly across Australia, even after controlling for population characteristics. For example, in 2010-11, the per capita admission rate for knee arthroscopy in public hospitals (standardised for age and sex) ranged from one-third of the national rate in one region to almost four times the national rate in another area (figure 4.2). Knee arthroscopy is a procedure used to examine and, if necessary, repair the inside of the knee joint. There is evidence that it is of little benefit for people with osteoarthritis and may in fact cause harm

(ACSQHC and AIHW 2014; ACSQHC and NHPA 2015; Doctors Reform Society of Australia, sub. 144).

Figure 4.2   Regional variation from national per capita admission rate for selected conditions, 2010-11[a]

Public hospitals
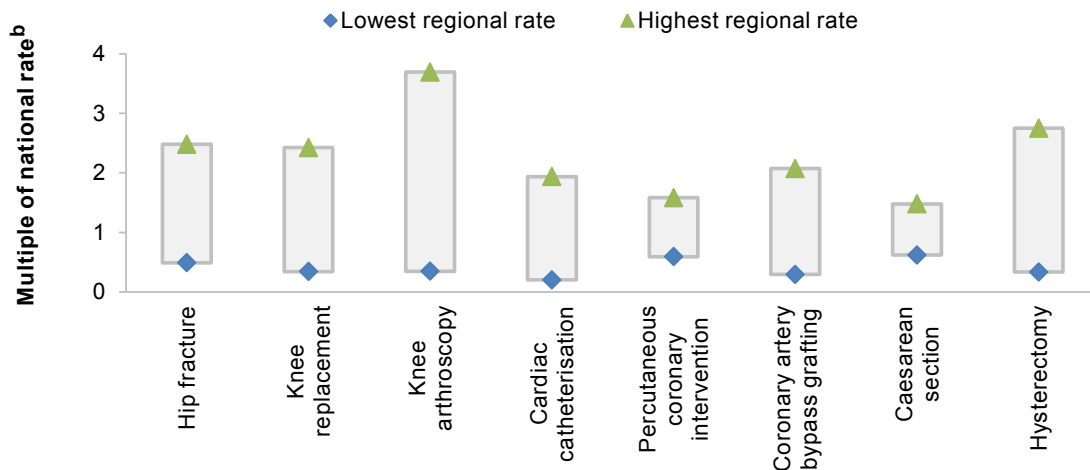
a Per capita admission rates were standardised for age and sex to enable like-for-like comparisons between regions. Regional disaggregation was based on the 61 regions that existed for Medicare Locals in 2010-11. Each patient was assigned to a region based on place of residence rather than the admitting hospital. The caesarean section admission rate is based on the number of events per live birth in a region. **b** National rate for public hospitals.

Source: ACSQHC and AIHW (2014).

Care that is not in accordance with evidence-based practice is only one potential reason for regional variation in services provided by public hospitals. Other possibilities include differences in access to services, disparities in how healthcare is organised, and greater use of private hospitals in some regions (ACSQHC and NHPA 2015; Royal Australian College of General Practitioners, sub. 8).[1] However, Australia's national health quality and data agencies have noted that 'much variation is unwarranted, and is not based on the needs or preferences of patients and populations. This means that some patients are having unnecessary or potentially harmful care, while others are missing out on care that may be helpful' (ACSQHC and AIHW 2014, p. 5).

Where a particular service is provided, quality typically meets the relevant standards but there have been some cases of substandard care, including leading to death (ACSQHC 2015a; Beattie 2005; NSW Government 2016a; Skinner, J 2016). The precise

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1   In the case of knee arthroscopy, private hospitals provided around 80 per cent of services in 2010-11. However, regional variation was also evident for public and private provision combined. The per capita admission rate (standardised for age and sex) ranged from less than two-thirds of the national rate in one region to almost twice the national rate in another area.

level of clinical incidents that harm patients is unclear due to weaknesses in monitoring regimes, including under-reporting (VAGO 2016). The data that are published provide few insights into quality differences between public hospitals.[2] What they do show is that, in 2014-15, almost 7 per cent of public hospital separations (admitted episodes of care) involved the treatment of an adverse event (harm while receiving healthcare). The rate of adverse events was higher for overnight hospitalisations (12 per cent), sub-acute and non-acute care (16 per cent) and emergency admissions (10 per cent). Another indicator is the rate of unplanned readmissions to the same public hospital following surgery. Almost 4 per cent of tonsillectomy and adenoidectomy surgeries were followed by an unplanned readmission within 28 days. The equivalent rate for hysterectomies was 3 per cent and for prostatectomies 2 per cent (AIHW 2016a).

Equity

The provision of public hospital services is founded on the principle of universal access. That is, all people eligible for Medicare are entitled to receive services free of charge.

Actual use of public hospital services is disproportionately by people who reside in disadvantaged areas. In 2014-15, half of all admitted episodes of care in public hospitals were for the lowest 40 per cent of the population on a scale of socioeconomic advantage (this group only comprised one-third of patients in private hospitals) (figure 4.3). One of the reasons for this is that better-resourced consumers sometimes have the option of using a private hospital instead (Doctors Reform Society of Australia, sub. 144). Another factor is that socioeconomically disadvantaged groups can require more services because they experience more ill health and complex or chronic conditions (PC 2009; SA Government, sub. 281).

Available data also suggest that public hospitals provided about 90 per cent of admitted episodes of care for Aboriginal and Torres Strait Islander people in 2014-15, but the accuracy of this number is doubtful due to under-identification of the target group across the public and private sectors (AIHW 2016a).

The role of public hospitals in serving disadvantaged groups indicates that they are largely meeting community expectations about equitable access to healthcare. However, a number of inquiry participants noted a lack of equitable access for people living in regional and remote areas (for example, National Rural Health Alliance, sub. 269; Royal Flying Doctor Service, sub. 174).

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[2] For private hospitals, Medibank Private and the Royal Australasian College of Surgeons (2016a, 2016b, 2016c, 2016d, 2016e) have published a series of reports showing variation in patient outcomes between (unidentified) surgeons.

Figure 4.3   **Share of admitted hospital services by sector and socioeconomic status of patient, 2014-15**
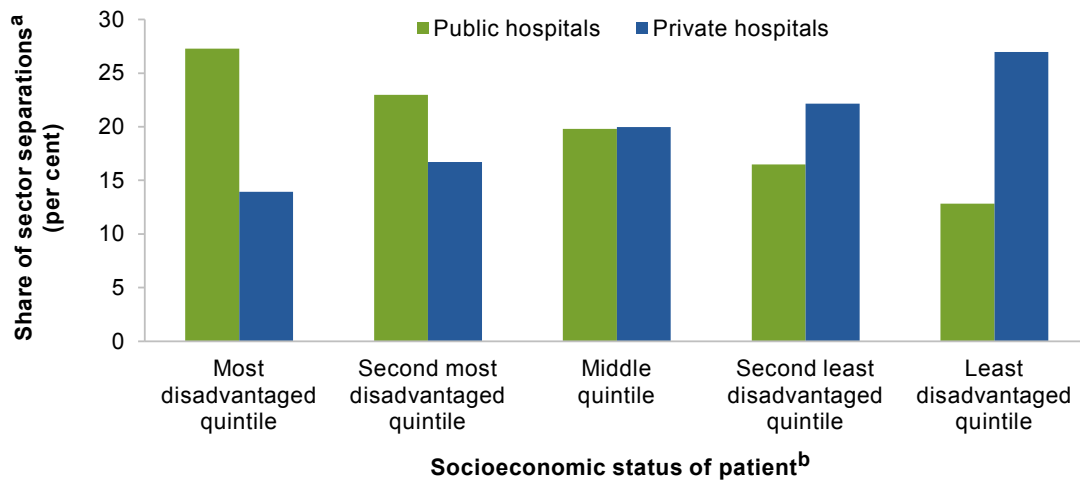
a A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). **b** Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a patient resided. The index summarises population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

Source: AIHW (2016a).

Figure 4.4   **Median waiting time for elective surgery in public hospitals by socioeconomic status of patient, 2014-15**
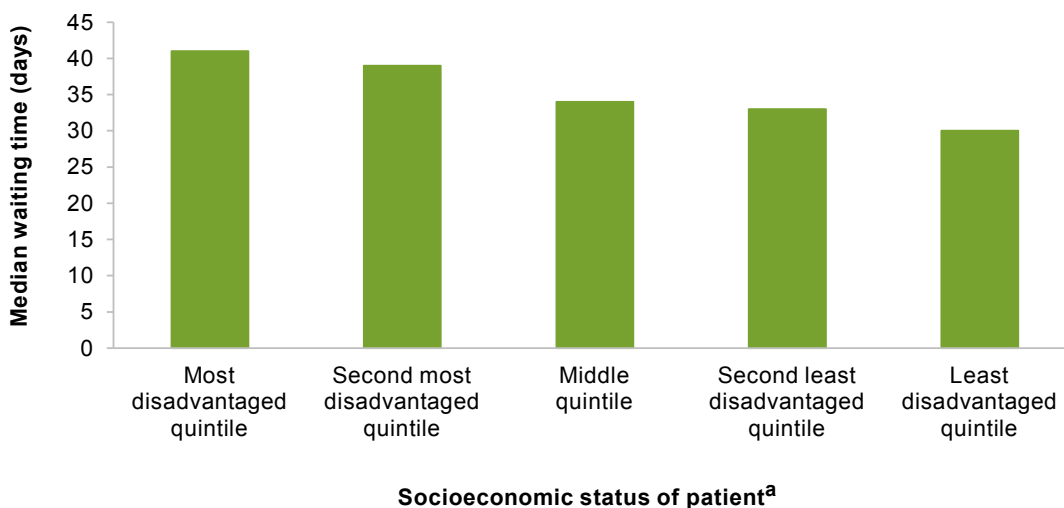
a Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a patient resided. The index summarises population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

Source: AIHW (2016a).

The Australian Nursing and Midwifery Federation (sub. 202) suggested that nurse practitioners in regional and remote areas could be given a greater role in assisting people to receive advice from city-based specialists via telehealth initiatives. Scott, Yong and Mendez (sub. 87) observed that, despite significant growth in the number of specialists in recent years, only 3 per cent of them have decided to locate in outer regional, remote or very remote areas.

A further issue is that people residing in more disadvantaged areas typically experience longer waiting times for elective surgery in public hospitals. In 2014-15, the median waiting time was 41 days for patients in the most disadvantaged quintile (fifth of the population) compared to 30 days for those in the least disadvantaged quintile (figure 4.4).

Efficiency

There are significant differences in the average cost of providing similar services in similar public hospitals, suggesting considerable scope for many hospitals to move closer to best practice on efficiency. In 2013-14, the average cost of acute admitted services at one major metropolitan public hospital ($3100, Frankston Hospital) was almost half that at another ($6100, Canberra Hospital) after controlling for differences in the mix of services they provided. Significant variation was also evident among other types of public hospitals (figure 4.5). Using similar data for 2010-11, Duckett and Breadon (2014) estimated that public hospitals could reduce their annual expenditure by more than $900 million without lowering service quality.

Responsiveness and accountability

The good health outcomes that Australia generally achieves compared to other countries indicates that, from a clinical perspective, public hospitals are typically responsive to the needs of patients. It is harder to discern responsiveness to patient preferences. On the one hand, a national survey of experiences in (public and private) hospitals in 2014-15 showed that around 90 per cent of patients thought that hospital doctors, specialists and nurses listen carefully, show respect and spend enough time with patients (ABS 2015c). On the other hand, public patients are placed on waiting lists for some treatments and they are often given little or no choice over who treats them and where. One of the few exceptions is maternity services.

The accountability of public hospitals to those who fund them has improved in recent years due to various reforms, including more consistent and transparent reporting of funding and patient outcomes under the National Health Reform Agreement. However, more could be done on this front, including public reporting on the service quality of individual hospitals and health professionals, and more transparent criteria and processes for replacing board members and senior management in cases of underperformance (discussed further below).

Figure 4.5   **Average cost of acute admitted services in individual public hospitals by type of facility, 2013-14[a]**
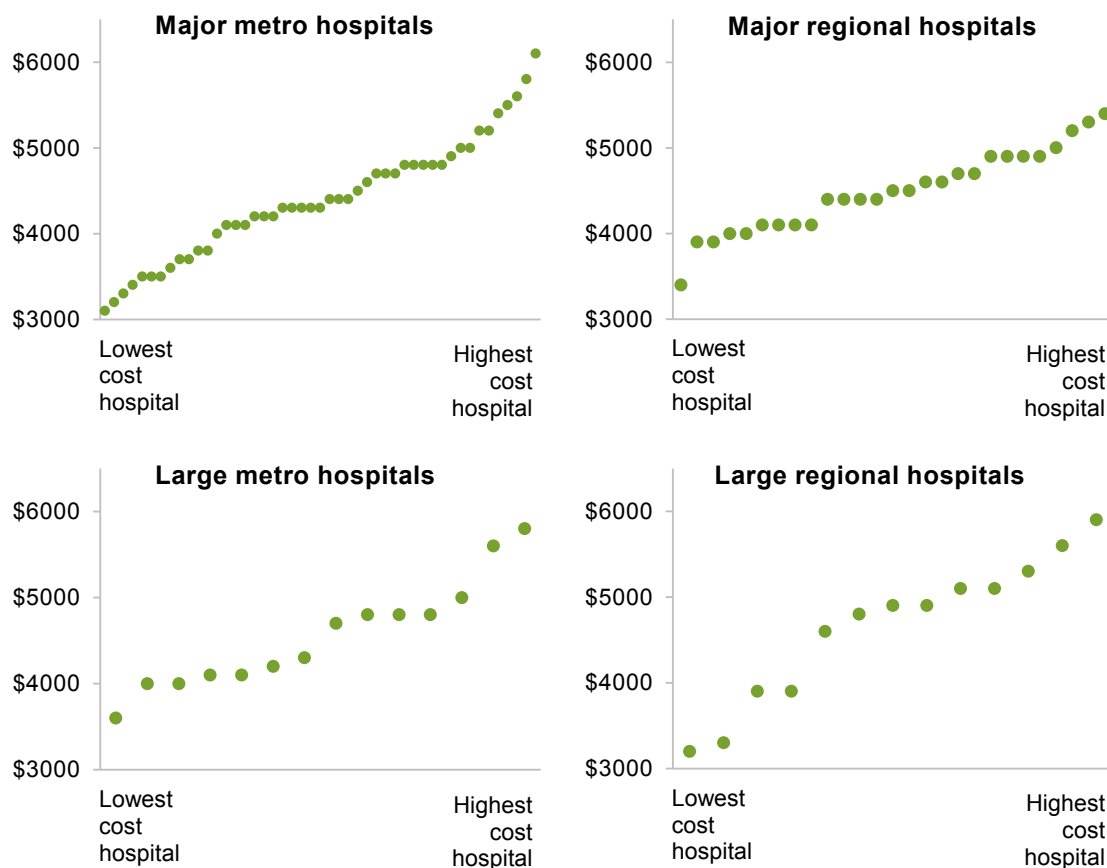
a Each dot in the figure represents an individual public hospital. Average cost is quantified by using a hospital's Cost per National Weighted Activity Unit, which measures the cost of a notional 'average' public hospital service provided to acute admitted patients whose treatment was eligible for activity-based funding. Type of facility is based on the hospital peer groups used by the Australian Institute of Health and Welfare in 2011-12 but with the Principal Referral group divided into major metro and major regional categories in the above figure, based on the 2006 Australian Standard Geographical Classification.

Sources: AIHW (2016c); NHPA (2016).

4.3   Factors influencing the potential benefits of reform

Key factors influencing the benefits from reform are the ability of patients to make informed choices, and the diverse and complex supply characteristics of the sector.

Consumers need information and support

Consumers often face barriers to informed choice because there is imperfect information about providers (hospitals and their doctors) and consumers rarely have medical training

(Australian Healthcare and Hospitals Association, sub. 134; Royal Australian College of General Practitioners, sub. 8; Scott, Yong and Mendez, sub. 87). Moreover, around 40 per cent of public hospital admissions are emergencies. However, overseas experience (detailed below) indicates that, when consumers are able to plan services in advance and access useful information to compare providers, user choice can lead to improved service quality and efficiency.

In 2014-15, Australia's public hospitals provided more than 3.2 million episodes of admitted care that were not emergencies. Many of these would have been repeated dialysis for individuals with kidney disease, which was by far the most common reason for being admitted to a public hospital (1.1 million separations and almost always as a same-day procedure). Around a quarter of non-emergency separations involved surgery. Among the most common planned (elective) surgical procedures in public hospitals were cataract surgery, removal of skin cancers, removal of tonsils or adenoids, and knee replacements. Overall, public hospitals accounted for about one-third of elective surgical admissions in Australia but almost 50 per cent for patients in the most disadvantaged quintile (figure 4.6). Thus, greater choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

Figure 4.6   Elective surgery by sector and socioeconomic status of patient, 2014-15
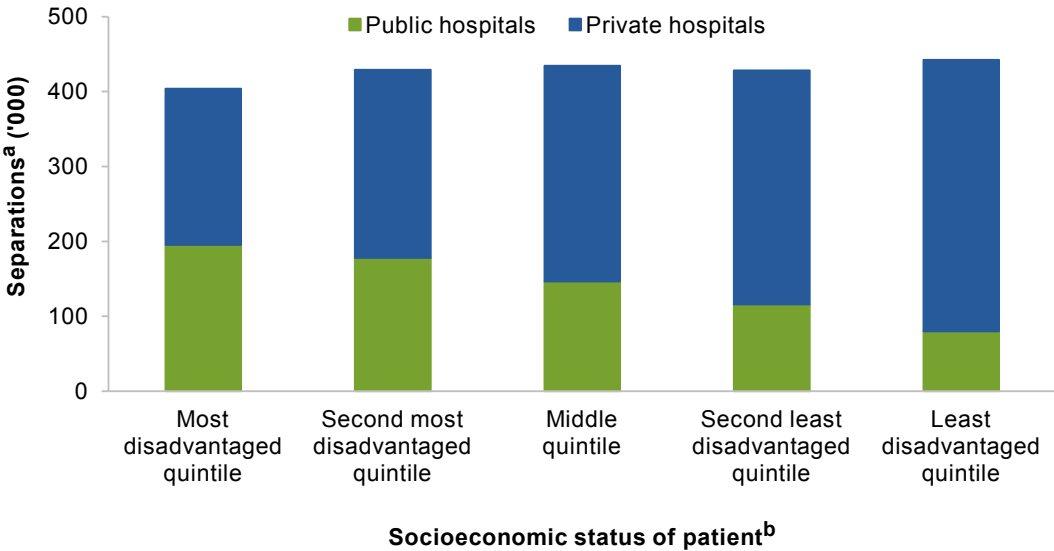
^{a} A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). ^{b} Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a patient resided. The index summarises population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

Source: AIHW (2016a).

Under current arrangements, public patients are often given little choice over their provider and limited information to compare alternatives. There is a website (MyHospitals) to compare individual hospitals but many of the indicators concern waiting times. There is almost no information on the outcomes from specific treatments, apart from average length of stay in hospital for a few conditions. There is also an official website (managed by the Australian Health Practitioner Regulation Agency) to compare individual healthcare professionals but it only provides their registration details. Some health insurers participate in an information initiative for private patients called 'Whitecoat' but it also has limitations, such as partial regional coverage and a focus on professions other than doctors.

If public patients were given greater opportunity and information to make choices, low levels of health literacy may mean that many of them would be unwilling or unable to make choices independently. Australian Unity (sub. 94) noted that more choice will not improve outcomes unless consumers understand the range of services available and the differences between those options. Catholic Health Australia (sub. 236) observed that cultural and socioeconomic factors can be important in this regard.

Various methods have been used to measure the health literacy of Australians and they have generated different results (Barber et al. 2009). Australia's national health quality agency has estimated that almost 60 per cent of adults have a low level of skills, knowledge, motivation and capacity to access, understand, appraise and apply information to make effective decisions about their health and take appropriate action (ACSQHC 2014). The level of health literacy may be even lower among the disadvantaged groups that public hospitals largely serve.

Providing greater choice at the point where individuals are referred to a specialist by their general practitioner (GP) might be one way of supporting choice for people with low levels of health literacy. This would allow GPs to continue to support consumers in making decisions, with both parties being better informed than currently if choice was accompanied by better information provision. Better information provision could also be beneficial more broadly for health professionals by highlighting which types of treatment are the most effective.

