Australian Government
Productivity Commission

Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services

Productivity Commission Draft Report

June 2017

This is a draft report prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

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The Productivity Commission

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

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

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

Opportunity for further comment

You are invited to examine this draft report and comment on it by written submission to the Productivity Commission, preferably in electronic format, by **Friday 14 July 2017** and/or by attending a public hearing. Further information on how to provide a submission is included on the inquiry website www.pc.gov.au/inquiries/current/human-services/make-submission.

The final report will be prepared after further submissions have been received and roundtables and public hearings have been held, and will be submitted to the Australian Government in October 2017.

Public hearing dates and venues

Location	*Date*	*Venue*
Sydney	Monday 24 July	Adina Apartment Hotel, Surry Hills, 359 Crown St, Surry Hills
Canberra	Tuesday 25 July	Productivity Commission, Level 2, 4 National Cct, Barton
Melbourne	Thursday 27 July	Productivity Commission, Level 12, 530 Collins St, Melbourne
Perth	Monday 31 July	Mantra on Murray, 305 Murray St, Perth

Please note, public hearings may be held in other locations if needed, and you may also participate via teleconference. Please visit the inquiry website www.pc.gov.au/inquiries/current/human-services to register your interest in participating in a public hearing.

Commissioners

For the purposes of this inquiry and draft report, in accordance with section 40 of the *Productivity Commission Act 1998* (Cwlth) the powers of the Productivity Commission have been exercised by:

Stephen King	Commissioner
Richard Spencer	Commissioner

The Commission has been assisted in this inquiry by Sean Innis, as 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]

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Abbreviations

AACQA	Australian Aged Care Quality Agency
ACCC	Australian Competition and Consumer Commission
ACFI	Aged Care Funding Instrument
ACP	Advance care plan
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
CDA	Community Dental Agency
CDBS	Child Dental Benefits Schedule
CDDS	Chronic Disease Dental Scheme
COAG	Council of Australian Governments
CPI	Consumer price index
CRA	Commonwealth Rent Assistance
DEX	Data Exchange Framework
DHSV	Dental Health Services Victoria
DSS	Department of Social Services
FACS	NSW Department of Family and Community Services
GP	General practitioner
IAS	Indigenous Advancement Strategy
ICU	Intensive care unit
IHPA	Independent Hospital Pricing Authority
IPART	NSW Independent Pricing and Regulatory Tribunal
LASA	Leading Age Services Australia
MHR	My Health Record
MRI	Magnetic resonance imaging
MUCHE	Macquarie University Centre for the Health Economy
NCOSS	NSW Council of Social Services
NDIS	National Disability Insurance Scheme

NEP	National Efficient Price
NFP	Not-for-profit
NHPF	National Health Performance Framework
NHS	Nation Health Service
NPA RSD	National Partnership Agreement on Remote Service Delivery
NRSCH	National Regulatory System for Community Housing
NSQHS	National Safety and Quality Health Service
NSW FHA	NSW Federation of Housing Associations
NYSCSRS	New York State Cardiac Surgery Reporting System
PAF	Performance and Accountability Framework
PHN	Primary Health Network
POA	Patient Opinion Australia
PROM	Patient-reported outcome measure
RACF	Residential aged care facility
RACP	Royal Australasian College of Physicians

OVERVIEW

Key points

- This inquiry is about finding ways to put the people who use human services, such as health care, social housing and family and community services, at the heart of service provision. This matters because everyone will use human services in their lifetime and change is needed to enable people to have a stronger voice in shaping the services they receive, and who provides them.
- Competition and contestability are means to an end and should only be pursued when they improve the effectiveness of service provision.
  - This report sets out the Commission's proposed reforms for: end-of-life care services; social housing; government-commissioned family and community services; services in remote Indigenous communities; public hospitals; and public dental services.
  - The Commission's proposed reforms vary according to the purposes of the services in question, the settings where they are accessed and, importantly, the users themselves.
- Each year, tens of thousands of people who are approaching the end of life are cared for and die in a place that does not reflect their choice or fully meet their **end-of-life care** needs. Most people who die do so in two of the least preferred places — hospitals and residential aged care.
  - More community-based palliative care services are needed to enable more people who wish to die at home to do so.
  - End-of-life care in residential aged care needs to be better resourced and delivered by skilled staff, so that its quality aligns with that available to other Australians.
- The **social housing** system is broken. The current two-tiered system of financial assistance for people who live in social housing or the private rental market is inequitable, and limits tenants' choice over the home they live in. The system would be improved if a single model of financial assistance applied across social and private housing, based on an increase and extension to Commonwealth Rent Assistance.
  - Social housing should continue to provide a home for people who are not well placed to rent in the private market.
- **Family and community services** are not meeting the needs of people experiencing hardship. The system is designed for the convenience of governments, not people. Practical changes to system planning, provider selection and contract management could shift the focus to improving outcomes for people who use these services.
- Human services are not making the contribution they should be to improving the wellbeing of **Indigenous people living in remote communities**. Increasing contract lengths for service providers, developing better planning, evaluation and feedback systems, and improving processes for selecting and managing service providers would contribute to improving outcomes for Indigenous people living in remote communities.
- **Public hospital** patients should be given greater control over the pathway leading to planned admissions. This requires removing barriers to patients choosing the outpatient clinic or specialist they initially attend when given a referral by their general practitioner. Improved public reporting on individual hospitals and specialists would support greater user choice and encourage performance improvements in hospitals.
- **Public dental** patients have little choice in who provides their care, when and where, and most services are focused on urgent needs. Patients' choice and outcomes could be improved by a new payment and care model, with a focus on preventive treatments.

Overview

1 What this inquiry is about

This inquiry is about finding ways to put the people who use human services, such as health care, social housing and family and community services, at the heart of service provision. This matters because everyone will access human services in their lifetime and change is needed to enable and support people and their families to have a stronger voice in shaping the services they receive, and who provides them.

Human services are essential for the wellbeing of individuals and their families, and underpin economic and social participation. Ensuring that everyone, regardless of their means or circumstances, has access to a minimum level of high-quality human services promotes equity and social cohesion, which in turn contributes to the welfare of the community as a whole.

Public and private expenditure on human services is significant — over $300 billion in 2014-15 — with demand for services projected to grow as more people live longer, incomes grow and technological advances increase the types of services that can improve a person's quality of life. The number of services provided each year in Australia is considerable — for example, there were more than 10 million admissions to public and private hospitals in 2015. Other services, such as homelessness services and social housing, are each used by hundreds of thousands of people every year.

The Commission has been asked by the Australian Government to recommend reforms to improve the effectiveness of human services using the policy 'tools' set out in the inquiry terms of reference — the introduction of greater user choice, competition and contestability. The Commission's study report identified six services where these tools could put users at the centre of service provision. The six services that were identified are end-of-life care services; social housing; government-commissioned family and community services; services in remote Indigenous communities; public hospitals; and public dental services. This draft report seeks feedback from inquiry participants on reform proposals for these six services. Details about how to participate in this inquiry are in box 1.

Box 1 **How can you participate in this inquiry?**

This inquiry has been conducted in two stages. A study report completing the first stage of the inquiry was released by the Commission in December 2016. The study report sets out the Commission's reasoning for identifying the six services that are best suited to reforms to introduce greater user choice, competition or contestability: end-of-life care services; social housing; government-commissioned family and community services; services in remote Indigenous communities; public hospitals; and public dental services.

This is the draft report for the second stage of the inquiry. This report presents the Commission's draft recommendations for each of the six services, and seeks feedback from participants to inform its final report.

Participants are invited to provide written submissions to respond to this draft report. Submissions are due by 14 July 2017. The Commission will hold public hearings in Canberra, Melbourne, Sydney and Perth in July and August, and encourages parties to register their interest to participate. Details of how to prepare a submission and to register for public hearings are included at the front of this report and on the Commission's website at www.pc.gov.au/inquiries/current/human-services. The Commission will hold roundtables and consultations in several locations, including outside major capital cities.

The final inquiry report will be provided to the Australian Government in late October 2017.

Details of the consultation process leading to this draft report can be found in appendix A. The Commission thanks all those who have participated in this inquiry.

2 Government involvement in human services

Governments have several roles in markets for human services. Governments are the primary funder of most human services and play a major role in determining who has access to a service and who does not. There are sound efficiency and equity reasons for this. Markets left to their own devices would not deliver the appropriate level, or distribution, of human services across the community. Governments' approach to filling these gaps can take a number of forms including funding universal access to a service, as is the case for emergency health care, and fully or partly covering the cost of a service to targeted groups in the community, as is the case for public dental services. Governments also choose whether to provide services directly (as is the case for the management of public housing tenancies) or contract out to other providers.

Governments will (or should) always have the role of system stewards. This role incorporates a range of functions that help to ensure service provision is effective at meeting its objectives, including policy design, regulation, oversight of service delivery, monitoring of provider performance, and developing ways for the system to learn and continuously improve. Stewardship arrangements are difficult to get right — the design and performance of these functions should be tailored to each service, and to the settings in which it is delivered. Stewardship is a core part of the reform and delivery process and the

Commission's work on this inquiry has highlighted areas where governments need to improve.

- *Greater coordination*: Coordination problems can arise between governments, agencies and providers when, for example, services are funded by more than one level of government, or when services delivered by one provider duplicate or detract from another's. In some cases, policy is developed in government silos which can lead to competing objectives, and stewards losing sight of the users' overall wellbeing.
- *More transparency*: The provision of information to improve accountability and facilitate performance assessment can benefit all parties within the human services system. Without it, users are unable to assess providers, providers are unable to plan their services, and governments cannot effectively evaluate how providers or systems are performing.
- *Smoother transitions*: Policy reform in human services is a complex and delicate task. Reforms can be large, costly and disruptive to users and providers, take considerable time to fully implement, and affect the lives of many (sometimes vulnerable) users. Better planning and preparation for change should aim to preserve continuity of outcomes and minimise any negative effects on users from the transition. Transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Information and clarity about changes in advance can help.

Some inquiry participants have argued that for-profit providers should not be allowed to supply human services. The Commission disagrees. Human services are currently provided by a mix of government, not-for-profit and for-profit organisations. Experience suggests that no one type of provider has a monopoly over good service provision and each has had their share of successes and failures.

Governments need to focus on the capabilities and attributes of service providers when designing service arrangements and selecting providers — not simply the form of an organisation. Governments, as stewards, need to ensure that all providers meet minimum standards and have incentives that align with users' and governments' objectives.

3 Introducing greater user choice, competition and contestability

Informed user choice

There are different types of choice that users could make in markets for human services: which provider; which service; and where, when and how that service is delivered. Some of these choices will be dependent (only certain types of providers can offer a specific service), and some will not be feasible for an individual user (a person with late-stage dementia, for example, may not be well-placed to choose a medical specialist). The type of choice on offer

is important because the net benefits of introducing greater choice differ according to which type of choice is being considered and for whom.

The Commission's starting point is that users should have choice over the human services they access and who provides them, unless there are clear reasons why not. These reasons could include a lack of capacity to exercise informed choice and the inability of an agent to do so on a user's behalf, or when there is a need for decisions to be taken quickly in a crisis (such as a medical emergency).

In a well-designed and managed market, informed choice can improve outcomes for users because it:

- has intrinsic value by empowering people to have greater control over their lives
- enables people to make decisions that best meet their needs and preferences
- can generate powerful incentives for providers to be more responsive to users' needs and can drive innovation and efficiencies in service delivery.

A common theme in submissions is that people have a strong desire to have choice, and the empowerment that comes with it. In its submission to this inquiry, Alzheimer's Australia stated:

> Alzheimer's Australia is strongly supportive of the principle of user choice in human services. For people living with dementia, their families and carers, having a say in their everyday lives is a basic desire and underpins a sense of purpose and wellbeing. Many people living with dementia have expressed a desire to feel that they are participating in decision making regarding their care but also recognise that their ability to do so can be impacted by their diagnosis: capacity to make informed decisions may change from day to day or may decline rapidly.

Not everyone shares this view. Some participants in this inquiry did not consider that user choice should be increased, pointing out that recipients of human services may not possess full knowledge of their preferences, have the capacity to act on their preferences, or have access to information that is necessary to make decisions.

The Commission recognises that there are circumstances where user choice is not appropriate, but the onus should be on those seeking to remove choice to justify why. If not the user, someone — the government or the provider — will be making a choice as to which services a person should receive and who should provide them. Even when user choice is not appropriate, a focus on users can be achieved through other approaches, such as increasing 'user voice' and co-design so a person's (or community's) preferences are taken into account when others make decisions on their behalf.

Putting the focus on users though greater competition and contestability

Competition and contestability are means to an end — improving the effectiveness of service provision — rather than ends in themselves. In the right circumstances, competition provides

powerful incentives to deliver more effective services. When competition between multiple service providers is not possible or desirable, contestability, by mimicking competitive pressures, can deliver many of the same benefits as competition. Contestable arrangements for provider selection are used widely in the context of commissioning — an increasingly common approach that governments use when engaging organisations to deliver human services.

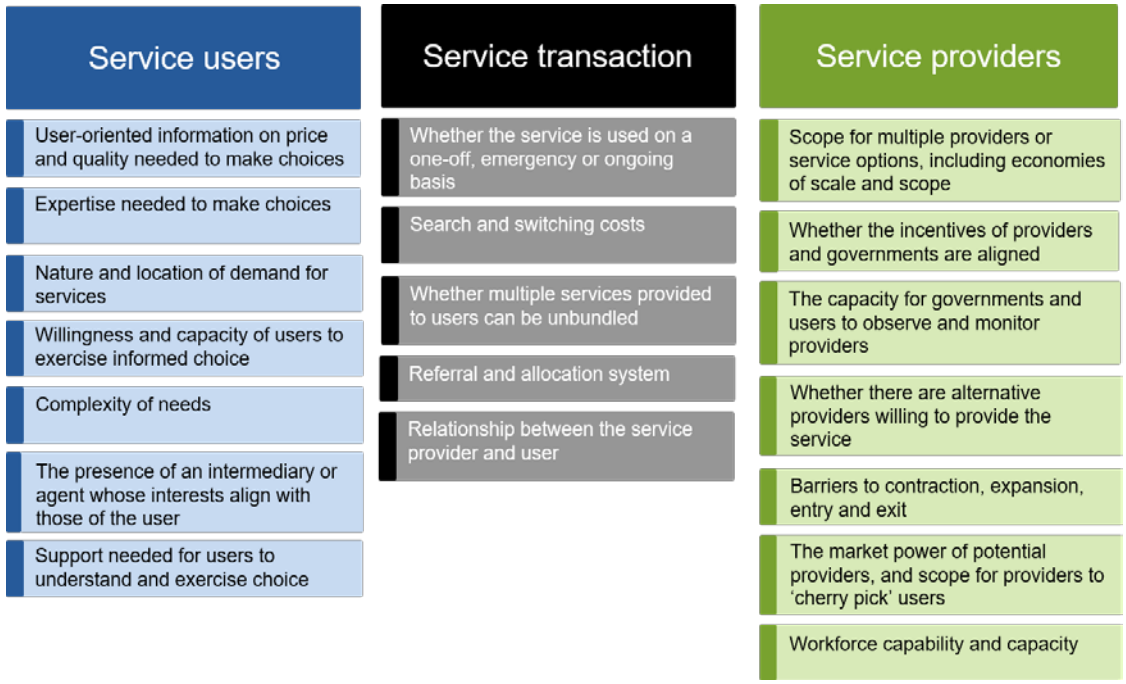
As with user choice, several participants in this inquiry questioned whether competition should have a place in the provision of human services. Some were sweeping in their rejection. Anglicare Australia, for example, in its submission did not accept that competition is a driver of efficiency; that efficiency is an inherently good thing in human services; that the innovation that comes with competition between providers is of benefit to service users; or that it is appropriate to equate individual consumer choice with agency and wellbeing. Others were more specific, describing the harmful effects of competition and contestability, including providers focusing on writing tender applications at the expense of their core business, and competition damaging the collaboration between providers needed to drive positive outcomes for users with multiple and complex needs.

Unlocking the potential benefits of competition or contestability in human services markets requires careful stewardship from governments and there are instances where neither competition nor contestability are appropriate. In considering the potential role of competition and contestability, the Commission has carefully examined the characteristics of each of the six services in this inquiry to assess whether: the likely benefits to the community of its proposed reforms would be expected to outweigh the costs; the incentives of providers and users would be aligned; and government objectives would be achieved.

4 The Commission's approach to assessing reforms

A key aspect of the Commission's approach is identifying the characteristics of service users, transactions and providers, how these characteristics affect the incentives of users and providers, and ultimately the potential costs and benefits of reform (figure 1). These characteristics affect not only how the proposed reforms would influence the effectiveness of service delivery, but also what stewardship arrangements would need to be put in place to support the reform. Each of the services the Commission has proposed for reform is different — there is diversity in the type and number of users, their capacity and willingness to make choices, the setting and circumstances under which services are provided, and the financial contribution made by users and governments. This makes the policy design task in each of these services unique.

Figure 1 **Characteristics that influence the effectiveness of service provision**



In its analysis, the Commission has assessed the *attributes* of effective service delivery:

- *Quality:* Whether the reform options would lead to incentives for providers to offer high-quality services to users
- *Equity:* Who would be affected by the reform options and how they would be affected
- *Efficiency:* Whether the reform options would lead to incentives for providers to reduce the costs of providing services while still maintaining quality, and for users to select the services that best meet their needs
- *Accountability* and *responsiveness:* Whether the reform options would result in service providers being more responsive to the needs of service users and more accountable to those who fund the services (taxpayers and users).

The proposed reforms to introduce greater user choice, competition or contestability would affect the attributes of effectiveness in different ways and, in some cases, negatively. Some reforms may lead to large increases in quality, with minimal effects on the other attributes. Some may lead to increases in the attributes across the board. The potential costs and benefits of reform will also fall unequally across the community. Recognising these trade-offs, the Commission's overarching objective in assessing policy recommendations is to improve the welfare of the community as a whole.

Delivering more effective human services may involve additional costs for governments, especially in the early years of implementation. In some cases this may be somewhat offset

by reduced spending over time. More effective end-of-life care and public dental services could, for example, reduce demand for some hospital services. These fiscal effects will not fall evenly across levels of government, with spending by one level potentially resulting in reductions in spending by others. On the basis of the available information, the Commission considers that the benefits of its draft recommendations, including improved service outcomes for users, would outweigh the fiscal (and other) costs. Governments should not allow the unequal distribution of these fiscal effects to become a barrier to reform.

The Australian, Territory and some State Governments have committed to working collaboratively to develop funding agreements for priority areas, such as the delivery of human services, through an intergovernmental agreement on competition and productivity-enhancing reforms. This agreement, which includes a commitment by the Commonwealth to provide incentive payments to participating State and Territory Governments, could help to provide much-needed impetus for reform.

5 Caring for people at the end of life

Too many people approaching the end of life miss out on quality end-of-life care. The availability of services is variable and few of those who would prefer to die at home are able to do so. Improving access to high-quality end-of-life care could play a major role in enhancing community welfare, by ensuring people have more choice about how they are cared for and where they die.

Between 80 000 and 140 000 of the 160 000 people who die each year in Australia would benefit from high-quality 'end-of-life care' — physical, spiritual and psychosocial services provided by health professionals and ancillary staff to people who are likely to die within the next 12 months.[1]

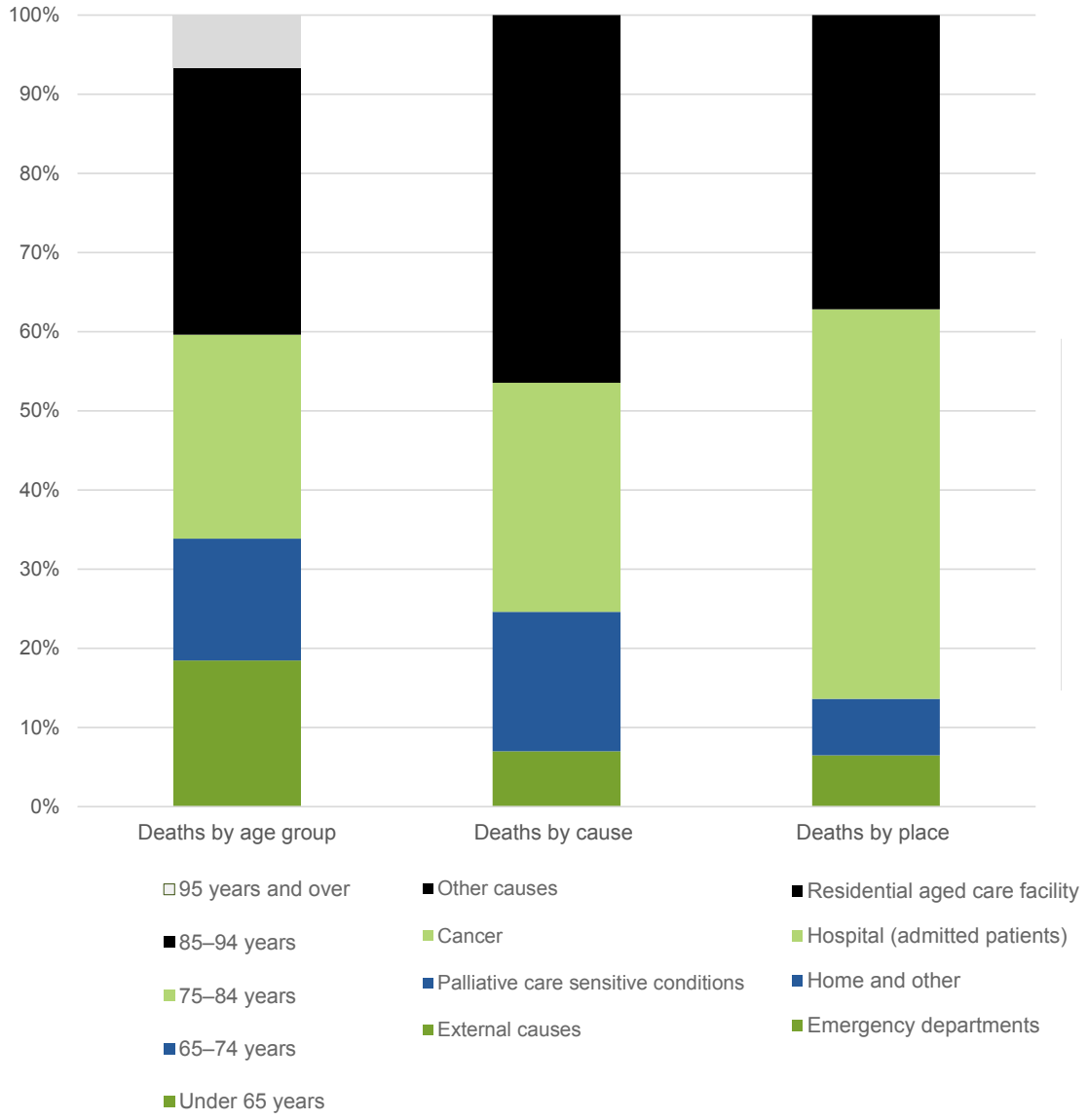
A comprehensive approach to end-of-life care recognises that the patient and clinicians are both essential participants in discussions and decision-making about care needs at the end of life. This shifts the emphasis of care delivery from life extension toward care that attempts to fulfil each patient's choices, values and preferences, given the realities of the patient's clinical condition and treatment options.

There are significant gaps in information about the provision of end-of-life care in Australia. What is known is that:

- the quality, availability and affordability of end-of-life care in Australia are among the world's best, but only a small proportion of those who die each year receive such care
- more than 80 000 people die in hospitals each year and about 60 000 die in residential aged care (figure 2) — two of the least preferred places to die

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

Figure 2 **Age, location and cause of death in Australia, 2015**



- people approaching the end of life in hospitals can find it hard to access care that is responsive to their preferences, and sometimes receive medical interventions that are not beneficial to them. This has an adverse effect on their quality of life
- about 70 per cent of Australians would prefer to die at home but few are able to do so. The number of people wishing to die at home with the support of a community-based palliative care service far exceeds the availability of that care, particularly for those with illnesses other than cancer. For many, access to community-based palliative care is determined by where they live, rather than where they would prefer to die
- four out of five residents of aged care facilities die in them but the lack of palliative care expertise and qualified staff to administer pain relief mean residents often make traumatic (and costly) trips to hospital to receive medical care that could have been provided in

surroundings that are familiar to them. Some aged care residents die in unnecessary pain causing distress to themselves and the people who care for them.

Without significant policy reform, tens of thousands of people will die in a way, and in a place, that does not reflect their values or their choices. Their end-of-life journey will likely be punctuated with avoidable, or unwanted, admissions to hospital with the confusion, loss of dignity and loss of control that comes with it. This is not acceptable.

Reforms to better align care at the end of life with user preferences should be a high priority for governments. Reform is needed now to ensure that the growing number of people needing end-of-life care are able to receive services that better match their preferences.

Few people can access community-based palliative care

Tens of thousands of the people who die each year have a medical condition that would be amenable to palliative care, prefer to die at home, and have family and friends who are able to provide the considerable support needed to remain in their homes as they approach the end of life. But they cannot access the community-based palliative care that would enable them to be cared for and to die at home. Addressing this gap will require State and Territory Governments to **substantially increase the availability of community-based palliative care**. This expansion will require careful planning and stewardship. Systems will be needed to assess demand, commission services and ensure consumers receive consistent high-quality care with appropriate protections. While governments should consider options for offering choice of provider, the first priority should be on better meeting demand.

The Commission's proposed approach would require governments to assess the needs of different regions and populations, and to determine priorities for service expansion. Once current gaps in service provision are better understood, State and Territory Governments should determine the appropriate approach to addressing those gaps. In most places, this would be to run competitive processes to select providers of additional community-based palliative care services. The providers selected to deliver community-based palliative care services should be able to achieve integrated and coordinated nursing, medical and personal care, and provide access to care and support 24 hours a day, seven days a week.

Approaching the market to provide additional community-based palliative care services would not require any changes to existing service arrangements — governments could choose to leave current services in place while adding to the service offering.

While data on the costs of care at the end of life are scarce, community-based care can cost less to provide than hospital-based care, and so care that better aligns with patients' preferences may be delivered at lower overall cost to governments than the current model. Ultimately, though, potential longer-term savings should not be the primary driver of reforms to increase access to community-based palliative care services.

Residential aged care is ill equipped to meet end-of-life care needs

End-of-life care should be core business for residential aged care facilities but the quality of end-of-life care in residential aged care remains patchy. There is also a disconnect between the way in which the health system considers, or aims to consider, end-of-life care (the last 12 months of life) and definitions used in the aged care system (where intensive nursing and other end-of-life care services are only funded in the last week or days of life).

People living in an aged care facility should receive end-of-life care that aligns with the quality of care available to other Australians. To achieve this, two main reforms are needed.

First, addressing concerns about the quality of end-of-life care in residential aged care facilities will require providing greater access to services delivered by clinically qualified staff. As it stands, **aged care facilities need more staff with the skills to lead and coordinate end-of-life care for residents**. There are many possible staffing and contracting arrangements that could increase end-of-life care skills in aged care. For example, residential aged care facilities could purchase services from community-based palliative care providers or employ additional skilled staff themselves, such as nurses or end-of-life care nurse practitioners. Regardless of the model used, it is essential that people living in residential aged care facilities receive more care from trained staff, who can prepare advance care plans, administer pain medications, effectively coordinate care and train other (largely unqualified) aged care staff in relevant end-of-life care skills. Unavoidably, additional funding from the Australian Government would be required for these arrangements. The Australian Government will also need to ensure that consumers are appropriately protected, including through quality standards.

Second, consumers and their families need more **information to help them select aged care facilities** that deliver high quality end-of-life care. A good first step would be for the Australian Government to ensure that all of its aged care publications — both for consumers and for policy makers — explicitly acknowledge that one of the roles of residential aged care is to provide end-of-life care.

Other measures to deliver better end-of-life care

Ensuring that care is aligned to people's preferences is critical to the effectiveness of end-of-life care. Not everyone will be capable of communicating their preferences at the time they receive care. To ensure a real choice people will often need to communicate their wishes ahead of time using an advance care plan (ACP). ACPs can include anything from a formal directive to a simple values statement, and have been shown to improve end-of-life experiences for patients, families and clinicians. Yet, despite efforts to promote advance care planning, less than 15 per cent of Australians have an ACP. People who could be more likely to need an ACP, such as those aged over 65 years, are not more likely to have one. Reforms are needed to **increase the rate and quality of advance care planning**. Primary care providers and residential aged care facilities are well placed to promote advance care planning and to facilitate the ongoing conversations that it requires. This will require training

and supporting clinicians to hold advance care planning conversations and improving access to plans once they are made, including through electronic health records.

End-of-life care in acute hospitals will improve when hospitals implement a range of new practices to identify, and deliver higher quality care to, patients approaching the end of life. This includes an updated version of the National Safety and Quality Health Service (hospital accreditation) Standards, which will commence in 2019 and contain new end-of-life care standards. Provided clinical governance systems include end-of-life life care, and hospital clinicians are trained to engage patients (and their families and carers) in shared decision making, the new standards will help to ensure that patients are encouraged and supported to express their preferences about end-of-life care, and receive care that is responsive to those preferences.

6 Social housing

Australia's social housing system is broken. It is inequitable, with people in similar circumstances receiving vastly different levels of support, and offers little choice of home for tenants. Over 150 000 households are waiting to enter social housing and, at any time, the number of households eligible for social housing substantially exceeds the availability of properties. Reform is needed to place users at the centre of the system.

Social housing provides a safety net for people experiencing homelessness, or who face high barriers, including financial barriers, to sustaining tenancy in the private rental market. It is part of the broader housing assistance system in Australia. The social housing system covers the allocation of tenants to properties, the ownership and management of properties, and the provision of financial assistance to tenants.

The circumstances and needs of people eligible for social housing vary significantly (box 2). Many households that satisfy the income eligibility criteria for social housing live in private housing. One estimate puts this number at 465 000 households, while another estimate puts the number at about 900 000 households. Some of these households are facing 'rental stress' in the private market and seek to enter social housing to reduce the cost of housing to a more affordable level. People can enter social housing because private market landlords are reluctant to rent to them, or because they value the stability offered by greater security of tenure. Increasingly, social housing has focused on people who have difficulty finding and maintaining a tenancy for reasons other than affordability. These people often draw on support services, such as treatment for mental health conditions, to help them maintain their tenancy.

Box 2 A two-tiered system of financial assistance

Currently, two models of financial assistance are potentially available to tenants with low incomes — assistance received by tenants in social housing who have their rent set at a proportion of their income, and the provision of Commonwealth Rent Assistance (CRA) to tenants currently renting in the private market. The type of assistance a household is eligible for depends on the tenure of the housing they live in.

Social housing

There are two main types of social housing in Australia, both of which are rationed using (what are often very long) waiting lists.

- **Public housing** — properties managed by State and Territory Government housing authorities, such as Housing SA or Housing NSW.
- **Community housing** — properties managed (and, in some cases, owned) by non-government providers.

Tenants in social housing properties pay rent that is set as a proportion of their income (typically 25 per cent), or at the estimated market rent, whichever is lower. Tenants living in community housing can also receive CRA but this assistance is generally passed straight through to the housing provider. Public housing tenants are not eligible for CRA.

Many people in the private rental market who receive CRA would also be eligible to apply for social housing.

Commonwealth Rent Assistance

A household renting in the private rental market or in community housing is eligible for CRA if they pay more than a minimum rent threshold, and are receiving a qualifying social security payment (such as Newstart Allowance, Youth Allowance and the Age Pension).

CRA is payable at the rate of 75 cents for every dollar of rent above the rent threshold, up to a maximum amount. The rent thresholds and maximum amount vary depending on household characteristics, such as the number of children they have, and are increased with the consumer price index.

The two models of assistance lead to a two-tiered system of financial assistance. This means that tenants in social and private housing can receive vastly different levels of financial assistance, even though their circumstances are similar, except for the tenure of their housing. The Commission estimates that households in public housing in Victoria, for example, on average receive about $50 per week more in financial assistance than if they received CRA.

The Commission identified social housing as a priority sector for reform because:

- the current system of financial assistance is inequitable. People on the same income and with the same characteristics, such as size of the household, can receive vastly different rates of assistance, both *within* social housing and *between* social housing and private rentals. There is a strong financial disincentive for many eligible tenants to move from social housing to the private rental market
- people have little choice over the home in which they live, which limits incentives for housing providers to respond to tenant preferences, and has flow on effects on the quality

of housing and the efficiency of the system. Empowering a tenant to choose a home can lead to tenants being more likely to be satisfied with the property they receive, and having greater engagement with the broader community. Choice of home can have flow on effects to other aspects of the tenant's life — they can locate closer to employment opportunities and to any support services they need.

The current system of social housing is failing those in housing need. There are people in the community who wait 10 years or more to access the financial support and security of tenure offered by social housing. About 400 000 families live in social housing but many have little incentive to exit and, in some cases, there is a considerable financial disincentive to do so. The two-tiered system of housing assistance drives decisions about where people choose to live, rather than the needs of the users themselves.

The Commission's proposed reforms (figure 3) seek to put users at the centre of service provision by:

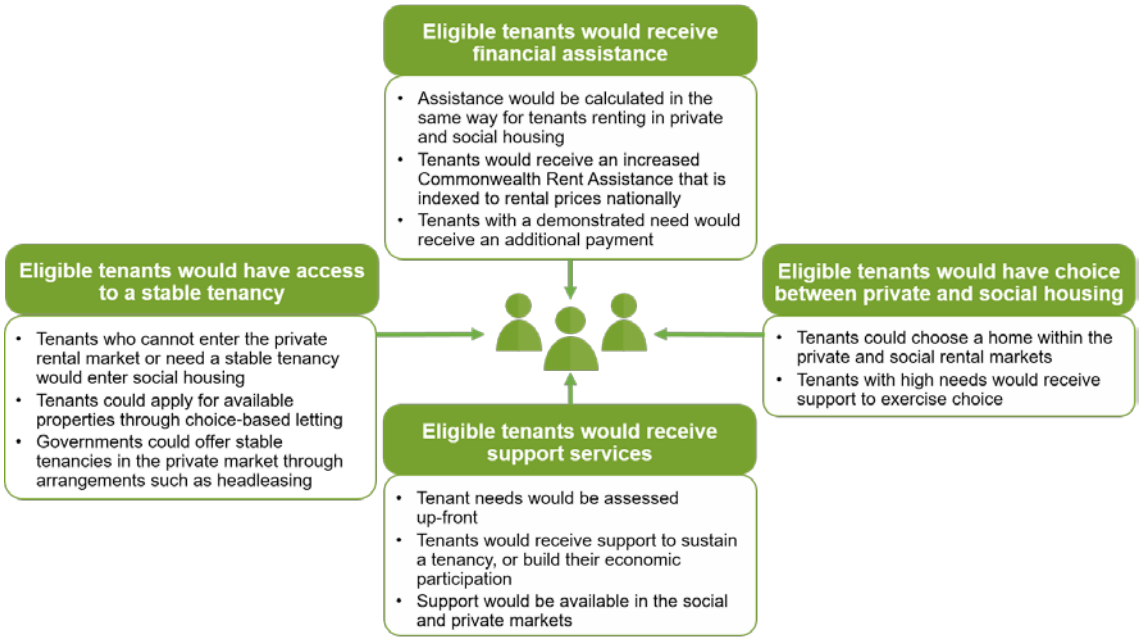
- moving to a **single model of financial assistance** for eligible households that is based on their circumstances, rather than whether they rent social or private housing
- improving the incentives, and the opportunity, for them to access the private rental market because their financial assistance would be calculated the same way for both social and private housing
- ensuring they have **access to tenancy support services** whether they choose to live in social housing or the private rental market
- focusing the social housing system on those who are not well placed to enter the private rental market.

Unlocking user choice through a single model of financial assistance

People eligible for social housing should have genuine choice over where they live, including the choice to rent in the private market, but whether they live in social or private housing should *not* determine the level of financial assistance they receive. A model where the level of assistance the government provides is based on a proportion of the rent the tenant pays, as is the case for Commonwealth Rent Assistance (CRA), is the Commission's preferred mechanism. This model retains incentives for tenants to select a home that meets their requirements because they will pay some of the costs if they elect to rent a more expensive property. This is not the case when the rent a tenant pays is set as a proportion of their income, as is currently the case in social housing. The Commission is proposing that CRA should be extended to cover tenants in public housing (those in community housing already receive CRA), combined with a move to market rents for tenants in social housing.

A single model of financial assistance based on CRA would not, of itself, address the disincentives and inequities in the social housing system. More would need to be done.

Figure 3 **Proposed reforms to improve outcomes for users of social housing**



The need to address affordability concerns

Using Victoria as a case study, the Commission found the implicit subsidy received by social housing tenants is about, on average, $2500 per household each year higher than they would receive under CRA. A shift to rent payments that were based on market rates would address the inequity between private and social housing tenants, but would lead to affordability concerns for some social housing tenants. Three reform actions should be implemented together to help address these concerns.

- Conditions for current social housing tenants should be protected by allowing them to continue to pay rents set at a proportion of their income for an extended period of time.
- **CRA should be increased**. The relative value of CRA has fallen, because average rents have risen faster than CRA since 2007. To address this gap, the maximum CRA payment should be increased by about 15 per cent, and indexed to reflect changes in rental prices nationally.
- State and Territory Governments should **provide an additional payment for tenants with a demonstrated need** for additional assistance. Eligibility for, and the level of, this 'high-cost housing payment' would be a matter for State and Territory Governments but could include assistance for those who need to live in high-cost areas for work or other reasons. This payment could be delivered to the tenant as a top-up to CRA. Eligible tenants living in either private or social housing should be able to receive the payment.

These proposed reforms would result in a transfer of fiscal costs between the Australian, State and Territory Governments. The Australian Government would see an increase in its expenditure on CRA. State and Territory Governments would receive increased rental payments from public housing which may be offset by expenditure on the high-cost housing payment.

Reforms to improve the effectiveness of the social housing system need to be seen in the context of the housing market as a whole. If implemented, the Commission's draft recommendations would increase the opportunity for people who are eligible for housing assistance to access the private rental market. Governments have policy initiatives underway to improve rental affordability in the private market and to reform rental tenancy rights. Longer tenure for private properties would be particularly valuable for those who are currently seeking social housing. The Australian Government announced in its 2017-18 Budget that it will work with State and Territory Governments to standardise the use of long-term leases, and also announced measures to facilitate access to lower-cost finance for the community housing sector. If well-designed and implemented, these initiatives would be expected to increase the net benefits of the Commission's proposed reforms.

Improving the effectiveness of social housing

Reform of financial assistance would take some pressure off the social housing system. Those eligible for social housing would be able to choose whether to enter social housing (via a waiting list) or use their financial assistance in the private rental market. The Commission has outlined several draft recommendations to further improve the effectiveness of social housing, including:

- enabling and supporting social housing tenants to have more choice over their home
- improving available data on the efficiency of social housing and tenant outcomes
- improving information available to tenants, such as information on waiting times for social housing properties and on provider performance
- using contestable processes to select housing providers that are best-placed to improve outcomes for tenants.

7 Family and community services

Current approaches to commissioning family and community services are not delivering the benefits they should. Poorly designed contracting and contestability arrangements are hindering the ability of providers to deliver outcomes for users. The characteristics of family and community services do not lend themselves to the introduction of greater user choice at this time. Instead, governments need to focus on practical reforms to improve the way they select providers on behalf of users, and to plan and contract services in a way that puts users at the centre of service provision.

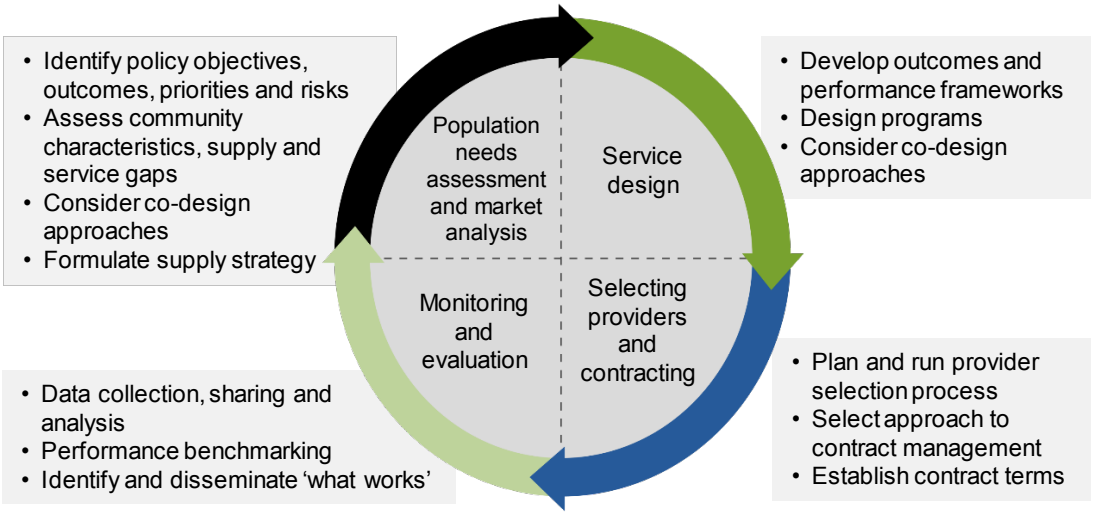
Family and community services cover a range of activities targeted at achieving improvements in the wellbeing of individuals and families. Some services provide support to people experiencing crisis situations, such as some homelessness services. Others offer longer term support, or episodic support, such as for recurrent mental health conditions. Some services aim to build people's capability and resilience — family support services and settlement support services for example. A subset of services focus on communities.

