Australian Government

Productivity Commission

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

Productivity Commission Study Report

November 2016

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).

Foreword

The Australian Government asked the Commission to investigate whether the efficiency and effectiveness of human services could be improved by introducing greater competition, contestability and informed user choice. The inquiry is to be undertaken in two parts. The first part is 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 publication of this study report marks the conclusion of the first part of the inquiry and sets out the Commission's view on the priority areas where reform could offer the greatest improvements in individual wellbeing and community welfare.

For the services identified as best suited, the second stage of the inquiry 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.

The Productivity Commission acknowledges the valuable contribution of all those who contributed to this study through consultations and written submissions.

Stephen King   Sean Innis
Commissioner   Special Adviser

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

[Received 29 April, 2016]

Contents

Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACNC	Australian Charities and Not-for-profits Commission
AIHW	Australian Institute of Health and Welfare
CAPDS	Child and Adult Public Dental Schedule
CDBS	Child Dental Benefits Schedule
CRA	Commonwealth Rent Assistance
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DHSV	Dental Health Services Victoria
DSS	Department of Social Services
GP	General Practitioner
IHPA	Independent Hospital Pricing Authority
MBS	Medicare Benefits Schedule
NDIA	National Disability Insurance Agency
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 has prioritised six areas where outcomes could be improved both for people who use human services, and the community as a whole. Reform could offer the greatest improvements in outcomes for people who use:
    - social housing
    - public hospitals
    - end-of-life care services
    - public dental services
    - services in remote Indigenous communities
    - government-commissioned 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.

- 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. The introduction of greater competition, contestability and choice does not preclude government provision of services.

- Access to high-quality human services, such as health and housing, underpins economic and social participation.
    - The enhanced equity and social cohesion this delivers improves community welfare.

- Government stewardship — the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives — is critical.
    - Stewardship 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 and for providers to tailor their service offering to better meet users' needs.
    - Transparent use of data drives improvements in the performance of the system for the provision of human services and increases accountability to those who fund the services.

Overview

Introduction

High-quality human services, such as health and housing, 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, of the 256 000 people who accessed specialist homelessness services in 2014-15, about 28 000 people 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. People with multiple needs can face particularly high barriers to access — barriers that are often made even higher by difficulties navigating a complicated system of service delivery.

Designing and managing 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, cooperatives and mutual organisations, mission-driven organisations that rely on volunteers and donations, and for-profit entities. Each will have a different balance between profit, organisational, social and other motivations. They can be large or small. Some will provide multiple services while others will specialise in specific services, or cater for specific users. The people who are served are diverse in their needs, preferences and capabilities, including their capability to exercise informed choice. Data are critical to system design. Data on service provider costs and performance, and linked data about service users, have the potential to be used for more effective and targeted interventions, and ultimately to improve outcomes from the provision of human services.

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.

Figure 1   **Expenditure on human services**
$ billion, 2013-14
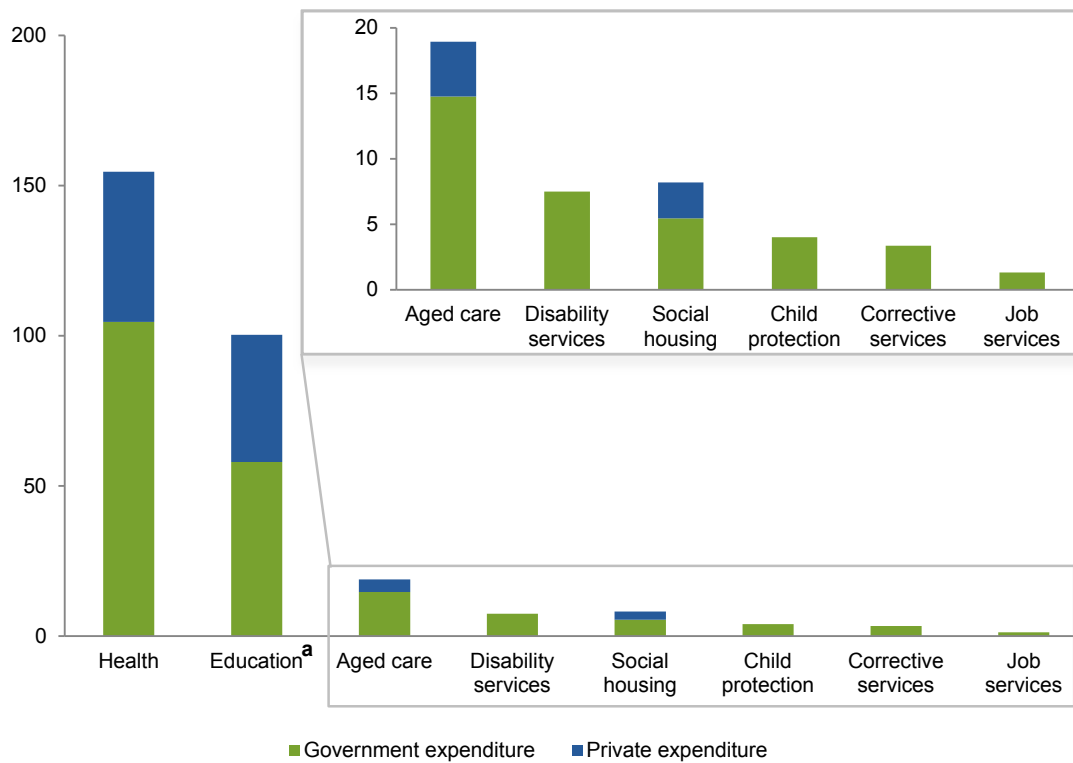
■ Government expenditure   ■ Private expenditure

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 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 reforms to introduce greater competition, contestability or informed user choice. For the services identified as best suited, the second part of the inquiry 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.

The Commission released a preliminary findings report in September 2016, outlining its initial views on which services should be carried forward to the second part of the inquiry, and sought feedback on those findings. The publication of this study report marks the conclusion of the first part of the inquiry and sets out the Commission's view on the priority areas where reform could offer the greatest improvements in individual wellbeing and community welfare.

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.

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.

Markets for human services are fundamentally different to those for other services. For example, the 'size' of the market for many human services is largely determined by the level of government expenditure. Who is able to access services is — at a broad level — decided by governments and can be targeted to users through eligibility criteria or open to all through universal access arrangements. Users rarely face the full cost of service provision. 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.

The nature of funding flows from governments to service providers and users — who receives the funding, when and on what basis — is a significant driver of outcomes from the provision of human services. For example, outcomes for service users, and the community more broadly, will differ depending on whether access to a service is demand-driven or if there is a fixed funding constraint imposed by governments. Some services are funded through payments to suppliers, while for others funding is placed in the hands of the consumer. Payments to service providers 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. At the extreme, user co-payments for a service may lead some users to go without the service, but services that are provided free to users could lead to overconsumption from a social perspective.

Governments have a stewardship role

Governments' stewardship role in the delivery of human services is broader than overseeing the market. Government stewardship relates to the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives. These functions include identifying policy objectives and intended outcomes, and designing models of service provision. Stewardship also includes developing regulatory and institutional arrangements to underpin service provision that is responsive to users, accountable to those who fund the services, equitable, efficient and high quality. Even in highly devolved delivery systems, governments retain ultimate responsibility for ensuring services deliver their intended outcomes.

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 vocational education and training (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 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 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 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 in 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.

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 this inquiry.

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.

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. Participants argued that not-for-profit providers deliver 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 which 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.

Additional benefits, such as those potentially offered by not-for-profit organisations, should be considered by governments when determining how best to maximise community welfare from the provision of human services. Where governments have objectives that are broader than improving outcomes for individuals and their families, these objectives should be transparent, both in terms of outcomes and funding decisions. Each type of provider, whether they are for-profit, not-for-profit or government providers, will have distinct capabilities and motivations. 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 over others.

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 users' hands lets individuals exercise greater control over their own lives. The increased agency this creates has merit. User choice can also generate powerful 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), 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 their own decisions. People vary 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. Very young people or people living with some types of mental illness, for example, may not be well-placed to make decisions — although some will have agents or carers who are able to make decisions on their behalf. 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, or to replace a poor provider with better performers. 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 active provider), with a 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.

Increasing competition and contestability is not an end in itself. Rather, competition and contestability 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, for example, due to thin markets in regional and remote areas.

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

Models of provision drawing on digital technology have the potential to improve service responsiveness and the ability of users to access a range of services. In health and aged care, telehealth and telecare technologies 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. Telehealth services are also being used in medical facilities and dental clinics to connect healthcare professionals in regional and remote areas with specialists based in capital cities.

Some providers are beginning to develop and evaluate telehealth and telecare technologies in Australia.

- GP2U is an online doctor service that allows users to have video consultations using an app on their smart phone or tablet. After the consultation, the GP2U service can electronically forward the users' pathology requests, specialist referrals or prescriptions for collection from a local pharmacy. About 20 000 patients use the GP2U service each year.

- Curo is a telecare provider that allows users to place sensors in their own home that unobtrusively monitor movement and room temperature. Curo's app interprets this information and alerts care providers and family members when the user completes daily tasks or when the room temperature is too hot or cold. Over time, Curo can determine changes in behaviour, such as waking up later than usual, which can assist providers to tailor services or detect early warning signs.

- CSIRO has partnered with not-for-profit organisations, local health districts and for-profit telecommunications companies to undertake a 12-month trial of home monitoring services for elderly patients with a chronic disease. The results found that users were less likely to need to visit a GP or be admitted to hospital, and users reported improvements in their quality of life and understanding of their condition.

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 factors, 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, needs and capabilities of users; and the diversity in purpose, size, scale and scope of providers. Not all of these factors 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.

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 improve the coordination of services and target service provision more accurately to the people who 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 draft report for its inquiry into *Data Availability and Use* has made recommendations to address these types of issues.

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

Non-government providers have been delivering many human services for a long time. Non-government provision has increased in some sectors since the mid-1990s, including school education, social housing 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.

The government and non-government provision of human services has involved instances of controversy or failure — there are examples of both government and non-government providers failing to meet standards of quality and accountability. Several participants expressed concerns 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 risk 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 include 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-driven, rather than profit-driven, will reinvest any surplus back into services to support less profitable areas. However, flaws in governments' processes for commissioning services can have negative effects on providers' ability to achieve outcomes for service users

- 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

- Power to Persuade, an organisation that moderates a discussion blog on public policy, noted that competition and contestability have the potential to fragment the human services sector and lead to a loss of provider diversity. The submission also noted that there had been examples of competition and contestability leading to exploitation of, and poor outcomes for, users, and that users of human services are often not well placed to make rational, informed decisions.

Each of these concerns is legitimate but may be minimised or avoided 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 models of service provision that capture one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice. The Disability Council NSW 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 improve the effectiveness of the service. Effectiveness can be 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 of effectiveness 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.

The Commission's framework

To assist with its task, the Commission has developed a three-stage framework to consistently assess the suitability of each service for competition, contestability and user choice reform (figure 2).

Figure 2   Identifying services best suited to reform

The framework 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 through submissions, consultations and roundtables, 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.

Table 1   Services assessed in this study[a]

Alcohol and drug services	**End-of-life care**	Mental health services
Allied health services	Family support services and out-of-home care	**Public dental services**
Child and family health services	General practitioners (GPs)	**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**	**Social housing**
Early childhood education and care	Job services	Vocational education and training
Emergency payments	Maternity services	

a Services are in alphabetical order. Services in bold are those identified by the Commission as best suited to reform. Commissioning arrangements for family and community services has also been identified as best suited to reform.

In identifying services, the Commission considered a number of factors, including:

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

- whether reforms to introduce greater competition, contestability or user choice are already proposed, or are underway (examples 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 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 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

- end-of-life care

- public dental services

- human services in remote Indigenous communities

- commissioning arrangements for family and community services.

In the case of family and community services, governments expend significant resources on services that provide emergency relief and ongoing support to people experiencing hardship. Much of that funding is allocated through contestable processes undertaken by governments but inquiry participants identified common issues with these processes in submissions, roundtables and other consultations. In the Commission's view, there is scope to improve outcomes for service users, and the community as a whole, by reforming the way governments commission service providers to deliver family and community services.

The priority areas identified by the Commission as best suited to reform 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. Many other services could also benefit from reform, but the areas identified reflect the Commission's views on the highest priorities for the Commission's current task. 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 *Caring for Older Australians* 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 that 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, greater user choice is being introduced in home-based aged care. Other human services, such as disability supports through the NDIS and early childhood education and care, are also being

reformed. All warrant continued scrutiny and evaluation to ensure the potential net benefits of those reforms are realised.

The Australian Government has also committed to reforming mental health services, including making the delivery of mental health services more contestable, evidence-based and person-centred. The Australian Government also noted that funding should target, and support, the choices of the individual user based on the level and type of need. The Commission supports the objectives of these important reforms, but notes that it is too early to evaluate their effectiveness.

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. Housing assistance can take three broad forms.

- Assistance with the costs of housing (through subsidised rents, such as those received by social housing tenants, or through income support payments).

- Support to access or maintain a tenancy (such as support for people with a mental illness or poor tenancy records, which make holding a private rental tenancy difficult).

- Transitional support for people to move into the private housing market from social housing or the social housing waiting list.

The Commission's focus is on services to people receiving support through the social housing system, and those who require support but are currently unable to access it. A number of services, assets and processes make up the social housing system, including the ownership and management of properties, the allocation of tenants to specific homes, and some tenant support services. Social housing covers both public housing (properties managed by state government housing authorities) and community housing (properties owned or managed by non-government providers). The Commission will consider the operation of the social housing system, as well as the interaction of the system with broader housing assistance policies, such as the effect of Commonwealth Rent Assistance on the demand for social housing.

About 400 000 households live in social housing. Recipients of social housing assistance, 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 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 with 20 per cent for other working-age recipients of an income support payment.

The focus of the social housing system has changed profoundly over time in Australia. There has been a shift in the demographics of people receiving support through the 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 assistance. It has also resulted in funding pressures on the system. A mismatch also exists between the level of support delivered via the income support system through Commonwealth Rent Assistance and the income-based rent model used in social housing. This mismatch is undermining the effectiveness of housing assistance in Australia.

A wide range of social housing systems exist internationally. In some systems, social housing makes up a significant proportion of the total housing stock, while in others (like Australia) social housing represents only a small percentage of the total housing stock. There is no benchmark for the 'right' level of social housing in an economy. 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 and assess the performance of service providers.

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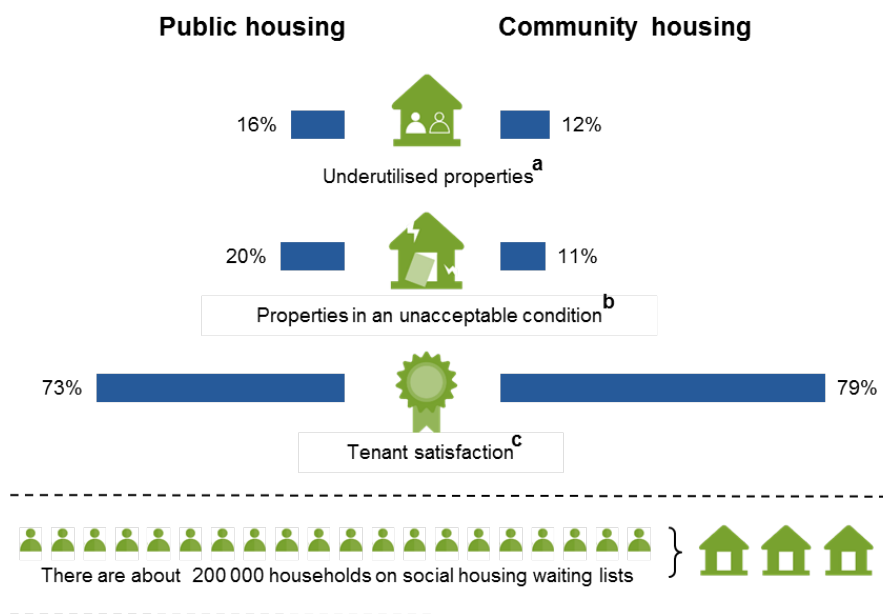
Public housing   **Community housing**

16%   Underutilised properties[a]   12%

20%   Properties in an unacceptable condition[b]   11%

73%   Tenant satisfaction[c]   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. **b** 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. **c** Tenant satisfaction is the percentage of people who reported being satisfied or very satisfied with their housing.

Offering more choice to social housing tenants

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

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. In other countries, efforts to improve users' choice of home have led to a range of benefits. 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 have been used to identify the housing characteristics that tenants prefer, and to target areas of high demand and need.

Demand for social housing outstrips supply. This has resulted in long waiting lists and waiting times. Approaches have been implemented overseas to provide greater 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.

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 government and non-government 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.
- 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 Australian health system is complex, with many different, but connected, parts and varying degrees of government involvement in funding and providing services. Policy objectives include equitable access to healthcare, timely delivery of services that meet the health needs and preferences of individuals (both to prevent illnesses and treat them when they occur), and that services are provided as efficiently as possible. An ongoing, and increasingly important, challenge has been to coordinate care that individuals receive across multiple providers, care settings and services.

The Commission considered the scope for greater competition, contestability and choice to contribute to these policy objectives across the numerous types of health services and concluded that this inquiry could add most value by focusing on public hospital services, for the reasons outlined below. While the inquiry will focus on this area, the Commission is mindful that public hospital services do not operate in isolation from other parts of the health system (such as private hospitals) and that coordinating an individual's care can lead to better patient outcomes.

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. Greater contestability and user choice could, as part of a wider range of reforms, lead to better outcomes for patients.

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).

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 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.

Greater user choice in Australia would need to be supported by more user-oriented information than is currently available, particularly on the clinical outcomes achieved by

individual hospitals and doctors. Overseas evidence suggests that some (but not all) consumers would use such information to seek out better-performing providers (box 4). There is also evidence that hospitals and doctors would use publicly reported data to benchmark themselves against other providers and seek to improve when they are below best practice. The opportunity for third parties, such as health academics, policy think tanks and consumer advocacy groups, to analyse publicly reported data would create further pressure on providers to improve outcomes.

The benefits of user choice would depend on the health literacy of patients because this would influence their ability and willingness to make informed choices. Providing greater choice at the point where individuals are referred to a specialist by their GP might be one 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, based on their place of residence (figure 4). This suggests that greater choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

Figure 4   **Elective surgery by sector and socioeconomic status of patient, 2014-15**
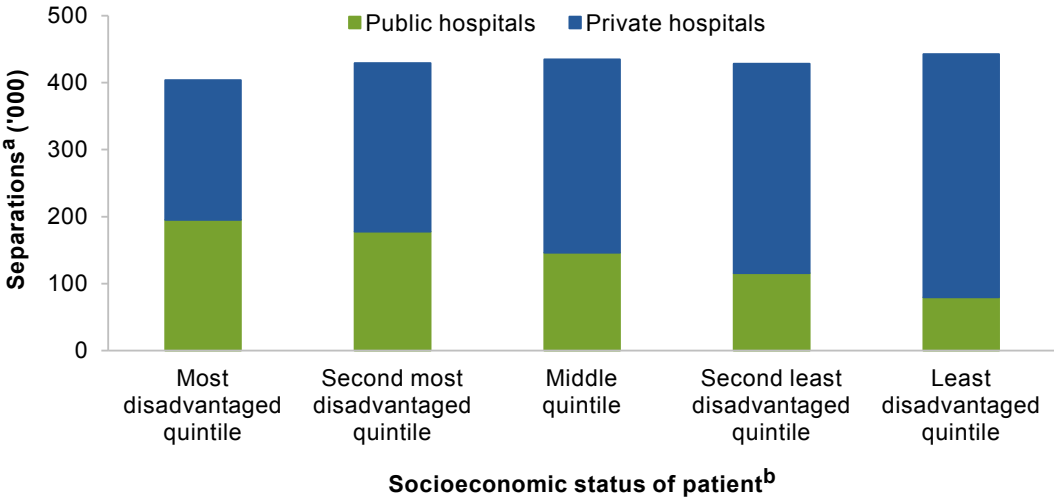
a A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). **b** Quintile of socioeconomic 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 reforms require careful design and implementation — 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.

FINDING 4.1

The Australian health system is complex, with many different, but connected, parts. There is already a high degree of choice and competition for many services, such as primary care provided by GPs and optometrists. A key exception is public hospital services, where greater user choice and contestability could, as part of a wider range of reforms, lead to better outcomes for patients.

- Australian hospitals generally perform well against those in comparable countries but there is still scope for many to improve patient outcomes and lower costs by matching the practices of better-performing hospitals within Australia.

- Overseas experience shows that user choice can lead to improved service quality and efficiency when patients are able to plan services in advance and access useful information. In Australia, this would require more user-oriented information on the clinical outcomes achieved by individual hospitals and doctors. Patients with low levels of health literacy would also need support, such as from their GP.

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

- 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.

End-of-life care

Major advances in medical science have enabled Australians to live longer and healthier lives but inadequate attention has been paid to ensuring Australians get the care they desire at the end of life.[1] The best available data suggest that most Australians wish to die at home — perhaps as many as 70 per cent — but few manage to do so (less than 13 per cent). A 2015 survey undertaken by Palliative Care Australia 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.

Better satisfying patient preferences regarding the timing and setting of care requires changes to end-of-life care services. As defined by the Australian Commission on Safety and Quality in Health Care, these services include physical, spiritual and psychosocial assessment, and care and treatment by health professionals and ancillary staff, provided to people who are 'likely to die in the next 12 months'. End-of-life care services also include support for families and carers during what is a difficult and stressful time, and care of the patient's body after their death.

Scope to improve outcomes

Australia's end-of-life care services are well regarded internationally, but more could be done to ensure patients receive the right care, in the right place at the right time. End-of-life care could be more responsive to patient preferences with regard to both where care takes place and when it takes place. Access to high-quality care is variable both within and between jurisdictions. There is evidence that Indigenous Australians, and people from culturally and linguistically diverse backgrounds are underserviced, as are people suffering illnesses other than cancer even though they have many of the same end-of-life care needs. A lack of comprehensive, publicly available national data about expenditure, patient activity and patient outcomes also limits the accountability of services and hampers efforts to improve service delivery.

Patient preferences could be better satisfied, and patient outcomes improved, if patients were provided with more choice about the timing and setting of end-of-life care. This could include extending access to high-quality care in different settings, and introducing greater contestability and competition as part of a broad suite of reforms.

Issues to consider in undertaking reforms

Any measures to increase user choice would need to accommodate changing preferences as death approaches (patients can become concerned about the burden placed on their family or carers, and opt to use inpatient services closer to end of life) and the special

---

[1] End-of-life care does not include assisted suicide or euthanasia.

circumstances associated with making choices at the end of life. Development of a life-limiting illness is emotionally taxing and psychologically distressing for patients, carers and loved ones. In this environment, making choices about end-of-life care arrangements is difficult. Unpredictable trajectories of deterioration in cognitive and physical functioning may also limit the ability of some patients (and their families) to plan ahead and express preferences for care. Greater awareness and implementation of advance care planning could help to address this.

Patients will need different medical and personal services as part of their end-of-life care, and so achieving improved outcomes will require change across different services and professions. Deeper integration of end-of-life care within existing service delivery models (including those used in primary and community care, hospitals and aged care facilities) will be crucial. Better coordination across services provided in different settings will also be important.

Introducing greater user choice would require careful design to ensure that the interests of patients and their families are well served. To the extent that this involves changes to the way end-of-life care services are commissioned, the benefits associated with collaboration between services would need to be recognised and arrangements put in place to ensure continuity of care between providers. Special measures for consumer protection may be needed given the vulnerability of users of end-of-life care services, the limited capacity of many users to exercise choice and the potential magnitude of harm should a service provider act without due care. More extensive data collection and improved monitoring and benchmarking of provider performance would also be required.

FINDING 5.1

Many Australians wish to die at home, supported by family, friends and effective care services, but often their wishes are not being met.

- There is scope to improve end-of-life care services by providing users with greater choice about the care they receive, and the setting of care. As part of a wider suite of reforms, contestability and competition could play a role in promoting user choice.

- Efforts to promote user choice would need to address the challenges associated with making decisions at the end of life. Complementary measures would also be required to improve the integration and coordination of care services across a variety of settings, allow for better measurement and monitoring of patient outcomes, and provide protection for vulnerable consumers.

Public dental services

Unlike most other forms of healthcare, governments only fund a small proportion of dental services but, when they do, these services are also typically provided by government. This is in contrast to, for example, eye tests and GP services, where the vast majority of funding

comes from the Australian Government via Medicare, but services are almost always provided by the private sector.

Public dental services act as a safety net by providing access to basic dental care. In 2013-14, public dental services accounted for about 14 per cent ($1.2 billion) of Australian expenditure on dental care. Among people who saw a dental professional in 2013, about 14 per cent attended a public clinic (including school clinics) at their last visit.

There is scope to improve outcomes

Publicly funded dental services play an important role in providing basic dental care for people who face financial and other barriers to access. Such services are often provided in clinics (and dental hospitals in some jurisdictions) operated by state and territory governments. Public dental clinics play a relatively large role in delivering dental services to remote communities. Even so, concerns have been raised about access to dental services in remote areas, including for Indigenous Australians. People living in remote Australia are more likely to suffer from poor oral health and to be hospitalised for potentially preventable dental conditions. More contestable delivery arrangements for public dental services that encourage more innovative and flexible service provision could improve access to dental services in remote communities.

The current emphasis on government provision of public dental services can limit the ability of patients to choose the time and location of their treatment. While users can sometimes choose between different public dental clinics, options may be more limited than if users were able to attend private dental practices. Voucher schemes have been used in some jurisdictions and have provided public dental patients greater choice over the timing and location of treatment, and their dental professional, by making use of private dental practices.

Among other things, greater choice over the timing and location of treatment, and dental professional may encourage some users to seek timely treatment for oral health conditions. Unfavourable visiting patterns, which are slightly more prevalent among adults eligible for public dental services, can ultimately lead to poor oral health (figure 5). Barriers that cause people to leave dental problems untreated are a concern not only for the individuals affected but also the wider community because they can lead to more costly treatment, particularly if the patient requires hospitalisation. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14.

The states and territories publish information on public dental activity levels, overall expenditure and waiting lists. However, there remains considerable scope to further improve accountability to those who fund public dental services (governments and users through co-payments). This includes greater public reporting, on a consistent basis, of clinical and other patient outcomes (such as from patient satisfaction surveys). Accountability would also be improved by releasing more detailed expenditure data, including on the cost effectiveness of public dental services.

Some participants observed that governments have found that public dental services are more costly when provided by the private sector. For example, a submission from Dr Martin Dooland noted that private sector provision was, on average, 30 per cent more costly than public provision for a course of general dental care for adults. Participants attributed the cost difference primarily to private clinics providing more services per patient. Other factors could also be at play, such as cross-sector differences in service quality, economies of scale, and the way costs are measured. The Commission will explore these issues in greater depth in the next stage of the inquiry.

Figure 5   **Oral health indicators, 2013[a]**
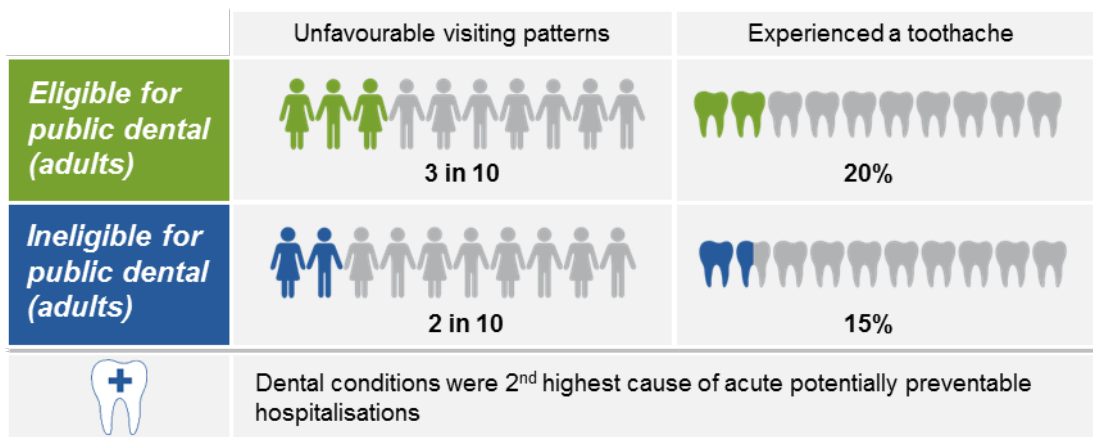
a Adults eligible for public dental care include people who held an Australian Government concession card. People were classified as having an unfavourable dental visiting pattern if: they visited a dental provider less than once every two years typically to receive treatment for a dental problem; or they visited once every two years typically to receive treatment for a dental problem, but do not have a regular dental provider. Visiting patterns and toothache data are based on the 2013 National Dental Telephone Interview Survey. The reported numbers are statistically significant at the five per cent level.

Potential models for greater competition, contestability and user choice

The preferred approach to reform may vary between urban, regional and remote regions, and between segments of the population. In areas where there is limited capacity to sustain multiple providers, the provision of public dental services could be made more contestable. There are many different models of contestability that could be applied to these services, such as inviting bids from government and non-government providers to operate or manage all or part of the service offering.

Delivery mechanisms that allow users to choose between competing dental practices could be used for populations that generally do not face difficulties in accessing care and are well serviced by the private sector. Such mechanisms are already used to some extent in all jurisdictions and this has shown that private dental practices can supply high-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 informed choices for users of public dental

services, possibly through a combination of information provision and person-to-person advice. Governments would also need to monitor the types of services provided, and how these services contribute to clinically- and cost-effective outcomes for individuals and the eligible population.

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.

- Public dental services act as a safety net by providing access to basic dental care, but there is scope to improve outcomes. Access to services is a concern for certain populations and the uncontested provision of services in government-operated clinics limits responsiveness to user preferences. While governments regularly publish information on public dental activity levels, overall expenditure and waiting lists, accountability could be improved through greater public reporting on patient outcomes and cost effectiveness.

- Users could benefit from having greater choice over the timing and location of treatment, and their dental professional. Greater choice may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary. In addition to initiatives already implemented by governments, encouraging more innovative and flexible public dental services could improve oral health in communities not well serviced by the private sector.

- The approach to greater competition, contestability and user choice should reflect the characteristics of users, availability of dental professionals, and cost effectiveness of alternative models. Service provision could be made more contestable in areas where there may be limited capacity to sustain multiple providers. More competition and choice could involve using delivery mechanisms that allow users to choose between competing dental practices.

Human services in remote Indigenous communities

The inquiry terms of reference ask the Commission to have regard to the challenges facing the provision of human services in rural and remote areas, small regional cities and emerging markets, and the need to improve Indigenous outcomes. These issues will be taken into consideration in the Commission's assessment of reform options in each of the services identified in this report. However, the provision of human services in remote Indigenous communities warrants additional consideration.

About 85 per cent of Australia is classified as remote. These areas are home to just over 2 per cent of Australia's population. In remote areas, the distance to the nearest town or service centre can be in the hundreds of kilometres. Service providers face barriers to effective service provision, such as a lack of and difficulty in accessing infrastructure, and difficulty recruiting and retaining staff. The challenges of remoteness can make the cost of providing services in remote Australia several times the cost in urban areas.

About one in five Indigenous Australians live in remote areas. In 2011, there were over 1000 discrete Indigenous communities in remote areas of which more than three quarters had a population under 50.

Physical isolation is a key reason why remote 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, reflecting a combination of factors, including culture and past experiences with government services. About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared with 2 per cent of Indigenous Australians living in non-remote areas. 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 were not culturally appropriate. The NDIS trial in the Barkly region of the Northern Territory 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.

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. For example, services may need to be coordinated between different remote locations and less remote towns to provide continuity of care to people who are mobile and need to access several providers. Technology can also assist in this area. In the Kimberley region, web-based electronic patient records are shared between health professionals, including Aboriginal Community Controlled Health Organisations and hospitals to enable continuity of care for the region's highly mobile population.

Improving outcomes in remote Indigenous communities

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 6).

Improvements to arrangements for purchasing and delivering human services for Indigenous Australians living in remote communities could lead to more effective service provision and better outcomes for service users. The service delivery arrangements for people living in remote Indigenous communities are overly complex. Funding and responsibility for service provision and outcomes are split across governments, departments, programs and providers. Although this is also the case in human services more generally, the negative effects of this are stark for remote communities with high levels of service fragmentation, and duplication in some areas and gaps in others.

In its submission to this inquiry, the Aboriginal Medical Services Alliance NT gave the 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 and yet this was the result of government policy to introduce greater competition and contestability into service delivery.

Figure 6   **Outcomes for Indigenous Australians, by remoteness, 2014-15**
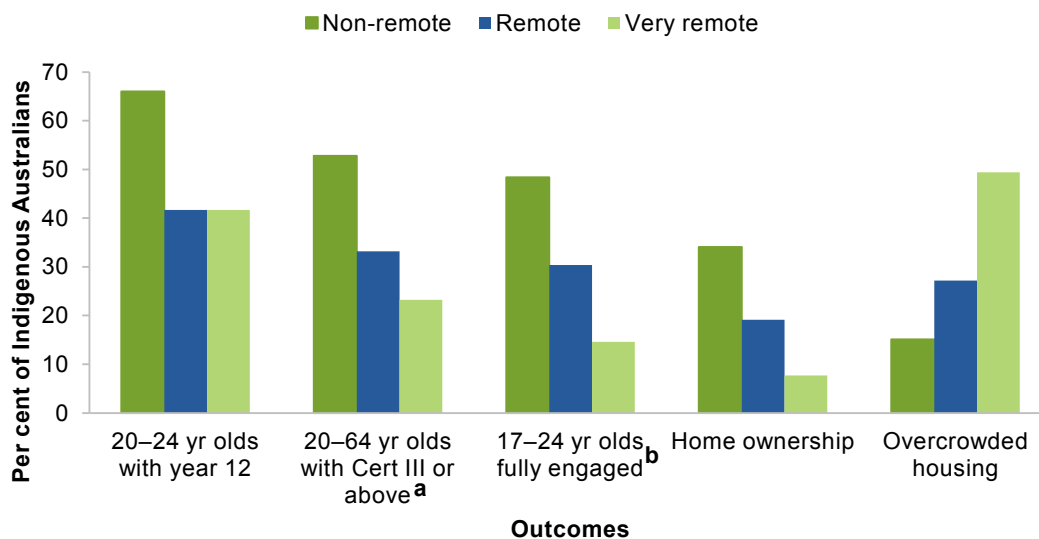
a Includes current students. **b** Fully engaged in post-school education, training and/or employment.

A way forward

Many economic and social factors drive outcomes in remote Indigenous communities. The nature of service provision and the characteristics of users mean that the service models that work in remote Indigenous communities may be different to those that work in other parts of the country.

There is a clear need to improve service delivery in remote Indigenous communities, but expectations of a quick fix are unrealistic. There is scope to improve outcomes over the long term through better design and implementation of policies to commission and deliver services in remote Indigenous communities.

The introduction of greater competition, contestability or user choice could improve outcomes for Indigenous Australians living in remote communities. Competition between

providers will not always be feasible or appropriate in remote communities, for example, when there are few providers, or for all services and service users. In these situations, effective contestability among service providers may deliver many of the benefits of competition. Redesigning arrangements for commissioning services and providers could encourage providers to improve service quality, use innovative service models, expand access so more people get the support they need, and reduce the costs to government and users who pay for those services.

Service responsiveness could be improved by introducing greater user choice, place-based service models, or greater community engagement. Improvements to commissioning arrangements could involve better coordination of service delivery and more integrated services. Many of the ideas discussed in the next section on commissioning family and community services also apply to services in remote Indigenous communities. Regardless of the service model chosen, more stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving the wellbeing of Indigenous Australians living in remote communities.

FINDING 7.1

Indigenous Australians living in remote areas are more likely to experience poor outcomes than other Australians. Inadequate access to human services is one factor that contributes to these poor outcomes.