The Australian Healthcare and Hospitals Association supported such an approach.

> While medical practitioners should support patients in making an informed choice about which specialist to attend, consideration should be given to patients being provided with referrals directing them to a type of specialist, to ensure it is clear they are aware of their right to choice, and that there is sufficient information to support informed patient choice. (sub. 134, p. 12)

St Vincent's Health Australia (sub. 207) also favoured greater provision of information to patients to support their choices and noted that this should include performance information for both hospitals and physicians.

Providing choice at the referral stage is broadly the model that has existed in England (although not the rest of the United Kingdom) since 2006. Quantitative studies have found that this reform was followed by improved patient outcomes. Other overseas examples of

choice combined with useful information provision also indicate that it can be beneficial (box 4.1).

Box 4.1   **Overseas examples of choice and information provision**

In England, patients referred to a specialist by their GP have a legal right to choose the hospital or clinic and consultant-led team they attend, a useful website to compare alternatives, an online booking service when they have chosen, and a strong consumer advocate to make sure their voice is heard. Quantitative studies have found that following these reforms:

- consumers sought out better-performing providers — hospitals with lower pre-reform mortality rates and waiting times had a greater increase in elective patients post-reform than those with higher mortality rates and waiting times. Among people seeking a coronary artery bypass graft, choices made by sicker patients were more sensitive to reported mortality rates

- hospitals in more competitive locations improved service quality the most — death rates for patients admitted after a heart attack fell the most in hospitals that had more nearby competitors. Hospitals located in more competitive areas also had larger declines in mortality from other causes and lower lengths of stay for elective surgery.

This is in contrast to UK pro-competitive reforms in the 1990s, which did not include public reporting of service quality. As a result, hospitals facing competition focused on reducing publicly reported waiting times at the expense of unreported quality. Moreover, they had scope to trade off unreported quality for observable price reductions.

Studies of other countries have also found benefits following the public release of information on service quality.

- In Sweden, service quality scores for cardiac patients (measuring adherence with clinical guidelines) increased significantly after the scores began to be publicly reported for individual hospitals. Improvements were greatest for hospitals that previously had below-average scores. Separate reporting on hip replacements was followed by a decline in the share of patients requiring an artificial hip repair or replacement to among the lowest rates in the world.

- In the United States, around 90 per cent of hospitals responding to a survey about the Hospital Compare website stated that the reported indicators (including measures of mortality, readmissions and patient experience) were included in their hospital's annual goals, reported outcomes were regularly reviewed by the hospital's clinicians and management, and had stimulated quality improvement.

Campanella et al. (2016) undertook a meta-analysis of 27 studies that investigated the relationship between public reporting and clinical outcomes, mostly in Canada and the United States. They found that the studies supported the view that public reporting can stimulate providers to improve service quality.

Sources: AIHW (2016e, 2016f); Bevan and Skellern (2011); Bloom et al. (2015a, 2015b); BUPA (sub. 258); Campanella et al. (2016); Cooper et al. (2011); Gaynor, Moreno-Serra and Propper (2012, 2013); Gaynor, Propper and Seiler (2102); Larsson et al. (2012); Lindenauer et al. (2014); NHS (2014); Propper (2013); Propper and Dixon (2011); Propper, Burgess and Green (2004); St Vincent's Health Australia (sub. 207); UK Department of Health (2016).

Scott, Yong and Mendez (sub. 87, p. 2) noted that at 'the core of achieving the desirable outcomes of competition and choice in healthcare is improved information' and that when a GP decides to refer a patient, they should be able to inform their patients of the relative waiting times, fees, and quality of care of available alternatives. Scott, Yong and Mendez suggested that current GP referral behaviour may be dominated by referral networks and preferred specialists, rather than factors important to patients, and this could limit competition between specialists. The English approach of allowing patients to independently choose a specialist-led team if they want to could partially address this.

Scott, Yong and Mendez (sub. 87) also observed that more research is required on the effects of competition in hospital services. They warned that it will not necessarily lead to better patient outcomes because most of the assumptions of economic theory that are necessary for competition to work do not hold in the case of healthcare. The available evidence, mostly from the United Kingdom and United States, shows mixed results from competition (for example, the differing outcomes noted in box 4.1 under UK reforms in the 1990s compared to current arrangements in England). Mixed evidence was also found in one of the few Australian studies — of cardiac patients in Victoria in the early 2000s — which showed that greater competition was associated with lower unplanned readmissions but also a slight increase in mortality (Palangkaraya and Yong 2013). The mixed findings in the empirical literature indicate that good market design, including information provision and government oversight, is critical to achieving benefits.

Diverse and complex supply characteristics

Australia had 698 public hospitals in 2014-15 and there was considerable diversity across them in terms of location, available services and size (table 4.1). Efforts to increase choice in planned services and contestability more broadly will need to take account of this diversity and the sector's complex supply characteristics, which are summarised in box 4.2.

State and territory governments have primary responsibility for public hospital services and the Australian Government provides around 40 per cent of the funding. Most services are delivered by hospitals that are owned by the states and territories and managed as part of a local health network. Funding arrangements with the Commonwealth require each local health network to have a (published) service agreement with its state or territory government specifying the number and broad mix of services to be provided, service standards to be met, and how the network will be paid. These agreements are renegotiated at regular intervals (usually annually).

Distinct service units, negotiated service agreements and explicit performance indicators are features that Sturgess (2015) has identified as being key elements of a contestable system for human services, irrespective of whether the provider is a government or non-government body. Another element Sturgess has identified is that senior management would ultimately be replaced in cases of underperformance. He observed that, where senior management is replaced, it is usually desirable for staff to continue to deliver services to avoid significantly disrupting provision. Current arrangements for replacing the senior

management of public hospital services — particularly the level of underperformance that would trigger replacement and the associated process — could be more transparent.

| Table 4.1 | Public hospitals by type, location, services and size, 2014-15 |

	Location				Available services				Size	
Hospital type[a]	Major cities	Regional	Remote	Total	Emergency department	Outpatient clinic	Elective surgery	Intensive care unit	Average beds	Average separations
	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.
Principal referral	27	3	0	30	30	30	30	30	650	70 988
Women's and children's	12	0	0	12	9	12	10	10	211	22 639
Public acute group A	33	28	1	62	60	62	57	48	267	32 175
Public acute group B	24	20	1	45	45	45	43	9	138	16 980
Public acute group C	11	114	18	143	55	141	86	2	40	3 595
Public acute group D	4	134	52	190	59	169	9	0	17	594
Very small	0	84	38	122	24	88	0	0	8	90
Psychiatric	16	4	0	20	0	5	0	1	103	599
Subacute and non-acute	28	11	0	39	0	32	0	0	65	1 532
Outpatient	0	4	4	8	5	7	0	0	1	31
Other	23	4	0	27	1	16	5	1	34	4 063
All public hospitals	178	406	114	698	288	607	240	101	86	8 567

a The definition for each hospital type is detailed in the publication *Australian Hospital Peer Groups* published by the Australian Institute of Health and Welfare (AIHW 2015b).

Source: AIHW (2016b).

Box 4.2 Public hospital supply characteristics

Public hospitals and the services they provide are very heterogeneous, with many sub-markets. There can be sizeable economies of scale and scope due to the fixed cost of buildings and equipment, and the variety of services a patient may need as part of their care. Moreover, service quality can improve when demand for a given treatment is satisfied by a smaller number of providers because they are able to practise the treatment more regularly.

A further issue is that it is not in the community's interest for public hospitals to operate in isolation from the rest of the health system. A current priority for governments is to reduce demand for (avoidable) hospital admissions by encouraging more timely and effective primary care by GPs and allied health professionals. Coordination across hospitals and primary care is also seen as critical to good patient outcomes and efficiency. That is why public hospitals are often managed as part of a local health network that includes a community health service.

(continued next page)

There are complex links between public hospital services and those provided to private patients and by private hospitals. Governments often require their public hospitals to raise a certain amount of revenue from private patients, which sometimes leads to public and private hospitals competing to offer substitutable services. On the other hand, public and private hospitals complement each other to some extent by specialising in the provision of different services and treating different patient populations. In some cases, public and private hospitals are co-located, share resources and coordinate services through contracted care arrangements. Visiting medical officers (specialists) may provide services in both hospitals and for both public and private patients. A further complexity is that there are two distinct types of private hospital operators (for-profit and not-for-profit providers).

The Commission would welcome evidence on whether governments use the regular renegotiation of service agreements as an opportunity to consider commissioning alternatives to existing public sector providers. Such commissioning could be for an individual service, subset of services or an entire major hospital providing a wide range of healthcare. For most public hospitals, there does not appear to be a formal selection process and providers rarely change.

Not-for-profit bodies already manage some major public hospitals and so may have potential to provide a credible threat to underperforming government operators (and vice-versa). Examples include St Vincent's Hospital (Sydney); Mercy Hospital for Women (Melbourne); Mater Adult, Children's and Mother's Hospitals (Brisbane); St John of God Midland Public Hospital (Perth); and Calvary Public Hospital (Canberra).

Commissioning for-profit operators to manage entire public hospitals is rare, following a series of failed attempts in the 1990s (ACTU, sub. 100; Duckett 2013; NSW Nurses and Midwives' Association, sub. 247). Governments found it difficult to transfer risk and sufficiently codify public hospital service requirements in a contract that prevented gaming by operators motivated by profits. This may be less of a problem now because there are better frameworks for measuring outputs and quality. Nevertheless, a large number of submissions to this inquiry indicated that many in the community continue to be concerned about for-profit operators providing public hospital services (for example, Health Care Consumers Association, sub. 239). Moreover, the Royal Australian College of General Practitioners (sub. 8) cautioned that competitive commissioning of services is labour intensive and costly.

The NSW Government (sub. 122) is currently trialling an approach where for-profit involvement in operating a (yet to be completed) public hospital at Frenchs Forest in Sydney was sought as part of infrastructure development. This particular model is only applicable in cases of major infrastructure improvement but it provides an interesting case study of what may be possible. More generally, for-profit providers have for many years been supplying individual services to public hospitals that do not have in-house capacity.

St Vincent's Health Australia recommended that the states and territories commission a portion of their 'routine' hospital services from non-government providers. It noted that:

> … orthopaedic and most heart surgeries can be delivered cheaper in the private setting. These are areas of strong growth into the future. Shifting the delivery of a proportion of these services to the private sector should free up resources in the public system to meet rising demand for more complex services. (sub. 207, p. 4)

A shift to more contestable approaches will need to take account of reforms that the Independent Hospital Pricing Authority and others are developing for the payment models used in public-hospital service agreements. This includes a system that pays hospitals less when poor service quality leads to avoidable readmissions (COAG 2016b). Another is bundled payments across different episodes of care for the same patient, which would allow more flexibility over provided services (IHPA 2015). Australian Unity (sub. 94) supported a shift in funding incentives from activity to patient outcomes.

4.4   The potential costs of reform

There would be costs associated with increasing choice for public patients, including the following.

- Information provision — overseas experience shows that it is possible to provide user-oriented information to facilitate informed choice. In Australia, COAG endorsed plans almost five years ago for the reporting framework underpinning the MyHospitals website to include public reporting of patient outcomes — such as mortality rates and unplanned readmissions for specific conditions — at the level of individual hospitals (but it specifically ruled out reporting on individual clinicians) (AIHW 2016j; NHPA 2012). Further work would be required by the Australian, state and territory governments to achieve this, including gaining the acceptance of healthcare providers and professionals. Catholic Health Australia (sub. 236) considered that the MyHospitals website could be progressively augmented to provide more information to consumers on the performance of hospitals and clinicians.

- Demand management — given the lack of a price signal for public hospital services, governments typically set targets for the volume of services that each local health network delivers, with any excess demand managed through measures such as waiting lists and encouraging people to be private patients. Greater user choice is likely to require governments to fine-tune their approaches to managing demand. In particular, the distribution of a given service volume across different health networks, hospitals and doctors may need to be more responsive to patient preferences.

- Interaction between public and private services — one of the key selling points for being a private patient is that they can choose their specialist. Reducing this advantage compared to public patients would have implications for public and private hospitals because they both earn revenue from private patients. In 2013-14, private patients accounted for 15 per cent of acute admitted separations in public hospitals at a national

level, but the share in individual hospitals was sometimes much lower or higher than this (figure 4.7). If increased user choice for public patients resulted in fewer people choosing to be a private patient, it would directly increase state and territory government health expenditure. Private health insurers would also be affected. On the other hand, government initiatives to improve information provision for public patients could have spin-off benefits for private patients, who also currently face information barriers to informed choice (BUPA, sub. 258; Catholic Health Australia, sub. 236; Doctors Reform Society of Australia, sub. 144; Scott, Yong and Mendez, sub. 87).

Figure 4.7   **Share of acute admitted services provided to private patients in individual public hospitals by type of facility, 2013-14[a]**
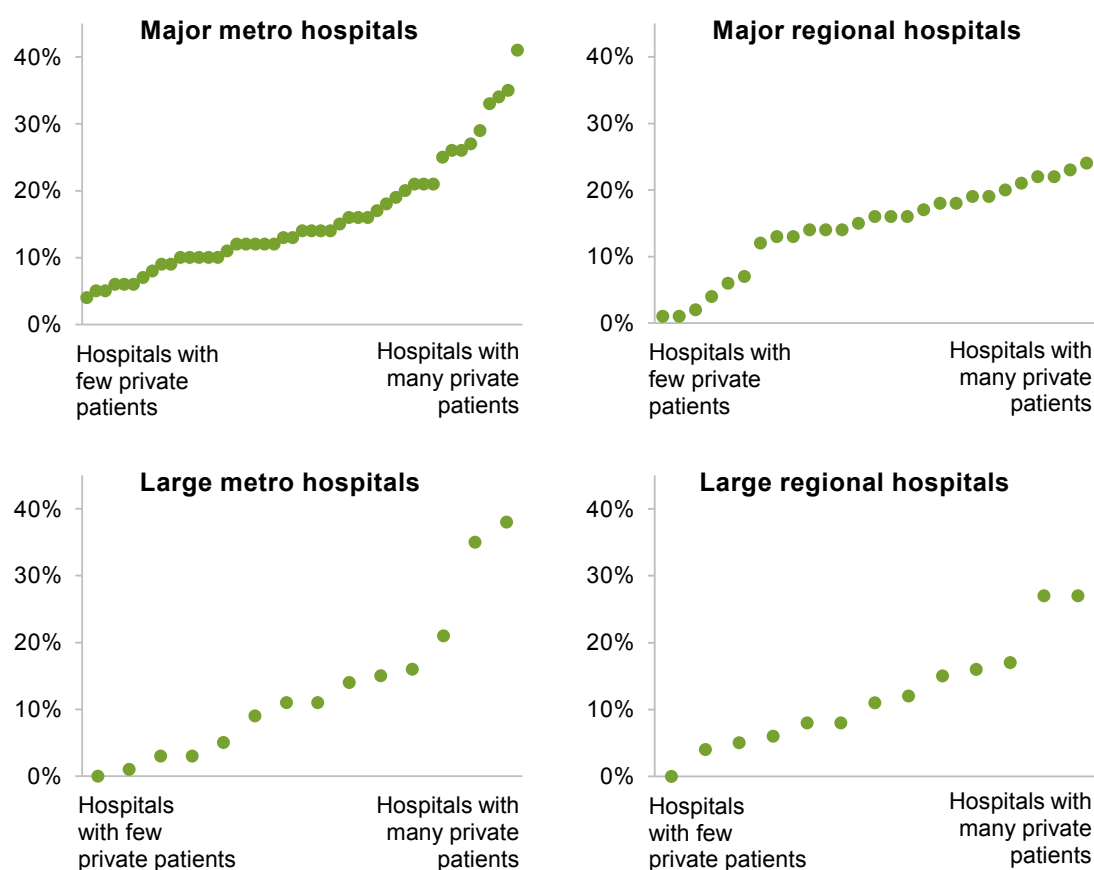
[a] Each dot in the figure represents an individual public hospital. The share of private patients in each hospital was calculated by dividing the number of private and self-funded patient separations by total acute admitted separations. A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Type of facility is based on the hospital peer groups used by the Australian Institute of Health and Welfare in 2011-12 but with the Principal Referral group divided into major metro and major regional categories in the above figure, based on the 2006 Australian Standard Geographical Classification.

Sources: AIHW (2016c); NHPA (2016).

Greater contestability raises further issues, such as the following.

- How to create a credible threat of competition — there is a history of governments bailing out underperforming hospitals due to a fear of significant disruption to an essential service that may have few local alternatives, especially in regional areas.[3] Workforce issues pose particular challenges to changing providers, particularly if public sector hospital employees have to transition to private employment or vice-versa. The relationships that a hospital builds with local specialists could also be a barrier to new providers entering the market. For government-operated hospitals, it may be more feasible to implement contestability as a more transparent mechanism to replace the management team (or board of the local health network), rather than switch to a non-government provider. As noted above, current arrangements could be more transparent in this regard.

- Alignment of provider incentives with broader community goals — current governance arrangements facilitate coordination between public hospitals and the rest of the health system, including to reduce demand for (avoidable) hospital admissions by encouraging more timely and effective primary care from GPs and allied health professionals. More contestable commissioning of public hospitals would need to be implemented in a way that ensures public hospitals operate in concert with the rest of the health system.

PRELIMINARY FINDING 4.1

Introducing greater user choice and contestability in public hospital services could, as part of a wider range of reforms, lead to better outcomes for patients.

- Australian hospitals generally perform well against those in other countries. There is still scope for many to improve outcomes for patients, and to lower costs, by matching the practices of better-performing hospitals within Australia.

- Greater user choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

- Other countries have shown that user choice can benefit patients when they have access to useful consumer-oriented information on services and referring practitioners support them in making decisions.

- There is an opportunity for state and territory governments to test more contestable approaches to commissioning services when they regularly renegotiate service agreements with local health networks. More transparent arrangements for replacing senior management of government-operated hospitals (or local health network boards) in cases of underperformance could also increase contestability. This would not require switching to a non-government provider.

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3 For example, five NSW local health districts received cash assistance in 2014-15 to pay their bills on time (AONSW 2015b). In Victoria, the Department of Health and Human Services issued letters of support to 31 public hospitals to enable their boards to attest in their June 2015 financial statements that they could operate as a going concern (VAGO 2015).

5   Specialist palliative care

5.1   Defining specialist palliative care

Broadly defined, palliative care refers to any medical care that focuses on relieving the symptoms of a life-limiting illness rather than treating the underlying causes of that illness.[1] Palliative care is not just about treating physical symptoms, but also providing emotional and spiritual comfort to patients, caregivers and family members during a difficult and stressful time. Palliative care is not only provided in the last stages of life. For many people with a serious life-limiting illness, palliative care may be beneficial from the time of diagnosis to assist with symptom management even while curative treatment is ongoing (PCA 2016b).

The palliative care needs of most patients can be met by general practitioners, generalist community nurses, aged care workers and allied health providers. Some patients, however, have physical, social, emotional or spiritual needs that exceed the capabilities of primary care providers and require the services of specialist care providers (PCA 2005). These specialist providers are the focus of this chapter.

Specialist palliative care providers are multidisciplinary teams that provide assessment, consultancy and management of palliative care needs. A specialist palliative care team may include doctors, nurses, social workers, counsellors, chaplains, pharmacists, physiotherapists and other allied health workers and volunteers (AIHW 2016k).

A key distinction in specialist palliative services is between inpatient and community-based care. Inpatient care is provided to patients admitted to a hospital (often within a dedicated palliative care ward) or a standalone palliative care service (often called a hospice). Community-based care is provided in the home and residential aged care facilities. Services can include advice and coordination of care, nursing and personal care, 24-hour hotlines, day hospice respite, emotional and practical support from volunteers, and access to equipment (LSIC 2016). In 2015, more than 40 000 patients across Australia accessed specialist palliative care services (PCOC 2016a).

The use of inpatient specialist palliative care services has grown strongly in recent years (similar data are not available for community-based care). Over the past decade, the number of palliative care related hospitalisations has grown by 4.4 per cent per year. This

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[1]   The focus of palliative care is on providing support to people with life-limiting illnesses, not to hasten or postpone death. Assisted suicide and euthanasia are not considered part of palliative care and are not examined as part of this inquiry.

is more than twice the rate of growth for all hospitalisations and three times the rate of growth of deaths in the general population (ABS 2015; AIHW 2014b, 2016a).