This inquiry's focus is on family and community services where governments select providers, user choice is limited and funding is often not linked to outcomes. Many of these services are delivered by not-for-profit organisations. Government funding to not-for-profit organisations whose main activities were in social services totalled $7.2 billion across over 5000 organisations in the 2015 reporting year. (This figure includes some activities, such as disability services, which are outside the scope of family and community services.)

Many governments have endorsed 'commissioning' as their preferred approach to designing, delivering and improving services, and as the process through which governments implement contestability in this sector. Commissioning is often conceptualised as a cycle that begins with planning the service system and moves through stages including designing services, selecting providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement (figure 4).

Recent innovations, like the introduction of social impact bonds, have focused government attention on the importance and effort involved in establishing clear outcomes and a user-centric focus for services. Although social impact bonds have limited application, they highlight the need for further government investment in understanding users and defining outcomes in the broader delivery of family and community services.

Figure 4 **The commissioning cycle**



Better systems to support the commissioning cycle

Building better support systems for commissioning can improve the effectiveness of family and community services.

Family and community services have developed in an ad-hoc way over time. Decisions made by all levels of government about what services are commissioned, where and for whom, are siloed and uncoordinated. Many users, particularly those with complex needs, interact with a range of often poorly-coordinated services. Uncoordinated commissioning is wasteful and can result in inequitable access — some services, in some areas, are duplicated while there are service gaps in other regions and for some groups of people.

Governments could avoid these problems by undertaking systematic mapping and planning across services. A focus for governments should be on building a better understanding of users and their needs. Governments could commission services more systematically if they collected information on the characteristics and needs of service users, the performance of providers, and the costs of provision across the population. Recent work done by the Australian Government through the Priority Investment Approach to Welfare provides one example where a more detailed understanding of users can provide a sounder basis for the targeting of service investment. Collection of data on existing services (across funding streams) and publication of maps based on these data would also support better planning and could avoid inadvertent duplication of services by different levels of government.

Smarter contracting

Smarter tendering and contracting arrangements can improve the effectiveness of family and community services. Changes are needed to service system design, provider selection processes and the use of evaluations.

Tender processes that include opportunities for service providers to develop high-quality proposals, individually or as part of a group could increase contestability and lead to better coordination among service providers. Longer contact terms, with appropriate monitoring and safeguards, can provide more certainty for providers and users, improve investment incentives, and focus the attention of both providers and governments on delivering high-quality services, rather than worrying about the next funding cycle. Better handover periods would support service continuity for users and avoid periods of unproductive uncertainty for workers and providers. Selection processes that better identify the attributes, capabilities and areas of specialisation of providers help improve the delivery of outcomes for users.

Timing selection processes and contracts to support service improvement

Tendering and contracting arrangements should match the needs of users and assist providers to efficiently deliver services. Currently they appear designed to fit the cycles and needs of governments. This is the wrong way around.

The timing of tenders and the length of contract terms were often raised by inquiry participants as barriers to better services. Governments generally only hold tenders open for four to six weeks, which is not long enough for potential new providers to develop a high-quality proposal, or for providers to formalise consortium arrangements to take advantage of synergies. Holding tenders open for longer and **coordinating tender rounds** so that related services come up for tender at the same time could open up opportunities for new providers and consortium bids. Governments could provide more certainty by **announcing forward schedules of tenders** and committing to a clear timetable for decision making.

Currently, contracts for family and community services generally default to three years or less. This can deter providers from investing in service improvement, especially when combined with uncertainty about contract renewal until very close to contract end dates. As a result, service providers spend too much time seeking short-term funding, which is a costly distraction from delivering and improving services. Instability also creates difficulties in attracting and retaining staff and can also have adverse effects on service users, particularly where providers need to invest time to develop trust from users to achieve outcomes. For example, the Queensland Network of Alcohol and other Drug Agencies stated:

> We are further concerned that the stop-start nature of short term funding arrangements impacts the development of a skilled workforce, as people seek more stable employment, which ultimately further disadvantages those who are most vulnerable.

A **seven year default contract term** would give providers a better opportunity to improve user outcomes while still retaining the benefits of periodic contestability. This would better recognise the time needed for setup (making the investments that are necessary to deliver effective services, including workforce capacity, and building relationships in the community) and the time needed for a smooth transition to a new provider at the end of the contract. In between, service providers should have a period of stability. Where circumstances demand, such as program trials, the default could be replaced with a shorter contract term. In all cases, contracts should incorporate safeguards to manage under-performance, including provisions to allow governments to remove providers in any cases of serious failure.

Longer contracts need to be combined with changes in the way governments relate to service providers. Many participants were concerned that governments did not provide the space and scope to innovate or find the best way of delivering an outcome. Micro-managing providers is not consistent with service effectiveness.

An alternative approach is to adopt more ‘relational’ approaches to contract management, where the parties to the contract seek to maximise the effect of their joint efforts on

improving user outcomes over time. Governments should be prepared to state the intended outcomes of the program and then step back and allow service providers some latitude to choose the right approaches for each person or family that comes to their door, and to innovate to improve services over time. Although this will require governments to develop new expertise and change their attitudes to risk, collecting more evidence on service user outcomes will help — governments will be able to take a more 'hands off' approach to contract management and still keep service providers accountable for their actions.

Greater use of evidence in provider selection

The changes proposed by the Commission emphasise the importance of good provider selection processes by governments. Many participants argued that, when selecting service providers, governments tend to focus on the cost of service delivery and the 'quality' of tender applications rather than the ability of providers to deliver outcomes for users. This can favour the larger non-government organisations (which have resources to prepare professional quality bids) and providers that bid at a low price (even if the bid price is inconsistent with delivering quality services). This is not necessarily consistent with selecting the mix of providers that achieves the best outcomes for the service user population.

> The Brotherhood strongly believes that a diversity of providers is necessary to deliver choice and accountability. However present trends in commissioning threaten diversity by placing undue pressure on smaller and mid-sized community sector organisations to merge in order to compete with larger providers. (Brotherhood of St Laurence)
>
> Some negative impacts result from the natural advantages accruing to bigger players in the market with the greater brand recognition and resources to put forward their case. This means that the creativity and diversity generated within small 'outlier' services are lost. (Good Shepherd Australia New Zealand)

Governments need to place more emphasis on identifying the outcomes they are seeking and the skills and attributes needed from providers to deliver those outcomes. Doing this will require a stronger understanding of the users themselves. Governments could make more informed decisions about providers and services if they collected more evidence on the effects of services on users' wellbeing. Developing outcome measures and collecting this data across programs is difficult and will have costs. However, it provides the foundation for more effective commissioning and the benefits, in terms of better life outcomes for people in hardship, could be substantial.

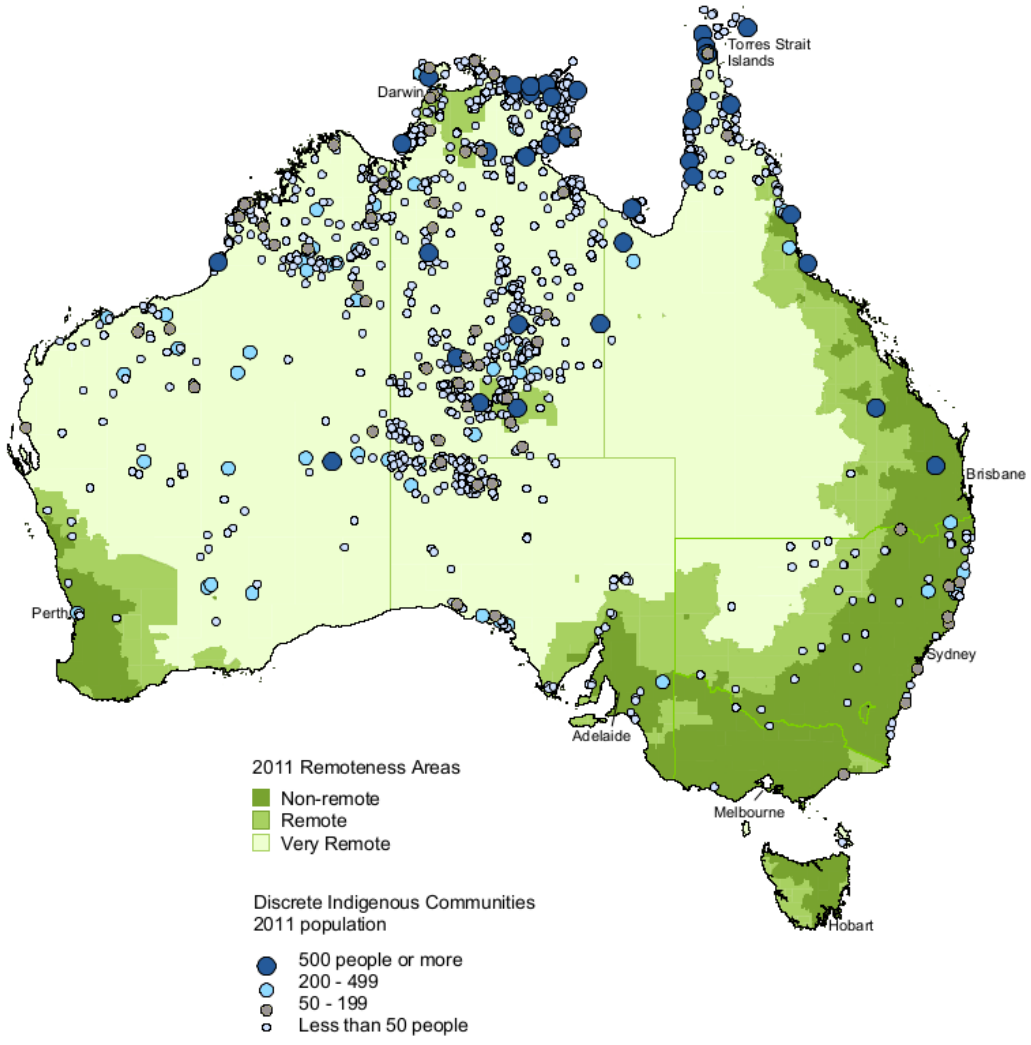
8 Services in remote Indigenous communities

Human services are not making the contribution they should be to improving the lives of Indigenous people living in remote communities. No one should pretend that more effective services alone will address the disadvantage and dysfunction existing in some remote Indigenous communities, but they can make a greater contribution than today. Changes are

needed to improve the effectiveness of services, build local capacity, and enable remote Indigenous communities to better influence the services they receive.

About one in five Indigenous Australians live in a remote area. In 2011, there were over 1000 discrete Indigenous communities in remote areas of which more than three quarters had a population of less than 50 people (figure 5). Indigenous Australians living in these communities have significantly worse quality of life than other Australians. Since 2003, the Commission has published the *Overcoming Indigenous Disadvantage* report of indicators of Indigenous people's wellbeing. Over that time, there has been evidence of improvement in some areas, but outcomes have stagnated or declined in others.

Figure 5 **Discrete Indigenous communities by size and remoteness, 2011**



Service delivery in remote Indigenous communities faces challenges, many of which are related to scale and remoteness. Travel can be difficult, and at times, impossible.

Communities with small populations may not be able to support full-time services, there may be few local people who have the skills necessary to deliver services, recruiting and retaining staff can be difficult and there may be a lack of fit for purpose infrastructure (such as buildings suitable for service delivery). High levels of unemployment and few economic opportunities both challenge — and are influenced by — service delivery. In some remote Indigenous communities, the delivery of government services can be the main economic activity.

Despite many announcements and a level of goodwill, decisions about service provision in remote Indigenous communities are characterised by a lack of coordination, duplication and inefficiency. For example, 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. The Aboriginal Medical Services Alliance Northern Territory gave another example of a remote community in Central Australia where about 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. The Alliance described what happens on the ground.

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

The history of Indigenous policy has been characterised by instability, shifts between centralised and place-based approaches, between Indigenous-specific and mainstream programs, and by overlapping and shifting responsibilities within and across different levels of government.

> [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)

Principles for service delivery in remote Indigenous communities

Effective service provision in remote Indigenous communities requires long-term strategies that are developed to suit the circumstances and meet the needs of each community, and are developed in partnership with and owned by that community. Communities should be involved across the 360 degrees of the commissioning cycle — from needs assessment through to evaluation (figure 4). This requires a recognition that, while governments play a critical role in creating and maintaining the conditions for improving outcomes, the actions of Indigenous people themselves will also play a major role in determining outcomes.

Governments need to adopt a mindset of working with — and investing in — remote Indigenous communities.

Increasing user choice is not a practical approach to putting Indigenous people at the centre of service provision in most remote communities. The majority of remote Indigenous communities are too small to support more than one provider of most human services, so user choice of service provider is not feasible. Nonetheless, governments that provide services in remote Indigenous communities are making choices about who will provide which services and how. Ensuring these investments better align with and support the priorities and preferences of a community, through **greater community voice**, has the potential to improve service effectiveness.

A focus on the priorities and preferences of communities can only be meaningful if services are planned at a local level. **'Place-based'** approaches are service delivery models based on achieving outcomes for a place rather than aligning with jurisdictional, departmental or program boundaries. To be effective, place-based approaches require giving greater priority to community-led-and-owned needs assessment and planning, decision making and accountability, and should be tailored to the situation of each community. These approaches can overcome coordination issues by shifting the emphasis of planning to what is needed within a community, rather than what can be provided by each arm or level of government. In doing so, they can also build a community's capacity to identify and develop responses to issues. These two principles — community voice and place-based approaches — are ways of improving service delivery in remote communities. They are consistent with the 'success factors' for programs for Indigenous Australians that the Steering Committee for the Review of Government Service Provision has identified in its series of reports on *Overcoming Indigenous Disadvantage*.

Learning lessons from history

This inquiry is the latest of many recognising the unacceptable outcomes experienced by Indigenous Australians living in remote communities, and suggesting community voice and place-based approaches as a basis for a solution. Many previous reforms (including the Council of Australian Governments trials, the National Partnership Agreement on Remote Service Delivery and the Indigenous Advancement Strategy) have been based on similar principles.

Despite goodwill and significant resources, initiatives aimed at improving outcomes for Indigenous Australians have often fallen short at the implementation stage. The Commission has drawn lessons from the experience of these initiatives, including that governments must:

- implement structures and processes that support a whole of government, place-based approach
- take into account community perspectives on how reforms should be developed and implemented

- allow enough time for implementation in order to establish relationships in the community and to build trust
- start small and grow slowly
- use flexible approaches that can be tailored to local circumstances and culture — a one-size-fits-all approach will not succeed (this includes flexibility over time within the community as needs may change)
- draw on existing arrangements and the strengths of communities
- build the capacity of governments (to implement reforms and work with communities) and communities (to work with governments, express voice and improve governance).

A vital lesson is that governments and communities must have realistic expectations about what changes can be implemented and how quickly change can occur. Successful implementation would depend on the capacity of both government and the community to fully engage in more localised approaches. This capacity does not exist everywhere, takes time and effort to build and would require changes to the highly centralised decision making currently used across Australia. Governments would need to make careful decisions about priorities and resources for implementation. Changing the way governments make decisions would be a gradual process that must evolve from governments' current approaches to service delivery and be compatible with the fundamentals of the Australian system of government.

It is also inevitable that some changes will fail and some communities will show little or no sign of improvement, at least initially. Governments and communities must be patient and avoid overreacting to the first sign of falter.

Toward a better model of service provision

Delivery arrangements for human services in remote Indigenous communities, like those in family and community services, are largely designed around a model of commissioning where providers 'compete' periodically for funding to deliver services. This can be a sound model if implemented well. However, current approaches are often not delivering the benefits of contestability (better outcomes, more innovation and greater efficiency) and are exacerbating its potential weaknesses (poor collaboration and a lack of service continuity). Although many past reforms have been based on sound principles for service delivery in remote Indigenous communities, governments have not been effective in implementing these principles. As Phillips-Brown, Reddel and Gleeson noted:

> Indigenous affairs is largely characterised by a litany of reports and strategies, but implementation failure.

Like family and community services, implementation requires effective stewardship with governments engaging in a continual cycle of designing, delivering and improving services, albeit with the extra challenges posed by the remote context. To be effective, implementation requires ongoing bottom-up consultation and engagement. Indigenous communities will

only develop trust in governments if they see that there is genuine commitment to taking their views into account when decisions are made.

The provision of government-funded human services is a large part of the economy in remote Indigenous communities and is an opportunity for governments to invest in building local capacity. Where appropriate, the effectiveness of human services delivery in remote Indigenous communities can be improved by using local and/or Indigenous-specific providers. For example, Aboriginal Medical Services Alliance Northern Territory argued that, compared with mainstream primary care, Aboriginal Community Controlled Health Organisations provide greater health benefits, improve access for Indigenous people, deliver culturally appropriate services, are more likely to be committed to processes of clinical governance and evidence-based medicine and employ more Indigenous people (and develop their skills and career path). They also argued that Aboriginal Community Controlled Health Organisations are instrumental in developing and supporting innovative models of care (including through partnering with mainstream providers). Currently, government processes to select service providers do not adequately take these kinds of benefits into account.

Effective service delivery includes evaluation and continuous improvement. Explicitly requiring that programs are monitored and evaluated with input from communities can enhance community voice and improve service implementation and ongoing provision. Evaluations that are carried out after programs have concluded are not adequate — **evaluation needs to be an ongoing process embedded in program design**.

Many stakeholders have pointed to the potential of place-based approaches and the need for Indigenous people living in remote communities to have more voice in influencing the services they receive. Different models have been proposed. Some people favour providing Indigenous people with more control over the funding and design of local services at a community level. Others promote a regional governance approach. Others stop short of passing on control and promote greater engagement instead. **No single model has universal support**. To be effective any of these models would require a transfer of some control from centralised decision making in government.

The Commission has not developed specific recommendations in the area of greater community engagement and input, but may do so in its final report. It has been considering ways to empower communities, including using community plans to articulate community aspirations and incorporate community views in service planning and delivery. Plans would be developed by the community, with governments offering support. Minimum criteria would need to be developed, but communities would have flexibility in how the plans were developed and what they involved.

Once developed, governments would be obliged to: take each plan into account when funding services for the relevant community; and report publicly (to Parliament and to the community) on whether, and if so how, funding and other government actions have supported the community plan. The Commission is, however, conscious that many community planning approaches have been tried in the past and have not worked, and that many other approaches are possible. The Commission also recognises that a number of

Indigenous communities already have plans or planning processes in place (for example, Empowered Communities and the Murdi Paaki Regional Assembly). Between this draft report and the final report the Commission will seek further feedback on community planning approaches, including through submissions, roundtables and participation in public hearings.

Proposed reform directions

The Commission has made draft recommendations in two areas.

Improved contestability arrangements: The Commission's draft recommendations for improved family and community services are relevant for services in remote Indigenous communities. Some, however, need to be adjusted to better reflect the remote context. Specifically, the Commission proposes **longer default contract terms** (ten years rather than seven, with contracts to incorporate safeguards to manage under-performance), a greater focus on encouraging collaboration and coordination between providers, and better alignment between tender processes for related services to encourage greater coordination between government agencies. Commissioning processes would also have a much stronger focus on developing local capacity, including local employment, community engagement and governance.

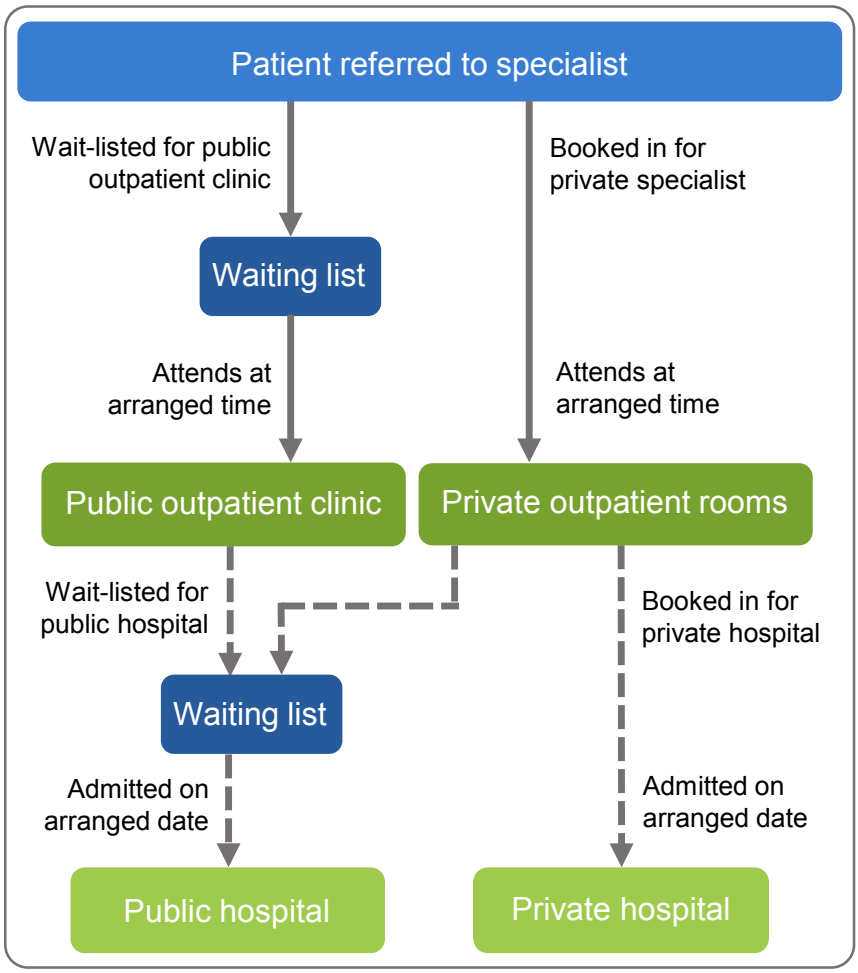
Planning, evaluation and feedback systems: The Commission is also proposing that governments develop systems to support service planning, evaluation and the identification and sharing of best-practice approaches.

9 Public hospital services

Many Australians will be admitted to a public hospital at some stage of their life, often for elective (planned) care. Better information and greater patient choice can improve the outcomes for patients.

There are more than 2.3 million admissions to public hospitals each year for people receiving elective care. About 700 000 patients are admitted to public hospitals for elective *surgery* (and about 1.4 million are admitted to private hospitals). Elective patients are often given limited control over the pathway which determines the hospital and clinician that treats them. That pathway typically begins with a referral from the patient's general practitioner (GP) to an initial specialist consultation at either a public outpatient clinic or private outpatient rooms (figure 6).

Figure 6 **Pathways to elective hospital admission**



Almost 10 per cent of GP consultations result in a specialist referral, amounting to about 14 million referrals annually, with some of these leading to an admission to a public hospital. The most frequent referrals include those to orthopaedic surgeons, dermatologists and cardiologists.

The Commission is proposing that, when given a referral for an initial specialist consultation, all patients should have the opportunity to choose either the:

- public outpatient clinic they attend (with the specialist chosen by the clinic)
- private specialist they see (usually in private rooms and possibly involving out-of-pocket charges).

Under current arrangements, patients wishing to attend a public outpatient clinic are often given no choice but to attend the clinic nearest to their home. This can be due to custom and practice among local GPs, public outpatient clinics having a policy of refusing appointments for people who do not reside in the clinic's catchment area, or (in Perth) a requirement that

referrals be processed through a central booking service that allocates patients to their nearest public clinic.

Patients wishing to choose a private specialist also face barriers to choice. GPs usually give their patients a 'named referral' to a specific specialist, based on the GP's knowledge of local clinicians. This has led to a mistaken belief among many doctors and patients that a referral must name a specific specialist and, if it does, the patient cannot use it to book an appointment with an alternative clinician practising the same speciality. The Commission has heard that patients often contact their GP's office to change the name of the specialist on a referral letter. In some cases, specialists will refuse to see a patient if a different clinician is named on the referral letter.

To give patients greater control over the referral pathway that they take to receive specialist health care, the Australian, State and Territory Governments should:

- direct public outpatient clinics to **accept any patient with a valid referral**, regardless of where the patient lives
- amend the regulation of referrals to make it clearer that patients can **choose their clinic or specialist**, irrespective of which service provider is named in a referral
- work with GPs to develop best-practice guidelines on how to **support patient choice**.

GPs would continue to play a vital role in supporting patients at the point of referral, with the level of support provided to exercise choice varying according to patients' preferences. If they wish, patients would still be able to rely on their GP to make decisions on their behalf. There should also be scope for patients, after receiving a referral and associated advice from their GP, to independently choose a public outpatient clinic or private specialist after leaving the GP's office. This would give patients the opportunity to do their own research, consider their options and perhaps consult family and friends before making a decision.

Greater choice at the point of referral has intrinsic value for patients because it empowers them to have greater control over their lives. This in itself is likely to improve the wellbeing of patients. Choice also allows patients to make trade-offs between options to better match their preferences — such as choosing a public clinic that has a shorter waiting time but is further from home. Overseas studies have shown that greater choice at referral, together with public information to support choice, can lead to better clinical outcomes — including fewer deaths — because it enables patients to seek out higher-performing hospitals and prompts service providers to move closer to best practice among their peers. The combined benefits from patients having greater control over their health care, making choices that better match their preferences and experiencing better clinical outcomes are likely to be significant at a communitywide level, given that there are around 14 million referrals annually.

There are risks to greater choice, but their likelihood is low. The Commission's proposed reforms are unlikely to have a significant effect on the take up of private hospital insurance. They would not affect the advantages of being admitted to hospital as a private (rather than public) patient, such as being able to choose the treating specialist and avoid waiting times

in the public system by choosing to be treated in a private hospital. Patients who initially attend a public outpatient clinic would still be treated by specialists chosen by managers of the public system.

Information to support patient choice and provider self-improvement

Patients can currently access some information to help them make choices on alternative hospitals and specialists, such as the advice of their GP, published waiting times for hospital admissions, and the views of the patient's family and friends. However, **more information could be publicly reported** to facilitate comparisons between alternative providers, including on clinical outcomes and the wide variation in out-of-pocket charges for private specialist outpatient consultations. Other countries have shown that publishing more information would further empower consumers and help GPs to support them. In addition to benefits to patients, there is also evidence that publishing such information would prompt hospitals to engage in more self-improvement activity.

Governments in Australia already collect a large amount of information about individual hospitals and specialists but much of it is withheld from public view. The Commission's recently completed inquiry on data availability and use identified this as a common problem across the economy and recommended a package of general reforms to make data more accessible. This included a new Data Sharing and Release Act, National Data Custodian, and sectoral Accredited Release Authorities to streamline access to datasets. These would complement the health care-specific information reforms proposed in this report.

Central to this report's proposed information reforms is strengthening and expanding the commitment to public reporting that the Australian, State and Territory Governments made in the 2011 National Health Reform Agreement. In particular, it is proposed that the jurisdictions would, as **part of their health funding arrangements**, agree to:

- adopt a general policy of **publishing all data** they hold on individual hospitals and specialists unless it would clearly harm the interests of patients
- make the published data available in a **format that other organisations can readily incorporate** in advisory services they provide (for example, in the software used by GP clinics)
- transform the MyHospitals website into a national **vehicle that better supports choice** by patients, and encourages self-improvement by individual hospitals and clinicians, including by reporting more outcome indicators such as patient-reported outcome measures, user ratings and reviews, and clinical outcomes such as readmission rates
- phase-in **public reporting on individual specialists**, possibly beginning with their registration details, followed by process data (such as location, levels of activity and out-of-pocket charges), user ratings and reviews, and, in the longer term, whether clinical outcomes are within an acceptable range.

10 Public dental services

Public dental services do not focus on the prevention and early intervention needed to improve Australia's oral health. Patients lack choice and too often require emergency and restorative treatments. Reforms to improve and support choice, better identify patient need and to focus public dental providers on timely intervention, can improve patient outcomes.

Publicly funded dental services provide safety net access to basic dental care for people who face financial and other barriers to accessing care, such as some people with a disability. Approximately 5.5 million adults and 3 million children are eligible for public dental services — about a third of Australia's population. Public dental services operate alongside a substantial private sector.

Unlike some other parts of the health system, governments have paid scant attention to public dental services. Public dental providers face difficulties in tracking patients over time, and services exist in a silo, with little integration with the broader health system. Policy and funding uncertainty limits the long-term planning and evaluation needed to improve services. Short-term funding boosts in recent years have improved access to public dental care, but have done little to 'break the cycle' of treatment and repair.

People who receive public dental services have little choice in who provides their care, when and where. Services are largely provided in government operated clinics that have limited capacity. In people's day-to-day lives this can mean the difference between an appointment near work or home, or one that requires a commute (or in rural areas, travelling to the next town), or being able to choose a time that does not conflict with school pick-up, rather than one that fits with the clinic. Ad hoc use of fee-for-service vouchers has not resulted in a systemic improvement in user choice, and has done little to improve the effectiveness of public dental services over time.

Improved choice would enable users to make decisions that suit them, and generate incentives for providers to be more responsive to patients' needs (providing the right treatment at the right time). Consumer directed care, where the user's choice determines which provider receives the funding allocated to them, if carefully designed and employed in the right settings, could make greater use of the private dental profession, enabling users to have choice over a greater range of providers.

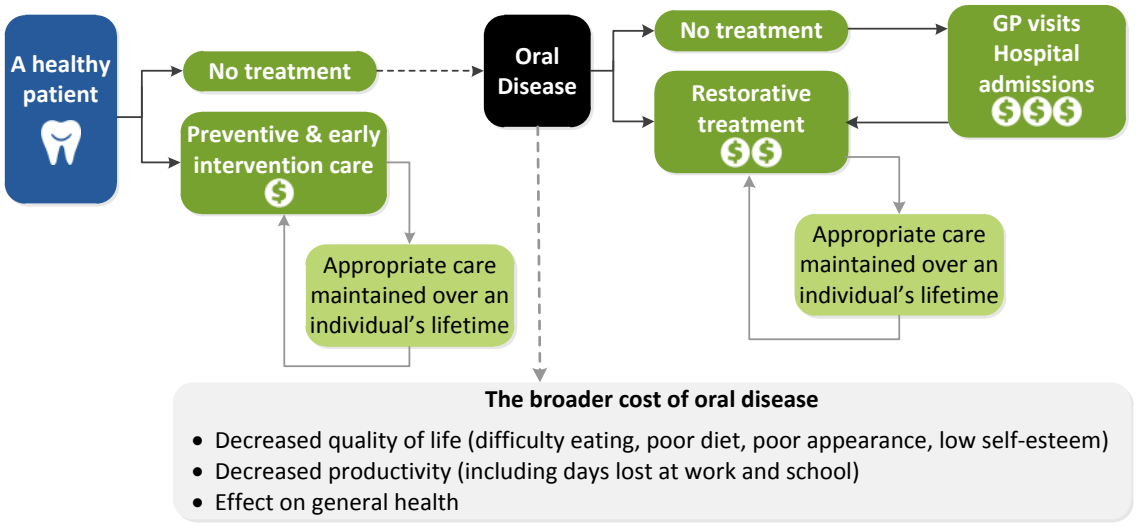
A shift toward targeted preventive dental care

Most dental conditions are preventable. However, high levels of demand and government funding constraints mean that public dental services focus on treating emergency patients (seeing the most urgent cases first) and place other patients on a largely 'first come, first served' waiting list. While waiting times for non-urgent public dental care vary across jurisdictions and over time (with variations in levels of funding from governments), patients can wait up to two or three years to receive care.

This means that, for those at high risk of developing oral disease, their oral health deteriorates while waiting to receive care — resulting in larger costs to them, to governments and the community for largely preventable conditions (figure 7). Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015-16. The time to treatment is therefore an important metric for improving the effectiveness of public dental services. **Public reporting of performance** in treating patients within clinically-acceptable waiting times (by risk category) would improve accountability in the sector.

For public dental services to be able to move beyond the short-term focus on urgent care, they need to be able to measure the effectiveness of services in terms of the oral health outcomes of users. **Developing an oral health outcomes framework** would not only improve accountability, but also provide the basis for more comprehensive reforms to promote targeted preventive care. Outcome measures are not currently in use in Australia, but are being developed (in Victoria in the first instance). In England, outcomes have been measured by clinical indicators, such as rates of tooth decay, and patient reported indicators, such as being able to speak and eat comfortably.

Figure 7 **A stylised pathway of dental health care and the costs**



Performance benchmarks and outcome measures are important prerequisites for reform and should be developed and implemented as soon as practicable. These must be developed before the next stage of more fundamental and long-term reforms to introduce consumer directed care, and shift the system's focus to targeted preventive care, can proceed.

Improving choice and outcomes for users

Introducing consumer directed care reforms for public dental services could give users choice over their provider, and by shifting the focus of care toward prevention, avoid the

costs of deteriorating dental conditions, and improve outcomes and the effectiveness of services.

Implementing choice will require development of a new payment model for public dental services. At this stage, the Commission proposes **development of a blended payment model** that rewards preventive care and the overall quality of care, rather than the number of treatments provided. This approach balances introducing greater user choice with incentives for prevention and avoids some of the issues that are associated with fee-for-service vouchers. Similar to the model being progressively trialled and introduced for public dental contracts in England, the model should involve the user choosing their dental provider, and thereafter the provider would receive:

- a payment per enrolled patient, weighted to reflect their risk and treatment needs (a risk-weighted capitation payment)
- payments for achieving clinical and patient outcomes
- activity payments for complex and hard to define treatments (such as dentures).

Patients would be able to choose between public dental clinics and participating private clinics. By making better use of private and public dental clinics, the proposed reforms could also help to overcome any capacity constraints in the current system.

Triaging patients according to their escalating risk of oral disease would target the oral health of those most at risk in the eligible population and retain governments' ability to constrain the costs of service delivery. **A digital oral health record** incorporated into the My Health Record system could improve linkages with the broader health system (including GPs and hospitals), assist in the identification and triaging of high-risk patients, and support user choice by ensuring a person's records are portable between providers.

The payment model should not apply to all treatments and will require the development of a list of eligible services that provide patients with the clinically- and cost-effective treatments needed to have a disease-free mouth. State and Territory Governments could choose to provide eligible services free-of-charge or impose a co-payment (as some currently do). Patients could also choose to pay extra to access treatments beyond the eligible services. For example, these arrangements could allow individuals to choose to pay extra for a more expensive filling that better matches the colour of their teeth. Careful monitoring of patient outcomes and the payment of extra fees would be needed to ensure consumers are not exploited.

Patients would also be provided with consumer-oriented information (locations, waiting times, outcomes) to enable their choice of provider. In contrast to the current system, under a consumer directed care approach, an individual in need of non-urgent public dental services would be able to **choose the location or clinic** that suits their needs, see and understand provider ratings, and be treated on the basis of their risk rather than the date they joined the waiting list.

Improving contestability within public dental services

Some of the benefits from consumer directed care (to the user and the system) arise from the effects of choice. However, there are some circumstances where competition in the market would not be effective, such as in remote locations with small populations that may not be able to support multiple dental providers (or even a single provider all year round). Here, choice is not feasible. In these circumstances, governments would need to commission providers to deliver services. Improvements to governments' commissioning processes are required, including a more **systematic approach to selecting providers** and monitoring their performance. Governments should use an outcomes framework to design contracts and select providers that focus on promoting the oral health of the people they treat. In the longer term, governments should focus on their role as system stewards (rather than primary service providers), driving service improvements and encouraging innovation by providing advice around best practices, benchmarking and monitoring outcomes.

Draft recommendations and information request

End-of-life care

DRAFT RECOMMENDATION 4.1

State and Territory Governments should ensure that people with a preference to die at home are able to access support from community-based palliative care services to enable them to do so. To achieve this, State and Territory Governments should:

- assess the need for additional community-based palliative care services
- design services to address identified gaps in service provision
- use competitive processes to select providers (or a single provider) to deliver additional community-based palliative care services
- monitor and evaluate the performance of community-based palliative care services to ensure that those services deliver integrated and coordinated nursing, medical and personal care, and provide access to care and support on a 24 hours a day, 7 days a week basis
- ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.

DRAFT RECOMMENDATION 4.2

The Australian Government should:

- remove current restrictions on the duration and availability of palliative care funding in residential aged care so that palliative care is available to residents who have pre-existing high health care needs, and for periods of time that align with those provided in the health care system
- provide sufficient additional funding to residential aged care facilities to ensure that people living in residential aged care receive end-of-life care that aligns with the quality of that available to other Australians.

DRAFT RECOMMENDATION 4.3

The Australian Government should promote advance care planning in primary care by:

- including the initiation of an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. At a minimum, this would require the general practitioner to introduce the concept of advance care planning and provide written material on the purpose and content of an advance care plan
- introducing a new Medicare item number to enable practice nurses to facilitate advance care planning.

DRAFT RECOMMENDATION 4.4

The Australian Government should amend the aged care Quality of Care Principles to require that residential aged care facilities ensure that clinically trained staff hold conversations with residents about their future care needs. This should include helping each resident (or their family or carers) to develop or update an advance care plan (or to document that the resident would prefer not to complete an advance care plan) within two months of admission to the facility.

DRAFT RECOMMENDATION 4.5

The Australian, State and Territory Governments should ensure that there are sufficient data to enable governments to fulfil their stewardship functions by monitoring how well end-of-life care services are meeting users' needs across all settings of care.

Governments should work together to develop and implement an end-of-life care data strategy that leads to the provision of, at a minimum, linked information on:

- place of death
- primary and secondary diagnoses
- details of service provision at time of death (what, if any, health or aged care did they receive, at what level and for how long)
- whether they had an advance care plan.

Social housing

DRAFT RECOMMENDATION 5.1

The Australian Government should enhance Commonwealth Rent Assistance (CRA) by:

- extending CRA to cover tenants in public housing
- increasing the current maximum CRA payment by about 15 per cent to address the fall in the relative value of CRA caused by average rents rising faster than the consumer price index since 2007
- indexing the maximum CRA payment amount to reflect changes in rental prices nationally.

DRAFT RECOMMENDATION 5.2

State and Territory Governments should abolish the current assistance model for social housing where rents are set at a proportion of the tenant's income and enhance user choice by:

- providing a high-cost housing payment funded by State and Territory Governments for eligible tenants, such as those with a demonstrated need to live in a high-rent area
- delivering the high-cost housing payment to the tenant in a way that would enable it to be used in either the social or private rental markets
- offering existing tenants in social housing an option between continuing to pay rent set at a proportion of their income for up to ten years, or electing to move to the new assistance model
- charging market rents for tenants in social housing.

DRAFT RECOMMENDATION 5.3

State and Territory Governments should introduce choice-based letting for tenants entering into, and transferring between, social housing properties.

DRAFT RECOMMENDATION 5.4

State and Territory Governments should continue to make the management of social housing properties contestable, on a staged basis. The management of social housing properties should be subject to a tender process that is open to all providers, including the government provider.

DRAFT RECOMMENDATION 6.1

When commissioning tenancy support services, State and Territory Governments should:

- clearly separate the funding and commissioning of tenancy support services from tenancy management services
- ensure that tenants renting in the private market have the same access to support services as tenants in social housing.

DRAFT RECOMMENDATION 6.2

State and Territory Governments should ensure that the entity responsible for managing social housing assets is separate from the entity responsible for social housing policy. The entity managing social housing assets should be subject to competitive neutrality policies.

DRAFT RECOMMENDATION 6.3

State and Territory Governments should ensure that applicants for social housing assistance:

- receive a comprehensive up-front assessment of their eligibility for: a social housing placement; the high-cost housing payment (draft recommendation 5.2); and tenancy or other service support, including support to enable the tenant to choose their home
- are made aware: that the high-cost housing payment would be payable if they chose to live in either the private or social housing markets; and of the extent to which support services available in social housing would also be available in the private market.

DRAFT RECOMMENDATION 6.4

State and Territory Governments, in conjunction with the Australian Institute of Health and Welfare, should improve the data that are collected on:

- the efficiency of social housing
- tenant outcomes, including high-cost housing payment and service recipients who choose to rent in the private housing market.