- The service delivery arrangements for Indigenous Australians living in remote communities are complex and fragmented.
- Greater responsiveness to community needs through user choice, place-based service models or greater community engagement could improve outcomes.
- Many services are already contestable, but approaches to contestability are poorly designed and are not effective at meeting intended outcomes. Redesign of these arrangements is needed which, coupled with better coordination between governments, could improve outcomes including the efficiency of service provision.
- More stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving service outcomes for Indigenous Australians living in remote communities.

Commissioning family and community services

Family and community services play a broad role within the Australian community. Services generally seek to provide support for people who are in crisis or who are experiencing deep and persistent hardship, while building capacity and resilience. Examples include emergency payments and services for family support, homelessness, family and domestic violence, and alcohol and other drugs. Although many of these services are referred to as 'community services', government funding is not generally aimed at community-level projects, but at improving the lives of individuals and families. Hundreds of thousands of people access 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 a significant proportion 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 agreements with several governments.

Government funding for family and community services amounts to billions of dollars each year. In July 2016, the Australian Government Department of Social Services reported that it had about 7000 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). The focus in this inquiry is the arrangements that underpin the way governments commission family and community services using contestable processes.

There is scope to improve outcomes

There is scope to improve the quality of many family and community services, make access to services more equitable, increase the efficiency of both the services and the system as a whole, and to achieve a better balance between accountability and responsiveness.

- People outside metropolitan areas, culturally and linguistically diverse groups and Indigenous Australians can face significant barriers to accessing the family and community services that meet their needs.

- People with complex needs require coordinated assistance across several services. For example, a person escaping family violence who needs access to crisis accommodation, mental health support, financial counselling and legal advice is inadequately served when the system is fragmented and difficult to navigate.

- Resources are not allocated efficiently — there are gaps in some service types and locations, and duplication and overlap in others.

- Prescriptive contract terms that focus on managing funding flows (the inputs and outputs of services) rather than achieving outcomes for service users leave little scope for innovation or flexible approaches to service delivery. For example, the Community Council for Australia described how a government response to poor school attendance in a remote community might be to fund home visits by social workers, and to measure the success of the program by the number of home visits. This type of program does not provide scope for other approaches that could be more effective at achieving the intended outcome (higher school attendance).

Increasing the benefits of contestability

Most family and community services are commissioned by governments through processes that entail some degree of contestability — service providers face a threat of replacement. Commissioning is a broad concept, and contestability can be introduced at several stages of the commissioning process, including when governments engage, select and monitor service providers (figure 7). In practice, commissioning processes are often flawed and do not consistently deliver the benefits from contestability that should flow to governments and importantly, they are not effective at delivering outcomes for users. The scope for improving the effectiveness of family and community services largely relates to the *way* they are commissioned by governments, rather than increasing the use of contestable processes.

Figure 7   **Commissioning services to deliver outcomes**
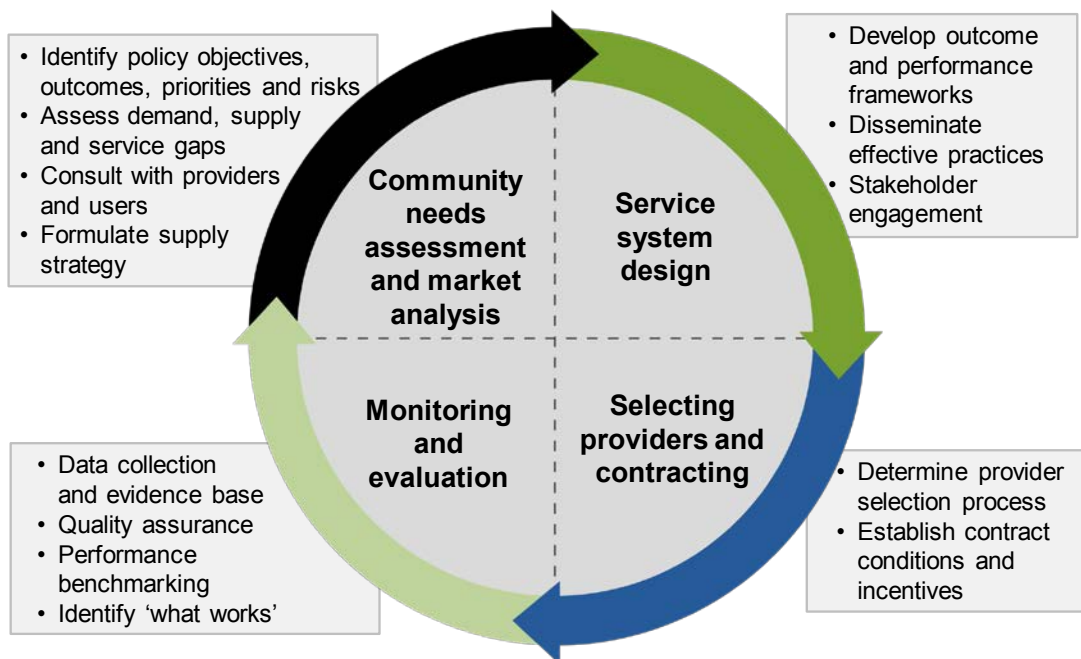
The first stage of effective commissioning is to identify community needs, policy priorities and service outcomes. This stage is essential for effective service planning and creates the framework for contestability between providers. Currently there is no overarching system for identifying community needs and the outcomes that can be achieved by family and community services.

The second stage of the process involves designing systems of service provision that will contribute to achieving outcomes, and the performance frameworks that establish the terms of funding agreements. Governments seldom take advantage of providers' experience and expertise in program delivery when designing systems of service provision. Instead,

programs are designed by government agencies that are often remote from the realities of 'what works'. Often what looks good on paper does not translate to the real world, and contracts specify approaches to service delivery that are inconsistent with achieving high quality services, equity or efficiency.

There are several flaws in provider selection processes and contract management. One is short time frames — service providers can have four weeks or less to submit tenders for funding. Short timeframes to submit tenders is a barrier to providers arranging joint ventures to exploit economies of scale and scope, and reduces the potential gains in quality and efficiency of using contestable processes. Another issue is the length of funding agreements, which generally run for three years or less. Time limits can sharpen the incentives of contestable processes by increasing the threat of replacement, but can also affect providers' ability to deliver and invest in services to improve outcomes for users.

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. Prescriptive funding arrangements limit the potential for contestable processes to improve outcomes for service users.

FINDING 8.1

There is scope for improvements in arrangements for commissioning family and community services that could lead to better outcomes for service users.

- A systematic approach to identifying community needs and prioritising services could lead to more equitable and efficient allocation of resources for family and community services.

- Service users are diverse in their needs and characteristics. Some have complex needs and require access to a range of services. Systems of service delivery that are flexible and enable service providers to be responsive to users are necessary to meet the needs of service users. Greater application of choice — of provider or of service — could improve outcomes for some users.

- Improvements to the way governments commission family and community services could capture more of the benefits of contestability, leading to higher quality services, better outcomes for individuals and families and more efficient use of government funds.

- Systems of performance management, compliance and evaluation should provide incentives for providers to focus on outcomes, innovate and disseminate effective practices.

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 this study report to identify services that are best suited to reforms to introduce greater competition, contestability or informed user choice.

For the services identified as best suited, the second part of the inquiry 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 a preliminary findings report in September 2016, which outlined the Commission's initial views on which services should be carried forward to the second part of the inquiry. The Commission sought feedback on these findings, and 105 submissions were received in response to this report

- further consultations prior to the release of this study report, including roundtables on social housing, public hospital services, end-of-life care services, public dental services, services in remote Indigenous communities, and commissioning arrangements for family and community services.

Further details on the consultation process can be found in appendix A.

The publication of this study report marks the conclusion of the first part of the inquiry and sets out the Commission's view on the priority areas where reform could offer the greatest improvements in individual wellbeing and community welfare.

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, submissions and public hearings.

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 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.

1.2   Roles for government in the provision of human services

High-quality human services underpin economic and social participation. 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.

Markets for human services are fundamentally different to those for other services. For example, the 'size' of the market for many human services is largely determined by the level of government expenditure. Who is able to access services is — at a broad level — decided by governments and can be targeted to users through eligibility criteria or open to all through universal access arrangements. Users rarely face the full cost of service provision. 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.

The nature of funding flows from governments to service providers and users — who receives the funding, when and on what basis — is a significant driver of outcomes from the provision of human services. For example, outcomes for service users, and the community more broadly, will differ depending on whether access to a service is demand-driven or if there is a fixed funding constraint imposed by governments. Some services are funded through payments to suppliers, while for others funding is placed in the hands of the consumer. Payments to service providers 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. At the extreme, user co-payments for a service may lead some users to go without the service, but services that are provided free to users could lead to overconsumption from a social perspective.

Designing and managing 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, cooperatives and mutual organisations, mission-driven organisations that rely on volunteers and donations, and for-profit entities. Each will have a different balance between profit, organisational, social and other motivations. They can be large or small. Some will provide multiple services while others will specialise in specific services, or cater for specific users. The people who are served are diverse in their needs, preferences and capabilities, including their capability to exercise informed choice.

Data are critical to system design. Data on service provider costs and performance, and linked data about service users, have the potential to be used for more effective and targeted interventions, and ultimately to improve outcomes from the provision of human services. Data relating to one human service can also have implications for other services — better use of data can improve service integration and improve whole-of-government decision making (chapter 2).

Governments have a stewardship role

Governments' stewardship role in the delivery of human services is broader than overseeing the market. Government stewardship relates to the range of functions undertaken by governments that help to ensure service provision is effective at meeting its objectives. These functions include identifying policy objectives and intended outcomes, and designing models of service provision. Stewardship also includes developing regulatory and institutional arrangements to underpin service provision that is responsive to users, accountable to those who fund the services, equitable, efficient and high quality. Even in highly devolved delivery systems governments retain ultimate responsibility for ensuring services deliver the intended outcomes.

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 vocational education and training (VET) FEE-HELP scheme demonstrates what can happen when governments fail to discharge their stewardship role well (box 1.1).

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 this inquiry.

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.

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 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 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 in 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. In October 2016, the Government announced its intention to replace VET FEE-HELP with a new VET Student Loan scheme. The proposed scheme will increase consumer safeguards by tightening access to eligible courses, capping loan amounts, and requiring students to demonstrate their understanding of the loan and course progression. A new VET student loans ombudsman has also been proposed. Increased monitoring of providers will include a focus on student completion rates and employment outcomes, and strengthened compliance and payment conditions.

Better oversight of providers and tighter controls on service users' access to government funds under VET FEE-HELP would have had administrative costs, but could have helped avoid other costs that ended up being much larger.

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

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. Participants argued that not-for-profit providers deliver 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; Catholic Social Services Victoria, sub. 272; CEWA, sub. PFR368; Jesuit Social Services, sub. 284 and sub. PFR336; GSANZ, sub. 282; St Vincent de Paul Society National Council, sub. 285). Some participants were concerned that service models which 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.

Additional benefits, such as those potentially offered by not-for-profit organisations, should be considered by governments when determining how best to maximise community welfare from the provision of human services. Where governments have objectives that are broader than improving outcomes for individuals and their families, these objectives should be transparent, both in terms of outcomes and funding decisions. Each type of provider, whether they are for-profit, not-for-profit or government providers, will have distinct capabilities and motivations. 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 over others.

1.3 Competition, contestability and informed user choice

The task in this inquiry is to apply the principles of competition, contestability and informed 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. Providers will have more incentive to provide services that users want, including packages of services. 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, or coalitions 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. The term contestability is used widely in the context of commissioning arrangements used by governments to select service providers — which can be from within or outside government. 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 people 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 users do not wish, or are 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 users or their agents 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 users' hands lets individuals exercise greater control over their own lives. The increased agency this creates has merit. User choice can also generate powerful 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 general practitioners, 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 Victoria (sub. 272), and the Benevolent Society (sub. 129), highlighted the benefits of user choice. For example, Catholic Social Services Victoria (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 well-placed to make their own decisions (ACMHN, sub. 4; Australian Red Cross, sub. PFR325; Hope Community Services, sub. 204; Municipal Association of Victoria, sub. 256; PeakCare Queensland, sub. 128). People vary 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. Very young people or people living with some types of mental illness, for example, may not be well-placed to make decisions — although some will have agents or carers who are able to make decisions on their behalf.

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. 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, or to replace a poor provider with better performers — ensuring that providers of human services face a credible threat of replacement. A contestable market (including one with a single active provider), with a 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 (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 and monitor service providers (chapter 8).

Increasing competition and contestability is not an end in itself. Rather, competition and contestability 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 services are commissioned using contestable processes to select multiple providers. Users may have a choice over the provider they use, the service they use or both. 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, for example, due 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 factors, 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, needs and capabilities of users; and the diversity in purpose, size, scale and

scope of providers. Not all of these factors 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.

The benefits of introducing greater competitive pressures need to be weighed against the costs. Greater competition could lead to some service providers contracting, withdrawing from the market, or changing the way they deliver services, leading to a loss of connection for some service users (ASU, sub. 85). 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).

Some participants expressed concern over the introduction of greater competition, contestability and user choice

The government and non-government provision of human services has involved instances of controversy or failure — there are examples of both government and non-government providers failing to meet standards of quality and accountability. Several participants expressed concerns 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 risk 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 and sub. PFR334; ASU, sub. 85 and sub. PFR326; Illawarra Forum, sub. 238; St Vincent de Paul Society National Council, sub. 285; YFCC sub. 90)

- the users of human services include 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. 276; Australian Red Cross, sub. PFR325; Brotherhood of St Laurence, sub. 286; McAuley Community Services for Women, sub. 241; Merri Health, sub. PFR307; 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 and sub. PFR334; ADJ Consultancy Services, sub. PFR356; 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-driven, rather than profit-driven, will reinvest any surplus back into services to support less profitable areas. However, flaws in governments' processes for commissioning services can have negative effects on providers' ability to achieve outcomes for service users (ACOSS, sub. 276; ACTU, sub. 100; ASU, sub. 85; Brotherhood of St Laurence, sub. 286; CSSA, sub. 226; Merri Health, sub. PFR307; 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 and sub. PFR364; Hope Community Services, sub. 204)

- 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 and sub. PFR326)

- Power to Persuade (sub. PFR390), an organisation that moderates a discussion blog on public policy, noted that competition and contestability have the potential to fragment the human services sector and lead to a loss of provider diversity. The submission also noted that there had been examples of competition and contestability leading to exploitation of, and poor outcomes for, users, and that users of human services are often not well placed to make rational, informed decisions.

Each of these concerns is legitimate but may be minimised or avoided 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 models of service provision that capture one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice. The Disability Council NSW (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.

Improving the effectiveness of human 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 improve the effectiveness of the service. The CPSA (sub. 121 and sub. PFR364) considered that effectiveness refers to the quality, responsiveness and accessibility of the service. The NSW Government (sub. 122) considered that effectiveness refers to the quality and appropriateness of services and access to services, and is a critical indicator as to whether interventions by governments are improving outcomes.

In the Commission's view, effectiveness can be 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 of effectiveness 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 has developed a three-stage framework to consistently assess 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).

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.

Box 1.3　　The attributes of human services

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 (sub. PFR353, p. 4) noted that 'equity is about the fairness of the distribution of resources and services between different individuals and regions'. A key challenge when considering equity issues is balancing community expectations about service quality 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.

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.

Figure 1.1   Identifying services best suited to reform

Scope for improvement in the provision of human services	Factors influencing the potential benefits of greater competition, contestability and user choice	The potential costs of greater competition, contestability and user choice
Policy settings to achieve intended outcomes	**User characteristics** Willingness and capacity of users to exercise informed choice Access to user-oriented information on price and quality Access to expertise	**Costs to users** Search and switching costs Adapting to new arrangements
Scope for improving effectiveness Quality Equity Efficiency Accountability Responsiveness	**Nature of transactions** Relationship between user and provider Whether the service is used on a one-off, emergency or ongoing basis Whether multiple services provided to a user can be unbundled Whether providers offer multiple services to clients with complex needs	**Government stewardship** Oversight of provision Consumer protection Initiatives to inform users Mitigating and managing risks, such as the risk of provider failure Implementation costs, such as commissioning costs Costs of complementary policies
Current policy settings	**Supply characteristics** Economies of scale and scope Barriers to providers responding to change Nature and location of demand for services	**Costs to providers** Adapting service delivery Complying with regulatory requirements

Current and future drivers of supply and demand that affect suitability for reform

Technology · Demographics · Income growth and distribution · User preferences · Government policy · Community expectations

The potential benefits of user choice will be higher for services where it is possible to provide accurate, timely, cost-effective and reliable 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 an emotionally difficult time (NSW Treasury, sub. 122; Vision Australia, sub. 28).

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, and providers, and the costs of government stewardship. It 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. 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 grant-based funding.

Governments 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 identified as 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 through submissions, consultations and roundtables, 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.

Table 1.1   Services assessed in this study[a]

Alcohol and drug services	**End-of-life care**	Mental health services
Allied health services	Family support services and out-of-home care	**Public dental services**
Child and family health services	General practitioners (GPs)	**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**	**Social housing**
Early childhood education and care	Job services	Vocational education and training
Emergency payments	Maternity services	

a Services are in alphabetical order. Services in bold are those identified by the Commission as best suited to reform. Commissioning arrangements for family and community services has also been identified as best suited to reform.

In identifying services, the Commission considered a number of factors, including:

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

- whether reforms to introduce greater competition, contestability or user choice are already proposed, or are underway (examples 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 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 view of where well-designed reform could offer the greatest improvements in community wellbeing, based on the framework outlined in section 1.4. The assessment has identified six priority areas:

- social housing

- public hospital services

- end-of-life care

- public dental services

- human services in remote Indigenous communities

- commissioning arrangements for family and community services.

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

In the case of family and community services, governments expend significant resources on services that provide emergency relief and ongoing support to people experiencing hardship. Much of that funding is allocated through contestable processes undertaken by governments but inquiry participants identified common issues with these processes in submissions, roundtables and other consultations. In the Commission's view, there is scope to improve outcomes for service users, and the community as a whole, by reforming the way governments commission service providers to deliver family and community services.

The priority areas identified by the Commission as best suited to reform 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. Many other services could also benefit from reform, but the areas identified reflect the Commission's views on the highest priorities for the Commission's current task. 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 *Caring for Older Australians* 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 that 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, greater user choice is being introduced in home-based aged care. Other human services, such as disability supports through the NDIS and early childhood education and care, are also being reformed. All warrant continued scrutiny and evaluation to ensure the potential net benefits of those reforms are realised.

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 Australian Government (2015b, p. 7) noted that 'a renewed focus on the person at the centre of care is essential' and that funding should target, and support, the choices of the individual user based on the level and type of need. The Commission supports the objectives of these important reforms, but notes that it is too early to evaluate their effectiveness.

Evaluation of reform is important, not only to improve policy settings for the service, but also to provide insights for reforms of other services. Where reforms have been implemented, or are underway, to introduce greater competition, contestability or user choice for a service that has not been identified as a priority area for reform by the Commission, the Commission will draw upon lessons from the reforms in developing policy recommendations in its inquiry report.

2   Trends and drivers

2.1   A snapshot of human services

High-quality human services, such as health and housing, 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, such as drug and alcohol counselling, family support workers and disability services workers, have emerged to respond to social issues (Victorian DHS 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, visits to a health practitioner or occasional admission to a 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.

Some people have multiple and complex needs

Some people will have multiple and complex needs and require access to several coordinated services, potentially for long periods. For example, of the 256 000 people who accessed specialist homelessness services in 2014-15, about 28 000 people 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 2016o). People with multiple needs can face particularly high barriers to access — barriers that are often made even higher by difficulties navigating a complicated system of service delivery.

Recognising cultural differences is important to effective service provision

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, 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 2016f). Language and cultural barriers can also impede the ability of some 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 high levels of support

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 between two and eleven times the rate of hospitalisations for chronic conditions, almost two times the rate of disability and about five times the use of social housing as non-Indigenous Australians (SCRGSP 2016a). (Data gaps impede comparisons of need between Indigenous and non-Indigenous Australians for most other human services.)

- Most permanent immigrants arrive when they are of working age (ABS 2014), and, as a consequence, they generally have low health, education and aged care needs. 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 little or no English language skills (Refugee Council of Australia, sub. 271), and consequently need to access English language and education services (PC 2016a).

- Temporary immigrants arriving to work and study have lower human service needs than permanent immigrants, reflecting that they are generally younger (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 (ABS 2016g), 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, particularly in remote areas (chapter 7). 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 human 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 general practitioners (AHMAC 2012). Moreover, users in regional and remote areas cite greater difficulty in accessing hospital, general practice and dental services (ABS 2015a). These issues are particularly relevant for Indigenous Australians, who represent a higher proportion of the population in remote areas than in non-remote areas (ABS 2013b).

The providers of human services

Governments provide some human services directly, although non-government providers have been delivering 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 and include unpaid informal carers, sole traders, cooperatives and mutual organisations, mission-driven organisations that rely on volunteers and donations, and for-profit entities. Each will have a different balance between profit, organisational, social and other motivations. They can be large or small.

Some will provide multiple services while others will specialise in specific services, or cater for specific users. 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 PricewaterhouseCoopers (2016a) showed 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 school education, 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[a]**
Per cent of total
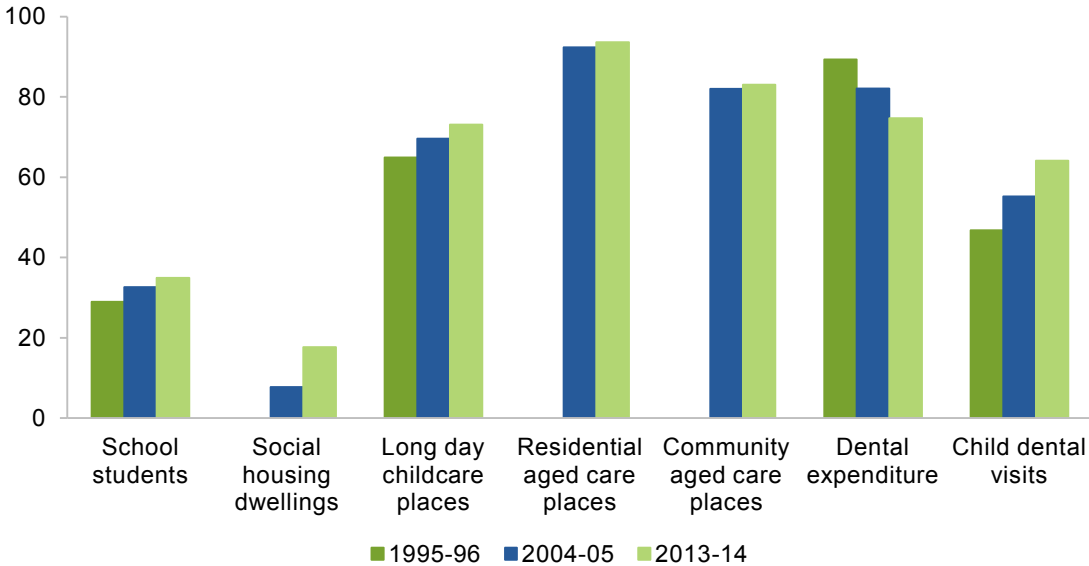
a Data for long day childcare places relate to for-profit providers in 1994, 2003 and 2012.
Sources: ABS (2016h); AIHW (2005b, 2015e, 2015f, 2016c); PC (2014); SCRGSP (2010, 2015).

The trend toward non-government provision for some services has increased in recent years. In particular, non-government provider participation in disability services has increased from 1350 to 1957 across seven National Disability Insurance Scheme (NDIS) trial sites in 2014-15 (NDIA 2015a) and will likely continue to grow as the NDIS is rolled out. In many cases, increased service provision by non-government organisations has been

---

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

accompanied by greater access with users having choice over the service they receive, who provides it or perhaps both.

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). Total 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.

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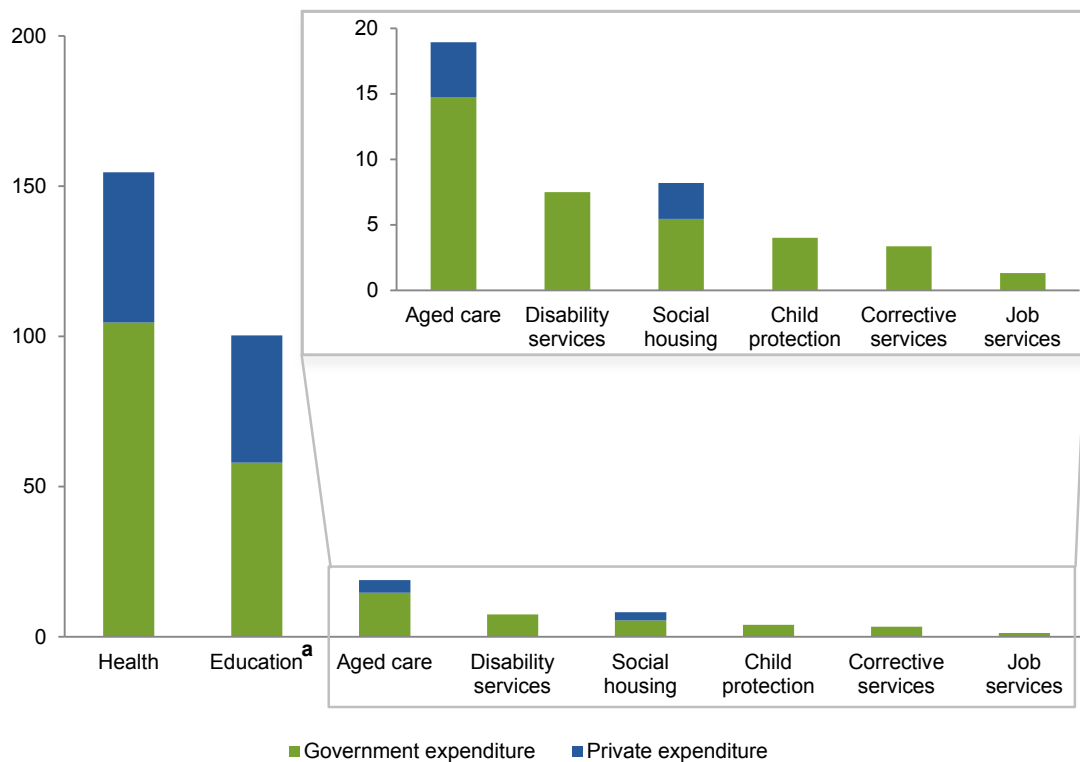
a Private expenditure on education is based on ABS government financial data and may include some government payments to private individuals that are spent on education services and are also included as government expenditure on education.

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

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 healthcare and, ultimately, fulfilling employment. Expenditure will also underestimate the demand for services that 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, changing technology and improved data availability and analysis, and a move toward more tailored and integrated services (figure 2.3).

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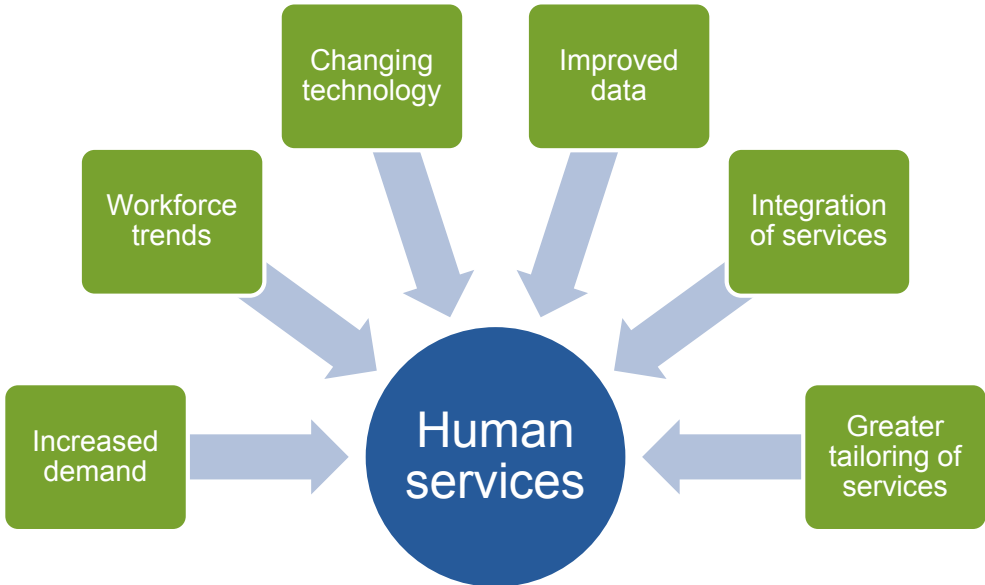
Demand for human services will continue to grow

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

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

Total growth in real expenditure per person, 2014-15 to 2024-25
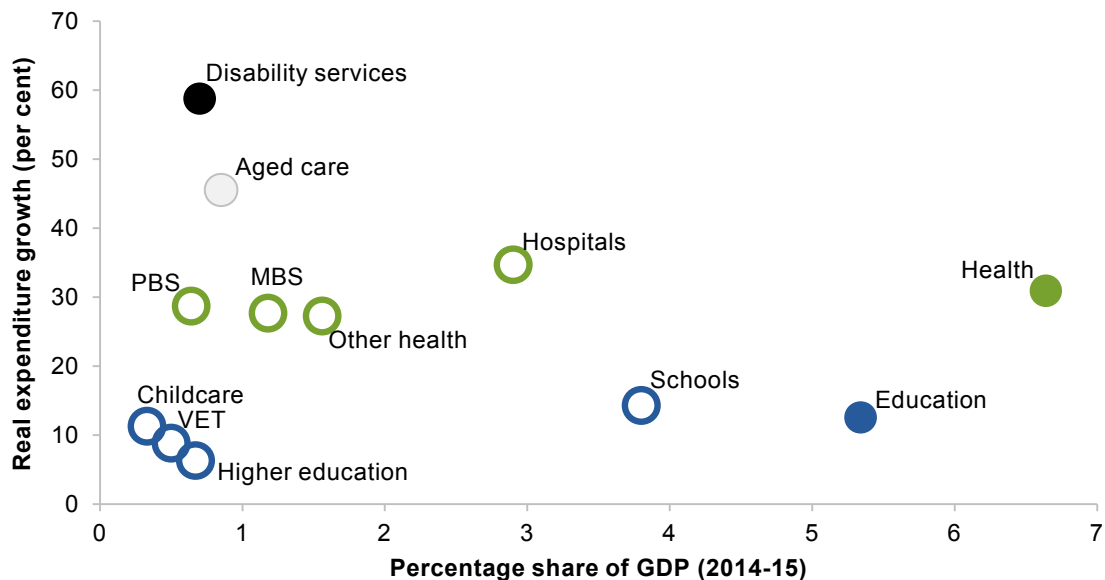
a Unshaded circles are components of health and education expenditure. PBS refers to the Pharmaceutical Benefits Scheme, MBS refers to the Medicare Benefits Schedule and VET refers to vocational education and training. Higher education excludes the cost of offering income-contingent loans to university and vocational education 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 needs 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 where the elderly represent a larger share of the population (NSW Government 2016c). The elderly also use services such as social housing and public dental more intensively, and demand for these services is expected to grow with population ageing (ANZASND and ASSCID, sub. 200; AONSW 2013).

- *increased incidence of 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 2016h) 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 and changes in income distribution* — higher incomes generally increase demand for more and higher-quality human services, particularly health and care services. 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 (SCSPAH 2014).

- *changing technology* — innovation in services such as health have increased the 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).

Figure 2.5   **Use of selected human services by age[a]**
Expenditure by all governments, 2011-12
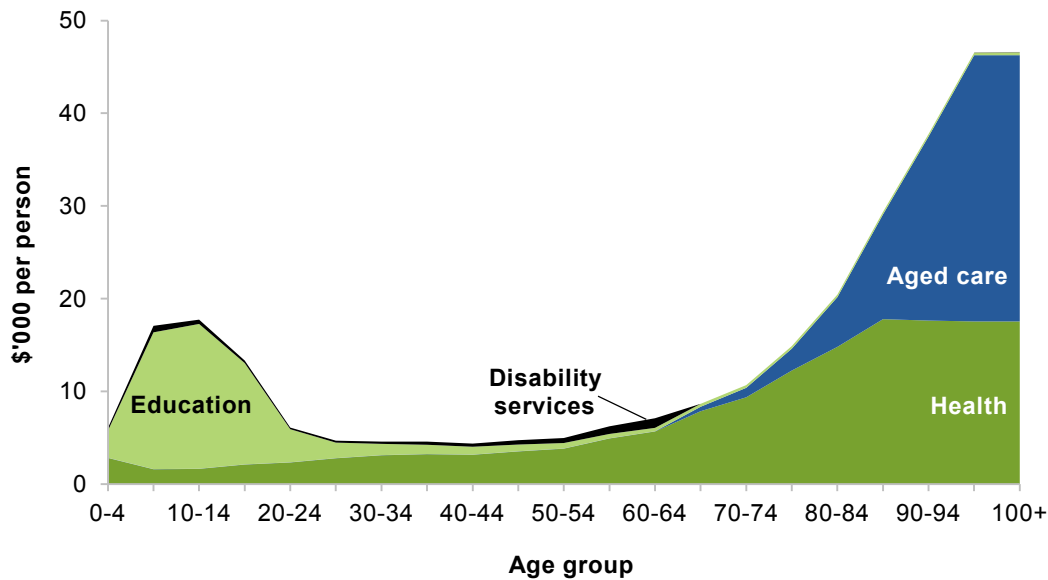
a Aged care refers to Australian Government expenditure only.
Source: Estimates based on PC (2013).

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). These factors are also linked. Population ageing in part reflects improvements in healthcare technology and advances in health care have changed the treatment and severity of some chronic diseases.

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 2016e). 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 of high-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 greater professionalisation within human services as paid qualified staff have replaced informal service providers. Examples of the trend toward professionalisation of the workforce include:

- *childcare* — a shift in focus to early childhood education rather than basic care services has 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. 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 the frontline staff. For example, some not-for-profit organisations now recruit professionals to help them participate in tender processes to provide family and community services (PC 2010).

Workforce changes

Greater demand for human services could give rise to workforce shortages. Shortages are recognised as a particular challenge in regional and remote areas, as a lack of professional development opportunities and housing act as barriers to attracting and retaining appropriately qualified health professionals (CARC 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 change due to demographic factors such as population ageing, increased female workforce participation (CPSA sub. 121) and a general decline in the proportion of Australians who volunteer (ABS 2015a). 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 can be a key driver of the outcomes delivered. 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, including in home-based aged care and disability services (box 2.1).

Box 2.1   Technology in home-based aged care and disability services

Online platforms are connecting users and individual providers

Hireup is a for-profit platform that enables users of disability services to find, engage and manage their support needs. Users are able to manage all aspects of the service to meet their needs, while Hireup manages payment, insurance and compliance matters. Hireup has raised capital from both private investors and philanthropic organisations (Impact Investing Australia 2015).

Better Caring is a for-profit platform that connects home-based aged care and disability services users with care and support workers in their local area. Similar to hotel reservation websites, Better Caring allows users to publicly review each support worker they engage through the service (Better Caring, sub. 252).

Technology is improving how users engage with traditional models

Baptist Care has developed the You Choose website that allows home-based aged care users and their carers to mix and match from a range of support services to best suit their needs. Users are also able to adjust the length and frequency of the selected services to meet their budget or the value of their government-funded Home Care Package.

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 (NT DTF, sub. 261), and greater use of telehealth and telecare will enable remote service delivery and allow users to live more independently (box 2.2). Remote service delivery can reduce the costs of supplying services to regional and remote areas,

and as a result, for some human services, it can increase the scope for multiple service providers to offer services to the region, increasing competition and user choice.

Digital communication technologies will not be the way of the future for all services or for all users. 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 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 (CQFCS, 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.

Box 2.2   Telehealth and telecare services: an example of innovative delivery models

Models of provision drawing on digital technology have the potential to improve service responsiveness and the ability of users to access a range of services. In health and aged care, telehealth and telecare technologies 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. Telehealth services are also being used in medical facilities and dental clinics to connect healthcare professionals in regional and remote areas with specialists based in urban areas.