5.2   Scope to improve outcomes

The Australian Government, and most state and territory governments, have strategic plans or frameworks in place for palliative care that recognise the growth in demand and the need to expand and improve the provision of these services to the community. Recent years have seen improvements in some indicators of patient outcomes (PCOC 2016e) and Australia's palliative care services are well-regarded internationally, with a 2015 study ranking Australia second out of 80 countries in terms of the quality, availability and affordability of palliative care (EIU 2015). Even though, as a whole, Australia performs well internationally, there is considerable variation in the quality of care, and access to care, across different jurisdictions. This variation suggests that outcomes could be improved for users of palliative care, and for those seeking access to high-quality services that may be missing out.

Quality

There is considerable room for improvement in service quality, particularly in community settings. Data collected by the Palliative Care Outcomes Collaboration (PCOC) (box 5.1) indicate that services provided in community settings generally perform less well against patient outcome measures than inpatient services. For example, Western Australia aside, patient outcomes related to the management of pain and distress are consistently lower in community settings than in inpatient settings (figure 5.1).

Box 5.1   The Palliative Care Outcomes Collaboration

Established in 2005, the Palliative Care Outcomes Collaboration (PCOC) is a national program that uses standardised clinical assessment tools to measure and benchmark outcomes for palliative care patients in both inpatient and community settings. Funded by the Australian Government, PCOC is managed by a partnership of four universities led by the University of Wollongong's Australian Health Services Research Institute.

Service providers contribute data to PCOC on patient demographics and episodes of care. These data are used to benchmark services with regard to time spent waiting for care, time spent in an unstable phase, changes in pain levels and changes in patient symptoms. Service providers participate in PCOC on a voluntary basis, and not all contribute data. Since reporting began in 2006, the number of participating providers has increased from 8 to 102.

Source: PCOC (2016a).

In community settings, patient outcomes also vary substantially across jurisdictions. In Western Australia, 73 per cent of patients in community settings that began a phase of care

with moderate or severe pain ended that phase of care with no pain or mild pain. In Victoria, the equivalent figure was 44 per cent, and in Queensland, just 37 per cent. Considerable variation also exists with regard to the management of other symptoms such as nausea, breathing problems and bowel problems (PCOC 2016b, 2016c, 2016d, 2016f, 2016g).

Figure 5.1   **Community-based services underperform inpatient services[a]**
Performance against pain management outcome measures by service setting and jurisdiction, July to December 2015
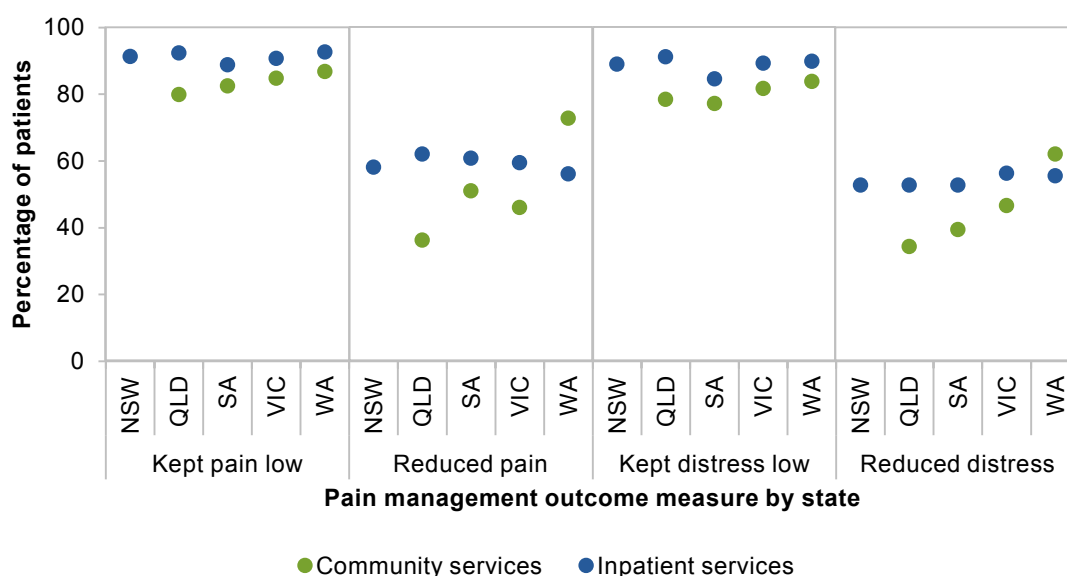
a Based on data reported by providers participating in PCOC against outcome benchmarks 3.1 to 3.4. New South Wales data include ACT. New South Wales community services are not shown because few providers participate. Data are unavailable for Tasmania and the Northern Territory.

Sources: PCOC (2016b, 2016c, 2016d, 2016f, 2016g).

Equity

National and state reviews of palliative care have repeatedly raised equity concerns. These include differences in the range and quality of services available across jurisdictions, variability in access to services between urban and non-urban areas, and under-servicing of Indigenous Australians, people from culturally and linguistically diverse backgrounds, and people with disabilities (HCSC 2013; LSIC 2016; NSW ACI 2014; SCARC 2012).

Inequity in the provision of services is also apparent in the extent to which people with diagnoses other than cancer use specialist palliative care services. People with a life-limiting illness other than cancer have many of the same palliative care needs as those with cancer (Moens et al. 2014), yet non-cancer patients are commonly under-represented among specialist palliative care users (Currow et al. 2008; LSIC 2016). Variation across

states and territories indicates there is room for improvement. The share of palliative care patients with a non-cancer diagnosis is much higher in some jurisdictions than in others (figure 5.2), even though rates of death from cancer, and those from chronic illnesses other than cancer, are fairly consistent across jurisdictions.

Figure 5.2   **Percentage of specialist palliative care patients with a diagnosis other than cancer[a]**
By jurisdiction, July to December 2015

a Based on data reported by providers participating in PCOC. Data are unavailable for Tasmania and the Northern Territory.
Sources: PCOC (2016b, 2016c, 2016d, 2016f, 2016g).

Efficiency

While there have been many reviews of palliative care in Australia, little emphasis has been placed on improving efficiency. As with many other types of healthcare, evaluating the efficiency of specialist palliative service providers is challenging because the outputs are difficult to define and measure, and there is a lack of data.

Near the end of life, the use of community-based care instead of inpatient care is often portrayed as less costly. However, further research is required to identify the magnitude of any cost savings. Swerissen and Duckett (2014) estimated that increased expenditure on community-based palliative care near the end of life would be almost entirely offset by decreased expenditure in hospitals and residential aged care facilities. Analysis by the Silver Chain Group (sub. 176) found that each dollar invested in extending home-based

palliative care services in New South Wales would free up $1.44 of expenditure on inpatient bed capacity at metropolitan hospitals.

Providing earlier access to palliative care may improve efficiency by reducing the frequency of hospital treatments near the end of life that are of little benefit to patients, but the evidence for this is limited (Harris and Murray 2013).

Responsiveness

An important measure of the responsiveness of palliative care services is how well patient preferences are satisfied. On this topic, two issues are often raised — unsatisfied preferences with regard to the setting of care, and the availability and the timing of care.

Preferences for the setting of care

With regard to preferences for the setting of care, much has been made of the discrepancy between where people say they would prefer to die and where people actually die. A 2014 survey by Palliative Care Australia (2014a) found that 68 per cent of Australians would prefer to die at home, but the latest data indicate that only about 22 per cent of those receiving specialist palliative care actually do (PCOC 2016a). Instead, most die in hospitals (70 per cent) with the remainder dying in residential aged care facilities (7 per cent).

There are reasons to be cautious in interpreting these data. Surveys of the general population about preferred place of death may not accurately reflect the preferences of specialist palliative care patients, and data on actual place of death are not available from all specialist palliative care providers. Further, research suggests that preferences for place of care and place of death are not always the same and can change over time, with more patients preferring to die in hospices or hospitals as death approaches (Agar et al. 2008). Patients often value receiving care in a familiar setting and appreciate the privacy and autonomy that home care allows (Wenk 2015), but care at home can also place a greater physical and emotional toll on family and friends as caregivers. This is particularly the case when patient needs become more complex as death approaches. The desire of patients to relieve the burden on caregivers is a commonly cited reason for preferring to receive care in a setting other than home (Woodman, Baillie and Sivell 2015).

For patients, relatives and physicians, factors such as freedom from pain, mental awareness and satisfying treatment choices may also take precedence over preferences for setting of care (Steinhauser KE et al. 2000). In some cases, external factors may also make palliative care at home impractical. For example, some people in need of specialist palliative care may not have family or friends that are able to act as caregivers at home.

The choice between inpatient and community care is not always an 'either/or' proposition. Across jurisdictions, the level of specialist palliative care offered differs by provider, with the most specialised services often concentrated in hospitals and other inpatient facilities.

For example, a patient may access hospital care when an unexpected problem emerges or when an existing problem becomes more severe, but return home and rely on specialist community care (or primary care) when their condition stabilises. Victorian data indicate that about 22 per cent of all patients accessed a combination of specialist inpatient and community services before death between 2013 and 2015 (PCOC, pers. comm., 1 September 2016).

While keeping in mind the above caveats, there does seem to be scope to improve responsiveness with regard to patient preferences for setting of care. A 2015 survey found that not being able to die in one's place of choice was the most common concern about care expressed by Australians who had recently experienced someone close to them die from a long-term illness (PCA 2015). The best available data indicate that, for specialist palliative care patients, rates of both care and death at home are much higher in some states and territories than others (figure 5.3).

Figure 5.3   **Place of care and place of death by jurisdiction[a]**
Specialist palliative care patients, July to December 2015
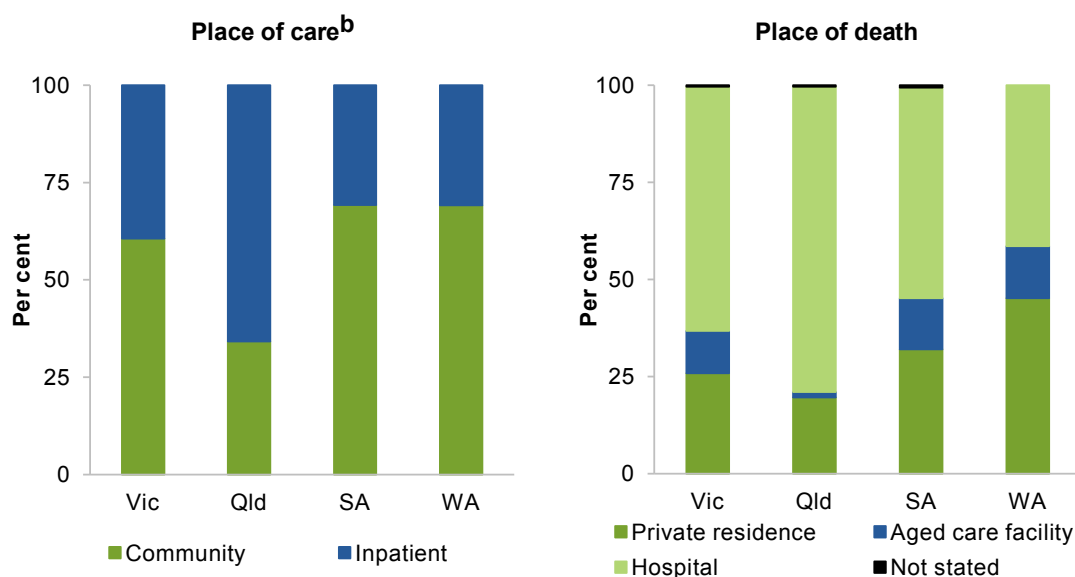
a Based on data reported by providers participating in PCOC. Data are unavailable for Tasmania and the Northern Territory. Data for New South Wales and the ACT are excluded because few community-based providers participate in PCOC. **b** Patient episodes by service setting.

Sources: PCOC (2016b, 2016c, 2016d, 2016f, 2016g).

Preferences for the timing and availability of care

The responsiveness of palliative care could also be improved by placing greater emphasis on user preferences with regard to when and how people access palliative care. Surveys indicate that most older people oppose medical interventions that prolong life in poor health and would prefer end of life care focused on maximising comfort (Corke 2015;

Nahm and Resnick 2001). However, referrals to palliative care sometimes take place later than would be ideal and patients can be subject to unhelpful tests and treatments in acute hospital settings. Untimely referrals can limit possibilities for care at home and for patients to express their values and goals for palliative care (Philip and Collins 2015).

Untimely referrals occur for a range of reasons. Sometimes patients and caregivers are resistant to referral or the characteristics of a patient's illness may make it difficult to determine the optimal timing of referral. In other cases, however, medical specialists lack 'the knowledge, experience, or inclination to give due consideration to referral to palliative care' and may fail to consider palliative care as complementary to continued curative treatment (Broom et al. 2012, p. 1250). Patients close to death may also receive treatments with limited benefits because doctors in emergency situations lack access to information on patient preferences (Willmott et al. 2016).

Accountability

There is significant scope to improve the public accountability of palliative care services. Of particular note is the lack of comprehensive publicly available national data on even the most basic elements of community-based specialist palliative care, such as the total number of patients and total government expenditure in each state and territory.

PCOC has made a valuable contribution to measuring the quality and responsiveness of service provision. However, data are provided to PCOC on a voluntary basis and significant gaps remain. For example, little information is publicly available on carer experience or satisfaction with palliative care services. In fact, many state and territory governments do not seem to routinely or systematically collect these data.

Further, many state and territory governments do not collect the data necessary to follow patients through different episodes and levels of care across inpatient and community settings. This creates challenges for coordinating services, determining costs of care, appropriately allocating funding and evaluating measures designed to improve service provision (Bartel 2016; PCA 2005).

5.3 Factors influencing the potential benefits of reform

While the scope to improve palliative care services is clear, the extent to which introducing greater competition, contestability and user choice can facilitate this depends on the characteristics of palliative care recipients and providers, and the nature of palliative care transactions.

Characteristics of users and transactions

One important consideration is the trajectory of a patient's illness (figure 5.4). Many patients, particularly those with a primary diagnosis of cancer, tend to have predictable illness trajectories and full cognitive and communicative capacity until close to death. For many other patients, the trajectory of the illness can be less predictable and may involve progressive deterioration in cognitive and physical capacity over a prolonged period of time (Lynn and Adamson 2003). For patients in the latter group, the ability to plan for, and directly express preferences for care is reduced.

Figure 5.4   **Stylised illness trajectories[a]**
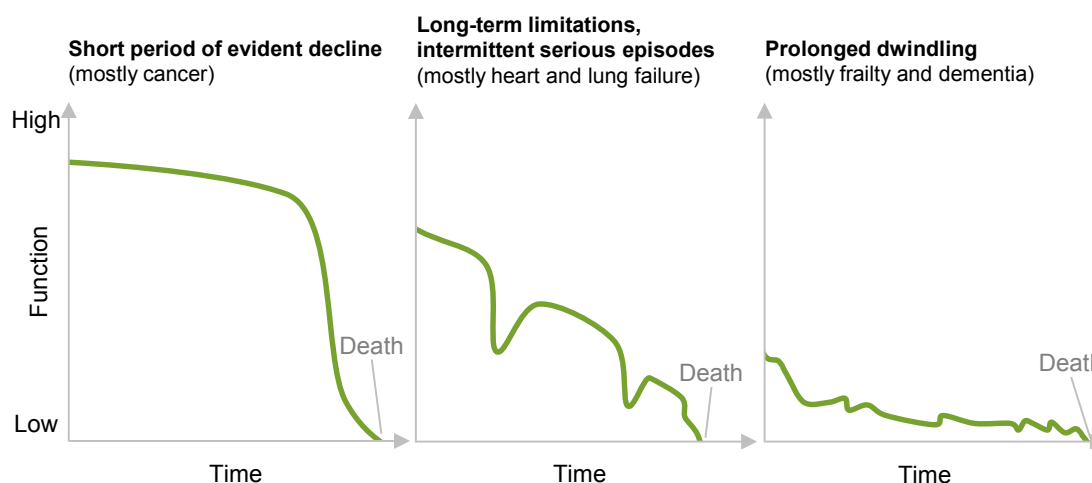
a 'Function' refers to the ability of a patient to function physically and mentally.

Source: Based on Lynn and Adamson (2003).

At present, about three quarters of patients accessing specialist palliative care services have a primary diagnosis of cancer. However, hospital inpatient data indicate that the proportion of palliative care patients with a primary diagnosis other than cancer has increased over time (AIHW 2011). The remaining quarter of patients with a non-cancer diagnosis have a variety of primary diagnoses of which the most common include cardiovascular disease (4 per cent), respiratory disease (4 per cent), dementia (2 per cent), end-stage kidney disease (2 per cent) and stroke (2 per cent) (PCOC 2016a).

These data probably understate the prevalence of reduced cognitive and physical capacity among specialist palliative care users because most people who die of natural causes suffer from multiple illnesses (AIHW 2012). Use of palliative care is skewed strongly toward older Australians (figure 5.5), who are much more likely to suffer from conditions associated with physical and mental decline. For example, almost one-third of all Australians aged 85 and over in 2015 had dementia (AIHW 2016g).

Figure 5.5   **Older Australians account for most palliative care episodes[a]**

Specialist palliative care episodes by age group, July to December 2015
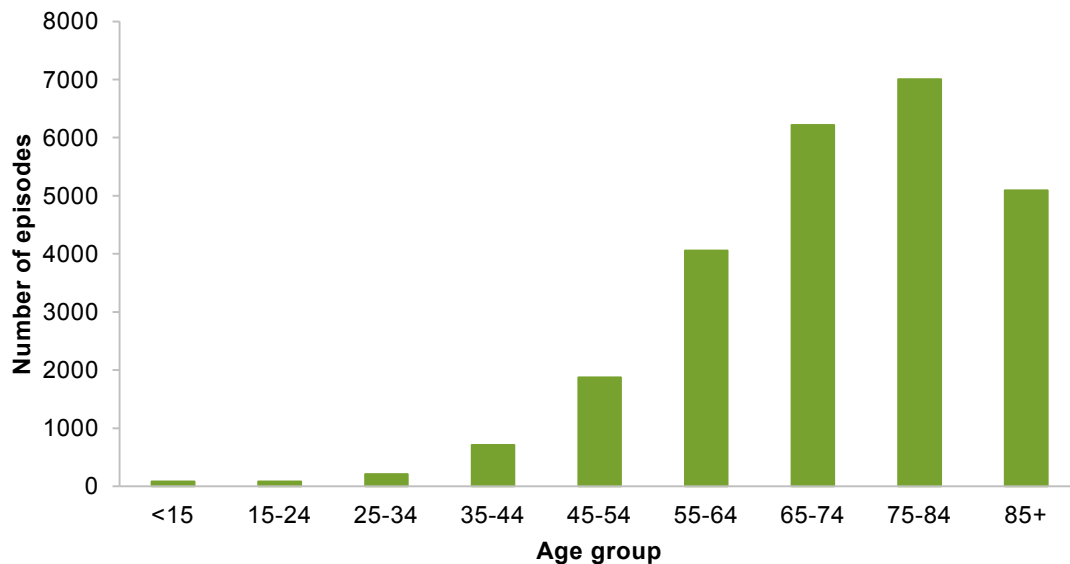
a Based on data reported by providers participating in PCOC. An episode of care is a period of contact between a patient and a palliative care service that is provided by one palliative care service and occurs in one setting.
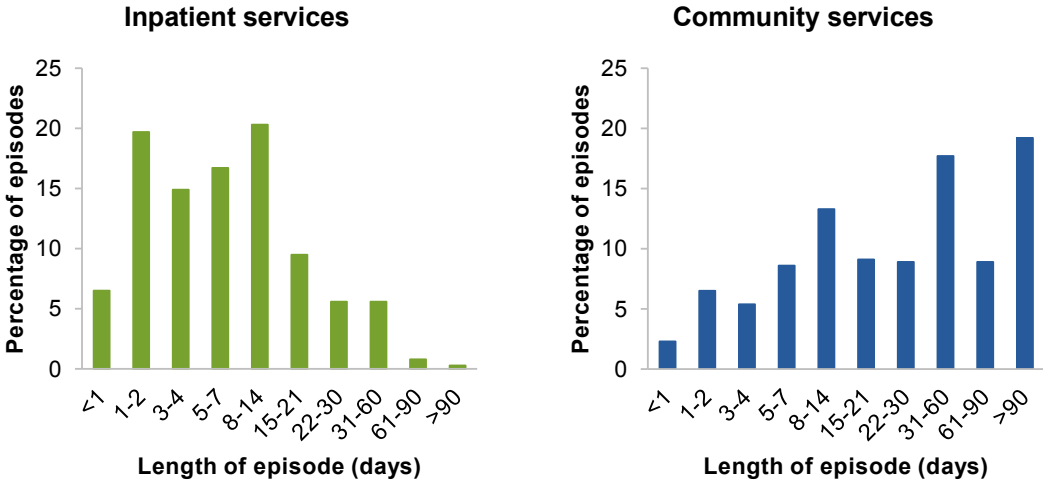
Source: PCOC (2016a).