State and Territory Governments should clearly define the outcomes they are seeking to achieve to support the commissioning of tenancy management and tenancy support services, and put in place frameworks to assess their success in meeting these outcomes over time. Outcomes data should, to the extent possible, be consistent and comparable to that developed for family and community services (draft recommendation 7.3).

DRAFT RECOMMENDATION 6.5

State and Territory Governments should:

- publish information on expected waiting times to access social housing, by region, in a format that is accessible to prospective tenants
- make publicly available the regulatory reports on the performance of community providers that are undertaken as part of the National Regulatory System for Community Housing.

To facilitate choice-based letting, State and Territory Governments should publish information on available social housing properties, such as the rent charged for the property, number of bedrooms and the location of the property. This information should be disseminated across a range of mediums, such as online and printed leaflets.

INFORMATION REQUEST

The Commission supports the principle of consistent regulation across different types of social housing providers. The Commission is seeking information and evidence on whether changes to the National Regulatory System for Community Housing (NRSCH) are needed to accommodate different types of providers. This includes information and evidence on:

- *whether the NRSCH is flexible enough to regulate different types of providers and, if not, the changes that are necessary*
- *the costs and benefits of extending the NRSCH to include different types of providers of tenancy management services*
- *the extent to which inconsistencies between jurisdictions add to administration costs and create barriers to entry (the Commission would welcome quantitative evidence on the costs incurred by providers)*
- *what changes to the regulatory system should be made to provide incentives for providers to improve outcomes for tenants, improve provider responsiveness to the needs of tenants and improve provider accountability to governments.*

Family and community services

DRAFT RECOMMENDATION 7.1

The Australian, State and Territory Governments should work together to develop and publish:

- data-driven maps of existing family and community services
- analysis of the characteristics and needs of the service user population to assist with system and program design and targeting
- service plans to address the needs of people experiencing hardship.

DRAFT RECOMMENDATION 7.2

The Australian, State and Territory Governments should adjust provider selection processes in family and community services to reflect the importance of achieving outcomes for service users. Governments should:

- design selection criteria that focus on the ability of service providers to improve outcomes for service users
- not discriminate on the basis of organisational type (for-profit, not-for-profit and mutual for example)
- allow sufficient time for providers to prepare considered responses (including the development of integrated bids across related services).

DRAFT RECOMMENDATION 7.3

The Australian, State and Territory Governments should prioritise the development of user-focused outcome measures for family and community services — indicators of the wellbeing of people who use those services — and apply them consistently across all family and community services.

Governments should also identify outputs from family and community services that can be used as proxies for outcomes or measures of progress toward achieving outcomes.

In developing outcome measures and outputs, governments should define the indicators broadly so they can be used in provider selection, performance management and provider, program and system-level evaluations across the full range of family and community services.

DRAFT RECOMMENDATION 7.4

The Australian, State and Territory Governments should improve systems for identifying the characteristics of service delivery models, service providers, programs and systems that are associated with achieving outcomes for the people who use family and community services. To achieve this, governments should:

- monitor the performance of providers of family and community services in achieving outcomes for service users
- evaluate service providers, programs and systems in ways that are commensurate with their size and complexity
- proactively support the sharing of data between governments and departments, consistent with the Commission's inquiry report *Data Availability and Use*
- release de-identified data on family and community services to service providers and researchers
- develop processes to disseminate the lessons of evaluations to governments and service providers.

DRAFT RECOMMENDATION 7.5

The Australian, State and Territory Governments should set the length of family and community services contracts to allow adequate time for service providers to establish their operations, have a period of stability in service delivery and for handover before the conclusion of the contract (when a new provider is selected).

To achieve this the Australian, State and Territory Governments should:

- increase default contract lengths for family and community services to seven years
- allow exceptions to be made, such as for program trials which could have shorter contract lengths
- provide justification for any contracts that differ from the standard term
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of serious failure.

DRAFT RECOMMENDATION 7.6

The Australian, State and Territory Governments should provide payments to providers for family and community services that reflect the efficient cost of service provision.

DRAFT RECOMMENDATION 7.7

The Australian, State and Territory Governments should:

- train staff to increase their capacity to implement outcomes-based approaches to commissioning and relational approaches to contract management
- trial relational approaches to contract management in family and community services.

Services in remote Indigenous communities

DRAFT RECOMMENDATION 8.1

The Australian, State and Northern Territory Governments should set the length of human services contracts in remote Indigenous communities to allow adequate time for service providers to establish their operations, have a period of stability in service delivery and for handover before the conclusion of the contract (when a new provider is selected). The contract period should take into account the additional challenges of service delivery in remote communities.

To achieve this the Australian, State and Northern Territory Governments should:

- increase default contract lengths for human services in remote Indigenous communities to ten years
- allow exceptions to be made, such as for program trials which could have shorter contract lengths
- provide justification for any contracts that differ from the standard term
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of serious failure.

DRAFT RECOMMENDATION 8.2

When conducting provider selection processes for services in remote Indigenous communities, the Australian, State and Northern Territory Governments should:

- better align tender processes for related services
- allow sufficient time for providers to prepare considered responses (including the development of integrated bids across related services)
- notify providers of the outcome of tender processes in a timely manner
- allow enough time for transition when new providers are selected.

DRAFT RECOMMENDATION 8.3

The Australian, State and Northern Territory Governments should ensure that commissioning processes for human services in remote Indigenous communities have a strong focus on transferring skills and capacity to people and organisations in those communities.

DRAFT RECOMMENDATION 8.4

When selecting providers of human services in remote Indigenous communities, the Australian, State and Northern Territory Governments should take into account the attributes of providers that contribute to achieving the outcomes sought. This may include:

- culturally appropriate service provision (specific to the region where the service is being delivered)
- community engagement and governance (including through considering communities' feedback on provider performance)
- collaboration and coordination with existing service providers, and community bodies
- employment and training of local and/or Indigenous staff.

DRAFT RECOMMENDATION 8.5

The Australian, State and Northern Territory Governments should invest in better systems to underpin service delivery by working together to:

- develop objectives for human services in remote Indigenous communities
- conduct and publish ongoing assessments of the characteristics and needs of Indigenous Australians living in remote communities, including mapping the existing services delivered in communities
- establish systems to identify and share information on 'what works' in human services in remote Indigenous communities.

The Australian, State and Northern Territory Governments should involve communities at all stages of this process.

Public hospital services

DRAFT RECOMMENDATION 9.1

The Australian Government should amend the Health Insurance Regulations 1975 to make it clearer that patients referred to a specialist can choose the public outpatient clinic or private specialist they attend for their initial consultation. This includes clearly specifying that:

- referrals do not need to name a particular clinic or specialist
- any specialist can accept a referral to a specialist of their type, irrespective of whether another person is named as the specialist in the referral
- when making a referral to a specialist, general practitioners (GPs) must explain to patients that they can attend a specialist or public outpatient clinic other than the one named in the referral, and patients can choose independently after receiving support and advice from their GP at the time of referral
- referral letters should clearly indicate that patients must be offered choice by their GP, can attend a specialist or clinic other than the one named in the referral, and can choose independently after receiving the referral.

DRAFT RECOMMENDATION 9.2

The Australian Government should develop, with general practitioners (GPs), best-practice guidelines on how to support patient choice. These should form part of a broader strategy — designed with the relevant professional bodies — to help GPs, specialists and other health professionals implement the amendments to the Health Insurance Regulations 1975 in draft recommendation 9.1.

DRAFT RECOMMENDATION 9.3

State and Territory Governments should direct their public outpatient clinics to accept any patient with a referral letter for a condition that the clinic covers, regardless of where the patient lives. Where a local hospital network or the WA Central Referral Service processes referrals, that service should be directed to:

- allow patients to lodge requests for an initial outpatient appointment when they have received a referral
- give patients the option of specifying the public outpatient clinic they will attend.

DRAFT RECOMMENDATION 9.4

State and Territory Governments should change patient travel assistance schemes so that assistance is available to eligible patients regardless of which healthcare provider they attend. The level of assistance should continue to be based on the cost of getting to the nearest provider.

DRAFT RECOMMENDATION 9.5

The Australian Government should undertake an evaluation of the referral choice reforms five years after they commence operation.

Information to support patient choice and performance improvement in hospitals

DRAFT RECOMMENDATION 10.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the National Health Reform Agreement to better support patients and their general practitioners to exercise patient choice, and encourage performance improvement by hospitals and specialists. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare (AIHW) to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in draft recommendation 10.2
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals and specialists unless it is clearly demonstrated that releasing the data would harm the interests of patients
- make the information that a jurisdiction publicly releases on hospitals or specialists available in a format that other organisations can readily incorporate in advisory services they provide.

To facilitate reporting on individual specialists, there should also be a commitment by:

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that medical specialists are required to participate in public information provision, as specified by the AIHW
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision, as specified by the AIHW.

DRAFT RECOMMENDATION 10.2

The Australian Government should, in consultation with State and Territory Governments, direct the Australian Institute of Health and Welfare to transform the MyHospitals website into a vehicle that better supports choice by patients and encourages self-improvement by hospitals and specialists. The changes should:

- draw on lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England
- be based on market research on who would use an improved MyHospitals website, how their needs and health literacy vary, what indicators are useful to them, and how they could be informed by using best-practice approaches to presenting health information online
- put greater emphasis on reporting outcomes, such as by publishing patient-reported outcome measures, user ratings and reviews, and clinical outcomes such as readmission rates
- include the phasing-in of reporting on individual specialists as data become available, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges), user ratings and reviews, and, in the longer term, whether clinical outcomes are within an acceptable range.

Public dental services

DRAFT RECOMMENDATION 11.1

State and Territory Governments should report publicly against a consistent benchmark of clinically-acceptable waiting times, split by risk-based priority levels.

Once data systems are developed, provider-level reporting should be published monthly and aggregate measures included in public dental services' annual reporting processes.

DRAFT RECOMMENDATION 11.2

State and Territory Governments should establish outcomes frameworks for public dental services that focus on patient outcomes and include both clinical outcomes and patient reported measures.

State and Territory Governments should assess Dental Health Services Victoria's work to date on outcome measures, once implemented, with a view to identifying and commencing implementation of a nationally consistent outcomes framework.

DRAFT RECOMMENDATION 11.3

State and Territory Governments should develop comprehensive digital oral health records for public dental services. Once developed, these systems should be incorporated within the My Health Record system.

DRAFT RECOMMENDATION 12.1

State and Territory Governments should introduce a consumer directed care approach to public dental services. Under the new approach, participating providers should be paid based on a blended payment model that incorporates:

- risk-weighted capitation payments for preventive and restorative services for enrolled patients that incentivises the provision of clinically- and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)
- performance based outcome payments, incorporating payments for clinical and patient outcomes
- activity-based payments for complex and hard to define procedures (such as dentures). The dental treatments that would be eligible for activity-based payments should be determined by governments based on available evidence on the clinical- and cost-effectiveness of treatments.

State and Territory Governments should ensure that under the scheme:

- patients are offered choice of provider (public or private clinic) who will care for them for a defined enrolment period
- the enrolment period aligns with the time required to effectively measure outcomes
- users are able to change provider in certain circumstances (such as, when moving city).

DRAFT RECOMMENDATION 12.2

The Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, should be funded by the Australian Government to determine the efficient prices for consumer directed care payments.

DRAFT RECOMMENDATION 12.3

State and Territory Governments should transition to a consumer directed care approach by first establishing initial test sites to evaluate new blended payment models and allocation systems, before a staged roll out.

DRAFT RECOMMENDATION 12.4

State and Territory Governments should provide access to consumer directed care through a centrally managed allocation system. Under the allocation system, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease.

Governments should ensure that, when allocated funding, a patient has access to:

- clinically- and cost-effective treatments that are necessary for the patient to have a disease-free mouth
- payment arrangements where patients can choose to pay extra to the provider to access a range of clinically-effective treatments beyond the basic treatments
- consumer-oriented information on participating providers including, for example, clinic locations and published outcome measures, to enable their choice of provider.

DRAFT RECOMMENDATION 12.5

State and Territory Governments should establish outcomes-based commissioning systems for public dental services. Once systems are established, State and Territory Governments should examine opportunities for introducing greater contestability in public dental services.

At first, greater contestability should be introduced in those settings where it is clear that competition is not feasible, including remote provision and other outreach services.

1 The Commission's approach

1.1 What the inquiry is about

In April 2016, the Commission was asked by the Australian Government to examine whether the effectiveness of human services could be improved by introducing greater informed user choice, competition and contestability (box 1.1). This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will access human services at some point in their lifetime and change is needed to enable and support people and their families to have a stronger voice in shaping the services they receive, and who provides them.

The inquiry has been conducted in two stages. A study report completing the first stage of the inquiry was released in December 2016. The Commission identified six priority services where the policy tools of greater informed user choice, competition and contestability could put users at the centre of service provision.

- End-of-life care services.
- Social housing.
- Government-commissioned family and community services.
- Services in remote Indigenous communities.
- Public hospitals.
- Public dental services.

The study report sets out the Commission's reasoning for identifying these services (PC 2016a).

This is the draft report for the second stage of the inquiry. It sets out the approach used by the Commission to identify and assess reform options to introduce greater user choice, competition or contestability into the priority services. It also presents the Commission's draft recommendations for those services and seeks feedback from inquiry participants to inform its final report. The final inquiry report will be provided to the Australian Government in late October 2017.

Box 1.1 **The terms of reference for the inquiry**

In making recommendations to introduce greater user choice, competition and contestability to the services identified as best suited to reform, the terms of reference ask the Commission to consider:

- the roles and responsibilities of consumers, service providers (including the private sector, government agencies and the not-for-profit sector) and governments in the delivery of human services
- the factors affecting consumers' use of services and their preferences for models of service delivery, noting the challenges facing consumers with complex and chronic needs, or reduced capacity to make informed choices
- the costs and benefits of promoting competition in the provision of human services
- how best to promote innovation and improvements in the quality, range and funding of human services
- 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
- the evaluation of new arrangements and the need to encourage continuous learning.

The conduct of the inquiry

The Commission has consulted widely during the course of this inquiry. The process has included:

- publications inviting participant feedback, including an issues paper, preliminary findings report and study report as part of the first stage of the inquiry, and an issues paper and this draft report for the second stage of the inquiry. In total, the Commission has received 486 submissions, including 91 following the release of the issues paper for the inquiry report on 12 December 2016
- consultations with the Australian, State and Territory Governments, service providers and their peak bodies, employer representatives, consumer advocates and academics
- a series of roundtables focusing on the priority services during the first and second stages of the inquiry.

Full details of the consultation process can be found in appendix A. The Commission thanks all those who have participated in this inquiry.

Participants are invited to provide written submissions to respond to this draft report. Submissions are due by 14 July 2017. The Commission will hold public hearings in Canberra, Melbourne, Sydney and Perth in July and August, and encourages parties to register their interest to participate. Details of how to register for public hearings are included at the front of this report and on the Commission's website. The Commission will hold roundtables and consultations in several locations, including outside major capital cities.

1.2 The roles of government

Human services such as health care, family and community services and social housing, are essential for the wellbeing of individuals and their families, and underpin economic and social participation. Ensuring that everyone, regardless of their means or circumstances, has access to a minimum level of high-quality human services promotes equity and social cohesion, which in turn contributes to the welfare of the community as a whole.

Public and private expenditure on human services is significant — over $300 billion in 2014-15 — with demand for services projected to grow as more people live longer, incomes grow and technological advances increase the types of services that can improve a person's quality of life. The number of services provided each year in Australia is considerable — for example, there were more than 10 million admissions to public and private hospitals in 2015 (AIHW 2016e). Other services, such as homelessness services and social housing, each serve hundreds of thousands of people every year.

The circumstances and the settings in which people will access human services will vary. Some people will be able to plan their use of services, others will face a short-term crisis or emergency. Some people will be well-informed, able to articulate their needs and make choices that improve their wellbeing, whereas some will rely on others to make choices on their behalf. The system for funding, providing and stewarding human services needs to cater for this diversity, now and into the future as demand for high-quality services continues to grow.

Government involvement in human services

The objective of government policies to provide human services is to improve the wellbeing of individuals and improve community welfare by promoting economic and social participation, as well as the broader community benefits of enhanced social cohesion. Meeting this objective requires that governments have a strong involvement in human services — through funding services, stewarding markets for services and, in some circumstances, directly providing services.

Governments have several roles in markets for human services. Governments are the primary funder of most human services and play a major role in determining who has access to a service and who does not. There are sound efficiency and equity reasons for this. Governments may be involved in human services due to the presence of 'externalities' — some human services generate benefits beyond those that accrue to the recipient of the service. School education, for example, may benefit an entire society, not just the student, by assuring a more literate and numerate workforce, raising productivity and contributing to social capital. Without government intervention, markets for education would be unlikely to take these broader benefits in to account and would 'fail' to generate an efficient outcome from the perspective of the community — the service would be underprovided. In the case of school education, governments seek to address this externality by requiring children of a particular age to attend school, and providing funding to support their attendance.

Governments also may be involved in markets for human services because of information asymmetries. Human services are complex, and it is often difficult for users to assess the quality of a service provider, or know what services they need, especially for one-off or 'emergency' services (such as some health procedures). Unless governments can address these information asymmetries, such as through requiring that tailored information is provided to users, it can lead to providers under- or over-servicing some users, and users selecting services and providers that do not meet their needs.

From an equity perspective, markets for human services will not deliver an appropriate distribution of services across the community, leading to societal consequences that do not meet community expectations. Examples include people with limited incomes, or in particular locations, being excluded from certain services, such as hospital or dental care, without government support. Governments' approach to filling this gap can take a number of forms including funding universal access to a service, as is the case for emergency health care, and fully or partly covering the cost of a service to targeted groups in the community, as is the case for public dental services. Governments also choose whether to provide services directly (as is the case for the management of public housing tenancies) or to rely on other providers.

The funding and provision of human services

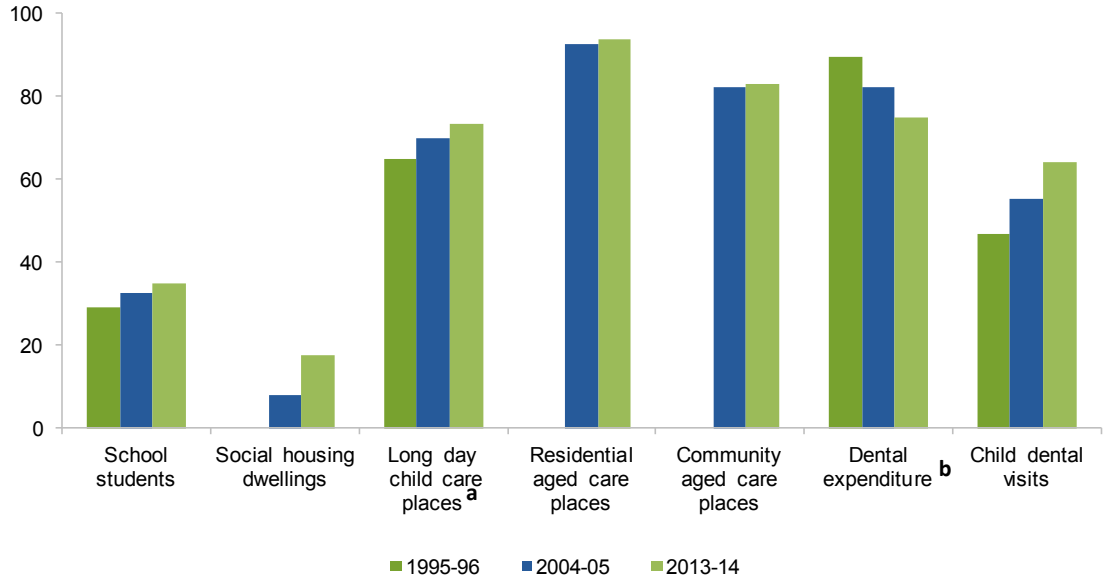
The way human services are provided and funded has evolved over time. Traditionally, governments played little role in the funding and provision of human services, and people relied on social and family networks and, later, on not-for-profit bodies for support (Brown and Keast 2005). The Royal Hospital for Women in Sydney, for example, was opened in 1905 by what is now The Benevolent Society. Disability support services, aged care and many family and community services were originally provided by not-for-profit organisations through charitable donations and volunteerism (APSC 2013; Kendig and Duckett 2001; Phillips 2008).

Over time the growing demands for support, and the need for *coordinated* support across different service areas, led to increased government involvement. Some services were brought within the ambit of government and jurisdictional responsibilities started to emerge as governments took on a greater role, partially or fully funding and even providing some services. This role expanded to include public housing, health and education, eventually followed by specialist programs such as childcare and community health services (Brown and Keast 2005).

In recent decades Australian governments have increasingly sought to decouple the funding of human services from the provision of those services. Governments were considered to be rigid in their model of service delivery, not responsive to community needs, or worse, ineffective and inefficient (Keast 2001; Keating 2000). Since the mid-1990s, there has been a trend away from government provision of many services including school education, social housing and childcare. Non-government providers, including not-for-profits, for-profits, sole

traders and mutuals or cooperatives, are more prevalent in some services, such as general medical practice, allied health, optometry, job, community and aged care services (figure 1.1). Some services, such as hospital and school education services are provided by both government and non-government providers. The rollout of the National Disability Insurance Scheme (NDIS) will lead to further growth in the level of service provision by non-government providers.

Figure 1.1 **Non-government provision of human services**
Per cent of total



a Data for long day childcare places relate to for-profit providers in 1994, 2003 and 2012. **b** Data relate to the share of non-government expenditure on dental services. While this has declined over the period considered, the share of private-sector dentists (as a proportion of all dentists) increased between 2000 and 2014 (from 84 per cent to 87 per cent).

Sources: ABS (2016d); AIHW (2005, 2015b, 2015c, 2016b); PC (2014a); SCRGSP (2010, 2015).

The role governments take in markets for human services has not evolved in a systematic way. Changes in part reflect a difference of views on the benefits of a user focus in service delivery. Where previously providers were allocated fixed grants-based budgets and had discretion over who should receive services, some current models of provision, such as the NDIS, enable funding to 'follow the user'. This person-centred model of provision means that users, rather than providers or governments, allocate their budgets to the providers, supports and services that best meet their needs. This represents a departure from previous systems where, for some services, providers' considerations could take priority over users'.

Governments' role as stewards of human services

Governments will (or should) always have the role of system stewards. This role incorporates a range of functions that help to ensure service provision is effective at meeting its objectives. The stewardship role is broader than overseeing the market and includes policy design, regulation, oversight of service delivery, monitoring of provider performance, and developing ways for the system to learn and continuously improve. Stewardship also includes developing institutional and regulatory arrangements to underpin service provision that is responsive to users, accountable to those who fund the services, equitable, efficient and high quality. Three linked phases of government stewardship — service design, delivery and improvement — are discussed in greater detail in chapter 2 but one further point is worth making here: governments retain ultimate responsibility for ensuring human services deliver their intended outcomes *regardless* of the arrangements under which those services are funded or provided.

1.3 The objective of reform

The objective of reform is to improve the effectiveness of the provision of human services such that it improves outcomes for the users of those services and the welfare of the community as a whole. The Commission's task in this inquiry is to recommend reforms that improve outcomes for people who use end-of-life care services, social housing, government-commissioned family and community services, services in remote Indigenous communities, public hospitals and public dental services.

The Commission's focus is on reforms using the policy 'tools' set out in the inquiry terms of reference — the introduction of greater user choice, competition and contestability (box 1.2). Competition (as an adjunct to user choice) and contestability are a means to an end — improving the effectiveness of service provision — rather than ends in themselves. The Commission's approach recognises that greater informed user choice, competition or contestability will not always be beneficial. The costs and benefits of a reform option depend on the characteristics of the people accessing the service, the characteristics of the service itself and the market conditions where service providers and users interact.

For example, well-designed reform to introduce greater user choice in the provision of public dental services may generate net benefits for the service user and the broader community in areas with a vigorous private sector where providers are able to differentiate their services on the basis of quality or price. The same reform option could impose net costs on the community if introduced in sparsely populated areas where the private sector is dominated by a single provider of dental services who is able to exert market power. Similarly, enabling choice of service provider can be empowering for a well-informed user who is able to act on their preferences, but will be of no direct benefit to those who do not have the capacity (or an agent) to make a decision in their best interest.

Box 1.2 Informed user choice, competition and contestability

Informed user choice

Someone, whether the user, the provider or a third party such as a regulator, must decide which services a particular user can receive. Informed user choice models empower users of human services to be actively involved in decisions about the services they use. There are many types of user choice. Users can directly make decisions about the services that they receive (for example, a person with a disability deciding which services best support their needs) and which organisation will provide services to them (for example, deciding between different residential aged care facilities). A 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 rehabilitation for drug dependency.

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 offer 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 Medicare funding for general practitioner 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. Contestable arrangements for provider selection are used widely in the context of commissioning — an increasingly common approach that governments use when engaging organisations (which could be government or non-government providers) to deliver human services. Contestability means that a provider of human services, or the management team of that provider, faces 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. 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.

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

The potential costs and benefits of reforms that change the way human services are provided will fall unequally across the community. Recognising the trade-offs inherent in reforms to

improve outcomes for users of human services, the Commission's overarching objective when assessing policy recommendations is to improve the welfare of the community as a whole. The Commission's approach to assessing the potential costs and benefits of its proposed reforms to determine whether they would be expected to generate net benefits for the community is outlined in section 1.5.

1.4 Introducing greater informed user choice, competition and contestability

Informed user choice

There are different types of choice that users could make in markets for human services — which provider; which service; and where, when and how that service is delivered. Some of these choices will be dependent (only certain types of providers can offer a specific service), and some will not be feasible for an individual user (a person with late-stage dementia, for example, may not be well placed to choose a medical specialist). The type of choice on offer is important because the net benefits of introducing greater choice differ according to which type of choice is being considered and for whom (Le Grand 2007).

The Commission's starting point is that users should have choice over the human services they access and who provides them, unless there are clear reasons why not. These reasons could include a lack of capacity to exercise informed choice and the inability of an agent to do so on a user's behalf, or when there is a need for decisions to be taken quickly in a crisis (such as a medical emergency).

In a well-designed and managed market, informed choice can improve outcomes for users because it:

- has intrinsic value by empowering people to have greater control over their lives
- enables people to make decisions that best meet their needs and preferences
- can generate powerful incentives for providers to be more responsive to users' needs and can drive innovation and efficiencies in service delivery.

The intrinsic value of user choice means it has meaning to people *for its own sake*, independent of whether it drives changes in price or quantity, or drives innovation and efficiencies. People benefit from having increased control over their own lives. For example, increased choice in disability services in the United Kingdom and United States resulted in increased satisfaction with services and users feeling a greater sense of control over their lives (PC 2011b).

A common theme in submissions is that people have a strong desire to have choice, and the empowerment that comes with it. These are people that may not have had the opportunity to exercise a great deal of choice and control over their own lives (UnitingCare Australia, sub. 249). For example, Alzheimer's Australia (sub. 431, p. 7) stated:

> Alzheimer's Australia is strongly supportive of the principle of user choice in human services. For people living with dementia, their families and carers, having a say in their everyday lives is a basic desire and underpins a sense of purpose and wellbeing. Many people living with dementia have expressed a desire to feel that they are participating in decision making regarding their care but also recognise that their ability to do so can be impacted by their diagnosis: capacity to make informed decisions may change from day to day or may decline rapidly.

Similarly, Queensland Advocacy Inc. (sub. 442, p. 4) noted that:

> Choice is empowering and uncontroversial: it can facilitate greater independence and improve overall quality of life, particularly for people with disability who have long been denied dignity and full status as citizens and human beings, let alone choice and opportunities for self-determination.

Users benefit from choice when it better aligns the services they receive with the services they value and desire. The introduction of choice-based letting for social housing in the United Kingdom resulted in increased tenant satisfaction with the home they received. Increased choice in UK hospitals resulted in consumers seeking out better performing hospitals. YFoundations (sub. 438) noted that young people who are homeless have described a range of potential benefits from choice, such as the ability to find a place that best fits them, and to 'feel more at home' in their accommodation.

Providers respond to the user-centred incentives created by user choice. COTA Australia (sub. 456) highlighted some of the costs of not having decisions in the hands of users in aged care — higher-quality providers are unable to expand, poor providers receive a guaranteed supply of users, and people with greater needs have not had their needs met well.

Some participants in this inquiry did not consider that user choice should be increased, pointing out that recipients of human services may not possess full knowledge of their preferences, have the capacity to act on their preferences, or have access to information that is necessary to make decisions (for example, the ACTU, sub. 100). Participants raised concerns that user choice can worsen outcomes for vulnerable users. The Australian Council of Trade Unions (sub. 100, p. 7), for example, stated that user choice 'often leaves behind those for whom publicly-funded services are most needed'.

Anglicare Australia went further, stating that choice in human services is, in their words, a 'furphy'. Anglicare questioned whether people have a real choice over their general practitioner (GP), for example, because it is a choice based on convenience, location, availability (where there is a waiting list for new patients) and whether the visit is bulk billed, which for many people 'is no choice at all' (sub. 445, p. 17). Some participants also noted that price and quantity signals from service recipients to providers (and governments) that direct effort to service innovation, and resources to more highly valued uses, will be distorted when recipients do not face the full cost of providing the service, which is often the case.

The Commission agrees that there are limitations to capturing the potential benefits of user choice but considers that, in some cases, these limitations can be cost-effectively overcome or managed through government stewardship arrangements. Examples include arrangements

to allow trusted friends or family to make decisions on a user's behalf, default options where no explicit choice is taken, or co-payments to provide an incentive for users to consider the costs of service provision when deciding which services to consume.

For reasons discussed above — including a lack of alternative providers in sparsely populated regions, information asymmetries, or a user's lack of agency or willingness to make choices — the Commission recognises that there are circumstances where user choice is not appropriate, but the onus should be on those seeking to remove choice to justify why.

Where users cannot, or do not, make choices themselves, *someone* will be making a choice as to which services a person should receive and who should provide them. These could be decisions taken by governments (about who should be able to provide services or which services should be provided to a particular community, for example) or by providers (about which services should be offered to an individual). Even when user choice is not appropriate, a focus on users can be achieved through other approaches. Examples include increasing 'user voice' and co-design so a person's (or community's) preferences are taken into account when others make decisions on their behalf. Mechanisms for communicating preferences between users, governments and providers that do not rely on user choice include co-design so users' preferences can be reflected in need identification, the articulation of service outcomes and service design (Mission Australia, sub. 277). Mechanisms to put users at the heart of service provision where informed user choice is not possible are discussed in chapters 2, 7 and 8.

Putting the focus on users though greater competition and contestability

In the right circumstances, the potential benefits of competition as a driver include:

- powerful incentives for providers to deliver more effective services and to be more focused on meeting user needs and preferences
- placing downward pressure on prices
- a more efficient allocation of resources as providers are rewarded for delivering services that users want
- incentives to innovate to improve efficiency and quality.

As discussed above, governments have a strong presence in markets for human services, either through fully or partially funding services, stewarding the services market, or by providing the services themselves. This affects whether competition in markets for human services would have the above benefits, and how competition could be introduced. For example, in most markets consumers decide how much they want to spend on a particular good or service and the size of the market will expand (or contract) depending on user preferences. Each provider's share of a market will vary as they try to attract more custom by lowering their prices or improving the quality of their offering.

In contrast, more often than not, decisions about whether a human service can be accessed by users are currently made by others — governments based on the funding available or by providers where they are service 'gatekeepers'. Prices for human services may be fixed by governments, rather than adjust up and down in response to changes in demand.

There are several options for how greater competition could be introduced to markets for human services and the way in which it is done is an important determinant of the costs and benefits of reform (table 1.1). The expected net benefits of each reform option (including the accompanying changes to stewardship arrangements) would be driven by the characteristics of the service (figure 1.2). Broadly, the options include:

- opening a market to competition where users choose among alternative suppliers through, for example, a voucher scheme or consumer-directed budgets
- government-run contestable processes, such as competitive tendering, to select service providers (or a single provider if the market can only sustain a local monopoly). Contestable processes can be used when competition between multiple service providers is not possible or desirable and, by mimicking competitive pressures, can deliver many of the same benefits as competition.

Where competition would not be effective, a third option could include contracts with incentives that are also designed to mimic competitive pressures, such as outcomes-focused budgets, performance-related funding or benchmarking.

Well-designed and managed systems of service provision could employ different combinations of informed user choice, competition and contestability depending on the characteristics of the service. Competition to provide the service may be used when there are sufficient suppliers, while contestability could be used for the same service to select a single provider where competition would be ineffective due, for example, to thin markets.

As with user choice, several participants in this inquiry questioned whether competition should have a place in the provision of human services. Some were sweeping in their rejection. Anglicare Australia (sub. 445), for example, did not accept that competition is a driver of efficiency; that efficiency is an inherently good thing in human services; that the innovation that comes with competition between providers is of benefit to service users; or that it is appropriate to equate individual consumer choice with agency and wellbeing. Others were more specific, describing the harmful effects of competition and contestability, including providers focusing on writing tender applications at the expense of their core business (ASU, sub. PFR326) and competition harming the collaboration between providers that is needed to drive positive outcomes for users with multiple and complex needs (CMHA, sub. 399; Merri Health, sub. 418; PHI, sub. 413; Shelter Tasmania, sub. 422; YACSA, sub. 408).

Table 1.1 **Filtering reform options**

Model	*Description*	*More likely to have net benefits when:*	*Supporting stewardship arrangements can include:*
User choice	Users are able to choose the provider and/or service that best meets their preferences. Where users are unable to choose their provider (for example, because the market can only support one), they may have limited choice over other features, such as which service they receive, and when and where they receive the service.	Users (or their agent) have information, time and capability to make decisions that suit their preferences Users (or their agent) are able to assess service quality. Users are motivated because the decision is important (for example, service differentiation is large). Services are used fairly often and users can learn from experience. Providers can respond to user preferences and users are able to switch providers at low cost.	Arrangements for user-oriented information on service offering, quality and/or price. Default options where choice is not explicitly made by a user (or their agent). Payments to providers that reflect the efficient cost of provision and can follow the user. Mechanisms for managing excess demand where the user does not face the full cost of provision. Safeguards to protect service users.
Competition	Users can choose to receive their service from multiple competing providers. Users may be able to choose their service and provider (for example, individual budgets), or choose a specified service from a range of providers (for example, vouchers).	Providers are able to respond to users by improving or differentiating their service offer or price. The market can support multiple providers and there are low barriers to market entry, expansion and exit.	Mechanisms to enter the market (for example, licence allocations). Payments to providers that reflect the efficient cost of provision. Safeguards to protect service users.
Contestability	Contestable approaches can be used when governments select service providers (could be a monopoly or multiple providers) to supply a market.	Alternative providers are willing to provide the service, even if they do not currently do so. Governments are able to assess service quality and contracts can be specified such that service provision will be effective. User preferences are taken into account when governments determine which services should be provided and by whom.	Needs-based assessment of services and clarity as to what is being commissioned. Credible threat of replacement of the provider (or its manager) if there is underperformance. Contracts specifying terms of provision, such as payment terms, quality obligations, mechanisms for addressing underperformance and incentivising good performance. Ongoing performance monitoring of providers, learning and evaluation. Safeguards to protect service users.

As noted above, markets for human services are not like other markets. COTA Australia (sub. 456, p. 7), for example, noted that 'human services are not simple exchange markets and the role of government should remain central in any delivery model'. The Commission acknowledges these concerns. This means that, in some cases, the costs of introducing reform

to increase user choice and competition would be expected to exceed the benefits and should not be pursued. In other cases, governments can use their stewardship role to lower the costs of reform, such as by making tender processes simpler, and ensuring that providers have the incentives and capacity to collaborate where it would be beneficial to service users.

Unlocking the potential benefits of competition or contestability in human services markets requires careful stewardship from governments and there are instances where neither competition nor contestability are appropriate. Policy settings should ensure that the incentives of providers and users are aligned and that government objectives are met. Chapter 2 highlights Australia's experience with the vocational education and training FEE-HELP scheme as a costly example of what can happen when policies are poorly designed. Counter-examples that demonstrate the value that user choice and competition can have in human services include well-established markets for childcare, dentists, schools, optometrists, GPs and allied health professionals, among others. In considering the potential role of competition and contestability, the Commission has examined the characteristics of each of the six services in this inquiry to assess whether the likely benefits to the community of its proposed reforms would be expected to outweigh the costs; the incentives of providers and users would be aligned; and government objectives would be achieved (section 1.5).

1.5 Assessing reform options

Reforms to introduce greater user choice, competition and contestability need to be carefully assessed to determine whether they would lead to better outcomes for users and their families, and whether they would be expected to generate net benefits for the community. The Commission has conducted a qualitative, principles-based analysis of the potential costs and benefits of its proposed reforms. This analysis has taken into account:

- the incentives faced by service providers and users, such as whether providers would have incentives to improve the quality of services under the proposed reform
- evidence from case studies where user choice, competition and contestability have been introduced to human services, both in Australia and overseas
- quantitative evidence where available.

There are three key types of costs and benefits that the Commission has taken into account in its analysis.

- Reforms could change the effectiveness of service delivery — measured by the quality, equity, efficiency, accountability and responsiveness of service delivery (box 1.3).
- Reforms could have effects on the community that go beyond their direct effects on service effectiveness.
- Reforms could have implementation and compliance costs, including the costs of introducing and maintaining stewardship arrangements.

These costs and benefits are discussed below.

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 a medical treatment that successfully reduces chronic pain, 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 acknowledging and reacting 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.

The Commission has taken into account the effects that reforms may have on costs and benefits over time. Reforms could have one-off or more enduring effects on providers' incentives to keep innovating and responding to users' preferences, and improve service quality, efficiency and equity. Reforms could even have variable or perverse effects over time. The effects of key trends and drivers, such as developments in technology and data availability could also influence the costs and benefits of reform.

A key factor is the risk of reform options — it is not just the quantum of costs and benefits that has been considered, but also how likely they are to be incurred or achieved. The Commission has considered the risk of reform options in policy design and implementation — this is particularly important given the potentially severe consequences of getting the provision of human services wrong. Reforms that are risky may be suited to a staged implementation so further information and evidence can be gathered before proceeding with a full roll out.

The effectiveness of human service delivery

The potential costs and benefits from introducing greater user choice, competition and contestability may show up as improvements (or deteriorations) in the five service attributes of quality, equity, efficiency, accountability and responsiveness. In its analysis, the Commission has assessed the attributes of effective service delivery.

- *Quality*: Whether the reform options would lead to incentives for providers to offer high-quality services to users. The definition of 'quality' will vary depending on the type of service and on an individual users' perspective of what constitutes quality (discussed below).
- *Equity*: Who would be affected by the reform option and how they would be affected. The Commission has assessed the effect of its proposed reforms on various groups within the community.
- *Efficiency*: Whether the reform options would lead to incentives for providers to reduce the costs of providing services while still maintaining quality, and for users to select the services that best meet their needs.
- *Accountability and responsiveness*: Whether the reform options would result in service providers being more responsive to the needs of service users and more accountable to those who fund the services (taxpayers and users).

What constitutes effective service delivery differs across the human services considered in this inquiry. For each service, the Commission has outlined its view of what effective service delivery would look like drawing on the attributes presented in box 1.3, and developed draft recommendations that would contribute to these outcomes.

The proposed reforms would affect the attributes of effectiveness in different ways and, in some cases, negatively. Some reforms may lead to large increases in quality, with minimal effects on the other attributes. Some may lead to increases in the attributes across the board.

Increasing the overall effectiveness of service provision may require trade-offs between the attributes. The potential costs and benefits of reform will also fall unequally across the community. Recognising these trade-offs, the Commission's overarching objective in assessing policy recommendations is to improve the welfare of the community as a whole.

Assessing how reforms would influence effectiveness

When assessing how reforms would change the effectiveness of service delivery, considering the incentives of service providers and users is key. The analysis of reform options has considered whether the reform would result in the incentives of service providers and users being aligned with government objectives for service delivery, and whether users would receive services that best meet their needs.