Some providers are beginning to develop and evaluate telehealth and telecare technologies in Australia.

- GP2U is an online doctor service that allows users to have video consultations using an app on their smart phone or tablet. After the consultation, the GP2U service can electronically forward the users' pathology requests, specialist referrals or prescriptions for collection from a local pharmacy. About 20 000 patients use the GP2U service each year (GP2U 2016).

- Curo is a telecare provider that allows users to place sensors in their own home that unobtrusively monitor movement and room temperature. Curo's app interprets this information and alerts care providers and family members when the user completes daily tasks or when the room temperature is too hot or cold. Over time, Curo can determine changes in behaviour, such as waking up later than usual, which can assist providers to tailor services or detect early warning signs (Curo 2016).

- CSIRO has partnered with not-for-profit organisations, local health districts and for-profit telecommunications companies to undertake a 12-month trial of home monitoring services for elderly patients with a chronic disease. The results found that users were less likely to need 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).

In the context of evolving communication technologies, the Commission's concurrent *Telecommunications Universal Service Obligation* inquiry has been asked to examine government policies that support universal access to telecommunications services. The inquiry will consider the degree to which expanded availability of high-speed internet

services already supports universal access. In particular, the inquiry will consider the needs of particular sections of the community, for example, Indigenous Australians, people with a disability or people living in regional and remote areas (PC 2016b).

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 of using technology to delivery human services (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

Benefits from greater data availability and use

The type and volume of human services data being generated and collected has grown substantially, as has 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. Despite this uncertainty, the potential benefits of greater availability and use of data are already apparent across a range of human services, particularly health (box 2.3). In other areas, such as education, the Department of Prime Minister and Cabinet (2016) is leading a cross-agency project to integrate public data sources that will improve outcomes for Indigenous Australians through better targeting of early childhood interventions.

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 improve the coordination of services and target service provision more accurately to the people who would benefit from them most (Wareing 2013). 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.

Further, better use of data has the potential to reduce the fragmentation of services and improve the ability of users with multiple and complex needs to navigate a complicated system of service delivery. 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).

Issues with current access arrangements

While improved use of human services data would have a range of benefits, this is hindered by the limited access to the data that are currently collected. Access to the data can be complex (BSL 2016) and can involve lengthy approval processes that limit the ability of researchers to make discoveries that help to improve service delivery. Similarly, providers are sometimes unable to access data about users that would allow them to better determine user needs and the services that will best improve outcomes.

Box 2.3   Better use of health data presents many opportunities

The Commission is currently undertaking a broad ranging inquiry into *Data Availability and Use* practices across the private and public sectors. The inquiry's draft report found that data in health services could be used to help save lives by:

- *targeting services to meet user needs* — access to administrative health data can help policy makers and researchers identify patients most likely to benefit from particular interventions, and predict users whose condition is likely to deteriorate. For example, administrative hospital records in the United Kingdom have been matched with cancer screening registries to improve how and when cancer is diagnosed (Elliss-Brookes et al. 2012).

- *improving service provision* — integrated data about service users could be used to prevent duplicate diagnostic tests and allow new services to emerge in response to user needs. For example, more granular data on health insurance claims for dental procedures by location and the socioeconomic status of the user could allow for services to be established in areas of high demand or greater need (ADA 2016).

- *giving users greater control* — expanded user control of, and access to, their own health data would not only improve the ability of users to share information with medical professionals, but would give users greater ability to manage the health care services they use. For example, Health& is an online platform that allows users to centrally store their health data, including medical records and data from fitness devices, to help users to monitor their health and improve the sharing of health information with service providers. The platform allows users to search a library of evidence-based health topics and informs users when they should see a doctor (Health& 2016).

The data that are available are often fragmented and not comparable across users, providers or jurisdictions, particularly in health (AHCWA 2016; AHHA, sub. 134). Human services data also tends to focus on service inputs, costs and the number of services provided (Benevolent Society, sub. 129) rather than user outcomes. Governments need to ensure that the data they do collect helps them measure outcomes, noting that data collection can impose a cost on users, providers (Hornagold, sub. 246) and governments.

Improving data availability and use

The Commission's draft report of its inquiry into *Data Availability and Use* has made recommendations to address issues relating to the availability and use of data, including that a national framework be established to improve data access and sharing processes,

particularly for public and, in specific cases, private datasets of national interest. The inquiry also recommended that users have more control over how their personal data are used and governments should retain the right to release data created through contracts with private providers.

In addition, 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 has undertaken actuarial analysis of administrative and longitudinal data to determine the lifetime liability of Australia's welfare system, which in turn could be used to tailor community and social services to prevent long-term dependence on income support (PwC 2016b).

Another example of governments using data collection and analysis to improve the delivery of services is the introduction of social impact bonds in Victoria, New South Wales, Queensland and South Australia. 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.

Technology and data are critical to informing users

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; NT 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 a parent's choice of school for their children.

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 (for example, Better Caring discussed above). 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 was supportive of technologies that improve availability of information to users:

> 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 the ability of vulnerable users to access and effectively use the platform (The Australian Red Cross, sub. PFR325), and 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 (chapter 4).

There is a push toward 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 (NT 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, has the potential to deliver better outcomes, particularly for people with complex needs who find it difficult to navigate the service system. Greater integration can simplify access to human services and reduce duplication of services. Moreover, integration can 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). A more integrated system of providing health care services would enable a seamless transition between different settings of care, different providers, or different services with a patient's data and preferences travelling with them.

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 in community health and social housing. The Victorian Government has implemented Services Connect — a small scale trial of integrated human services delivery (chapter 8). 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.

The costs and benefits of delivering integrated services can vary and often requires a high degree of planning around the individual and systems for bringing services together effectively. 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 toward integration (CSIA, sub. 192; GSANZ, sub. 282; ISCHS, sub. 244; MAV, sub. 256; Mission Australia, sub. 277; Uniting Church in Australia, Synod of Victoria and Tasmania, sub. 173). These concerns reflect the view that competition and contestability damage the collaboration needed for individuals and organisations to work together to achieve the best outcomes for users (Whiting, sub. 27; chapter 8).

Well designed and implemented systems can build the platform for delivering both integration and increased competition or contestability. For example, portable health records can facilitate both as the patient's details and clinical history can be transferred between providers. Similarly, 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; NT 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 than previous generations of exercising control over the services they receive and of receiving services tailored to their needs (PC 2011a). Further, users are increasingly preferring to receive services at home rather than in a residential aged care facility (AIHW 2013c; 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; 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 simpler arrangements will be extended to people with complex mental health 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 FACS 2016a).

Tailoring services to individually meet user needs may not be appropriate in all circumstances as it can be costly and, because most users do not pay the full cost of human services, may place excessive 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 toward 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 as 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 (figure 3.1). Different types of housing assistance are provided by government and non-government (including not-for-profit and for-profit) organisations.

Housing assistance can take three broad forms.

- Assistance with the costs of housing (through subsidised rents, such as those received by social housing tenants, or through income support payments).

- Support to access or maintain a tenancy (such as support for people with a mental illness or poor tenancy records, which make holding a private rental tenancy difficult).

- Transitional support for people to move into the private housing market from social housing or the social housing waiting list.

In government expenditure terms, the two largest assistance programs are the provision of social housing and Commonwealth Rent Assistance (CRA) (box 3.1).

A number of services, assets and processes make up the social housing system, including the ownership and management of properties, the allocation of tenants to specific homes, and some tenant support services. Social housing covers both:

- public housing — 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 — a mix of properties either owned by a non-government provider, or managed by a non-government provider but owned by the government. Currently all community housing providers are not-for-profit organisations or housing cooperatives. There are about 320 registered community housing providers of varying sizes across Australia (Milligan et al. 2016).

State and territory governments dominate the ownership of properties in the social housing system, although some jurisdictions house tenants in privately-owned properties. For example, the NSW Department of Family and Community Services will on occasion lease

properties in the private rental market and sub-lease them to public housing tenants (NSW FACS 2011). Western Australia is trialling an approach where a small number of private landlords are involved in the provision of rental homes (for up to four years) to people eligible for social housing (WA Housing Authority 2016b).

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 community 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 equal to 75 per cent of rent 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

Shelters and transition housing for homeless people.

Provided by specialist homelessness providers.

Crisis accommodation

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 (2016b).

The Commission's focus is on services to people receiving support through the social housing system, and to those who require support but are currently unable to access it. The Commission will consider the operation of the social housing system, as well as the interaction of the system with broader housing assistance policies, such as the effect of CRA on the demand for social housing. Although user choice and competition are already

a feature of other types of housing assistance, there may be opportunities in social housing to adjust policy through increased user choice and competition to improve outcomes.

Access to social housing is rationed using waiting lists, which are usually divided into two broad categories — 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) noted that the level of housing assistance received is determined more by housing tenure (such as whether the tenant occupies a social rental property, a private rental property or is a home owner), rather than their need for support.

Box 3.1   Commonwealth Rent Assistance

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 social housing tenants. In part this reflects fundamental design differences between the two assistance models, as well as 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. It also reflects a faster rate of growth in rents than the maximum CRA amount over the past decade.

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

A wide range of social housing systems exist internationally. In some systems, social housing makes up a significant proportion of the total housing stock, while in others (like Australia) social housing represents only a small percentage of the total housing stock. There is no benchmark for the 'right' level of social housing in an economy. 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.

3.2   Scope to improve outcomes

Recipients of social housing assistance 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 (AIHW 2014b). Nonetheless, there appears to be scope for improvement

in the way social housing services are delivered. This 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 profoundly over time in Australia. There has been a shift in the demographics of people receiving support through the system — from working families to recipients of income support who have additional barriers to entering the private housing market (Groenhart and Burke 2014; NSWFHA et al. sub. PFR328). In some jurisdictions, governments are increasingly using social housing to provide transitional support, rather than as permanent accommodation, for some tenants (NSW FACS 2014).

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 assistance (AHV, sub. PFR316). It has also resulted in funding pressures on the system. In 1990, nearly all state housing authorities were running an operating surplus. 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 the cost of maintaining a property and the rent paid by its occupants has continued to grow (SCRGSP 2000, 2016b). Given that 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). There is also a mismatch between the level of support delivered via the income support system through CRA and the income-based rent model used in social housing. This mismatch is undermining the effectiveness of housing assistance in Australia.

Quality

The quality of the services received through the social housing system has deteriorated due to funding pressures and demographic changes. 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 2016b). 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 managed by governments are 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

The current housing system produces some inequitable outcomes. 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. In public housing, satisfaction was lower for households with a member with a disability than for the public housing cohort as a whole (figure 3.3). This might reflect too few houses being modified to be suitable for a person with a disability. For example, in Tasmania there were about 4000 households in public housing with a member with a physical disability compared to about 1500 modified public housing properties (Tasmanian Audit Office 2016). Satisfaction was also lower in state-owned and managed Indigenous housing.

Efficiency

There is limited evidence available on the efficiency of the social housing system in Australia — governments do not collect or publish data that allow a thorough analysis of the system's efficiency. 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 2016j), 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.

Responsiveness and accountability

There is little user choice in social housing

The current social housing system limits the ability of tenants to choose their home. Once applicants reach the top of the waiting list, they are generally allocated a home based on their preference for the area in which they would like to live (which may contain multiple suburbs), and the household's characteristics such as the number of people and any special needs arising from a disability (NSW FACS 2016b; Victorian DHHS 2015). Properties can be very different in their size, physical condition, and proximity to preferred amenities (Wiesel et al. 2004).

The suitability of a property can be a question of timing and luck. Tenants cannot hold out for a preferred property because those that reject two offers of housing, or sometimes even one, are relegated to the back of the often long waiting list.

Figure 3.2   Indicators of public and community housing, 2014[a]
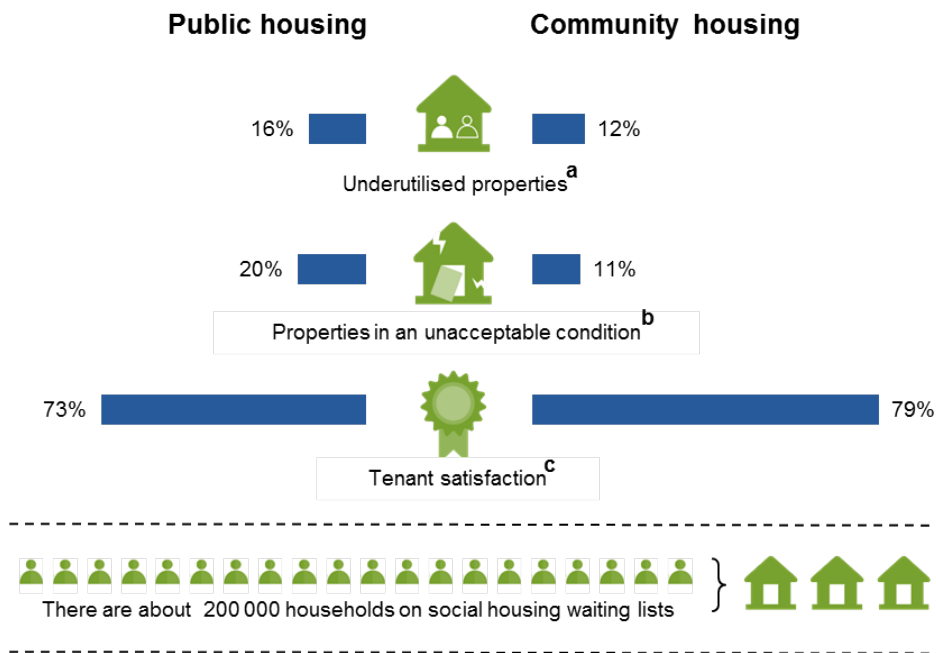
Public housing   **Community housing**

16%   Underutilised properties[a]   12%

20%   Properties in an unacceptable condition[b]   11%

73%   Tenant satisfaction[c]   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. **b** 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. **c** Tenant satisfaction is the percentage of people who reported being satisfied or very satisfied with their housing.

Source: SCRGSP (2016b).

Figure 3.3   Tenant satisfaction

Per cent of tenants satisfied or very satisfied with their housing

Public housing

Public housing (member with a disability)

State-owned and managed Indigenous housing

0 10 20 30 40 50 60 70 80 90 100
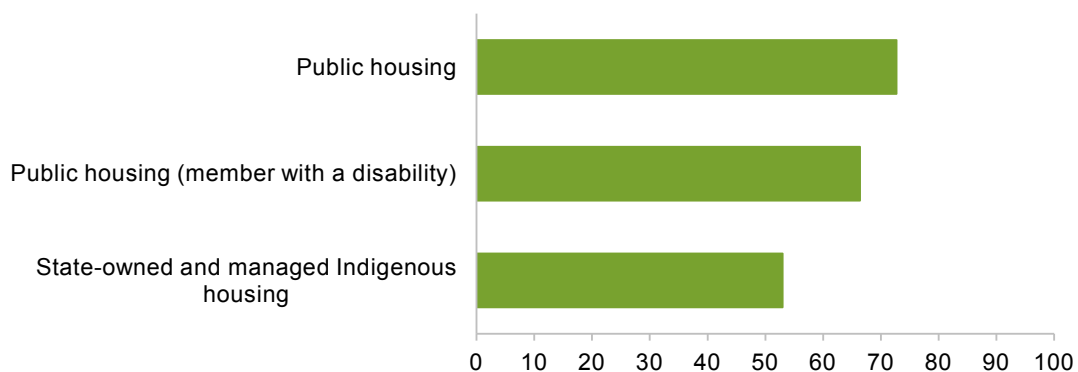
Source: SCRGSP (2016b).

Tenants able to access the private rental market using 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 people 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, and has flow-on effects on the quality and efficiency of the system (section 3.3). It can also 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 inquiries 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. Youngcare (sub. PFR323) argued the need for tenants with disabilities to have choice of home and to be able to move to different homes as their needs change. Participants to a 2010 Victorian Legislative Council inquiry, including the Victorian Council of Social Services and 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 social housing in Australia is publicly managed and service provision is 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 (NSW Government 2016b; SA DCSI 2016). Properties have not been transferred to for-profit providers.

Community housing providers are subjected to a capability assessment and ongoing monitoring as a requirement for registration (AHV, sub. PFR316; NRSCH 2014). However, limited data on tenant outcomes restrict the ability of governments to monitor and assess the performance of service providers. The NSW Federation of Housing Associations et al. (sub. 235) noted that government data collection has focused on inputs

and outputs, rather than outcomes for individuals and communities. Pawson et al. (2015) noted that official social housing performance measures are inadequate, and that there is currently no means of measuring tenants' 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.

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 transferred the management of 500 properties 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 transferred the management of 3 500 homes in total, 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 program 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. This is expected to slow the decline in social housing property numbers in Tasmania.

The program includes an assessment framework that takes into account social and economic benefits. 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); NSWFHA et al. (sub. PFR328); Pawson et al. (2013); Tasmanian Government (2015).

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 increase 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 greater competition, contestability and user choice is the best way to address the issues highlighted in section 3.2 will depend on several factors. These include 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 had substantial benefits, including improving the responsiveness, efficiency and quality of social housing (box 3.3).

Nonetheless, the capabilities of people who 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; Q Shelter, sub. PFR352). The type of support required will differ between individuals and groups, each of whom may face a different type of 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 in a language other than English), while those who are unable to inspect properties or articulate preferences may require an agent to act on their behalf.

For many tenants, support to find a home will not be sufficient unless support is also provided to meet their other needs 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).

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 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

Choice-based allocation schemes in the United Kingdom have led to a range of benefits.

- About 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, as it gave them increased agency over their housing situation and resulted in a more open and transparent allocation process.

- Choice-based allocation schemes have led to minority households being more geographically dispersed and, despite concerns, there has been no indication that formerly homeless households are disadvantaged under the schemes.

- 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. 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 schemes have been used to identify the housing characteristics that tenants prefer, and to 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); Pawson and Watkins (2007); PC (2015b); Shelter (2014, 2015).

At times, tenancy management can cross the boundary into tenancy support. Community housing providers aim to build close and trusting relationships with their tenants (CSSA, sub. PFR315; 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 tenants, including both those in social housing, and those that require social housing, or who have transitioned from the social housing system.

Characteristics of supply

Demand for social housing outstrips supply. This has resulted in long waiting lists and waiting times, 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 more than ten years, depending on the area in which they wish to live.

There are several factors that lead to excess demand for social housing. In part, it reflects the fact that social housing tenants generally receive a substantially higher rental subsidy than they would receive in the private market. Once in social housing, there is little incentive for tenants to exit the system, and many tenants receive permanent support — over 40 per cent of tenants in public housing in 2015 had been there for over ten years (AIHW 2016k). Another factor is the limited supply of social housing — many organisations point to a lack of investment in new properties as a cause of the shortage (ACOSS et al. 2015; CHFV et al. 2014; Shelter WA, sub. PFR341; TUV 2015). The reliance on this limited supply of (generally government-owned) housing, coupled with the long-lived nature of housing assets, significantly reduces the ability of the housing system to respond to changing demographics and need. Limited supply means fewer houses for tenants to choose from, which constrains the potential benefits from introducing greater user choice.

To realise the potential benefits of greater user choice, the above features of social housing may need to be taken into consideration. Nonetheless, approaches have been implemented overseas to provide greater 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).

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. There are no 'silver bullets' to increase the supply of social housing, and proposals to increase supply need to be evaluated carefully to ensure that they will improve outcomes for tenants, and the welfare of the community as a whole.

One way to increase options available for prospective social housing tenants is to make it easier for people to choose between social housing and renting in the private rental market. One example is a subsidy that provides a similar level of financial support regardless of which home they choose (SA Government, sub. 281). Some states provide assistance, such as bond guarantees, to help people rent in the private market (section 3.1). As noted above, some jurisdictions have, or are piloting, programs that involve private landlords in the provision of government-subsidised housing to people on a social housing waiting list.

- Western Australia is undertaking an Assisted Rental Pathways pilot, where pre-approved private landlords are paid a government subsidy to house people on the social housing waiting list (WA Housing Authority 2016b).

- In Victoria, 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 (City of Toronto 2016b).

The management of social housing could be made more contestable. There is a large number of housing providers — both not-for-profit, cooperative and mutuals, and for-profit — that could provide this service. Some governments already have a policy position of further transfers of public housing to non-government providers (NSW Government 2016b; SA Government 2013; WA Housing Authority 2010). In 2009, state and territory housing ministers agreed to develop a community housing sector that manages about one in three social housing properties by 2014. This target remains unmet, with one in five social housing properties currently managed by community providers (section 3.1).

Allowing community housing providers to manage social housing appears to have had benefits, both in Australia and elsewhere (box 3.5). Where further transfers are considered, making the management of housing contestable would allow governments to select providers that will strongly focus on improving tenant outcomes. 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 Department of Treasury and Finance (sub. 261) considered that community housing providers should be managing about 500 properties to achieve adequate scale.

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

There is evidence of 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. Q Shelter (sub. PFR352) stated that responsiveness to local needs can be improved by having a diverse range of community housing providers — a particular benefit for states with large regional differences.

- 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).

3.4   The potential costs of reforms

The potential costs of introducing greater 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 also incur costs in supplying applicants with information such as the properties that are available and how the allocation process will work (Wiesel, Easthope and Liu 2011). Information would need to be provided in a way that allows prospective tenants to easily compare waiting times for properties, such as by integrating community and public housing waiting lists into a single housing register, and by standardising data (NSWFHA et al., sub. 235). There would also be costs involved in providing support for tenants who are less able to exercise choice or sustain a tenancy.

Reforms to introduce more effective contestability would have implementation costs for governments, who would need to play a strong stewardship role for the system. Governments would need to rebalance their focus from managing the housing stock to a focus on improving outcomes for tenants through evaluating and monitoring providers.

Bidding for and evaluating any tendered services will also involve costs, both for governments and providers (NSWFHA et al., sub. PFR328).

In addition to these costs, there would be a transfer of costs and risks from the public sector to the non-government sector. For example, where the management of housing has been transferred from the public sector to the community sector, community providers receive the rents paid by tenants, and take on the costs of maintaining and managing properties.

Finally, changes to the social housing system would need to consider how the system interacts with other options for housing assistance.

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 government and non-government 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.

- 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

The Australian health system is complex, with many different, but connected, parts and varying degrees of government involvement in funding and providing services. Policy objectives include equitable access to healthcare, timely delivery of services that meet the health needs and preferences of individuals (both to prevent illnesses and treat them when they occur), and that services are provided as efficiently as possible. An ongoing, and increasingly important, challenge has been to coordinate care that individuals receive across multiple providers, care settings and services.

The Commission considered the scope for greater competition, contestability and choice to contribute to these objectives across the numerous types of health services. In many cases, such as primary care provided by GPs and optometrists, there is already a high degree of choice and competition. Significant reform is under way in other areas, such as mental health.

Some inquiry participants asked the Commission to consider the scope to reform private hospital services, where there is already a high degree of competition, contestability and choice (for example, BUPA, sub. 258; Catholic Health Australia, sub. 236; Doctors Reform Society of Australia, sub. 144). Policy options beyond the scope of this inquiry will often be better suited to addressing many of the concerns raised, and various initiatives are currently in progress in this regard. These initiatives include regulatory changes to reduce the cost of prostheses for private patients and the development of private health insurance reforms to make policies less costly and easier for consumers to understand (Ley 2016b, 2016c).

The Commission concluded that this inquiry could add most value by focusing on how to introduce greater competition, contestability and choice to public hospital services, for the reasons outlined below. While the inquiry will focus on this area, the Commission is mindful that public hospital services do not operate in isolation from other parts of the health system (such as private hospitals) and that coordinating an individual's care across different providers, services and settings can lead to better patient outcomes.

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]**
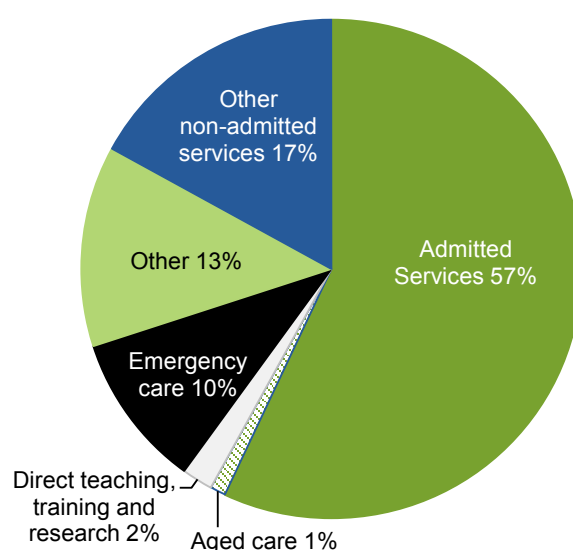
a Recurrent expenditure including depreciation.
Data source: AIHW (2016d).

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.

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 be 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).

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 2015b; Beattie 2005; NSW Government 2016a; Skinner 2016). The precise level of clinical incidents that harm patients is unclear due to weaknesses in monitoring regimes, including under-reporting (Duckett, Cuddihy and Newnham 2016; VAGO 2016b). The data that are published provide few insights into quality differences

---

[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.

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).

Figure 4.2   **Regional variation from national per capita admission rate for selected conditions, 2010-11[a]**
Public hospitals
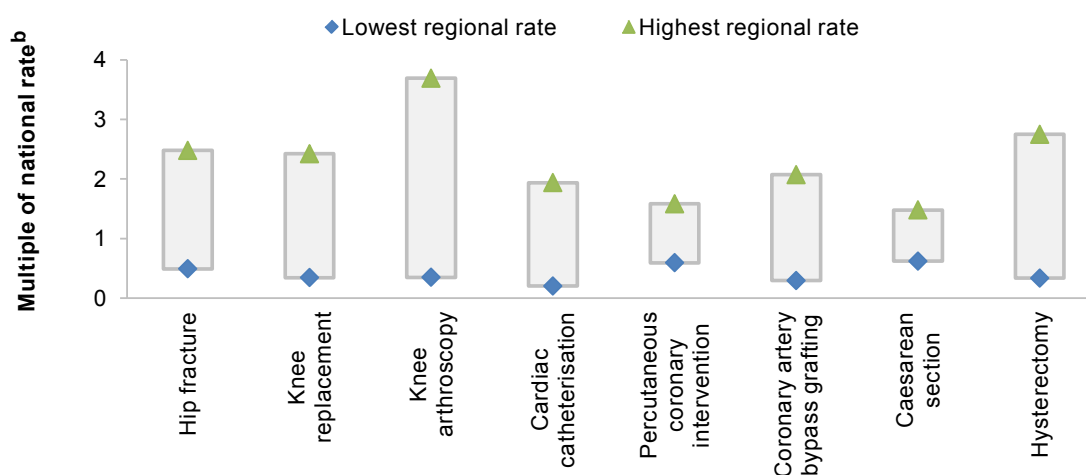
a Per capita admission rates were standardised for age and sex to enable like-for-like comparisons between regions. Regional disaggregation was based on the 61 regions that existed for Medicare Locals in 2010-11. Each patient was assigned to a region based on place of residence rather than the admitting 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.

Data source: ACSQHC and AIHW (2014).

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.

---

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. The Royal Australasian College of Surgeons (sub. PFR374) also facilitates ongoing improvement through the Australian and New Zealand Audit of Surgical Mortality.

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).

Figure 4.3   Share of admitted hospital services by sector and socioeconomic status of patient, 2014-15
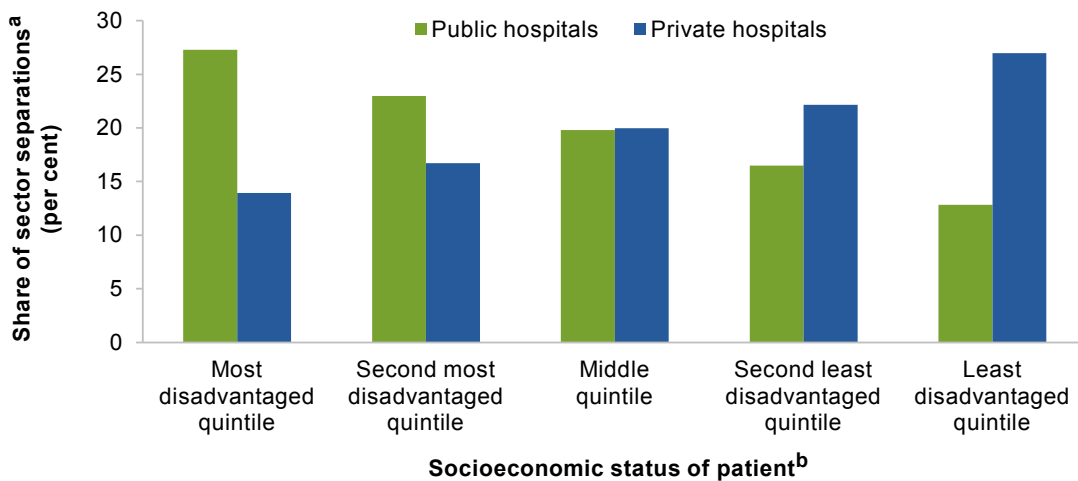
a A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). **b** Quintile of socioeconomic 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.

Data source: AIHW (2016a).

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).

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).

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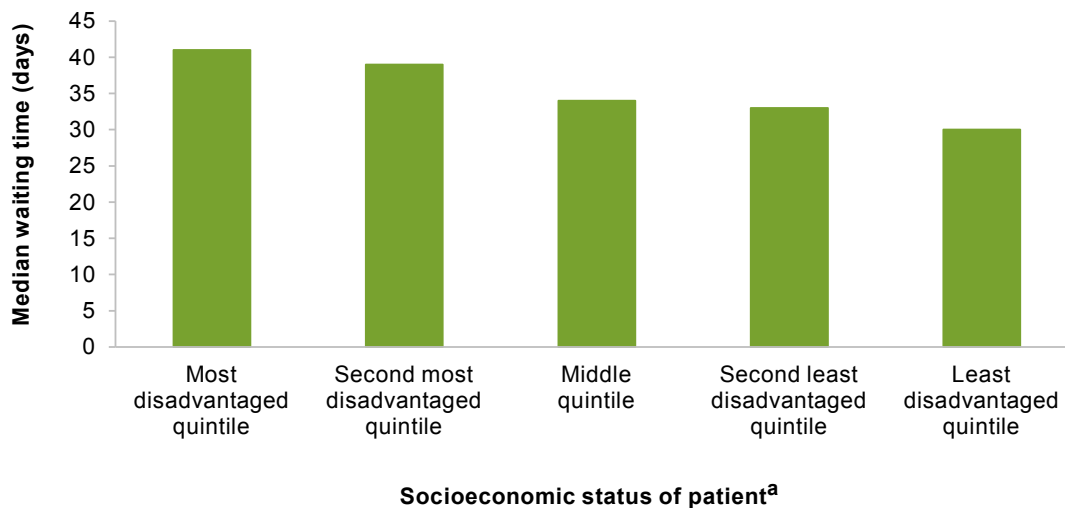
a Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a patient resided. The index summarises population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

Data source: AIHW (2016a).

Efficiency

At a national level, growth in the average cost of providing public hospital services has slowed significantly since the adoption of a national system of activity-based funding in mid-2012 (Independent Hospital Pricing Authority, sub. PFR322). However, there continue to be 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.

Figure 4.5   **Average cost of acute admitted services in individual public hospitals by type of facility, 2013-14[a]**
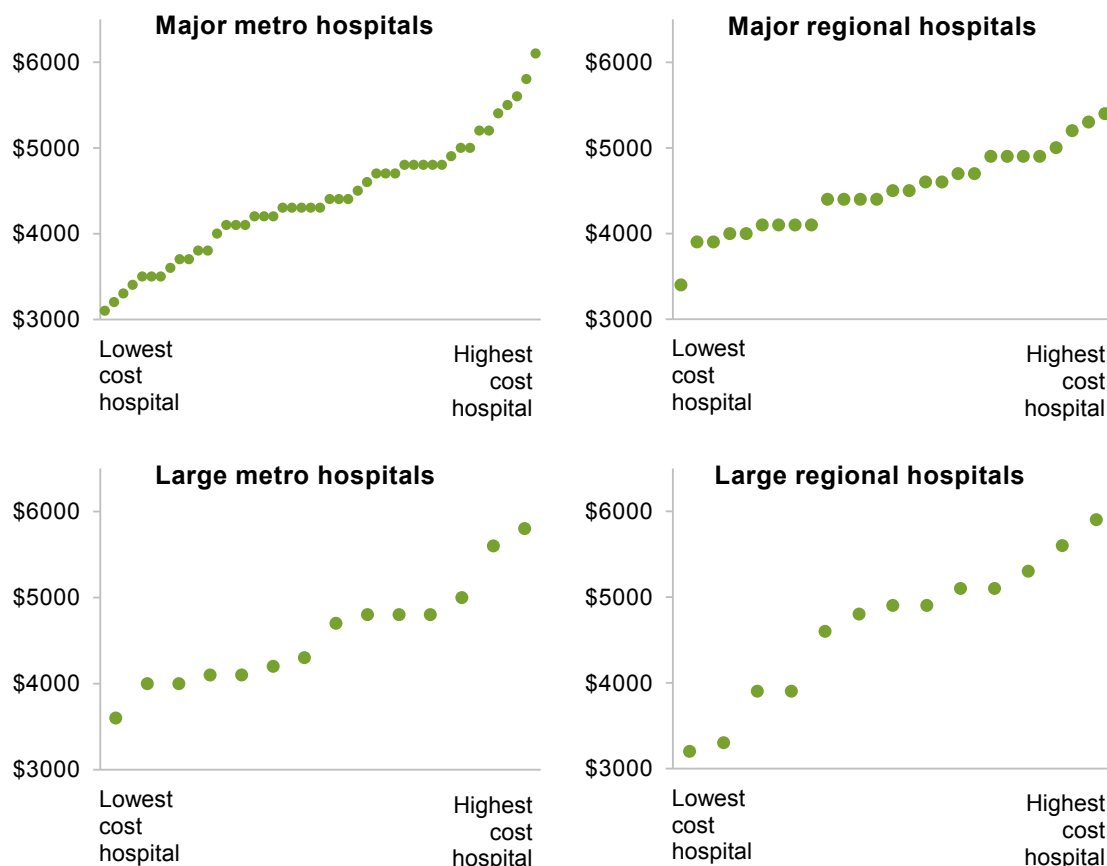
a Each dot in the figure represents an individual public hospital. Average cost is quantified by using a hospital's Cost per National Weighted Activity Unit, which measures the cost of a notional 'average' public hospital service provided to acute admitted patients whose treatment was eligible for activity-based 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.

Data sources: AIHW (2016c); NHPA (2016).

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 2015b). 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. The Independent Hospital Pricing Authority (IHPA, sub. PFR322) noted that the associated shift to activity-based funding, which it is responsible for developing and maintaining at a national level, will facilitate greater contestability because it has led to more systematic approaches to measuring activity and costs. IHPA recently launched a National Benchmarking Portal which allows clinicians and hospital managers to use the collected data to benchmark their activity and efficiency against similar hospitals.

As detailed further below, more could be done to improve the accountability of public hospitals. In particular, public reporting on the service quality of individual hospitals and clinicians, and more transparent criteria and processes for replacing board members and senior management in cases of underperformance.