Regardless of diagnosis, the development of a chronic life-limiting illness is emotionally taxing and psychologically distressing for patients, carers and loved ones. In this environment, making choices about palliative care arrangements may be difficult. When the trajectory of an illness is brief, patients and family members may have had little time to come to terms with the presence of an illness, let alone impending death. When the illness trajectory is prolonged, physical and emotional fatigue can make patients and family members reluctant to engage in the decision-making process (Cherny 2011; Sainio, Lauri and Eriksson 2001). Depression, anxiety and adjustment disorders are common among both patients and their family members (O'Connor et al. 2010; Vanderwerker et al. 2005).

To some extent, concerns about the inability of users to express preferences for care at the time of need can be addressed if carers, relatives and medical professionals are well informed about user preferences in advance. Through 'advance care planning' users can discuss and document their preferences and priorities for care at the end of life. Good advance care planning requires timely access to information and support, honest and forthright communication, and ongoing conversations so that plans can be revisited as patient preferences or circumstances change (Bartel 2016). Taboos about death can prevent these discussions from taking place (SCARC 2012). Patients often rely on medical professionals to initiate conversations about palliative care, many of whom are inadequately trained about, and intimidated by, holding such conversations (Bartel 2016). Advance care directives (legal forms that can underpin advance care planning) are

under-utilised relative to other end-of-life planning instruments like wills and financial power of attorney documents (Bradley et al. 2014; White et al. 2014).

In many cases, there is limited opportunity for users to switch providers if they are dissatisfied with the services they receive. Changing providers could be disruptive and distressful for users and undermine the benefits of care. For many users, the ability to switch services is also limited because engagement with services can be brief. While some patients receive months of palliative care and repeated episodes of care, others may have no contact with specialist palliative care services until their last days of life. Between 2013 and 2015, 60 per cent of patients in Victoria had just one episode of care before their death (PCOC, pers. comm., 1 September 2016). Across Australia, 42 per cent of care episodes last seven days or less (figure 5.6).

Figure 5.6   **Length of palliative care episode[a]**
July to December 2015

[a] Based on data reported by providers participating in PCOC. An episode of care is a period of contact between a patient and a palliative care service that is provided by one palliative care service and occurs in one setting.

Source: PCOC (2016a).

Patients (and their carers) can have difficulty judging the quality of services available to them. As with other forms of healthcare, there is 'information asymmetry' — medical professionals tend to have more and better knowledge about the services being provided than patients do (Scott, Yong and Mendez, sub. 87; Doctors Reform Society of Australia, sub. 144). Palliative care does not involve a single transaction of a well-defined service and making like-for-like comparisons between providers is difficult. Specialist palliative care often involves a number of different services associated with the physical, psychological and spiritual comfort offered not just to patients but also to carers, relatives and friends. Even within a state or territory, the services on offer can differ from provider to provider and from region to region.

Information asymmetry between palliative care users and providers could be lessened through the provision of high-quality, consumer-oriented information about the quality of services. While some information on patient outcomes is currently available through PCOC, it is not provider-specific and is not designed to be consumer-oriented. Well-designed consumer information is critical for effective decision making and needs to reflect the decision-making dynamics of patients and their families.

Another consideration relevant to the potential benefits from greater competition, contestability and user choice is the extent to which users have needs that require the coordinated provision of services. While some patients with life-limiting illnesses will require continuous use of specialist palliative care services, many others may only require specialist care on an episodic basis with services provided in partnership with primary care providers including general practitioners, and aged care and home care providers (PCA 2005).

Transitions between service providers and between care settings are considered 'potentially high-risk' events (Bartel 2016). When not well coordinated, appropriate data and information about a patient's condition and preferences may not be shared, and patients and families can be left feeling confused and abandoned. Measures to introduce greater contestability and competition would need to ensure continuity of care across palliative care settings and between primary care, specialist palliative care, aged care and home care providers.

Supply characteristics

Across Australia, there are roughly 224 providers offering specialist palliative care services, about 162 of which provide some form of community support to patients in the home (PCA 2016a). These providers range from large public and private hospitals offering community outreach services to small standalone hospices run by independent charitable organisations that rely on bequests and donations for a portion of funding.

For inpatient services, there can be economies of scale associated with maintaining the physical infrastructure of an inpatient unit, and economies of scope from co-location with other hospital services that a patient may require while receiving palliative care. This may present a barrier to new providers entering the market, particularly in less densely populated areas with limited demand for palliative care.

Conversely, community-based services do not need to maintain the physical infrastructure of an inpatient unit and so economies of scale are less of an issue. As Silver Chain (sub. 176, p. 6) noted, community-based providers can leverage the 'soft infrastructure' of patients' homes to allow for more flexible delivery of services. However, community-based providers may benefit from economies of scope by offering generalist community nursing services and aged care services in conjunction with specialist palliative care services. As noted above, coordination of these services is an important part of the

seamless provision of care, though services can still be well-coordinated while being run by different providers.

Non-government provision of community-based palliative care services is common, but provision arrangements vary by jurisdiction. States and territories with larger populations tend to fund non-government providers to supply community-based services in metropolitan areas, but rely on government providers in remote areas. In jurisdictions with smaller populations — Tasmania and the Northern Territory — all services are provided by government. In Western Australian and South Australia, the majority of specialist palliative care services are offered by a single provider, while in Victoria, New South Wales and Queensland there are several non-government community-based providers in metropolitan areas each operating within a defined region under contract with a local hospital network.

There may be scope to introduce greater choice by removing any barriers to the funding of community-based services by private health insurers. Private health insurance is the primary source of funds for a quarter of all palliative care separations in hospitals, but very few separations in the community (AIHW 2016b). To the Commission's knowledge, Cabrini Hospital in Victoria is the only provider of community-based specialist palliative care services in Australia that receives funding through private health insurance (Sullivan, Walker and Brooker 2012; N. Sullivan, pers. comm., 19 July 2016). Given that there may be cost savings from greater use of community-based care, the reasons why community-based care is so rarely funded by private health insurers is unclear. There are no legislative barriers to the involvement of health insurers in community-based services (SCARC 2012), but other barriers may exist. This is an area worthy of further exploration as present circumstances can constrain user choice. Palliative Care Australia (2014b) has reported that some private patients rely on inpatient services even though they would prefer to receive care at home.

The potential to introduce greater contestability and competition will depend in part on the size of the market for specialist palliative care services in a given region. Approaches to reform will likely vary by region. While little data are publicly available to determine the size of regional markets, workforce data indicate that the national market is relatively small. In 2014, there were 192 specialist palliative care physicians and 3269 palliative care nurses working across inpatient and community settings, accounting for 0.7 per cent of all specialist physicians and 1.1 per cent of all nurses respectively (AIHW 2016e, 2016l). Outside of major cities, there were just 27 specialist physicians and 855 nurses (AIHW 2016l).

It is unclear to what extent current differences in the provision of services across jurisdictions reflect careful consideration of the most appropriate market structure by policymakers or just the organic historical development of palliative care services. In recent years, however, there has been little turnover of service providers despite substantial variation in the quality of services across jurisdictions. In these circumstances, introducing

greater competition, contestability and user choice could improve outcomes for people using palliative care services.

5.4   The potential costs of reform

Introducing greater user choice through contestability or competition would require careful design to ensure that the interests of patients and their families are well served. If users were given greater choice of provider, special measures for consumer protection may be needed given the vulnerability of many palliative care users and the potential magnitude of harm should a service provider act without due care. If contestability were increased, arrangements would need to be in place so that continuity of care is uninterrupted in the event that a service provider's contract is not renewed.

Increasing contestability would also require more extensive data collection and improved monitoring and benchmarking of provider performance. It may also entail greater costs for providers and governments associated with tendering and contract management. Introducing greater contestability could, however, make providers more accountable for their performance and spur the innovation required to lift patient outcomes among poor performers.

PRELIMINARY FINDING 5.1

Placing greater emphasis on user choice could help to better satisfy patient preferences regarding the setting, timing and availability of palliative care.

- The quality of specialist palliative care services is highly variable, there are concerns about patients not being able to access services and there is limited performance reporting, particularly in community settings.

- There is little evidence that service providers are being held to account for relatively low service quality. Introducing greater contestability could make providers more accountable for their performance and spur the innovation required to lift patient outcomes among the poor performers.

- The potential to increase user choice through greater competition between providers or through more contestable arrangements would depend on market size and the ability to cost-effectively provide user-oriented information, among other things. The preferred reform option will likely vary across regions.

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6 Public dental services

6.1 Public dental services in Australia

Unlike most other health services, the majority of dental care in Australia is privately funded by users. Public dental services only provide basic dental care to adults with a concession card and most children. In 2013-14, government spending on public dental services accounted for 14 per cent ($1.2 billion) of expenditure on dental care in Australia, compared with users who funded almost 80 per cent of expenditure. The remaining expenditure was largely on private health insurance rebates and government-funded services for veterans. Of those people (aged 5 and over) who saw a dental professional in 2013, about 84 per cent visited a private practice at their last visit, while most of the remaining 16 per cent last visited a public (including school) practice (AIHW 2015f).

Most public dental services are provided in clinics (and dental hospitals in some jurisdictions) operated by state and territory governments, and are not open to being contested by alternative providers. The major role that state and territory governments play in providing public dental services is in contrast to, for example, optometry, where the service is almost wholly provided by the private sector.

There is some private sector provision of public dental services, which varies between jurisdictions. It is relatively large in New South Wales, which has had a voucher scheme since 2000 and recently awarded a contract to a private operator to work in its public clinics from 2016 until 2019 (NSW Government 2016b). Victoria, Western Australia and Tasmania also have voucher schemes. Vouchers have been used in Queensland as a short-term measure to reduce long waiting lists for some users (such as those waiting more than two years). The provision of vouchers is sometimes driven by specific funding from the Australian Government, such as to reduce waiting lists, rather than being motivated by the goal of increasing choice for users. The Australian Government also funds a separate Child Dental Benefits Schedule (CDBS), which allows eligible children (in families receiving Family Tax Benefit Part A) to access basic dental services from public or private providers.

6.2 Scope to improve outcomes

Australia has a well-developed and regulated dental sector that generally delivers high-quality services. Publicly funded dental services play an important role in increasing access to care, although there continue to be concerns about the ability of certain groups to access services, such as people living in remote areas. The current emphasis on providing

services in government-operated clinics limits responsiveness to user needs and preferences. There is also scope to improve accountability because public performance reporting is currently minimal.

Quality

The Commission has not seen any evidence to suggest that there are systemic problems with the quality of public dental services provided in government-operated clinics or private dental practices. Available information provides few insights into the precise quality of services but dental practitioners, regardless of whether they treat public or private patients, are required to register with the Dental Board of Australia (the national dental regulator), which sets industrywide standards, codes and guidelines, and handles complaints. Only about 4 per cent of dental practitioners were the subject of a complaint in 2014-15. Of those complaints closed, less than one-third were taken beyond the assessment stage (AHPRA 2015).

Equity

Adults receiving public dental services are disproportionately from disadvantaged areas. Among people aged 15 or over who received public dental care in 2014-15, about half were in the bottom two quintiles on a scale of socioeconomic disadvantage (figure 6.1). However, there was also a significant share (30 per cent) in the top two quintiles. Other data show that, in 2013, about 30 per cent of people with private insurance cover for dental care were eligible for public dental services (AIHW 2015f).

Among people who received public dental services in 2013, almost half reported that they would have a lot of difficulty paying for a basic preventative care package. In comparison, less than one-quarter of adults ineligible to receive public dental services reported that they would have a lot of difficulty paying for basic dental care (AIHW 2015f).

Equity concerns have been raised about access to public dental services in regional and remote areas (COAG Health Council 2015). Compared with major cities, there are far fewer dental professionals per head of population in regional and remote areas (figure 6.2). In these areas, public dental clinics and school dental services play a larger role in delivering services. In 2014, the number of public dentists per head of population was highest in remote and very remote areas (7.9 full-time equivalents per 100 000 people) and lowest in major cities and inner regional areas (6.6 and 6.1 full-time equivalents per 100 000 people respectively) (SCRGSP 2016b). In 2013, about 32 per cent of people in remote and very remote Australia (aged 5 years and over) reported that their last dental visit was to a public (including school) clinic, compared with 12 per cent in major cities (AIHW 2015f).

Figure 6.1   **Adults who received public dental care by socioeconomic status, 2014-15[a]**
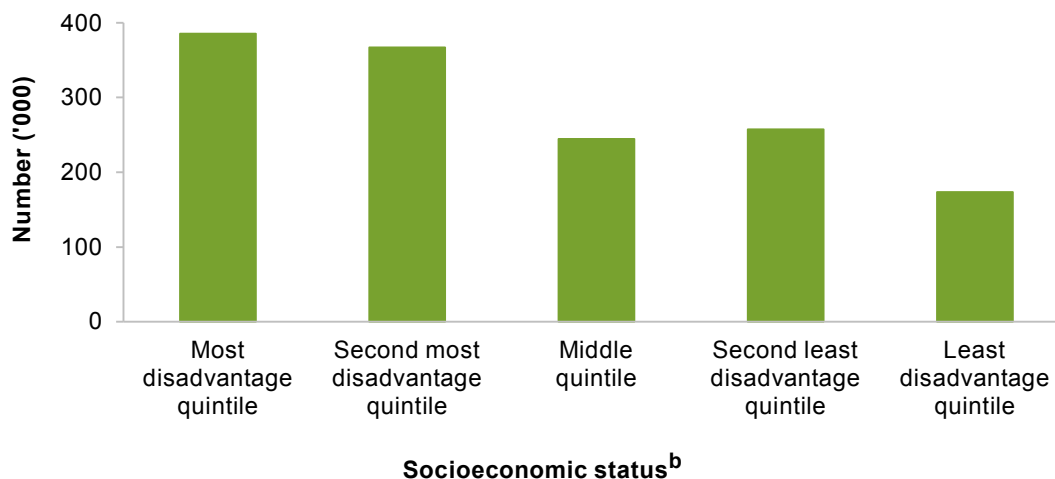
[a] Persons aged 15 and over. [b] Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a person resided. The index is derived from census variables related to disadvantage, such as low income, low educational attainment, unemployment, jobs in relatively unskilled occupations and dwellings without motor vehicles.

Source: ABS (Patient Experiences in Australia 2014-15, Cat. no. 4839.0).

Limited access to local dental professionals, combined with a lack of transport options, is associated with a lower rates of 'favourable' visiting patterns in regional and remote areas (figure 6.2). A favourable dental visiting pattern is where a person visits a usual dental care provider at least once a year for a check-up rather than a problem. The National Advisory Council on Dental Health (NACDH 2012) noted that higher rates of unfavourable visiting patterns increase the risk of poorer oral health in regional residents compared with urban residents. Survey evidence suggests that Australian adults living in remote and very remote areas have the highest rates of untreated tooth decay and periodontal disease (inflammation of tissues surrounding teeth) in Australia (AIHW 2015f).

Access in remote areas is a particular concern for Indigenous Australians. Just over 2 per cent of Australia's population live in remote areas, including about one-fifth of Indigenous Australians (ABS 2013b). Indigenous Australians are 'less likely to receive treatment to prevent or address poor oral health, resulting in oral health care in the form of emergency treatment' (COAG Health Council 2015, p. 55).

Financial and other barriers that cause people to leave dental problems untreated is a concern not only for the individuals concerned but also the wider community because it can ultimately lead to more costly taxpayer-funded services being required. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14 (AIHW 2015a). These are hospitalisations for conditions that could have potentially been avoided if timely and adequate non-hospital care had been provided. In 2013-14, people living in very remote areas were about 40 per cent more likely to be

hospitalised for conditions that could have potentially been avoided if timely and adequate dental care had been provided, after controlling for age differences between regions (AIHW 2015f).

Figure 6.2 **Prevalence of dental professionals and favourable visiting patterns by region, 2014[a,b]**
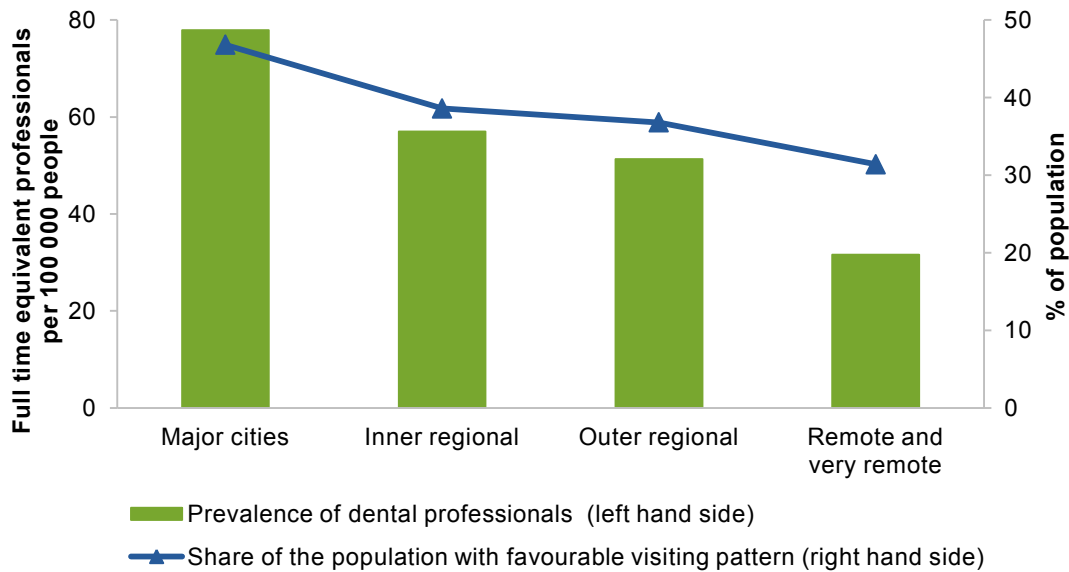
a The latest available data for favourable visiting patterns is for 2013. **b** In addition to dentists, dental professionals include: dental therapists who provide examinations, diagnoses and treatment to children, teenagers and young adults; dental hygienists who provide preventative services to people of all ages; oral health therapists who are dual qualified in dental therapy and dental hygiene; and dental prosthetists who make, fit, supply and repair dentures.

Sources: AIHW (Dynamic data for Australia's registered health workforce by location, accessed 31 August 2016); AIHW (2015 Table 3.7).

Efficiency and accountability

The Commission has not found any published evidence on the efficiency of public dental services. A lack of published information on this issue is symptomatic of a broader problem with accountability to those who fund public dental services (taxpayers and users through co-payments). It is also evident in a lack of public performance reporting on service quality and patient outcomes.

There has been some public reporting of the effectiveness of voucher schemes in reducing waiting lists for public dental services (Competition Policy Review 2015). However, the Commission is not aware of any broader evaluations within Australia of how vouchers have affected the quality and cost-effectiveness of public dental services. For the CDBS, the Australian National Audit Office noted that the only indicator used to measure

performance was the number of children accessing the program, which 'does not provide a complete picture of the performance of the CDBS in meeting program objectives' (ANAO 2015, p. 52).

More generally, the limited reporting of outcomes for oral health services has been identified as an issue in the sector. In setting the national strategic direction for oral health in Australia, the Council of Australian Governments (COAG) 2015 *National Oral Health Plan* identified the need to improve safety and quality in the sector by encouraging participation in clinical audit and benchmarking programs, and to develop a national picture of consumer experiences.