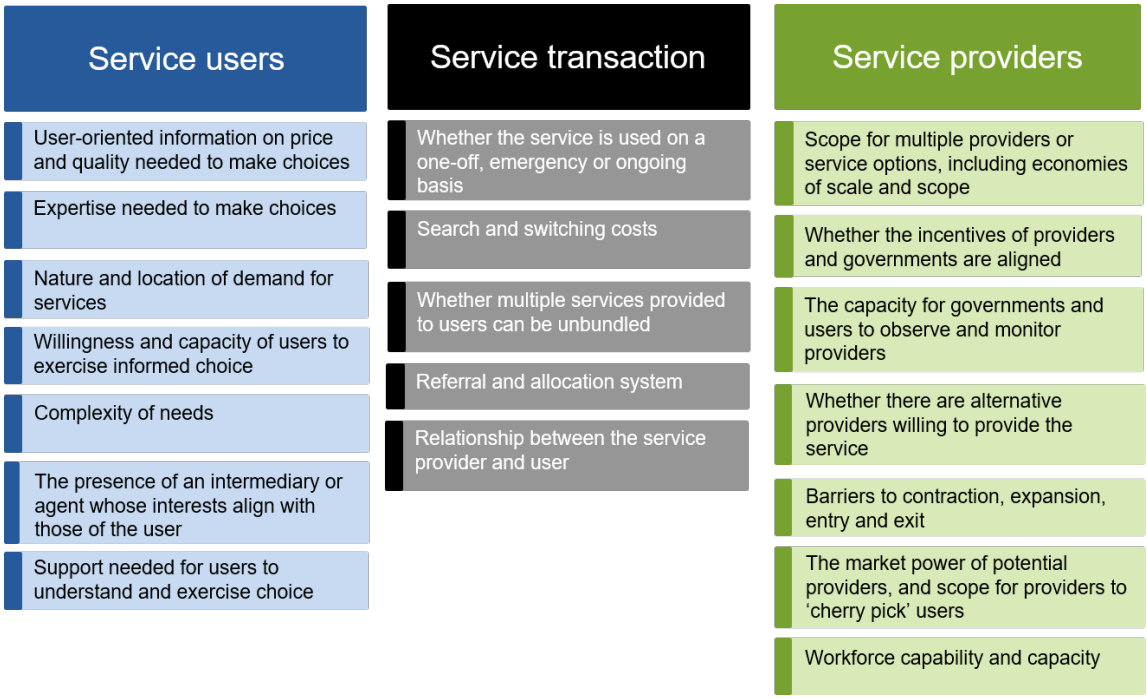
The key aspect of the Commission's framework is identifying the characteristics of service users, transactions and providers, how these characteristics affect the incentives of users and providers, and ultimately the potential costs and benefits of reform. The characteristics the Commission has taken into account are presented in figure 1.2. Each human service will have different characteristics. Some services have users who have the information and capacity to choose, while others have users who may need high levels of support to exercise choice. For some services and locations there may be a large number of providers willing and able to offer the service, while other services may be best delivered as regional monopolies. For some services, governments may be able to easily define outcomes in contracts with providers and monitor those providers, while for other services this would be more difficult.

These characteristics affect not only how reforms would influence the effectiveness of service delivery, but also what stewardship arrangements would need to be put in place to support the reform (which would have implications for the costs of reform options) (chapter 2). Each of the services the Commission has proposed for reform is different — there is diversity in the type and number of users, their capacity and willingness to make choices, the setting and circumstances under which services are provided, and the financial contribution made by users and governments. This makes the policy design task in each of the services unique.

Assessing changes in effectiveness is complex

Different users place different weights on certain attributes over others, and they may even have different views on what an attribute, like quality, means. For example, for people with multiple and complex needs, quality may relate to how well services are integrated to meet their needs. For a person who makes occasional visits to a GP, their assessment of service quality will place less emphasis on integration and more on other factors, such as convenience and cost. Governments themselves may focus on indicators of quality such as mortality rates in public hospitals.

Figure 1.2 **Characteristics that influence the effectiveness of service provision**



Users' experience and satisfaction with the way a service is provided is key to evaluating changes in effectiveness. However, sometimes users are unable to assess certain dimensions of service quality. They may not be well enough informed or have the necessary expertise. For example, a patient may rate highly his or her experience of choosing a particular specialist to perform a procedure because the specialist and support staff were well mannered, minimal pain was experienced and the facilities were comfortable. Data may show the specialist has higher avoidable complications and mortality rates than other specialists. If users had access to these data, they would be able to make a better informed choice taking account of the trade-offs between comfort and a higher risk of adverse medical events.

The Commission has taken care to not disproportionately rely on measurable indicators of the costs and benefits of reforms to users. Measurable and objective indicators of quality should not necessarily take precedence over more subjective or even intangible factors that matter to users. For reforms to truly put users at the heart of human service delivery, governments need to take into account user-reported outcomes, and not look to substitute their own views of what is in users' best interests.

Reforms could have broader effects on the community

Good outcomes from human services benefit the community as well as the individual. As noted earlier, economic and social participation is underpinned by high-quality human services such as health and housing. Good economic and social outcomes benefit the community as well as the individual, for example through a more socially cohesive society.

Reforms to one human service could influence the demand for other human services. For example, reforms to improve public dental services so that more dental problems are treated in a timely manner may create added benefits by reducing preventable hospitalisations. Similarly, improvements in social housing have been cited as being correlated with improvements in health outcomes for tenants (NSW FACS 2016d).

These broader costs and benefits can be difficult to measure or attribute to particular services or funding streams. Nonetheless, the Commission has taken them into account where they can be clearly identified and attributed to a reform.

Reform would have stewardship, implementation and compliance costs

Governments, users and providers would all face both upfront and ongoing costs of reform. The nature of these costs would vary depending on the reform — the Commission has not provided an exhaustive list of potential costs in this chapter, but has considered the range of costs relevant to each reform in its analysis.

Many of the costs of reforms would fall on governments as a result of implementing and maintaining stewardship arrangements (chapter 2). These could include the costs of establishing and maintaining institutions, monitoring providers, protecting consumers, enforcing regulations and being a 'provider of last resort'.

Reforms will involve implementation costs as both providers and users adjust to the new arrangements. Service providers may need to change the services they deliver, and some providers may exit the market. This is not a reason to not proceed with reform — indeed a benefit of reforms may be to replace poorer performing providers with better providers. However, for many users of human services continuity of service provision is important, and if their provider is replaced, this continuity can be disrupted. This transition needs to be managed from the user's perspective, so that transition costs are not unreasonably high (chapter 2).

Similarly, providers and users would face compliance costs. Users may need to be more active in searching for services, and deciding which services meet their needs. Providers would need to comply with regulatory and stewardship arrangements, including providing information and providing support to users.

Delivering more effective human services may involve additional costs for governments, especially in the early years of implementation. In some cases, this may be somewhat offset by reduced spending over time. More effective end-of-life care and public dental services could, for example, reduce demand for some hospital services. These fiscal effects will not fall evenly across levels of government, with spending by one level of government potentially resulting in reductions in spending by others. On the basis of the available information, the Commission's considers that the benefits of its draft recommendations, including improved service outcomes for users, would outweigh the fiscal (and other) costs. Governments should not allow the unequal distribution of these fiscal effects to become a barrier to reform.

The Australian, Territory and some State Governments have committed to working collaboratively to develop funding agreements for priority areas, such as the delivery of human services, through an intergovernmental agreement on competition and productivity-enhancing reforms. This agreement, which includes a commitment by the Commonwealth to provide incentive payments to participating State and Territory Governments, could help to provide much needed impetus for reform.

2 Government stewardship

Key points

- Stewardship relates to the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives. It involves three linked phases in a continuous cycle: service design, delivery and improvement.
- Governments have not always given sufficient focus to the stewardship of human services, which has contributed to poor outcomes for users. Any reforms to human services need to be mindful of governments' ongoing stewardship role to keep users at the centre of service provision.
- Stewardship arrangements are difficult to get right and work on this inquiry has highlighted areas where governments need to improve.
  - More focus on the user: the interaction between governments and providers can dominate design and delivery considerations. A better understanding of, and focus on, users by governments would improve the design and delivery of services.
  - Greater coordination: coordination problems can arise between governments, agencies and providers. In some cases, policy is developed in government silos which can lead to competing objectives, and stewards losing sight of the users' overall wellbeing. Greater coordination, and engaging users and providers more during service design and delivery, can improve the effectiveness of service provision.
  - More transparency: the provision of information to improve accountability and facilitate performance assessment can benefit all parties. Without it, users are unable to assess providers, providers are unable to plan their services, and governments cannot effectively evaluate how providers or systems are performing.
  - Smoother transitions: policy reforms can be large, costly and disruptive. Better planning and preparation for policy change should aim to preserve continuity of outcomes and minimise negative effects on users. Transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Information and clarity about changes in advance can help.
- Other elements of stewardship that are important for effective service delivery include:
  - systematic service planning which involves identifying community needs and government objectives, and planning service delivery. Proper service planning allows resources to be allocated more effectively to meet evolving needs.
  - performance frameworks that use (ideally outcome) data to assess the performance of a service. The frameworks can be used for monitoring provider performance, and evaluating individual programs and the entire system. Such frameworks can improve accountability and efficiency.
  - consumer protections such as professional or quality standards, regulation, enforcement and complaints mechanisms. These promote quality and protect users, and are required regardless of the type of provider (government, not-for-profit or for-profit).

2.1 Governments' role as stewards

Governments will (or should) always have the role of system stewards. Stewardship relates to the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives. Importantly, governments retain ultimate responsibility for ensuring human services deliver their intended outcomes, regardless of the arrangements under which those services are provided.

Stewardship arrangements are difficult to get right — the design and performance of these functions should be tailored to each service, and to the settings in which it is delivered. A particular consideration in human services is the role of governments as primary funders. Some users and providers do not bear costs themselves, and therefore may not have the same incentives as participants in a typical market. This affects how they respond to regulations designed to meet government objectives, and adds complexity to stewardship decisions.

Governments have not always given stewardship sufficient focus — a point made by participants to this inquiry (for example, Brotherhood of St Laurence, sub. 286, Jesuit Social Services, sub. 284, ACPET, sub. 279, CALC, sub. 260). This has led to some prominent policy failures involving both government and non-government providers, where users experience poor and sometimes harmful outcomes (box 2.1). The Commission's work in this inquiry has highlighted some particular areas where government stewardship should be improved. Implementation and ongoing maintenance of sound stewardship arrangements needs to be a core part of the reform and delivery process, rather than an add on.

The stewardship framework outlined in this chapter involves three linked phases that exist in a continuous cycle of service design, delivery and improvement (figure 2.1). It incorporates policy design, regulation, oversight of service provision, monitoring of provider performance and means for the system to learn and continuously improve.

Box 2.1 Case study: Stewardship failures

Case studies of policy failures in parts of the health system and the vocational education and training (VET) system underscore the importance of good stewardship to ensure positive outcomes for users.

In 2015, the Victorian Department of Health and Human Services was notified of a cluster of perinatal deaths at Djerriwarrh Health Services. A clinical review identified that seven of the deaths were avoidable or potentially avoidable. A review by the Australian Commission on Safety and Quality in Health Care found that the department lacked processes to monitor and act on serious clinical incidents.

A further review of hospital safety and quality assurance (Duckett, Cuddihy and Newnham 2016) found that the department's oversight of hospitals was inadequate: the department did not have the information it needed to provide assurance on the quality of care; conducted no routine monitoring of patient outcomes or serious incidents; did not use the routine data at its disposal; and over-relied on accreditation processes.

The review recommended (among other things) changes to the stewardship of hospital safety and quality. These included legislative changes to clarify the system's *objective*, a stronger *focus on users* (patients), improvements in *transparency* by publishing safety and quality performance indicators, adoption of *payment models* to align incentives, and several improvements to the *performance monitoring framework* for safety and quality in the system, including the use of a range of *outcome measures*. Chapter 10 of this inquiry examines reforms to information provision in hospitals.

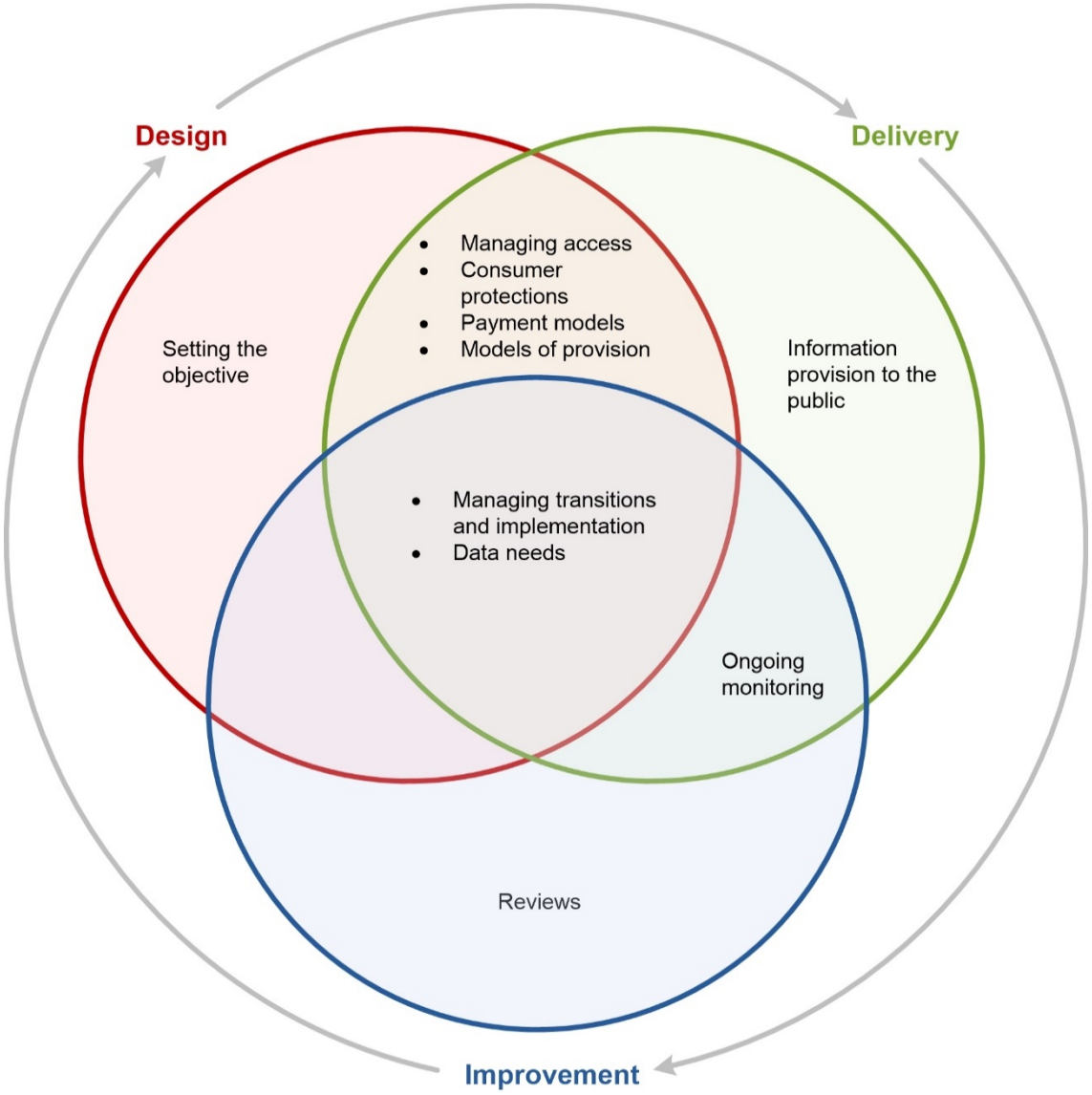
In the VET system, reforms were not accompanied by adequate safeguards or oversight of providers. In 2012, the Australian Government expanded the VET FEE-HELP scheme. With the change, students undertaking some courses at VET providers that did not have credit transfer arrangements with a higher education institution, could access VET FEE-HELP loans.

As a result, there was a sharp increase in the number of (mainly full-fee) students. This led to many students accumulating large debts that many are unlikely to ever repay. 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). Thousands of students signed up for courses that they had little prospect of completing. Better oversight of providers, combined with *quality standards* and *improved information*, could have avoided some of these issues.

Stewardship issues arising from a lack of user focus, transparency (including inadequate information collection and provision), coordination and consumer protections also occur in other human services; and as this chapter highlights, these are areas that require improvement from governments in their stewardship role.

Sources: Australian Government (2016b); Birmingham (2016); DET (2015); Duckett, Cuddihy, and Newnham (2016); NCVER (2015); Senate Standing Committees on Education and Employment (2015).

Figure 2.1 **Stewardship cycle**



2.2 Design

The stewardship process for a new service or program begins with its design. This involves the conceptual and planning elements that should be considered before a service can be delivered. Key elements for consideration include:

- setting the objective
- managing access to the service
- data needs
- consumer protections.

Setting the objective

Policy and program objectives will be influenced by the efficiency and equity reasons that underlie government involvement in markets for human services. Setting objectives is critical to providing clear direction for the design and delivery of a service, and setting a frame for the service to be evaluated against. Setting a broad objective that is consistent across programs can facilitate a holistic approach to assessing the effect of a number of services.

Broad system-level objectives can provide little direction as to how services should be designed, funded and delivered. Programs that meet the system-level objective will usually have more specific objectives. For example, the National Disability Insurance Scheme (NDIS):

> … will provide about 460 000 Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. (NDIS 2017b)

A specific objective facilitates decisions within the program to target the service and also sets benchmarks for monitoring and evaluation. The program objective often identifies the subset of the population that should be eligible for a service.

Systematic service planning

Systematic service planning (discussed further in chapter 7) guides the design of an objective by developing an understanding of community needs, the outcomes sought from the users' perspectives and the number and types of providers available to deliver services. Systematic service planning involves governments:

- *identifying and articulating outcomes* that services and providers should achieve for users, and specify outcomes at the program and overall system level
- *identifying the service user population* that services should target, and understanding their characteristics. This guides the mix of services that will most effectively achieve outcomes for users
- *planning for specialised services* which may be needed to meet the needs of particular groups, such as culturally and linguistically diverse users
- *planning for regional needs* which considers the needs of the population as a whole, taking into account that the needs of some users can differ from others'. Regional planning also involves coordination between and within governments. The level at which planning occurs should be appropriate for the services being considered (including issues of scale, geography and jurisdictional responsibility for service provision). For example, each of the Primary Health Networks commission medical and healthcare services within their own region by undertaking needs assessments and identifying the region's priorities.

In developing its reforms, the Commission has identified a need for governments to develop systematic service plans in a number of areas, including:

- a detailed assessment of current and future needs for additional community-based palliative care (chapter 4)
- data-driven maps of existing family and community services, and analysis of the characteristics and needs of their users (chapter 7)
- planning to understand patients' needs as a precursor to improved commissioning for public dental services (chapter 12).

Incorporating provider and user voice

Many human services have been funded and delivered in a way that suits governments and providers, rather than with a focus on users (chapter 7). This is in part due to traditionally close relationships between providers and government, and the role that many providers play in enabling users to access services. Insufficient focus has been placed on users' needs, preferences and circumstances leading to ineffective services and weak outcomes (box 2.2). Improvements in users' wellbeing should be central to a service's objective and should not be lost in the design and delivery process.

One way to improve the focus on the user is through engagement with users to understand their needs and preferences during the objective setting process.

Engagement can include *co-design* for some aspects. Co-design is a process whereby users become 'active partners in designing, shaping and resourcing services, rather than being passive recipients of pre-determined services' (Burkett nd, p. 7). Notably, co-design is more than seeking the views of users and providers through consultation as it also:

- seeks to understand the service from the users' point of view (and to engage users to consider the providers' point of view)
- starts with the end goal in mind, rather than focusing on problems with the existing services
- focuses on practical and implementable solutions to issues affecting users, including through testing ideas in practice and refining them as solutions are developed
- involves a range of communication methods to make possibilities and solutions tangible. This is particularly important when engaging with a range of participants who may interact with complex systems from different perspectives (Burkett nd).

Box 2.2 Area for improvement: Focus on the user

Focusing on the user in designing and delivering services benefits users and can improve the effectiveness of service provision. Chapter 1 notes the importance of choice in empowering people to have greater control over their lives, and enabling them to make decisions that best meet their needs and preferences. User choice also generates incentives for providers to be more responsive to users, which can lead to innovation and efficiencies in service delivery.

However, providers and governments have often decided what is best for service recipients. The aged care and disability systems were two examples. As part of the Commission's inquiries into *Caring for Older Australians* and *Disability Care and Support*, participants expressed their frustration at not being able to influence care decisions under the arrangements in place at the time, and having minimal choice over matters that affected their quality of life (PC 2011a, 2011b).

A comment reported by Aged Care Crisis (2010, p. 32) highlighted an instance where the provider's considerations took priority over users' preferences:

> Eating is one of the few pleasures left to some elderly folk and where are the inspectors at the vital times. Why should the residents be fed at 4pm so staff can go home and not cost extra in wages? Ask anyone if they eat their dinner at 4pm.

In the context of reforms to disability support services, one participant noted the limited scope for service users to replace their provider:

> There was no option, whatever this service provided, good and bad, and all in between, I had to wear it; I was in effect held hostage because I dare not depart for fear of losing funding support … There were times I became despondent. I do not intend to illustrate specific instances of bad care or good care. The fact is, I was held virtual hostage to one service because of [the Australian Government's HACC program] being the nature it is, not supporting portability. (Dunstan 2010, p. 1)

The lack of a user-directed system was a main impetus for the Commission's recommendations for a more consumer directed model of care in both aged care and disability support services, which governments are now implementing (PC 2011a, 2011b).

Sometimes direct user choice is not possible, but there are often benefits from engaging users and eliciting their views. This can be done in a number of ways. For example, place-based approaches discussed in this inquiry in relation to services in remote Indigenous communities (chapter 8) target design and delivery on a particular location or group, and shift the emphasis of planning to what is needed within a community. Co-design, where users are active partners in the design of services, can also be used. Both of these methods can assist in bringing the focus onto the user during the design phase.

As with other forms of engagement, the choice of participants for a co-design process matters. The users and providers directly involved in the service in question form a good starting point, but including those outside of the 'usual suspects' can be just as important for bringing in new ideas to solve longstanding issues.

> Co-design processes are inclusive and draw on many perspectives, people, experts, disciplines and sectors. … it is important to draw on many perspectives, to challenge orthodoxies, to question assumptions, and to draw in other possibilities. Co-design processes thrive when boundaries are flexible and silos are broken down, when real listening and dialogue can occur across unlikely alliances. (Burkett nd, p. 6)

Coordination between and within governments

Poor (and siloed) planning, design and communication between and within governments leads to overlaps and gaps in service funding and provision. Coordination between governments is a broad area for improvement for stewards when designing human services (box 2.3). (Another important element of coordination — between providers — is discussed in section 2.3.) A coordinated approach from governments also assists providers. Funding and objectives that are aligned provide clarity about the specific role of each provider.

Box 2.3 Area for improvement: Greater coordination

At the service design stage, coordination between and within levels of government, and with providers and users is critical for effective service delivery. However, in many cases, providers and governments struggle to achieve proper coordination in human services.

Poor coordination is an issue for services in remote Indigenous communities. On the funding of these services, a Closing the Gap Clearing House report noted:

> Many evaluations [of services in remote Indigenous communities] have reported on the fragmented and siloed funding arrangements that constrain the ability of Indigenous organisations, service providers and governments themselves to respond to community need. (Moran, Porter and Curth-Bibb 2014, p. 22)

The Council of Australian Governments' Trial in Wadeye aimed to explore ways to coordinate governments' work with the community. An evaluation of the Wadeye Trial noted that the burden of administering government funds increased rather than decreased, adding to the workload of the local government administering services. A broader evaluation of all the trial sites (including seven other sites) noted that an additional challenge was achieving consistent decision-making across all levels of government.

The broader evaluation also highlighted the need to effectively engage with users and understand their perspectives. Some lessons included the need for mutual understanding between governments and Indigenous communities, training government staff on how to engage with Indigenous communities, and developing governance mechanisms that reflect local communities views.

The need for greater coordination arises in many of the services examined in this inquiry, and can be addressed in different ways. For example, place-based approaches can be used to promote coordination of services in remote Indigenous communities (chapter 8). In the context of family and community services (chapter 7), tender periods could be held open for longer to facilitate the formation of consortium bids by providers, and contracts could include funding to allow coordination between service providers.

Sources: Gray AM (2006); Morgan Disney & Associates (2006); Moran, Porter and Curth-Bibb (2014).

Place-based approaches can be used to coordinate services from a user (or community) perspective (discussed further in the context of remote Indigenous communities (chapter 8)).

Place-based approaches are 'programs designed and delivered with the intention of targeting a specific geographical location(s) and particular population group(s) in order to respond to complex social problems' (Wilks, Lahausse and Edwards 2015, p. viii). Place-based approaches can be a more effective way of tackling 'wicked problems' (complex problems

with multiple interdependencies) than traditional, siloed approaches to public policy. They involve giving greater priority to community-level planning, decision making and accountability, and require an understanding of the current situation of each community.

A place-based approach is one way to overcome coordination issues by shifting the emphasis of planning to what is needed within a community, rather than what can be provided by each arm or level of government. In doing so, it can also build a community's resilience and capacity to identify and develop responses to issues.

> Focusing program interventions at the local level is a positive way to build community capability and social capital through community development activities. Location-based approaches may also address concentrated and entrenched problems found in the most disadvantaged locations. (Australian Social Inclusion Board 2011, p. 21)

Implementing place-based approaches requires significant resources, skills, patience and support from both government and the community. There have been many examples of poorly implemented approaches that have not delivered on the promise of the place-based method. A strong focus on managing implementation risks is therefore important.

Managing access to the service

Governments have sound reasons to fully or partially fund many human services, but they will need to manage access to ensure that services flow to the intended beneficiaries and to manage fiscal costs. The way in which governments can do this depends on a number of factors including the objective of the service, who the intended service recipients are and the model of service provision. Reforms to introduce greater user choice, for example, can be difficult to design in a way that allows governments to maintain control of expenditure. Governments that are seeking to constrain costs (or target services) can use a range of mechanisms including co-payments, waiting lists (box 2.4), capping funding (for individual users or the service as a whole) and limits on access to services, such as requiring a referral from a general practitioner to access specialist services or identifying a schedule of basic services that will be funded by government.

Box 2.4 Mechanisms to manage access

Access mechanisms are used widely in human services. Two of the primary mechanisms are waiting lists and co-payments.

Waiting lists effectively require users to 'pay' with their time to access services and can be an efficient means to manage limited funding (where, for example, those who can afford private services weigh up the relative financial and time costs of the options available to them).

However, they will not be efficient where users' circumstances are allowed to worsen when they stay on a waiting list (for example, a health condition developing complications if left untreated), adding costs to the user and community. In this sense, rather than the number of people on a list, it is the time they spend on the list that is of greater concern. In a health context, waiting list times can be guided by clear, transparent clinical guidelines for benchmark periods beyond which the costs (particularly to the wellbeing of the user) worsen.

Co-payments are charges paid by users to cover part of the cost of accessing a service; governments (or other funders) cover the remainder. Co-payments can provide an incentive for users to consider the costs of service provision when deciding which services to access.

Co-payments can raise equity concerns if users from low socioeconomic backgrounds cannot afford the co-payment; or users face particular barriers, such as having complex needs that require multiple visits. Some programs, such as the Safety Net Scheme under the Pharmaceutical Benefits Scheme account for such circumstances by placing a cap on the users' total co-payment per year, with further access free at point of use (or at a greater concession).

Data needs

The Commission's inquiry report on *Data Availability and Use*, which had a broader scope than human services, put forward a framework that will improve general data infrastructure within human services (PC 2017). Key elements relevant to human services included facilitating access to national interest datasets, creating a culture favouring data release, and a 'comprehensive right' to give individuals more control over data held on them.

In a human services context, data are particularly important to ensure that services are designed and targeted well. Data are also critical to facilitate transparency and provide a basis for performance assessment and improvement. Collecting data can, however, impose additional burdens on both providers and users which also needs to be considered.

Outcomes and performance frameworks

An *outcomes framework* identifies the relevant data (outcome measures) which quantify how activities contribute to specific outcomes, and how the data are collected. Frameworks can encompass several categories of outcomes, including:

- *user outcomes* which are the effects of services on the wellbeing of individuals and families

- *community or place-based outcomes* which assess the combined effect that services have on a particular community or location
- *provider outcomes* which are the contributions that individual providers make to the wellbeing of the people they serve
- *program outcomes* which are the outcomes achieved through an overall program or funding stream (often involving a group of service providers)
- *system-level outcomes* which are the effects of the service system as a whole (including a number of programs, and providers, across portfolios and governments) on users, providers and the broader community.

Outcomes frameworks and the data to support them are discussed in the context of several human services in this inquiry, such as:

- measuring the outcomes of community-based palliative care in order to monitor and evaluate services' performance (chapter 4)
- consistent outcome measures for family and community services (chapter 7) to be used in provider selection, performance management and provider, program and system-level evaluations
- developing objectives for human services in remote Indigenous communities (chapter 8) with a focus on outcomes for users and communities, underpinned by an understanding of Indigenous Australians' preferences, priorities and conception of wellbeing
- an outcomes framework for public dental services based on clinical and patient-reported measures (chapter 11).

The sources of data affect the cost of collection, and the uses that the data can be put to. In the context of human services, relevant data sources include:

- *administrative data* collected primarily for the administration of services that relate to the transactions involved in accessing a service
- *provider data* relating to the providers' own functions including the cost, quantity, quality of services provided, and data that they collect on users
- *user-generated data* coming directly from users, commonly obtained through surveys. These are directly relevant to the user's outcomes and can also provide insights about changes in user behaviour.

Outcomes frameworks feed into *performance frameworks*, which are used to assess the performance of a system, program or provider (including as part of contract management). In practice, outcome measures can be difficult to quantify and costly to collect. 'Second-best' metrics such as measures of outputs that proxy outcomes, combined with appropriate caveats and used in concert with other means, can be useful alternatives. The choice of performance measure is important, particularly when they are tied to providers' remuneration as there is a risk that providers may focus on meeting specific measures rather than improving people's wellbeing (box 2.5).

Box 2.5 Case study: Perverse incentives — lessons from the United Kingdom

Harwich, Hitchcock and Fischer (2017, p. 40) stated in their report *Faulty by design — The state of public-service commissioning:*

> The four-hour waiting-time target for Accident and Emergency (A&E) care … was set in 2000 [in the United Kingdom] to improve care. Evidence supports the argument that longer emergency-department waiting times have been linked to mortality. Yet, the target put unnecessary pressure on clinicians to meet input targets, rather than address users' health needs.
>
> Hospitals who miss the target are investigated by NHS regulators, and – despite NHS England allowing some hospitals to miss targets – A&E departments still receive negative media attention for breaching them. In the past, this has resulted in ambulances being parked outside A&E departments until staff believe they can treat [the patients] within four hours, and patients being admitted to hospital unnecessarily. One third of doctors surveyed by the [British Medical Association] had manipulated data to meet waiting targets. This distracts clinicians from focusing on treating the needs of patients in A&E.
>
> Targets have led to negative behaviour elsewhere. At NHS Lothian, this targets-driven culture resulted in the manipulation of waiting-time data; at NHS Mid Staffordshire a target-driven, bullying culture contributed to poor care and mortality. The 2015 Francis report quoted an NHS worker who spoke of the 'pressure to put targets over ethics'.

Data infrastructure

While outcomes and performance frameworks guide much of the data needed, data infrastructure — which includes systems to manage, analyse, coordinate, share and present collected metrics — is critical to effectively collect and use data.

In addition to systems to manage risks associated with privacy concerns (PC 2017), other considerations for data infrastructure in human services are:

- *who should pay for what?* Data collection and management are costly. Providers and stewards often collect data for their own purposes and can sometimes benefit from analysing and disseminating these data more broadly.

  Stewards should look to create incentives for data to be collected, analysed and shared when there would be an overall benefit to the community from greater data availability. In most human services, governments (as funders) will likely bear the cost relating to data. For example, they may increase their payment specified in contracts with providers in order to account for these costs (chapter 7) or pay 'in kind': the Department of Social Services' (DSS) Data Exchange gives providers analysis of their own data in exchange for providers reporting performance data (DSS 2017b)

- *can systems adapt to future requirements?* Data requirements for a service constantly change, particularly with continuing advances in technology. These changes can be difficult to predict. However, stewards can set up systems that better manage change, for example, by establishing data frameworks that can easily accommodate and adapt to new types of data and new uses for them (PC 2017).

Consumer protections

Consumer protections are needed to help protect users from poor quality providers (and outcomes) and help ensure continuity of service. Ensuring appropriate consumer protection arrangements are in place can be particularly important in circumstances where governments fund a substantial expansion of services — as would be the case in expanding end-of-life care services (chapter 4).

Consumer protections can include measures to ensure that services are safe and fit for purpose and meet minimum quality standards, and typically focus on managing (rather than eliminating) risks. There are broad safeguards in the Australian Consumer Law but, as some participants argued, these may not offer the protection required to maintain the standard of care in human services expected by the community. As Alzheimer's Australia submitted:

> There must be a high level of government stewardship and a robust framework of consumer protections to ensure access and quality are maintained and improved, particularly for vulnerable users, including people living with dementia, their families and carers. (sub. 431, p. 2)

There is a range of other regulatory levers available to governments to protect users, including direct regulation and oversight, licensing of providers and complaints and appeal processes.

Last resort arrangements ensure continuity of service when a provider cannot deliver services to some or all users. Governments can coordinate other providers to take on users, bail out a failing provider, increase funding to the provider, or directly provide the service.

2.3 Delivery

There are many aspects to delivery that should be considered by system stewards, including:

- payment models
- models of provision
- information provision to the public
- managing transitions and implementation.

Payment models

Providers change their service offerings in response to the payments they receive. The incentives associated with payments are affected by three decisions: who determines where governments payments should go; the type of payment model used; and the level of the payment.

Who determines where government payments should go?

Broadly, three types of parties can determine which providers receive a payment for human services: users, third parties acting on users' behalf, or governments.

Under user-driven models, users choose a service provider and governments' payments follow their choice, such as through vouchers or consumer directed budgets. For example, arrangements under the NDIS give users control of how to use their funds, creating incentives for providers to satisfy users' demand (NDIS 2017a). These arrangements help align providers' incentives with users' preferences as providers are only funded when users choose them.

However, user-driven models are not suited to every circumstance, such as for some complex decisions that require expert opinion. In these cases, a third-party can choose a provider for a user and government payments would follow the third-party's choice. Governments can also use contestable processes to choose which providers to allocate funding to.

The types of payment models

There are a number of ways that providers can be paid for delivering a service, each of which rewards different sorts of behaviour. The basic types of payment model include block funding, fee-for-service, capitation and pay-for-performance (figure 2.2). Each model has advantages and disadvantages, some of which can be overcome by using a blend of models, or other levers, including regulation, to limit adverse outcomes.

For example, capitation payment models, where providers are paid a periodic payment for each enrolled user in the service, create incentives to deliver services to more users, but can lead to providers 'cherry picking' (only providing services to low cost patients in order to maximise return). The risk of adverse outcomes can be managed by, for example, weighting payments to incentivise providers to meet government objectives. A blended payment model using capitation payments — as well as payments that reward providers for improving outcomes for users — is proposed by the Commission in its reforms to public dental services (chapter 12).

Figure 2.2 **Basic types of payment models**

	Advantages	Disadvantages
Block (Lump sum payment to provider covering all services for a set period of time)	• Expenditure is predictable • Simple to administer • Adopting innovations does not impact providers' budgets	• Incentive to underprovide services to reduce workloads • No explicit incentive to improve quality of service • Limited accountability in how payments are spent • Better providers attract more work but not necessarily resources
Fee-for-service (Reimbursement for each unit of service provided)	• Can support user choice • Incentive to provide services to more people • Incentive to provide services regardless of costs	• Incentive to increase activity and 'over service' users • Incentive to limit or reduce resources allocated to user • Few incentives to work with other providers • Funder bears financial risk of increased demand
Capitation (Periodic lump-sum payments for each enrolled user)	• Expenditure is predictable • Incentive to reduce costs • Incentive to provide preventive services • Can encourage coordination between providers	• Difficult to monitor and enforce quality of service • Incentives to shift service delivery to other providers • Providers may not select users if the cost of providing to those users is not compensated by the risk formula • Little incentive to increase quality/quantity of services
Pay-for-performance (Rewards or penalties linked to performance measures)	• Incentive to undertake beneficial services that would otherwise not be remunerated • Can aid consistency in meeting quality standards	• Significant monitoring effort required • Indicators hard to define; may not link well to outcomes or factors under provider's control • Can be high compliance costs for providers • Risk of unintended consequences such as 'cherry picking' users to meet targets • May be little incentive for improvement beyond targets

Source: Adapted from PC (2015a).

Determining the level of payments

Getting the (efficient) level of payments for providers right is important to encourage and allow for the effective provision of human services, but setting and implementing this payment is difficult.

Simplified approaches to determining the level of payment to providers may be attractive to governments when designing a service or contract, but can have downsides. For example, a standard payment (which could be based on an average cost of delivering the service) may be paid for delivering a service to any user even though the cost of achieving outcomes can

be higher for some people than others. In such cases, providers have an incentive to cherry pick users or focus on certain settings (where the government's payment is above the actual cost of providing the service) and may deny or limit services to more costly users or settings (where the government's payment is below the cost of provision). This can adversely affect equity outcomes as the cost of delivering services to a user, rather than their need for the service, may drive providers' decisions about who can access services. Issues of effectiveness can also arise — the users who are more costly to serve may be the people who would have benefited the most from access to services.

Limiting downsides is not straightforward. Using alternative (possibly more complex) payment models or changing other design aspects (such as quality standards to guard against harmful cost-cutting) can help if they are carefully designed to limit gaming by providers.

Payment systems need to be considered in the context of broader mechanisms designed to encourage best practice from providers. Many human services are provided by professionals and organisations who have a strong interest in delivering quality outcomes for users. Promoting high standards through means such as performance monitoring and quality standards can provide an important complement to payment models.

Models of provision

Governments have several options when determining which model of service provision would best meet the needs of users, and generate net benefits to the community as a whole. Broadly these options are: direct provision by government, opening a market to competition (the exact model of competition determines who is able to provide services) and using contestable processes to select service providers (chapter 1).

The preferred model of service provision depends on a range of factors including:

- the structure of the market (for example, the number of potential providers, or ease of market entry and exit)
- whether governments or service users are able to monitor service quality
- the ability for service providers to differentiate their services (and for users to make choices based on those differences)
- the costs of government stewardship arrangements.

Of particular relevance to this inquiry is the *commissioning* process, which is commonly associated with the contracting out service delivery model, but can involve provision by government or non-government service providers. Commissioning involves many of the elements of stewardship, but has a particular focus on relationships with providers, including careful consideration of provider selection processes (such as tenders) and government's contract management practices. Commissioning is examined in social housing (chapter 6), family and community services (chapter 7), services in remote Indigenous communities (chapter 8) and public dental services (chapter 12).

Choosing providers

Where the model of provision has moved away from sole service delivery by government, different types of providers can deliver services to users. Government's stewardship role involves making sure that those providers that are best placed to achieve outcomes are in a position to do so. Good stewardship should ensure that the only barriers to entering (and exiting) a market are those necessary to ensure positive outcomes for users and the overall effectiveness of service provision.

There are a number of ways that governments can enable providers to enter a market. First, there are criteria that assess whether a provider is fit to enter a market, usually in the form of licences and accreditation. These set minimum quality and education standards, and can be used for a range of other regulatory purposes; revocation of a licence is a substantial enforcement tool. Second, beyond these entry criteria, governments can play a role in choosing providers, for example through competitive tendering. Finally, in circumstances of consumer directed care (such as home-based aged care or the NDIS), the users themselves choose their providers. Depending on the model of delivery chosen, these choices may coexist in a given market.

Historically, there has been ongoing debate about whether one organisational form is intrinsically 'better' at delivering (some particular) human services than any other (box 2.6). In this inquiry, several participants, including the Australian Services Union (sub. 480), the Centre for Social Impact (sub. 448) and Anglicare Australia (sub. 445), raised concerns about the relative performance of for-profit providers in human services delivery.

The overall effectiveness of a provider is a factor of a number of attributes, and organisational form is not a good guide to a provider's performance. Other attributes that are relevant to effectiveness of a provider (and thereby, users' outcomes) include their:

- on the ground experience (in a given service, location or with a particular user group)
- past performance (in the same or analogous services)
- existing and potential workforce
- pre-existing relationships (with users or linkages with other relevant providers) or any local presence they may have.

In the Commission's view, stewards should focus on such operational capabilities over and above organisational forms when selecting providers.

Box 2.6 Substance over form: providers' motivations

While each of the main organisational forms involved in human services may have different primary motivations, careful program design by stewards can harness these in a manner that aligns providers' and governments' objectives. To do so, stewards should have an understanding of the primary motivations of each form, and how these motivations affect the choice of stewardship levers.

For-profit providers *(FPs)* are motivated to maximise their profits, which are distributed to owners. Typically, this manifests through a desire to meet specified outcomes (embodied in contracts, regulation or payment models) for the least cost. This creates an incentive to drive down costs and innovate, potentially resulting in savings to government that can be redeployed to more, or other, services. The focus on profits can also make them more responsive to changes in funding.