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, based on

their place of residence (figure 4.6). This suggests that 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**
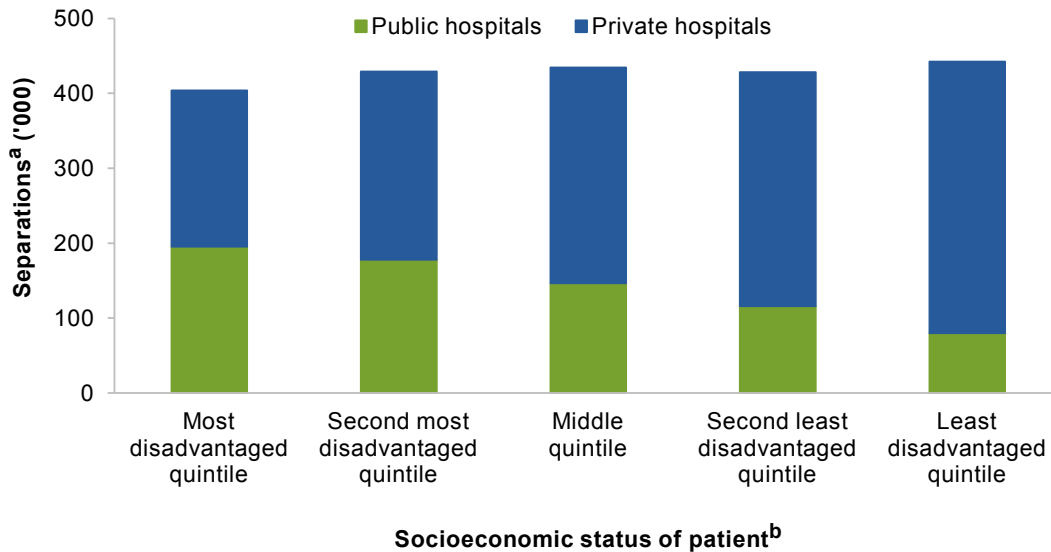
a A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). **b** Quintile of socioeconomic 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.

Data 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.

Greater user choice for public patients will require more user-oriented information than is currently available, particularly risk-adjusted data on clinical outcomes achieved by individual hospitals and doctors. Overseas evidence suggests that some (but not all) consumers would use such information to seek out better-performing providers (box 4.1). There is also evidence that hospitals and doctors would use publicly reported data to

benchmark themselves against other providers and seek to improve when they are below best practice. The opportunity for third parties, such as health academics, policy think tanks and consumer advocacy groups to analyse publicly reported data would create further pressure on providers to deliver good outcomes.

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 (2012); 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).

Suppliers of prosthetic devices are another group whose behaviour can be influenced by published performance data. Catholic Health Australia (sub. PFR350) noted that outcomes published by the National Joint Replacement Registry have often prompted suppliers to withdraw poorer performing devices from the market, even though consumers do not base their choices on the performance data.

St Vincent's Health Australia (sub. 207) favoured greater provision of information to patients to support their choices and noted that this should include performance information for both hospitals and physicians. The Australian Healthcare and Hospitals Association (sub. PFR306) noted that more transparent hospital performance indicators that are timely, clinically meaningful and consumer-relevant could provide incentives for public hospitals to improve outcomes and facilitate more consumer choice.

The Royal Australasian College of Surgeons (sub. PFR374) did not support public reporting on individual surgeons because it considered patient outcomes to be the result of teamwork rather than an individual clinician. It also noted that a recent NZ Government review concluded that the typical caseload of specialists is too small to have enough statistical power to identify poorer performers (NZHQSC 2016). However, public reporting on individual surgeons has existed in countries such as the United Kingdom and United States for some years.

The benefits of user choice will depend on the health literacy of patients because this will influence their willingness and ability to choose. The Tasmanian Government (sub. PFR297) noted that groups with low health literacy face significant challenges in making informed choices. Australian Unity (sub. 94) cautioned 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 is broadly the model that has existed in England (although not the rest of the United Kingdom) since 2006. It would allow GPs to continue to support

consumers in making decisions, with both parties being better informed about specialists than currently, if choice was accompanied by better information provision.[3]

The Australian Healthcare and Hospitals Association supported giving patients choice at the time of referral to a specialist.

> 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)

The Royal Australian College of General Practitioners (sub. PFR337, p. 1) noted that the 'role of GPs in supporting patient choice is already well established' but acknowledged that 'sufficient information to support patient choice is often unavailable to both the patient and GP'. The college also cautioned that 'when sufficient information is available to inform both the GP and the patient, [greater choice] will increase the length of consultation and likely increase the cost of care to the patient'.

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.

---

[3] There is also scope for GP practices to be better informed about their own performance. Mossialos et al. (2016) reported that only 13 per cent of Australian primary care practices routinely receive data comparing their performance to other practices, compared to 71 per cent in the United Kingdom and 61 per cent in New Zealand.

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.

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).

Data source: AIHW (2016b).

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) 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 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. Public hospitals are currently subject to performance frameworks that could ultimately lead to the replacement of senior management but this could be made more transparent, particularly regarding the level of underperformance that would trigger replacement and the associated process.

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.

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).

Governments do not generally 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 rarer, following a series of failed attempts in the 1990s (ACTU, sub. 100; Duckett 2013; NSW Nurses and

Midwives' Association, sub. 247).[4] 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, ACTU, sub. PFR334; Health Care Consumers Association, sub. 239; Victorian Allied Health Professionals Association, sub. PFR361). Moreover, the Royal Australian College of General Practitioners (sub. 8) cautioned that competitive commissioning of services is labour intensive and costly. The Australian Healthcare and Hospitals Association (sub. PFR306) had similar concerns and anticipated that the private sector would need to invest in its clinical governance and data reporting arrangements to match the public sector.

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. For example, the Tasmanian Health Service uses a flexible mix of public and private providers for elective surgery, through contract arrangements with private hospitals in Tasmania and Victoria (Tasmanian Government, sub. PFR297).

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)

Catholic Health Australia warned that governments would need to:

> … offer a volume of work that makes it worthwhile for providers to spend the necessary time and expense required to prepare a bid. A market offering would also need to cover a reasonable period of time — say a contract length of 5–10 years. Ad-hoc short-term offerings, particularly to clear long elective surgery waiting lists in pre-election periods, are unlikely to [be] the most competitive responses and generally offer little long-term benefit to the community. (sub. PFR350, pp. 1–2)

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

---

4 Apart from Joondalup Health Campus in Perth, the few public hospitals currently run by for-profit operators tend to be relatively small facilities located outside capital cities. This includes Mildura Base Hospital, Peel Health Campus, Noosa Hospital and Albury Border Cancer Hospital (Australian Private Hospitals Association, sub. PFR381).

when poor service quality leads to avoidable readmissions (COAG 2016). 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. The Australian Government's foreshadowed trial of capitation payments to GPs (in place of the current fee-for-service model) under its Health Care Homes initiative is also relevant, given the role of GPs in referring patients to specialists (Ley 2016a).

Presence of alternative providers

Without more innovative models for commissioning and delivering services, the benefits from user choice could be constrained by a lack of alternative hospitals and health professionals in close proximity to a patient's residence. This is particularly an issue for patients in remote areas. 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 number of inquiry participants were concerned that patients living outside metropolitan areas have few practical alternatives when it came to choosing a public hospital (for example, Australian Healthcare and Hospitals Association, sub. PFR306; Combined Pensioners and Superannuants Association of NSW, sub. PFR364). The Victorian Healthcare Association (sub. PFR376) was concerned that the emergence of new competitors would be problematic in all regions because large public hospitals (and hospitals in smaller rural towns) are often 'natural monopolies'. In the case of highly specialised services, it noted that these require costly infrastructure, high levels of expertise and client throughput to maintain clinical skills.

The mismatch between the geographic distribution of the health workforce and general population might be addressed in a number of ways. 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. Another option could be greater use of fly-in-fly-out arrangements for specialists to service areas outside major cities.

With respect to concerns that hospitals are natural monopolies, this is not necessarily a barrier to competition for all services. There are already numerous facilities specialising in more routine same-day services, such as colonoscopies and cataract surgery. Moreover, the Australian Private Hospitals Association (sub. PFR381) noted that there are already private hospitals in metropolitan and regional areas which could service public patients in those locations.

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 2016l; 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 (Australian Healthcare and Hospitals Association, sub. PFR306; Catholic Health Australia, sub. PFR350). 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. The Australian Healthcare and Hospitals Association (sub. PFR306) noted that, under current arrangements, there is a risk that, if consumers gravitated towards public hospitals that are seen to be better performing, this could increase congestion and lower efficiency at these sites.

- 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).[5] 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).

---

[5]   There is also significant variation between jurisdictions. The Australian Private Hospitals Association (sub. PFR381) reported that private patients accounted for almost 20 per cent of separations in NSW public hospitals in 2014-15, compared to around 7 per cent in SA and WA public hospitals.

Figure 4.7   **Share of acute admitted services provided to private patients in individual public hospitals by type of facility, 2013-14[a]**
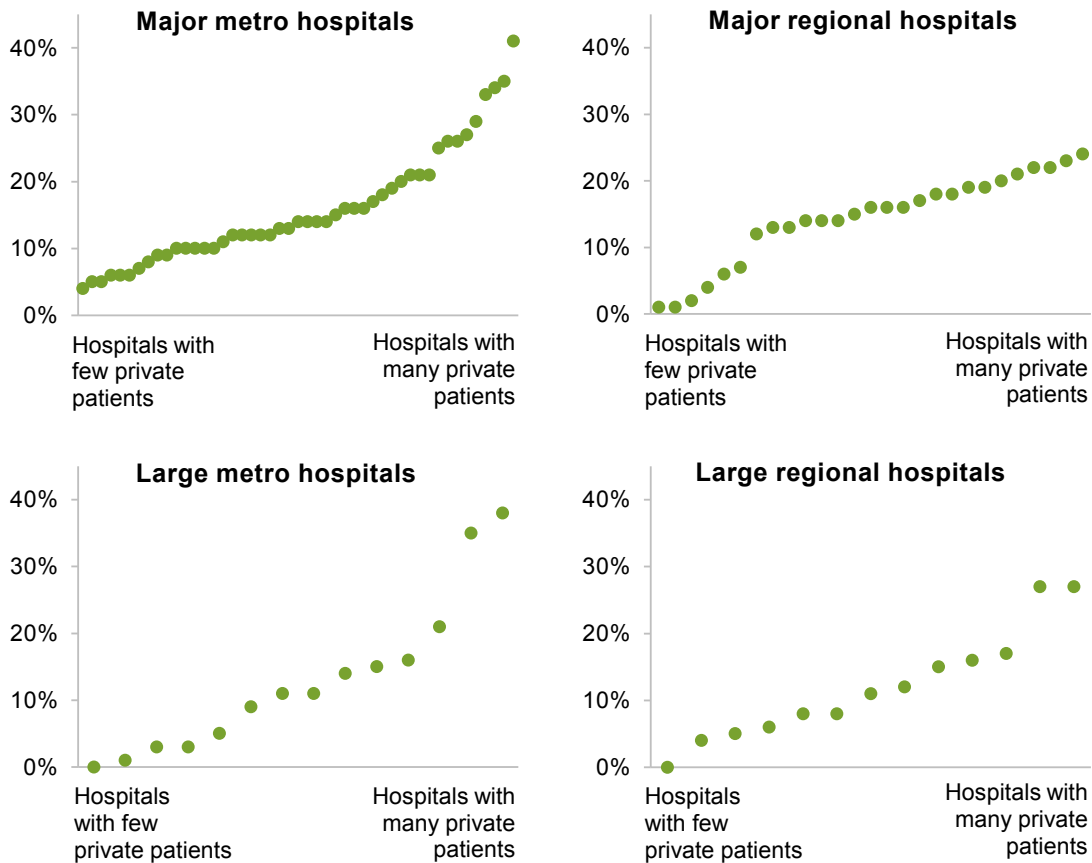
a Each dot in the figure represents an individual public hospital. The share of private patients in each hospital was calculated by dividing the number of private and self-funded patient separations by total acute admitted separations. A separation is an episode of care for an admitted patient, which 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.

Data 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.[6] Workforce issues pose particular challenges to changing providers, particularly if public sector hospital employees have to transition to private employment or

---

6   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).

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.

FINDING 4.1

The Australian health system is complex, with many different, but connected, parts. There is already a high degree of choice and competition for many services, such as primary care provided by GPs and optometrists. A key exception is public hospital services, where greater user choice and contestability could, as part of a wider range of reforms, lead to better outcomes for patients.

- Australian hospitals generally perform well against those in comparable countries but there is still scope for many to improve patient outcomes and lower costs by matching the practices of better-performing hospitals within Australia.

- Overseas experience shows that user choice can lead to improved service quality and efficiency when patients are able to plan services in advance and access useful information. In Australia, this would require more user-oriented information on the clinical outcomes achieved by individual hospitals and doctors. Patients with low levels of health literacy would also need support, such as from their GP.

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

- 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.

5   End-of-life care

Death is an inevitable part of life, but the end-of-life care that many Australians receive has only recently begun to garner the attention it deserves. While Australia's end-of-life care services are well regarded internationally and are improving, recent reviews have identified that patient preferences are not always well satisfied, access to high-quality care is variable and services are often not as well integrated as they could be.

As defined by the Australian Commission on Safety and Quality in Health Care (2015a, p. 33), end-of-life care services include 'physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff' provided to people who are 'likely to die in the next 12 months'. It also includes support for families and carers during what is a difficult and stressful time and care of the patient's body after their death.[1]

End-of-life care is provided in a variety of settings (such as acute hospitals, general practices, residential aged care facilities and people's homes) and by a range of healthcare professionals (such as nurses, general practitioners (GPs), palliative care specialists, psychologists, physiotherapists, pharmacists, social workers, personal care assistants and music therapists). Informal carers (friends and relatives) and volunteers also provide unpaid care (AIHW 2016e).

Some patients approaching the end of life have physical, social, emotional or spiritual needs that require the services of specialist palliative care providers (PCA 2005). Specialist palliative care providers are multidisciplinary teams that provide assessment, consultancy and management of palliative care needs (including end-of-life care) in admitted patient settings, hospices and community-based settings (AIHW 2016e).

Specialist palliative care was the focus of the Commission's Preliminary Findings Report for this inquiry. The Commission received feedback through roundtables and submissions that lead it to take a broader view. While palliative care and end-of-life care overlap, end of life care covers a broader set of health and community services.

There is no comprehensive national collection of data on palliative and end-of-life care activity. The available data can only provide a rough indication. The latest available annual data indicate that there were:

- 62 200 palliative-care related admissions reported from public and private hospitals (2013-14)

---

[1]   End-of-life care does not include euthanasia or assisted suicide.

- 59 000 palliative-care related prescriptions provided to 29 800 patients (2014-15)

- 71 500 Medicare Benefits Schedule subsidised services provided to 13 000 patients by palliative medicine specialists (2014-15)

- somewhere between 85 000 and 159 000 GP encounters related to palliative care (2014-15) (AIHW 2016n).

Some of these figures are likely to be underestimates because activities are sometimes recorded according to the disease to be managed rather than the type of care provided. Furthermore, a large proportion of specialist palliative care is provided in community settings where data collection is limited.

The Australian Government (2010) has suggested that 25 to 50 per cent of deaths are expected.[2] Given that just under 160 000 Australians died in 2015, this suggests that there are between 40 000 and 80 000 Australians who could potentially benefit from end-of-life care each year (ABS 2016c).

5.1   Scope to improve outcomes

Australia's end-of-life care services are well-regarded, but more could be done to ensure patients receive the right care, in the right place, and at the right time. A 2015 study ranked Australia second out of 80 countries in terms of the quality, availability and affordability of end-of-life care, but noted that 'even top-ranked nations currently struggle to provide adequate palliative care services for every citizen' (EIU 2015, p. 6).

The Australian Government, and most state and territory governments, have strategic plans or frameworks in place for end-of-life care that recognise 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 in specialist palliative care and the range of variation in patient outcomes has declined (Currow et al. 2015; PCOC 2016b). Nonetheless, it is widely recognised that end-of-life care could be more responsive to patient preferences, access to high-quality care varies within and across jurisdictions, and the publicly available data required to ensure end-of-life care services are transparent and accountable are lacking.

Responsiveness

An important measure of the responsiveness of end-of-life care is the extent to which patients can choose the care they receive. Two issues are often raised — unsatisfied preferences with regard to the setting of care, and with regard to the timing of care.

---

[2] More recent cross-country research has indicated the proportion of people who could benefit from end-of-life care in the last year of life could be even in higher, in the range of 69 to 82 per cent (Murtagh et al. 2014).

Preferences for setting of care

To have choice and control over where death occurs is considered central to a good death (Arnold, Finucane and Oxenham 2015). Much has been made of the discrepancy between where people say they would prefer to die and where people actually die. Surveys conducted by Palliative Care Australia (sub. PFR329) consistently indicate that 70 per cent of Australians would prefer to die at home, but half of all deaths actually take place in hospital (figure 5.1).

Figure 5.1   **Deaths by setting**
Per cent of total deaths, Australia, 2001-02 to 2013-14
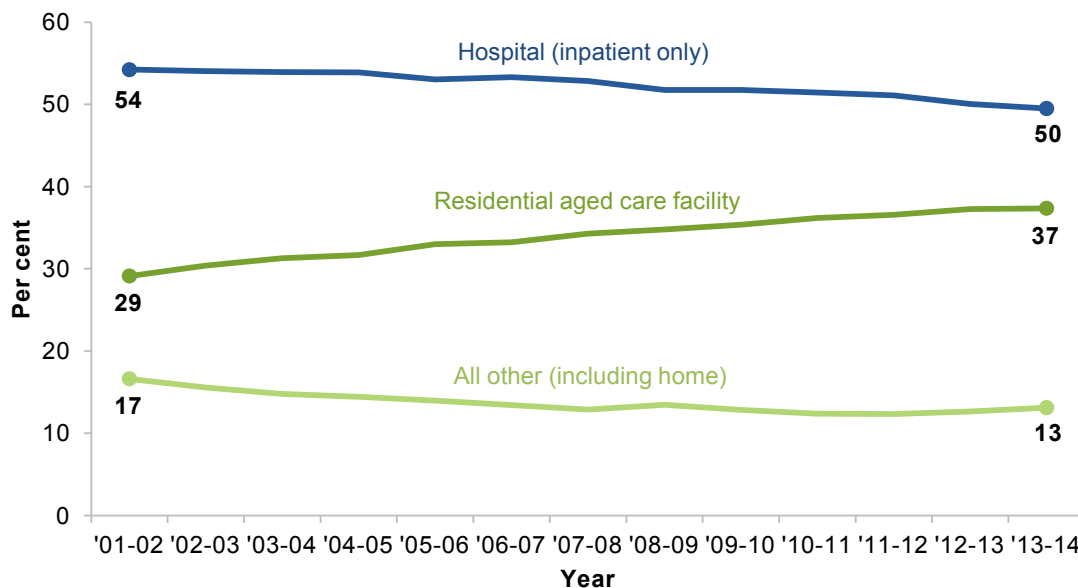
Sources: ABS (*Deaths, Australia, 2015*, Cat. no. 3302.0); AIHW (2002a, 2002b, 2003a, 2003b, 2004a, 2004b, 2005a, 2005c, 2006a, 2006b, 2007a, 2007b, 2008a, 2008b, 2009a, 2009b, 2010a, 2010b, 2011a, 2011b, 2012a, 2012b, 2013a, 2014a, 2014c, 2015a, 2015g, 2016b).

There are reasons to be cautious in interpreting these data. For patients, relatives and physicians, factors such as freedom from pain, mental awareness and satisfying treatment choices may take precedence over choices about setting of care (Steinhauser et al. 2000). In some cases, external factors may also make end-of-life care at home impractical. For example, some people in need of end-of-life care may not have family or friends who are able to act as caregivers at home.

Surveys of the general public about their preferred place of death may not accurately reflect the choices of people with life-limiting illnesses. 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).

A recent review of 210 studies across 33 countries reported that most of these studies found that a majority of respondents preferred to die at home (Gomes et al. 2013). This preference was generally consistent across studies reporting on the responses of the general public, patients and carers. Examining 10 studies that assessed changes in patient preferences over time, the review found that preferences for setting of care were unchanged over the course of an illness for 80 per cent of patients. Findings on whether preferences for place of care systematically differed from place of death were inconclusive.

The choice between inpatient and community care is not always an 'either/or' proposition. Across jurisdictions, the level of end-of-life 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 a problem emerges or when an existing problem becomes more severe, but return home when their condition stabilises. Data from Victorian palliative care services participating in the Palliative Care Outcomes Collaboration (PCOC, pers. comm., 1 September 2016) (box 5.1) indicate that about 22 per cent of all patients who accessed specialist palliative care used a combination of inpatient and community services before death between 2013 and 2015.

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).

While keeping in mind the above caveats, there does seem to be scope to improve responsiveness with regard to patient choices 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).

Preferences for the timing of care

The responsiveness of end-of-life care could also be improved by placing greater emphasis on user choice with regard to when and how people access end-of-life 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 end-of-life 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 end-of-life care (Philip and Collins 2015).

Palliative Care Australia (sub. PFR329, pp. 4–5) explained that the timing of referral to end-of-life care is sometimes perceived as too late and at other times perceived as too early:

> [We] have heard many stories of patients in hospitals who are being treated by a specialist medical team – for example oncology, renal, respiratory, cardiac – where the chronic condition of the patient has been deteriorating over time, but the specialists do not recognise that their patient may benefit from a different approach to their care that identifies their ongoing values and wishes for their health care. In some cases the reverse is true as well, [we] have heard stories of patients who perceive they have been forced into palliative care when not all treatment options have been fully explored.

Similarly, Bupa (sub. PFR380, p. 15) noted that 'we currently hear many anecdotal stories of members receiving "heroic" end of life care by medical practitioners to prolong life when this may be contrary to the member's desire'.

Untimely referrals can 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 this 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).

Quality and equity

A lack of consistent access to high-quality end-of-life care has been repeatedly raised by national and state reviews and by participants to this inquiry (for example, HammondCare, sub. PFR330; Palliative Care Australia, sub. PFR329). Concerns include differences in the range and quality of services available across jurisdictions, variability in access to services between urban and non-urban areas, inadequate access to 24-hour services 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 (and end-of-life care services in general). People with a life-limiting illness other than cancer have many of the same 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).

Efficiency

While there have been many reviews of end-of-life care in Australia, little emphasis has been placed on improving efficiency. As with many other types of health care, evaluating the efficiency of end-of-life care service providers is challenging because the outcomes 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 for governments. For example, analysis by the Silver Chain Group (sub. 176) found that each dollar invested in extending home-based care services in New South Wales would free up $1.44 of expenditure on inpatient bed capacity at metropolitan hospitals. However, Swerissen and Duckett (2014) estimated that increased expenditure on community-based care near the end of life would be closer to cost neutral. Further research is required to identify the magnitude of any cost savings. Providing more care in the community may also have wider costs such as increasing the burden on unpaid carers (Royal Australian College of General Practitioners, sub. PFR337).

Accountability

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

PCOC has made a valuable contribution in terms of measuring patient outcomes in specialist palliative care, but there is much more that can be done. 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 end-of-life care services. Many state and territory governments do not routinely or systematically collect these data at all.

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).

5.2   Factors influencing the potential benefits of reform

While the scope to improve end-of-life care services is clear, the extent to which introducing user choice can facilitate this depends on the characteristics of end-of-life care users and suppliers, and the nature of end-of-life care transactions.

Characteristics of users and transactions

Qualitative evidence indicates that end-of-life care patients value the ability to make informed choices about the care they receive (Gourdji, McVey and Purden 2009; McCaffrey et al. 2016). However, the characteristics of users and transactions can sometimes constrain the scope to provide patients with choice about what care they receive, where they receive it and from whom they receive it.

One important consideration is the trajectory of a patient's illness (figure 5.2). Many patients, particularly those with a primary diagnosis of cancer, tend to have relatively 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. US data suggest that perhaps 70 per cent of older people who require decisions to be made about their treatment in the final days of life lack decision-making capacity (Silveira, Kim and Langa 2010).

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 arrangements for end-of-life care is 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 patients, relatives and medical professionals engage in discussions about end-of-life care early in the progression of an illness or prior to diagnosis. 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). Evidence from abroad indicates that patients who undertake advance care planning are significantly more likely to die at home than in hospital (Dixon, King and Knapp 2016), are more likely to have preferences for end-of-life

care that are stable over time (Auriemma et al. 2014) and are more likely to be satisfied with the care they receive (Brinkman-Stoppelenburg, Rietjens and Heide 2014; Dixon, King and Knapp 2016).

Figure 5.2   Stylised illness trajectories[a]

Short period of evident decline (mostly cancer)

Long-term limitations, intermittent serious episodes (mostly heart and lung failure)

Prolonged dwindling (mostly frailty and dementia)
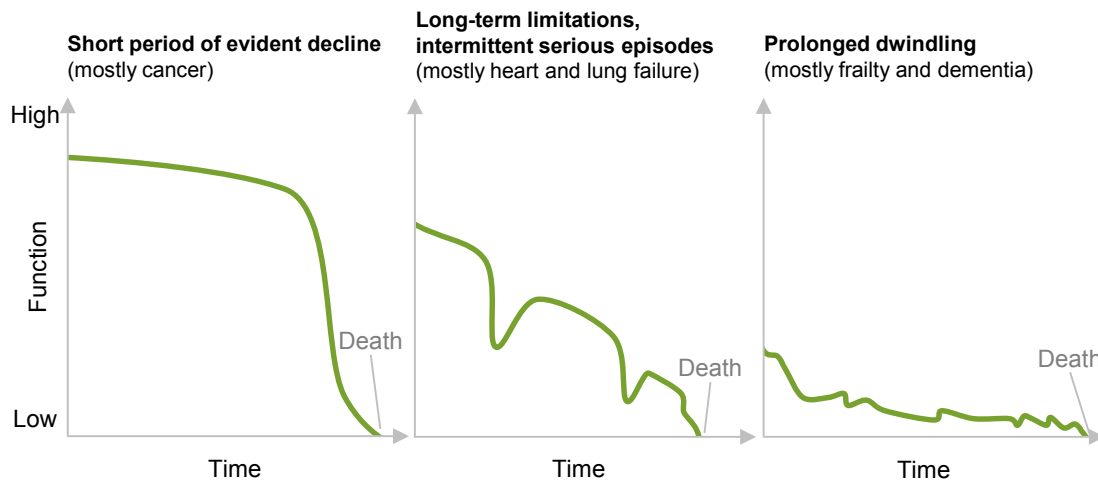
a 'Function' refers to the ability of a patient to function physically and mentally.
Source: Based on Lynn and Adamson (2003).

Taboos about death can prevent advance care planning from taking place (SCARC 2012). Patients often rely on medical professionals to initiate conversations about end-of-life care, many of whom are inadequately trained about, and intimidated by, holding such conversations (Bartel 2016). Across Australia, 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).

Patients (and their carers) can have difficulty judging the quality of services available to them. As with other forms of health care, 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). End-of-life care does not involve a single transaction of a well-defined service and making like-for-like comparisons between providers is difficult. Even within a state or territory, the services on offer (and who provides these services) can differ from region to region.

Information asymmetry between end-of-life 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.

Supply characteristics

Across Australia, a broad range of providers offer end-of-life care services including: specialist palliative care providers in inpatient and community settings, residential aged care providers, community nursing providers and GPs. Often, the end-of-life care services a patient receives requires the coordination of a number of different providers.

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 end-of-life care. This may present a barrier to new providers entering the market, particularly in less densely populated areas with limited demand for end-of-life 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 Group (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. 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 end-of-life 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 and GPs to provide services in more remote areas. In jurisdictions with smaller populations, such as Tasmania and the Northern Territory, all specialist palliative care services are provided by government. In Western Australia 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.

The capacity to offer a choice of providers and the potential to introduce greater contestability will depend in part on the level of demand for end-of-life care services in a given region. However, even in regions where demand is low, related approaches can benefit users, such as 'benchmarking' service providers across regions, with procedures to reform or replace under-performing providers.

5.3   Introducing greater user choice

There is scope to improve end-of-life care services by providing users with greater choice about the care they receive and the setting in which that care takes place. Introducing greater choice will entail costs and requires a suite of reforms, of which contestability and competition could play a part.

In some areas, and among some groups, a lack of access to high-quality end-of-life care presents a major barrier to exercising choice. Improving the delivery of end-of-life care across care settings would need to be a key component of any reform package. This may require changes to funding arrangements.

Choice can only be effective if patient preferences are well-informed, clearly expressed and implementable. Clarifying responsibilities for initiating advance care planning, and providing training and incentives for healthcare professionals to engage patients and their families in ongoing end-of-life conversations, will be important.

Patients often need access to a variety of medical and personal services as part of their end-of-life care. Achieving improved outcomes will require change across different services and professions. Deeper integration of end-of-life care within existing service delivery models (including those used in primary and community care, hospitals and aged-care facilities) will be crucial. Better coordination across services provided in different settings will also be important.

Introducing greater user choice will require careful design to ensure that the interests of patients and their families are well served. To the extent that this involves changes to the way end-of-life care services are commissioned, the benefits associated with collaboration between services would need to be recognised, and arrangements put in place to ensure continuity of care between providers. Special measures for consumer protection may also be needed given the vulnerability of users of end-of-life care services, the limited capacity of many users to exercise choice and the potential magnitude of harm should a service provider act without due care. More extensive data collection and improved monitoring and benchmarking of provider performance would also be required.

Many Australians wish to die at home, supported by family, friends and effective care services, but often their wishes are not being met.

- There is scope to improve end-of-life care services by providing users with greater choice about the care they receive, and the setting of care. As part of a wider suite of reforms, contestability and competition could play a role in promoting user choice.

- Efforts to promote user choice would need to address the challenges associated with making decisions at the end of life. Complementary measures would also be required to improve the integration and coordination of care services across a variety of settings, allow for better measurement and monitoring of patient outcomes, and provide protection for vulnerable consumers.

6 Public dental services

6.1 Public dental services in Australia

Unlike most other forms of healthcare, governments only fund a small proportion of dental services but, when they do, these services are also typically provided by government. This is in contrast to, for example, eye tests and general practitioner (GP) services, where the vast majority of funding comes from the Australian Government via Medicare, but services are almost always provided by the private sector.

Public dental services are not open to all through universal access arrangements, as is the case with public hospitals, but targeted to users through eligibility criteria. Adults with a concession card and most children are eligible to receive public dental services funded by state and territory governments.[1] Reflecting their role as a safety net, public dental services only accounted for about 14 per cent ($1.2 billion) of Australian expenditure on dental care in 2013-14 (AIHW 2015e).[2] Among people who saw a dental professional in 2013, about 14 per cent attended a public clinic (including school clinics) at their last visit (AIHW 2015f). Dr Martin Dooland (sub. PFR300) estimated that in a given year about 20 per cent of eligible adults receive public dental services.

The relevant state or territory government is also often the service provider, with care provided in a variety of settings, including public dental clinics, dental hospitals, mobile clinics and schools. There is also some private sector provision of public dental services funded by the states and territories.

The Australian Government funds a separate Child Dental Benefits Schedule (CDBS), that contributes up to $1000 of benefits over two years for basic dental services for children in families receiving Family Tax Benefit Part A. Such services can be provided in either a private dental practice or a public clinic operated by a state or territory government. Almost 80 per cent of CDBS claims have been for services provided in the private sector (Australian Government 2016b).[3]

---

[1] 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.

[2] The remaining 86 per cent of Australian dental expenditure was largely funded by patients (78 per cent of spending, of which 17 per cent was via insurance premiums) and the Australian Government through private health insurance rebates (7 per cent) and services for veterans (1 per cent).

[3] In April 2016, the Australian Government announced its intention to replace the CDBS with a Child and Adult Public Dental Scheme, which would contribute to the funding of state and territory public dental

6.2   Scope to improve outcomes

Public dental services act as a safety net by providing access to basic dental care. Access continues to be a concern for certain populations, such as people living in remote areas. The current emphasis on providing services in government-operated clinics can limit the responsiveness of services to user preferences (and other factors such as changing demographics). While governments regularly publish information on public dental activity levels, overall expenditure and waiting lists, accountability could be improved through greater public reporting on patient outcomes and cost effectiveness.

Introducing greater competition, contestability and user choice to public dental services could, as part of a suite of reforms, lead to better outcomes for patients and the wider community. These reforms may include the development of a consistent and well-accepted standard for measuring health outcomes within oral health (DHSV, sub. PFR366). Other policy instruments that governments can and do use to improve outcomes include investment in oral health promotion, and greater alignment and integration of the oral and general health systems (COAG Health Council 2015).

Quality

The Commission has not seen any evidence to suggest that there are systemic problems with the quality of public dental services provided in either government-operated clinics or private dental practices. However, as detailed further below, publicly available information provides few insights into the precise quality of services. What is known is that 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 formal complaint in 2014-15. Of the complaints closed in 2014-15, less than one-third were taken beyond the assessment stage (AHPRA 2015).

Equity

Publicly funded dental services play an important role in providing access to basic dental care for people who face financial and other barriers. Dr Martin Dooland (sub. PFR300) estimated that about 20 per cent of eligible adults receive public dental services in a given year, but a further 30 per cent receive treatment in the private sector and pay for it themselves. Among people eligible for public dental services in 2013, close to half reported that they would have a lot of difficulty paying for a basic preventive care package, compared with less than one-quarter of adults ineligible to receive public dental services (AIHW 2015f).

schemes based on a national efficient price similar to activity-based funding for public hospitals. The Health Minister stated that the CDBS would be closed because it is poorly targeted (Ley 2016d).

Given that public dental services for adults are targeted at concession card holders, it is not surprising that a high proportion of service recipients live in disadvantaged areas. Among people aged 15 or over who received public dental care in 2014-15, about half resided in areas that were in the bottom two quintiles on a scale of socioeconomic disadvantage (figure 6.1). A further 30 per cent were in the top two quintiles based on place of residence — to some extent, this would reflect that disadvantaged adults sometimes reside in areas where, on average, the population is relatively better off.

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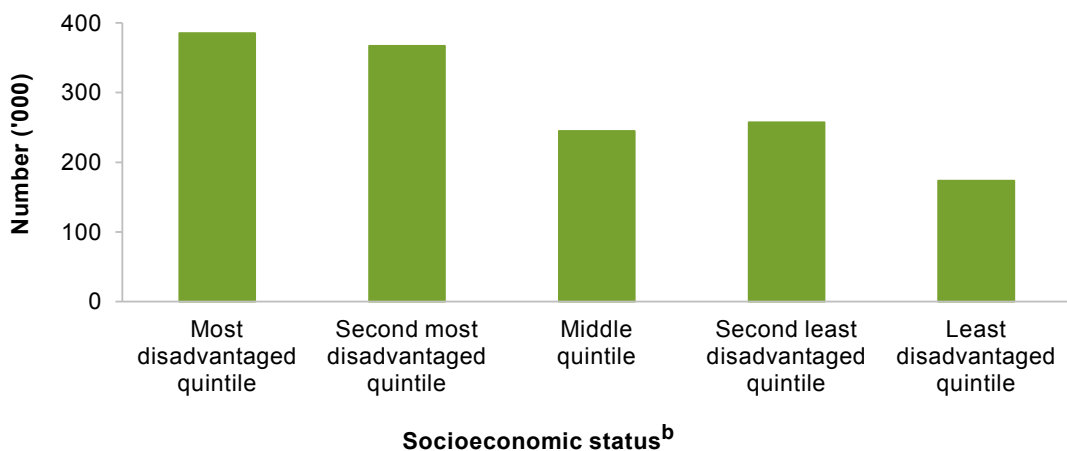
a Persons aged 15 and over. **b** Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a person resided. The index is derived from census variables related to disadvantage, such as low income, low educational attainment, unemployment, jobs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

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

Equity concerns have been raised about access to public dental services in remote areas where the population have poor oral health compared with those living in major cities (COAG Health Council 2015). For example, 14 per cent of Indigenous Australians living in remote areas in 2014-15 reported problems in accessing dental services, compared with 6 per cent of Indigenous Australians residing in other areas (ABS 2016f).

More contestable delivery arrangements of public dental services that encourage more innovative and flexible service provision (such as telehealth to diagnose conditions) could improve access to dental services in remote communities. Indeed, the *National Oral Health Plan 2015-2024* (COAG Health Council 2015) suggested that in areas where there may be limited capacity to sustain multiple providers, services can be made more sustainable and affordable when developed and managed using collaborative models that involve the private, public and non-government sectors.

Difficulties accessing dental services that cause people to leave dental problems untreated are a concern not only for the individuals affected but also the wider community because it

can ultimately lead to more costly treatment being required, particularly if the patient requires hospitalisation. 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 in remote areas were about 40 per cent more likely than those in major cities 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). Indigenous people were more than twice as likely to experience an acute potentially preventable hospitalisation for a dental condition if they resided in a remote area (SCRGSP 2014b).