Responsiveness

The majority of people receiving dental services funded by state and territory governments are required to attend a clinic operated by the relevant government. In some cases, they may be allowed to choose between different government-operated clinics. However, the options within a reasonable distance of a user's residence can be more limited than those available to public patients who have a voucher that can be used at a private dental practice. The Australian Dental Association (ADA sub. 230) pointed to a number of towns that do not have a public dental clinic within a reasonable travelling distance and noted that residents of these towns would benefit from being allowed to be treated at a closer private dental practice.

A national survey of experiences in (public and private) dental clinics in 2014-15 showed that about 80 per cent of patients thought that their dental professional always listened carefully, showed respect and spent enough time with patients (ABS 2015c). However, the continuity of care that public clinics provide to their patients can be an issue. People attending public dental clinics may be treated by a different person each time, making the experience more impersonal. In a qualitative investigation into the oral health and access to dental care of older people in Perth, users of public dental services reported that a high turnover of staff meant that they were less able to build a relationship with a dental professional (Slack-Smith et al. 2010).

Without continuity of care, users could be discouraged from maintaining a favourable visiting pattern. Unfavourable visiting patterns have been linked to poor oral health. Almost one-third of adults eligible for public dental care had unfavourable visiting patterns in 2013, compared with just over one-fifth of those not eligible (AIHW 2015f). Adults with unfavourable visiting patterns are half as likely to receive preventive treatment and four times more likely to receive a tooth extraction when remedial treatment is required, compared with adults with favourable visiting patters (Ellershaw and Spencer 2011).

A related issue is fear of dental treatment, which can be a significant underlying cause of unfavourable visiting patterns and lead to more extensive remedial care being required when a person does ultimately seek treatment (NACDH 2012). A public dental service that is impersonal and lacking continuity of care is likely to reinforce the avoidance behaviour

of people with high levels of dental fear. Moreover, there is evidence that people from low socioeconomic backgrounds, who are the predominant users of public dental services, tend to suffer greater dental fear (Armfield, Spencer and Stewart 2006).

For some people, an extended time on a waiting list means that what could have originally been addressed by preventive or restorative treatment becomes an emergency case. Waiting times for public dental services can vary from year to year due to changes in funding and other policy arrangements, including the provision of vouchers. In 2014-15, the median waiting time to access public dental care was 121 days in the ACT and 933 days in Tasmania (SCRGSP 2016b).[1] People who have difficulty accessing dental care may seek treatment for pain and infection from other health services, including general practitioners, outpatient clinics and hospitals. More broadly, poor oral health has been associated with a number of other diseases, such as heart and lung infections and stroke (COAG Health Council 2015).

6.3   Factors influencing the potential benefits of reform

User characteristics

It is not possible to point to a single user characteristic that is representative of people who use public dental services because a broad spectrum of the population is eligible to receive such services — adults holding a concession card and most children in the case of state and territory services[2] and children in families receiving Family Tax Benefit Part A in the case of the CDBS. Moreover, dental health problems requiring care are present across the population and result from a complex interaction of many different factors (COAG Health Council 2015; House of Representatives Standing Committee on Health and Ageing 2013; NACDH 2012).

For the purpose of introducing greater competition, contestability and user choice, one of the most relevant user characteristics is probably the disproportionate share of adult users from disadvantaged areas. There is evidence that disadvantaged adults have lower oral health literacy and a greater prevalence of high dental fear than other groups (Armfield, Spencer and Stewart 2006; COAG Health Council 2015). This may partly explain why they are more likely to have untreated tooth decay and periodontal disease (AIHW 2015f). Many are therefore likely to need support, including through information provision, to understand the benefits of receiving dental care and find a dentist. Follow-up support from

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[1] Median waiting times are not directly comparable across jurisdictions due to differences in the way public dental services are arranged, and the process for determining who is placed on a public dental waiting list.

[2] All children are eligible for public dental services in New South Wales, South Australia, Tasmania and the Northern Territory. In Victoria, children aged 13 and over must be covered by a concession card. In Queensland, children younger than 4 or who have completed year 10 of secondary school must be covered by a concession card. In Western Australia, only school children are eligible. In the ACT, children aged over 14 must be covered by a concession card.

providers may also be required for patients who experience dental fear to ensure continuity of care. Some users will have special care needs (such as mental or physical disability or mental illness) that create difficulties in accessing dental care.

There are also likely to be issues specific to groups that face problems in accessing care, such as regional and remote residents, Indigenous Australians, the frail and elderly, low-income groups and the homeless. For example, assistance with transport to a dental clinic could be critical to ensuring that some of these groups receive care.

Supply characteristics

State and territory governments provide dental services in a variety of settings, including community health centres, dental hospitals, mobile dental clinics, and clinics rented from private dental practices. For children, dental services are sometimes provided in clinics located within schools. Some Aboriginal Community Controlled Health Services (ACCHOs) also provide oral and dental health services as part of an integrated health service. Overall, the Commission estimates that state and territory governments operate about 1100 dental clinics across Australia, including mobile ones.[3] In comparison, there were about 13 100 businesses mainly engaged in the practice of general or specialised dentistry services in June 2015 (ABS 2016b).

Emergency care comprises a greater share of services provided to public dental patients, compared with those provided to private patients, and there is proportionately less preventive or restorative care, even after controlling for differences in age and sex. Responses to the 2004–06 National Survey of Adult Oral Health showed that 44 per cent of public patients had their teeth cleaned (oral prophylaxis), compared with 73 per cent of private patients (Brennan, Luzzi and Roberts-Thomson 2008).

Differences in the types of services provided by public and private dental clinics are reflected in their workforces (figure 6.3). The public sector's focus on services for children is reflected in its workforce composition, with dental therapists comprising a greater proportion of the workforce compared with the private sector. Dental therapists provide examinations, diagnoses and treatment to children, teenagers and young adults. The smaller amount of preventive care provided to adults in the public sector means that it employs proportionately fewer dental hygienists, who specialise in preventive services.

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[3] The number of government-operated clinics was estimated based on: ACT Government (2016); Dental Health Services Victoria (2016); NSW Ministry of Health (2014); NT Department of Health (2016); Queensland Health (2013); SA Health (2016); Tas DHHS (2016b); WA DHS(2016).

Government-operated clinics can be organised as a network of providers that coordinate care between different sites. For example, the NSW Government has opted for a 'hub and spoke' network to facilitate its provision of services in less densely populated regions.

> Through this model, higher capability sites (Hubs) provide services and support to smaller sites with lower capability (Spokes). This model increases the ability of smaller services to provide improved access to a broader range of services, particularly in rural and remote areas where the efficient provision of services is challenged by workforce and physical capacity. (Centre for Oral Health Strategy 2013, p. 14)

Figure 6.3   Distribution of dental workforce in the public and private sectors, 2014[a]
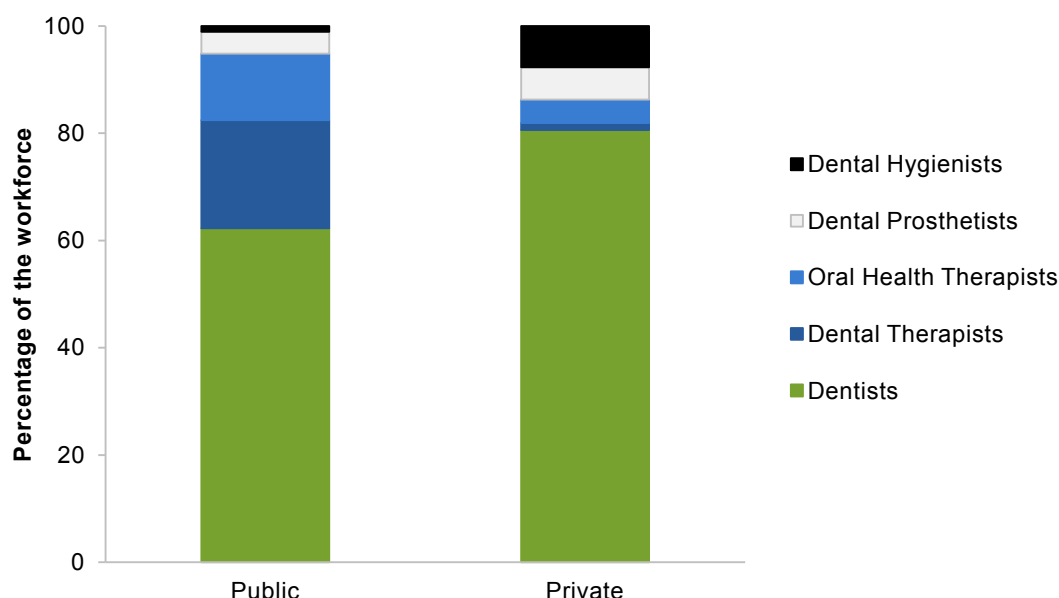
a Dental therapists provide examinations, diagnoses and treatment to children, teenagers and young adults. Dental hygienists provide preventative services to people of all ages. Oral health therapists are dual qualified in dental therapy and dental hygiene. Dental prosthetists make, fit, supply and repair dentures.

Source: AIHW (National Health Workforce Data Set 2014).

The NSW Government has observed that this balances the goal of meeting the needs of public patients outside major cities with the economies of scale and other benefits that can be achieved with larger clinics.

> The most efficient public sector clinics have four or more dental chairs: this level of service capacity allows for economies of scale, improves staff security, and provides student clinical placements. Into the future, while clinics with lesser capacity (e.g. two-chairs) will still be required, these will be linked to 'Hub' clinics (i.e. those with four or more chairs). Single chair surgeries will also still be required in small communities where there are special needs for visiting services. (Centre for Oral Health Strategy 2013, p. 14)

In contrast, dental practices in the private sector are typically independent enterprises and have a small number of dentists, with about one-third working in a solo practice (AIHW 2015f). The independent nature of many private dental practices does not necessarily prevent them from operating a de facto hub and spoke model like the NSW public dental service, given that private dental practices can refer patients on to more specialised providers when required. The small size of most private practices suggests that there are not significant economies of scale in the type of care they provide. The required capital equipment may be greater than, for example, a general practitioner clinic but not so significant that it would give a major cost advantage to larger providers. Nor are there decreasing returns to scale which would constrain providers from becoming larger, according to a quantitative study of Australian private dental practices over the period 1993 to 2003 (Gutacker et al. 2015).

As noted above, the prevalence of dental professionals per head of population is much higher in major cities than in remote areas (figure 6.2). As a result, the most appropriate approach to introducing greater competition, contestability and user choice could vary across regions. In urban areas, where the number of dental professionals per head of population is relatively high, more competition and choice could involve using delivery mechanisms that allow users to choose between competing private dental practices. In regional and remote settings, public dental service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics or provide mobile clinics.

Greater contestability of government-funded dental care could assist in the development of more flexible and responsive service models. More innovative service delivery may be especially important in remote areas, where there is a substantially lower number of dental professionals per head of the population. The COAG Health Council (2015) noted that regional and remote oral health services could benefit from implementing innovative approaches to diagnosis and care, such as tele-health.

6.4   The potential costs of reform

As noted above, governments would need to ensure that they support the disadvantaged groups who use public dental services, possibly through a combination of information provision and person-to-person advice. Governments already do this to some extent with current voucher schemes, although the information is generally limited to providing a list of eligible providers.

Groups that may have particular difficulty in making choices — such as those with intellectual disability or severe cognitive impairment — could need another person to support their decision-making. The Australian and New Zealand Academy of Special Needs Dentistry and the Australian Society of Special Care in Dentistry (sub. 200, p. 6) noted that 'people with intellectual disability and cognitive impairment may not have the capacity to exercise "informed choice"'. While family and carers can assist in making

choices, oral health may be only one of a number of health issues which need to be managed and carers may lack time and energy for regular oral health visiting (COAG Health Council 2015).

Children also rely on their family or carers to make choices on their behalf regarding their oral care but this does not appear to negatively affect children's dental visiting patterns. Almost 80 per cent of children aged 5 to 14 had visited a dentist in the past 12 months when surveyed in 2014, compared with only 55 per cent of adults aged 25 to 44 (AIHW 2015f).

The Commission has not seen any evidence that additional quality or safety regulations would be required to safeguard consumers if there were to be greater competition, contestability and user choice. All jurisdictions have shown through their voucher schemes that private providers can typically supply good quality services to publicly funded clients. The experience of the CDBS also shows that safe outcomes can be provided by the private sector, with no need for additional quality regulation (box 6.1). The only requirements for a provider to supply CDBS-funded services are registration with the Dental Board of Australia, as all providers must be, and to hold a Medicare provider number (Department of Health 2016). The NSW voucher scheme requires providers to register with the state government, in addition to registration with the Dental Board, pay for a criminal record check and complete a working-with-children check (Centre for Oral Health Strategy 2016).

Some commentators have raised concerns about differences in accreditation arrangements between government and private dental clinics (see, for example Kruger and Tennant 2015). Most government-operated dental clinics are required to gain accreditation against the National Safety and Quality Health Service Standards (NSQHSS), which encompass six areas where it is known that people have been harmed as a result of healthcare and there is good evidence on how to achieve better outcomes. In contrast, NSQHSS accreditation is voluntary for private dental practices. This does not necessarily mean that the outcomes achieved by private sector dentists are inferior. The Australian Dental Association has observed that the NSQHSS duplicates other standards and regulations, and is based on hospital models of healthcare delivery that are not appropriate for clinics in other settings (ADA 2015). In any case, Australia's national health quality agency noted in its 2014-15 annual report that more than 1300 private dental practices had completed or enrolled in an accreditation program (ACSQHC 2015b).

If there were to be a shift to a greater share of public dental patients being treated in private dental practices, there may be additional monitoring costs for governments due to the greater number of such clinics compared with those in the public sector. However, this does not appear to have been a concern for state and territory governments when operating their voucher schemes. In the case of the CDBS, a recent audit did not find that the administrative costs of the scheme were such that major changes were required (ANAO 2015).

Monitoring could be facilitated by having services readily defined by reference to the existing dental services schedules — such as the CDBS or the Department of Veterans' Affairs Fee Schedule of Dental Services for Dentist and Dental Specialists — which

describe the service to be performed and set a benefit amount for the service. Moreover, the Australian Government's shift to activity-based funding for public dental services will also improve financial accountability of state and territory schemes (box 6.1).

Box 6.1   Child Dental Benefits Schedule (CDBS)

Since 2014, the Australian Government's CDBS program has provided up to $1000 of benefits over two years for basic dental services for eligible children. The CDBS provides a good example of publicly funded dental care being provided by a mix of private and public providers, with 78 per cent of claims made in the private sector. Two reviews of the CDBS — an audit by the Australian National Audit Office and an independent legislative review — found no major issues with using the private sector to deliver services. About 70 per cent of eligible providers participated in the scheme, demonstrating that compliance costs were not too onerous to discourage participation.

The market appears competitive ensuring that eligible users had real choice of provider. While private providers were free to charge a co-payment, the vast majority chose not to. Over 90 per cent of providers charged at or below the schedule fee. The Australian Dental Association (sub. 230, p. 3) noted that the CBDS 'provides timely, affordable, high quality and appropriate dental care through both public and private dental practitioners which enables competition among the public and private sector dentists and supports user choice'.

In May 2016, the Australian Government announced its intention to replace the CDBS with a Child and Adult Public Dental Scheme (CAPDS), which will provide payments to the states and territories for public dental services, based on a nationally efficient price similar to activity-based funding for public hospitals. The Health Minister stated that the Government intended to close the CDBS because it was poorly targeted. At the time of writing this report, a bill to replace the CDBS with the CAPDS had been introduced to Parliament following the July 2016 election but had not been passed.

Sources: ANAO (2015); Australian Government (2016b); Ley (2016).

PRELIMINARY FINDING 6.1

Introducing greater competition, contestability and user choice in public dental services could lead to better outcomes for patients and the wider community.

- Users could benefit from having greater choice over the timing and location of treatment. Greater continuity of care may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary.

- The uncontested provision of services in government-operated clinics results in limited responsiveness to user needs and preferences. Minimal public performance reporting limits accountability to those who fund services.

- Service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics. More competition and choice could involve using delivery mechanisms that allow users to choose between competing private dental practices.

7 Human services in remote Indigenous communities

The terms of reference for this inquiry recognise the importance of improving Indigenous outcomes and the challenges facing the provision of human services in remote areas. The Commission has had regard to these issues in its assessment of the human services that are discussed in chapters 3–6 and in chapter 8. This chapter addresses cross-cutting issues that affect the provision of human services in remote Indigenous communities, including some services that are not covered in other chapters.

7.1 Remote communities and services

About 85 per cent of Australia is classified as remote or very remote — the physical distance to the nearest town or service centre can be in the hundreds of kilometres (CRCREP 2015). A lack of transport infrastructure, coupled with extreme seasonal conditions, makes travelling those distances uncomfortable and time-consuming at best or impossible at worst. Just over 2 per cent of Australia's population, including about one fifth of Indigenous Australians, live in remote areas[1] (ABS 2013b).

The cost of providing services in remote Australia can be several times the cost in urban areas. Service providers also face barriers such as difficulty accessing infrastructure, and recruiting and retaining staff.

> Additional effort is required to attract and retain providers in remote regions, acknowledging the challenges of workforce availability, service delivery costs and the need to ensure a reasonable level of support for participants. (NDIA 2015b, p. 11)

In 2006 there were over 1000 discrete Indigenous communities[2] in remote areas of which more than three quarters had a population under 50 (ABS 2007). Figure 7.1 shows the location and size of these communities. Remote Indigenous communities vary significantly in size and the services available. Many smaller communities, such as homelands and outstations, have cultural significance for their residents, but the level of service provision is minimal due to their size and remoteness. Larger remote communities generally have a larger range of services either provided directly or funded by government. As such, the larger communities will be the Commission's primary focus in considering human services

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[1] References in this chapter to remote areas include very remote areas, unless otherwise specified.

[2] Discrete Indigenous communities are defined as being inhabited predominately by Indigenous Australians with housing or infrastructure that is managed on a community basis.

in remote communities. Physical isolation underpins many of the challenges to providing high-quality human services to these communities. Only 36 per cent of remote Indigenous households, for example, have an internet connection (compared to 73 per cent of remote non-Indigenous households) (PC 2016c). The Northern Territory Department of Treasury and Finance stated:

> … infrastructure in remote communities is limited and there is a high demand on its use. Similarly, many remote communities are not accessible by road for many months of the year due to location and weather conditions — meaning that expensive charter planes are required for face to face service delivery for a small number of clients. (sub. 261, p. 6)

Figure 7.1   Discrete Indigenous communities by size and remoteness, 2011
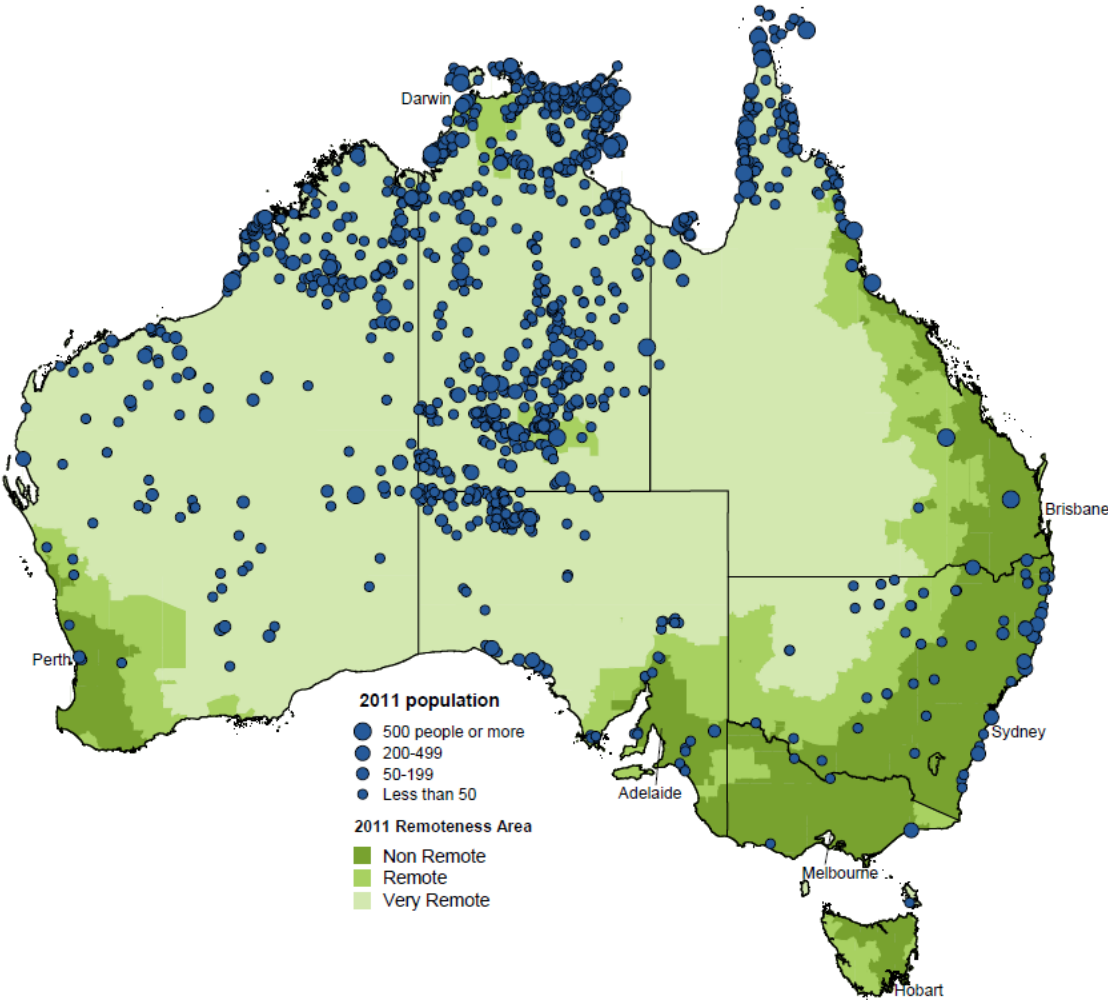
Source: ABS (*Census of Population and Housing,* unpublished).