A focus on cost reductions brings with it a risk of quality reduction, potentially to detrimental levels. In a competitive market driven by informed user choice, users can signal their quality preferences by avoiding low-quality providers and seeking, even paying a premium for, high-quality providers. However, most human services markets do not meet these conditions, and where reforms are unable to introduce them, there is a need for stewards to ensure that quality is maintained (for example, by setting and enforcing minimum quality standards or service coverage requirements).

In contrast, ***not-for-profit providers*** *(NFPs)* must use any excess earnings for further production of their services. This shifts the primary motivation for NFPs to generally one of 'mission' or 'community purpose'. In a human services context, this purpose is often focused on improving outcomes for target groups (such as the homeless). The Centre for Social Impact (sub. 448) put forward views that this focus results in NFPs outperforming FPs in terms of quality of outputs, and engagement with, and trust from, users. However, if they are not aligned, there is a risk that an NFP's mission could take priority over users' and governments' objectives.

While varying across providers, another general focus of NFPs is on the process of delivering services. In a pure financial sense 'more participatory and inclusive processes can reduce the volume and/or quality of outputs absorbing resources and slowing down delivery' (PC 2010, p. 19). However, users and the community can benefit from being involved in service delivery. In addition, an inclusive process can help build trust and networks, improving service outcomes, and increasing social capital through volunteering, networking and community engagement activities to NFPs.

Another organisational form in human services is ***co-operative and mutual enterprises*** (CMEs) which are owned by, and run for the benefit of, members. The motivations of CMEs vary depending on the nature of members, which can be consumers, employees, businesses, or a combination of these.

Proponents (BCCM, sub. 470) argue that CMEs' focus on members offer several benefits. Outside of the direct benefits to members, these include grass roots user involvement in service provision (potentially improving user choice at a group level) and adaptable and innovative services that focus on member needs.

Sources: Folland et al. (2013), PC (2010, 2011b), SERC (2016).

Governments, as stewards, need to ensure that all types of providers meet minimum standards and have incentives that align with users' and governments' objectives. Governments can use a range of levers discussed elsewhere in this report (including contract terms, quality standards,

payment models and performance monitoring) to align providers' incentives with governments' objectives, and promote effective service provision. In some cases, governments may provide services directly when effective stewardship of providers is too costly.

Importantly, the attributes of any given provider do not absolve governments from their continued stewardship responsibilities. No one organisational type has a monopoly on good, or bad, service delivery. In particular, continued consumer protections are required regardless of the types of provider involved in delivering a service.

Coordination for providers and users

Services can be more effective when providers coordinate their efforts. Coordination can increase the effectiveness of service provision by allowing services to reduce duplication, and specialise (SPRC 2005). For example, in relation to hospital services, the Royal Australasian College of Physicians stated that:

> … rather than every hospital attempting to deliver every possible service in competition with its neighbours, each should develop its own strengths and niche, and should develop cross-referral and transfer procedures for access to specialised services that one or the other does not offer. (sub. 473, p. 5)

Some participants argued that for some types of services, such as areas of complex need, coordination and collaboration amongst service providers is more beneficial than the application of competition and contestability:

> The provision of some areas of service provision — particularly services to vulnerable populations such as those with a mental illness, those living in regional areas, Indigenous Australians, as well as people with multiple and complex chronic conditions where continuity, collaboration and coordination between service providers are required may be less suited to the application of contestability and competition. (Catholic Health Australia, sub. 440, p. 4)

However, reforms to introduce greater competition and contestability can also include scope for coordination (the Commission has considered options to do so in the context of family and community services (chapter 7)).

Coordination centred around particular users may also be required to ensure that their needs are met. This may require program design that brings services together in a manner that centres on users (for example, co-locating a range of health and social services that are likely to be needed by a particular group). Where this is not possible, an alternative is the use of service 'navigators' — third party agents who work on behalf of users to identify and bring together services for them.

Competitive neutrality

Government and non-government providers can compete in some human service markets. Maintaining competitive neutrality (a 'level playing field') between government and

non-government providers is important to encourage competition and the efficient allocation of resources. Doing so 'requires that government business activities not enjoy a net competitive advantage over competitors by virtue of their public ownership' (Treasury and Department of Finance and Administration 2004, p. 1).

Australian, State and Territory governments agreed to competitive neutrality principles under the *Competition Principles Agreement* in 1995 and each jurisdiction has policies outlining how the principles apply (COAG 2007). Although there is some variation, each jurisdiction has its own competitive neutrality policy and complaint handling body (either independent bodies, or housed within other regulators or departments). The Australian Government is currently reviewing its Competitive Neutrality Policy (although the review will not make recommendations specific to human services) (Treasury 2017a).

Competitive neutrality will be important where reforms to human services expand user choice, competition, and contestability (as is the case for the Commission's proposed reforms to social housing (chapter 6)). The 2015 *Competition Policy Review* noted some challenges in securing competitive neutrality in human services including 'structural separation; determining the operational form for government business activities, particularly when the activities sit within a broader range of government functions; and transparent costing and funding of [community service obligations]' (Competition Policy Review 2015, p. 265). These challenges can be overcome, and should be considered as part of the reform and transition process (for example, by identifying the relevant government business unit for service delivery, and ensuring that appropriate costing is applied to government applicants in a tender process).

Information provision to the public

Public information can influence users', providers' and governments' decisions, leading to effective service provision and better outcomes for users. For example, simply presented information that caters to users' different needs and characteristics helps them find and choose a provider and make decisions about the particular services they need, promoting competition. In addition, publishing information on providers and using benchmarks can motivate providers to improve service provision (which evidence suggests can be a stronger channel for provider improvement than user choice (chapter 10)).

Many areas within this inquiry focus on improved information, including information on:

- waiting lists and provider performance to help tenants choose social housing properties (chapter 6)
- hospital performance to improve users' choice of public hospitals (chapter 10)
- what to expect in public dental services, where to find a provider, waiting times and provider outcomes (chapters 11 and 12).

Stewards should carefully consider the nature of the information and the users they seek to inform. Some considerations include:

- *is the information valuable to users?* Information in a clear form can help users to understand the consequences of their choices. Public information on provider performance can also reduce users' susceptibility to being exploited by unscrupulous providers
- *how much will the information cost to provide and who should pay?* Information provision to users, providers and governments comes at a cost, such as the additional effort required to tailor information to users (rather than providing aggregated medical data, for example). In most cases, it is likely that government should pay for this as they fund many services.

Managing transitions and implementation

Reforms to human services can be large, costly and time-consuming. Transitioning to new arrangements following policy reform often disrupts service delivery and can affect many users and providers. Transitioning between providers can also be disruptive as users find and familiarise themselves with new providers. Stewards should plan for all transitions, with a focus on continuity of outcomes. This involves considering many of the aspects of all three phases of the stewardship framework. Experience suggests stewards have not always done this well (box 2.7).

Stewards could utilise rollouts and policy trials to assist with smooth *transitions through the implementation of reforms*. Staged rollouts allow for continuity in service delivery while the groundwork for future reforms is put in place. Learnings from initial sites can lead to improvements when the reforms are fully implemented. An example of a staged rollout is the ongoing reforms to Australia's aged care system, which are planned to be implemented in three phases over 10 years (from 2012 to 2022) and are shifting the system as a whole toward consumer directed care (Department of Health 2017b).

While similar, in comparison to staged rollouts, policy trials suggest that a service 'might' be expanded, managing expectations and allowing governments greater freedom to wind back a substandard service. Trials allow testing ideas, including simultaneous testing of variations of a program, such as different contract structures or delivery models at different trial sites. The information obtained from trials can improve services, as the DSS noted:

> People will not always act in the way policy makers assume they will … [T]he potential gap between policy makers' behavioural assumptions and actual behaviour should be tested and learnings incorporated into support mechanisms and information services. (sub. 476, p. 4)

Box 2.7 Area for improvement: Smoother transitions

Transitioning through the implementation of reforms

The *Western Australian Suicide Prevention Strategy 2009–13* highlighted problems from inadequate planning for implementation of programs (Western Australian Auditor General 2014).

The Strategy focused on improving the state's understanding of and capacity to prevent suicide. It aimed to promote a coordinated approach across all levels of government and the whole community, mainly through Community Action Plans (CAPs) involving community engagement, consultation, training and suicide prevention activities.

A report by the Western Australian Auditor General concluded that despite the Strategy engaging communities in planning, the 'benefits could have been greater' (2014, p. 4).The Auditor General found that unclear governance arrangements (including a lack of guidelines for communities to formulate CAPs) led to delays and shortened the timeframe available for the delivery of services.

In addition, the Strategy lacked proper planning and monitoring, which could have led to more effective services for users. In particular, an implementation plan was not in place for the life of the Strategy and limited quantifiable and objective measures of CAPs' performance made it difficult to assess the implementation of the program and evaluate 'what works'.

The Western Australian Suicide Strategy highlights the need for systematic service planning, an area of particular importance in this inquiry in relation to family and community services (chapter 7) and end-of-life care (chapter 4).

Transitioning between providers

Transitioning between providers can be disruptive as users find and familiarise themselves with new organisations and staff. Participants in a 2015 Senate Community Affairs References Committee's inquiry into Department of Social Services' (DSS') tendering processes highlighted the importance of relationships of trust between providers and users, particularly for vulnerable people (SCARC 2015). WACOSS (2015, p. 3) said:

> Vulnerable people who face significant life challenges … require higher levels of certainty and trust, and there is significant evidence to indicate that the ongoing relationships with dedicated and caring support staff are critical to delivering outcomes that increase their resilience and improve their health and wellbeing … These impacts [from DSS' commissioning processes] have been exacerbated by the lack of communication and clarity about the timelines and processes for decision-making and notification, with service providers unable to discover who will be delivering new services within their areas so they can provide a supported referral.

In addition to greater information and clarity about processes, participants to this inquiry also highlighted the benefits of longer contracts to provide greater certainty for providers to foster relationship with users. For example, CHP said:

> Many programs delivered by [Specialist Homelessness Services] require long-term contact, or significant investment in relationship building — both of which are common needs amongst those experiencing homelessness … The homelessness sector may be severely exposed should funding renewal not occur. Alternatively, consumers could have their long-term supports, which have been built on trust, summarily withdrawn. This practice can be discouraged through long-term forward planning of contracts (sub. 434, p. 12)

This inquiry has recommended measures for smoother transitions to ensure continuity of services, including through longer, more 'relational' contracts in family and community services (chapter 7).

In practice, trials have not always been designed and implemented in a way that delivers these potential benefits. Trials also offer less certainty for providers and users going forward, and may limit their willingness to participate.

Smoother *transitions between providers*, such as after a tender process, are important for users. This is particularly the case for those with complex needs who may be reliant on the continuity of a service (Benevolent Society, sub. 457). From the users' perspective, building relationships of trust takes time with each new provider. Stewards can provide information and clarity about changes (in a tailored form for particular user groups) in advance to allow adjustment to occur smoothly. During periods of transition, greater coordination and user navigation may be required (discussed above).

2.4 Improvement

A steward's role does not end once services are designed and delivered — they should look for ways to continually improve services and guard against poor outcomes. This involves ongoing monitoring and one-off and systemic reviews.

Ongoing monitoring helps identify emerging trends which can lead to expansion, contraction or modification of services. For example, monitoring may reveal persistently increasing waiting times for a service, triggering design and delivery changes. Monitoring measures may not be perfect, but instead act as 'red flags' that alert stewards to the need for further investigation. Monitoring can increase transparency, a key area for improvement within human services (box 2.8).

While data forms the backbone of any monitoring, less formal methods can also be used. For example, in the context of commissioning services, maintaining an ongoing relationship with providers allows stewards to identify and share problems, lessons and examples of what works. Ongoing discussions can act as informal benchmarks and as 'early warning systems' to identify challenges before they are picked up in the data. The incentive for providers to be honest with this feedback is improved if the relationship is one of mutual learning and improvement, rather than solely relying on punitive measure such as financial penalties.

One-off and systemic reviews are useful for identifying larger service problems and reforms. Systemic reviews (such as every five years) are beneficial as they embed a framework for constant improvement, and can proactively identify issues. One-off reviews are often carried out when responding to a particular problem with a service, such as the *Targeting Zero* (Duckett, Cuddihy and Newnham 2016) review into hospital safety and quality assurance in Victoria (box 2.1).

Box 2.8 Area for improvement: More transparency

Transparency around all aspects of human services is critical to achieving the best outcomes for users. Transparency helps facilitate user choice, hold providers to account, foster effective service delivery, and promote accountability of governments and the system.

For example, Henke, Kelsey and Whately (2011, p. 66) highlighted the importance of publicly available data in ensuring transparency of hospitals' performance.

> In 2009, Dr Foster (a private infomediary) analysed public data and found that a hospital in Stafford, England, had unusually high mortality rates. The NHS's Care Quality Commission then initiated an investigation, which revealed poor clinical practices. Two subsequent inquiries concluded that transparency was the key factor that led to the investigation — and that lives had been saved as a result.

Some of the factors that can limit transparency include:

- limited availability and use of data, as in the health system where barriers such as privacy concerns, fragmented data frameworks across jurisdictions, and diversity in IT platforms have curtailed the benefits from data use to the community (PC 2017)
- inadequate monitoring measures, such as where *output* measures are collected but *outcome* measures are not, meaning the effectiveness of services cannot be accurately assessed (NSW BHI 2015a)
- inadequate use of evaluations, such as across services for remote Indigenous communities, where evaluations are often not conducted and governments cannot learn about or implement 'what works' (SCRGSP 2016a).

Ways to increase transparency include:

- separating governments' responsibilities as the regulator, funder and provider, as has been put forward by this inquiry in relation to social housing (chapter 6). This limits conflicts of interest and, as a result, governments' incentives to conceal human service issues and failures.
- greater information collection and provision as proposed in relation to public hospitals (chapter 10), public dental services (chapter 12), and end-of-life care (chapter 4). For example, performance benchmarking facilitates user choice, and signals weak performance to governments and providers. Better data management and infrastructure will also help.

In general, reviews should:

- be *transparent and engage users and providers*, such as through submissions, public hearings or using principles of co-design
- have *appropriate timeframes* that match the urgency, complexity and size of the issue being examined
- take into account the *broad effect of changes and ongoing developments* (such as demographic change). Recommended changes to one service can interact with other programs and affect different aspects of users' wellbeing (for example, changes to social housing programs can affect employment and health outcomes).

Regardless of whether they are identified through monitoring or reviews, potential improvements to services will only change user outcomes if they are implemented. Continual improvement to a service may be preferred as it often causes minimal disruption, allowing

relationships (between consumers and providers, and providers and government) to develop. However, stewards should not shy away from larger reforms when they are needed, particularly where poor outcomes are damaging, systemic and persistent.

Reviews and improvements should identify problems and consider if the solutions lie in stewardship improvements or more direct service reforms. Importantly, systemic reviews should identify means (such as types of data or information to collect) of 'checking' that the reforms are progressing as intended towards their objective, and that unintended consequences are not emerging. Ultimately, stewardship is a continuous cycle, as the reforms identified in the improvement phase can trigger further changes to the design and delivery of a service.

3 End-of-life care in Australia

Key points

- End-of-life care is provided to people who have a medical condition that means they are likely to die within the next 12 months. Care services include physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff.
- There are significant gaps in information about the provision of end-of-life care in Australia. What is known is that most of the 160 000 people who die in Australia each year receive some end-of-life care, and demand for end-of-life care will grow rapidly in coming years as those born in the post-World War II baby boom enter the older age groups in which more deaths occur.
- While the quality of end-of-life care services in Australia is often excellent, they perform less well on equity considerations, as too many people end up with little real choice over the care they receive.
- There is not enough community-based palliative care available, with gaps in some locations and for those with illnesses other than cancer. Many, perhaps tens of thousands of, people cannot access desired support to die in their own home and die in hospital instead. Offering only hospital services to many people who would prefer to be, and could be well, cared for at home reduces the overall efficiency of end-of-life care.
- About 60 000 people die in residential aged care facilities each year. End-of-life care should be core business for residential aged care facilities but the quality of end-of-life care in residential aged care is patchy at best. Too often, people are transferred to acute hospitals for pain management or to die, due to a lack of palliative care expertise and qualified staff to administer pain relief.
- Patients approaching the end of life in acute hospitals can find it hard to understand whether or not hospital is the best place for them and, if they would prefer to forgo certain medical interventions, can find it hard to access services that are responsive to those preferences.
- Many people are unable to communicate their wishes for end-of-life care at the time the care is provided. Yet only about 15 per cent of Australians have prepared for this possibility by documenting their preferences in an advance care plan.
- Reforms are needed in order to put users' needs and choices at the heart of end-of-life care services, and to give services that can meet users' needs the capacity to do so. The aim of reforms to end-of-life care services should be to ensure that:
  - users receive end-of-life care that matches their preferences and clinical needs, are empowered to choose the types of care they receive, and to die in their place of choice
  - service providers respond to the preferences of people approaching the end of life (and their families and carers) and use those preferences to guide care
  - governments collect better data to enable them to understand the care needs and preferences of people approaching the end of life, and fund services that best align with those needs and preferences.

3.1 What is end-of-life care?

The Australian Commission on Safety and Quality in Health Care describes end-of-life care services as including 'physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff' provided to people who are 'likely to die within the next 12 months' (ACSQHC 2015a, p. 33).[1]

End-of-life care is not a single service provided by a particular profession, but rather is provided in almost all settings where health care is provided, including in people's homes (AIHW 2014a, p. 291; Department of Health 2017f). It can encompass a broad range of services, including advice and coordination of care, nursing and personal care, 24 hour hotlines, day hospice respite, emotional and practical support, and access to equipment (LSIC 2016). It also includes services for families and carers, such as bereavement support.

While some end-of-life care is provided by specialist inpatient or community-based palliative care services, most is provided by generalist services, such as hospitals, community health services and residential aged care facilities. There is scope for improvement in end-of-life care in each of these settings.

There is also scope for improvement in the choices available to people approaching the end of life about the setting in which they receive end-of-life care. About 70 per cent of Australians would prefer to die at home (Palliative Care Australia, sub. PFR329), but most end up dying in hospital instead (box 3.1). This is the case even though preferences for place of care and place of death are not always the same and can change over time.

The terms 'end-of-life care' and 'palliative care' are used differently in different contexts throughout Australia, although they largely entail the same approach to care provided to the same users (figure 3.1). Many scholarly articles refer to 'end-of-life' and 'palliative care' interchangeably (Bloomer, Moss and Cross 2011), and the Commission has taken the same approach in this report.

Estimates of the proportion of people who could potentially benefit from end-of-life care vary, typically from 50 to 90 per cent of those who die (for example, Murtagh et al. 2013; NHS England 2016; Rosenwax et al. 2005). Given that just under 160 000 people died in Australia in 2015 (ABS 2016a), this implies that between 80 000 and 140 000 people are likely to require end-of-life care each year.

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

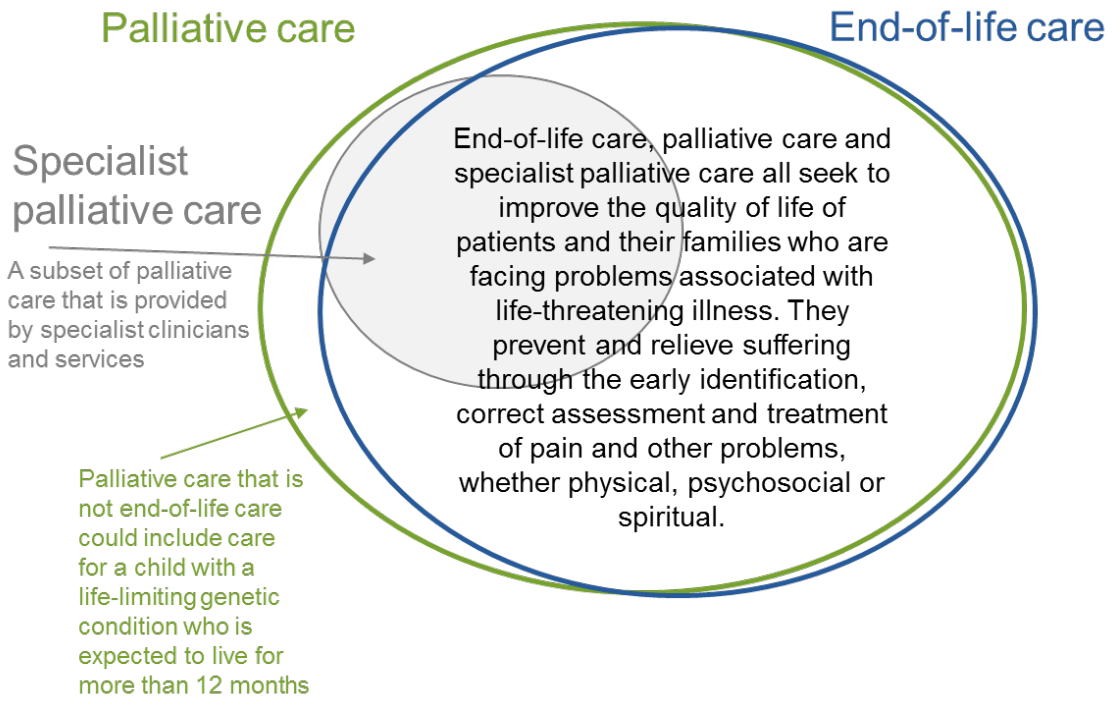
Box 3.1 Many people who would prefer to die at home do not

The Australian literature on end-of-life care (for example, Broad et al. 2013; Swerissen and Duckett 2014) and inquiry participants (including BUPA, sub. PFR380; HammondCare, sub. PFR330; Hobart District Nursing Service, sub. 419) referred to the discrepancy between the proportion of Australians who would prefer to die at home and the proportion who actually do so.

The proportion of Australians who die at home is typically said to be 14 per cent. In the Commission's view, that is likely to be an overestimate. The 14 per cent figure is often attributed to Broad et al. (2013), who used ABS and Australian Institute of Health and Welfare data from 2005 to infer the proportion of people over 65 who die in hospital, in residential aged care facilities or 'other including private home', with the latter category comprising 14 per cent.

However, these figures do not include those who died in emergency departments. Once deaths in emergency departments are considered, the proportion of people who die at home is smaller than the commonly reported rate, and was likely to have been less than 10 per cent in 2013-14. This implies that the extent of change that is needed to enable those who would prefer to die at home to do so is likely to be greater than previously thought. In numerical terms this equates to an extra 7000 people per year who need community-based palliative care.

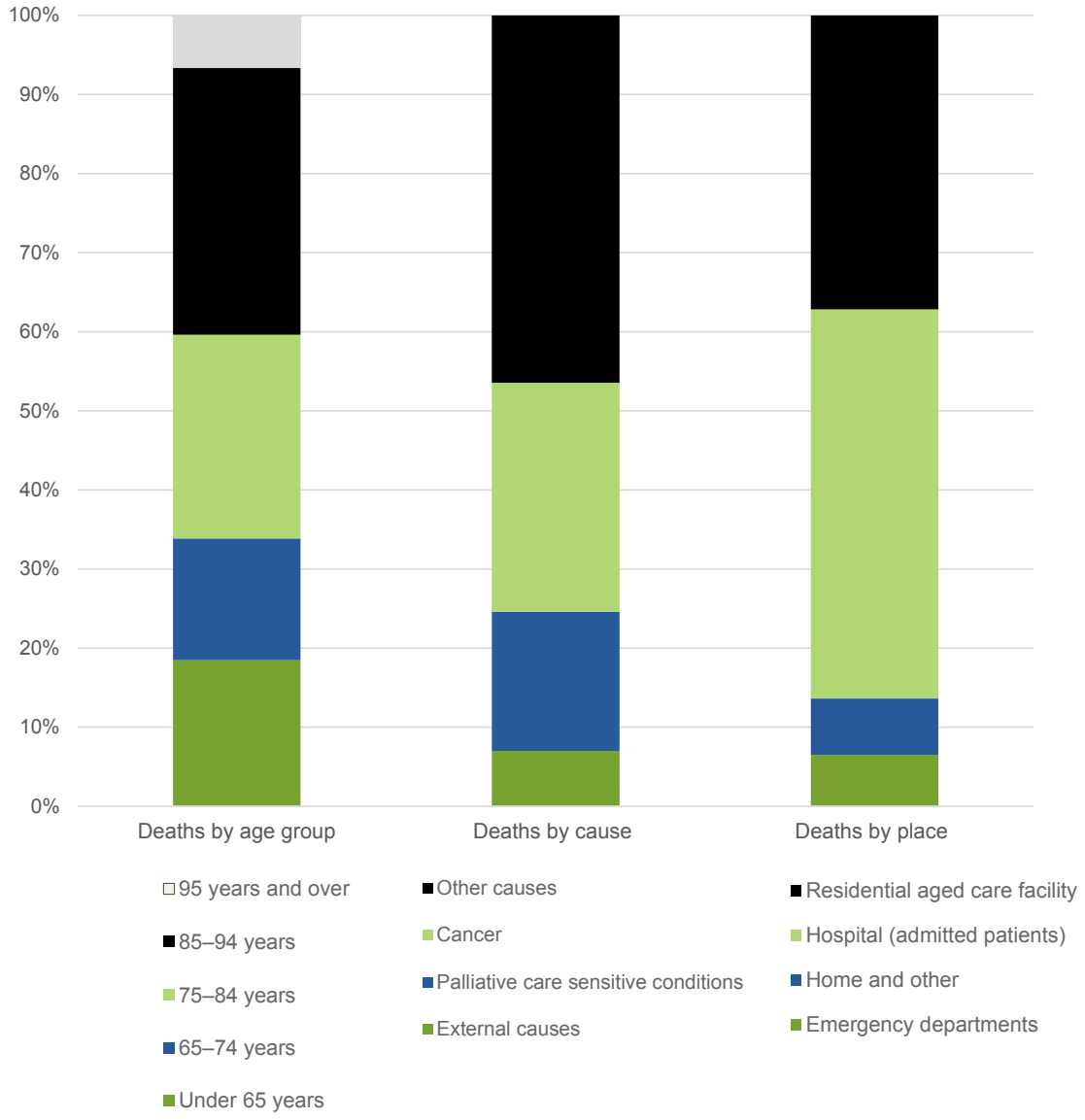
Figure 3.1 Stylised representation of end-of-life and palliative care



Sources: Based on PCA (sub. PFR329), SA Health (2009) and WHO (2015).

While there are data on the age, location and cause of deaths in Australia (figure 3.2), these data cannot be put together in such a way as to determine the need for end-of-life care, or the types of care provided in response to that need. This means that it is not currently possible to provide an overall picture of the type, amount and quality of end-of-life care Australians receive (AIHW 2016d, p. 375).

Figure 3.2 **Piecing together end-of-life care needs in Australia**
Age, location and cause of death, 2015[a]



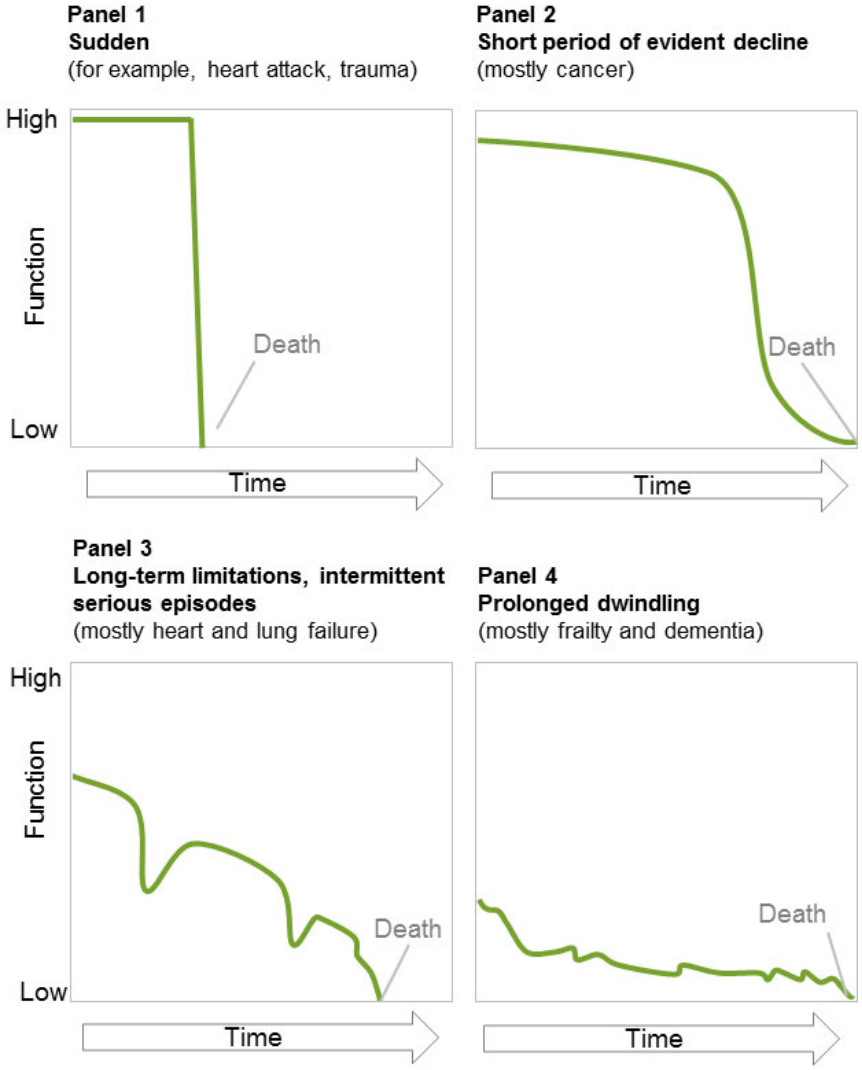
[a] Palliative care sensitive conditions comprise 11 conditions and diseases used by the Australian Institute of Health and Welfare to identify patients with diseases other than cancer who are likely to require palliative care (AIHW 2012a). Data for place of death are from 2014-15.

Sources: Productivity Commission estimates based on ABS (2016a) and AIHW (2015a, 2016a, 2016p).

What is clear is that demand for end-of-life care is growing, and will increase substantially in coming years. The annual number of deaths will double in Australia in the next 40 years, as a result of the ageing of the population and the progression of the large cohorts born during the post-World War II 'baby boom' into the older age groups (ABS 2013b). This will mean that end-of-life care providers will face a 'tsunami of palliative care admissions … as our baby boomers move through the system' (Little Haven Palliative Care, sub. 458, p. 2).

End-of-life care needs are also changing, with fewer people dying suddenly and fewer dying from illnesses that have a predictable trajectory (panels 1 and 2 of figure 3.3), and more dying 'with unpredictable timing from a predictably fatal chronic disease' (ACSQHC 2013, p. 10) (panels 3 and 4 of figure 3.3).

Figure 3.3 **Stylised illness trajectories**



[a] 'Function' refers to the ability of a patient to function physically and mentally.

Source: Based on ACSQHC (2013).

3.2 Some end-of-life care is excellent

Australia's end-of-life care services are among the best in the world in terms of quality, availability and affordability (EIU 2015) (although 'even top-ranked nations currently struggle to provide adequate palliative care services for every citizen' (EIU 2015, p. 6)).

The Australian Commission on Safety and Quality in Health Care provides clear guidance to acute hospitals on end-of-life care through its *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care* (ACSQHC 2015a). Developed in consultation with health consumers and carers, the consensus statement describes ten elements that are essential for delivering safe and high quality end-of-life care. When hospitals deliver care that is in line with the consensus statement, that care is typically efficient and in line with consumers' preferences (though this is not always the case, as the actions described by the statement are currently 'aspirational' rather than required standards).

In some locations, hospices and community-based palliative care services largely succeed in supporting those who wish to die at home to die at home or in home-like environments. For example, Little Haven Palliative Care said that it supports 60 per cent of its patients to remain at home to die, and a further 24 per cent die with less than five days in hospital (sub. 458, p. 1). The Royal Australasian College of Physicians suggested that the Silver Chain group in Western Australia has been 'successful in facilitating the integration of end-of-life care across hospital, hospice and home' settings (sub. 473, p. 9).

There are also examples of effective end-of-life care in residential aged care. HammondCare said that its Lavender Palliative Care Suite is:

> … an innovative, integrated service within an existing HammondCare residential home … [It is a] specialist palliative care unit [that] supports up to nine people who have been diagnosed with a life limiting disease and have an estimated prognosis of less than 12 months. The Suite enables personalised and flexible care routines, and comprehensively provides for residents' individual physical, psychological, social and spiritual needs. (sub. 407, p. 9)

Through its Geriatric Rapid Acute Care Evaluation (GRACE) program, the Hornsby Ku-ring-gai Hospital Service in New South Wales helps residents of local aged care facilities to avoid the physical and emotional disruption of hospital admissions, including by providing advice on palliative care treatment options (NSW ACI 2013).

Despite examples of excellent care, the supply of such care is limited, and only a small proportion of those who die each year receive it.

- In acute hospitals, the overall momentum of care delivery is toward life extension, and many clinicians regard patient death as their 'failure' or a result of their inadequacy (Bloomer, Moss and Cross 2011). Patients often rely on clinicians to initiate conversations about end-of-life care, but many clinicians are inadequately trained about, and are intimidated by, holding such conversations (Bartel 2016).

- ‘There is not enough palliative care’ (Swerissen and Duckett 2014, p. 18) in some locations or for patients with illnesses other than cancer. Palliative Care Australia and the Palliative Care Outcomes Collaboration said that ‘the greatest current barrier to patients receiving their preferred care is the availability and quality of palliative care services, including in the primary health sector’ (PCA and PCOC, sub. 417, p. 2).

There is also a disconnect between the way in which the health system considers, or aims to consider, end-of-life care (the last 12 months of life) and definitions used in the aged care system (where intensive nursing and other end-of-life care services are only funded by the Australian Government in the last week or days of life). Taken together, these factors can severely limit the options that are available when people come to make choices about their end-of-life care.

3.3 Too many Australians miss out on high-quality end-of-life care

In light of the constraints on the supply of the types of care that users would prefer, particularly skilled palliative care at home and in residential aged care, it is unsurprising that many people who need end-of-life care do not get the right care, in the right place, and at the right time. As a report published by the Australian Centre for Health Research put it:

> … too many people are dying in a way they wouldn’t choose, and too many of their loved ones are left feeling bereaved, guilty, and uncertain. The care most Australians receive at the end of life often does not reflect their values, goals, or informed choices. (Bartel 2016, p. 4)

There is scope for improvement in end-of-life care in all settings (including hospitals, community-based palliative care services and residential aged care facilities).

Treatment in acute hospitals does not always meet the needs of dying patients

Acute hospitals are, by definition, designed to provide acute care, and the doctors who work in hospitals find it much easier to continue active treatment rather than make a decision to stop (ACSQHC 2013, p. 25). This has led to hospitals being likened to a ‘conveyor belt’ (Hillman and Cardona-Morrell 2015, p. 1701), a ‘treadmill’ or an ‘express train that only goes in one direction … where a patient once admitted receives a “chain reaction” of interventions’ (Willmott et al. 2016, p. 500).

Once they are on the hospital 'conveyor belt', patients approaching the end of life, and their families and carers, can find it hard to understand whether or not hospital is the best place for them and, if they would prefer to forgo certain medical interventions, can find it hard to express those preferences. This inhibits user choice and can lead to poorer care. As Aged & Community Services Australia put it:

> With their focus on curative treatment, acute hospitals are often not ideal places for providing appropriate end of-life care that promotes comfort and quality of life. (sub. 411, p. 4)

Systemic issues in acute care at the end of life include uncertainty of prognosis, delayed recognition of dying by junior clinicians, poor communication with patients, families and community care providers, and the focus of specialist clinicians on the organ or disease group of their specialty (which can come at the cost of holistic assessment and management of end-of-life care needs) (ACSQHC 2013, pp. 24–25).

Admission to hospital can be particularly difficult and risky for people with dementia as they 'face numerous hazards during their stay in hospital and often experience adverse outcomes, including physical and cognitive functional decline, under-nutrition, skin tears and fall-related injuries' (AIHW 2013a, p. 1). In addition:

> People with dementia are frequently not recognised to be dying, and are admitted to acute hospitals in the final few days or weeks of life for the treatment of conditions such as pneumonia or urinary tract infection. This is despite evidence to suggest that acute hospital admission can be detrimental to people with dementia and stressful for their carers (Hennings, Froggatt and Keady 2010, p. 114).

Not all hospitals have formal systems in place to help identify people approaching the end of life. For example, in New South Wales, only 61 per cent of clinical units in local health districts said that they routinely identified patients that are likely to die in the next 6 to 12 months so that end-of-life planning can begin (CEC 2013, p. 7). This leads to a situation where 'almost two-thirds of terminally ill people for whom home or hospice palliative care would be appropriate die in hospital, often receiving heroic interventions' (Scott 2014, p. 127). Even for those who receive palliative care in hospital, such care often comes too late. For example in Victoria, close to two thirds of patients with metastatic lung cancer were engaged with palliative care services at the time of death, but about a quarter of those were referred to those services in the final hospital admission, during which they died (Philip et al. 2015).

There is also evidence that many of the people who are approaching the end of life in acute hospital receive non-beneficial treatments (Cardona-Morrell et al. 2016) or undergo tests and scans that do not have a clear effect on care (Clark et al. 2014). While some of these tests and treatments may be sought by patients, many patients and families can have unrealistic expectations about the likelihood of success of medical interventions such as cardiopulmonary resuscitation (ACSQHC 2013, pp. 12–13).

Indeed, a high degree of medical intervention may have an adverse effect on the quality of care at the end of life. Intensive care physicians are often among those who express concern

about the quality of some deaths in hospital. For example, an intensive care consultant told the Australian Commission on Safety and Quality in Health Care that:

> To answer your question very directly, you asked 'Do people die well in this hospital?' They absolutely do not. People are allowed to linger for far too long, in far too much pain, and causing far too much distress to themselves and their family and the people who care for them … The current situation, to speak frankly, is completely unacceptable. (ACSQHC 2013, p. 8)

Non-beneficial or unwanted treatments performed near the end of life are often conceptualised as something that occurs in intensive care units (ICUs). Yet only a minority of people are admitted to an ICU at the end of life. In New South Wales, 12 per cent of those who died spent time in an ICU in their last year of life (Goldsbury et al. 2015, p. 7). Similar results were found in South Australia, where the Health Performance Council of South Australia found that 13 per cent of people who died were admitted to an ICU at some stage in the twelve months prior to their deaths, and that a minority (17 per cent of ICU patients, or 2 per cent of total patients) were identified as palliative in the twelve months prior to their death yet spent time in an ICU (HPC 2013, p. 26).

Many patients would benefit from conservative disease management and support (such as outpatient programs to manage chronic heart or kidney failure) instead of, or in conjunction with, acute care as they approach the end of life. However, those who would benefit are not assured of access to such programs, as outpatient supportive care programs can struggle to obtain resources. For example, only half of chronic heart failure disease management programs have secured long-term funding (Scott and Jackson 2013). Indeed, the very success of supportive care and disease management programs in helping people with progressive illnesses to manage their conditions and avoid hospitalisation can be a barrier to such programs obtaining ongoing funding. If such programs are successful in keeping people in relatively good health in the community for longer, they can no longer claim to be treating people who would otherwise be in hospital, and so may lose funding.

End-of-life care is not always available where it is needed

Often, people who require certain types of end-of-life care — such as specialist palliative care or support to die at home — miss out on it. Many, perhaps tens of thousands of, people cannot access desired support to die in their own home and die in hospital instead. For example, the Victorian Auditor-General found that:

> Demand for home-based care is increasing and some metropolitan community palliative care services have struggled to meet this demand, resulting in waiting lists to access services. This can place additional stress on patients and carers, and can mean that some people who have chosen to die at home cannot spend their last days there. (VAGO 2015, p. vii)

Catholic Health Australia said that 'many Australians are unable to access any palliative care at all' (sub. 440, pp. 5–6). The Australian Health and Hospitals Association considered that:

> Palliative care services have not been broadly embedded into the health system and are fragmented, with varying access and capacity across the country, depending on diagnosis, age,

> cultural background, geographical location, available resources and clinician knowledge. (AHHA, sub. 427, p. 10)

One indicator of this variation is that family members of those who died under the care of an in-home palliative care service consider themselves among the lucky few (McMillen 2017). Other indicators are concern about poor end-of-life care services in rural areas (box 3.2), and that the number of community-based palliative care providers across Australia is not known with certainty. The best measure is the number of community-based palliative care services that contribute data to the Palliative Care Outcomes Collaboration — there are 36 of these throughout Australia (Connolly et al. 2016) (though Palliative Care Australia has a directory that currently lists about 200 community-based palliative care providers (PCA 2017)).