Accountability

The states and territories regularly publish information on public dental activity levels, overall expenditure and waiting lists. They also reported data on waiting lists and activity levels to the Australian Government under the *National Partnership Agreement on Treating More Public Dental Patients*.

In setting the national strategic direction for oral health in Australia, the *National Oral Health Plan* identified the need for consistent performance reporting on patient experiences that would enable benchmarking of services and support continuous improvement in the sector. Work on developing a report on the key performance indicators, as set out in the *National Oral Health Plan*, is due to be completed in June 2017 (DHSV, sub. PFR366). Dental Health Services Victoria (DHSV) is also working with the International Consortium for Health Outcomes Measurement, and partners from the Harvard School of Dental Medicine and HCF Australia to develop a consistent and well-accepted set of standards for measuring oral health outcomes (DHSV, sub. PFR366).

However, there remains considerable scope to improve accountability to those who fund public dental services (governments and users through co-payments). This includes greater public reporting, on a consistent basis, of clinical and other patient outcomes (such as from patient satisfaction surveys).

Accountability would also be improved by releasing more detailed information on expenditure, including on the cost effectiveness of public dental services. In its preliminary findings report, the Commission noted that there was no publicly reported information which could be used to assess whether the current emphasis on providing services in government-operated clinics is more efficient than private sector provision under voucher schemes. In response, a number of participants submitted that governments have typically found that public dental services are more costly when provided by the private sector (AHHA, sub. PFR306; Dr Martin Dooland, sub. PFR300; DHSV, sub. PFR366) (discussed below).

Efficiency

Dr Martin Dooland (sub. PFR300, attachment A) estimated that private sector provision is, on average, 30 per cent more costly than public provision for a course of general dental care for adults. The cost difference was attributed primarily to private clinics tending to provide more services per patient. Comparing the Dental Weighted Activity Units (DWAUs) provided during a course of care, the DHSV (sub. PFR366) found that, in Victoria, public patients treated at a private practice (using a voucher) received 51 per cent more general dental services and 17 per cent more emergency services compared with those treated at a public dental clinic.

Participants also raised concerns about the quantity and types of services that the private sector has provided to patients whose treatment has been subsidised on a fee-for-service basis by the Australian Government, particularly under the (now closed) Chronic Disease Dental Scheme (CDDS). The cost of the CDDS increased significantly in 2008 after the spending cap was increased more than ninefold to $4250 per patient and the range of eligible services was broadened to include reconstructive services. Subsequently, over two-thirds of expenditure was on aesthetic crowns, for which Lam, Kruger and Tennant (2015) noted there was limited evidence of the disease-control benefits. Dr Martin Dooland (sub. PFR300, attachment A) noted that, under the CDDS in South Australia, many private providers 'cherry picked' complex and lucrative treatment items, and referred patients back to the public sector for more basic general dental care. Similarly, Barwon Health (sub. PFR355) raised concerns about 'over servicing' by private mobile practices under the CDBS, which is also a fee-for-service scheme, but with more limited eligible treatments and lower spending caps.

Differences in the approach to care may help explain the observed differences in the mix of services provided to public patients in the private and public sector. The private sector may focus on providing preventive care to the patient who is 'in the chair' irrespective of their disease risk profile. By way of contrast, Dr Martin Dooland (sub. PFR300, attachment A) described the public dental sector as using a 'public health approach' to provide these services in a more targeted way to match the individual patient's risk profile. This approach aims to maximise the oral health outcome for the population of eligible people within the funding available, rather than focusing solely on the patient they are currently seeing.

Other reasons for the cost differential could include efficiencies arising from the range of innovations undertaken in the SA public dental system in response to limited funding for public dental services (Dr Martin Dooland, sub. PFR300). For example, in the 1980s and 1990s the SA Dental Service targeted preventive treatment on high-risk children at the same time as withdrawing these services for low-risk children (this submission did not provide further detail on how children were categorised as low- or high-risk). Changes to the approach to children's dentistry resulted in better oral health outcomes and major financial savings (Dr Martin Dooland, sub. PFR300).

The cost differences identified by participants could also be due to other factors, such as cross-sector differences in service quality, economies of scale, the way costs are measured, and a tendency for governments to fund private provision on an ad hoc basis, for example, to reduce waiting lists. The Commission will explore these issues in greater depth in the next stage of the inquiry.

Introducing greater competition, contestability and user choice could spur efficiency and innovation. However, improvements in the efficiency of providing public dental services would depend on designing a system where the financial incentives facing private providers promote clinically- and cost-effective treatment that leads to the best outcomes for users.

Responsiveness

The current emphasis on government provision of public dental services can limit the ability of patients to choose the time and location of their treatment. People receiving dental services funded by state and territory governments are often required to attend a clinic operated by the relevant government. In some cases, they may be able to choose between different government-operated clinics. For people in urban areas, these clinics may be located within a reasonable distance of a user's residence. For example, in Victoria, the DHSV (sub. PFR366) estimated that about 82 per cent of people eligible for public dental services live in postcodes within 10 kilometres of the nearest public dental clinic, and a further 8 per cent live in postcodes within 20 kilometres. Nonetheless, options may be more limited than if users were able to attend private dental practices, which could also potentially offer greater choice over the timing of treatment.

Voucher schemes have been used in some jurisdictions and have provided public dental patients greater choice over the timing and location of treatment by making use of private dental practices (box 6.1). In addition, in the 18 months to June 2015, over three-quarters of claims under the CDBS were for services provided in private practices (Australian Government 2016b).

In some regional communities there may be limited scope for multiple dental professionals to operate. That said, the Australian Dental Association (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. Western Australia's *Country Patients' Dental Subsidy Scheme* already provides financial assistance for eligible patients to use a private dental practice if there is no public dental clinic in their town (WA DHS nd).

Box 6.1 Mechanisms used to fund public dental services provided by the private sector

State and territory voucher schemes

Vouchers have been used to some extent in all states and territories. Some schemes are longstanding. New South Wales has had a voucher scheme since 2000, and South Australia has been using vouchers since the early 1980s (Dr Martin Dooland, sub. PFR300, attachment A). In other states, such as Queensland, vouchers have been used as a short-term measure to reduce long waiting lists for some users (such as those waiting more than two years). South Australia and Western Australia provide vouchers in areas where there is no public dental clinic.

Child Dental Benefits Schedule

The CDBS subsidises basic dental services for children that are provided in either a private dental practice or a public clinic. A total of 73 dental services can be claimed, ranging from diagnostic, preventive and restorative services to oral surgery and prosthodontic (denture) services. While private providers are free to charge a co-payment, the vast majority choose not to. Over 90 per cent of providers charge at or below the fee set out in the CDBS (Australian Government 2016b).

The Australian Dental Association (sub. 230, p. 3) stated that the CDBS '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'. Two reviews of the CDBS — by the Australian National Audit Office (ANAO) and a panel chaired by the Commonwealth Chief Medical Officer — found no major issues with the private sector providing eligible services (ANAO 2015; Australian Government 2016b). However, the DHSV (sub. PFR366) noted that the ANAO's review of the CDBS did not consider whether there was any inappropriate service provision, or if the services provided improved health outcomes.

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 2015b). Similarly, a 2015 survey found overall patient satisfaction levels of 88 per cent at the Royal Dental Hospital of Melbourne (which offers emergency treatment to public and private patients) (DHSV, sub. PFR366). Although overall satisfaction is high, there is some evidence that people attending a public dental clinic may be treated by a different professional each time, which could make it difficult for patients to establish a rapport with their provider (Slack-Smith et al. 2010). Dr Martin Dooland (sub. PFR300, attachment A) considered that continuity of dental provider is valuable but noted that this cannot always be achieved because, for example, the public sector plays an important role in giving dental students a wide range of clinical experience, making it infeasible for all patients to see the same provider each time.

Among other things, greater choice over the timing and location of treatment, and dental professional may encourage some users to seek more timely treatment for oral health conditions. Unfavourable visiting patterns, which are slightly more prevalent among adults

eligible for public dental services, can ultimately lead to poor oral health (figure 6.2). (Note the data are based on a phone survey, which could lead to under-sampling of the disadvantaged adults, and an underestimation of the gap between the oral health of those eligible and ineligible for public dental services.)

Examining the 2004-06 National Survey of Adult Oral Health, Ellershaw and Spencer (2011) found that adults with unfavourable visiting patterns were half as likely to receive preventive treatment and nearly four times more likely to receive a tooth extraction compared with adults with favourable visiting patterns.

Figure 6.2   **Oral health indicators, 2013[a]**
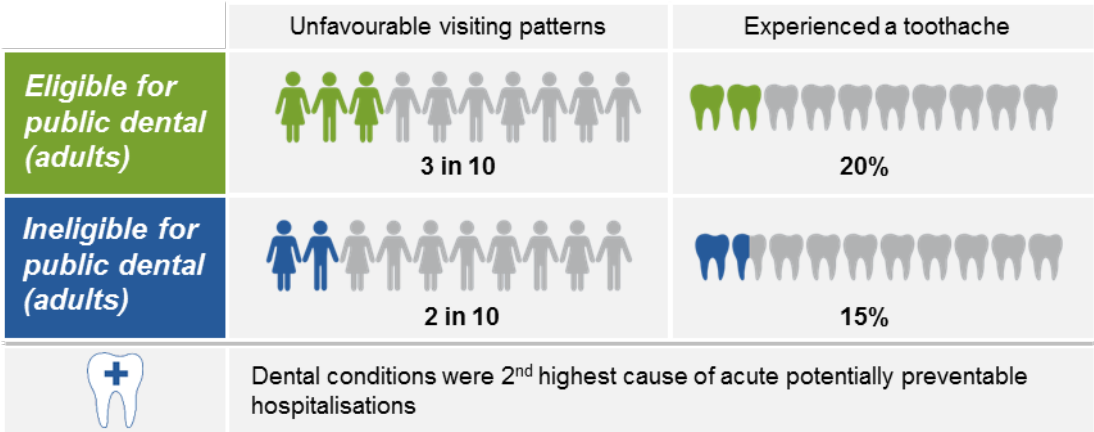
a Adults eligible for public dental care include people who held an Australian Government concession card. People were classified as having an unfavourable dental visiting pattern if: they visited a dental provider less than once every two years, typically to receive treatment for a dental problem; or they visited once every two years typically to receive treatment for a dental problem, but do not have a regular dental provider. Visiting patterns and toothache data are based on the 2013 National Dental Telephone Interview Survey. The reported numbers are statistically significant at the five per cent level.

Data sources: AIHW (2015a, 2015f).

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).[4] People who have difficulty accessing dental care may seek treatment for pain and infection from other health services, including GPs, outpatient clinics and hospitals.

As noted above, dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14. Poor oral health has also been associated with a

---

4   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.

number of other diseases, such as heart and lung infections and stroke (COAG Health Council 2015). The Victorian Auditor General has noted potential issues with delayed access to dental care and the resulting need for emergency treatment for preventable conditions, and is currently undertaking a review into access to public dental services in Victoria (VAGO 2016a).

6.3 Factors influencing the potential benefits of reform

User characteristics

There is no 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. 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; HRSCHA 2013; NACDH 2012).

For the purpose of introducing greater competition, contestability and user choice, it is relevant to note that public dental services are provided as a safety net for disadvantaged groups, rather than as a universal service. 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). In addition to issues with access to care, lower oral health literacy may contribute to higher rates of untreated tooth decay and periodontal disease in disadvantaged adults (Armfield, Spencer and Stewart 2006; COAG Health Council 2015). Many are therefore likely to need support, including through information provision, to understand the benefits of receiving dental care and choose a dental professional. Follow-up support from providers may also be required for patients who experience high dental fear to help ensure continuity of care.

There are also likely to be difficulties accessing dental care that are specific to certain populations, such as people with special care needs, residents of regional and remote areas, Indigenous Australians, the frail and elderly and the homeless. These groups are potentially not well serviced by the private sector. A number of existing government dental programs target certain disadvantaged segments in the population. For example, Victoria, Western Australia and South Australia currently provide services in a patient's residence if they are homebound due, for example, to disability or dementia (DHSV nd; SA Health nd; WA DHS nd). South Australia has a number of other programs targeted at groups with high needs (AHHA, sub. PFR306; Dr Martin Dooland, sub. PFR300, attachment A). There are many different models of contestability that could be applied to these services, such as inviting bids by government and non-government providers to operate all or part of the service offering.

The preferred approach to greater competition, contestability and user choice in public dental services may vary between urban, regional and remote regions, and between segments of the population. Delivery mechanisms that allow users to choose between

competing dental practices could be used for populations that generally do not face difficulties accessing care and are well serviced by the private sector. Indeed, the CDBS, which allows eligible families to choose their own provider, demonstrates that many users of publicly funded dental services are able to make decisions about their dental care (box 6.1).

Supply characteristics

The Commission estimates that state and territory governments operate about 1100 dental clinics across Australia, including mobile ones.[5] In comparison, there were about 13 100 businesses mainly engaged in the practice of general or specialised dentistry services in June 2015 (ABS 2016b).

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)

The NSW Government 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)

The DHSV (sub. PFR366) similarly suggested that the public dental sector in Victoria is able to provide services in rural and remote areas at a relatively low cost due to the economies of scale achieved in operating a number of clinics. The DHSV argued that if greater competition and contestability led to the public sector operating fewer clinics in rural and remote Victoria, the scale efficiencies in these areas could be compromised, potentially increasing the average cost of service provision.

In contrast to the public sector, dental practices in the private sector are typically independent enterprises and have a small number of dentists, with about one-third working

---

5   The number of government-operated clinics was estimated based on: ACT Government (2016); DHSV (2016); NSW Ministry of Health (2014); NT Department of Health (2016); Queensland Health (2013); SA Health (2016); Tasmanian DHHS (2016); WA DHS (2016).

in a sole 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 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 GP 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).

Service mix

With high demand for emergency treatment, public patients are triaged based on their clinical need, and emergency care comprises a greater share of services provided to public dental patients compared with those provided to private patients. There is also proportionately less preventive or restorative care provided to public patients, 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).

Workforce composition and location

Dental professionals working in the public sector accounted for about 17 per cent of all dental professionals on a full time equivalent basis in 2014 (AIHW 2016m). Differences in the types of services provided by public and private dental clinics are reflected in the composition of their workforces (figure 6.3). The public sector's focus on services for children is reflected in the relatively high share of dental therapists employed in the sector. Dental therapists provide examinations, diagnoses and treatment to children, teenagers and young adults. While the public sector employs proportionately fewer dental hygienists than the private sector, it employs more oral health therapists, who are dual qualified in dental therapy and oral hygiene (ADOHTA, sub. 99, attachment 1).

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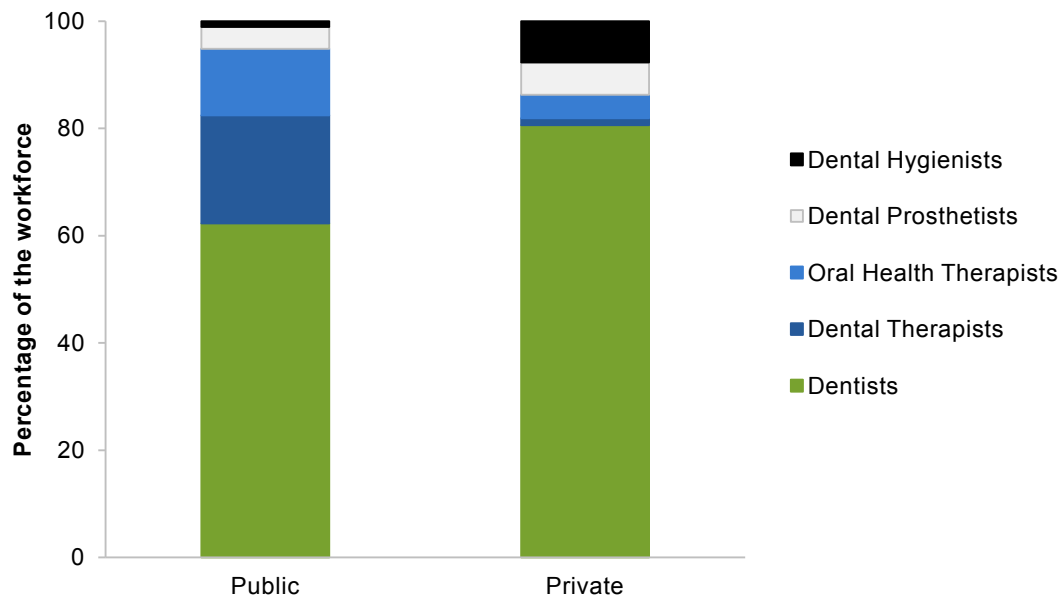
a Based on the full time equivalent number of professionals. b Dental therapists provide examinations, diagnoses and treatment to children, teenagers and young adults. Dental hygienists provide preventive services to people of all ages. Oral health therapists are dual qualified in dental therapy and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

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

Dr Martin Dooland (sub. PFR300, attachment A) claimed that the public sector has made maximum use of dental therapists and oral health therapists and that, as a result, treatment provided by government providers under the CDBS costs about two-thirds of the fee level being paid by the Commonwealth. Dr Dooland and the Australian Dental and Oral Health Therapists' Association (sub. 99) suggested that even greater use of the skills of the full dental workforce could be achieved by giving dental therapists, dental hygienists and oral health therapists their own Medicare provider number, rather than the current arrangement of having to rely on a dentist's provider number.

Compared with major cities, there are far fewer dental professionals per head of population in remote areas (figure 6.4). This mismatch between the distribution of the dental workforce and the wider population would be even greater without the public sector because it employs more dentists per head of population in remote and very remote areas (7.9 full-time equivalents per 100 000 people in 2014) than in major cities (6.6) and inner regional areas (6.1) (SCRGSP 2016b). Public dental clinics play a relatively large role in delivering services in remote areas. In 2013, about 32 per cent of people (aged 5 years and over) in remote and very remote areas reported that their last dental visit was to a public clinic, compared with 12 per cent in major cities (AIHW 2015f).

Figure 6.4   **Number of dental professionals per capita, by region, 2014[a]**

Bar chart. Y-axis: Full time equivalent professionals per 100 000 people (0 to 80). Categories: Major cities (~78), Inner regional (~57), Outer regional (~51), Remote and very remote (~31).
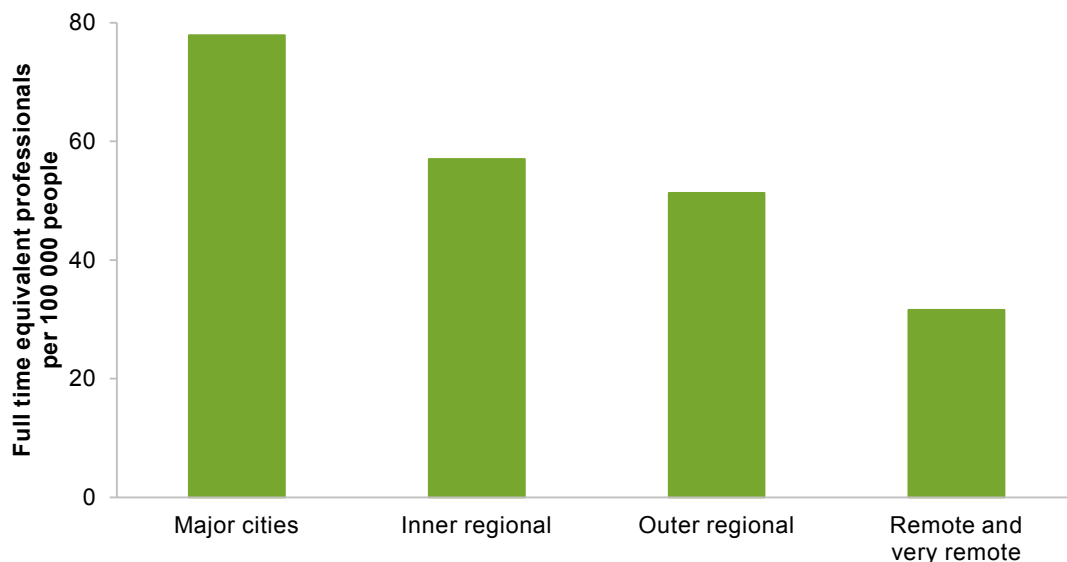
a In addition to dentists, dental professionals include: dental therapists who provide examinations, diagnoses and treatment to children, teenagers and young adults; dental hygienists who provide preventive services to people of all ages; oral health therapists who are dual qualified in dental therapy and dental hygiene; and dental prosthetists who make, fit, supply and repair dentures.

Data source: AIHW (*Dynamic data for Australia's registered health workforce by location*, accessed 31 August 2016).

6.4   The potential costs of reform

Supporting users

As noted above, governments would need to ensure that they support informed choices for users of 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 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 or 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 2013, compared with only 55 per cent of adults aged 25 to 44 (AIHW 2015f).

Government stewardship

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 high-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 parties raised concerns about differences in accreditation arrangements between government and private dental practices (for example, DHSV, sub. PFR366; 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 in private dental practices are inferior. The Australian Dental Association 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 2015c).

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 and compliance costs for providers. Existing voucher schemes are typically based on the Department of Veterans' Affairs Fee Schedule of Dental Services for Dentist and Dental Specialists, which describes the service to be performed and sets a benefit amount for the service. Monitoring in current and past voucher schemes has often been limited to providers invoicing and documenting services provided, with no reporting on the health outcomes of patients (DHSV, sub. PFR366). As well as monitoring the types of services provided, governments would need to monitor how these services contribute to clinically- and cost-effective outcomes for individuals and the eligible population.

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.

- Public dental services act as a safety net by providing access to basic dental care, but there is scope to improve outcomes. Access to services is a concern for certain populations and the uncontested provision of services in government-operated clinics limits responsiveness to user preferences. While governments regularly publish information on public dental activity levels, overall expenditure and waiting lists, accountability could be improved through greater public reporting on patient outcomes and cost effectiveness.

- Users could benefit from having greater choice over the timing and location of treatment, and their dental professional. Greater choice may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary. In addition to initiatives already implemented by governments, encouraging more innovative and flexible public dental services could improve oral health in communities not well serviced by the private sector.

- The approach to greater competition, contestability and user choice should reflect the characteristics of users, availability of dental professionals, and cost-effectiveness of alternative models. Service provision could be made more contestable in areas where there may be limited capacity to sustain multiple providers. More competition and choice could involve using delivery mechanisms that allow users to choose between competing dental practices.

7   Human services in remote Indigenous communities

The inquiry terms of reference ask the Commission to have regard to the challenges facing the provision of human services in rural and remote areas, small regional cities and emerging markets, and the need to improve Indigenous outcomes. These issues will be taken into consideration in the Commission's assessment of reform options in each of the services identified in this report. However, the provision of human services in remote Indigenous communities warrants additional consideration.

Remote Indigenous communities vary significantly in size. The number and type of services provided to these communities also varies. Many smaller communities, such as homelands and outstations, have a minimal level of service provision due to their low population and remote location. This inquiry will not focus on whether certain services should be provided to particular communities, but on ways to improve the quality, equity, efficiency, accountability and responsiveness of services.

7.1   Remote communities and services

About 85 per cent of Australia is classified as remote[1] (CRCREP 2015). These areas are home to just over 2 per cent of Australia's population (ABS 2013b). In remote areas, the distance to the nearest town or service centre can be in the hundreds of kilometres. Service providers face barriers to effective service provision, such as a lack of and difficulty in accessing infrastructure (including buildings and transport infrastructure). The NT Department of Treasury and Finance (sub. 261, p. 6) highlighted the practical aspects of operating in remote communities that need to be factored into the reform agenda.

> … 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.

Recruiting and retaining staff is also more difficult than in non-remote areas.

> Services also face difficulties associated with attracting and retaining suitably qualified staff and with the higher costs associated with remote locations. (UnitingCare Australia, sub. PFR313, p. 7)

---

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

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)

The challenges of remoteness can make the cost of providing services in remote Australia several times the cost in urban areas.

About one in five Indigenous Australians live in remote areas. Although the majority of Indigenous Australians live in non-remote areas, only about 35 per cent live in the major cities (compared with 71 per cent of non-Indigenous Australians). The remaining 44 per cent live in regional areas (ABS 2013b). In 2011, there were over 1000 discrete Indigenous communities[2] in remote areas of which more than three quarters had a population under 50 (ABS unpublished data). Figure 7.1 shows the location and size of these communities. Physical isolation underpins many of the challenges to providing high-quality human services to these communities.

Government expenditure per person is generally higher for Indigenous Australians. The 2014 Indigenous Expenditure Report estimated that the expenditure per person for Indigenous Australians was $43 449 compared with $20 900 for non-Indigenous Australians (SCRGSP 2014a). (These figures include Australian, state and territory government expenditure across a range of categories including human services such as health, housing, education and job services.) The report identified two reasons for this difference:

- greater intensity of service use (due to greater need as a result of the higher incidence of disadvantage, and the younger age profile of the population which drives higher spending on school education)

- higher cost of service provision (due to location, cultural differences and the compounding effects of multiple disadvantage).

Comprehensive, comparable data on government expenditure for remote Indigenous communities are not readily available, in part due to the complex nature of funding arrangements. However, data are available for some specific programs and services. The Australian Institute of Health and Welfare (2013b) found that health expenditure was higher for Indigenous Australians living in remote areas compared with 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.

---

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

Figure 7.1   **Discrete Indigenous communities by size and remoteness, 2011**

2011 Remoteness Areas
- Non-remote
- Remote
- Very Remote

Discrete Indigenous Communities
2011 population
- 500 people or more
- 200 - 499
- 50 - 199
- Less than 50 people
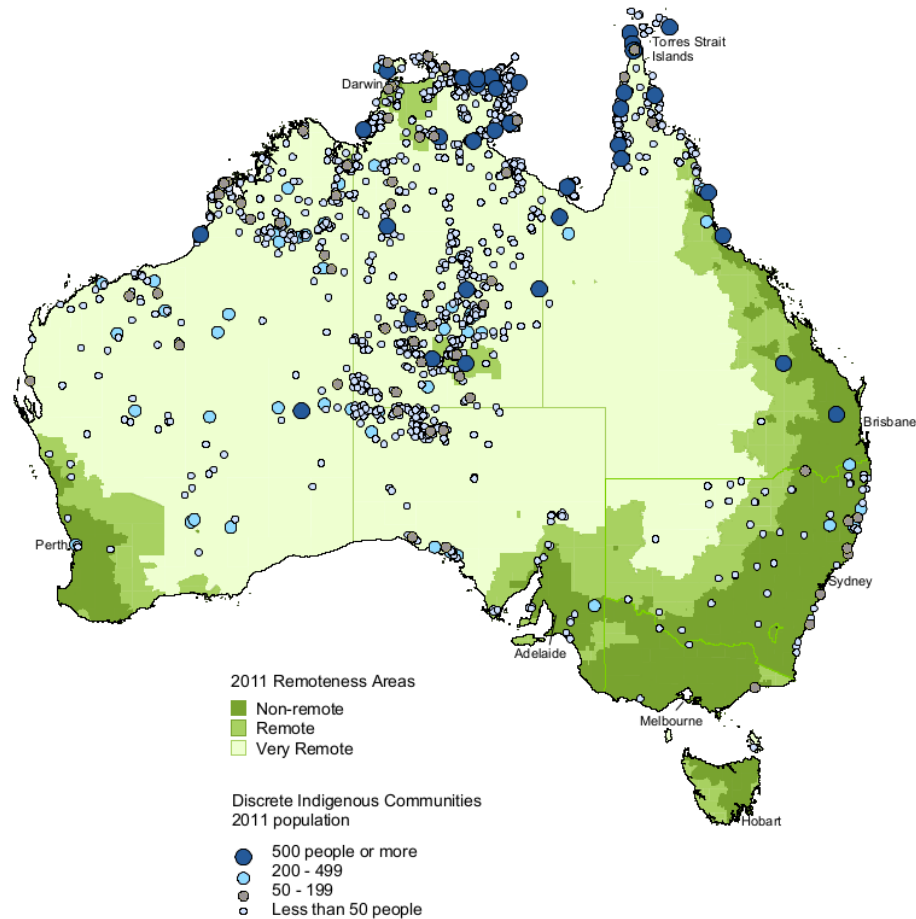
Source: ABS (*Census of Population and Housing,* unpublished).

Competition, contestability and user choice in remote Indigenous communities

Competition between service providers is not commonplace in remote Indigenous communities, even where there are multiple providers, and user choice of service or provider is limited. Reforms introducing greater user choice are underway in disability services and aged care and the outcomes of these changes are important sources of evidence for this inquiry. Private provision of services is rare, even in cases where this type of service provision is common elsewhere in Australia. General practice medicine in the Northern Territory is an example of the differences in the way services are provided outside of major population centres.

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. (AMSANT, sub. 274, p. 2)

Contestable arrangements to provide services are common, with many services commissioned through tendering arrangements. For example, the Australian Government provides Indigenous-specific grants across a range of service areas through the Indigenous Advancement Strategy. State and territory governments also commission human services through tendering processes, such as housing for remote Indigenous communities. For services directly purchased (rather than through a competitive process), providers may still face the credible threat of replacement. It is clear, however, that in many cases these arrangements could be improved.

Service delivery arrangements require reform

Improvements to arrangements for purchasing and delivering human services for Indigenous Australians living in remote communities could lead to more effective service provision and better outcomes for service users. The service delivery arrangements for people living in remote Indigenous communities are overly complex. Funding and responsibility for service provision and outcomes are split across governments, departments, programs and providers. Although this is also the case in human services more generally (chapter 8), the negative effects of this are stark for remote communities with high levels of service fragmentation, and duplication in some areas and gaps in others.

Examples of this 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 of less than 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 (sub. 274, p. 5) 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 and yet this was the result of government policy to introduce greater competition and contestability into service delivery.

The Western Australian Government Regional Services Reform Roadmap pointed to a focus by governments on the acute and immediate symptoms of disadvantage (including directing resources to law enforcement and crisis services) that, while important, comes at the expense of addressing the causes of disadvantage. 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).

The fragmented nature of services means providers often rely on funding from a variety of sources and programs. These separate sources of funding come with their own compliance requirements, placing a particularly significant burden on smaller organisations (Dwyer et al. 2009). Alford (2014) gave an extreme case of one Aboriginal Community Controlled Health Organisation (ACCHO) with over 90 funding agreements, and an associated compliance burden of about 423 reports annually. Funding also tends to be short term and uncertain in nature. As a result, providers and governments spend considerable time and effort managing funding flows rather than focusing on delivering better outcomes. These issues are also apparent in family and community services (chapter 8).

There is a lack of transparency around service provision and funding, and evidence on the effectiveness of programs, all of which are important for policy design and implementation. Gaps and overlaps in service provision cannot be readily identified or addressed without information on what services are provided, where and to whom. Services cannot be targeted to improve outcomes without an understanding of what works.

The end result can be inconsistent and intermittent service delivery to remote communities. This significantly undermines the effectiveness of services and their ability to improve the poor outcomes experienced by some Indigenous Australians living in remote communities.

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) experience substantially poorer outcomes than other Australians. Further, 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, however, some indicators for which outcomes are better for Indigenous Australians in remote areas, such as connection with country and language maintenance and revitalisation (SCRGSP 2016a).

Since 2003 the Steering Committee for the Review of Government Service Provision has been producing regular reports on indicators of Indigenous disadvantage. Progress is mixed, with evidence of improvement in some areas (including life expectancy, childhood mortality rates, year 12 completion rates and income from employment), little or no change in others (reading, writing and numeracy, family violence and chronic disease) and worsening results in yet others (psychological distress, self-harm and imprisonment) (SCRGSP 2016a).

Figure 7.2   **Outcomes for Indigenous Australians, by remoteness, 2014-15**
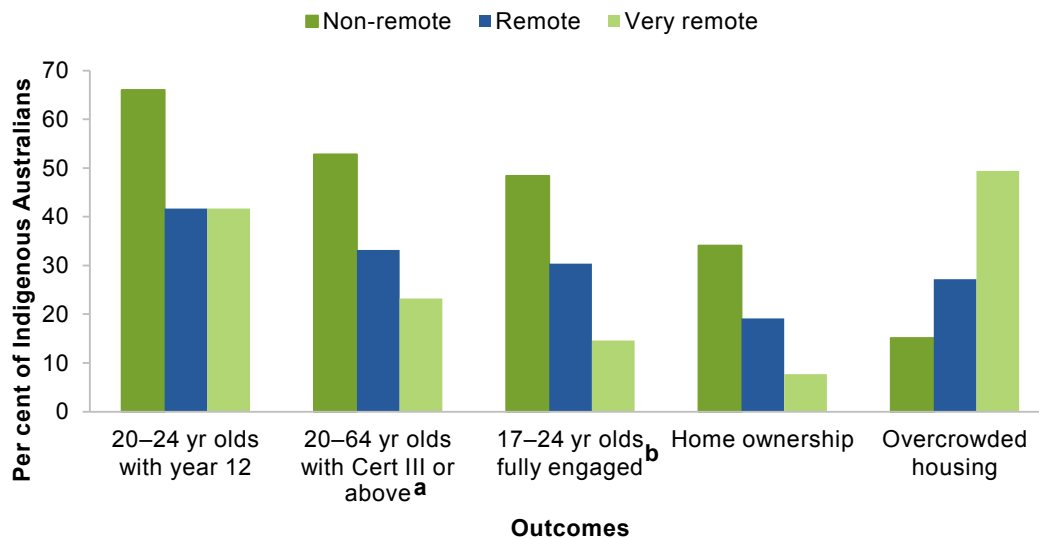
a Includes current students. b Fully engaged in post-school education, training and/or employment.
Source: SCRGSP (2016a).

Access to human services

Inadequate access to high-quality human services in remote Indigenous communities is one factor that contributes to poor outcomes. 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 reasons related to remoteness, such as the lack of a service or inadequate service in their area, or transport, as the reason for this difficulty (ABS 2016f). 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 were not culturally appropriate (NMHC 2014).

The reality of remote Australia is that not all services can be delivered everywhere. For example, secondary education is not provided within all remote communities, due to their size. One consequence of community size is that people will need to travel for some services, and in some cases, relocate permanently. For example, a study in Central Australia found that over an 18 month period, more than three quarters of new dialysis patients had to relocate to access services (Gorham et al. 2016). This is a significant issue 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, the Menzies School of Health Research (2015) reiterated the health, social and economic consequences of relocation as part of a project underway on models of providing dialysis.

Figure 7.3   **Indigenous Australians experiencing problems accessing services, by remoteness**
Per cent of persons, 2014-15
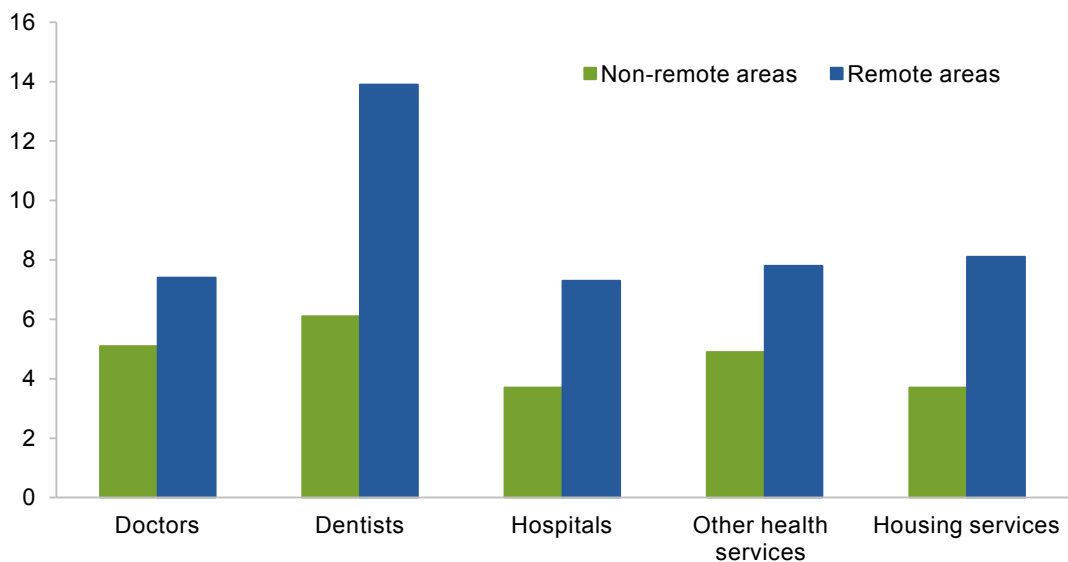
Source: ABS (*National Aboriginal and Torres Strait Islander Social Survey, April 2016*, Cat. no. 4714.0).