Comprehensive, comparable data on government expenditure for remote communities are not readily available, due to the complex and fragmented nature of funding arrangements. However, data are available for some specific programs and services. The Australian

Institute of Health and Welfare (2013a) found that health expenditure was higher for Indigenous Australians living in remote areas compared to both Indigenous Australians in non-remote areas and non-Indigenous Australians in remote areas. It is likely that this would be the case for many other services. The higher cost of delivery in remote areas contributes to this disparity as well as the higher use of government services by Indigenous people.

Service delivery arrangements require reform

The Commission's early investigations suggest that current arrangements for purchasing and delivering human services are not fully meeting the needs and preferences of Indigenous Australians living in remote communities. Responsibility for service provision is split across governments and departments, and funding is delivered through numerous programs. Service providers face many challenges with the way services are funded, such as uncertainty of funding streams and large administrative burden (chapter 8). Problems arise from a lack of coordination across services, including duplication in some areas, gaps in others, and unclear lines of responsibility across and within governments for identifying and achieving the intended outcomes for people who are receiving the services. The end result can be inconsistent and intermittent service delivery to remote communities, undermining the welfare of the people living in these communities.

Examples of fragmentation, duplication and inefficiency abound. The remote community of Jigalong in Western Australia received 90 different social and community services in 2013-14 for a population under 400 (WA DPC 2014). The Aboriginal Medical Services Alliance NT gave another example of a remote community in Central Australia where about 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. The Alliance described what happens on the ground.

> There was little in the way of communication or coordination with the local ACCHS [Aboriginal Community Controlled Health Service], with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The resulting fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients is totally counter to the improved outcomes sought by this inquiry. (Aboriginal Medical Services Alliance NT, sub. 274, p. 5)

The Western Australian Government Regional Services Reform Roadmap points to a focus by governments on the acute and immediate symptoms of disadvantage at the expense of addressing the causes. This leads to 'an array of uncoordinated services, which are expensive and difficult to deliver but do little to support individual and family success' (WA RSRU 2016, p. 10).

Often, there is little if any choice over who provides services, or over the services themselves, for people living in remote Indigenous communities. Nor is competition

between service providers commonplace, even where multiple providers deliver services to a community. Privately provided services are rare. In the case of the Northern Territory:

> In most areas of the NT outside the main centres there are no private practice general practitioners — all general practitioners are employed through the Aboriginal PHC [Primary Health Care] sector (either community controlled or government services). There are also no private providers operating in the areas of allied health or counselling outside urban areas. (Aboriginal Medical Services Alliance NT, sub. 274, p. 2)

Reforms introducing greater user choice are underway in disability services and aged care and are important sources of evidence for this inquiry.

7.2 Scope to improve outcomes

Outcomes in remote Indigenous communities

Across a range of indicators of quality of life Indigenous Australians (in remote and non-remote areas) have substantially higher rates of negative outcomes than other Australians. There is, however, evidence of some progress. Since 2003 the Steering Committee for the Review of Government Service Provision has been producing regular reports on indicators of Indigenous disadvantage. The most recent report shows improvement in several indicators of wellbeing, including life expectancy, childhood mortality rates, year 12 completion rates and income from employment. There is still much to do — in other areas there has been little or no change (reading, writing and numeracy, family violence and chronic disease) and some indicators have gone backwards (psychological stress, self-harm and imprisonment) (SCRGSP 2014).

Indigenous Australians living in remote communities are more likely to experience poor outcomes than other Australians, including Indigenous Australians living in non-remote areas (figure 7.2). There are some indicators related to culture that improve with remoteness, such as 'connection with country and language maintenance and revitalisation' (SCRGSP 2014, p. 1.6).

Access to human services

Inadequate access to high-quality human services is one factor that drives poor outcomes among Indigenous Australians living in remote communities. Indigenous Australians living in remote areas are more likely to report problems accessing services than those living in non-remote areas (figure 7.3). They are also significantly more likely to nominate the lack of a service in their area as the reason for this difficulty (ABS 2016e). The Australian Government's 2014 Mental Health Review found that Indigenous Australians had poorer access to mental health services, in part because services designed for the broader population are not culturally appropriate (NMHC 2014).

The reality of remote Australia is that not all services can be delivered everywhere. As a consequence, people often need to travel to receive quality services. For example, a study in Central Australia found that over an 18 month period, over three-quarters of new dialysis patients were required to relocate to access services (Gorham et al. 2016). This is a significant problem for Indigenous Australians living in remote areas who, as a population, experience rates of chronic kidney disease twice as high as Indigenous Australians living in non-remote areas (AIHW 2015c). Relocation has negative effects on service users, their families and communities:

> In the [Northern Territory] there is a hidden cost burden in taking people to services rather than services to people. There are very stark and obvious examples of this type of cost burden when people in need of care are taken to urban centres for treatment. In many cases they are followed by extended family, stays become indeterminate and associated with the added social costs of homelessness, alcohol and drug abuse, and at the same time there is a negative impact on the community from which they come. (Banscott Report 2003, quoted in Rivalland 2006, p. xii)

More recently, a project underway on dialysis models of care reiterated the health, social and economic consequences of relocation (Menzies School of Health Research 2015).
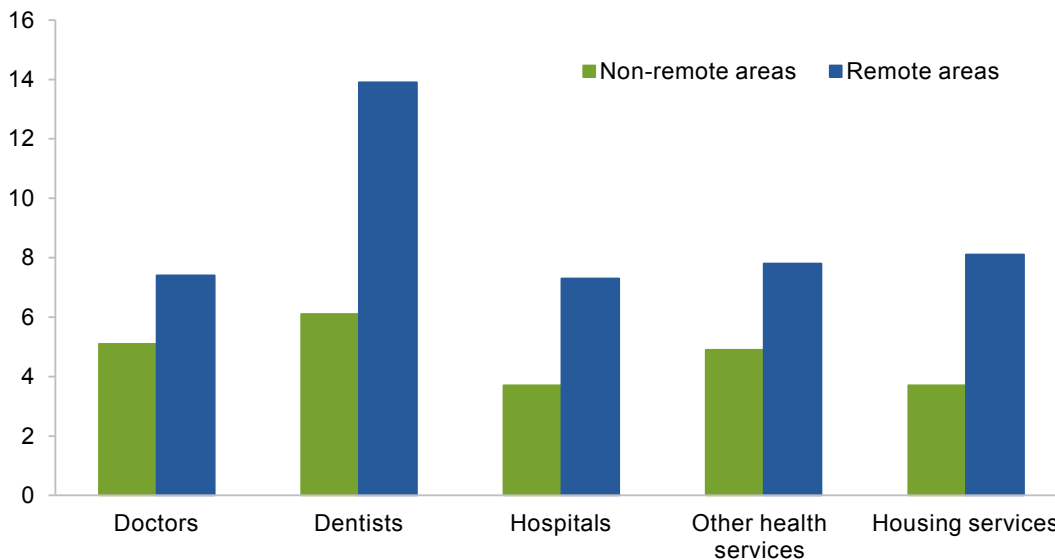
Figure 7.2   **Outcomes for Indigenous Australians by remoteness**
Per cent of Indigenous Australians, 2012-13
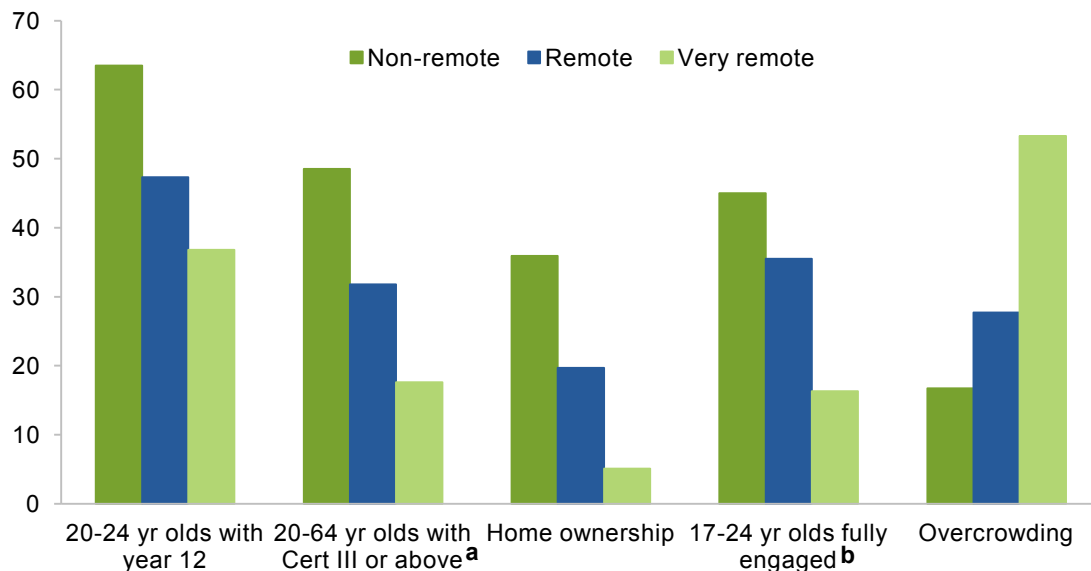
[a] Includes current students. [b] Fully engaged in post-school education, training and/or employment.
Source: SCRGSP (2014).

Figure 7.3 **Indigenous Australians experiencing problems accessing services, by remoteness**

Per cent of persons, 2014-15

Source: ABS (*National Aboriginal and Torres Strait Islander Social Survey, April 2016*, Cat. no. 4714.0).

7.3   Factors influencing the potential benefits of reform

User characteristics

As is the case in all locations, there is wide variation in the capacity, needs and preferences of people who live in remote communities. Indigenous Australians living in these communities may also interact with services differently to other Australians.

One area of significant difference is language. About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared to 2 per cent for Indigenous Australians living in non-remote areas. Another area of difference is culture. Indigenous Australians living in remote communities are more likely than those living in non-remote areas to identify with a clan, tribal or language group and to be involved in cultural events, ceremonies or Indigenous organisations (ABS 2016e). Service provision needs to take into account these differences. The Barkly NDIS trial identified some of the challenges that arise in providing services to remote communities (box 7.1).

> **Box 7.1   NDIS Barkly trial**
>
> Barkly was chosen as a trial site for the NDIS to test the scheme in remote Australia. The Barkly region is one of the most sparsely populated areas in Australia.
>
> > As most Aboriginal languages in the Barkly don't have a word for 'disability', it is key that the NDIA [National Disability Insurance Agency] works closely with communities to build an understanding of what the Scheme is about, and who it can assist. (NDIA 2015b, p. 11)
>
> The experience of the Barkly trial highlighted the need to provide information that is tailored to the needs of those accessing support:
>
> > One issue identified from the initial roll out in Barkly was that potential participants were not able to read information pamphlets. Indigenous clients preferred to build relationships and trust before being sufficiently comfortable to hold meaningful conversation about sensitive health-related topics. Recognising the need for a different approach, and acknowledging cultural preferences, the NDIA worked with the Aboriginal Interpreter Service to develop key messages for potential participants, ensured interpreters are used during the planning process, and developed simplified documents for accessing the NDIS. Key messages are proving to be more effectively delivered through story-telling, a method that is becoming easier through success stories being experienced in the trial. (Northern Territory Government, pers. comm., 15 July 2016)

The history of Indigenous Australians' interaction with services can also have significant effects on service provision. Some Indigenous Australians living in remote communities may have never had a choice about the services they receive. Some might prefer not to exercise user choice, and others might need extra support if greater choice were to be introduced. This point was echoed by the Indigenous Affairs Group of the Department of Prime Minister and Cabinet.

> The onus is on government to ensure that citizens are appropriately supported to exercise choice, including through culturally appropriate information, advice, interpreter and other services. (sub. 265, p. 6)

Supply characteristics

Remote communities, due to their isolation and size, cannot support multiple service providers, or in some cases even a single provider. Risks to service users from poor service quality and provider failure can be particularly high as switching is not generally possible due to a lack of user choice and alternative providers. In some cases government may need to act as provider of last resort to ensure delivery of services.

The need to provide culturally appropriate services can also present a challenge, particularly to providers that are not experienced in remote communities. Indigenous Australians tend to relocate more frequently than other Australians, which can lead to significant variability in the level and nature of demand for services in communities and can be challenging for providers to respond to. For example, services may need to be coordinated between different remote locations and less remote towns to ensure continuity of provision to people who are mobile. About 7 per cent of Indigenous Australians were away from their usual place of residence on Census night in 2011, compared to 4 per cent

of non-Indigenous Australians. More Indigenous Australians changed their place of usual residence between the 2006 and 2011 Census — 44 per cent compared to 38 per cent (Biddle and Markham 2013). Kinship is a key reason for mobility in remote communities and the need to travel to access services also contributes (Memmott, Long and Thomson 2006).

7.4   A way forward

There are many economic and social factors that drive outcomes in remote Indigenous communities. The nature of service provision and the characteristics of users mean that the service models that work in other parts of the country will not necessarily work in remote Indigenous communities. For example, introducing greater competition, when there are at best one or two providers, is unlikely to be the most effective model for improving service outcomes for users. This also suggests that governments may need to be more flexible in their approach to service models and providers, to allow for better ways of working and achieving governments' intended outcomes.

Expectations of a quick fix are unrealistic. More promising, given the issues with current service delivery arrangements used by governments, is the scope to improve outcomes over the long term through better design and implementation of policies to purchase services in remote Indigenous communities. Outcomes should be defined holistically, rather than being narrow and program-driven. Better service provision could involve better coordination, place-based service models, increased community voice in service design and delivery, and stable policy settings.

Better coordination and service integration

Services that are designed around the complex and interrelated needs of Indigenous Australians living in remote communities are generally more likely to be effective at achieving outcomes than those that are not. Consistency and coordination at the policy level can assist in serving complex needs. A review of the evidence for greater coordination in service delivery to remote communities found that, although the evidence base is limited:

> International and Australian research suggests that coordinating services can reduce complexity, enhance service quality and provide a foundation to deliver achievable outcomes to users. (Stewart, Lohoar and Higgins 2011, p. 3)

The characteristics of remote communities mean that service models involving bundling of services might deliver benefits over standalone services. While current arrangements have contributed to fragmentation, there is no reason why bundled services cannot be purchased through tendering processes. For example, in 2012 the WA Government commenced a Transitional Housing Program in Kununurra. The Housing Authority built 40 houses and, in collaboration with the Kimberly Development Commission, a community housing

provider, and a community services provider, manages the tenancies and provides wrap-around support to the participants. Services are tailored to the participants' needs and may include financial management, healthy living, and home maintenance support and mentoring as well as referrals to community support networks. Early indications suggest that the program is achieving favourable outcomes.

As of June 2015, 39 of the 40 households in the program have at least one adult employed. There are 43 school-aged children in the program with attendance at 96%, well above the Kimberley average of 66.5% for Aboriginal children. Two participants have progressed to home ownership with a further two obtaining home loan pre-approval. Another four participants have home loan applications pending. (WA Housing Authority 2016)

Greater community control and engagement

To be effective at achieving their intended outcomes, human services must be responsive to the needs of users, and to the needs of the communities they operate in. In remote communities decisions around service delivery, such as who receives services, when and where, are too often made by governments and service providers with little opportunity for informed user choice or community voice.

Place-based service models, which take into account the circumstances and preferences of communities, may be more suitable for remote Indigenous communities.

Importantly, place-based approaches build community capacity to identify and develop solutions to issues. These approaches are also more likely to lead to sustainable improvements over the longer term. (Indigenous Affairs Group DPMC, sub. 265, p. 2)

Expanding community control over human services can lead to better outcomes. Community control has been associated with better outcomes for Indigenous people in Canada (box 7.2).

Approaches in some areas of human services demonstrate that services designed around the needs of Indigenous communities can improve access to essential services. The Aboriginal Community Controlled Health Organisations (ACCHOs) are an example and are widely used where they are available. The peak body, the National Aboriginal Community Controlled Health Organisation stated:

ACCHO's are the dominant choice of Aboriginal people in all geographical areas where they are located. (sub. 227, p. 7)

And further:

Our sector has direct interaction with over 50% of the total Aboriginal population nationally and close to 100% of the Indigenous population living within a 60 minute access in those areas in which an ACCHO is located. (sub. 227, p. 3)

The preference for community controlled health services is apparent even in areas with private alternatives:

> Of note, Danila Dilba (the ACCHS servicing the Darwin region) is rapidly expanding with episodes of care almost doubling from 2009/10 to 2014/15. This large service now provides care to most of the Aboriginal population in Darwin, despite the plethora of private general practices operating in Darwin. (Aboriginal Medical Services Alliance NT, sub. 274, p. 3)

Box 7.2   Community control in Canada

Lavoie et al. (2010) investigated the relationship between community control, access to health services and health outcomes for people living in Indigenous communities in Manitoba. Outcomes were measured using the rate of hospitalisation for ambulatory care sensitive conditions (conditions for which hospitalisations may be avoided by access to primary care). The authors found that communities which had signed an agreement increasing local autonomy over resource allocation had lower rates of hospitalisation. They also found that greater local access to primary health care was associated with reduced hospitalisations.

Chandler and Lalonde (1998) examined Indigenous youth suicide rates in Canada. They found that youth suicide rates varied significantly across Indigenous communities:

> … some communities show rates 800 times the national average, while in others suicide is essentially unknown. (Chandler and Lalonde 1998, p. 1)

They also found that the rate of suicide was strongly (negatively) related to a community's level of 'cultural continuity'. The measure of cultural continuity included the level of self-government, community control (of traditional lands and services such as education, police and fire protection and health) and preservation of culture (existence of cultural facilities in the community). Each indicator of cultural continuity was found to be associated with lower rates of youth suicide.

More stable policy settings

Indigenous Australians living in remote communities have experienced frequent and disruptive change to policies, programs and organisations. This limits the ability of service providers to form relationships and establish trust with communities, and to attract and retain staff. It also limits the capacity of governments, providers and communities to learn from experience, innovate and improve service delivery. Over time it leads to communities being reluctant to engage with new initiatives.

> Indigenous leaders and communities trying to take responsibility for improving the future of their peoples are too often stuck in a morass of red tape and policy churn associated with the political cycle and the all-too-temporary whims of successive governments and their ministers. While we have the knowledge about our lives and communities, government holds nearly all the power. (Empowered Communities 2015, p. 8)

Given this history of instability, it is particularly important that the costs of reform (including transition costs) be taken into account when considering policy changes.

PRELIMINARY FINDING 7.1

Current arrangements for purchasing and delivering human services are not fully meeting the needs and preferences of Indigenous Australians living in remote communities.

- Improving the quality of services and providing services in a more culturally appropriate way could improve outcomes for Indigenous Australians living in remote communities.