Box 3.2 End-of-life care in rural areas

There is limited evidence about the quality and accessibility of end-of-life care in rural areas, and the way in which this care compares to that available in urban areas. It is clear there is a strongly increased chance of dying in hospital in remote and very remote regions. This could, in part, be due to aged care facilities being located in hospitals in some country areas (HPC 2013).

Several participants told the Commission that Australians living in rural areas have limited access to, and choice about, the end-of-life care services they receive. HammondCare said:

> … services are inadequate in many rural and remote areas of Australia and the provision of around-the-clock services is also limited. Rural areas also have poorer access to specialist palliative care services which results in a greater reliance on general practitioners and community nurses, especially after hours, many of whom are not appropriately trained in the provision of palliative care. (sub. 407, p. 3)

Further 'those living in rural and remote areas are likely to find it much more difficult to access specialised palliative care services' (CHA, sub. 440, p. 5), with 85 per cent of specialist palliative medicine physicians working in major cities (AIHW 2016o).

There can also be some advantages to receiving palliative care in a small rural hospital, as palliative care can become an extension of the sense of community fostered in rural areas (Urbis 2016a).

Another indicator of the room to improve end-of-life care is that many Australians who would prefer to die at home do not have their preference fulfilled (box 3.1). Australia is not alone in apparently having rates of dying at home that are much lower than people say they want. In 2011, 65 per cent of deaths in Canada occurred in acute care hospitals, even though many Canadians (63 per cent according to an Ontario survey) express a preference to die at home (Costa et al. 2016, p. 2).

Many participants called for an increase in palliative care services that would enable more people to die in their own homes (for example, CHA, sub. 440; Hobart District Nursing Service, sub. 419). Some community-based palliative care providers report that government funding covers a relatively small proportion of their costs. For example, 35 per cent of the annual budget of Little Haven Palliative Care ($256 000) is covered by Queensland

Government funding (sub. 458). (The remainder is covered by fundraising, bequests and donations (sub. 458, att. 2)).

Access to both inpatient and outpatient palliative care services is lower among certain groups, including Indigenous Australians, people from culturally and linguistically diverse backgrounds, and people with disabilities (HCSC 2013; LSIC 2016; NSW ACI 2014; SCARC 2012; Urbis 2016a). While people with illnesses other than cancer have many of the same end-of-life care needs as those with cancer (Moens et al. 2014), they are commonly under-represented among those receiving specialist palliative care (Currow et al. 2008; LSIC 2016).

Aged care services often struggle to meet end-of-life care needs

Residential aged care is transforming into an end-of-life care service

The aged care system includes a range of different services, many of which are designed to help older Australians live independently in their own home. As people approach the end of life their care needs increase and many move to a residential aged care facility (RACF), with just over 80 per cent of permanent RACF residents dying there (about 60 000 people per year) (AIHW 2017d).[2]

Residential aged care is increasingly provided to people who are older and who have higher care needs. Between 2012 and 2015, the proportion of RACF residents who were assessed as having high care needs across all three care domains (activities of daily living, behaviour and complex health care) rose from 18 per cent to 27 per cent (an increase of just over 15 000 people) (AIHW 2012b, 2015d). Based on current trends, residential aged care is transforming into an end-of-life care service (PC 2015c).

Too many residential aged care facilities fail to meet end-of-life care needs

While some RACFs provide excellent care, participants told the Commission that palliative and end-of-life care are poorly provided in many facilities.

Alzheimer's Australia said that it 'receives multiple reports from consumers about … people in extreme pain at end-of-life not having access to palliative care' (2017, p. 11). Similarly, Palliative Care Australia expressed concern about 'unmanaged severe pain' in RACFs (PCA 2016a, p. 3), and said that its members report 'an inability for some [aged care] services to provide palliative care at the end of life, particularly if the person dying has complex symptoms' (PCA 2016a, p. 6). This can lead to RACFs being 'reluctant to accept clients who are dying, despite the fact that there is no clinical need for them to remain in an acute setting'

[2] In this inquiry, the Commission has focused its consideration of aged care on residential aged care. While end-of-life care would sometimes be provided by aged care home care services, the Commission was unable to obtain data to suggest that this occurs in anything but a handful of cases.

(NSW Ministry of Health 2016a, p. 7). The evaluation of the National Palliative Care Strategy quoted a service manager who said that end-of-life care in aged care is:

> … dire with few [registered nurses] being employed in aged care facilities, high turnover of staff, lack of skilled staff and lack of awareness of dying and palliative care needs. People enter aged care facilities now with little time left to live (3-6 months in many cases) and yet the staff are not skilled in palliative care and round the clock pain medication cannot be given as there are no [registered nurses] available. (Urbis 2016a, p. 31)

HammondCare said that RACFs are 'one of the settings which require improved access to specialist palliative care services' (sub. 407, p. 9). The Health Care Consumers' Association of the ACT said that aged care residents are often transported to hospital:

> … for medical care which they could have received at their residential facility had there been a suitably trained practitioner (nurse or doctor) available to treat the individual. This situation is ridiculous, costly, traumatic and inefficient. (HCCA ACT 2010, p. 6)

Palliative Care Australia said that in RACFs, the 'structure and staff mix is heavily weighted in the lower paid unregulated staff (PCAs) [personal care assistants] with inadequate levels of qualified health care staff especially outside standard business hours' (PCA 2016b, p. 6). People who are approaching the end of life are transferred to acute hospitals for pain management because these staff do not have the skills to lead and coordinate end-of-life care for residents. In 2008-09 about 9600 permanent residents of RACFs died in hospital (AIHW 2013c). More recent data are not available.

Recognition of the particular end-of-life care needs of people with dementia, who comprise about two thirds of those in residential aged care, was an area of particular concern (Alzheimer's Australia, sub. 431; Davis et al. 2009; SCARC 2012). There was also concern that some community members can find it hard to access end-of-life care in aged care. The Federation of Ethnic Communities' Councils of Australia told the Commission that:

> … culturally appropriate care under the current home and residential care for older people from CALD [culturally and linguistically diverse] backgrounds is scarce or inadequate … Many people from CALD communities are not aware of the palliative care supports available to them and do not plan the end of life needs. (FECCA, sub. 433, p. 3)

The Victorian Aboriginal Community Controlled Health Organisation said that the aged care assessment process can limit Aboriginal peoples' access to aged care services because 'it's daunting to ring a government agency and a lot won't do it because it's too daunting. This will actually deter people getting support until it's critical and they need to go to hospital' (sub. 455, p. 8).

Another constraint on access to aged care is the current system of accreditation and approvals of aged care providers and the allocation of bed licences. In some cases, restrictions on the number of aged care places and their locations limit consumers' ability to choose RACFs that best suit their end-of-life care needs. Aged care reforms are moving toward providing users with greater choice over the services they receive, and a move toward a fully demand-driven system of residential aged care has been signalled by the relevant Australian

Government committee, but the timeline remains uncertain (Aged Care Sector Committee 2016).

Assessment and funding systems do not take proper account of palliative care needs

Many participants told the Commission that current funding arrangements have adverse effects on end-of-life care in RACFs (box 3.3). For example, Leading Age Services Australia said that the current funding system 'certainly does not encourage nor support end-of-life care and services to the resident, let alone the family and others' and that there is 'a disconnect between the funding provided for care and the actual care people receive in residential aged care' (sub. 463, p. 7). Indeed, only one in six people who died in residential aged care received funding for palliative care (AIHW 2016n).

Box 3.3 Limits on funding for end-of-life care in residential aged care

The Aged Care Funding Instrument (ACFI) is used to assess the care needs of those living in residential aged care. ACFI assessment involves determining whether the resident has low, medium or high care needs across three care domains (activities of daily living, behaviour and complex health care). Funding in each of these domains is categorised as either high, medium, low or nil.

Time limits on palliative care

The ACFI specifies that funding specifically for palliative care is only allowable 'in the last week or days' of a resident's life. This limit is strictly adhered to in Australian Government decisions, which has pursued Administrative Appeals Tribunal cases against aged care facilities that sought funding to provide palliative care for too long (for example, Southern Cross Care [2014] AATA 623).

The 'high' funding ceiling

Not only does the ACFI severely restrict the duration of palliative care, ACFI funding for palliative care is not available to all residents — if a resident is already receiving 'high' funding for an ACFI domain, no additional funding is made available if their care needs in that domain increase further. The AIHW reported that in 2014-15 more than 50 per cent of residents of RACFs received 'high' level funding for their health care (AIHW 2016b). This means that no additional funding is available for palliative care (or any other additional health care needs) for more than half the residents of aged care facilities as they approach the end of life.

In light of these concerns, reforms are needed to ensure that people residing in residential aged care receive end-of-life care that aligns with the quality of care available to other Australians.

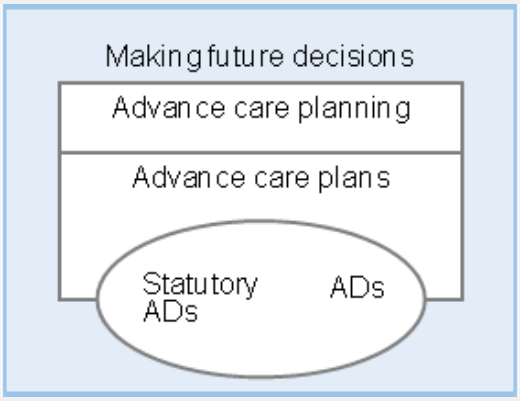
Few Australians make plans for their end-of-life care in advance

Many people will be unable to communicate their wishes for end-of-life care at the time the care is provided. Consequently, to have a real choice in the care they receive, people must communicate their wishes in advance, ideally by preparing and maintaining a high-quality advance care plan (ACP) (box 3.4).

Box 3.4 Advance care plans: some definitions

What is an advance care plan?

An advance care plan outlines a person's preferences regarding future medical treatment in the event they are incapacitated and unable to communicate this themselves. Advance care plans are one component of future decision making about medical care, as illustrated below.



An advance care plan may include an advance directive (AD) (see below), a letter to the person who will be responsible for this decision making, an entry in the patient medical record, a spoken instruction or other communication which clearly enunciates a patient's view, or any combination of these (Department of Health 2012, p. 25).

What is a high-quality ACP?

High-quality ACPs are often termed 'complex ACPs' because they include multiple sources of information about a patient's preferences. For example, high-quality ACPs may include an AD completed in consultation with a substitute decision maker and a clinician (Street and Ottmann 2006). Maintenance of a high-quality ACP requires an ongoing conversation, and ACPs should be regularly reviewed and updated (Scott et al. 2013). Well-maintained, high-quality ACPs have been shown to increase compliance with patients' end-of-life wishes and to improve family members' perceptions of the quality of their loved one's death (Detering et al. 2010).

What is an advance directive?

An advance directive (sometimes advance care directive) is an advance care plan that has been formally recorded, according it legal status under common law or state legislation (PCA 2012, p. 2). Currently all States and Territories offer some kind of pro forma advance directive and, in most cases, these can be downloaded and completed at home. A list of these plans is accessible at www.advancecareplanning.org.au, a website funded by the Department of Health.

Sources: Advance Care Planning Australia (2017); AHMAC (2011); Brinkman-Stoppelenburg et al. (2014); Department of Health (2012); PCA (2012); Street and Ottmann (2006).

Governments, local health districts and non-government organisations have made efforts to promote advance care planning, as it has a range of demonstrated individual and societal benefits, including increased likelihood that patients will receive medical treatment in accordance with their wishes and die in their place of choice, reduced burden on substitute decision makers, and a reduction in the practise of defensive medicine (where doctors engage in costly, active treatment that patients may not want) (Detering et al. 2010; Respecting Patient Choices Program 2012).

Despite these efforts, relatively few people have an ACP. A national telephone survey conducted in 2012 found that only 14 per cent of Australians had an ACP (White et al. 2014). In a separate study of people aged over 65 years presenting to emergency departments, 13 per cent had ACPs (Street et al. 2015).

There are several reasons for the continued low uptake of ACPs. People are often reluctant to contemplate their own frailty or mortality. Others may simply prefer to live 'one day at a time' and, provided the person has sufficient information and understanding about what an ACP entails, this wish should be respected (Rietjens, Korfage and Heide 2016, p. 421).

Another barrier to advance care planning is that advance care planning conversations, particularly those that are necessary to develop high-quality ACPs, take time. Several sessions are usually required to discuss all the relevant issues with patients and their families, often over a period of weeks (HammondCare, sub. 407; Scott et al. 2013). Clinicians can struggle to find the time to have these conversations in busy hospital or general practice environments. For these reasons, it will never be possible or desirable for everyone to have an ACP. As it stands, however, many people approach the end of life unable to speak for themselves and without a plan in place to guide their care.

Not enough is known about end-of-life care

Several inquiry participants (including COTA, sub. 456; Queensland Nurses' Union, sub. 405) pointed out a need for more rigorous transparency and accountability for both service providers and commissioning bodies working in this space. The Health Performance Council of SA said that:

> … more performance information about quality, access, equity and health outcomes of … end-of-life care services, aged care services and primary care should be transparent and in the public domain. (sub. 437, p. 6)

Such performance data are a fundamental starting point for improving the delivery of those activities to the community (PC 2017). Yet there are significant gaps in even the most basic administrative data about end-of-life care. In some cases, this is because the variables are simply not recorded — for example, the number of days that residents of RACFs spend in hospital (each year, or in their last year of life) is not counted. Other data are collected but are not linked or made available in an affordable, accessible format. For example, information on the age, location and cause of deaths in Australia is available but the linking

of these datasets is not routinely carried out, and the process for obtaining linked datasets is complex, lengthy and expensive (PC 2017, p. 509). Consequently, these details cannot be put together in such a way as to provide an overall picture of the type, amount and quality of end-of-life care Australians receive (AIHW 2016d).

3.4 Reform directions for end-of-life care

There is scope for improvement in each of the attributes of service effectiveness set out in chapter 1. While the quality of end-of-life care services in Australia is often excellent, they perform less well on equity considerations, as too many people approaching the end of life end up with little real choice about the care they receive. Similarly, while some services are efficient, offering only hospital services to many people who would prefer to be, and could be well, cared for at home, reduces the overall efficiency of end-of-life care in Australia. It also means that end-of-life care services are not as responsive as they should be to users' needs and choices. Accountability for this shortfall is lacking, partly because information and data about end-of-life care are so limited, and partly because there are no policies or guidelines that set clear directions for end-of-life care throughout Australia.

- The COAG Health Council has asked for advice on 'actions to improve culturally appropriate end-of-life care' (2016, p. 1), but this work is still ongoing.
- There is a National Palliative Care Strategy (Australian Government 2010), but a recent evaluation found that it is not clear what it is seeking to achieve and how achievements can be demonstrated, and so it 'has not been effective in aligning state, territory and Commonwealth planning and policies' (Urbis 2016a, p. 43).
- While most State and Territory Governments have end-of-life and palliative care policies and plans, these contain few tangible measures or goals for ensuring that all of the people who would benefit from palliative care receive it, and some omit the palliative care needs of those in aged care.
- The Australian Commission on Safety and Quality in Health Care provides clear guidance on essential elements of safe, timely and high-quality end-of-life care (ACSQHC 2015a), but only for adults in acute hospitals.
- The standards required of aged care providers are very broad — they are required to ensure that 'the comfort and dignity of terminally ill care recipients is maintained' (AACQA nd). The existing guidelines for palliative care in residential aged care and in community aged care expired in 2011. A new set of consolidated palliative care guidelines for the aged care sector is expected to be released by 30 June 2017 (Department of Health 2015b).

The lack of direction on end-of-life care in Australia stands in sharp contrast to the clear aim articulated by the National Health Service in the United Kingdom — to provide person-centred end-of-life care that delivers 'the right care in the right place at the right time with the right resource' (NHS England 2016, p. 3).

What would an effective system of end-of-life care look like?

In the Commission's view, an effective system of end-of-life care would put users' needs and choices at the heart of end-of-life care services. In formulating draft recommendations to achieve this goal, the Commission has considered what an effective system of service provision would look like from the perspective of users, providers and governments.

Users

For people approaching the end of life and their families, the reforms would mean that they have timely access to end-of-life care that meets their clinical needs and is coordinated across settings. They would be supported and empowered to choose types of care (and the degree of medical intervention) they receive, and to die in their place of choice, regardless of their diagnosis, location or financial circumstances. To ensure people receive care that matches their end-of-life care preferences — even if they are unable to communicate those preferences — people approaching the end of life would be supported to record their preferences in an advance care plan.

Service providers

Service providers would respond to the preferences of people approaching the end of life (and their families and carers) and ensure those preferences guide the care that those people receive. Service quality and access to care would be aligned across settings, including hospitals, community-based palliative care providers, and residential aged care facilities. In all settings, providers would ensure that clinicians are suitably trained for their roles, including in the facilitation of advance care planning and the provision of end-of-life care. Providers would collect and publish data on their performance, and be accountable for using those data to improve end-of-life care.

Governments

Governments would understand the care needs and preferences of people approaching the end of life, and would fund services that best align with those needs and preferences. Governments would apply the principles of good stewardship and use a wide range of relevant data to ensure that end-of-life care service provision is effective, timely and coordinated across settings.

Chapter 4 describes the reform strategies proposed by the Commission to achieve these objectives.

4 Reforms to end-of-life care

Key points

- Improving end-of-life care would significantly enhance the wellbeing of those dying and their families. Hospitals, community-based palliative care services and residential aged care facilities could be more responsive to users' needs, underpinned by initiatives to increase the use of advance care planning and to prepare for future increases in demand for end-of-life care.
- A major increase in the availability of community-based palliative care is required.
  - To achieve this, State and Territory Governments should run tenders or other competitive processes to select providers of additional community-based palliative care services.
  - The providers selected to deliver community-based palliative care should be able to achieve integrated and coordinated nursing, medical and personal care, and provide access to care and support on a 24 hours, 7 days a week basis.
- In metropolitan areas, commissioning multiple providers of community-based palliative care services and enabling people approaching the end of life who wish to make a choice to choose between providers is the ultimate objective (recognising that offering one option for community based palliative care to those who currently lack any is the first priority).
- People living in residential aged care facilities should receive end-of-life care that aligns with the quality of that available to other Australians. This will require:
  - removing current restrictions that limit the duration of palliative care in residential aged care and its availability to residents who have pre-existing high care needs
  - providing additional funding to residential aged care facilities so that they can ensure that end-of-life care is led and coordinated by staff with the requisite skills.
- General practitioners and practice nurses could play a much larger role in helping people to articulate their preferences for end-of-life care through advance care planning. Changes to Medicare items numbers are needed to enable this to occur.
- Hospital accreditation standards will, from 2019, prescribe a range of best practice elements of end-of-life care. This should drive the changes that are needed in hospitals to ensure that patients are encouraged and supported to express their preferences about end-of-life care, and receive care that is responsive to those preferences.
- Data on several components of end-of-life care are insufficient for governments to execute their stewardship functions. A strategy to deliver improvements in the quality and availability of data on end-of-life care is therefore a critical component of any reform process.

A comprehensive approach to end-of-life care recognises that the patient and clinicians are both essential participants in discussions and decision-making about care needs at the end of life. This shifts the emphasis of care delivery from life extension toward care that attempts to fulfil each patient's choices, values and preferences, given the realities of the patient's

clinical condition and treatment options. In order to achieve this, the Commission is recommending a number of proposed reforms designed to put users' needs and choices at the heart of end-of-life care services (table 4.1).

Table 4.1 **Overview of proposed reforms to end-of-life care**

Proposed reforms	*Timeframe*	*Potential costs and benefits*
Community-based palliative care		
Draft recommendation 4.1 **State and Territory Governments** to ensure that people with a preference to die at home are able to access support from community-based palliative care services to enable them to do so.	Assess needs as soon as practicable. Implementation timeframe depends on assessed needs.	Patients would be able to access a community-based palliative care package that supports them to die at home if they choose. Community-based palliative care could cost less than its hospital equivalent.
End-of-life care in residential aged care		
Draft recommendation 4.2 The **Australian Government** to remove current restrictions on the availability and duration of funding for palliative care in residential aged care, and provide sufficient additional funding to ensure that people living in residential aged care receive end-of-life care that aligns with the quality of that available to other Australians.	As soon as practicable.	Residents of residential aged care facilities would receive end-of-life care that aligns with the quality of that available to other Australians. Costs would depend on the extent of unmet need, which is currently unknown.
Advance care planning		
Draft recommendation 4.3 The **Australian Government** to: • include initiating an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. • introduce a new Medicare item number to enable practice nurses to facilitate advance care planning.	As soon as practicable.	More people would prepare advance care plans and receive care that matches their end-of-life care preferences even if they were unable to communicate those preferences. There would be extra demand on general practitioners' time, but enabling practice nurses to assist would reduce this.
Draft recommendation 4.4 The **Australian Government** to include the facilitation of ongoing conversations about advance care planning in the aged care Quality of Care Principles.	As soon as practicable.	Residential aged care facilities would spend time ensuring that the choices of residents and their families guide their end-of-life care.
Better data on end-of-life care		
Draft recommendation 4.5 The **Australian, State and Territory Governments** to ensure there is sufficient data to enable them to monitor how well end-of-life care services are meeting users' needs.	Develop an end-of-life care data strategy as soon as practicable. Implementation timeframe depends on chosen strategy.	The cost of additional data collection would be determined during the strategy development. Improvements to efficiency resulting from better data would contribute to a reduction in costs.

The reforms have been designed to be implemented as a package to increase their effectiveness and to ease the transition. In particular, reducing demand for some hospital services, by reducing the number of people who have no other choice than acute hospitals

for their end-of-life care, may free up funds that could be used for improvements in end-of-life care in residential aged care facilities and in the community. Ultimately, though, potential longer-term savings should not be the primary driver of reforms to increase access to high-quality end-of-life care.

4.1 Improving acute care at the end of life

Most Australians die in hospital, and many more receive end-of-life diagnoses while in hospitals or outpatient clinics. Hospitals are therefore the starting point for considering how to deliver reforms to end-of-life care. This will require addressing the many systemic issues that can make it difficult for hospital staff to deliver good end-of-life care (chapter 3).

New standards to improve end-of-life care in acute hospitals

Reforms to improve the way in which patients approaching the end of life are supported in acute hospitals are already underway, as part of ongoing revision of the National Safety and Quality Health Service (NSQHS) Standards.

Hospitals must meet the NSQHS Standards in order to obtain and retain accreditation. Version 2 of the NSQHS Standards, which will be implemented in 2019, will require hospitals to meet the elements of the *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care* (ACSQHC 2017). As noted in chapter 3, the consensus statement describes ten elements that are essential for delivering safe and high quality end-of-life care, with a focus on patient-centred communication and shared decision-making, and the organisational prerequisites necessary for delivering patient-centred care.

Implementation of the new end-of-life care standards

One notable element of the consensus statement is a requirement to use triggers to recognise patients approaching the end of life. This includes recognition of patients who are likely to die within the next 12 months, and those who have days or weeks to live, and are likely to die during the current admission (ACSQHC 2015a). Many hospitals across Australia are already using triggers to identify patients who are approaching the end of life, but others are yet to do so.

Training clinicians to talk about end-of-life care with patients

Triggers will only be effective if they prompt clinicians to overcome barriers to initiating end-of-life conversations, and thereby enable patients to have timely discussions about their end-of-life care with their clinicians, families and carers. Individual clinicians may not have

time for such discussions, and often fear causing distress or damaging hope. There is, however, evidence that this reluctance can be reduced through targeted training (box 4.1).

Box 4.1 Training clinicians to talk about end-of-life care with patients

Clinicians feel unprepared to talk about dying

For clinical staff, patient deaths are often expected. Yet the heavy, emotive nature of death, dying and future care needs make them difficult subjects for clinicians to address (Scott et al. 2013). Families can interpret planning as an attempt to hasten the process of dying.

Triggers may prompt clinicians to have conversations with patients about their future care needs and preferences, and assist clinicians to determine the best timing for those conversations. But clinicians do not always have the skills or understanding necessary to know when and how to hold these difficult conversations (Nedjat-Haiem et al. 2016) or the technical knowledge to facilitate planning (Seal 2007; Street et al. 2015).

Training can help

Several inquiry participants, including HammondCare (sub. 407), MIGA (sub. 432), Leading Age Services Australia (sub. 463) and the Royal Australasian College of Physicians (sub. 473) suggested that training is needed to give the clinicians the confidence necessary to start conversations about end-of-life care.

There are a number of training programs that have demonstrated their effectiveness in teaching clinicians to engage patients and their families in shared decision making about end-of-life care. For example, the Respecting Patient Choices program is designed to help hospitals establish systems that cater for improved care planning, including staff training programs with a 'person centred' 'complex' advance care planning approach (Brinkman-Stoppelenburg, Rietjens and Heide 2014). Based on a US model and first implemented in Australia at the Austin Hospital, Respecting Patient Choices includes additional practical training (role plays and scenarios) that are specific to the Australian context.

Prior to the introduction of Respecting Patient Choices at the Austin, about 9 per cent of patients had advance directives and only about half of those were active (Lee et al. 2003). After implementing the Respecting Patient Choices training program, 47 per cent of patients were offered advance care planning, of which 70 per cent went on to prepare a written plan. Of the patients who died, about three quarters had some expression of their treatment wishes recorded in their medical record, and one quarter had completed a formal advance care plan document (Lee et al. 2003). The Respecting Patient Choices program has now been adopted by health services and communities across Australia and implemented in at least one lead hospital in every state (CareSearch 2017b).

Focusing on the needs and preferences of individual patients

It is important that efforts to systematically identify patients who are approaching the end of life, and to equip clinicians to hold conversations about end-of-life care with them, do not become 'tick and flick' exercises. The experience in the United Kingdom with the Liverpool Care Pathway (box 4.2) highlights the risk that the approaches used to implement triggers and care pathways may not give sufficient regard to each individual patient and their preferences.

Box 4.2 The rise and demise of the Liverpool Care Pathway

A new End of Life Care Strategy was adopted in England in 2008. It was developed with the aim of giving people approaching the end of life more choice about where they would like to live and die (UK Department of Health 2008).

The strategy encouraged hospitals to adopt a care pathway originally developed for the care of cancer patients in acute hospital settings — the Liverpool Care Pathway (LCP). In 2008, the LCP had been implemented in hospices and aged care homes, and been modified to be used for people with other conditions, for example renal disease and heart failure. The LCP was actively promoted by the National Health Service and was adopted as standard practice by more than 1800 health care institutions (Chan et al. 2014).

By 2012, allegations emerged that patients had been placed on the pathway prematurely, or been poorly managed once they were on the pathway. The UK Government commissioned an independent review of the LCP, which found that although the LCP had clear benefits when used correctly, it had been treated as a 'tick box exercise'. The review recommended that the LCP name be abandoned, the term 'pathway' avoided and that the LCP be replaced by an 'end of life care plan' (Neuberger 2013).

Responses to the review pointed out it is 'as illogical to discredit guidance because of errant clinicians as it is to ban the Highway Code because of bad drivers' (Regnard 2014, p. 172). After significant media attention, however, the damage was done and the LCP was abandoned.

The UK experience also highlights the importance of ensuring that institutional arrangements at the hospital level (including training and clinical governance systems) are designed to support good end-of-life care, and that triggers are used to prompt discussions, not to force decisions or transitions in care.

Responsibility for end-of-life care in acute hospitals

In hospitals, where many health professionals can be involved in a patient's care, training clinicians to talk about end-of-life care is only part of the story. It is also important to clarify responsibilities for initiating and conducting end-of-life conversations. Even with appropriate triggers and training for clinicians, this will require concerted effort by hospital leadership. The common refrain that 'end-of-life care is everyone's responsibility', while true, needs to be reinforced by the actions of hospital leadership.

Under the NSQHS Standards, the hospital board, chief executive or senior executive are already required to demonstrate that they monitor the safety and quality of care. This will be extended in version 2 of the NSQHS Standards to include a requirement for formal governance process to 'oversee the development, implementation and ongoing review of systems for end-of-life care' (ACSQHC 2015a, p. 23).

In England, the importance of senior oversight of end-of-life care has been reinforced through public reporting on hospital quality. Hospitals that do not have clear senior oversight of end-of-life care receive poorer ratings for it (box 4.3). Similar measures could, in time, be incorporated into Australia's public reporting on hospital performance (chapter 10).

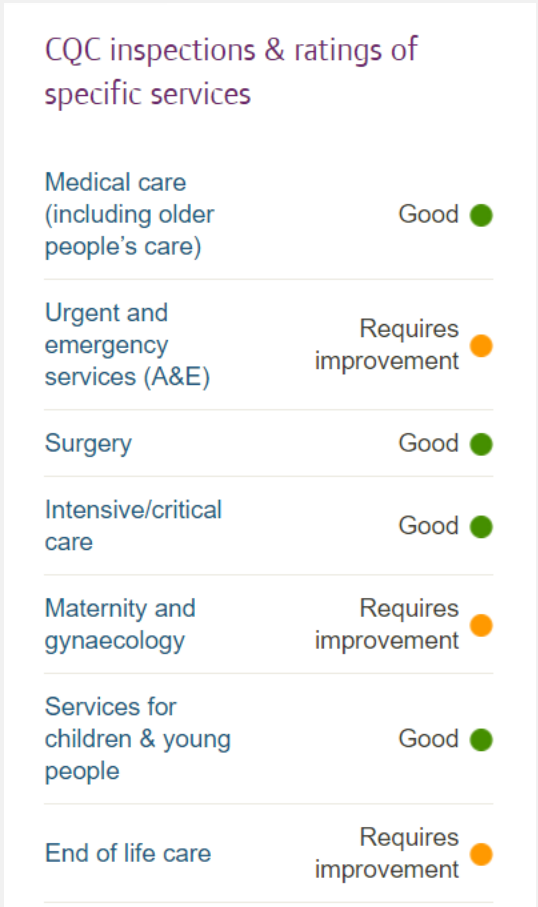
Box 4.3 **Transparency about end-of-life care quality in the United Kingdom**

In England, a large amount of consumer-oriented information about healthcare providers has been made available online. Patients can see an overall rating that England's healthcare regulator — the Care Quality Commission (CQC) — has given to individual hospitals.

The CQC's assessment of each hospital provides easily accessible information about the quality of each service area, including end-of-life care, using a traffic light system (see example at right). These service ratings can be disaggregated into ratings for five objectives (safety, effectiveness, caring, responsiveness or well-led).

The hospital whose ratings are shown below was rated as inadequate for 'well-led' in end-of-life care because:

- there was insufficient time for senior staff to provide leadership and governance
- it was slow to develop end-of-life care services in line with national guidelines
- quality, performance and risks were not effectively managed.



	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Source: CQC (2016).

4.2 Enabling more people to be supported to die at home if they wish

Under current arrangements, the supply of quality end-of-life care services to help people to die at home or in a home-like environment is not sufficient to meet demand, with tens of thousands of people missing out on the home-based care they would prefer (chapter 3). As the Grattan Institute pointed out:

> … in principle, dying people should be able to choose a community-based palliative care package that supports them to die in place, particularly if they want to die at home. (Swerissen and Duckett 2014, pp. 27–28)

In practice, only a small proportion of people who would prefer this type of care have access to it in a way that meets their needs. Addressing the current shortfall in community-based palliative care should start with State and Territory Governments commissioning additional community-based palliative care services. (Commissioning is an approach that governments use when engaging government or non-government providers to deliver human services (chapter 1)).

Governments should take a systematic approach to commissioning and service delivery by being clearer about what outcomes they are seeking to achieve, for whom and where. In the long term, enabling people approaching the end of life who wish to die at home to choose between community-based palliative care providers is the ultimate objective (recognising that increasing the availability of community-based palliative care is the more immediate priority).

This section considers the issues that will be particularly important to address for effectively commissioning community-based palliative care services. The draft recommendations relating to commissioning family and community services (chapter 7) are also likely to have broader lessons for commissioning palliative care services.

Assessing the need for additional community-based palliative care services

The starting point for providing additional community-based palliative care should be a detailed assessment of the current and future needs for such care, and current gaps in service provision.

It is highly likely the assessed needs and identified gaps will differ in different regions, as 'there is huge variability in the delivery of palliative care services across the country' (Catholic Health Australia, sub. 440, p. 5). Specifying the highest priorities for additional community-based palliative care services would enable governments to target funding to the areas where it would have the greatest effect on end-of-life care outcomes.

While data are scarce, it is possible to ascertain some of the regions and populations where there are substantial unmet demands. A prime example is the gap in community-based palliative care service provision that has recently emerged in Tasmania (where Australian Government funding for the hospice@HOME program has ceased and no new clients have been accepted for palliative care services since 31 March 2017). The assessment of unmet needs would then help governments to determine priorities for service expansion.

As part of tailoring services to specific regions, State and Territory Governments would need to work with Local Health Districts and Primary Health Networks to assess the need for additional community-based palliative care. Indeed, many Primary Health Networks have, in their 2016–18 work plans, already committed to undertaking an assessment of local palliative care needs. This local involvement is consistent with the experience of commissioning in England, which has shown that 'fundamental to any commissioning plan

for end-of-life care is a local strategy, jointly developed with local people and key partners, clearly setting out your vision for end-of-life care' (NHS England 2016, p. 12). The cooperation of the Australian Government will also be important, including through the provision of Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and aged care data, given the scarcity of data on end-of-life care.

Drawing on the experience and expertise of service providers, service users and the organisations that represent them will also be an essential component of a comprehensive needs analysis. Bringing this experience and expertise into the process of service design 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. In this regard, user-focused information on the needs assessment process, such as the '10 Questions to ensure good end of life care in your area' publication available in the United Kingdom (NCPC 2013), could prove useful.

Designing services to meet the identified needs

The objective of the design stage of the commissioning process is to develop and implement systems of service provision that will contribute to meeting the needs identified during the needs assessment. Depending on the extent and location of the identified needs, this will not be achievable quickly. The substantial increases in services that are required may take years to be operational throughout Australia. That said, a large increase in service availability was recently achieved in Tasmania — the hospice@HOME program cared for over 2000 people between its establishment in December 2014 and June 2016, servicing people for whom community-based end-of-life care was previously unavailable (The District Nurses 2017, p. 9).

Participants highlighted the need to ensure that service delivery models are designed for different geographic areas. In metropolitan areas, this could involve commissioning multiple providers of community-based palliative care services. Were this to be the case, State and Territory Governments would need to determine if people should have choice between providers, and if so, how to enable that choice. The benefits of enabling choice between providers would be greater where there is greater variation in people's preferences, and so greater scope for different providers to better meet those different preferences.

In regional areas, options may be more limited if there is not the population base to support more than one service provider. Remote service provision may be possible for some users and for some (but not all) services. For example, the National Rural Health Alliance said:

> The need for access to good telehealth and ongoing access to appropriate specialist care is also important to ensure people approaching the end of life are able to remain in their community with the appropriate care and support for themselves and their carers. (sub. 428, p. 12)

Remote service delivery models such as telehealth have been demonstrated to help patients 'to feel supported and remain in their place of residence, hence reducing the pressure for avoidable hospital admissions and use of other services' (Middleton-Green et al. 2016, p. 1).

Building on existing person-centred services

People approach the end of their lives with different illnesses, different preferences and different levels of family and community support, which leads to a wide degree of variation in end-of-life care needs. Further, as noted in chapter 3, end-of-life care can encompass a broad range of services, including advice and coordination of care, nursing and personal care, 24 hour hotlines, day hospice respite, emotional and practical support, and access to equipment (LSIC 2016). It also includes services for families and carers, such as bereavement support.

While community-based palliative care providers can, and should, respond to the urgent and diverse needs of their patients in a flexible way, it is also important to ensure that the providers limit their service offerings to those that are clinically necessary or that are essential for peace and wellbeing at the end of life. This would include nursing and medical care and the provision of equipment. Users would need assistance from family, friends or carers to provide meals and linen, as well as personal care when the provider is not available (such as help with personal care between nurse visits).

In broad terms, important service specifications for community-based palliative care could include:

- providing a full range of services including advice and coordination of care, nursing and personal care, and access to equipment
- providing access to care on a 24 hours a day, 7 days a week basis
- working with patients to smooth transitions between different settings of care (both before their discharge from hospital to community-based care and, should their care needs or preferences change, prior to their admission to hospital or hospice)
- helping patients, and their families and carers, to plan their care needs and preferences
- integrating with specialist and allied health providers
- maintaining records and collecting data on the cost, quantity and quality of services provided.

Within these broad parameters, and subject to appropriate consumer safeguards, providers should then be responsible for delivering care that meets the needs of individual clients. This could look very different for different people. Some will require regular assistance to cope with increasing pain and nausea, while others will be in less physical pain but greater distress about their relationships with loved ones. The palliative care provider would be expected to provide more nursing care to the former, and counselling to the latter.

Dozens of community-based palliative care providers across Australia already deliver services that meet this description using a range of different models. The details of service agreements between State and Territory Governments and providers are not published, so the Commission has not been able to assess the extent to which those arrangements would provide a good starting point for the expansion of community-based palliative care.

Determining eligibility for services

Several criteria are already used to determine eligibility for existing community-based palliative care services. Most rely on the judgments made by treating doctors, typically involving an assessment that the person is likely to die within the next 12 months. This reliance on clinical assessment is appropriate as end-of-life trajectories are inherently uncertain, and determining when a person would benefit from end-of-life care requires medical skill and judgment. Doctors also need support and guidance in making those judgments, as well as training in initiating conversations about end-of-life care (box 4.1).

Although rates of death from cancer and from chronic illnesses other than cancer are fairly consistent across jurisdictions, the share of palliative care patients with a non-cancer diagnosis varies a lot between jurisdictions. There appears to be limited rationale for this variation, and so it will be important to ensure that eligibility criteria to access community-based palliative care services are not biased against those who currently miss out on palliative care.

It will also be important to ensure that palliative care services remain focused on meeting the needs of those approaching the end of life. If the duration of care extends beyond the last 12 months of life, it will necessarily cost more to provide. There is therefore a need to monitor that palliative care service providers deliver their services to those with a diagnosis that clearly indicates their need for end-of-life care. Tracking the mean and median duration of care provision, as well as variance around those measures, may be useful in this regard.

Designing palliative care services that are well integrated with other services

While good end-of-life care will be different for each individual, a consistently important factor is that it is provided in an integrated manner. From a user's perspective, 'an individual receiving palliative care should experience that care as a single service regardless of how it is administrated' (PCA and PCOC, sub. 417, p. 2). The Victorian Healthcare Association pointed out that 'individual components of the public health system such as palliative care do not work in isolation and are highly integrated with other services such as acute, specialist and community-based care' (sub. 464, p. 1).

In order for care to be well integrated from the user's perspective, gaps between hospital and community-based care need to be minimised. As Alzheimer's Australia said:

> It is also important that palliative care providers are required and supported to collaborate with other health care and human services, as integrated care is critical at end-of-life. (sub. 431, p. 14).

Hobart District Nursing Service achieves this by commencing the package of care before the recipient leaves an acute care facility (sub. 419).

The Royal Australasian College of Physicians (RACP) considered that integration of end-of-life care into the healthcare system could be assisted by 'a designated Navigator to advise and guide the integration of services for particular patients' (sub. 473, p. 9). While navigators are one way to promote service integration, there are also other ways of providing integrated, individualised services. For example in the Netherlands, Buurtzorg Nederland uses self-governing nurse teams to deliver the full range of medical and support services (including end-of-life care) to clients in their homes (Gray, Sarnak and Burgers 2015). Although the Commission has focused on the urgent need to provide more community-based palliative care services to enable people to die at home, there is also a need to further develop models of care that enable people approaching the end-of-life to receive better outpatient care (box 4.4).

Palliative care service provider selection and contracting

Once palliative care needs have been assessed and service models designed to meet those needs, State and Territory Governments should consider the most suitable approach to selecting a service provider in each region. In general, the preferred approach would be to run competitive tenders or other competitive processes to select providers for the additional community-based palliative care services. In some regional and remote areas however, the absence of suitable providers may mean that governments choose to directly provide the necessary services.

Selecting the service provider

Contestability can have a range of potential benefits in human services (chapter 1), and could also have benefits for community-based palliative care services. Indeed, community-based palliative care is ideally suited to this type of contestable approach, as there are no substantial barriers preventing a provider that is not currently supplying services to users from doing so now or in the future. This was recently demonstrated in Tasmania where, until recently, substantial increases in the availability of community-based palliative care had been achieved.

Approaching the market to provide additional community-based palliative care services would not require State and Territory Governments to make changes to existing service arrangements — governments could choose to leave current services in place while adding to the service offering. Existing service providers could:

- tender to increase the availability of services so more people could access care
- tender to provide services in additional locations
- act as a 'prime provider' and subcontract to others.