Travel and relocation are not the only alternatives to direct service provision within communities. Options such as mobile services and visiting specialists are already widely used within remote communities.

Telehealth consultations are now covered by the Medicare Benefits Schedule and are increasingly being used. The Torres and Cape Hospital and Health Service provides telehealth consultations via videoconference to patients living in remote communities (Queensland Health 2015). Integratedliving, an aged care provider, provides telehealth remote monitoring services to older Indigenous Australians through its Staying Strong program. A report on the program's pilot noted the potential for remote monitoring to improve health outcomes, particularly for Indigenous Australians in regional and remote

areas. Participants in the pilot found the technology clear and understandable, easy to use and easy to learn. Some of the benefits identified from the pilot included better self-management of health conditions, accurate and timely diagnosis and referrals, better access to care and improved relationships with health professionals. In addition, the cost of service provision was found to be less than half the cost of face-to-face service delivery (Integratedliving 2015).

Improvements in technology will continue to open up new possibilities for service delivery in remote Indigenous communities. There may also be opportunities to achieve better outcomes through increased access to existing technology. Only 36 per cent of remote Indigenous households had an internet connection in 2011 (compared with 73 per cent of remote non-Indigenous households) (PC 2016b). This may restrict access to services that require an internet connection, such as telehealth remote monitoring in the home.

7.3 Factors influencing the potential benefits of reform

User characteristics

As is the case in all locations, there is variation in the capacity, needs and preferences of people who live in remote communities. Indigenous Australians as a group are amongst those most likely to experience deep and persistent disadvantage (McLachlan, Gilfillan and Gordon 2013). The causes and consequences of disadvantage are complex and interrelated, and must be taken into account in service provision. The term 'social determinants of health' is used to denote causes of poor health outcomes such as income, education, housing, employment, social support and access to nutritious food.

Indigenous Australians living in remote communities may also interact with services differently to other Australians, reflecting a combination of factors, including culture and past experiences with government services. 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. About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared with 2 per cent of Indigenous Australians living in non-remote areas (ABS 2016f). The NDIS trial in the Barkly region of the Northern Territory identified some of the differences that need to be taken into account when providing disability services to people in remote communities (box 7.1).

Indigenous Australians tend to relocate more frequently than other Australians. About 7 per cent of Indigenous Australians were away from their usual place of residence on Census night in 2011, compared with 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 with 38 per cent (Biddle and Markham 2013). Kinship is a key reason for mobility in remote communities and, as discussed earlier in this chapter,

the need to travel to access services also contributes (Memmott, Long and Thomson 2006). Mobility can lead to significant variability in the level and nature of demand for services. For example, services may need to be coordinated between different remote locations and less remote towns to provide continuity of care to people who are mobile and need to access several providers. Technology can also assist in this area. In the Kimberley region, web-based electronic patient records are shared between health professionals, including ACCHOs and hospitals to enable continuity of care for the region's highly mobile population (Glance 2012).

Indigenous Australians' previous experience with services can also influence the effectiveness of service provision. For some Indigenous Australians living in remote communities their past experiences may have resulted in a lack of trust of government and service providers. Others may have never had a choice about the services they receive. Some Indigenous Australians might prefer not to exercise 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 (sub. 265, p. 6).

> 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.

Box 7.1   The NDIS Barkly trial

The experience of the NDIS Barkly trial highlighted the need to provide information that is tailored to the needs of those accessing support.

> 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)

> 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. (NT Government, pers. comm., 15 July 2016)

7.4   A way forward

Many economic and social factors drive outcomes in remote Indigenous communities. The nature of service provision and the characteristics of users mean that the service models that work in remote Indigenous communities may be different to those that work in other parts of the country.

The National Rural Health Alliance (sub. PFR385, p. 1) emphasised this for remote communities more generally.

> A key issue the Alliance would like to see the Commission consider is the extent to which solutions that suit a metropolitan setting adapt to a rural and remote setting where lack of workforce, cultural differences and distances complicate access on many levels.

The suitability of service models will also vary across the different service types delivered in remote Indigenous communities.

There is a clear need to improve service delivery in remote Indigenous communities, but expectations of a quick fix are unrealistic. There is scope to improve outcomes over the long term through better design and implementation of policies to commission and deliver services in remote Indigenous communities. Many of the ideas discussed in chapter 8 also apply to services in remote Indigenous communities.

Competition, contestability and user choice

The introduction of greater competition, contestability or user choice could improve outcomes for Indigenous Australians living in remote communities. However, as noted above, improving the effectiveness of service provision in remote communities might require service models that are different to those that are used in other locations. A number of participants expressed concern about the introduction of greater competition in remote Indigenous communities (including ACOSS, sub. PFR377; AMSANT, sub. PFR384; CAAC, sub. PFR382; NDS, sub. PFR363). The Commission agrees that competition between providers will not always be feasible or appropriate in remote communities, for example, when there are few providers, or for all services and service users. In these situations, effective contestability among service providers may deliver many of the benefits of competition.

Many services provided to people living in remote communities are already contestable, but approaches to contestability are poorly designed and are not serving remote Indigenous communities well. Redesigning arrangements for commissioning services and providers could encourage providers to improve service quality, use innovative service models, expand access so more people get the support they need, and reduce the costs to government and users who pay for those services. Introducing or expanding contestability for services that are currently not fully contestable could make it possible for a better performing service provider to expand its service offering and for a poorer provider to be replaced with a better performer.

Effective government stewardship is important regardless of the service model chosen. In the case of user choice, users may need to be supported to exercise informed choice (section 7.3). In thin markets, where there may only be one provider of a service, the risks to service users from poor service quality and provider failure can be particularly high as switching is not generally possible, and governments have a stewardship role in ensuring

there is a provider of last resort. Effective feedback and complaints processes are also an element of stewardship. The Commonwealth Ombudsman (sub. PFR314) noted the importance of these processes in improving service quality, and that Indigenous people can face barriers in exercising their right to complain and provide feedback.

Greater responsiveness to community needs

To achieve their intended outcomes, human services providers must be responsive to the diverse needs of users. There are a number of ways of improving the responsiveness of service providers. Greater user choice, as discussed in the previous section, is one way.

Another way to increase the responsiveness of service providers is for governments to engage with communities to better understand their needs and take them into account in decision making. Co-design is one option that was raised by several participants. In some cases responsiveness to community needs could extend to community involvement in decisions and a role for community-led organisations. This is often referred to as 'community control', although the term is used to mean different things in different contexts. Noting the Canadian context is different to that of remote Australia, community control has been associated with better outcomes for Indigenous people in Canada (box 7.2).

In Australia, the ACCHOs were raised by participants as an example of the positive effects of greater community control, and are significant service providers. ACCHOs have boards of management elected by the local community, and are widely used to access services where they are available. The peak body, the National Aboriginal Community Controlled Health Organisation stated:

> ACCHOs 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 health services delivered by ACCHOs is apparent even in areas with alternative providers.

> 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. (AMSANT, sub. 274, p. 3)

Aboriginal Housing Victoria (sub. PFR316, p. 4), an Aboriginal community controlled housing agency, stated that its levels of tenant satisfaction compare favourably to tenant satisfaction in public housing and state-owned housing.

> Our high rates of tenant satisfaction are indicative of the strong preference of many Aboriginal people for Aboriginal community controlled services.

Place-based service models, which take into account the circumstances and preferences of communities, may also be a way of making service providers more responsive to the needs of people living in 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)

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). Communities had access to three levels of community control:

- transfer (where communities can take on the administration of a range of community-based and regional programs based on their own community needs and priorities)

- integrated (where communities share responsibility for delivery with government)

- non-transfer non-integrated (where communities manage a limited number of programs, each under a separate agreement).

The authors found that communities which had signed an agreement increasing community control 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) 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.

Better coordination and service integration

Consistent and well-coordinated service delivery arrangements are important for users with complex needs. In the context of services to remote Indigenous communities, coordinating service delivery requires coordination between governments and between departments and

agencies within governments. One way of improving service coordination is integrated service delivery, which the Tasmanian Government (sub. PFR297, p. 2) described as:

> … partnership arrangements that rely on cooperation and collaboration across organisation and discipline boundaries to use resources effectively and respond to the needs of Tasmania's dispersed communities.

The level of integration can vary from, for example, information sharing to pooled funding and complete merging of service delivery (delivering previously separate services through a single provider). Service integration may also provide efficiency benefits where providers face difficulties in achieving economies of scale or scope, which is often the case in remote areas.

Well-designed commissioning arrangements can enhance integration and collaboration as well as deliver greater contestability. 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 Kimberley Development Commission, a community housing provider, and a community services provider selected through a tender process, 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 2016a)

More stable policy settings

Indigenous Australians living in remote communities have experienced frequent and disruptive change to policies, programs and organisations (including service providers and government agencies).

> [Likewise,] 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)

This limits the ability of service providers to form relationships and establish trust with people in remote Indigenous communities, and to attract and retain staff. Over time, it leads to communities being reluctant to engage with new initiatives. Policy instability makes it difficult to collect and disseminate evidence on what works to improve outcomes

and to evaluate programs. It also limits the capacity of governments, providers and communities to learn from experience, innovate and improve service delivery.

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.

FINDING 7.1

Indigenous Australians living in remote areas are more likely to experience poor outcomes than other Australians. Inadequate access to human services is one factor that contributes to these poor outcomes.

- The service delivery arrangements for Indigenous Australians living in remote Indigenous communities are complex and fragmented.

- Greater responsiveness to community needs through user choice, place-based service models or greater community engagement could improve outcomes.

- Many services are already contestable, but approaches to contestability are poorly designed and are not effective at meeting intended outcomes. Redesign of these arrangements is needed which, coupled with better coordination between governments, could improve outcomes including the efficiency of service provision.

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

8   Commissioning 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 emergency payments and services for family support, homelessness, family and domestic violence, alcohol and other drugs.

Historically in Australia, governments have had a fairly limited role in directly providing most family and community services. Most services are provided by non-government organisations that are commissioned by governments. These commissioning arrangements will be the focus of the inquiry. Although many of these services are referred to as 'community services', government funding is not generally aimed at community-level projects but at improving the lives of individuals and families.

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

- about 256 000 people received homelessness services in 2014-15 (AIHW 2016o)

- about 115 000 people received alcohol and other drug treatment in 2014-15 (AIHW 2016d)

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

A significant proportion of services are provided by mission-driven not-for-profit organisations. 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 (NT DCF 2015; SA Government 2015; WA CPFS 2016). Limited for-profit provision also occurs.

Service providers are diverse in size and scope. Data collected by the Australian Charities and Not-for-profits Commission (ACNC) included 2545 charities that reported activities in the social services sector as their main activity in 2013-14. The ACNC classifies charities according to their income as small (less than $250 000), medium ($250 000–$1 million) or large (more than $1 million). In 2013-14, about 23 per cent of the organisations within the social services sector were 'large' according to this benchmark (Cortis et al. 2015).

By number, the majority of providers are small organisations that operate in a single location. Larger organisations often provide a range of services across many locations — 15 per cent of social services not-for-profits operated in more than one jurisdiction in 2013-14 (ACNC 2016). Not-for-profit providers make extensive use of volunteers — in 2013-14 about 92 per cent of organisations reported that they had volunteers, and 45 per cent had no paid employees (Cortis et al. 2015).

Many providers collaborate, both through informal 'on the ground' collaboration and formal collaboration through joint ventures and subcontracting arrangements (Georgopoulos (2016); St Vincent de Paul Society (2016); The Smith Family, sub. 257).

Arrangements for allocating funding to service providers

In July 2016, the Australian Government Department of Social Services (DSS) reported that funding agreements in place for the Families and Communities Programme had a combined value of about $2.8 billion (DSS 2016c). State and territory governments together expend significantly more than the Australian Government. For example, the Victorian Department of Human Services allocated about $1.6 billion to more than 1600 organisations to deliver services in 2013-14 (Victorian DHS 2014). The Queensland Government spent approximately $1.8 billion in 2015-16, allocated to 901 organisations (Queensland DCCSDS 2016).

Each government has different processes for allocating funds to family and community services, and uses different terminology. Governments periodically announce when funding is available for specific purposes, and they use a range of mechanisms to allocate funds. For example, for each funding round initiated by the DSS, the Department chooses either an open competitive selection process, a restricted competitive selection process or a direct selection process (DSS 2016d). In Western Australia, the *Delivering Community Services in Partnership* policy clarified how the WA Government determines whether to put services out to open tender, or to use a non-market based approach (WA Government 2011). The NSW Government's *Market Approaches Guide* described various procurement options and when each is best suited, including requests for tender (open, multi-stage and selective), expressions of interest, requests for proposals, and strategic commissioning approaches such as outcomes-based contracts (NSW OFS 2015).

The DSS allocates funds to three broad programmes — Families and Communities; Housing and Homelessness; and Disability, Mental Health and Carers. As at October 2016, about 89 per cent of active grants within the Families and Communities Programme had been allocated through an open competitive process, and 6 per cent through a direct selection process (DSS, pers. comm., 28 October 2016). By value, 43 per cent of the funds associated with these grants were allocated through processes that were not identified in the data. Of the remainder, 24 per cent of funds were allocated through open processes, 2 per cent through restricted competitive processes and 31 per cent through direct selection.

As an example, for grants awarded by the DSS, applicants generally have a month or less to complete their application, and the successful applicant enters into an agreement with the Department. Agreements are time-limited and provide funding for between one and five years. Most of the funding allocated in the 2014 round was for two years (DSS 2016b). The DSS has about 7000 active funding agreements in place within the Families and Communities Programme as at July 2016, allocated to about 6000 service providers (DSS 2016c).

The number of family and community services activities that are funded, the overlap between activities and Australia's federal system of government all add up to a system that has many potential sources of funding for individual service providers and services (figure 8.1). Larger providers receive funding through many agreements with several governments — 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.

Figure 8.1   Funding sources for family and community service providers

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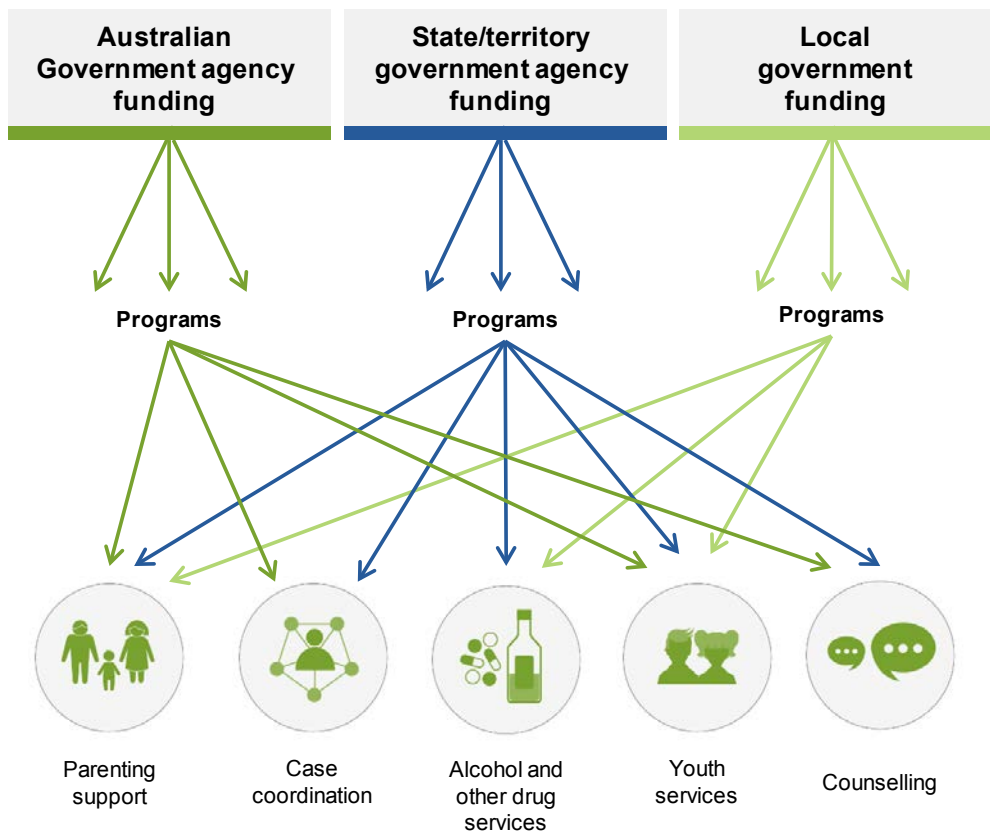
Source: Adapted from Dwyer et al. (2009).

Because contracts for service delivery are allocated through competitive processes, for limited periods, and can include clauses for termination before the agreed end date, service providers face a threat of replacement. That is, there is a degree of contestability in the funding processes. However, the credibility of the threat of replacement depends on many factors, including the tendency to renew funding agreements or use direct selection processes, the openness of selection processes when competitive tenders are used, barriers to new entrants, contract terms and conditions, and the effectiveness of performance monitoring and benchmarking (section 8.4).

8.2   Scope to improve outcomes

Through its consultation processes the Commission heard widespread agreement among inquiry participants that there is considerable scope to improve the effectiveness of family and community services in Australia. Although participants had different views on how to improve these services, most agreed that the system could deliver better outcomes.

Equity

Shortcomings in governments' processes for assessing community needs, setting priorities and designing service systems make it difficult to judge whether the system is meeting its intended outcomes for users, including whether access to services is appropriately distributed across the community. Evidence from participants suggests that there is scope to improve equity of access to many family and community services. Participants stated that some people do not have access to the family and community services they need and that there is significant unmet demand.

> Many people with mental health issues and their families in regional and remote areas "fall through the gaps" or receive minimal services. (Elizabeth Hogg, sub. 39, p. 1)

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

> We believe one of the most pressing issues in human services is the growing level of unmet need and the inability of those who are vulnerable and disadvantaged to access essential support services. (St Vincent de Paul Society National Council, sub. 285, p. 16)

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, evidence that particular groups of people or particular geographical areas experience worse access or outcomes than others suggests that government planning and targeting of services could be improved.

Quality and efficiency

There is scope to improve the quality of family and community services and the efficiency of service delivery. A high-level issue is the way resources are allocated by governments to various family and community services. Decisions about what services will be funded, who should receive the services and which organisations will deliver the services are split across different levels of government and different departments and agencies within governments. The lack of a coherent system for identifying overall community need is a barrier to efficient resource allocation, and contributes to the duplication of some services and service gaps in others.

A related shortcoming is that the current system does not place adequate emphasis on identifying the intended outcomes of family and community services, and the most effective way of delivering those outcomes. Instead, service providers have incentives to deliver the services defined in their contracts regardless of whether those services are the most effective way to achieve outcomes for service users.

The quality and efficiency of services are also influenced by the way governments and service providers manage access to family and community services, and prioritise the needs of service users. Compared with many other areas of human services provision, providers of family and community services have greater discretion about who receives services and the type of services they receive (within parameters set by governments). In social housing, for example, formal eligibility criteria play a key role in identifying need and targeting support. Most family and community services do not have transparent and consistent eligibility criteria or other processes to target services to the people who would benefit most. Provider discretion offers flexibility in identifying who needs services the most, but can reduce providers' accountability to government for achieving outcomes, and can be a further barrier to efficient resource allocation.

Several participants identified service 'fragmentation' as a source of inefficiency and an impediment to service quality. Service fragmentation has particularly serious effects for people who require 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 crisis accommodation and, as her situation becomes more stable, she might need help with financial counselling and legal advice. Other service users have complex needs and require coordinated assistance across several services. Users with these types of needs are inadequately served when the system is fragmented and difficult to navigate, and might need additional support to obtain the services that would help them.

Collaboration amongst service providers can be an effective approach to reducing the effects of service fragmentation, and can improve service quality, responsiveness and efficiency. According to some participants, the pressure to compete for contracts is undermining informal collaboration within the sector, and tender processes often do not 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)

Participants also identified current arrangements as a barrier to innovation that would increase service quality and efficiency. Funding agreements that are overly prescriptive leave little scope for innovative approaches to service delivery, and providers are not necessarily rewarded for innovative approaches. The Community Council for Australia (sub. 193) described how a government response to poor school attendance in a remote community might be to fund home visits by social workers, and to measure the success of the program by the number of home visits. This type of program does not provide scope for other approaches that could be more effective at achieving the intended outcome (higher school attendance). Another participant suggested that a lack of innovation is widespread.

> … 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)

Encouraging innovation in family and community services may require that governments not only remove barriers to innovation, but also provide incentives to service providers to innovate. Sturgess (2016, p. 5) identified a lack of investment in innovation:

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

Accountability and responsiveness

Service providers should be accountable to the providers of funds — including governments, service users and donors — for the outcomes achieved with those funds. However, accountability imposes a compliance cost on service providers. The challenge for governments and service providers is to draw the right balance between accountability and responsiveness. Several participants argued that current accountability arrangements are excessively prescriptive and focused on managing funding flows (the inputs and outputs of services) rather than on achieving outcomes for service users.

Prescriptive contract terms are 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 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)

Participants advised the Commission that compliance activities that impose excessive cost burdens can have a proportionately larger effect on smaller providers, which can be a barrier to new entrants and can reduce the diversity of service providers and delivery models (for example, St Vincent de Paul Society National Council, sub. 285).

8.3 Factors influencing the potential benefits of reform

There is diversity in service users' capacity to make choices

Users of family and community services have diverse characteristics and needs, and access services under different circumstances. Many people who access these services are able to exercise informed choice about the services they use, although in practice they often have limited information about the services that are available, or 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. Some service users require emergency assistance and make decisions at a time of stress, such as when they have lost their tenancy and become homeless (CHP, sub. 270). Some service users might have diminished capacity or authority to make informed choices or are not well-placed to make choices on their own behalf, such as the very young and people living with some types of mental illness (although some will have carers or guardians that act on their behalf and in their interest) (CMHA, sub. PFR304). 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).

It may take time and require investment for a user to gain the skills and information needed to exercise choice. 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)

Some family and community services operate on an outreach model, where the service provider 'chooses' the service user (such as some services supporting rough sleepers). Once their most urgent needs have been met, some users of outreach services will be better able to exercise informed choices about other services.

Measures to empower service users could lead to better outcomes for some people. The approach that will deliver the best outcomes depends on the users and the service. In some circumstances user-directed funding (like the model being rolled out in disability services through the National Disability Insurance Scheme) might increase competitive pressures, leading to improvements in users' outcomes. For this approach to work, users (or their agents) need to have access to a variety of service providers and the capacity and willingness to determine their own priorities as well as search for, compare and change providers.

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 2015; Tasmanian DHHS 2016; Victorian DHS 2015b). Service users 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. Person- and family-based approaches could be effective for many family and community services.

Supply characteristics

Many family and community services are provided by mission-driven not-for-profit organisations that, as well as delivering services to individuals and families, also seek to make a contribution to civil society and to advocate for social change. Several submissions revealed a tension between the value of supporting 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 services can increase the efficiency and effectiveness of provision. Where capital costs are substantial, larger providers can achieve efficiencies by bundling services funded through several sources. Where a single service provider is not able to achieve economies of scale, providers can co-operate through joint ventures or similar arrangements. The Business Council of Co-operatives and Mutuals (sub. 216, p. 28) suggested the use of enterprise co-operatives as a form of collaboration that helps small providers achieve scale.

> Enterprise co-operatives can support smaller local providers to compete by enabling them to share corporate functions including bulk purchasing, accounting, human resources, marketing, client software and occupational, health and safety services.

In regional and remote areas there might be less scope for diversity among service providers, or for economies of scale (CMHA, sub. PFR304). Economies of scale might also 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, and can achieve better outcomes. The Federation of Ethnic Communities' Councils of Australia (sub. 25, p. 3) stressed the importance of niche providers.

> Those 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

Most family and community services are commissioned by governments rather than being directly provided. Commissioning is a process that involves several stages, including:

- identifying and prioritising the needs of the community and the outcomes that family and community services are intended to achieve

- designing systems of service provision to achieve outcomes

- selecting providers and establishing the terms and conditions of funding agreements

- monitoring and evaluating service delivery.

Effective commissioning involves feedback at each stage of the process and can be depicted as a cycle (figure 8.2).

Governments' processes for commissioning family and community services entail some degree of contestability — service providers face a threat of replacement. Contestable arrangements in commissioning processes can mimic competitive pressures and these arrangements can, under the right conditions, deliver some, or even many, of the benefits of effective competition. Participants argued strongly that the current arrangements for commissioning family and community services are failing to achieve the intended benefits of contestability for users and governments (CSIA, sub. 192; TACSI, sub. 155).

> It is our strong contention that reform effort should be focused on improving both the stages which precede the procurement stage, and the manner in which competition is implemented in the procurement stage. (Mission Australia, sub. 277, p. 2)

Figure 8.2   **The commissioning cycle**

- Identify policy objectives, outcomes, priorities and risks
- Assess demand, supply and service gaps
- Consult with providers and users
- Formulate supply strategy

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

Community needs assessment and market analysis

Service system design

Monitoring and evaluation

Selecting providers and contracting

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

- Determine provider selection process
- Establish contract conditions and incentives

Sources: Based on Department of Health (2015); Dickinson (2015); NHS (2016); Routledge (2016).

Catholic Social Services Australia (sub. PFR315, p. 2) stated that although many of the principles of good commissioning are reflected in official documents, they could be applied more effectively.

> Further, the Commonwealth Grant Rules and Guidelines already state that government officials should work together with stakeholders to plan, design and undertake granting activities, particularly grants programmes and that granting activities should be designed and implemented so that grant recipients focus on outcomes and outputs for beneficiaries. Despite the existence of this legislative instrument we know from the Senate Standing Committees on Community Affairs Inquiry into the Department of Social Services tendering processes that more could have been done by the Department to enliven these principles and deliver better outcomes for the government, the community and service providers.

Reforms that establish more effective contestability through the commissioning process could contribute to improvements in service outcomes. Potential benefits are discussed below alongside the various stages of the commissioning cycle. Good commissioning is an important aspect of effective stewardship of family and community services, and is not easy to implement — it requires significant investment in expertise and resources. It is not necessary to implement every element of the cycle simultaneously — any one change, implemented well, could contribute to better outcomes.

Community needs assessment and market analysis

The first stage of effective commissioning of family and community services is to identify community needs, policy priorities and service outcomes. Identifying the needs of the community creates the framework for contestability between providers. Specifying the highest priorities for family and community services enables governments to target funding to the areas where it would have the greatest impacts. Targeted funding can create incentives for service providers to devote resources to achieving the outcomes that governments are seeking to improve.

This stage of the commissioning cycle involves 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. Currently this is not happening in any systematic way.

Resource allocation and planning will be more effective if commissioning agencies 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. Service providers highlighted to the Commission that current arrangements lead to gaps, overlaps and inconsistency in the approaches of different levels of government.

Part of effective stewardship of family and community services is understanding the characteristics of providers, and the market risks and opportunities to achieve better 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)

Designing systems of service provision

The objective of the next stage of the commissioning process is to design systems of service provision that will contribute to achieving outcomes, and the performance frameworks that establish the terms of funding agreements. If services and performance frameworks are not designed in a way that is consistent with achieving the desired outcomes, providers will face incentives to focus on the wrong things.

The shift from government service provision to contracting out family and community services has affected the capabilities 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 (CPD, sub. 124). A lack of experience and

expertise in service delivery affects governments' ability to design services that achieve outcomes. 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.

Governments that engage with service providers when designing services and performance management frameworks can take advantage of providers' experience in program delivery. 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 and 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 design stage, particularly when the government agency is no longer a provider of services and has less access to the knowledge associated with frontline service delivery.

Provider selection processes and contract management

Selection processes that incorporate contestability 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. For example, some participants stated that applying for funding consumes large amounts of time for senior managers. Regarding the preparation of funding applications, the Older Women's Network, Mackay Branch stated that 'small local services are often short of time, funds, and expertise in this area.' (sub. PFR298, 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)

Processes to apply (and periodically re-apply) for funding are an inherent part of a contestable system. However, streamlining funding arrangements to make the process of applying for funding more efficient could have benefits to governments, providers and service users.

An 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 and to providers forming consortiums to jointly tender for contracts.

> … 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, attachment 1, p. 8)

Many participants raised concerns about the terms of funding agreements for family and community services. Some stated that agreements tend to focus on inputs and processes. Service providers face the prospect of losing funding if they do not use the mandated processes, even if they are achieving better outcomes for service users than they would by following the service guidelines set out in agreements.

> 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)

In cases where outcomes can be specified and measured, contracts that emphasise the achievement of outcomes could create incentives for providers to innovate and to focus on meeting the needs of service users, rather than 'ticking boxes' to comply with contract terms. However, outcomes-based contracting can be difficult to implement. The Australian Council of Trade Unions (sub. PFR334, p. 5) cited the history of contracting out employment services in Australia as an example of how poor system design contributed to a situation where governments have felt the need to make contracts increasingly prescriptive over time.

> Initially privatised on the promise to deliver better services for less, what has in fact occurred has been a steady tale of provider misbehaviour followed by closer government regulation of provider conduct in response. This has resulted in a system in which the current jobactive deed, advertised by the government as giving providers 'more freedom', is over 175 pages long. The deed goes into excruciating detail about the way providers can behave, the services they can deliver and the ways in which those services can deliver. This is without even considering the hundreds of additional pages of program guidelines that govern how programs such as Work for the Dole are administered and delivered by employment service providers.

Some participants identified the challenges for service providers that are funded on relatively short contracts (three years or less). While time-limited contracts might increase the threat of replacement for providers, the length of contracts affects providers' ability to

deliver and invest in services to improve outcomes for users. Commissioning processes need to balance contestability with the funding stability needed for investment in workforce capacity and fixed assets, such as information technology (ECA, sub. PFR342). The need to frequently reapply for funding and the associated uncertainty about ongoing funding distracts providers from core service delivery activities and can be stressful for staff (ASU, sub. PFR326; GSANZ, sub. 282; Mission Australia, sub. 277; QNADA, sub. PFR312; VAADA, sub. PFR305). Funding uncertainty 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)

Provider performance monitoring and program evaluation

As stewards of family and community services, 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.

Governments collect information to enable them to undertake these functions. In some cases governments require providers to collect information, but not the right information. 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 (ACMHN, sub. 4; CSIA, sub. 192).

> 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)

In some areas, governments are developing and testing outcomes-based commissioning. For example, the Services Connect initiative in Victoria is supported 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 DHS 2015a). These are positive signs, but it is too early to know whether this approach is having the intended effect.

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 provider performance monitoring and program 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.

FINDING 8.1

There is scope for improvements in arrangements for commissioning family and community services that could lead to better outcomes for service users.

- A systematic approach to identifying community needs and prioritising services could lead to more equitable and efficient allocation of resources for family and community services.

- Service users are diverse in their needs and characteristics. Some have complex needs and require access to a range of services. Systems of service delivery that are flexible and enable service providers to be responsive to users are necessary to meet the needs of service users. Greater application of choice — of provider or of service — could improve outcomes for some users.

- Improvements to the way governments commission family and community services could capture more of the benefits of contestability, leading to higher quality services, better outcomes for individuals and families and more efficient use of government funds.

- Systems of performance management, compliance and evaluation should provide incentives for providers to focus on outcomes, innovate and disseminate effective practices.

A   Public consultation

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. Following the release of the issues paper, 290 submissions were received.

- A preliminary findings report was released on the 22 September 2016 and 105 submissions were subsequently received: a total of 395 submissions were received throughout the study (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 Commission also held roundtables in Brisbane, Canberra, Melbourne, Perth and Sydney (table A.3).

The Productivity Commission thanks all participants for their contribution to the study through written submissions and consultations.