- Better coordination of services to address people's needs could overcome some of the problems that arise from service fragmentation.

- Place-based service models and greater community voice in service design and delivery could lead to services that are more responsive to the needs of people in these communities.

- More stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving the wellbeing of Indigenous Australians living in remote communities.

8 Grant-based family and community services

8.1 Services to support individuals and their families

Family and community services provide 'relief of poverty, social disadvantage, social distress and hardship; the provision of emergency relief or support; and the advancement of disadvantaged groups' (PC 2010, p. xv). Examples include services for family support, homelessness, family and domestic violence, alcohol and other drugs, and financial counselling. While often grouped under the banner 'community services', government-funded services generally focus on improving outcomes through the provision of specific services for individuals and families, rather than being directed to community-level projects.

Hundreds of thousands of people use family and community services every year. For example:

- in 2014-15, about 260 000 people received homelessness services (SCRGSP 2016a)

- in 2013-14, about 22 000 children commenced intensive family support services (AIHW 2015d)

- in 2014-15, about 115 000 individual clients were estimated to have received alcohol and other drug treatment (AIHW 2016c).

The majority of family and community services are provided by mission-driven not-for-profit organisations that receive grant funding from governments. Some services are provided directly by governments, such as some family support services that are provided by the governments of Western Australia, South Australia and the Northern Territory (WA CPFS 2016; NT DCF 2015; South Australian Government 2015). Limited for-profit provision also occurs, including some out-of-home care services in the Northern Territory (NT DCF 2015).

Service providers are diverse in size and scope. By number, the majority of providers are small organisations that operate in a single location, often with the help of volunteers, and focus on a single service. Some larger organisations provide a range of services across many locations, and receive funding through numerous grants from several governments. One such organisation, Mission Australia (sub. 277), stated that it delivers 589 programs and services and receives funds from 41 government agencies as well as foundations and trusts.

Government funding for family and community services runs to billions of dollars each year. At July 2016, the Australian Government Department of Social Services reported that it had about 7000 grant funding agreements in place for 'families and communities' programs, with a combined value of about $2.8 billion. These funds were allocated to about 6000 service providers using different types of competitive tender processes, or a direct selection process (DSS 2016b). State and territory governments together expend significantly more than the Australian Government. For example, the Victorian Department of Human Services allocates more than $1.4 billion per year to more than 1000 organisations to deliver services (Victorian DHHS 2014). The Queensland Government also spent approximately $1.4 billion in 2014-15, allocated to almost 1200 organisations (Queensland DCCSDS 2015).

8.2   Scope to improve outcomes

Current approaches to commissioning family and community services constrain the ability of these services to meet the needs of many people. There is significant unmet demand and some people who would benefit from services are not able to access them (St Vincent de Paul Society National Council, sub. 285). Most of these services are provided with no charge to service users so unmet demand does not, of itself, indicate that access to services is inequitable. However, some people can face barriers to accessing family and community services that meet their needs.

> Often those in rural and regional areas do not receive a service due to the higher cost of service provision. (YFCC, sub. 92, p. 1)

> … data of Victorian Specialist Homelessness Services, shows that on average 108 people are turned away from services each day. (CHP, sub. 270, p. 3)

Service fragmentation is an impediment to the quality, efficiency, equity of access and responsiveness of family and community services. One determinant of effective service provision is how well services meet the needs of people requiring access to more than one service. In some cases service users progress from one service to another over time. For example, a woman escaping family violence might initially need emergency accommodation and, as her situation becomes more stable, she might need help with financial management and finding a job. Other service users have multiple, ongoing and complex needs and require coordinated assistance across several services, but are inadequately served when the system is fragmented and difficult to navigate. Not all users will require access to more than one service but, for those that do, effective service provision may mean that additional support is needed to help them navigate a fragmented system.

Although family and community services are widely used, there is no overarching system for identifying eligible service users, directing them to service providers or coordinating their care. Nor is the supply of services planned or coordinated — multiple agencies across all levels of government have a role, as do non-government organisations, and decisions about what services to provide, where and to whom, are often made in 'silos'. A lack of a

coherent system has led to duplication of some services and service gaps for others (Tasmanian DHHS 2016a). For providers, a fragmented system means they face overly complex funding flows that are based on 'programs' that do not always align with needs of service users and can exceed the capabilities of individual service providers (figure 8.1).

Figure 8.1   **Grant funding sources for family and community service providers**

Stylised model of the flow of grant funding for a hypothetical medium-sized provider of family and community services
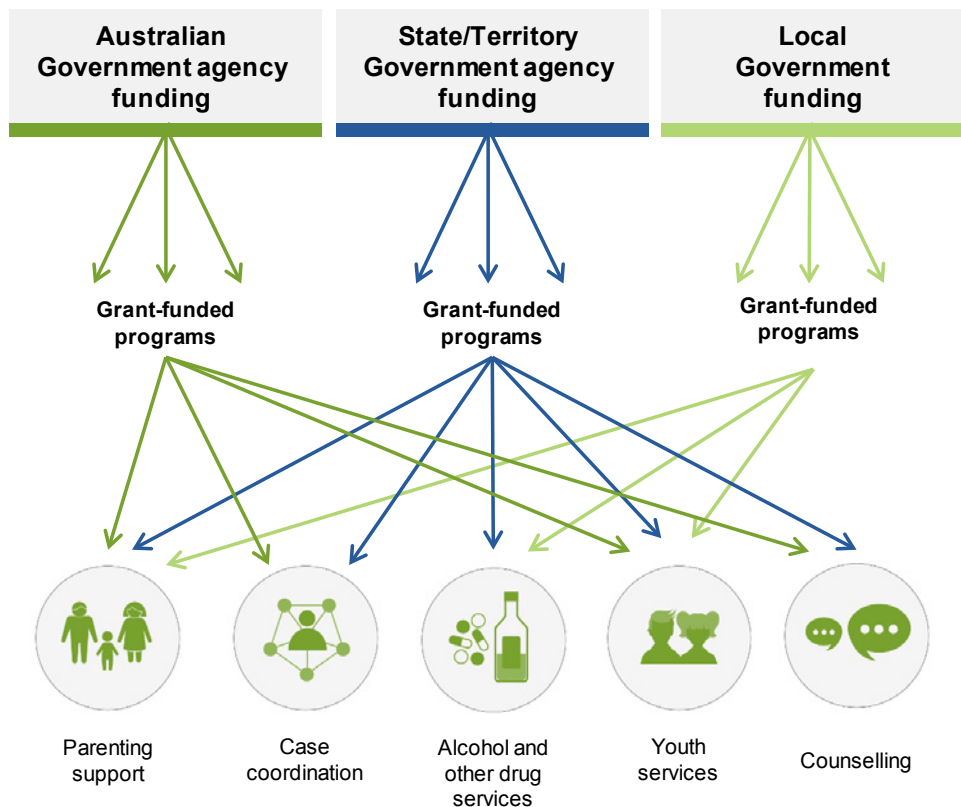
Source: Adapted from Dwyer et al. (2009).

Collaboration between service providers can reduce the effects of service fragmentation, and can improve service quality, responsiveness and efficiency. According to some participants the pressure to compete for contracts can undermine informal collaboration within the sector, and tender processes rarely provide adequate opportunities for providers to formalise collaboration through joint ventures.

> While governments rightly value the accountability of public expenditure what is often lost is a recognition that competition policy coupled with the segmentation of government social programs, works against collaboration between service providers, leading to poorer outcomes for individuals and communities. (CSSA, sub. 226, p. 3)

… we need to move away from tender processes that request collaboration but create competition. (CSIA, sub. 192, p. 4)

Contract terms that impose excessive administrative burdens can be a barrier to smaller providers. Monitoring and compliance activities are an essential part of governments' stewardship role. However, several participants stated that many of the reporting and compliance obligations that are currently part of service agreements are more focused on managing funding flows (the inputs and outputs of services) than on achieving outcomes for service users. Compliance activities that impose excessive administrative burdens can have a proportionately larger effect on smaller providers, which can be a barrier to new entrants and has the potential to reduce the diversity of service providers and delivery models (St Vincent de Paul Society National Council, sub. 285).

Prescriptive contract terms can be legitimate where they are necessary to protect community safety. For example, the Australian College of Mental Health Nurses (sub. 4) and Kim McMullan (sub. 9) stressed that minimum qualification requirements are important for effective service provision in community-based mental health and child protection services, respectively. However, requirements that are out of proportion to the risks involved in the activities can lead to high compliance costs and can stymie responsiveness and innovation.

> This command-and-control model of funding provides little scope to negotiate priorities and to evolve and innovate beyond prescriptive contractual obligations. (St. Vincent de Paul Society National Council, sub. 285, p. 8)

> … there is little improvement in the performance of services over time and there are few breakthrough innovations. Many social services have changed little over the last 20 years or more. (TACSI, sub. 155, p. 3)

Sturgess made a broader point about the willingness of governments to foster innovation.

> Government would like greater innovation in public services, but refuses to recognise the necessity of compensation for the risks involved in innovation. (2016, p. 5)

Increasing equity of access to family and community services, addressing fragmentation, reducing administration costs and designing contracts to foster innovation could all improve outcomes for service users.

8.3 Factors influencing the potential benefits of reform

There is diversity in service users' capacity to make choice

Users of family and community services have diverse characteristics and needs, and come to services in different circumstances. Some service users require emergency relief and make decisions at a time of stress, such as victims of family and domestic violence (CHP, sub. 270). Some service users might have diminished capacity to make informed choices or are not well-placed to make choices on their own behalf, such as the very young or those

with severe cognitive impairment. Participants identified that some service users are unaccustomed to making choices about their life.

> The disempowered consumer is someone who has not had the opportunity to exercise much agency in their life. They are unaccustomed to making proactive choices and need to build their capability in this area. This consumer often sits in the many disadvantaged population groups that draw on social services. (UnitingCare Australia, sub. 249, p. 11)

The diversity of service users' characteristics and circumstances influences the range of choices that are available to them and their capability to make informed choices. Many people who use family and community services are able to exercise informed choice about the services they access, although in practice they often have limited information and choice about their service provider or the type of service they receive.

It will not always be the case that users are well-placed to make decisions on their own behalf. In some cases the nature of the service can constrain people's ability to identify all their options and make an informed choice. For example, some family and community services are based on an outreach model, where the service provider 'chooses' the service user (such as, services supporting rough sleepers). For others, participation in a service, such as intensive family support or counselling, is a condition of a court order (NSW FACS 2014a; Victorian DHHS 2016).

Measures to empower service users and increase competitive pressures could lead to better outcomes for some service users and communities. The approach that will deliver the best outcomes for service users depends on the users and the service. For some services, 'supported choice' or 'person-centred care' might be appropriate. The Victorian, Tasmanian and ACT Governments are trialling person- and family-based service delivery models (ACT Government 2015b; Tasmanian DHHS 2016a; Victorian DHHS 2015c). Participants are supported by a lead worker who plans and coordinates tailored services, navigating the complexity of the service system, identifying service gaps and empowering users to achieve their goals.

This approach could be effective for numerous family and community services. In some circumstances user-directed funding (like the model being rolled out in disability services through the National Disability Insurance Scheme) might lead to improvements in users' outcomes. For this approach to work service users need to have access to a variety of service providers and to have the capacity and willingness to search for, compare and change providers.

Supply characteristics

The majority of family and community services are provided by mission-driven not-for-profit organisations that receive government grants and general assistance through, for example, the tax system. Mission-driven organisations provide services to individuals and families and also seek to make a contribution to civil society and to advocate for social

change. Several submissions revealed a tension between the value of funding not-for-profit organisations to pursue a positive (but often broad and unmeasurable) social mission, and funding models that are primarily focused on providing services to improve the wellbeing of individuals and their families (GSANZ, sub. 282; St Vincent de Paul Society National Council, sub. 285).

Family and community service providers face very different conditions depending on their location and types of clients. In some services and locations there can be economies of scale and scope that mean that serving large numbers of people and/or providing several different services can increase the efficiency and effectiveness of provision. Larger providers can achieve these efficiencies by bundling services that are funded through several grants, while smaller providers sometimes rely on cooperation with other organisations. Some providers engage in formal collaboration through joint ventures and subcontracting arrangements, but many collaborate informally 'on the ground' (Georgopoulos (2016); The Smith Family, sub. 257; St Vincent de Paul Society (2016)).

In regional and remote areas there might be less scope for diversity among service providers, or for economies of scale. Economies of scale might be less achievable for highly specialised or 'niche' services (such as services for people from specific cultural or linguistic backgrounds). Although their cost per user might be higher, smaller providers can be more responsive and efficient than larger providers at meeting the needs of specific groups. The Federation of Ethnic Communities' Councils of Australia (sub. 25, p. 3) stressed the importance of the role of niche providers:

> … consumers who are generally serviced by niche providers, such as ethno-specific providers, lose out in a market-based system because those niche providers may be disadvantaged in the market and would have to change and adapt. When designing systems for human services, it must be recognised that choice may be limited for those consumers.
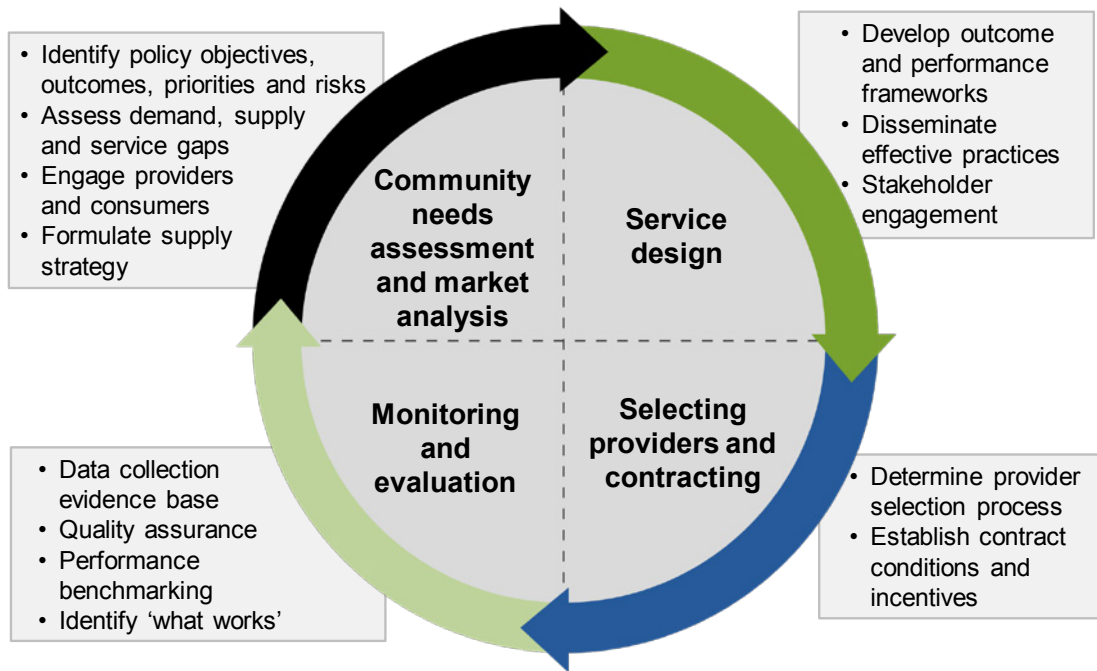
8.4 Increasing the benefits of contestability

Funding to deliver family and community services is usually contested through tender processes that entail at least a nominal threat of replacement by an alternate provider. Governments can seek to mimic competitive pressures through contestable arrangements to select providers and these arrangements can, under the right conditions, deliver some, or even many of, the benefits of effective competition. Participants suggested that the current arrangements for selecting providers are failing to achieve the benefits of contestability for governments and providers. Improvements to these arrangements could substantially improve service users' outcomes and reduce the costs to the community (CSIA, sub. 192; Jesuit Social Services, sub. 284; Mission Australia, sub. 277; TACSI, sub. 155).

In the context of family and community services, many of the relevant contestability arrangements are reflected in governments' processes for commissioning services. Commissioning is a broad concept and refers to a process by which governments identify policy priorities, design services and engage, select, monitor and evaluate providers. These

activities can be represented as a cycle (figure 8.2). The selected providers could be from within government (ideally with distance from the commissioning body) or from outside government, with contractual arrangements specifying the terms under which the service should be provided.

Figure 8.2   **The commissioning cycle**

- Identify policy objectives, outcomes, priorities and risks
- Assess demand, supply and service gaps
- Engage providers and consumers
- Formulate supply strategy

Community needs assessment and market analysis

Service design

- Develop outcome and performance frameworks
- Disseminate effective practices
- Stakeholder engagement

Monitoring and evaluation

Selecting providers and contracting

- Data collection evidence base
- Quality assurance
- Performance benchmarking
- Identify 'what works'

- Determine provider selection process
- Establish contract conditions and incentives

Sources: Based on Dickinson (2015); Department of Health (2015); NHS (2016); Routledge (2016).

Outcomes-focused planning, contracting and evaluation

Services should be planned and designed and providers selected and funded in a way that is oriented toward achieving positive outcomes for people using the services. Some participants agreed that governments should focus on outcomes to inform more effective commissioning at all stages of the cycle.

> There is scope to make reforms across the sector, and particularly in the child protection space, by introducing more flexible contracting models which place greater emphasis on achieving and rewarding outcomes. Current contracting models are generally prescriptive and are focussed on inputs and outputs, rather than outcomes and results. There is little incentive or scope to trial new approaches, evaluate and re-calibrate services to achieve better short and long term outcomes for clients. (Benevolent Society, sub. 129, p. 5)

Other participants regarded the emphasis on achieving results for individuals and accountability to governments as barriers to achieving their broader 'mission'.

The shift to competitive tendering and prescriptive contracts, often funded at below-cost, has led many NFP [not-for-profit] organisations to downgrade activities such as community development, social research and systemic advocacy, and to instead focus on meeting individual client demands and the performance indicators demanded by governments. (St Vincent de Paul Society National Council, sub. 285, p. 7)

The broader social effects of mission-driven organisations can be valuable and are supported through the tax system and other mechanisms. The focus of family and community services on improving individual and family outcomes needs to be the primary consideration for governments in designing and delivering family and community services funding.

Community needs assessment and market analysis

To be effective stewards of family and community services and to identify policy priorities, governments need to undertake systematic analysis of community needs, gaps in service delivery and risks. Commissioning agencies need to specify the program outcomes that are consistent with achieving policy priorities. These roles require data and analysis and engagement with providers and end users.

Resource allocation and planning should take into account any overlapping or complementary responsibilities across levels of government, and the varying costs of provision, particularly in regional and remote areas or for community groups with specific needs.

As stewards of family and community services, governments need to understand the characteristics of providers, and the risks and opportunities they pose for achieving outcomes for users. For example, providers that are 'too big to fail' can pose problems for governments.

In the UK, experience has shown that government departments, when faced with escalating costs and poor performance, persevere with established service providers, partly because they have become reliant on the knowledge and goodwill of their agents and do not believe changing providers is a practical or cost-effective option. (ACTU, sub. 100, p. 9)

Service design and stakeholder engagement

The shift to contracting out family and community services has affected the capability of governments and providers. Some governments have experienced a loss of corporate knowledge of how these services work and instead have developed expertise in managing contracts (Centre for Policy Development, sub. 124). At the same time, they have created incentives for service providers to become experts in tender writing.

Governments should engage with service providers when designing programs and performance management frameworks so they can take advantage of providers' experience

in program delivery. Sturgess (2016, p. 7) illustrated the shortcomings in some current approaches.

> When I asked the general manager of one of Sydney's largest public hospitals about the difference between his world and the world of policy, he responded: 'My world is dirty' … His world was full of people who vomited or bled or had a drug-induced fit at the most inconvenient moment. Their world was not. The delivery environment as it was imagined by policymakers when they drafted the rules rarely resembled the world in which he worked.

Bringing the expertise of service providers and users into the process of service design is referred to as 'co-design'. It gives stakeholders opportunities to influence program design, the development of outcome measures that will be used to determine success and to assist governments in assessing the costs of providing effective services.