Box 4.4 Barriers to providing effective alternatives to acute care at the end of life

Many models of supportive outpatient care have been used throughout Australia and overseas. These are typically tailored to the needs of patients with different diagnoses. For example, at the Austin Hospital in Melbourne:

> Renal supportive care is … offered to individuals with end-stage kidney disease if renal replacement therapy (dialysis/transplantation) is very unlikely to improve their quality or length of life and may even significantly reduce their quality of life. It includes symptomatic treatment of kidney failure and palliative care to minimise the burden of symptoms. Doctors and nurses from the Nephrology Department … understand that not all people with kidney disease will benefit from dialysis so they aim to help preserve kidney function for as long as possible and optimise quality of life. (Austin Health 2017)

Similar programs are available for those with heart failure and other long-term conditions where exacerbations are likely. Patients who receive this type of conservative disease management and support are significantly more likely to achieve out-of-hospital deaths, both in Australia and overseas (Lovell et al. 2017). Supportive care and disease management programs also have a good track record in helping people with progressive illnesses to manage their conditions and avoid hospitalisation, and in some cases even help them to live longer.

As noted in chapter 3, in Australia's federal system, outpatient supportive care programs can struggle to obtain resources. The current system of funding of acute care and primary care rewards the volume of activity over outcomes and cost effectiveness of care, and the funding of activities is poorly aligned with patient-centred care. While these problems are widely acknowledged, they are not unique to Australia and do not have clear solutions, short of fundamentally changing the funding responsibilities and payment models for most aspects of health care (PC 2015a).

Providers of other related services, such as aged care and community health, could also seek to enter the palliative care market. Like current providers of community-based palliative care, these organisations could come from the public, for-profit or not-for-profit sectors.

The process used to choose between these providers (or to assess the capacity of a lone applicant to provide the desired services) needs to focus on the services that will be provided to users and the users' experience of those services. The process should not unduly favour particular provider types or service models, nor should it disadvantage providers who are seeking to enter the market. The essential issue is whether providers will be able to meet the expected needs of their clients. This includes the needs of clients with cognitive impairments, as Alzheimer's Australia pointed out: 'all providers of palliative care should be required and supported to ensure that their services are dementia-friendly' (sub. 431, p. 14). This is of particular concern given the large proportion of people approaching the end of life who have dementia or other cognitive impairments.

Funding

Addressing the current shortfall in community-based palliative care is likely to be cost effective, as home-based care generally costs less (sometimes much less) than its hospital-based alternative (box 4.5). However, providing more people with access to

high-quality community-based palliative care services, rather than the potential for long-term savings, should be the primary driver of reform.

It is also important to recognise that providing more care in the community may also have wider costs such as increasing the burden on unpaid carers (RACGP, sub. PFR337).

Box 4.5 Community-based palliative care would better meet users' needs and could cost less than its hospital equivalent

Many participants told the Commission that community-based palliative care services cost less than their hospital equivalents. For example, Little Haven Palliative Care said that it:

> … is caring for 78 palliative patients in the community at an approximate cost to [Queensland Health] of $700/day (Total – not per patient). Should just one of these patients not have access to community-based palliative support and end up in hospital the cost would be upwards of $1600/day. (sub. 458, p. 1)

The District Nurses said that the average cost of one of their hospice@HOME packages 'is $39 per day, compared to an acute care admission of $1645 per day' (sub. 419, p. 9). Analysis by the Silver Chain Group (sub. 176) found that each dollar invested in extending home-based palliative care services in New South Wales would free up $1.44 of expenditure on inpatient bed capacity at metropolitan hospitals.

These figures suggest that reducing the proportion of people who die in hospital and supporting more people to die at home would not lead to an increase in costs, and may be less expensive. This was the view of the Grattan Institute, which found that the costs of supporting individuals to die at home are lower than hospital and residential care, and that overall savings could be achieved if hospital and residential care were replaced by community-based services (Swerissen and Duckett 2014, p. 21). An analysis of the international literature suggests that palliative care is frequently found to be less costly relative to comparator groups (Smith et al. 2014).

Community-based palliative care services are free to users at the point of care (as are the public hospitals that would otherwise provide care to most of those approaching the end of life). This should continue to be case, and State and Territory Governments should resource providers accordingly.

Some community-based palliative care providers offer a range of complementary therapies including 'massage, aromatherapy, relaxation, meditation, acupressure, or art and music therapy' (CareSearch 2017a). Complementary therapies and other services that are not included in the health care provided by hospitals or non-palliative community health services should continue to be funded from non-government sources, such as charitable donations or user contributions.

Monitoring and evaluation of community-based palliative care services

Consumer safeguards

When governments engage community-based palliative care providers to deliver end-of-life care, they must also put safeguards in place to ensure that the care that is delivered is high

quality. Safeguards are particularly important in end-of-life care, given the vulnerability of users, the time-critical nature of their care needs and the stress that an end-of-life diagnosis entails for users, their families and carers.

The design of appropriate safeguards depends on the risks that are being guarded against. In community-based palliative care, a critical risk is that the service provider may not respond to urgent care needs in the correct manner (for example, by failing to provide necessary medications, to answer an after-hours phone line or to respond to patient concerns in a timely manner).

To address risks to the safety and quality of care, many health services are required to meet the NSQHS Standards. Independent accreditation agencies monitor these health services to ensure that they deliver safe and high-quality care in accordance with the NSQHS Standards. The accreditation agencies provide data on the outcomes of their assessments to State and Territory Governments so that governments can support health service improvement and respond to emerging issues. Community-based palliative care services in several jurisdictions are already accredited under this system. State and Territory Governments that wish to take a proactive approach to the quality of care provided by community-based palliative care services could require those services to be accredited under the NSQHS system. Governments will also be in a better position to directly monitor the quality of care provided by community-based palliative care services as more data on those services become available (section 4.5).

In addition to the safeguards provided through accreditation, there is a health care complaints commissioner in every state and territory who is able to respond to concerns about the quality of health care, including complaints about community-based palliative care. In this inquiry, the Commission has not heard any concerns about inadequacies in health care complaints commissioners' oversight of community-based palliative care. To the extent that health care complaints commissioners are fulfilling this role, there is limited rationale for setting up a dedicated complaints system for community-based palliative care.

More critically, if people who are receiving community-based palliative care have urgent unaddressed care needs, the rest of the health system remains available. People in community care settings can access the broader health system through their general practitioner (GP) (or after hours GP), the ambulance service or through a hospital admission. These alternatives provide an important backstop and an assurance that people who need care will receive it.

There is a need to ensure that quality care continues to be provided, and that oversight is maintained, as the volume of services provided increases. The Commission would welcome participants' views on ways to ensure that consumer safeguards remain fit for purpose as community-based palliative care services expand.

How should the outcomes of the new services be assessed?

As stewards of palliative care services, governments have an ongoing role in monitoring service quality and value for money. An essential first step in creating accountability for these would be to publish details of service agreements between State and Territory Governments and the providers of community-based palliative care services.

Users' needs must be at the centre of the way in which governments consider and measure the outcomes of community-based palliative care. Possible metrics include the number and proportion of deaths that occur at home with the support of community-based palliative care (as opposed to unplanned deaths at home), but these are not the only measure of success. If people want to receive end-of-life care at home (and most do), and community-based palliative care helps them to stay at home for longer, this should be counted as a measure of success of the service. This is true regardless of whether people spend the last few days of life, when pain and care needs can be greatest, being cared for in a setting that better meets those care needs, such as a hospital or hospice. Measuring the number and proportion of people who receive most of their care at home would therefore be useful.

Information which provides insights into users' experiences of the service would be desirable, and better data are needed in order to track progress against outcome measures. Many of these measures will require data to be collected where it currently is not. Strategies for enhancing data on end-of-life care are considered in section 4.5.

DRAFT RECOMMENDATION 4.1

State and Territory Governments should ensure that people with a preference to die at home are able to access support from community-based palliative care services to enable them to do so. To achieve this, State and Territory Governments should:

- assess the need for additional community-based palliative care services
- design services to address identified gaps in service provision
- use competitive processes to select providers (or a single provider) to deliver additional community-based palliative care services
- monitor and evaluate the performance of community-based palliative care services to ensure that those services deliver integrated and coordinated nursing, medical and personal care, and provide access to care and support on a 24 hours a day, 7 days a week basis
- ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.

4.3 Supporting end-of-life care in aged care

About half the people who need end-of-life care each year receive that care, and die, in a residential aged care facility (RACF). Despite this, governments and aged care service providers rarely acknowledge that end-of-life care is core business for aged care, and many aged care services struggle to meet the end-of-life care needs of their residents (chapter 3).

A comprehensive review of the aged care system is currently underway, and will be completed by 1 August 2017 (Department of Health 2017a). It will examine all aspects of the aged care system and their interrelationships.

The review, however, will not be able to provide a detailed focus on the end-of-life care needs of those in aged care. Improving the effectiveness of end-of-life care service provision for residents of aged care facilities, irrespective of any other changes that may occur in the broader aged care system, is a key focus for this inquiry.

To ensure that older Australians, particularly those residing in RACFs, receive end-of-life care that aligns with the quality of care available to other Australians, two main reforms are needed. They are:

- helping consumers to select aged care providers that deliver high-quality end-of-life care.
- increasing the end-of-life care skills, and thus the quality of care, available in residential aged care.

Helping consumers to select residential aged care facilities that deliver high-quality end-of-life care

Information on the quality of aged care remains hard for consumers to access …

There are significant challenges in providing effective information for aged care clients. People turn to aged care services when they are experiencing an increase in their frailty and, for many, a reduction in their cognitive capacity. Information about aged care options typically needs to be obtained and understood in stressful circumstances, such as during recovery from an acute health episode or following the loss of support from a spouse or family carer. Decisions can be prompted by crises, and made when the person is vulnerable (PC 2015c). This makes it a particularly difficult time for aged care consumers and their families to consider their end-of-life care needs.

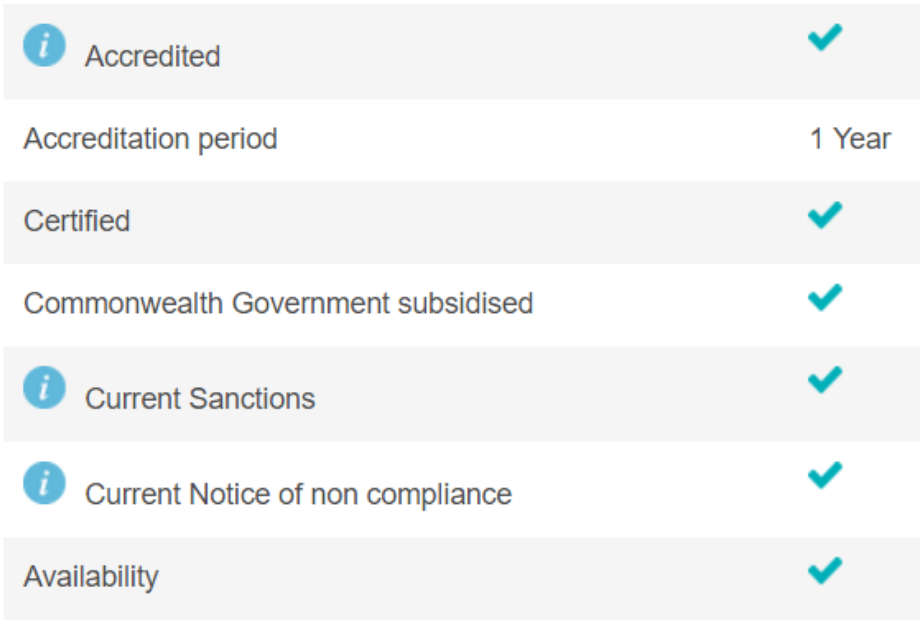
With this in mind, more needs to be done to give consumers information about the quality of end-of-life care provided by the RACFs they are considering. Without provision of such information, consumers have little to help them differentiate quality of care, and cannot select the RACF that best aligns with their care needs and preferences, including those for end-of-life care. This gives aged care providers little incentive to deliver the types of end-of-life care that consumers value, and to make improvements in that care. In this respect,

end-of-life care differs from many of the other services that users receive, and in some cases pay extra for, in residential aged care.

Despite the recent and ongoing aged care reforms, there has been limited progress in providing aged care recipients with information on quality of care, including the quality of end-of-life care.

- The Australian Government provides information on the system and data for consumers through the MyAgedCare website, including a list of, and search option for, RACFs around Australia.
- The Australian Aged Care Quality Agency (AACQA) publishes detailed accreditation reports that outline the agency's assessment of the quality of care provided by each RACF. These include consideration of palliative care. But this information is not nearly as easy to find as it could be, and is sometimes presented in a misleading fashion (for example, myagedcare.gov.au does not link to these reports, and uses the same 'big tick' symbol to denote facilities that are accredited and those that are currently being sanctioned for failing to meet the standards) (figure 4.1).

Figure 4.1 **Information shown on *My Aged Care* about a residential aged care facility that does not provide appropriate clinical care or behavioural management**



Source: Australian Government (2017d).

This contrasts with the system operating in the United States, which has a 'Nursing home compare' website that includes a user-friendly star rating system — based on health, staffing and quality benchmarks — of registered nursing homes. Research in the Netherlands found that 'an internet report card can be a useful tool for current and future consumers to assess

the quality of nursing home care, and thus support their decision-making process regarding the choice of a nursing home' (Van Nie, Hollands and Hamers 2010, p. 342). While the extent to which nursing home report cards and other similar rating systems are actually used by consumers to make decisions about care has yet to be definitively established, it is nevertheless in the interests of consumers to publish such information because of its potential to encourage provider self-improvement.

… and people remain reluctant to consider end-of-life care needs

The negative effects of the absence of information about the quality of aged care are compounded by a general reluctance to consider that a move to residential aged care will be the last stage of life. As Palliative Care Australia put it:

> … there is an unwillingness in the community to openly acknowledge that most people in residential care will be there until the end of their life. Legislation and policy are also silent on this matter. Consequently, when choosing a service the potential palliative care needs of the resident may not be given sufficient attention. (PCA 2016a, p. 4)

Increased efforts to promote and normalise advance care planning (section 4.4) should go some way to help reduce this reluctance.

As already noted, when consumers select a RACF, they are also making a choice about the type and quality of end-of-life care they will receive. However, they (and their families) may be reluctant to recognise this. In this regard, the absence of any mention of end-of-life care in publications designed to guide consumers' choice of RACF is striking. For example, *Five steps to entry into an aged care home* (Department of Health 2016b) suggests eleven questions for consumers to consider when choosing an aged care home, but makes no mention of end-of-life and palliative care (or even that people's care needs will change and increase over time). Similarly, the Aged Care Roadmap is notable for its focus on making dementia care core business throughout the aged care system, without any mention of end-of-life and palliative care (Aged Care Sector Committee 2016). A good first step would be for the Australian Government to ensure that all of its aged care publications — both for consumers and for policy makers — explicitly acknowledge that one of the roles of residential aged care is to provide end-of-life care.

Improving end-of-life care in residential aged care

Increasing the extent to which users consider end-of-life care when selecting a RACF will help to give RACFs an incentive to provide skilled, high-quality end-of-life care, but changes at the system level will also be required. Most importantly, there is a need to remove restrictions that unnecessarily limit the duration of palliative care in RACFs and its availability to residents who have pre-existing high care needs, and to ensure that the additional funding that flows as a result of this change is used by RACFs to improve end-of-life care for their residents.

Delivering adequate resourcing for palliative care in residential aged care

Several participants suggested that the aged care funding instrument (ACFI) (chapter 3) needs to be changed to address the longstanding and widespread concerns about poor quality end-of-life care in RACFs.

> The funding arrangements for home care and residential aged care should recognise palliative care as an intensive service provision activity that requires an appropriate level of funding to ensure the provision of quality palliative care services. (ACSA, sub. 411, p. 5)

Leading Age Services Australia (LASA) said that 'a financial supplement for palliative care services in both home and the residential setting' is required (sub. 463, p. 5).

Indeed, making intensive nursing and other palliative care services available only in the last week or days of life does not align with users' needs nor with the way in which the health system considers, or aims to consider, end-of-life care (the last 12 months of life). Nor does it accord with what is known about the trajectories of decline for those with dementia (chapter 3), who comprise more than two thirds of aged care residents.

There is therefore a need to address this unwarranted discrepancy by properly resourcing RACFs to provide palliative care to residents who already have pre-existing high health care needs, and to all residents over a longer period of time. To this end, restrictions in the ACFI that unreasonably limit the duration of palliative care in RACFs and its availability to residents who have pre-existing high care needs should be removed.

The Commission reached a very similar conclusion in its 2011 report on Caring for Older Australians, finding that palliative care should be funded such that equivalent levels of care can be provided across settings of care, and that the Australian Government should 'ensure that residential and community care providers receive appropriate payments for delivering palliative and end-of-life care' (PC 2011a, p. 234). These types of funding are still not available.

At the time, the Australian Government considered that this was 'not an issue the Australian Government can resolve by itself, noting that the delivery of specialist palliative care services are primarily the responsibility of state and territory governments' (Australian Government nd, pp. 23–24). While there is a need to remove barriers to accessing specialist palliative care services (box 4.6), the large majority of those who die each year, including those who die in residential aged care, do not require ongoing support from a palliative care specialist. They simply require skilled care delivered in the RACF that is their home. As such, end-of-life care is core business for the aged care system, and the Australian Government, as steward of the aged care system, is responsible for ensuring that people in the aged care system receive end-of-life care that aligns with the quality of care available to other Australians.

Box 4.6 Removing barriers to accessing specialist palliative care services

Participants suggested that people living in residential aged care facilities may not, in practice, be able to access specialist palliative care services if and when they need to do so. For example, LASA said:

> The delivery of specialist palliative care services varies across jurisdictions, where often, especially in residential services, access to specialist palliative care professionals can be very limited. There is often a misunderstanding that people residing in residential services are not eligible to receive state based services such as specialist care. This misconception needs to change. (sub. 463, p. 6)

The limited focus on residents of aged care facilities in most states' and territories' end-of-life or palliative care plans reinforces this misconception.

Palliative Care Australia said:

> Older Australians residing in Residential Aged Care Facilities should be provided equity of access to specialist palliative care if needed, in the same way that those services are available to other Australians. (PCA 2016a, p. 7)

The Commission agrees that people living in a residential aged care facility who require specialist palliative care should have the same access to it as those in the broader community. Where there are misconceptions about eligibility for services, the Australian, State and Territory Governments should work together to address them with hospitals, specialist palliative care services and residential aged care facilities.

Improvements to end-of-life care for close to 60 000 people who die in residential aged care each year (or who would have preferred to die there but are transferred to hospital due to lack of skilled care) can and should occur regardless of any issues that may exist in access to specialist palliative care. In doing this, the Australian Government Department of Health and the AACQA should consult with the Independent Hospital Pricing Authority about appropriate funding benchmarks. These could include, for example, the cost of providing palliative care in sub-acute care services. This will help to ensure that aged care funding is sufficient for people in the aged care system to receive end-of-life care that aligns with the quality of care available to other Australians.

Ensuring that additional funding results in better end-of-life care

Removing the unnecessary limitations on the duration and availability of palliative care in RACFs will only be effective at improving end-of-life care if it is accompanied by sufficient additional funding. The magnitude of funding required will depend on the extent of unmet need, which is currently unknown.

There is a range of ways in which RACFs could use the additional funding to improve end-of-life care for their residents. This could include, for example, RACFs purchasing the services of skilled staff from community-based palliative care providers, or employing additional skilled staff themselves.

Expert service providers or additional skilled staff

Hospital- and community-based palliative care providers deliver end-of-life care in many parts of Australia. In those places, RACFs could choose to engage their expertise in improving end-of-life care for their residents. Many of the considerations discussed in section 4.2 would then be relevant for the RACF in engaging such services.

Alternatively, RACFs could employ nurses or nurse practitioners whose role would be to lead and coordinate end-of-life care in the facility. This could be similar to the system suggested by the RACP, which recommended that the Commission consider 'the Scandinavian model which assigns on-site practitioners or senior nurses to attend to simple cases to avoid unnecessary hospitalisation' (sub. 473, p. 9). The nurses or nurse practitioners could coordinate care for residents approaching the end-of-life and facilitate advance care planning (including conducting advance care planning discussions with residents, families and carers). Nurse practitioners could also prescribe certain medications (within the nurse practitioner scope of practice).

Nurses or nurse practitioners could also train and support other RACF staff to deliver higher quality end-of-life care. Many RACF staff are untrained in aged care or end of life care, and many of those who are trained received training of poor quality (ASQA 2013). There is therefore a role for nurses or nurse practitioners in providing just-in-time training to their colleagues, with a focus on the immediate needs of particular residents.

Transition toward a more widespread presence of nurses and nurse practitioners in RACFs would take time. At the moment, there are nowhere near enough nurse practitioners for every one of the close to 2700 RACFs to be able to employ one, and workforce planning projections for the nursing workforce show a projected shortfall of about 123 000 nurses by 2030 (HWA 2014).

Coordination with primary care

When there are additional community-based palliative care providers, nurses and nurse practitioners providing end-of-life care in RACFs, they will need to be supported by doctors, typically GPs. While many GPs provide care to residents of RACFs and some RACFs even have onsite GPs, accessing GP care remains a problem for many. After hours care, in particular, can be lacking. This is why the Commission is not recommending relying solely on GPs to deliver improvements in end-of-life care for residents of aged care facilities.

The need to improve primary care in aged care is well known, and aged care is one of the six key priority areas for the Primary Health Networks (PHNs). PHNs are already delivering a range of initiatives, such as those in northern Sydney (box 4.7).

Box 4.7 End-of-life care focus at Sydney North Primary Health Network

Sydney North Primary Health Network (PHN) has a particular focus on improving the coordination and quality of end-of-life care for people living in Sydney North, in response to the findings of a local needs assessment.

For example, the Hospital Discharge Program for People with Dementia is a hospital-referred, hospital to home transition service for a person living with dementia in the Sydney North region. It has been designed to reduce the likelihood of admission or re-admission to hospital.

Sydney North PHN has also recently run a tender process for 'innovative and creative approaches' to supporting end-of-life care in RACFs, with a view to testing innovative methods of reducing unplanned hospitalisations of older people in residential aged care.

Other end-of-life care activities include working with and providing support to Ambulance New South Wales with the promotion of Advance Care Planning and Ambulance Authorised Care Plans. Sydney North PHN has also led the development of an 'Ageing Strategy Network', which brings local stakeholders together in order to facilitate networking opportunities.

Sources: Sydney North Primary Health Network (2016a, 2016b, 2017).

Consumer safeguards

The aged care system already has a range of consumer safeguards in place.

- The AACQA accredits Australian Government-subsidised aged care homes and provides compliance monitoring, information and training to providers.
- Since 1 January 2016, the Aged Care Complaints Commissioner has operated as an independent statutory office holder. The office of the Aged Care Complaints Commissioner provides an avenue for anyone to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government.

While the standards required of aged care providers are broadly worded (chapter 3), the AACQA conducts both scheduled and unannounced visits to RACFs to ensure that they are complying with them. It can and does issue sanctions and reduce accreditation periods in order to improve the quality of care at facilities that are found to be delivering substandard care.

A range of other measures are underway to provide more detail about the quality of end-of-life care that RACFs are expected to deliver. In particular, new guidelines for palliative care in the aged care sector are expected to be released by 30 June 2017 (Department of Health 2015b). Together with any related recommendations from the Aged Care Legislated Review and the Commission's recommended funding increase, these are likely to drive improvements in end-of-life care in aged care.

DRAFT RECOMMENDATION 4.2

The Australian Government should:

- remove current restrictions on the duration and availability of palliative care funding in residential aged care so that palliative care is available to residents who have pre-existing high health care needs, and for periods of time that align with those provided in the health care system
- provide sufficient additional funding to residential aged care facilities to ensure that people living in residential aged care receive end-of-life care that aligns with the quality of that available to other Australians.

4.4 Advance care planning

Increasing the uptake of high-quality advance care plans (ACPs) is a vital component of putting users' needs and choices at the heart of end-of-life care services, and preparing an ACP should be routine for people with life-limiting illness. This is true despite ongoing interjurisdictional variation in legal frameworks for advance care planning, particularly those surrounding advance directives (AHMAC 2011). Uncertainty or lack of knowledge about the applicable laws is not sufficient justification to hold back on efforts to promote, and thus to forgo the benefits of, advance care planning.

There was broad agreement among inquiry participants (including Cabrini Palliative Care, sub. PFR343; HammondCare, sub. 407; LASA, sub. 463) that a high-quality ACP (that is, a plan that is developed in consultation with family, generally with the support of a trained clinician) is a key component of effective end-of-life care for people who would otherwise be unable to make their wishes known. Several studies and reports echoed these sentiments (AHMAC 2011; Carter et al. 2015; Detering et al. 2010; Rhee, Zwar and Kemp 2012; Scott et al. 2013), while noting that competent and conversant patients can always speak for themselves, and should be supported to do so wherever possible.

Many inquiry participants advocated public awareness campaigns to encourage people to talk about death and dying and to increase awareness of advance care planning (box 4.8). But public awareness campaigns can only ever be small part of the solution in this space. Unlike, for example, road safety, where people can act independently in response to messages about safer driving, there is little evidence that awareness on its own inspires and equips people to have difficult conversations and write plans for a future they are reluctant to imagine (Ramsaroop, Reid and Adelman 2007).

Box 4.8 **Encouraging talk about death and dying**

Many inquiry participants supported increased efforts to encourage people to plan for their end-of-life care needs. The Palliative Care Outcomes Collaboration and Palliative Care Australia (sub. 417) recommended support for existing initiatives that encourage conversations about care at the end of life, citing Dying to Talk, Death Cafés and Compassionate Communities as examples. LASA (sub. 463) and HammondCare (sub. 407) recommended a community awareness campaign to encourage discussion around advance care planning. The Grattan Institute suggested a national mass and digital media marketing campaign to 'encourage people to consider and discuss their end-of-life preferences with their families and health care professionals and document them in Advance Care Plans' (Swerissen and Duckett 2014, p. 22).

Despite supporting them, even advocates of public awareness campaigns acknowledged that 'available [ACP] resources go widely unused and campaigns to normalise its practice have only resulted in minimal uptake' (HammondCare, sub. 407, p. 4). This may be due to what LASA described as a 'stigma' against discussing death and dying (sub. 463, p. 9).

Supporting advance care planning in primary care

When ACPs are prepared in a sensitive, professional way with appropriately trained doctors, nurses or allied health professionals (such as social workers), they are more likely to contain information that is both general enough to be applicable in most situations and specific enough to provide real guidance to the clinicians charged with the patient's end-of-life care (HammondCare, sub. 407; Scott et al. 2013).

Inquiry participants, including PCOC and PCA (sub. 417) and HammondCare (sub. 407), suggested that GPs and other primary care providers are well placed to facilitate advance care planning. Research also suggests there are clear benefits to advance care planning occurring in the primary care setting, before hospitalisation (ANZICS 2014; Scott et al. 2013).

Primary care providers will therefore have a key role in promoting advance care planning and facilitating the ongoing conversations that it requires. This will complement the work of clinicians in acute hospitals, who also have a role to play in initiating and conducting conversations about, and helping patients to develop plans for, end-of-life care (section 4.1).

Encouraging advance care planning in the GP's office

The Australian and New Zealand Intensive Care Society recommends incorporating advance care planning into the '75 plus' health check (ANZICS 2014, p. 52). This fits well with the idea of high-quality advance care planning as an ongoing conversation — once someone has an ACP, the annual health check provides a recurring opportunity to continue the conversation and revisit the plan if their circumstances or preferences have changed.

GPs are already required to complete a range of actions in order to claim the item numbers associated with the '75 plus' health check (items 701, 703, 705, 707) (for example taking a

detailed medical history, conducting a comprehensive physical examination and providing a preventive healthcare management plan). In addition to the mandatory items, the Australian Government has endorsed the use of the '75 plus' health check for advance care planning (Decision Assist 2015). Currently this is optional and is not explicitly mentioned in the Medicare Benefits Schedule guidance notes for GPs.

The Commission considers that initiating an advance care planning conversation should be an additional requirement for GPs to claim item numbers associated with the '75 plus' health check. Initiating advance care planning may be as simple as providing written material and introducing the purpose and content of ACPs to the patient. This written material could address questions such as the benefits of ACPs, the legalities of advance care planning, the role of the substitute decision maker, and where people can get further advice. An increasing volume of advance care planning information is already available, some of which is targeted to specific users (for example, people with dementia) (HammondCare, sub. 407). Research indicates written material is most effective if clinicians actively discuss the information provided with patients (Ramsaroop, Reid and Adelman 2007). As noted earlier, training may be required to increase doctors' confidence in this area (box 4.1).

If a follow-up appointment is required, which will often be the case so that a family member or other substitute decision maker can be present, general Medicare item numbers could be used as they are currently.

Practice nurses also have a role to play in advance care planning

Trained practice nurses or other allied health professionals are well placed to have advance care planning conversations. Advance care planning by trained nurses and health professionals has been shown to improve patient outcomes and also reduce stress, anxiety and depression in surviving relatives (Detering et al. 2010). A dedicated training package for practice nurses — called 'Advance' — is already operational. Supported by the Department of Health, Advance includes screening toolkits and assessment tools designed for use by nurses working in GP clinics (Advance 2016).

Despite this, the Australian Nursing and Midwifery Federation considered that nurses are under-utilised in advance care planning (ANMF, sub. 474). The Commission agrees, and considers that trained practice nurses could facilitate more advance care planning conversations in primary care settings. This will be an important means of increasing the availability of advance care planning to those aged under 75 years who may be approaching the end of life. To enable this, a practice nurse item number for advance care planning should be created, enabling GP clinics to allocate their practice nurses' time to advance care planning facilitation.

DRAFT RECOMMENDATION 4.3

The Australian Government should promote advance care planning in primary care by:

- including the initiation of an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. At a minimum, this would require the general practitioner to introduce the concept of advance care planning and provide written material on the purpose and content of an advance care plan
- introducing a new Medicare item number to enable practice nurses to facilitate advance care planning.

Making advance care planning a normal activity in aged care facilities

As part of their role in delivering good end-of-life care, residential aged care providers should have ongoing conversations with residents about their future care needs. Yet few residents of aged care facilities have ACPs. LASA identified this as a serious concern, noting that 'if a person has not been provided with information about advance care planning or a conversation has not been initiated prior to their admission into residential services then the system has failed them' (sub. 463, p. 6).

As noted above, people are more likely to prepare ACPs, and the advance care planning conversations are more effective, when they are guided by trained clinicians. As providers of care to about a third of people approaching the end of life, RACFs also need to have trained staff who can facilitate advance care planning in a professional, sensitive way. For example, if a RACF employs a nurse practitioner to provide palliative care services (section 4.3), the nurse practitioner should be able to conduct such conversations. Including advance care planning in the '75 plus' health check, as proposed above, may go some way to improving ACP uptake, both before people moved to RACFs and once they are in RACFs, as these health checks are also provided to RACF residents.

Despite these initiatives, more could be done to ensure that people approaching the end of life in residential aged care are given the opportunity to record their preferences for future care (Alzheimer's Australia 2013). While acknowledging that the move into residential aged care is already a difficult time for older people and their families and carers, completing a plan might be less stressful if it were mandated.

> Aged care providers should be required to discuss advance care plans with any new clients entering the community or residential aged care system. Arguably it should be a basic requirement for good care for the service provider to know the wishes of the client. It should of course be the choice of the individual as to whether they complete an advance care plan, but the topic should at least be discussed. (Abbey 2013, p. 3)

To this end, the Australian Government should include requirements for ACPs in the aged care Quality of Care Principles, which are the standard against which RACFs are accredited.

RACFs should be required to ensure that clinically trained staff hold ongoing conversations with residents about their future care needs. This would ideally be part of the role of nurses or nurse practitioners employed by the RACF, but could also be undertaken by GPs or as part of an arrangement between the RACF and a palliative care service. The requirement should include helping each resident (or their family or carers) to understand the purpose of ACPs, and to develop or update one. RACFs should demonstrate that they have met this requirement by having a current ACP for each resident, or by documenting that the resident does not wish to complete one, within two months of admission to the facility. This would substantially increase the extent to which a resident's choices guide their end-of-life care.

DRAFT RECOMMENDATION 4.4

The Australian Government should amend the aged care Quality of Care Principles to require that residential aged care facilities ensure that clinically trained staff hold conversations with residents about their future care needs. This should include helping each resident (or their family or carers) to develop or update an advance care plan (or to document that the resident would prefer not to complete an advance care plan) within two months of admission to the facility.

Ensuring advance care plans are available so that they can guide care

Even when someone has prepared an ACP, it is not uncommon for it to be overlooked or ignored, particularly when end-of-life care is provided in moments of crisis or by providers who are not known to the patient or their family. Inquiry participants attributed the tendency for ACPs to be overlooked to their being unavailable at the time care is provided. For example, HammondCare said:

> There is concern among consumer and healthcare organisations that individuals' wishes regarding their care are often not followed. Part of the reason for this is the lack of continuity of care, which means that relevant documents or [substitute decision makers] may not be known or available. Accessing [advance care directives] is difficult because they are not incorporated into a standard electronic record and is further complicated when care moves across settings, or occurs out of hours, or when locums may be used. (sub. 407, att. 1, p. 26).

As it stands, patients or their family are required to notify staff that the patient has an ACP. In emergency situations, if the ACP 'is not immediately available, life prolonging measures may be started until the treating doctors can hold discussions with the [substitute decision maker]/family regarding expressed preferences' (ACPA 2017).

Efforts are underway to make ACPs more accessible at the point of care. In particular, people can upload advance care planning documents to their My Health Record (MHR), which is a secure, online summary of a person's health information. About 4.8 million people have an MHR (although some were automatically enrolled and may not be aware of the existence of their MHR). Of these, about 13 000 MHR users have uploaded the name and contact details

of the person who holds their advance care planning documents, and about 1000 have uploaded an electronic copy of the documents.

While few people have chosen to include advance care planning documents in their MHR, the MHR system is still relatively new. It was established in 2012, and has only had capacity to store advance care planning documents since April 2016. Moreover, advance care planning documents can only be uploaded by users — health care staff do not have access to this part of the MHR, and so cannot assist users with low computer literacy to upload an ACP.

Inquiry participants supported making greater use of the MHR system as an access point for ACPs.

> The My Health Record accepts uploads of advance care planning documents. However, access to these documents should be enhanced, with greater linkage and alerts to the existence of these documents in primary health, hospital and community IT systems. (AHHA, sub. 427, p. 10)

> This [MHR] facility does not seem to be well-known either amongst health practitioners or the community. Options for encouragement of and incentives to patients and health practitioners to keep [advance care directives] on record should be explored. (MIGA, sub. 432, p. 5)

Governments are currently considering the timeframes for moving to an automatic enrolment (opt out) approach to the MHR system (Siggins Miller 2016), and there is still work to be done on its clinical usability (PC 2017). Until these issues are resolved, it is too soon to determine whether additional strategies or incentives are needed to encourage the use of the MHR system as a central repository for advance care planning documents.

4.5 Data on end-of-life care

Data that allow performance monitoring and comparison of government activities are a fundamental starting point for improving the delivery of those activities to the community (PC 2017). Data on end-of-life care are no exception.

While some data on end-of-life care are collected by service providers and by governments, too often, data do not exist or are not available, making it difficult or impossible to examine usage patterns, costs, or outcomes. To address this, several inquiry participants called for a coordinated approach to improving data on end-of-life care.

> Australia needs a national data strategy for palliative care that collect key data items such as the number of people accessing palliative care, the number of episodes of care each person receives, the services provided by palliative care and the quality of their life until death. Data on whether care was available to the family and carers is also essential. (PCA and PCOC, sub. 417, p. 2)

The Tasmanian Government (sub. 485), the Health Performance Council of SA (sub. 437) and the RACP echoed this view, with the RACP supporting 'the formulation and regular publication of key performance indicators by a relevant government agency to facilitate comparison of quality of death across sectors of the end of life space' (sub. 473, p. 9).

The Commission agrees that better data on end-of-life care are urgently needed in order for the Australian Government to fulfil its role as steward of end-of-life care in residential aged care, and State and Territory Governments to fulfil theirs as stewards of end-of-life care in hospitals and community-based palliative care. While each government could work independently to deliver some of the necessary data improvements, a comprehensive and coordinated approach will require the development of a national data strategy. The overarching aim of the strategy should be to ensure there are sufficient high-quality data to enable governments to monitor how well end-of-life care services are meeting users' needs and to drive improvements in end-of-life care.

Design of the end-of-life care data strategy should take into account the data stewardship framework outlined in the Commission's recently completed inquiry into Data Availability and Use (PC 2017).

At a minimum, the end-of-life care data strategy should set out a plan for delivering improvements to both the availability and the useability of data on end-of-life care. This may include gathering more data (for example, information about the number of hospital patients who usually reside in a RACF, or the availability of community-based palliative care in different regions) or drawing on existing data collections (notably the data on care delivery and outcomes collected by the Palliative Care Outcomes Collaboration).

Additionally, because end-of-life care is provided in almost all settings where health care is provided, including in people's homes, multiple data sources may need to be combined to provide complete and actionable information to policy-makers (Casarett, Teno and Higginson 2006). Data linkage (such as that undertaken in New South Wales, and in Western Australia — box 4.9) is likely to be required. Data linkage involves joining two (or more) data sets together where individuals are represented in both, enabling analysis of service provision across datasets.

Box 4.9 WA Data Linkage System

The WA Data Linkage System is a collaboration of the WA Department of Health, universities and health research institutes, and is now able to create linkages between 28 datasets (including seven core health datasets and the WA electoral roll).

While linked data is not freely available and users have expressed concern over long wait times and high costs involved in accessing data, the WA Data Linkage System has been a significant enabler for public health research, including ongoing and inter-related studies about the provision of palliative care. An academic assessment of the data linkage system found 'significant reforms in health policy and improvements in clinical practices in Western Australia' that resulted from research conducted using linked data (Brook, Rosman and Holman 2008, p. 22).

Sources: Data Linkage WA (2017); Brook, Rosman and Holman (2008); PC (2017).

Basic data requirements

At a minimum, data should be sufficient to enable governments to understand the care needs and preferences of people approaching the end of life, and fund services that best align with those needs and preferences.

Data should be published, shared between governments and made available to researchers in accordance with the framework for data sharing and release outlined in the Commission's report on Data Availability and Use (PC 2017).

Data on end-of-life care should include, at a minimum, linked information on basic end-of-life experiences, such as:

- place of death. Sufficiently detailed information about location to enable comparison between different locations and settings should be available, along with the name of the institution for hospital, hospice and RACF deaths
- primary and secondary diagnoses. For example, a patient with advanced dementia who died from pneumonia should have both conditions documented
- details of service provision at time of death. This should include details of what, if any, health or residential care funding they received at the time of death, at what level and for how long. This should be sufficient to track the mean and median duration of care provision, as well as variance around those measures
- whether the deceased had an advance care plan.

These data represent an essential minimum in order to have a broad outline of the type and availability of end-of-life care in Australia.

The costs of collecting these data will depend on the extent of the changes needed. These may vary between jurisdictions and settings of care, with details determined during development of the end-of-life care data strategy. Improvements to efficiency resulting from better data would contribute to a reduction in costs.

Next steps in end-of-life data

Once basic data are in place, information about the quality of care is needed. To ensure governments, providers and users have the necessary information to effectively commission, provide and evaluate end-of-life services, additional data collection would be needed to evaluate patients' psychosocial experiences and other details around their care. This could be derived from the experiences of family and carers, as is done in the United Kingdom (box 4.10).

Other relevant information might include the number and duration of hospital visits in the last year of life, whether the deceased was receiving active treatment or palliative care at the time of death, whether the advance care plan (if it existed) was followed and if not, why not,

and details of any additional support received. This might include support from a family member, carer or volunteer. A national data strategy should also seek to address problems with data management, for example to promote the accessibility of advance care plans.

Box 4.10 The VOICES survey of bereaved people

The Office for National Statistics runs an annual National Survey of Bereaved People (known as the VOICES survey), which collects information on people's views on the quality of care provided to a friend or relative in the last 3 months of life, for England.

The survey includes questions about the physical and practical experiences of dying, including perceived pain relief and coordination of care, but also about some of the psychosocial aspects, including the perceived level of deprivation, dignity and respect, and the level of support for relatives, friends or carers at the end of life. The results of the survey are used to inform policy decisions and to enable evaluation of the quality of end-of-life care in different settings, across different ages and different causes of death.

Source: Office for National Statistics (2016).

DRAFT RECOMMENDATION 4.5

The Australian, State and Territory Governments should ensure that there are sufficient data to enable governments to fulfil their stewardship functions by monitoring how well end-of-life care services are meeting users' needs across all settings of care.