Table A.1   **Submissions**[a]

Participant	Submission number
Aboriginal Housing Victoria (AHV)	PFR316
Aboriginal Health Council of Western Australia (AHCWA)	PFR393
Aboriginal Medical Services Alliance of the Northern Territory (AMSANT)	274, PFR384
Aboriginal Peak Organisations of the Northern Territory (APO NT)	275 #
Access Ministries	242
ADJ Consultancy Services	PFR356#*
Aged & Community Services Australia (ACSA)	243
Aged Care Crisis (ACC)	273, PFR387, PFR392 *
Aged Care Guild	219 #
Aitkenhead, Wendy	78
Andrew, Dr Jane and Baker, Dr Max	140 #
Anglicare Australia	217, PFR391
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
Australia Post	PFR319
Australian Acupuncture and Chinese Medicine Association Ltd (AACMA)	287
Australian Association of Massage Therapists (AAMT)	178
Australian Blindness Forum (ABF)	125, PFR331 #
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, PFR377
Australian Council of Trade Unions (ACTU)	100, PFR334
Australian Dental and Oral Health Therapists' Association (ADOHTA Inc)	99, PFR318 #
Australian Dental Association (ADA)	230
Australian Dental Association (ADA) NSW Branch	PFR339
Australian Education Union (AEU)	224 #
Australian Government Department of Social Services (DSS)	221, PFR378 #
Australian Healthcare and Hospitals Association (AHHA)	134, PFR306
Australian Nursing and Midwifery Federation (ANMF)	202
Australian Private Hospitals Association (APHA)	PFR381
Australian Red Cross	203, PFR325 #
Australian Services Union (ASU)	85, PFR326
Australian Unity	94
Azzopardi, Donna	180
Baensch, Dr Allison	48
Baptist Care (SA) Inc.	123 #
Barnes, Dr Richard	26
Barry, Laurie	113

(continued next page)

Table A.1 (continued)

Participant	Submission number
Bartlett, Francine	215, PFR354 *
Barwon Health	PFR355 #
Becker, Elizabeth	212
Benevolent Society	129
Best, Pat	65
Bestic, Dr Jill	159
Better Caring	252
Bordignon, Maria	115
Borland, Jody	143
Bowie, Ian	PFR295
Boyce, Evelyn	147
Brell, John	51
Brewer, Charlotte	96
Brotherhood of St Laurence (BSL)	286
Bupa	258, PFR380
Burrows, Matt	206
Business Council of Australia (BCA)	PFR371
Business Council of Co-operatives and Mutuals (BCCM)	216, PFR302
Butterworth, Matilda	22
Cabrini Palliative Care	PFR343
Cameron, Dr David	162
Campbell, Steven	290
Carers Australia	259
Carol O'Donnell	PFR301 #
Case Health	251 #
Catholic Health Australia (CHA)	236, PFR350
Catholic Social Services Australia (CSSA)	226, PFR315
Catholic Social Services Victoria (CSSV)	272
Central Australian Aboriginal Congress (CAAC)	PFR382
Central Queensland Financial Counselling Service (CQFCS)	119
Centre for Excellence in Child and Family Welfare (CFECFW)	PFR383
Centre for Policy Development (CPD)	124 #
Churches of Christ in Queensland (CofCQ)	PFR357
Cluney, William	112
Cochrane, Dr Fiona	169
CoHealth	240
Collins, Isabell	199
Combined Pensioners and Superannuants Association (CPSA)	121, PFR364
Commisso, Rosanna	209

(continued next page)

Table A.1 (continued)

Participant	Submission number
Commonwealth Ombudsman	PFR314 #
Community and Public Sector Union (CPSU) and State Public Services Federation Group (SPSF)	253, PFR375
Community Colleges Australia	264
Community Council for Australia (CCA)	193
Community Employers WA (CEWA)	126, PFR368
Community Housing Providers for Queensland (CHPs for QLD)	PFR359
Community Mental Health Australia (CMHA)	PFR304
Community Services Industry Alliance (CSIA)	192, PFR395 #
Consumer Action Law Centre (CALC)	260
Co-operatives Victoria	PFR310
Council of Private Higher Education (COPHE)	280
Council to Homeless Persons (CHP)	270, PFR349
Crain, Dave	165
Darby, Dr John	188
Darebin City Council	214
Davidson, Dr Bob	PFR353
Davill, Nicole	41
Davison, Andrew	15
Day, Helen	156
Deering, Patricia	225
Dental Health Services Victoria (DHSV)	PFR366 #
Disability Advocacy Victoria (DAV)	231
Disability Council NSW	118
Doctors Reform Society Australia (DRS)	144
Donaldson, Janine	157
Dooland AM, Dr Martin	PFR300 #
Doss, Dr Arockia	1 #
Douglas, Claire	60
Down, Judi	36
Early Childhood Australia (ECA)	PFR342
Egerton, Thorlene	117
Electrical Trades Union of Australia (ETU)	229, PFR324
Elliott-Rudder, Megan	63
Equality Rights Alliance (ERA)	PFR346
Esots, Jenny	73
Family & Relationship Services Australia (FRSA)	PFR370
Family Life	57
Federation of Ethnic Communities' Councils of Australia (FECCA)	25
Financial Counselling Australia (FCA)	PFR372

(continued next page)

Participant	Submission number
Flower, Beryl	137
Fong, Jenny	29
Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)	PFR333
Franklin, Jacqueline	103
Funder, Dr John	211
Fyfe, Angela	190
Gabriel, Julie	111
Gaggin, Patricia	23
Gamble, Carole	81
Gilkerson Legal	PFR394 #
Gillson, Robert and Gillson, Janet	185
Gilmour, Anne	201
Good Shepherd Australia New Zealand (GSANZ)	282
Goodfellow, Tony	20
Goodstart Early Learning	255
Gray, Donna	70
Grey, Dr Stephen	PFR292
Gruner, Barbara	187
Gunn, Dr Andrew	6
Hall, Stafford	11
Hallahan, Nicole	13
HammondCare	PFR330
Hanscombe, Norman	82
Health Care Consumers' Association (HCCA)	239
Heilbronn, Stan	53
Hendrickx, Leonardus	150
Henry, Gabrielle	146
Hill, Dr Christine	89
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
Humanist Society of Victoria (HVA)	PFR345
Hunt, Verena	68
Illawarra Forum Inc.	238, PFR309

Table A.1   (continued)

Participant	Submission number
Incerti, Kate	141
Independent Hospital Pricing Authority (IHPA)	PFR322
Independent Planning & Coordination Services Pty Ltd	PFR358
Independent Schools Council of Australia (ISCA)	179
Independent Schools Victoria (ISV)	58
Indigenous Affairs Group - Department of the Prime Minister and Cabinet (DPM&C)	265
Infrastructure Partnerships Australia (IPA)	PFR367 #
Inner South Community Health Services (ISCHS)	244
Irving, David	12
Jacobs, Prof. Keith	3, PFR296
Jesuit Social Services (JSS)	284, PFR336
Jobs Australia	268
Johnson, Guy; Scutella, Rosanna; Tseng, Yi-Ping; and Wood, Gavin	PFR299 #
Jolley, Dr Gwyn	72
Jones, Jackie	161
Jones, Krishna	19
Justice Action	101, PFR317
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
Launch Housing	PFR373
Lavery, Anne	59
Leading Age Services Australia (LASA)	177
Local Government NSW (LGNSW)	PFR338
Lochner, Sheri	93
Lodge, Teresa	164
Luckie, Paris	76
MacKenzie, Colin	75
Macular Disease Foundation (MDF) Australia	95, PFR335
Maddocks, Prof. Ian	116
Mallee Track Health and Community Service (MTHCS)	PFR294 #
Mamalis, Elle	18
Marsh, Prof. Ian	288 #

(continued next page)

Table A.1 (continued)

Participant	Submission number
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
Merri Health	PFR307
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
Muswellbrook Shire Council	PFR365
Name Withheld	24
Name Withheld	37
Name Withheld	38
National Aboriginal Community Controlled Health Organisation (NACCHO)	227
National Disability Services (NDS)	262, PFR363
National Mental Health Consumer and Carer Forum (NMHCCF)	PFR389
National Rural Health Alliance (NRHA)	269, PFR385
National Seniors Australia	PFR360
National Shelter Inc.	232, PFR369
Nayler, Tracey	98
Nepean Community & Neighbourhood Services (NCNS)	191

(continued next page)

Table A.1 (continued)

Participant	Submission number
Neyland, Nita	42
Nicholls, Taraeta	148
North Richmond Community Health (NRCH)	PFR320 #
NSW Government	122 #
NSW Meals on Wheels Association Inc.	7
NSW Nurses and Midwives' Association (NSWNMA)	247
NSWFHA, CHCSA, CHFV, CHIA and PowerHousing Australia	PFR328
NSWFHA, CHCSA, CHFV, CHIA, PowerHousing Australia and Shelter Tas	235
NT Department of Treasury and Finance (NT DTF)	261
O'Reilly, Stuart	91
Older Women's Network (OWN), Mackay Branch	PFR298
Optometry Australia	5
Ostrovska, Milena	153
O'Sullivan, Anne	183
Paech, Jason	16
Palliative Care Australia (PCA)	PFR329
Palliative Care Outcomes Collaboration (PCOC)	PFR308
Pande, Dr Divya	158
Parkes, Vanessa	136
PeakCare Queensland Inc.	128
Penrith Youth Interagency	PFR362
Pickard, Dr Marion	102
Power to Persuade	PFR390
Powles, Anne	196
Prader-Willi Syndrome Association of Australia (PWSAA)	PFR348
Q Shelter	PFR352
Queensland Network of Alcohol and other Drug Agencies (QNADA)	PFR312
Quiggin, Prof. John	PFR303
Ramsden, Robert	135
Real Estate Institute of Australia (REIA)	PFR340
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

(continued next page)

Table A.1 (continued)

Participant	Submission number
Royal Australasian College of Surgeons (RACS)	PFR374
Royal Australian College of General Practitioners (RACGP)	8, PFR337
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
Schizophrenia Fellowship of NSW (SF NSW)	PFR332
Schmidt, Dr Malgorzata	186
Scott, Prof. Anthony; Yong, Associate Prof. Jongsay; and Mendez, Dr Susan	87
Scott-Mills, Nicholas	210
Seldon, Prof. H Lee	170
Service, David	289
Settlement Council of Australia (SCoA)	278
Sex Workers Outreach Project (SWOP)	172
Shaw, Josephine	46
Shelter Tasmania	233, PFR344
Shelter WA	PFR341
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, PFR327
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

(continued next page)

Table A.1 (continued)

Participant	Submission number
Strutt, Sue	198
Tasmanian Government	PFR297 #
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, PFR388
The Centre for Independent Studies (CIS)	152, PFR347 #
The Smith Family	257
Thomas, Kerry	30
Toner, Dr Phillip	254
Toora Women Inc.	245
Triple P International Pty Ltd	127
Truscott, Karen	32
Tweed Shire Council	PFR311
United Voice	237
Uniting Church in Australia, Synod of Victoria and Tasmania	173
UnitingCare Australia	249, PFR313
van Kessel, Sister Susan (Lucy)	69
van Someren, Rachel	109
Varkey, Shobha	151, PFR291
Vaughan, Andrea	132
Victorian Alcohol and Drug Association (VAADA)	248, PFR305
Victorian Allied Health Professionals Association (VAHPA)	PFR361
Victorian Healthcare Association (VHA)	PFR376
Victorian Multicultural Commission	120 #
Villis, Angela	43
Vision Australia	28, PFR321 #
WA Regional Services Reform Unit (WA RSRU)	PFR351
Wall, Terry	110
Walshe, Sue	54
Warwick, Anne	131
Western Australian Department of Child Support and Family Services (CPFS)	PFR386
Western Australian Prison Officers' Union of Workers (WAPOU)	267
White Ribbon Australia	223
Whiting, Paul	27
Wicks, Genevieve	61
Worrall, Hugh	31
Yfoundations	PFR379
Youngcare	PFR323
Youth, Family and Community Connections Inc. (YFCC)	92, PFR293

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

Australian Dental Association (ADA)

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, Cancer Institute NSW

Cutler, Dr Henry; Centre for the Health Economy, Macquarie University

Eagar, Prof. Kathy; Australian Health Services Research Institute, University of Wollongong Australia

Homelessness NSW

Independent Hospital Pricing Authority (IHPA)

Mission Australia

NSW Federation of Housing Associations (NSWFHA)

NSW Government

Sturgess, Prof. Gary; Australia and New Zealand School of Government

TAFE Directors Australia (TDA)

YFoundations

Youth Action

Victoria

Australian Education Union (AEU)

Brotherhood of St Laurence (BSL)

Business Council of Co-operatives and Mutuals (BCCM)

Catholic Health Australia (CHA)

Disability Advocacy Network Australia (DANA)

Grattan Institute

HealthScope

Independent Schools Victoria (ISV)

Jobs Australia

Learning First

National Tertiary Education Union (NTEU)

Scott, Prof. Tony; Melbourne Institute of Applied Economic & Social Research

The Australian Centre for Social Innovation (TACSI)

Queensland

Australian Council for Private Education and Training (ACPET)

Brisbane Housing Company (BHC)

Head, Prof. Brian; Institute for Social Science Research (ISSR)

Logan Together

Memmott, Prof. Paul; Institute for Social Science Research (ISSR)

Table A.2   (continued)

Participant

Queensland (continued)

Moran, Prof. Mark; Institute for Social Science Research (ISSR)

National Shelter

Parsell, Dr Cameron; Institute for Social Science Research (ISSR)

Q Shelter

Queensland Government

UnitingCare Queensland

Western, Prof. Mark; Institute for Social Science Research (ISSR)

South Australia

National Centre for Vocational Education Research (NCVER)

South Australian Government

Western Australia

Aboriginal Health Council of Western Australia (AHCWA)

Anglicare WA

Disability Services Commission (WA)

Oral Health Centre of Western Australia (OHCWA)

Silver Chain Group

Western Australian Government

Tasmania

Tasmanian Government

ACT

ACT Government

Aged & Community Services Australia (ACSA)

Anglicare Australia

Australian Government Department of Education and Training (DET)

Australian Government Department of Employment (DoE)

Australian Government Department of Health (DoH)

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 Social Services Australia (CSSA)

Council of Private Higher Education (COPHE)

Council on the Ageing Australia (COTA)

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)

Table A.2   (continued)

Participant

ACT (continued)
National Home Doctor Service (NHDS)
Palliative Care Australia (PCA)
Save the Children Australia
UnitingCare Australia
Universities Australia

Northern Territory
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
National Disability Insurance Agency (NDIA)
NT Council of Social Service (NTCOSS)
NT Government
Santa Teresa Local Authority

New Zealand
New Zealand Productivity Commission

United Kingdom
Propper, Prof. Carol; Imperial College
Street, Prof. Andrew; University of York

Table A.3   **Roundtables**

Participant

Family and community services – 12 October, Brisbane
Aftercare
Brisbane Youth Service
Churches of Christ in Queensland
Communify Qld
Community Services Industry Alliance
Micah Projects
Mission Australia
Menzies, Jenny; Policy Innovation Hub, Griffith University
Relationships Australia Queensland
UnitingCare Queensland
YFS
yourtown

Family and community services – 17 October, Canberra
Catholic Social Services Australia
CatholicCare Melbourne
CatholicCare NT
CatholicCare Tasmania
Centacare Brisbane
Jesuit Social Services
MercyCare

Family and community services; services in remote Indigenous communities – 19 October, Perth
Accordwest
Anglicare WA
Baptistcare WA
Centrecare
Community Employers WA
Mercycare
Mission Australia
Nulsen
Parkerville
Richmond Wellbeing
Rise
Ruah Community Services
Technology Assisting Disability WA
UnitingCare West
WA Council of Social Service
Wanslea

(continued next page)

Table A.3   (continued)

Participant

Public dental services – 21 October, Melbourne
Australian Dental and Oral Health Therapists' Association
Australian Dental Association (ADA) Victoria
Australian Government Department of Health
Australian Healthcare and Hospitals Association
Australian Society for Special Care in Dentistry
Consumers Health Forum
NSW Ministry of Health
NT Department of Health
SA Health
Tasmanian Department of Health and Human Services

Public hospital services – 21 October, Melbourne
Australian Government Department of Health
Bupa
Medibank Private
NT Department of Health
Royal Australasian College of Surgeons
Royal Australian College of General Practitioners
SA Health
St Vincent's Health
Tasmanian Department of Health and Human Services
Victorian Department of Health and Human Services

Public hospital services – 24 October, Canberra
Australian Commission on Safety and Quality in Health Care
Australian Healthcare and Hospitals Association
Australian Medical Association
Australian Nursing and Midwifery Federation
Australian Private Hospitals Association
Catholic Health Australia
Consumers Health Forum
National Rural Health Alliance
NSW Ministry of Health
Private Healthcare Australia
Woods, Prof. Mike; Centre for Health Economics Research and Evaluation, University of Technology Sydney

Services in remote Indigenous communities – 24 October, Canberra
Empowered Communities
National Aboriginal Community Controlled Health Organisation
National Congress of Australia's First Peoples

(continued next page)

Table A.3 (continued)

Participant

Social housing – 25 October, Sydney

Australian Council of Social Service

Australian Government Department of Social Services

Bridge Housing

Brisbane Housing Corporation

Housing Action Network

Housing Tasmania

Milligan, Prof. Vivienne; University of New South Wales

National Affordable Housing Consortium

National Shelter

North Coast Community Housing Association

NSW Department of Family and Community Services

NSW Federation of Housing Associations

Pawson, Prof. Hal; University of New South Wales

PowerHousing Australia

Queensland Department of Housing and Public Works

SA Department for Communities and Social Inclusion

St George Community Housing

Tenants' Union of NSW

Victorian Department of Health and Human Services

End-of-life care – 25 October, Sydney

Agar, Prof. Meera; University of Technology Sydney

Australian Centre for Health Research

Australian Government Department of Health

Australian Healthcare and Hospitals Association

Bupa

HammondCare

McCaffrey, Dr. Nikki; Flinders University

NSW Health

Palliative Care Australia

SA Health

Silver Chain Group

St Vincent's Private Hospital Sydney

Tasmanian Department of Health and Human Services

Victorian Department of Health and Human Services

(continued next page)

Table A.3   (continued)

Participant

Family and community services – 26 October, Canberra

Anglicare Australia

Brotherhood of St Laurence

Community and Public Sector Union

Mental Health Community Coalition ACT

Australian Government Department of Finance

Australian Government Department of Social Services

North Western Melbourne Primary Health Network

References

ABS (Australian Bureau of Statistics) 2009, *TableBuilder, 2006*, Cat. no. 2065.0, 28 September, Canberra.

—— 2013a, *2011 TableBuilder Basic, 2011 Third Release*, Cat. no. 2072.0, 28 March, Canberra.

—— 2013b, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*, 30 August, Cat. no 3238.0.55.001, Canberra.

—— 2013c, *Housing Glossary*, www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Housing%20glossary%20(5.4.8) (accessed 11 November 2016).

—— 2014, *Characteristics of Recent Migrants, Australia, Nov 2013*, 30 June, Cat. no 6250.0, Canberra.

—— 2015a, *General Social Survey: Summary Results, Australia, 2014*, 29 June, Cat. no 4159.0, Canberra.

—— 2015b, *Patient Experiences in Australia*, Cat. no. 4839, Canberra.

—— 2016a, *Australian National Accounts: National Income, Expenditure and Product, Dec 2015*, 2 March, Cat. no 5206.0, Canberra.

—— 2016b, *Counts of Australian Businesses*, Cat. no. 8165.0, Canberra.

—— 2016c, *Deaths, Australia, 2015*, 28 September, Cat. no 3302.0, Canberra.

—— 2016d, *Government Finance Statistics, Education, Australia, 2014-15*, 26 April, Cat. no 5518.0.55.001, Canberra.

—— 2016e, *Labour Force, Australia, Detailed, Quarterly*, 23 June, Cat. no 6291.0.55.003, Canberra.

—— 2016f, *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*, 28 April, Cat. no 4714.0, Canberra.

—— 2016g, *Regional Population Growth, Australia, 2014-15*, Cat. no. 3218.0, 30 March, Canberra.

—— 2016h, *Schools, Australia, 2015*, 4 February, Cat. no 4221.0, Canberra.

ACFA (Aged Care Financing Authority) 2015, *Third Report on the Funding and Financing of the Aged Care Industry*, July, Canberra.

ACNC (Australian Charities and Not-for-profits Commission) 2016, *Explore Sector Detail*, australiancharities.acnc.gov.au/visualisations/explore-sector-detail/ (accessed 11 November 2016).

ACOSS, CHFA, HA, NATO and National Shelter (Australian Council of Social Service, Community Housing Federation of Australia, Homelessness Australia and National Association for Tenants' Organisations) 2015, *An Affordable Housing Reform Agenda: Goals and Recommendations for Reform*.

ACSQHC (Australian Commission on Safety and Quality in Health Care) 2014, *Health Literacy: Taking Action to Improve Safety and Quality*, Sydney.

—— 2015a, *National Consensus Statement: Elements Essential for Safe and High-Quality End-of-Life Care*, Sydney.

—— 2015b, *Review of the Department of Health and Human Services' Management of a Critical Issue at Djerriwarrh Health Services*, Sydney.

—— 2015c, *Vital Signs 2015: The State of Safety and Quality in Australian Health Care*, Sydney.

—— and AIHW (Australian Institute of Health and Welfare) 2014, *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study*, Sydney.

—— and NHPA (National Health Performance Authority) 2015, *Australian Atlas of Healthcare Variation*, Sydney.

ACT Government 2014, *Better Services: Human Services Blueprint*, May, Canberra.

—— 2015, *Strengthening Families in 2014-15*, Better Services, www.better services.act.gov.au/about/achievements-2014-15-strengthening-families (accessed 11 November 2016).

—— 2016, *Child and Youth Dental*, www.health.act.gov.au/our-services/dental/child-and-youth-dental (accessed 11 November 2016).

ADA (Australian Dental Association) 2015, *Submission to Department of Health Re: Reducing Regulation in the Health Portfolio*, June, Sydney.

—— 2016, *Submission to the Productivity Commission Inquiry into Data Availability and Use*, Submission no. 8 to the Productivity Commission's Report on Data Availability and Use, Canberra.

Agar, M., Currow, D.C., Shelby-James, T.M., Plummer, J., Sanderson, C. and Abernethy, A.P. 2008, 'Preference for place of care and place of death in palliative care: are these different questions?', *Palliative Medicine*, vol. 22, no. 7, pp. 787–795.

AHCWA (Aboriginal Health Council of Western Australia) 2016, *Submission to the Productivity Commission Inquiry into Data Availability and Use*, Submission no. 181 to the Productivity Commission's Report on Data Availability and Use, Perth.

AHMAC (Australian Health Ministers Advisory Council) 2012, *National Strategic Framework for Rural and Remote Health*, Canberra.

AHPRA (Australian Health Practitioner Regulation Agency) 2015, *Annual Report 2014/15*, November, Melbourne.

AIHW (Australian Institute of Health and Welfare) 2002a, *Australian Hospital Statistics 2000-01*, Canberra.

—— 2002b, *Residential Aged Care in Australia 2000-01: A Statistical Overview*, Canberra.

—— 2003a, *Australian Hospital Statistics 2001-02*, Canberra.

—— 2003b, *Residential Aged Care in Australia 2001-02: A Statistical Overview*, Canberra.

—— 2004a, *Australian Hospital Statistics 2002-03*, Canberra.

—— 2004b, *Residential Aged Care in Australia 2002-03: A Statistical Overview*, Canberra.

—— 2005a, *Australian Hospital Statistics 2003-04*, Canberra.

—— 2005b, *Australia's Welfare 2005*, Canberra.

—— 2005c, *Residential Aged Care in Australia 2003-04: A Statistical Overview*, Canberra.

—— 2006a, *Australian Hospital Statistics 2004-05*, Canberra.

—— 2006b, *Residential Aged Care in Australia 2004-05: A Statistical Overview*, Canberra.

—— 2007a, *Australian Hospital Statistics 2005-06*, Canberra.

—— 2007b, *Residential Aged Care in Australia 2005-06: A Statistical Overview*, Canberra.

—— 2008a, *Australian Hospital Statistics 2006-07*, Canberra.

—— 2008b, *Residential Aged Care in Australia 2006-07: A Statistical Overview*, Canberra.

—— 2009a, *Australian Hospital Statistics 2007-08*, Canberra.

—— 2009b, *Residential Aged Care in Australia 2007-08: A Statistical Overview*, Canberra.

—— 2010a, *Australian Hospital Statistics 2008-09*, Canberra.

—— 2010b, *Residential Aged Care in Australia 2008-09: A Statistical Overview*, Canberra.

—— 2011a, *Australian Hospital Statistics 2009-10*, Canberra.

—— 2011b, *Residential Aged Care in Australia 2009-10: A Statistical Overview*, Canberra.

—— 2012a, *Australian Hospital Statistics 2010-11*, Canberra.

—— 2012b, *Residential Aged Care in Australia 2010-11: A Statistical Overview*, Canberra.

—— 2013a, *Australian Hospital Statistics 2011-12*, Canberra.

—— 2013b, *Expenditure on Health for Aboriginal and Torres Strait Islander People 2010-11: An Analysis by Remoteness and Disease*, Canberra.

—— 2013c, *The Desire to Age in Place Among Older Australians*, April, Bulletin 114, Canberra.

—— 2014a, *Australian Hospital Statistics 2012-13*, Canberra.

—— 2014b, *National Social Housing Survey: Detailed Results 2014*, Canberra.

—— 2014c, *Residential Aged Care in Australia 2012-13: A Statistical Overview*, Canberra.

—— 2015a, *Admitted Patient Care 2013–14: Australian Hospital Statistics*, 19 March, Canberra.

—— 2015b, *Australian Hospital Peer Groups*, Health services series no. 66, Cat. no HSE 170, Canberra.

—— 2015c, *Cardiovascular Disease, Diabetes and Chronic Kidney Disease: Australian Facts, Aboriginal and Torres Strait Islander People*, Canberra.

—— 2015d, *Child Protection Australia: 2013–14.*, Child Welfare series 61. Cat. no. CWS 52, Canberra.

—— 2015e, *National Health Expenditure, Current and Constant Prices, 1985–86 to 2013–14*, Canberra.

—— 2015f, *Oral Health and Dental Care in Australia: Key Facts and Figures 2015*, Cat. no DEN 229, Canberra.

—— 2015g, *Residential Aged Care in Australia 2013-14: A Statistical Overview*, Canberra.

—— 2015h, *Social Housing Dwellings*, www.aihw.gov.au/housing-assistance/haa/ 2015/social-housing-dwellings/ (accessed 11 November 2016).

—— 2015i, *Social Housing Tenants*, www.aihw.gov.au/housing-assistance/haa/ 2015/social-housing-tenants/ (accessed 11 November 2016).

—— 2015j, *Working Age (25-64)*, www.aihw.gov.au/australias-welfare/2015/working-age/ (accessed 11 November 2016).

—— 2016a, *Admitted Patient Care 2014-15: Australian Hospital Statistics*, Health services series no. 68, Cat. no. HSE 172, Canberra.

—— 2016b, *Aged Care*, www.aihw.gov.au/aged-care/ (accessed 11 November 2016).

—— 2016c, *AIHW National Aged Care Data Clearinghouse*, Canberra.

—— 2016d, *Alcohol and Other Drug Treatment Services in Australia 2014–15*, Drug treatment series 27. Cat. no. HSE 173, Canberra.

—— 2016e, *Australia's Health 2016*, 13 September, Canberra, www.aihw.gov.au/ publication-detail/?id=60129555544 (accessed 11 November 2016).

—— 2016f, *Australia's Hospitals 2014-15: At a Glance*, Health services series no. 70, Canberra.

—— 2016g, *Costs of Acute Admitted Patients Data*, www.myhospitals.gov.au/docs/default-source/downloadable-data/myhospitals-cost-acute-admitted-patients-data.xls?sfvrsn=6 (accessed 11 November 2016), Canberra.

—— 2016h, *Dementia*, http://aihw.gov.au/dementia/ (accessed 11 November 2016).

—— 2016i, *Hospital Resources 2014-15: Australian Hospital Statistics*, Health services series no. 71, Cat. no. HSE 176, Canberra.

—— 2016j, *Housing Assistance in Australia 2016*, www.aihw.gov.au/housing-assistance/haa/2016/ (accessed 11 November 2016).

—— 2016k, *Housing assistance in Australia 2016 supplementary data*, *www.aihw.gov.au/housing-assistance/haa/2016/data/* (accessed 11 November 2016).

—— 2016l, *Myhospitals Overview, www.myhospitals.gov.au/about-myhospitals* (accessed 11 November 2016).

—— 2016m, *National Health Workforce Data Set*, Canberra.

—— 2016n, *Palliative Care*, www.aihw.gov.au/palliative-care/ (accessed 11 November 2016).

—— 2016o, *Specialist Homelessness Services Collection Data Cubes*, Canberra, www.aihw.gov.au/shs/data-cubes/ (accessed 11 November 2016).

—— 2016p, *Sweden: Disease Registries*, www.aihw.gov.au/health-performance/impacts-of-local-level-public-reporting/sweden-disease-registries (accessed 11 November 2016)

—— 2016q, *United States: Hospital Compare*, www.aihw.gov.au/health-performance/impacts-of-local-level-public-reporting/united-states-hospital-compare/ (accessed 11 November 2016).

Alford, K. 2014, *Economic Value of Aboriginal Community Controlled Health Services*, April, National Aboriginal Community Controlled Health Organisation, Canberra.

ANAO (Australian National Audit Office) 2015, *Administration of the Child Dental Benefits Schedule*, Report no. 12, Canberra.

AONSW (Audit Office of New South Wales) 2013, *Making the Best Use of Public Housing*, July, Sydney.

—— 2015a, *Community Housing*, September, Sydney.

—— 2015b, *Financial Audit Volume Ten 2015: Health*, New South Wales Auditor-General's Report no. 12, Sydney.

APSC (Australian Public Service Commission) 2013, *Policy Implementation Through Devolved Government*, August, Canberra www.apsc.gov.au/publications-and-media/archive/publications-archive/devolved-government (accessed 11 November 2016).

Armfield, J., Spencer, A. and Stewart, J. 2006, 'Dental fear in Australia: who's afraid of the dentist?', Australian Dental Journal, vol. 51, no. 1, pp. 78–85.

Arnold, E., Finucane, A.M. and Oxenham, D. 2015, 'Preferred place of death for patients referred to a specialist palliative care service', *BMJ Supportive & Palliative Care*, vol. 5, no. 3, pp. 294–296.

Auriemma, C.L., Nguyen, C.A., Bronheim, R., Kent, S., Nadiger, S., Pardo, D. and Halpern, S.D. 2014, 'Stability of end-of-life preferences: a systematic review of the evidence', *JAMA Internal Medicine*, vol. 174, no. 7, pp. 1085–1092.

Australian Government 2010, *Supporting Australians to Live Well at the End of Life - National Palliative Care Strategy*, Commonwealth of Australia, Canberra.

—— 2014, *Budget 2014-15: Portfolio Budget Statements 2014-15 - Employment Portfolio*, Budget related paper 1.6, Canberra.

—— 2015a, *2015 Intergenerational Report: Australia in 2055*, March, Canberra.

—— 2015b, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*, Canberra.

—— 2016a, *Redesigning VET FEE-HELP: Discussion Paper*, Canberra, https://docs.education.gov.au/documents/2017-vet-fee-help-scheme-redesign-discussion-paper (accessed 11 November 2016).

—— 2016b, *Report on the Third Review of the Dental Benefits Act 2008*, (Prof. Chris Baggoley, Chair), Canberra.

Bainbridge, R., McCalman, J., Clifford, A. and Tsey, K. 2015, *Cultural Competency in the Delivery of Health Services for Indigenous People*, Issues Paper no. 13, July, Australian Institute of Family Studies, Canberra.

Barber, M., Staples, M., Osborne, R., Clerehan, R., Elder, C. and Buchbinder, R. 2009, 'Up to a quarter of the Australian population may have suboptimal health literacy depending upon the measurement tool: Results from a population-based survey', *Health Promotion International*, vol. 24, no. 3, pp. 252–261.

Bartel, R. 2016, *Conversations: Creating Choice in End of Life Care*, Australian Centre for Health Research, Melbourne.

Baumol, W. 1982, 'Contestable markets: An uprising in the theory of industry structure', *The American Economic Review*, vol. 72, no. 1, pp. 1–15.

Beattie, P. (Premier of Queensland) 2005, *Bundaberg Hospital recommendations are a priority*, Media Release, 29 June.

Berends, L. and Ritter, A. 2014, *The Processes of Reform in Victoria's Alcohol and Other Drug Sector, 2011-2014: Final Report*, National Drug and Alcohol Research Centre, Sydney.

Bevan, G. and Skellern, M. 2011, 'Does competition between hospitals improve clinical quality?: A review of evidence from two eras of competition in the English NHS', *British Medical Journal*, vol. 343, pp. 1–7.

Biddle, N. and Markham, F. 2013, *CAEPR Indigenous Population Project: Mobility*, Census Paper no. 9, Centre for Aboriginal Economic Policy Research, Canberra, http://caepr.anu.edu.au/Publications/census-papers/2013CP9.php (accessed 11 November 2016).

Birmingham, S. (Minister for Education and Training) 2016, *New VET Student Loans a win-win for students and taxpayers*, Media Release, 5 October 2016.

Bloom, N., Propper, C., Seiler, S. and Van Reenen, J. 2015a, *Healthcare: How Competition Can Improve Management Quality and Save Lives*, Microeconomic Insights, http://microeconomicinsights.org/healthcare-how-competition-can-improve-management-quality/ (accessed 11 November 2016).

——, ——, —— and —— 2015b, 'The impact of competition on management quality: evidence from public hospitals', *Review of Economic Studies*, vol. 82, pp. 457–489.

Bradley, S.L., Woodman, R.J., Tieman, J.J. and Phillips, P.A. 2014, 'Use of advance directives by South Australians: results from the Health Omnibus Survey Spring 2012', *Medical Journal of Australia*, vol. 201, no. 8, pp. 467–469.

Brennan, D., Luzzi, L. and Roberts-Thomson, K. 2008, 'Dental service patterns among private and public adult patient in Australia', *BMC Health Services Research*, vol. 8, no. 1.

Brinkman-Stoppelenburg, A., Rietjens, J.A. and Heide, A. van der 2014, 'The effects of advance care planning on end-of-life care: A systematic review', *Palliative Medicine*, p. 269216314526272.

Broom, A., Kirby, E., Good, P., Wootton, J. and Adams, J. 2012, 'Specialists' experiences and perspectives on the timing of referral to palliative care: a qualitative study', *Journal of Palliative Medicine*, vol. 15, no. 11, pp. 1248–1253.

Brown, T. and Lishman, R. 2013, 'Introducing a choice-based lettings system for French social housing', *The Guardian*, 17 January, www.theguardian.com/housing-network/2013/jan/17/choice-based-lettings-france-social-housing (accessed 11 November 2016).

—— and Yates, N. 2015, 'Allocations and lettings – taking customer choice forward in England?', *European Journal of Housing Policy*, vol. 5, no. 3, pp. 343–357.

BSL (Brotherhood of St Laurence) 2016, *Submission to the Productivity Commission Inquiry into Data Availability and Use*, Submission 186 to the Productivity Commission's Report on Data Availability and Use, Melbourne.

Campanella, P., Vukovic, V., Parente, P., Sulejmani, A., Ricciardi, W. and Specchia, M. 2016, 'The impact of public reporting on clinical outcomes: A systematic review and meta-analysis', *BMC Health Services Research*, vol. 16, no. 1, pp. 1–14.

CARC (Community Affairs References Committee) 2012, *The Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas*, August, Canberra.

Celler, B., Varnfield, M., Sparks, R., Li, J., Nepal, S., Jang-Jaccard, J., McBride, S. and Jayasena, R. 2016, *Home Monitoring of Chronic Disease for Aged Care*, May, Australian e-Health Research Centre (AEHRC), CSIRO, Canberra.

Centre for Oral Health Strategy 2013, *Oral Health 2020: A Strategic Framework for Dental Health in NSW*, February, Sydney.

—— 2016, *Oral Health Fee for Service Scheme*, Policy Directive, 7 June, PD2016_018, Sydney.

Chandler, M.J. and Lalonde, C. 1998, 'Cultural continuity as a hedge against suicide in Canada's first nations', *Transcultural Psychiatry*, vol. 35, no. 2, pp. 191–219.

Cherny, N.I. 2011, 'The problem of suffering and the principles of assessment in palliative care', in Hanks, G.W.C., Cherny, N.I., Christakis, N.A. and Kaasa, S. (eds), *Oxford Textbook of Palliative Medicine*, OUP Oxford.

CHFV (Community Housing Federation of Victoria) 2016, *All Things Considered: A Response from the Community Housing Federation of Victoria*, 27 June, Melbourne.

——, VCOSS, CHP, VPTA, TUV, DVV and JCHL (Victorian Council of Social Services, Council to Homeless Persons, Victorian Public Tenants Association, Tenants Union of Victoria, Domestic Violence Victoria and Justice Connect Homeless Law) 2014, *Making Social Housing Work: Better Homes for Low-Income Victorians*, March, Melbourne.

City of Toronto 2016a, *A Better Way to Access Social Housing*, Housing & Homelessness Services, www1.toronto.ca/wps/portal/contentonly?vgnextoid=d5b4d9f9849b2410Vgn VCM10000071d60f89RCRD&vgnextchannel=c0aeab2cedfb0410VgnVCM10000071d 60f89RCRD (accessed 11 November 2016).

—— 2016b, *Housing Allowances FAQ*, Housing & Homelessness Services, www1.toronto.ca/wps/portal/contentonly?vgnextoid=d8673150672c3510VgnVCM100 00071d60f89RCRD (accessed 11 November 2016).

COAG (Council of Australian Governments) 2016, *Heads of Agreement Between the Commonwealth and the States and Territories on Public Hospital Funding*, Canberra.

COAG Health Council 2015, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015-2024*, Adelaide.

Competition Policy Review 2014, *Competition Policy Review: Issues Paper*, Canberra.

—— 2015, *Competition Policy Review: Final Report*, Canberra.

Cooper, Z., Gibbons, S., Jones, S. and McGuire, A. 2011, 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', *Economic Journal*, vol. 121, no. 554, pp. F228–60.

Corke, C. 2015, 'End-of-life Care: No, We Don't All Want "Whatever it Takes" to Prolong Life', *The Conversation*, http://theconversation.com/end-of-life-care-no-we-dont-all-want-whatever-it-takes-to-prolong-life-41495 (accessed 11 November 2016).

Cortis, N., Lee, I., Powell, A., Simnett, R. and Reeve, R. 2015, *Australian Charities Report 2014*, Commissioned by the Australian Charities and Not-for-Profits Commission (ACNC), Centre for Social Impact and Social Policy Research Centre, UNSW Australia, Sydney.

CRCREP (Cooperative Research Centre for Remote Economic Participation) 2015, *A Snapshot of Remote Australia*, www.nintione.com.au/about-nintione/where-we-work/facts-about-remote-australia (accessed 11 November 2016).

Cressman, R. 2014, 'Reimagining the Wait List', https://share.hscorp.ca/?upf=dl&id=4780 (accessed 11 November 2016).

Curo 2016, *Curo for families*, www.meetcuro.com/families (accessed 11 November 2016).

Currow, D.C., Agar, M., Sanderson, C. and Abernethy, A.P. 2008, 'Populations who die without specialist palliative care: does lower uptake equate with unmet need?', *Palliative Medicine*, vol. 22, no. 1, pp. 43–50.

——, Allingham, S., Yates, P., Johnson, C., Clark, K. and Eagar, K. 2015, 'Improving national hospice/palliative care service symptom outcomes systematically through point-of-care data collection, structured feedback and benchmarking', *Supportive Care in Cancer*, vol. 23, no. 2, pp. 307–315.