> Increasingly the community services sector is proposing the notion of co-design to enable the deep knowledge of the community services sector (this is particularly true for providers in long term services like housing, but also homelessness where service may be provided long after the initial "crisis response") to be utilized much earlier in the design phase of service delivery, program response and decisions around cost and scope of service provision. (National Shelter Inc., sub. 232, p. 5)

Co-design is not a prerequisite for effective commissioning, and excessively close relationships between governments and providers could have anticompetitive effects. Where these tensions can be managed, there is a case for considering this approach in the service planning and design stage, particularly when the government agency is no longer a provider of services and has less access to the knowledge associated with front-line service delivery.

Provider selection processes and contract management

Competitive tender processes can create incentives for providers to innovate and improve user outcomes and cost effectiveness, so they can secure ongoing funding. However, current approaches to procurement and contract management are not achieving the potential benefits of contestability, and are leading to negative consequences.

One issue that has often been raised in the context of competitive tenders is timing (Berends and Ritter 2014; KPMG 2015; SCARC 2015). Poor planning and timing of tender rounds can be a barrier to alternative providers applying to replace incumbents.

> … time allowed for tendering is typically two to four weeks, which inhibits proposed program development. And the forward schedule of tenders is often incomplete or out of date. (Robert Kerr, sub. 2, p. 8)

Some participants raised the challenges for service providers that are funded on relatively short contracts (three years or less). While time-limited contracts increase accountability and make the threat of replacement more meaningful for providers, the length of contracts affects providers' ability to deliver services and achieve positive outcomes. The need to

frequently reapply for funding and the associated uncertainty about ongoing funding distracts providers from core service delivery activities (CSIA, sub. 192; GSANZ, sub. 282; Mission Australia, sub. 277). Instability affects users too — the replacement of a provider or uncertainty about ongoing service provision can be highly disruptive for individuals (Benevolent Society, sub. 129), and can be particularly harmful for services that are based on trust.

> I'm reassessing whether to continue in the mental health sector rather than face constantly seeking new employment with limited contracts on offer. Many skilled workers I know have had to change jobs every few years and are leaving the sector, leaving the field bereft of their knowledge and experience. (Merinda Strahan, sub. 17, p. 1)

> Funding rounds need to be made at least for 5 years to reduce the stress placed on workers who have to resubmit for funding taking time away from the consumers they serve. (Nicole Hallahan, sub. 13, p. 2)

For large providers that receive numerous grants, the process of reapplying for funding is a never-ending process.

> ACCHS [Aboriginal community-controlled health services] face perennial funding shortages and multiple short-term funding contracts. One large ACCHS has more than 90 funding agreements and compliance requirements, only 16% of which are recurrent grants. (Alford 2014, p. 17)

Monitoring and evaluation

To exercise their stewardship role, governments need to ensure that providers are accountable for how they spend taxpayers' money and for providing services that meet quality standards. Stewardship of human services also includes evaluating outcomes to identify effective practices, and making ongoing improvements to policies and programs to disseminate innovations and improve service outcomes.

To undertake these functions, governments need to collect information. In some cases, governments require providers to collect information, but not the right information. This can be a barrier to identifying effective providers and practices, coordinating assistance for users with complex needs, learning from experience, refining contracts to deliver better outcomes and delivering user-oriented information to support choice. Several participants pointed out that data on inputs and outputs are not sufficient, and if the objective of data collection is to identify the effects of services, governments should collect data on user outcomes (CSIA, sub. 192; ACMHN, sub. 4).

> Government has a role (as market stewards) and a responsibility (as funder) to support organisations to develop consumer-centred outcomes measurement frameworks and tools. (White Ribbon Australia, sub. 223, p. 3)

Program evaluation is a critical input to the other stages of the commissioning cycle — without it, the spread and scale of evidence-based practices is significantly constrained (Deloitte Access Economics 2016; TACSI, sub. 155; White Ribbon Australia, sub. 223).

Program evaluation — and the identification of good practices and knowledge dissemination associated with it — is not occurring systematically and is not sufficiently resourced within government agencies (Donaldson 2016; Gruen 2016; Hudson 2016). Developing more consistent, systematic approaches to monitoring and evaluation could feed into the other stages of the commissioning cycle, and could contribute to better outcomes for the users of family and community services and lower costs for governments.

Governments are improving processes

Good commissioning is not easy to implement — it requires significant investments in expertise and resources. But it is not necessary to implement every element of the cycle simultaneously — any one change, implemented well, could contribute to better outcomes. Several state governments are trialling initiatives that seek to improve components of the commissioning for grant-based family and community services (box 8.1).

Box 8.1   Developments in commissioning practises

Efforts to improve outcomes for users of family and community services can be found within Victoria's *Services Connect* pilot, Tasmania's *Joined Up Human Services Project* and the ACT's *Better Services* initiatives.

In Tasmania and the ACT, place-based initiatives are being trialled. The aim is to better understand and plan for the community's needs and increase collaboration between providers, through local stakeholder engagement.

Services Connect is strengthened by an outcomes framework: 'to help fully understand and measure whether the services being funded and delivered are having a real and lasting impact on people's lives' (Victorian DHHS 2015a).

Other elements of the pilots include common needs assessment and referral processes and examining options for consolidating client records and sharing client information across service providers.

Sources: ACT Government (2015a); Tasmanian DHHS (2016a); Victorian DHHS (2015c).

Improving the way governments select, fund, monitor and evaluate providers of family and community services could improve outcomes for the users of those services.

- Governments could deliver a better mix of services if they took a systematic approach to identifying what the community needs.

- Engagement with service providers and users at the policy design stage could increase the quality and efficiency of services.

- Contract arrangements that are focused on outcomes for service users could increase the incentives for service providers to deliver services that meet people's needs and provide more scope for innovation in service delivery.

- Better use of data could help service providers and governments identify and disseminate effective practices.

- Measures to support user choice and introduce greater competition between service providers could create incentives for providers to improve services in some areas.

A Public consultation

In keeping with its standard practice, the Commission has actively encouraged public participation in this inquiry.

- Following receipt of the terms of reference on 29 April 2016, an advertisement was placed in The Australian newspaper and a circular was sent to identified interested parties.

- An issues paper was released on 16 May 2016 to assist those wishing to make a written submission. A total of 290 submissions were received prior to the publication of this preliminary findings report (table A.1). These submissions are available online at www.pc.gov.au/inquiries/current/human-services/identifying-reform/submissions.

- As detailed in table A.2, consultations were held with representatives from the Australian, state and territory governments, service providers and their peak bodies, unions, academics and researchers.

The Productivity Commission thanks all participants for their contributions to the study through written submissions and consultations. The Commission welcomes further written comment on the preliminary findings in this report, and will undertake consultations and hold roundtables to facilitate feedback from participants to inform the preparation of the study report. The due date for submissions is 27 October 2016.

Table A.1   **Submissions[a]**

Participant	Submission number
Aboriginal Medical Services Alliance of the Northern Territory (AMSANT)	274
Aboriginal Peak Organisations of the Northern Territory (APO NT)	275 #
Access Ministries	242
Aged & Community Services Australia (ACSA)	243
Aged Care Crisis (ACC)	273 *
Aged Care Guild	219 #
Aitkenhead, Wendy	78
Andrew, Dr Jane and Baker, Dr Max	140 #
Anglicare Australia	217
Asa, Shannon	208
Aspeling, Audrey	47
Australia and New Zealand Academy for Special Needs Dentistry (ANZASND) and Australian Society for Special Care in Dentistry (ASSCID)	200
Australian Acupuncture and Chinese Medicine Association Ltd (AACMA)	287
Australian Association of Massage Therapists (AAMT)	178
Australian Blindness Forum (ABF)	125 #
Australian Chamber of Commerce and Industry (ACCI)	283
Australian College of Mental Health Nurses (ACMHN)	4
Australian Council for Private Education and Training (ACPET)	279
Australian Council of Social Service (ACOSS)	276
Australian Council of Trade Unions (ACTU)	100
Australian Dental and Oral Health Therapists' Association (ADOHTA Inc)	99 #
Australian Dental Association (ADA)	230
Australian Education Union (AEU)	224 #
Australian Government Department of Social Services (DSS)	221 #
Australian Healthcare and Hospitals Association (AHHA)	134
Australian Nursing and Midwifery Federation (ANMF)	202
Australian Red Cross	203 #
Australian Services Union (ASU)	85
Australian Unity	94
Azzopardi, Donna	180
Baensch, Dr Allison	48
Baptist Care (SA) Inc	123 #
Barnes, Dr Richard	26
Barry, Laurie	113
Bartlett, Francine	215 *
Becker, Elizabeth	212
Benevolent Society	129
Best, Pat	65
Bestic, Dr Jill	159

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Table A.1 (continued)

Participant	Submission number
Better Caring	252
Bordignon, Maria	115
Borland, Jody	143
Boyce, Evelyn	147
Brell, John	51
Brewer, Charlotte	96
Brotherhood of St Laurence (BSL)	286
Bupa	258
Burrows, Matt	206
Business Council of Co-operatives and Mutuals (BCCM)	216
Butterworth, Matilda	22
Cameron, Dr David	162
Campbell, Steven	290
Carers Australia	259
Case Health	251 #
Catholic Health Australia (CHA)	236
Catholic Social Services Australia (CSSA)	226
Catholic Social Services Victoria (CSSV)	272
Central Queensland Financial Counselling Service (CQFCS)	119
Centre for Policy Development (CDP)	124 #
Cluney, William	112
Cochrane, Dr Fiona	169
CoHealth	240
Collins, Isabell	199
Combined Pensioners and Superannuants Association (CPSA)	121
Commisso, Rosanna	209
Community and Public Sector Union (CPSU) and State Public Services Federation Group (SPSF)	253
Community Colleges Australia	264
Community Council for Australia (CCA)	193
Community Employers WA	126
Community Services Industry Alliance (CSIA)	192 #
Consumer Action Law Centre (CALC)	260
Council of Private Higher Education (COPHE)	280
Council to Homeless Persons (CHP)	270
Crain, Dave	165
Darby, Dr John	188
Darebin City Council	214
Davill, Nicole	41
Davison, Andrew	15

(continued next page)

Table A.1   (continued)

Participant	Submission number
Day, Helen	156
Deering, Patricia	225
Disability Advocacy Victoria (DAV)	231
Disability Council NSW	118
Doctors Reform Society Australia (DRS)	144
Donaldson, Janine	157
Doss, Dr Arockia	1 #
Douglas, Claire	60
Down, Judi	36
Egerton, Thorlene	117
Electrical Trades Union of Australia (ETU)	229
Elliott-Rudder, Megan	63
Esots, Jenny	73
Family Life	57
Federation of Ethnic Communities' Councils of Australia (FECCA)	25
Flower, Beryl	137
Fong, Jenny	29
Franklin, Jacqueline	103
Funder, Dr John	211
Fyfe, Angela	190
Gabriel, Julie	111
Gaggin, Patricia	23
Gamble, Carole	81
Gillson, Robert and Gillison, Janet	185
Gilmour, Anne	201
Good Shepherd Australia New Zealand (GSANZ)	282
Goodfellow, Tony	20
Goodstart Early Learning	255
Gray, Donna	70
Gruner, Barbara	187
Gunn, Dr. Andrew	6
Hall, Stafford	11
Hallahan, Nicole	13
Hanscombe, Norman	82
Health Care Consumers' Association (HCCA)	239
Heilbronn, Stan	53
Hendrickx, Leonardus	150
Henry, Gabrielle	146
Hill, Dr Christine	89

(continued next page)

Table A.1   (continued)

Participant	Submission number
Hills, Dr Ian	88
Hogg, Elizabeth	39
Home Modifications Australia (MOD.A)	228
Homelessness Australia (HA)	149
Homelessness NSW	175
Hooper, Ron	163
Hope Community Services	204
Hornagold, Margaret	246
Hudson, Prof. Bob	182
Hunt, Verena	68
Illawarra Forum Inc	238
Incerti, Kate	141
Independent Schools Council of Australia (ISCA)	179
Independent Schools Victoria	58
Indigenous Affairs Group - Department of the Prime Minister and Cabinet (DPM&C)	265
Inner South Community Health Services (ISCHS)	244
Irving, David	12
Jacobs, Prof. Keith	3
Jesuit Social Services (JSS)	284
Jobs Australia	268
Jolley, Dr Gwyn	72
Jones, Jackie	161
Jones, Krishna	19
Justice Action	101
Kain, Diana	168
Kane, Jill	197
Keena, Daren	44
Keleher, Trina	56
Kenisciehad, Kaijin	114
Kerr, Robert	2 #
Kirkham, Pat	160
Kolosovs, Lisa	133
Kyd, Michael	171
Lavery, Anne	59
Leading Age Services Australia (LASA)	177
Lochner, Sheri	93
Lodge, Teresa	164
Luckie, Paris	76
MacKenzie, Colin	75

(continued next page)

Table A.1 (continued)

Participant	Submission number
Macular Disease Foundation (MDF) Australia	95
Maddocks, Prof. Ian	116
Mamalis, Elle	18
Marsh, Prof. Ian	288 #
Marshall, Linley	195
Martin, Paula	66
Mascarenhas, Dr Lester	184
Mathew, Rob	77
Mbanza, Rogers	35
McAuley Community Services for Women	241
McCall, Marguerite	74
McCarthy, Cheryl	105
McCluskey, Miriam	64
McCormack, Fay	21
McCreath, Sally	189
McGinty, Jared	107
McGrath, Sandra	14
McLeay, Dr Graeme	166
McLoughry, Kim	34
McMullan , Kim	9
McMurdo, Dr Rob	79
Melvin, Robert	106
Mid North Coast Human Services Alliance (MNC HAS)	220
Miller, Dr David	83
Miller, James	62
Mission Australia	277
Mitchell, Leigh	97
Morgan, Craig	108
Morley, Dr Tom	49
Municipal Association of Victoria (MAV)	256
Name Withheld	24
Name Withheld	37
Name Withheld	38
National Aboriginal Community Controlled Health Organisation (NACCHO)	227
National Disability Services (NDS)	262
National Rural Health Alliance (NRHA)	269
National Shelter Inc.	232
Nayler, Tracey	98
Nepean Community & Neighbourhood Services (NCNS)	191

Table A.1 (continued)

Participant	Submission number
Neyland, Nita	42
Nicholls, Taraeta	148
NSWFHA, CHCSA, CHFV, CHIA, PowerHousing Australia and Shelter Tas	235
NSW Government	122 #
NSW Meals on Wheels Association Inc	7
NSW Nurses and Midwives' Association (NSWNMA)	247
NT Department of Treasury and Finance (NTDTF)	261
O'Reilly, Stuart	91
Optometry Australia	5
Ostrovska, Milena	153
O'Sullivan, Anne	183
Paech, Jason	16
Pande, Dr Divya	158
Parkes, Vanessa	136
PeakCare Queensland Inc	128
Pickard, Dr Marion	102
Powles, Anne	196
Ramsden, Robert	135
Refugee Council of Australia (RCOA)	271
Regan, John	104
Ricketts, Michelle	84
Rigutto, Gemma	50
Roberts, Julie	167
Rose, Sally	67
Rosenblatt, Jennafa	45
Rosenthal, Stanley	181
Ross, Kathleen	33
Royal Australian College of General Practitioners (RACGP)	8
Royal Flying Doctor Service of Australia (RFDS)	174
Ruzzene, Nora	145
Sandon, Terry	55
Sarkies, Mitchell	80
Save the Children Australia	222 #
Scantlebury, Lynda	213
Schien, Dr Michael	52
Schmidt, Dr Malgorzata	186
Scott, Prof. Anthony, Yong, A.Prof. Jongsay and Mendez, Dr Susan	87
Scott-Mills, Nicholas	210
Seldon, Prof. H Lee	170

Table A.1   (continued)

Participant	Submission number
Service, David	289
Settlement Council of Australia (SCoA)	278
Sex Workers Outreach Project (SWOP)	172
Shaw, Josephine	46
Shelter Tasmania	233
Silberberg, Prof. Jonathan	194
Silberstein, Dr Nicholas	90
Silver Chain Group	176
Skappel, Robert	130
Slatyer, Beth	154
Smith, Catherine	218
Smith, Greg	71
Smith, James	139
Smith, John M.R.	142
South Australian Government	281
Southern Migrant and Refugee Centre (SMRC)	263
Southern Youth and Family Services (SYFS)	234
Spicer-Wensley, Merriwyn	138
St Vincent de Paul Society National Council	285
St Vincent's Health Australia (SVHA)	207
Steen, C	10
Stephenson, Una	86
Stevens, Natalie	205
Strahan, Merinda	17
Strutt, Sue	198
Tattersall, Karl	40
TEAMhealth Inc.	250
The Australian Centre for Social Innovation (TACSI)	155
The Bridge Youth Service, Connect GV, FamilyCare and Primary Care Connect	266
The Centre for Independent Studies (CIS)	152 #
The Smith Family	257
Thomas, Kerry	30
Toner, Dr Phillip	254
Toora Women Inc.	245
Triple P International Pty Ltd	127
Truscott, Karen	32
United Voice	237
Uniting Church in Australia, Synod of Victoria and Tasmania	173
UnitingCare Australia	249

Table A.1 (continued)

Participant	Submission number
van Kessel, Sister Susan (Lucy)	69
van Someren, Rachel	109
Varkey, Shobha	151
Vaughan, Andrea	132
Victorian Alcohol and Drug Association (VAADA)	248
Victorian Multicultural Commission	120 #
Villis, Angela	43
Vision Australia	28 #
Wall, Terry	110
Walshe, Sue	54
Warwick, Anne	131
Western Australian Prison Officers' Union of Workers (WAPOU)	267
White Ribbon Australia	223
Whiting, Paul	27
Wicks, Genevieve	61
Worrall, Hugh	31
Youth, Family and Community Connections Inc. (YFCC)	92

a An asterisk (*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

Table A.2 **Consultations**

Participant

New South Wales

Aged Care Guild

Australian Commission on Safety and Quality in Health Care (ACSQHC)

Australian Council of Social Service (ACOSS)

Benevolent Society

Better Caring

Centre for Independent Studies (CIS)

Currow, Prof. David

Eagar, Prof. Kathy

Homelessness NSW

Independent Hospital Pricing Authority (IHPA)

Mission Australia

NSW Federation of Housing Associations

NSW Government

Sturgess, Prof. Gary

TAFE Directors Australia (TDA)

YFoundations

Youth Action

Victoria

Australian Council for Private Education and Training (ACPET)

Australian Dental Association (ADA)

Australian Education Union (AEU)

Brotherhood of St Laurence (BSL)

Grattan Institute

Independent Schools Victoria

Jobs Australia

Learning First

National Disability Insurance Agency (NDIA)

National Tertiary Education Union (NTEU)

Scott, Prof. Tony

The Australian Centre for Social Innovation (TACSI)

Queensland

Brisbane Housing Company (BHC)

Institute for Social Science Research (ISSR)

Logan Together

National Shelter

Q Shelter

Queensland Government

UnitingCare Queensland

Table A.2 (continued)

Participant

South Australia

National Centre for Vocational Education Research (NCVER)

SA Government

Western Australia

Anglicare WA

Disability Services Commission (WA)

Silver Chain Group

Western Australian Government

Tasmania

Tasmanian Government

ACT

ACT Government

Aged & Community Services Australia

Australian Government Department of Education and Training

Australian Government Department of Employment

Australian Government Department of Health

Australian Government Department of Social Services (DSS)

Australian Government Department of the Prime Minister and Cabinet (PM&C)

Australian Healthcare & Hospitals Association (AHHA)

Australian Research Alliance for Children & Youth (ARACY)

Catholic Health Australia (CHA)

Catholic Social Services Australia (CSSA)

Council of Private Higher Education (COPHE)

Council on the Ageing Australia (COTA)

Disability Advocacy Network Australia (DANA)

Federation of Ethnic Communities Councils of Australia (FECCA)

Group of Eight Australia

Independent Schools Council of Australia (ISCA)

National Aboriginal Community Controlled Health Organisation (NACCHO)

National Home Doctor Service (NHDS)

Palliative Care Australia (PCA)

UnitingCare Australia

Universities Australia

Table A.2   (continued)

Participant

Northern Territory (continued)

Carers NT

CatholicCare NT

Central Australia Health Service (CAHS)

Central Australian Aboriginal Congress (CAAC)

Central Australian Affordable Housing Company (CAAHC)

Ltyentye Apurte Catholic School

MacDonnell Regional Council

NT Council of Social Service (NTCOSS)

NT Government

Santa Teresa Local Authority

New Zealand

New Zealand Productivity Commission

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