Davidson, B. 2011, 'Contestability in human services markets', *The Journal of Australian Political Economy*, no. 68, pp. 213–239.

Davis, K., Stremikis, K., Squires, D. and Schoen, C. 2014, *Mirror, Mirror On The Wall: How the Performance of the US Health Care System Compares Internationally: 2014 Update*, Commonwealth Fund, New York.

Deloitte Access Economics 2015, *The Economic Value of Informal Care in Australia in 2015*, Report for Carers Australia, June, Sydney.

—— 2016, *Forecasting the Future: Community Services in Queensland 2025 - Summary Report*, Commissioned by the Community Services Industry Alliance and the Department of Communities, Child Safety and Disability Services, Brisbane.

Department of Health 2015, *Needs Assessment Guide*, Canberra.

—— 2016, *Guide to the Child Dental Benefits Schedule*, February, Version 4, Canberra.

DET (Department of Education and Training) 2015, *2014 VET FEE-HELP Statistical Report - Completions tables*, https://docs.education.gov.au/node/38383 (accessed 11 November 2016).

DHSV (Dental Health Services Victoria) 2016, *Community Dental Clinics*, www.dhsv.org.au/clinic-locations/community-dental-clinics (accessed 11 November 2016).

—— nd, *Services for homebound patients (Domiciliary)*, www.dhsv.org.au/public-dental-services/services-for-homebound-patients-domiciliary (accessed 11 November 2016).

DIBP (Department of Immigration and Border Protection) 2016, *Fact sheet – Temporary Residence*, www.border.gov.au/about/corporate/information/fact-sheets/47temporary-residence (accessed 11 November 2016).

Dickinson, H. 2015, *Commissioning Public Services Evidence Review: Lessons for Australian Public Services*, Melbourne School of Government, Melbourne.

Disability Loop 2015, *Facebook - NDIS Grassroots Discussion group*, www.disability loop.org.au/resources/ndis_grassroots_discussion_group_facebook.html (accessed 11 November 2016).

Dixon, J., King, D. and Knapp, M. 2016, 'Advance care planning in England: Is there an association with place of death? Secondary analysis of data from the National Survey of Bereaved People', *BMJ Supportive & Palliative Care*, 16 June.

Donaldson, D. 2016, 'Parkinson: Indigenous funding has weak evidence base', *Mandarin*, www.themandarin.com.au/69432-martin-parkinson-indigenous-funding-has-weak-evidence-base/ (accessed 11 November 2016).

DPMC (Department of the Prime Minister and Cabinet) 2016, *Public Sector Data Management: Implementation Report*, July, Canberra.

DSS (Department of Social Services) 2016a, *Commonwealth Rent Assistance*, Housing Support, www.dss.gov.au/housing-support/programmes-services/commonwealth-rent-assistance (accessed 11 November 2016).

—— 2016b, *Frequently Asked Questions 2014 Grant Rounds*, www.dss.gov.au/grants/frequently-asked-questions (accessed 11 November 2016).

—— 2016c, *Grants Funding Report: July 2016*, Canberra, www.dss.gov.au/grants/grants-funding (accessed 11 November 2016).

—— 2016d, *Selection Types*, www.dss.gov.au/grants/general-information-on-grants/selection-types (accessed 11 November 2016).

Duckett, S. 2013, *Public-private hospital partnerships are risky business*, The Conversation, http://theconversation.com/public-private-hospital-partnerships-are-risky-business-16421 (accessed 11 November 2016).

—— and Breadon, P. 2014, *Controlling Costly Care: A Billion Dollar Hospital Opportunity*, Report no. 2014-2, Grattan Institute, Melbourne.

——, Cuddihy, M. and Newnham, H. 2016, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care*, Report of the Review of Hospital Safety and Quality Assurance in Victoria, Melbourne.

Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. and Sullivan, P. 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin.

EIU (The Economist Intelligence Unit) 2015, *The 2015 Quality of Death Index*, Commissioned by the Lien Foundation, www.eiuperspectives.economist.com/healthcare/2015-quality-death-index (accessed 11 November 2016).

Ellershaw, A. and Spencer, A. 2011, *Dental Attendance Patterns and Oral Health Status*, Dental statistics and research series no. 57, Cat. no DEN 208, AIHW, Canberra.

Elliss-Brookes, L., McPhail, S., Ives, A., Greenslade, M., Shelton, J., Hiom, S. and Richards, M. 2012, 'Routes to diagnosis for cancer–determining the patient journey using multiple routine data sets', *British Journal of Cancer*, vol. 107, no. 8, pp. 1220–1226.

Empowered Communities 2015, *Empowered Communities: Empowered Peoples Design Report*, Canberra, http://empoweredcommunities.org.au/about/report.aspx (accessed 11 November 2016).

FCDC (Family and Community Development Committee) 2010, *Inquiry into the Adequacy and Future Directions of Public Housing in Victoria*, Melbourne.

Gaynor, M., Moreno-Serra, R. and Propper, C. 2012, 'Can competition improve outcomes in UK health care?: Lessons from the past two decades', *Journal of Health Services Research and Policy*, vol. 17, Supplement 1, pp. 49–54.

——, —— and —— 2013, 'Death by market power: Reform, competition, and patient outcomes in the National Health Service', *American Economic Journal: Economic Policy*, vol. 5, no. 4, pp. 134–166.

——, Propper, C. and Seiler, S. 2012, *Free to Choose: Reform and Demand Response in the English National Health Service*, Discussion Paper no. 1179, Centre for Economic Performance, London School of Economics and Political Science, London.

Georgopoulos, M. 2016, *Planned western Sydney 'foyer' to give homeless or at risk youth a place to live while studying*, PowerHousing Australia, www.powerhousing australia.com.au/2016/06/29/planned-western-sydney-foyer-to-give-homeless-or-at-risk-youth-a-place-to-live-while-studying/ (accessed 11 November 2016).

Glance, D. 2012, *Everything you need to know about Australia's e-health records*, The Conversation, http://theconversation.com/everything-you-need-to-know-about-australias-e-health-records-5516 (accessed 11 November 2016).

Gomes, B., Calanzani, N., Gysels, M., Hall, S. and Higginson, I.J. 2013, 'Heterogeneity and changes in preferences for dying at home: a systematic review', *BMC Palliative Care*, vol. 12, p. 7.

Gorham, G., Cass, A., Howard, K. and Evans, K. 2016, *Central Australia Renal Study: Technical Report Update.*, Menzies School of Health Research, Canberra.

Gourdji, I., McVey, L. and Purden, M. 2009, 'A quality end of life from a palliative care patient's perspective', *Journal of Palliative Care*, vol. 25, no. 1, pp. 40–50.

GP2U 2016, *Online Doctor Service | GP2U Telehealth Australia*, https://gp2u.com.au/ (accessed 11 November 2016).

Groenhart, L. and Burke, T. 2014, *Thirty Years of Public Housing Supply and Consumption: 1981 - 2011*, AHURI Final Report no. 231, Australian Housing and Urban Research Institute, Melbourne.

Gruen, N. 2016, 'Why we accept travesties of "evidence-based" policymaking', *Mandarin*, www.themandarin.com.au/64557-nicholas-gruen-evidence-based-policy-part-one/ (accessed 11 November 2016).

Gutacker, N., Harris, A., Brennan, D. and Hollingsworth, B. 2015, 'The determinants of dentists' productivity and the measurement of output', *Social Science & Medicine*, vol. 124, pp. 76–84.

Hall, J. and Berry, M. 2004, *Operating Deficits and Public Housing: Policy Options for Reversing the Trend*, AHURI Final Report no. 55, March, Australian Housing and Urban Research Institute, Melbourne.

HCSC (Health and Community Services Committee) 2013, *Palliative and Community Care in Queensland: Toward Patient-Centred Care*, Report no. 22, Queensland Parliament, www.parliament.qld.gov.au/documents/tableoffice/tabledpapers/2013/ 5413t2591.pdf (accessed 11 November 2016).

Health& 2016, *Health&: Your Personal Health Companion*, Health&, https://healthand.com/au/ (accessed 11 November 2016).

Hibbard, J. and Peters, E. 2003, 'Supporting informed consumer health care decisions: Data presentation approaches that facilitate the use of information in choice', *Public Health*, vol. 24, pp. 413–433.

Housing Tasmania 2014, *Response to the Senate Inquiry into Affordable Housing*, Submission no. 217, Hobart.

HRSCHA (House of Representatives Standing Committee on Health and Ageing) 2013, Bridging the Dental Gap: Report on the Inquiry Into Adult Dental Service, June, Canberra.

Hudson, S. 2016, *Mapping the Indigenous Program and Funding Maze*, CIS Research Report no. 18, The Centre for Independent Studies.

IHPA (Independent Hospital Pricing Authority) 2015, *The Pricing Framework for Australian Public Hospital Services 2016-17*, Sydney.

Impact Investing Australia 2015, *Case Study: Hireup*, http://impactinvestingaustralia.com/ case-studies/hireup/ (accessed 11 November 2016).

Integratedliving 2015, *Staying Strong Pilot Project: Enhanced Care for Older Aboriginal and Torres Strait Islander Australians,* Concise Report, February, http://integratedliving.org.au /news-events/annual-reports (accessed 11 November 2016).

Jacobs, K., Hulse, K., Stone, W. and Wiesel, I. 2016, *Individualised Housing Assistance: Findings and Policy Options*, AHURI Final Report no. 269, August, Australian Housing and Urban Research Institute, Melbourne.

Kendig, H. and Duckett, S. 2001, *Australian Directions in Aged Care: The Generation of Policies for Generations of Older People*, Commissioned Paper Series 2001/05, Australian Health Policy Institute, Sydney.

Knight, K. and Hunter, C. 2013, *Using Technology in Service Delivery to Families, Children and Young People*, Child Family Community Australia Paper no. 17, October, Canberra.

KPMG 2010, *Accommodating Contestability in Social Housing*, August, New Zealand.

—— 2013, *The Integration Imperative: Reshaping the Delivery of Human and Social Services*, October.

—— 2014, *Rethinking Regulation in the Human Service Sector*, Sydney.

—— 2015, *Going Home Staying Home Post-Implementation Review*, Department of Family and Community Services, Sydney.

Kruger, E. and Tennant, M. 2015, *Quality in dentistry in Australia: Essential or volunteer extra?*, *Croakey*, 10 September, https://croakey.org/quality-in-dentistry-in-australia-essential-or-volunteer-extra/ (accessed 11 November 2016).

Lam, R., Kruger, E. and Tennant, M. 2015, 'Conundrums in merging public policy into private dentistry: experiences from Australia's recent past', *Australian Health Review*, vol. 39, pp. 169–174.

Larsson, S., Lawyer, P., Garellick, G., Lindahl, B. and Lundström, M. 2012, 'Use of 13 disease registries in 5 countries demonstrates the potential to use outcome data to improve health care's value', *Health Affairs*, vol. 31, no. 1, pp. 220–227.

Launch Housing 2016, *HomeGround Real Estate*, www.launchhousing.org.au/homeground-real-estate/ (accessed 11 November 2016).

Lavoie, J.G., Forget, E.L., Prakash, T., Dahl, M., Martens, P. and O'Neil, J.D. 2010, 'Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba?', *Social Science & Medicine*, vol. 71, no. 4, pp. 717–724.

Le Grand, J. 2007, *The Other Invisible Hand*, Princeton University Press, Princeton, New Jersey.

Ley, S. (Minister for Health and Aged Care) 2016a, *Health Care Homes to keep chronically-ill out-of-hospital*, Media release, 31 March.

—— 2016b, *New Committee to provide recommendations on private health insurance reform*, Media release, 8 September.

—— 2016c, *Turnbull Government to ease pressure on private health insurance premiums*, Media release, 10 October.

—— (Minister for Health, Minister for Sport and Minister for Aged Care) 2016d, *Dental Benefits Amendment Bill 2016, Second Reading Speech*, 5 May, Canberra, pp. 4469–4471.

Lindenauer, P., Lagu, T., Ross, T., Pekow, P., Shatz, A., Hannon, N., Rothberg, M. and Benjamin, E. 2014, 'Attitudes of hospital leaders toward publicly reported measures of health care quality', *JAMA Internal Medicine*, vol. 174, no. 12, pp. 1904–1911.

LSIC (Legal and Social Issues Committee) 2016, *Inquiry into End of Life Choices*, Final Report, June, Legislative Council and Parliament of Victoria, Melbourne, www.parliament.vic.gov.au/lsic/inquiry/402 (accessed 11 November 2016).

Lynn, J. and Adamson, D.M. 2003, *Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age*, RAND Corporation, California.

Marsh, A., Cowan, D. and Cameron, A. 2004, *Piloting Choice Based Lettings: An Evaluation*, Office of the Deputy Prime Minister, United Kingdom.

McCaffrey, N., Bradley, S., Ratcliffe, J. and Currow, D.C. 2016, 'What Aspects of Quality of Life Are Important From Palliative Care Patients' Perspectives? A Systematic Review of Qualitative Research', *Journal of Pain and Symptom Management*, vol. 52, no. 2, pp. 318–328.

McIntosh, G. and Phillips, J. 2002, *Disability Support and Services in Australia*, Parliamentary Library E-Brief, www.aph.gov.au/About_Parliament/Parliamentary_ Departments/Parliamentary_Library/Publications_Archive/archive/disability (accessed 11 November 2016).

McLachlan, R., Gilfillan, G. and Gordon, J. 2013, *Deep and Persistent Disadvantage in Australia*, Staff Working Paper, 11 July, Productivity Commission, Canberra.

Medibank Private and Royal Australasian College of Surgeons 2016a, *Surgical Variance Report: Ear, Nose and Throat Surgery*, Melbourne.

—— and —— 2016b, *Surgical Variance Report: General Surgery*, Melbourne.

—— and —— 2016c, *Surgical Variance Report: Orthopaedic Procedures*, Melbourne.

—— and —— 2016d, *Surgical Variance Report: Urology*, Melbourne.

—— and —— 2016e, *Surgical Variance Report: Vascular Surgery*, Melbourne.

Memmott, P., Long, S. and Thomson, L. 2006, *Indigenous Mobility in Rural and Remote Australia*, AHURI Final Report no. 90, Australian Housing and Urban Research Institute, Melbourne.

Menzies School of Health Research 2015, *Dialysis Models of Care Project Update*, Progress Report, July, Darwin, www.menzies.edu.au/page/Research/Projects/ Kidney/The_dialysis_models_of_care_project/ (accessed 11 November 2016).

Milligan, V., Martin, C., Phillips, R., Liu, E., Pawson, H. and Spinney, A. 2016, *Profiling Australia's affordable housing industry*, Australian Housing and Urban Research Institute, Melbourne.

Moens, K., Higginson, I.J., Harding, R., Brearley, S., Caraceni, A., Cohen, J., Costantini, M., Deliens, L., Francke, A.L., Kaasa, S., Linden, K., Meeussen, K., Miccinesi, G., Onwuteaka-Philipsen, B., Pardon, K., Pasman, R., Pautex, S., Payne, S. and Block, L.V. den 2014, 'Are there differences in the prevalence of palliative care-related problems in people living with advanced cancer and eight non-cancer conditions? A systematic review', *Journal of Pain and Symptom Management*, vol. 48, no. 4, pp. 660–677.

Mossialos, E., Wenzl, M., Osborn, R. and Sarnak, D. 2016, *2015 International Profiles of Health Care Systems*, Commonwealth Fund, New York.

Murtagh, F.E.M., Bausewein, C., Verne, J., Groeneveld, E.I., Kaloki, Y.E. and Higginson, I.J. 2014, 'How many people need palliative care? A study developing and comparing methods for population-based estimates', *Palliative Medicine*, vol. 28, no. 1, pp. 49–58.

NACDH (National Advisory Council on Dental Health) 2012, *Report of the National Advisory Council on Dental Health*, Final Report, February, Canberra.

Nahm, E.S. and Resnick, B. 2001, 'End-of-life treatment preferences among older adults', *Nursing Ethics*, vol. 8, no. 6, pp. 533–543.

NCVER (National Centre for Vocational Education Research) 2015, *A Preliminary Analysis of the Outcomes of Students Assisted by VET FEE-HELP*, Adelaide.

NDIA (National Disability Insurance Agency) 2015a, *2014-15 Annual Report*, 1 October, Geelong.

—— 2015b, *Barkly Progress Report: Year One*, Geelong, https://myplace.ndis.gov.au/ndisstorefront/document/barkly-progress-report-year1.html (accessed 11 November 2016).

NDIS (National Disability Insurance Scheme) 2015, *Assistive Technology Strategy*, October, Geelong.

Neely-Barnes, S. 2005, *Consumer Choice in Developmental Disability Services: Assessing the Quality of Life Indicators*, Washington.

NHPA (National Health Performance Authority) 2012, *Performance and Accountability Framework*, Sydney.

—— 2016, *Hospital Performance: Costs of Acute Admitted Patients in Public Hospitals from 2011-12 to 2013-14*, Sydney.

NHS (UK National Health Service) 2014, *Understanding the New NHS: A Guide for Everyone Working and Training within the NHS*, London.

—— 2016, *Commissioning Cycle*, Commissioning Handbook for Librarians, http://commissioning.libraryservices.nhs.uk/commissioning-cycle#cycle (accessed 11 November 2016).

NMHC (National Mental Health Commission) 2014, *Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services*, 30 November, Sydney.

NRSCH (National Regulatory System for Community Housing Directorate) 2014, *Regulatory framework*, NRSCH.

NSW ACI (Agency for Clinical Innovation) 2014, *To Inform the Model for Palliative and End of Life Care Service Provision*, Diagnostic Report, February, Sydney, www.aci.health.nsw.gov.au/palliative-care-blueprint/need-for-change (accessed 11 November 2016).

NSW FACS (Department of Family and Community Services) 2011, *Headleasing Policy*, www.housing.nsw.gov.au/forms,-policies-and-fact-sheets/policies/headleasing-policy (accessed 11 November 2016).

—— 2014a, *Intensive Family Support - Service Provision Guidelines*, Sydney.

—— 2014b, *Social Housing in NSW: A Discussion Paper for Input and Comment*, November, Sydney.

—— 2015, *What We Heard: A Summary of Feedback on the Social Housing in NSW Discussion Paper*, May, Sydney.

—— 2016a, *Future Directions for Social Housing in NSW*.

—— 2016b, *Social Housing Eligibility and Allocations Policy Supplement*, www.housingpathways.nsw.gov.au/additional-information/policies/social-housing-eligibility-and-allocations-policy-supplement (accessed 11 November 2016).

NSW Government 2016a, *Bankstown-Lidcombe Hospital Medical Gases Incident*, Interim Report, Prepared by the Chief Health Officer, Sydney.

—— 2016b, *Future Directions for Social Housing in NSW*, Sydney.

—— 2016c, *NSW Intergenerational Report 2016*, 26 May, Sydney.

NSW Ministry of Health 2014, *Public Oral Health Care in NSW*, www.health.nsw.gov.au/oralhealth/Pages/health_services.aspx (accessed 11 November 2016).

NSW OFS (Office of Finance and Services) 2015, *Market Approaches Guide*, Sydney.

NT DCF (Department of Children and Families) 2015, *Annual Report 2014-15*, Darwin.

NT Department of Health 2016, *Dental Clinics and Contacts*, Northern Territory Department of Health, www.health.nt.gov.au/Oral_Health/Dental_Clinics_and_Contacts/index.aspx (accessed 11 November 2016).

NZ PC (New Zealand Productivity Commission) 2015, *More Effective Social Services*, Final Report, September, Wellington, NZ.

NZHQSC (New Zealand Health Quality and Safety Commission) 2016, *Position Paper on the Transparency of Information Related to Health Care Interventions*, Wellington.

O'Connor, M., White, K., Kristjanson, L.J., Cousins, K. and Wilkes, L. 2010, 'The prevalence of anxiety and depression in palliative care patients with cancer in Western Australia and New South Wales', *Medical Journal of Australia*, vol. 193, no. 5, pp. S44–S47.

Ouwehand, A. and van Daalen, G. 2002, *Dutch Housing Associations: A Model for Social Housing*, OTB Research Institute for Housing, Urban and Mobility Studies, Netherlands.

Palangkaraya, A. and Yong, J. 2013, 'Effects of competition on hospital quality: An examination using hospital administrative data', *European Journal of Health Economics*, vol. 14, no. 3, pp. 415–429.

Pawson, H., Milligan, V., Liu, E., Phibbs, P. and Rowley, S. 2015, *Assessing Management Costs and Tenant Outcomes in Social Housing: Recommended Methods and Future Directions*, AHURI Final Report no. 257, Australian Housing and Urban Research Institute, Melbourne.

——, ——, Wiesel, I. and Hulse, K. 2013, *Public Housing Transfers: Past, Present and Prospective*, AHURI Final Report no. 215, Australian Housing and Urban Research Institute, Melbourne.

Pawson, H. and Watkins, D. 2007, 'Quasi-marketising access to social housing in Britain: assessing the distributional impacts', *Journal of Housing and the Built Environment*, vol. 22, pp. 149–175.

PCA (Palliative Care Australia) 2005, *A Guide to Palliative Care Service Development: A population based approach*, Canberra, http://palliativecare.org.au/wp-content/uploads/2015/05/A-guide-to-palliative-care-service-development-a-population-based-approach.pdf (accessed 11 November 2016).

—— 2015, *Patient Choice Key to a Good Death*, Media Release, 25 May, http://palliativecare.org.au/media-releases/ (accessed 11 November 2016).

PC (Productivity Commission) 2009, *Public and Private Hospitals*, Research Report, Canberra.

—— 2010, *Contribution of the Not for Profit Sector*, Research Report, Canberra.

—— 2011a, *Caring for Older Australians*, Inquiry Report, June, Canberra.

—— 2011b, *Disability Care and Support*, Inquiry Report, July, Canberra.

—— 2013, *An Ageing Australia: Preparing for the Future*, Research Paper, November, Canberra.

—— 2014, *Childcare and Early Childhood Learning*, Inquiry Report, October, Canberra.

—— 2015a, *Business Set-up, Transfer and Closure*, Inquiry Report, September, Canberra.

—— 2015b, *Housing Assistance and Employment in Australia*, Commission Research Paper, Canberra.

—— 2015c, *Housing Decisions of Older Australians*, Commission Research Paper, December, Canberra.

—— 2016a, *Migrant Intake into Australia*, Inquiry Report no. 77, April, Canberra.

—— 2016b, *Telecommunications Universal Service Obligation*, Issues Paper, June, Canberra.

PCOC (Palliative Care Outcomes Collaboration) 2016a, *National Report on Patient Outcomes in Palliative Care in Australia: July-December 2015*, Australian Health Services Research Institute, Wollongong, http://ahsri.uow.edu.au/pcoc/reports/index.html (accessed 11 November 2016).

—— 2016b, *Trends in Patient Outcomes: Palliative Care in Australia 2011-2015*, Australian Health Services Research Institute, Wollongong, http://ahsri.uow.edu.au/pcoc/reports/index.html (accessed 11 November 2016).

Philip, J. and Collins, A. 2015, 'Routine integration of palliative care: what will it take?', *Medical Journal of Australia*, vol. 203, no. 10, www.mja.com.au/comment/19594 (accessed 11 November 2016).

Propper, C. 2013, 'Competition, incentives and the English NHS', *CESifo DICE Report*, vol. 11, no. 1, pp. 16–20.

——, Burgess, S. and Green, K. 2004, 'Does competition between hospitals improve the quality of care?: Hospital death rates and the NHS internal market', *Journal of Public Economics*, vol. 88, pp. 1247–1272.

—— and Dixon, J. 2011, 'Competition between hospitals', in Mays, M., Dixon, J. and Jones, L. (eds), *Understanding New Labour's Market Reforms of the English NHS*, King's Fund, London, pp. 78–88.

PwC (PricewaterhouseCoopers) 2016a, *Australia's Social Purpose Market: Understanding Funding Flows and Exploring Implications*, April, PricewaterhouseCoopers and Centre for Social Impact.

—— 2016b, *Valuation Report 30 June 2015 Baseline Valuation*, Report for Department of Social Services, 20 September, Canberra.

Queensland DCCSDS (Department of Communities, Child Safety and Disability Services) 2016, *Annual Report 2015-16*, Brisbane.

Queensland Health 2013, *List of dental clinics*, www.health.qld.gov.au/oralhealth/services/dental_clinics.asp (accessed 11 November 2016).

—— 2015, *Torres and Cape Hospital and Health Service: Telehealth*, www.health.qld.gov.au/torres-cape/html/telehealth.asp (accessed 11 November 2016).

Rivalland, P. 2006, *Making all our Families Well*, Summary Report, November, Western Desert Nganampa Walytja Palyantjaku Tjutaku, Alice Springs.

Routledge, D. 2016, *Guidelines for Engagement with NSW Human Services Non-Government Organisations*, NSW Department of Finance, Services and Innovation, Sydney.

SA DCSI (Department for Communities and Social Inclusion) 2016, *More tenants to benefit from community housing providers*, www.dcsi.sa.gov.au/services/latest-news/media-releases-2016/more-tenants-to-benefit-from-community-housing-providers (accessed 11 November 2016).

SA Government 2013, *Housing Strategy for South Australia 2013-18*.

—— 2015, *Submission to the Child Protection Systems Royal Commission*, Adelaide.

SA Health 2016, *SA Dental Service Clinics*, www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/sa+dental+service+dental+clinics (accessed 11 November 2016).

—— nd, *Welcome to the South Australian Dental Service*, www.sahealth.sa.gov.au/ wps/wcm/connect/public+content/sa+health+internet/resources/welcome+to+the+south +australian+dental+service?contentIDR=d8699a00491785ff8bc2ff7675638bd8&useDe faultText=1&useDefaultDesc=1 (accessed 11 November 2016).

Sainio, C., Lauri, S. and Eriksson, E. 2001, 'Cancer patients' views and experiences of participation in care and decision making', *Nursing Ethics*, vol. 8, no. 2, pp. 97–113.

SCARC (Senate Community Affairs References Committee) 2012, *Palliative Care in Australia*, October, Parliament of Australia, Canberra, www.aph.gov.au/Parliamentary_ Business/Committees/Senate/Community_Affairs/Completed_inquiries/2010- 13/palliativecare/report/index (accessed 11 November 2016).

—— 2015, *Impact on Service Quality, Efficiency and Sustainability of Recent Commonwealth Community Service Tendering Processes by the Department of Social Services - Final Report*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2000, *Report on Government Services 2000*, Productivity Commission, Canberra.

—— 2010, *Report on Government Services 2010*, Productivity Commission, Canberra.

—— 2014a, *2014 Indigenous Expenditure Report*, Productivity Commission, Canberra.

—— 2014b, *Overcoming Indigenous Disadvantage: Key Indicators 2014*, Productivity Commission, Canberra.

—— 2015, *Report on Government Services 2015*, Productivity Commission, Canberra.

—— 2016a, *Overcoming Indigenous Disadvantage: Key Indicators 2016*, Productivity Commission, Canberra.

—— 2016b, *Report on Government Services 2016*, Productivity Commission, Canberra.

SCSPAH (Select Committee on Social, Public and Affordable Housing) 2014, *Social, Public and Affordable Housing*, September, New South Wales Parliament Legislative Council, Sydney.

Senate Standing Committees on Education and Employment 2015, *Getting Our Money's Worth: The Operation, Regulation and Funding of Private Vocational Education and Training (VET) Providers in Australia*, Canberra, www.aph.gov.au/Parliamentary_ Business/Committees/Senate/Education_and_Employment/vocationaled/Final_Report (accessed 11 November 2016).

SERC (Senate Economic References Committee) 2015, *Out of Reach? The Australian Housing Affordability Challenge*, Canberra.

Shelter 2014, *Priority for Council Housing*, Shelter, http://england.shelter.org.uk/ get_advice/social_housing/applying_for_social_housing/who_gets_priority (accessed 11 November 2016).

—— 2015, *Choice-Based Lettings*, Shelter, http://england.shelter.org.uk/ get_advice/social_housing/applying_for_social_housing/choice-based_lettings (accessed 11 November 2016).

Silveira, M.J., Kim, S.Y.H. and Langa, K.M. 2010, 'Advance directives and outcomes of surrogate decision making before death', *New England Journal of Medicine*, vol. 362, no. 13, pp. 1211–1218.

Skinner, J. (NSW Minister for Health) 2016, *Incorrect treatment of Southern Sydney cancer patients*, Media Release, 2 August, Sydney.

Slack-Smith, L., Lange, A., Paley, G., O'Grady, M., French, D. and Short, L. 2010, 'Oral health and access to dental care: a qualitative investigation among older people in the community', *Gerodontology*, vol. 27, no. 2, pp. 104–113.

SPRC (Social Policy Research Centre) 2005, *Coordinated and Integrated Human Service Delivery Models*, SPRC Report 1/05, January, University of New South Wales, Sydney.

St Vincent de Paul Society 2016, *What is Jim Da Silva Farm?*, www.vinnies.org.au/page/Find_Help/NSW/Housing/Jim_Da_Silva_Farm/ (accessed 11 November 2016).

Steinhauser, K., Christakis, N., Clipp, E., McNeilly, M., McIntyre, L. and Tulsky, J. 2000, 'Factors considered important at the end of life by patients, family, physicians, and other care providers', *Journal of the American Medical Association*, vol. 284, no. 19, pp. 2476–2482.

Sturgess, G. 2012, *Diversity and Contestability in the Public Service Economy*, NSW Business Chamber, www.nswbusinesschamber.com.au/Media-Centre/Resources/ Thinking-Business-Diversity-and-Contestability-in (accessed 11 November 2016).

—— 2015, *Contestability in Public Services: An Alternative to Outsourcing*, ANZSOG Research Monograph, Melbourne.

—— 2016, *Reflections on the Public Service Economy*, New South Wales Premier's ANZSOG Chair of Public Service Delivery, The Annual Lecture of the Business Services Association, London.

Swerissen, H. and Duckett, S. 2014, *Dying Well*, Grattan Institute, Melbourne, https://grattan.edu.au/report/dying-well/ (accessed 11 November 2016).

Tasmanian Audit Office 2016, *Provision of Social Housing*, Report of the Auditor General No. 8 of 2015-16, Hobart.

Tasmanian DHHS (Department of Health and Human Services) 2016, *Joined Up Project Overview*, www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/ joinedup/documents/joined_up_project_overview (accessed 11 November 2016).

—— 2016, *Oral Health Clinics*, Department of Health and Human Services, Hobart, www.dhhs.tas.gov.au/oralhealth/contact_us/oral_health_clinics (accessed 11 November 2016).

Tasmanian Government 2015, *Tasmania's Affordable Housing Strategy 2015-2025*, Hobart.

TUV (Tenants Union of Victoria) 2015, *Social Housing Supply and Demand*, Melbourne.

UK Department of Health 2016, *The NHS Choice Framework: What Choices are Available to Me in the NHS?*, London.

VAGO (Victorian Auditor General's Office) 2012, *Access to Public Housing*, Melbourne.

—— 2015, *Public Hospitals: 2014-15 Audit Snapshot*, Melbourne.

—— 2016a, *Audits in progress, Access to Public Dental Services in Victoria*, www.audit.vic.gov.au/audits_in_progress/audit_details.aspx#dental (accessed 11 November 2016).

—— 2016b, *Patient Safety in Victorian Public Hospitals*, Melbourne.

Vanderwerker, L.C., Laff, R.E., Kadan-Lottick, N.S., McColl, S. and Prigerson, H.G. 2005, 'Psychiatric disorders and mental healtCommh service use among caregivers of advanced cancer patients', *Journal of Clinical Oncology*, vol. 23, no. 28, pp. 6899–6907.

VCOSS (Victorian Council of Social Service) 2015, *Community Organisations in a Climate of Change*, May, Melbourne.

Victorian DHHS (Department of Health and Human Services) 2015, *Policy statement: Individual needs: Special housing requirements*, www.dhs.vic.gov.au/__data/assets/pdf_file/0010/972172/Policy-statement-Special-housing-requirements-February-2015_07-16.pdf (accessed 11 November 2016).

—— 2016, *Family Preservation Order - Information for Parents*, Melbourne.

Victorian DHS (Department of Human Services) 2011, *Human Services: The Case for Change*, December, Melbourne.

—— 2014, *Annual Report 2013–14*, Melbourne.

—— 2015a, *Outcomes Framework*, www.dhs.vic.gov.au/for-service-providers/for-funded-agencies/services-connect/what-is-services-connect/services-connect-outcomes-framework (accessed 11 November 2016).

—— 2015b, *What is Services Connect*, www.dhs.vic.gov.au/for-service-providers/for-funded-agencies/services-connect/what-is-services-connect (accessed 11 November 2016).

WA CPFS (Department for Child Protection and Family Support) 2016, *Building a Better Future: Out-of-Home Care Reform in Western Australia*, Perth.

WA DHS (Dental Health Services) nd, *Dental Health Services: General Dental Care for Adults*, www.dental.wa.gov.au/adult/general.php (accessed 11 November 2016).

—— 2016, *Information Statement, Dental Health Services*, www.dental.wa.gov.au/about/DHS%20Information%20Statement%202016.pdf (accessed 11 November 2016).

WA DPC (Department of Premier and Cabinet) 2014, *Location Based Expenditure Review 2014*, Perth, www.daa.wa.gov.au/accountable-government/expenditure-reviews/ (accessed 11 November 2016).

WA Government 2011, *Delivering Community Services in Partnership Policy*, Perth.

WA Housing Authority 2010, *Affordable Housing Strategy 2010-2020 - Housing Authority*.

—— 2016a, *Social Housing Investment Package*, www.housing.wa.gov.au/investorsandpartners/socialhousinginvestmentpackage/Pages/default.aspx (accessed 11 November 2016).

—— 2016b, *Kununurra and Halls Creek Transitional Housing*, www.housing.wa.gov.au/housingoptions/homeownershipoptions/transitionalhousing/Pages/Kununurra-Halls-Creek-Transitional-Housing.aspx (accessed 11 November 2016).

WA RSRU (WA Regional Services Reform Unit) 2016, *Resilient Families, Strong Communities: A Roadmap for Regional and Remote Aboriginal Communities*, July, p. 10.

Wareing, T. 2013, '5 trends driving the future of human services', *Government Technology*, 1 April, www.govtech.com/health/5-Trends-Driving-the-Future-of-Human-Services.html (accessed 11 November 2016).

Wenk, R. 2015, 'Palliative home care', in Bruera, E., Higginson, I., von Gunten, C. and Morita, T. (eds), *Textbook of Palliative Medicine and Supportive Care*, Second edition, CRC Press, United States.

White, B., Tilse, C., Wilson, J., Rosenman, L., Strub, T., Feeney, R. and Silvester, W. 2014, 'Prevalence and predictors of advance directives in Australia', *Internal Medicine Journal*, vol. 44, no. 10, pp. 975–980.

Wiesel, I., Easthope, H. and Liu, E. 2011, *Pathways and Choice in a Diversifying Social Housing System*, AHURI Final Report no. 137, March, Australian Housing and Urban Research Institute, Melbourne.

——, ——, Judd, B. and Hunter, E. 2004, *Pathways Into and Within Social Housing*, AHURI Final Report no. 186, May, Australian Housing and Urban Research Institute, Melbourne.

Willmott, L., White, B., Gallois, C., Parker, M., Graves, N., Winch, S., Callaway, L.K., Shepherd, N. and Close, E. 2016, 'Reasons doctors provide futile treatment at the end of life: a qualitative study', *Journal of Medical Ethics*, http://jme.bmj.com/content/early/2016/05/17/medethics-2016-103370 (accessed 11 November 2016).

Woodman, C., Baillie, J. and Sivell, S. 2015, 'The preferences and perspectives of family caregivers towards place of care for their relatives at the end-of-life. A systematic review and thematic synthesis of the qualitative evidence', *BMJ Supportive & Palliative Care*, http://spcare.bmj.com/content/early/2015/05/19/bmjspcare-2014-000794 (accessed 11 November 2016).