Governments should work together to develop and implement an end-of-life care data strategy that leads to the provision of, at a minimum, linked information on:

- place of death
- primary and secondary diagnoses
- details of service provision at time of death (what, if any, health or aged care did they receive, at what level and for how long)
- whether they had an advance care plan.

5 User choice and contestability in social housing

Key points

- Australia's social housing system is broken. Currently, people facing similar circumstances can receive vastly different rates of financial assistance depending on whether they rent in the private or social housing markets. Even within social housing the effective level of support varies significantly. This two-tiered model of financial assistance is inequitable.
- The two-tiered model of assistance also reduces tenant choice between private and social housing — tenants have an incentive to enter, and remain in, social housing.
  - There are people in social housing who have expressed dissatisfaction with the property they are in. They face a stark choice — remain in social housing in an unsuitable property, or move to the private rental market and receive a lower amount of financial assistance.
  - With a greater range of homes to choose from in the private rental market, there is a greater chance that tenants will find a home that better meets their needs.
  - Increasing choice would lead to some tenants moving into private housing, which would result in more social housing properties becoming available for tenants who need them.
- Moving to a single model of financial assistance that is calculated the same way for a person living in social or private housing would improve equity and increase user choice.
  - Financial assistance would be best provided through Commonwealth Rent Assistance (CRA), with social housing tenants charged market rents. This model retains incentives for tenants to select a home that meets their requirements because they would pay some of the costs if they elect to rent a more expensive property.
  - Growth in the maximum CRA payment has been outstripped by rental price growth over the past decade. To address this gap, CRA should be increased by about 15 per cent, and the maximum CRA payment indexed to reflect changes in rental prices nationally.
  - Where people have a demonstrated need for further financial assistance, State and Territory Governments should provide an additional 'high-cost housing payment'.
  - Existing tenants should remain on rents set at a proportion of their income for a period of up to ten years, unless they elect to move to the new system.
- Social housing should continue to provide a home for people who are not well placed to rent in the private market.
  - A choice-based letting model would provide these tenants with more choice of home.
- There is evidence that transferring the management of social housing to community housing providers has led to improved tenant outcomes, but it should be treated with caution.
  - The management of social housing should be made contestable, be backed by a full evaluation of the transfers, and be open to all providers.

Social housing provides a safety net for people experiencing homelessness, or who face high barriers, including financial barriers, to sustaining tenancy in the private rental market, and plays an important role in increasing their quality of life. It is part of the broader housing assistance system in Australia (figure 5.1). Housing assistance often involves financial assistance, such as the assistance received by tenants in social housing who have their rent set at a proportion of their income, and the provision of Commonwealth Rent Assistance (CRA) to tenants currently renting in the private market (box 5.1). Housing assistance can also include other forms of support, such as support services to maintain a tenancy (for example, assisting tenants to understand their tenancy obligations) and support for people to transition from social housing into private housing. The type of housing assistance a person is eligible for will depend on their circumstances, and in some cases they may be eligible for more than one type.

The social housing system covers the allocation of tenants to properties, the ownership and management of properties, and the provision of financial assistance to tenants. Social housing includes both public housing (properties managed by State and Territory Government housing authorities, such as Housing SA or Housing NSW) and community housing (properties managed and, in some cases, owned, by a non-government provider). Governments also manage culturally appropriate housing that is only allocated to Indigenous Australians, referred to as state-owned and managed Indigenous housing. State and Territory Governments dominate the ownership of social housing properties, although most jurisdictions also accommodate social housing tenants in privately owned properties.

The current system of social housing is failing those in housing need. Reform is needed to place users at the centre of the system. The Commission identified social housing as a priority sector for reform because:

- the current system of financial assistance is inequitable. People on the same income and with the same characteristics, such as size of the household, can receive vastly different rates of assistance, both *within* social housing and *between* social housing and private rentals. There is a strong financial disincentive for many eligible tenants to move from social housing to the private rental market
- the quality of service is deteriorating. Some homes are poorly maintained, and people eligible for social housing face long waiting times
- there is scope to improve efficiency. For example, many tenants are in properties that have more bedrooms than they require
- there is a lack of accountability for service providers. For example, the management of social housing has generally not been subject to contestable arrangements to select providers.

Significantly, people eligible for social housing have little choice over the home in which they live, which limits incentives for housing providers to respond to tenant preferences, and has flow on effects on the quality of housing and the efficiency of the system. Households are offered a property by the housing provider loosely based on their needs and preferences. Households that reject two — and in some cases, one — offers of a home are moved to the

back of a waiting list. Essentially this is a take it or leave it allocation process. Empowering a tenant to choose a home can lead to tenants being more likely to be satisfied with the property they receive, and having greater engagement with the broader community. Choice of home can have flow on effects to other aspects of the tenant's life — they can locate closer to employment opportunities and to any support services they need.

Figure 5.1 **Housing assistance in Australia**

Sources: DSS (2017a); SCRGSP (2017).

Box 5.1 Financial assistance for rental housing

Social housing

Access to social housing is rationed using (often very long) waiting lists, which are divided into at least two categories — one for general applicants, and a priority list for those in greatest need. A household's eligibility for the general waiting list mostly depends on their household composition, their income, and the value of the assets they hold. The specific limit varies between each state and territory. For example, a single person is eligible for the general waiting list in Victoria if their gross income is less than about $50 000 per year, compared to about $31 000 per year in New South Wales (for comparison, the Australian median income for a single person is about $31 000 per year). A single person receiving the maximum Age Pension amount (about $23 100 per year) would satisfy the income eligibility criteria in all states and territories. Eligibility for the priority waiting list is often based on criteria relating to personal safety, extreme hardship and homelessness.

Tenants in social housing properties pay rent that is set at a proportion of tenant income (typically 25 per cent) or at the estimated market rent, whichever is lower. The (implicit) amount of financial assistance received by the tenant is equal to the gap between the rent paid by the tenant and the estimated market rental price for the property. Tenants living in community housing can also receive Commonwealth Rent Assistance (CRA) but this assistance is generally passed straight through to the housing provider. Public housing tenants are not eligible for CRA.

Commonwealth Rent Assistance

A household renting in the private rental market or in community housing is eligible for CRA if they pay more than a minimum rent threshold, and are receiving a qualifying social security payment (such as Newstart Allowance, Youth Allowance and the Age Pension). CRA is not rationed, and all households who are eligible for the payment receive it. Many people in the private rental market who receive CRA would also be eligible to apply for social housing.

CRA is payable at the rate of 75 cents for every dollar of rent above the rent threshold, up to a maximum amount. The rent thresholds and maximum amount (and, hence, the level of subsidy) varies depending on household characteristics, such as the number of children they have, and are increased with the consumer price index. For example, a single person with two children will receive assistance if they pay more than $77 per week, and can receive a maximum payment of $78 per week. A household's CRA payment may be reduced if their income is higher than a threshold amount, which varies depending on the social security payment they receive.

The difference between CRA and assistance received in social housing

The two models of assistance lead to a two-tiered system of financial assistance. This means that tenants in social and private housing can receive vastly different levels of financial assistance, even though their circumstances are similar, except for the tenure of their housing. For example a couple with a combined income of $500 per week (before CRA) and paying the median rent for a one-bedroom apartment in Melbourne ($340 per week) to a private landlord would receive about $60 per week in financial assistance. The same couple in social housing would implicitly receive assistance equal to about $215 per week. If the couple were to pay the median rent for a one-bedroom apartment in regional Victoria ($180 per week) to a private landlord they would still receive about $60 per week in financial assistance, but the implicit assistance they would receive in social housing decreases to about $55 per week.

Sources: ABS (2015); DSS (2017a); NSW FACS (2016e); Victorian DHHS (2017b, 2017c).

The focus of social housing in Australia has shifted over time. Originally constructed as affordable rental housing for low-income working families, many of these households now receive financial support through CRA to rent in the private market. Increasingly, social housing has focused on people who have difficulty finding and maintaining a tenancy for reasons other than affordability. These people often draw on support services, such as treatment for mental health conditions, to help them maintain their tenancy.

The circumstances and needs of people eligible for social housing vary significantly, and in most cases those who seek its support have one or more of the following requirements.

- *Financial assistance.* Some households face 'rental stress' in the private market, and seek social housing because they require financial assistance to reduce the cost of housing to a more affordable level.
- *Access to housing*. Some people are unable to access the private rental market — landlords can be reluctant to rent to some people, including those with poor rental history and those with complex needs. Discrimination and racism on the part of the landlord can also prevent people from finding a home (AHV, sub. PFR316; Bleasdale 2007; JSS, sub. 420).
- *Stability of tenure*. There is greater tenure security in social housing than in the private market, which can provide a foundation for tenants to improve their economic participation, settle into and engage with the community, and get back into good health (TUNSW 2016). For example, some people in social housing are in a precarious employment situation, and the knowledge that they have somewhere to live should they be unable to keep their job provides some peace of mind (Wiesel et al. 2014). National Seniors Australia (sub. PFR360) stated that undesirable and unplanned relocations can have a negative effect on an older person's health and wellbeing.
- *Support to sustain a tenancy.* The social housing system provides support services to tenants, such as support to maintain a tenancy and to build their capacity for economic and social participation (chapter 6).

Social housing provides a safety net for people with these needs but the supply of social housing is severely constrained. Over 150 000 households are waiting to enter social housing and, at any time, the number of households eligible for social housing substantially exceeds the availability of properties. Many households that satisfy the income eligibility criteria for social housing live in private housing. One estimate puts this number at 465 000 households (Groenhart and Burke 2014), while another estimate puts the number at about 900 000 households (Wood and Ong 2016).

There are people in the community who can wait a very long time to access the financial support and security of tenure offered by social housing. In New South Wales, a non-priority applicant can wait 10 years or more, depending on the area in which they wish to live (NSW FACS 2016a). In some states, such as Tasmania, the waiting times are shorter, although most tenants can still expect to wait between six months and five years. Waiting times for priority applicants are shorter, but can still be lengthy (SCRGSP 2016b). Three out of four new allocations of social housing are from the priority lists.

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, and the level of housing assistance more broadly, will depend on interactions with other government policy, including the level of income support provided (box 5.2).

This chapter sets out who would benefit from greater choice between social and private housing, and how this can be achieved. It also considers whether and how the management of social housing could be made more contestable. The Commission's draft recommendations are summarised in table 5.1. Chapter 6 sets out the supporting reforms needed so that the draft recommendations of this chapter can reach their full potential.

Table 5.1 **The Commission's draft recommendations**

Introducing user choice and contestability into social housing

Reform direction	*Timeframe*	*Potential costs and benefits*
Draft recommendation 5.1 The Australian Government to: • extend Commonwealth Rent Assistance (CRA) to cover tenants in public housing • increase the maximum CRA payment by about 15 per cent and index the maximum payment to reflect changes in rental prices nationally.	Increase in CRA level could occur as soon as practicable. Expanding CRA would be a long-term reform, along with draft recommendation 5.2.	Increased CRA would improve affordability for tenants in social housing and the private rental market by addressing the fall in the relative value of CRA since 2007, and would provide greater access to the private rental market. Addresses inequities between private and social housing. Would have fiscal costs for the Australian Government.
Draft recommendation 5.2 State and Territory Governments to: • abolish the current financial assistance model in social housing • provide a high-cost housing payment to tenants in social and private rental housing • grandfather arrangements for existing social housing tenants • charge market rents for tenants in social housing.	Long-term, in combination with draft recommendation 5.1.	Addresses inequities between private and social housing, and grants tenants greater choice and access to the private market. High-cost payment would help address housing affordability for tenants with a demonstrated need for it. Budgetary costs are dependent on the design of the additional assistance, but could be high. Running two assistance models nationally would have an administrative burden.
Draft recommendation 5.3 State and Territory Governments to introduce choice-based letting for tenants entering into, and transferring between, social housing properties.	Introduced alongside draft recommendations 5.1 and 5.2.	Grants tenants in social housing a greater choice of home. Can provide information to governments about the type of housing that tenants prefer. Choice-based letting involves setup costs. Support needs to be given to tenants that may struggle to exercise choice.
Draft recommendation 5.4 State and Territory Governments to make the management of social housing properties more contestable through open tenders.	Ongoing — management transfers to be staged over time.	Contestability increases incentives for providers to improve outcomes for tenants. Tender processes can impose administrative costs for governments and providers.

Box 5.2 **Housing assistance in Australia and overseas**

Different countries structure financial support differently, placing more or less emphasis on direct support for housing. Commonwealth Rent Assistance is designed as a supplementary payment to other income support (for example, the Age Pension and Family Payments). Compared to some countries in the OECD, such as the United Kingdom, Germany and Ireland, it generally comprises a relatively small proportion of the total income support Australian households receive.

For example, compared to Australian households, households in the United Kingdom typically receive a higher level of housing assistance but a lower level of income support through other programs. The 'Housing Benefit' program in the United Kingdom can pay up to 100 per cent of an eligible tenant's rent in both private and social housing. Housing assistance is the second largest government welfare expense in the United Kingdom, after the age pension, and typically constitutes a large proportion of the total amount of income support received by people on low incomes.

Sources: OECD (2016, 2017); UK Government (2017); UK OBR (2017).

5.1 What would an effective social housing system look like?

In formulating draft recommendations to improve social housing services, the Commission has considered what an effective system of service provision would look like from the perspective of users, providers and governments.

Service users

Equity is a key principle that underpins an effective system of service delivery from the perspective of the user (chapter 1). It implies that tenants in similar circumstances receive similar levels of assistance, regardless of the type of housing they live in. Some people may need higher levels of support to meet their housing requirements, and a more equitable social housing system would provide a higher level of support to those who need it. This includes not only financial support, but also non-financial support to help tenants to sustain a tenancy and improve their economic participation.

An effective service system would be accountable to tenants, and responsive to their housing requirements (chapter 1). Allowing users to make decisions about where they live, both within the social and private rental markets, is a principle that places tenants at the heart of social housing services.

Service providers

An effective system of service delivery requires that providers understand the characteristics of their tenants, and are responsive to their needs. Providers would need to face incentives

to improve service delivery — such as offering suitable and well-maintained homes — and have clear guidance on the services they are expected to deliver, and the outcomes they are expected to achieve for tenants.

Governments

Governments would know the characteristics of the people who seek housing assistance, which of them would benefit from more intensive or targeted assistance, and the outcomes that are achieved by those receiving assistance. Intake and assessment services would be effective, and would identify and connect users to the support they require. This includes governments explicitly stating what services users are entitled to receive, who is responsible for providing them, and allocating funding where appropriate.

Effective stewardship involves governments planning for future social housing demand, collecting the data necessary to evaluate the providers of services, and using these data to inform any future awarding of contracts. Government bodies that make policy decisions and regulate housing providers are to be free from conflicts of interests.

5.2 Choice between social and private rentals

The characteristics of the Australian social housing system mean that it is often not responsive to the needs of tenants. There is a high demand for social housing, low turnover of housing stock, and the available stock is often not well suited to the requirements of tenants (AONSW 2013; RCFV 2016; SCRGSP 2016b). The bureaucratic allocation process for social housing ignores the human aspects of housing — tenants have preferences over aspects of homes such as its layout, location and size, but cannot choose a home based on these preferences. The suitability of the allocated property can often be a question of luck.

People eligible for housing assistance should have choice over the home they live in. This does not just mean choice within the social housing system, but also genuine choice between entering social housing and private housing. Most people entering social housing are capable of making a choice over the home they live in, if given the chance. Some people, such as those with severe mental health conditions, would require support to exercise choice — this is discussed in chapter 6 (CMHA, sub. 399; QAI, sub. 442).

What are the benefits of choice between social and private rentals?

With a greater number and range of homes to choose from, choice between private and social housing increases the chance that tenants will find a home that meets their requirements. A large number of social housing tenants could benefit.

- About 13 per cent of social housing tenants surveyed by Wiesel et al. (2014) expressed a desire to exit social housing in the short term, often due to dissatisfaction with their

property or neighbourhood. Their concerns include rowdy and unsafe neighbours, poorly maintained properties, undersized properties, and properties that were unsuitable for people with a disability.

- There is a mismatch between the housing requirements of some tenants, and the size of the homes they live in. About 5 per cent of households in social housing are in homes that are overcrowded (SCRGSP 2017).
- There are notable differences between people that intend to move from public housing and into private rentals, and those who actually do. For example, despite single parents expressing a greater intent to move into private housing than couples with children, the balance of evidence suggests they are no more likely to do so (Seelig et al. 2008; Whelan 2009; Wiesel et al. 2014).

These people currently face a stark choice — remain in social housing in a less suitable home, or move into a home in the private market and receive a (sometimes substantially) lower amount of financial assistance (box 5.1). Many who do move can face significant financial hardship, and can find it difficult to maintain their tenancy. About 17 per cent of households that exited public housing in 2002 were again living in public housing by 2010 (Wiesel et al. 2014).

Greater choice between social and private housing could be of particular benefit to people who need to quickly change their housing situation. The Victorian Royal Commission into Family Violence (2016, p. 85) found that while social housing may be a suitable long-term option for some family violence victims, it does not offer the flexibility to deliver a rapid response or a property in the right location to suit their needs.

> Compared with social housing, the private rental market can offer greater locational choice and flexibility in meeting the needs of family violence victims. Social housing is generally offered in areas where there is a vacancy, rather than where a woman needs to live.

The option to live in private housing may also lead to other benefits beyond simply improving a tenant's satisfaction with their home. The Brotherhood of St Laurence (sub. 286, p. 19) noted that a lack of choice of home can constrain 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'. Similarly, Henry et al. (2009) noted that choice between social and private housing could be of particular value to long-term recipients of housing support.

Not all social housing tenants are well placed to enter the private rental market. Participants have stated that private landlords are reluctant to rent to some tenants (AHV, sub. PFR316; JSS, sub. 420). Some people need or desire the stability and support offered within social housing (Wiesel et al. 2014).

Increasing opportunities to rent in the private rental market could still benefit tenants who stay in social housing. Some tenants — in particular those who are in social housing to reduce their housing costs — would move into private rentals or avoid moving into a social housing property in the first place. This could increase the number of social housing

properties available to those who need them, leading to both shorter waiting times, and potentially more social housing properties to choose from (section 5.3).

The current two-tiered scheme of financial assistance is inequitable and limits choice

Households in similar circumstances can receive a significantly different level of assistance depending on whether they rent social housing or in the private market, leading to inequitable outcomes. This is driven by differences in the way CRA and the implicit assistance received in social housing are designed (box 5.1). The Commission estimates that households in public housing in Victoria on average receive about $50 per week more in financial assistance than if they received CRA (box 5.3). Even *within* social housing, the level of assistance households receive is tied to the home they are allocated to, and can vary significantly (figure 5.2).

Some participants, including Queensland Advocacy Incorporated (sub. 442) and Jesuit Social Services (sub. 420), highlighted some of the hardships faced by people who miss out on social housing but lack the financial means to find a home in the private market. A more equitable social housing system would have people in similar situations receiving similar levels of support (box 1.3).

The two-tiered system of housing assistance drives decisions about where people choose to live, rather than the needs of the users themselves. Social housing tenants have little incentive to exit and, in some cases, there is a considerable financial disincentive to do so.

A single system of financial assistance

People eligible for social housing should have genuine choice over where they live, including the choice to rent in the private market, but whether they live in social or private housing should *not* determine the level of financial assistance they receive. The Commission considers that there should be one system that would offer financial assistance that is calculated the same way for a person renting either private or social housing. The sector from which a person rents their home is only a rough proxy for their need, making it a poor mechanism for targeting assistance (Henry et al. 2009). For example, the NSW Federation of Housing Associations et al. (sub. 406) estimated that there are roughly twice as many low-income people renting privately as there are renting social housing, yet tenants renting in the private market receive a lower level of assistance on average.

Box 5.3 The difference between CRA and income-based rents

The Commission has undertaken analysis of the difference between the implicit assistance received through rents set at a proportion of a tenant's income and what tenants would receive under the current Commonwealth Rent Assistance (CRA). The analysis was undertaken for tenants currently in public housing in Victoria (data are not available to include tenants in community housing in the analysis).

- The implicit assistance received through rents set at a proportion of income was estimated by subtracting the amount of rent paid by a household from the market rent of the property they live in. The Commission used market rents that were estimated by the Victorian Department of Health and Human Services.
- The level of CRA that a household would receive was estimated based on the market rent for the property they are currently in, as well as the characteristics of the household, such as the number of people. Where multiple households were sharing a home it was assumed that they split the rent evenly.

The Commission estimates that, as a whole, people currently in Victorian public housing receive $200 million more in financial assistance annually than they would if financial assistance was provided through the current CRA. This is an average of about $2500 per household annually.

The difference between assistance levels under rents set at a proportion of household incomes and what households would receive under CRA varies substantially between households. Assuming that tenants remain in their current home:

- just over a quarter of households would be better off if they were receiving the current level of CRA rather than paying rent set at a proportion of their income, as they are currently paying close to market rents
- just over half of households would be at least $500 worse off annually if they received the current level of CRA rather than paying rent set at a proportion of their income
- about 6 per cent of households would be at least $10 000 worse off annually if they received the current level of CRA rather than paying rent set at a proportion of their income. These households are commonly single tenant households renting two bedroom (or larger) properties in inner Melbourne.

These are upper-bounds estimates, and the proportion of people worse off would be lower if tenants are given a choice of home. Some tenants may be in properties that cost more than they are willing to pay at market rates — for example, a single person may currently be in a two-bedroom home and have no need for the extra bedroom. If they were given a choice, some of these tenants might choose to move into less expensive properties.

Source: Productivity Commission estimates based on DHHS (Vic) unpublished data.

Figure 5.2 **Implicit housing assistance received by single people with incomes between $400 and $500 a week**

Public housing in Victoria, gross income from all sources, as at June 2016[a]

[a] Does not include people in shared housing or single parents.

Source: Productivity Commission estimates based on DHHS (Vic) unpublished data.

The Commission has considered two ways in which a single system of financial assistance could be implemented:

- *extend rent assistance based on a proportion of income* to those receiving housing assistance in the private sector. This model is used to provide assistance to some tenants renting in the private market in the United States
- *contribute an amount toward the rental cost* of all tenants, regardless of whether they rent in the social or private sector. This would be calculated as a proportion of the tenant's rent. The Commission has assumed that under this model rents in social housing would be set at the market rate. CRA is an example of a payment that contributes to rental costs (box 5.1).

Drawing on the framework outlined in chapter 1, the Commission has considered several criteria to determine which of the above two models of financial assistance would be most likely to improve outcomes for tenants and the broader community. These include:

- the efficiency of financial assistance — the financial incentives for tenants to select a home that meets their requirements
- the affordability of housing for assisted households — whether households are able to find a home of a reasonable quality that meets their requirements
- the effect on incentives to find employment

- the effect on rental prices, including for tenants receiving assistance, and flow on effects to the broader community due to changes in rental price for tenants who do not receive financial assistance to rent
- the administrative costs of the assistance scheme.

These criteria are discussed in turn below. Participant views on the preferred model of assistance varied. Some, such as the South Australian Government (sub. 460) supported CRA being the primary assistance model in social housing. Others, such as the NSW Federation of Housing Associations et al. (sub. 406) and National Shelter (sub. 466) were opposed to moving away from rents set at a proportion of income in social housing on the basis that rents are currently affordable for most tenants, that the amount of assistance is automatically lowered as tenant income increases, and that the system is easy for tenants to understand.

The costs and benefits of different models of financial assistance

Incentives for tenants

An effective model of financial assistance would preserve the price incentive tenants have to rent a property that meets their requirements or preferences, while tailoring assistance to the specific circumstances of the household. Tenants who have a *requirement* to rent a more expensive property should be provided with additional assistance. At the same time, tenants who have a *preference* to rent a more expensive property should be able to rent one, but should face at least some of the additional cost of that decision.

A contribution to rent payment preserves the price incentive, whereas rents set at a proportion of income do not. A contribution to rent payment requires tenants to pay some of the costs of renting a more expensive property, and creates an incentive to reduce these costs. Where rents are set at a proportion of their incomes tenants do not face additional costs if they rent a more expensive property, and have an incentive to rent the most expensive property that governments would still subsidise.

Maintaining a price incentive can also improve the allocation of social housing. In an effective social housing system, housing authorities seek to allocate tenants to properties that best meet their requirements (section 5.1). A contribution to rent payment, when paired with choice-based letting (which allows tenants to apply for the social housing properties they prefer — section 5.3), could simplify this task, as tenants who do not value the property highly would not apply for the property. There is also an incentive for tenants to move to a more suitable home if their circumstances change, for example, if children move out of the family home. These properties can then be allocated to tenants who are better suited to them.

Affordability of housing

Setting rents at 25–30 per cent of tenant incomes — a commonly cited benchmark of rental affordability — prioritises affordability and stability for tenants. Some tenants place significant value on the certainty that this provides (Wiesel et al. 2014). While affordability of housing is a strength of setting rents at a proportion of tenant incomes, it does not necessarily guarantee that tenants will avoid 'rental stress'. There is evidence of households who exceed the 25–30 per cent income rental threshold facing little financial difficulty (Burke, Stone and Ralston 2011). Similarly, households that pay less than 25 per cent of their income in rent can face significant rental stress (box 5.4).

Affordability under a contribution to rent model would depend on payment design, including how it is calculated and the maximum amount payable. It is less certain that tenants would not pay more than 25–30 per cent of their income in rent under a contribution to rent model, however, as noted above, this is a flawed measure of rental stress. The Commission considers that the affordability achieved through setting rents at a proportion of tenant incomes can be achieved through additional, more targeted assistance to supplement a contribution to rent payment (discussed further below).

Employment disincentives

Employment disincentives are often cited as a key disadvantage of setting rents at a proportion of tenant incomes (Dockery et al. 2008; Henry et al. 2009). Several studies, including previous empirical work undertaken by the Commission, have found that changing rent setting arrangements is unlikely to boost employment among public housing tenants (Cigdem-Bayram, Ong and Wood 2017; IPART 2017; PC 2015b). Once the circumstances of public housing tenants are taken into account (such as being more likely to receive the Age Pension, and to have a disability), differences in rates of employment between public housing tenants and people renting in the private market prove to be very small. In other words, it is the characteristics of individuals, and not housing assistance that explain public housing tenants' relatively low employment rates. CRA, which is an example of a contribution to rent payment, also has a minimal effect on employment among its recipients (Cigdem-Bayram, Ong and Wood 2017).

The effect on rental prices

Most of the financial assistance provided to tenants through setting rents as a proportion of their income can be captured by private landlords. Because governments pay 100 per cent of any rent increase up to the rental cap, tenants have little incentive to push back on landlords who want to increase rents (Gibbons and Manning 2006). One study of assistance in the United States found that nearly 90 per cent of additional program expenditure was captured by landlords in the form of higher rents (Collinson and Ganong 2016). Under a contribution to rent model, tenants have an incentive to resist any opportunistic increases in rent by landlords because they pay part of any increase in rent.

A related concern is that private market housing assistance would raise housing costs for *non*-subsidised tenants (Pawson et al. 2016). The Commission acknowledges this concern, but is unaware of any research that has quantified the effect private rental assistance has on the Australian housing market. It notes that where housing assistance has been increased overseas there has generally been no increase in rents for non-subsidised tenants as a result, except for some homes priced near the 'rent cap' set for recipients of assistance through rents set at a proportion of their incomes (Eriksen and Ross 2015; Gibbons and Manning 2006; Lowry 1982).

Box 5.4 What is 'affordable' rent?

An often used indicator of rental housing affordability is the 'proportion of income rule' — a household is considered to be in rental stress if it spends more than a certain proportion of its income on rent. For the private rental market, this proportion is sometimes considered to be 30 per cent.

The proportion of income rule is at best a crude measure of affordability. It does not take into account important differences between households that affect their ability to meet housing costs, including the characteristics of the household (such as the age of family members), and their non-housing costs (such as food, transport and medical costs). Another indicator of housing affordability, known as the 'residual income' approach, considers whether households can afford to purchase essential non housing goods and services once they have paid their rent, although it requires subjective judgments about essential expenditure and suffers from a lack of data.

The point in time snapshot provided by indicators of housing stress must also be set against how housing experiences can change over time. As the circumstances of a household change — for example, once any children grow up and leave home — their capacity to meet rental costs will also change. By one estimate, nearly three in four households in housing stress will escape it within one year, and only a small minority fail to climb out of housing stress within five years. Some types of households are particularly susceptible to long periods of housing stress, including low income households with dependent children, migrants from non-English speaking backgrounds, and the self-employed.

Sources: AHWG (2016); Burke, Stone and Ralston (2011); IPART (2016); Wood, Ong and Cigdem (2014).

Administrative costs for governments

There will be administrative costs irrespective of the assistance model used. Both models of assistance require regular reporting of household incomes to determine the level of assistance households are eligible to receive, and ongoing assessment of eligibility. Reporting costs may be lowered if either assistance scheme was integrated with the broader social security system, which already collects data on household income in the course of administrating other payments.

Administering a scheme with rents set at a proportion of tenant income is likely to involve costs that are not incurred with a contribution to rent payment. Where rents have been set at a proportion of tenant incomes overseas, they typically involve periodic housing inspections to check if rents are set at a reasonable level for the property (US HUD 2001). The Tenant's

Union of New South Wales (2016, p. 13) has also noted that 'income-based and residual income based rents create high levels of complex administration' and that errors in income disclosure and rent calculation can 'lead to complex — and often unnecessary — investigations of fraud'.

Financial assistance is best provided through a contribution to rent payment

A contribution to rent payment, like CRA, is the Commission's preferred mechanism to provide financial assistance to people in social and private housing. It retains incentives for tenants to select a home that meets their requirements, is less likely to be captured by landlords and to increase rents, and is likely to be less expensive to administer. Affordability is less certain with a contribution to rent payment, but tenants who have a requirement to rent a more expensive property could be targeted with additional financial assistance.

CRA provides an existing mechanism for delivering a contribution to rent payment. CRA has design features that can be used to tailor assistance to the circumstances of the household — it provides a different level of assistance based on some household characteristics (such as number of children), and payment rates taper as income rises (box 5.1). The infrastructure for providing the payment is already established and integrated with the broader social security system. The Commission considers that the Australian Government should extend CRA to cover tenants in public housing (draft recommendation 5.1).

Social housing tenants should be charged market rents

A single model of financial assistance based on CRA would not, of itself, address the disincentives and inequities in the social housing system. As rents in the private rental market are set at market rates, rents for social housing properties would also need to be set at market rates, to ensure that there is not a different level of financial assistance provided to households based on where they choose to rent. State and Territory Governments could determine the market rent of a social housing property by benchmarking it to private properties with similar characteristics in the local area.

Charging market rents would also reduce some of the inequities between recipients of social housing (figure 5.2). When paired with providing financial assistance through a contribution to rent payment, market rents mean that households who are living in a more expensive property contribute towards the cost. At the same time as the Australian Government extends CRA to tenants in public housing, State and Territory Governments should charge market rents for tenants in social housing (draft recommendation 5.2).

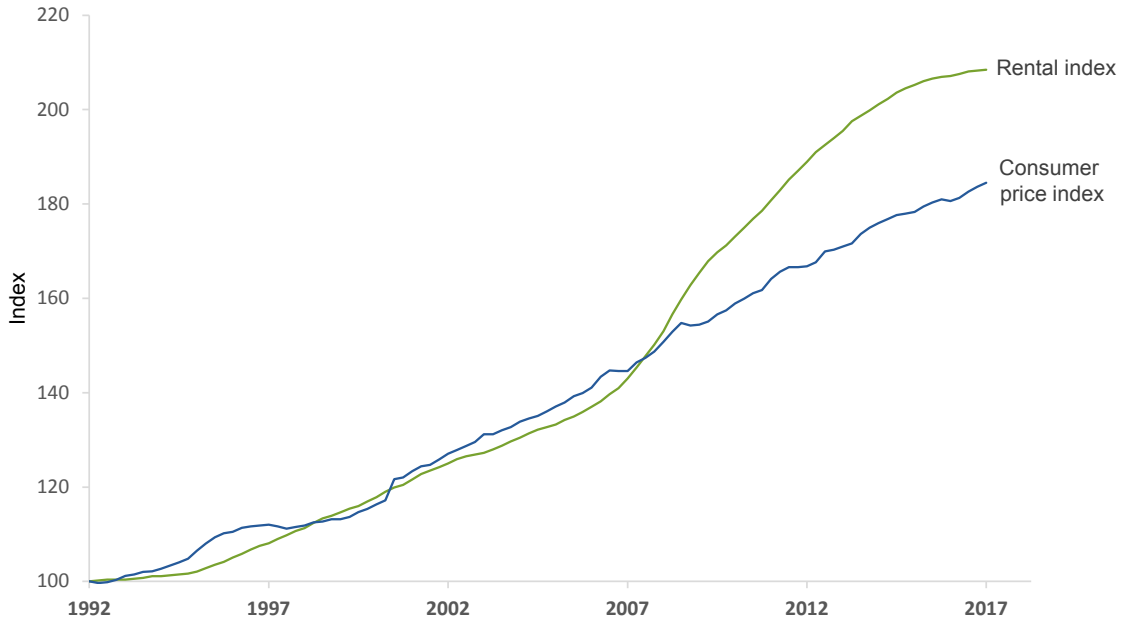
The level of housing assistance

A shift to a single model of financial assistance and rent payments that are based on market rates would address the inequity between private and social housing tenants, but would lead to affordability concerns for some social housing tenants. After receipt of CRA some households may still remain in 'rental stress', including those with very low incomes, those who need to rent a property modified to meet their needs, or those with a demonstrated need to rent in a high-rent area. Commission analysis suggests that, without additional assistance, over one half of households in public housing in Victoria would be made worse off if housing assistance was to move to CRA as it is currently designed. There are three reform actions that should be implemented together to help address these concerns.

Increasing the level of CRA

Increases in the maximum CRA payment are currently tied to the consumer price index (CPI), which has been outstripped by growth in rental prices over the past decade (figure 5.3). Between 2007 and the first quarter of 2017, the CPI increased by about 28 per cent, compared to an increase of about 48 per cent for rental prices nationally over the same period (ABS 2017). Growth in rental prices has been even higher in Sydney (about 58 per cent).

Figure 5.3 **Rental prices have increased faster than CPI since 2007[a]**
March quarter 1992 to March quarter 2017



[a] Rental index is constructed using a weighted average of the eight capital cities.

Source: ABS (Consumer Price Index, Australia, Mar 2017, Cat no. 6401.0).

A consequence is that the relative value of CRA has fallen. The rent cap — the minimum amount of rental expenditure needed to receive the maximum CRA payment — is now reached at a relatively low level of rent. About 80 per cent of households receiving CRA now receive the maximum amount of CRA, up from about 67 per cent in 2007 (SCRGSP 2008; 2016b). A couple with no children receives the maximum CRA payment if they are renting a property with market rent of about $180 per week or more (DSS 2017). In Melbourne, only 10 per cent of one-bedroom apartments rent for $235 per week or less (Victorian DHHS, pers. comm., 11 April 2017).

The objective of CRA is to provide tenants in the rental market on a low income with additional financial assistance in recognition of the housing costs they face. Consistent with this objective, the maximum CRA payment should be indexed to reflect changes in rental prices nationally. The Commission considers that the maximum CRA payment should be raised to the level it would have been had it kept pace with national rental prices since 2007 — the point where rental prices diverged significantly from CPI. This would require an increase in the maximum CRA payment of about 15 per cent.

Additional financial assistance would be required for some households

An increased level of assistance through CRA would provide an adequate contribution to rental costs for many tenants. CRA is not, however, flexible enough to cover the circumstances of all tenants and additional assistance will sometimes be needed to meet their legitimate needs. This is already recognised through special programs for some groups. For example, as part of the Australian Government's Home Care Package Program, some elderly people may be eligible for modifications to be made to their home, such as installing mechanical devices for lifting, and bed rails (Australian Government 2017e). The National Disability Insurance Scheme assists people with a disability to pay for necessary modifications to their home or private rental property, and contributes toward the cost of accommodation in situations where the participant has a need for specialised housing due to a disability (NDIA 2014). There is also some ad-hoc assistance with home modifications provided by State and Territory Governments.

For groups not covered by other types of support, State and Territory Governments should provide an additional payment for tenants with a demonstrated need for additional assistance. This additional assistance should be delivered through a high-cost housing payment that is paid to eligible tenants. This payment could be delivered to the tenant as a top-up to CRA. Eligible tenants living in either private or social housing should be able to receive the payment.

Eligibility for, and the level of, the payment would be a matter for State and Territory Governments, but could include assistance for those who need to live in high-cost areas for work or other reasons. This approach would allow States and Territories to calibrate payments and eligibility to the demographic and housing market differences in their jurisdiction.

Importantly, the design of the payment should recognise that a tenant's need for financial support can change over time. If, for example, a person's employment situation changes and they are earning a higher (or lower) level of income, then the amount of assistance that they receive should adjust. The payment could be made responsive to changes in the tenant's financial circumstances by tapering the payment as household income increases (and vice versa). Interactions with income support payments would need to be taken into consideration so as to avoid large financial disincentives to employment. One option would be for State and Territory Governments to apply the existing means testing arrangements for CRA.

The Commission would welcome feedback on ways to deliver the high-cost housing payment. For example, the Australian, State and Territory Governments could collaborate on delivery of the payment by using the Australian Government's existing income support payment system. This approach could remove the need for the development of separate State and Territory based payment systems, thereby reducing administrative costs, and streamlining delivery to the user.

Transitional arrangements for existing tenants

Some social housing tenants, if they stayed in their current property, could be worse off under the new system. Adjusting to this change would be difficult, requiring households to either pay a higher rent or move to a more affordable property. Some tenants would find the change more difficult, in particular when they are settled in their home and community, or if they are currently receiving a large amount of assistance.

The Commission is cognisant of these difficulties and is of the view that conditions for current social housing tenants should be protected by allowing them to continue to pay rents set at a proportion of their income for an extended period of time, unless they elect to move to the new system. Tenants that continue to pay their existing rents would not be eligible for CRA or the additional high-cost housing payment. Tenants that move home would be moved onto the new arrangements. Running two systems nationally would result in an administrative burden, which would add to the cost of transitioning between the assistance models.

Consequently, rents set at a proportion of tenant incomes for existing tenants should not proceed indefinitely. A period of 10 years would give tenants enough time to adjust to the new system. This is a substantial period of time over which tenants can continue with their current housing and rent arrangements, and recognises that some long-term decisions — such as where to enrol children in school — are often made with a particular housing situation in mind.

Rental affordability in the private market

Reforms to improve the effectiveness of the social housing system need to be seen in the context of the housing market as a whole. If implemented, the Commission's draft recommendations would increase the opportunity for people who are eligible for housing

assistance to access the private rental market. However, there are broader concerns about the current capacity of the private rental market to supply homes to everyone that needs affordable housing. Hulse et al. (2015) put the shortfall of affordable homes for households in the bottom income quintile at about 270 000 homes in 2011, mostly in Sydney, Melbourne and Brisbane.

Governments have policy initiatives underway to improve rental affordability in the private market.

- The Victorian Government's Homes for Victorians strategy includes changes to speed up planning approval processes, increasing access to surplus government land for developments, providing greater support for people renting in the private market, and a tax on vacant properties (Victorian Government 2017b).
- The Australian Government (2017c) announced in its 2017-18 Budget that it will:
  - establish a bond aggregator to facilitate access to lower-cost finance for the community housing sector, which could assist them to construct additional social and affordable housing
  - negotiate a new funding agreement for affordable housing with the State and Territory Governments, which will include housing supply targets and prioritise planning and zoning reforms and the renewal of public housing stock.
- The New South Wales and Victorian governments have established funds for the purpose of investing in additional social and affordable housing.

If well-designed and implemented, these initiatives would be expected to increase the net benefits of the Commission's proposed reforms. More affordable housing would mean some people eligible for social housing have more homes to choose from. Governments need to continue implementing reforms so that homes in the private rental market can be affordable and accessible for people on low incomes.

The fiscal effects of choice-based reform

Changing financial assistance from rents set at a proportion of tenant income to a CRA model with market rents would result in a transfer of fiscal costs between the Australian, State and Territory Governments. The Australian Government would see an increase in its expenditure on CRA. State and Territory Governments would receive increased rental payments from public housing which may be offset by expenditure on the high-cost housing payment. The Commission has conducted a back-of-the-envelope analysis of the fiscal effects of changing to the new model using Victoria as a case study. This analysis does not take into account factors such as households relocating as a result of the change in assistance model, or new households forming if renting independently becomes more affordable.

- Charging market rents in social housing would result in an increase in Victorian Government revenue of about $400 million annually (SCRGSP 2017). The increase in revenue would be realised over several years, as some existing social housing tenants

would likely continue to pay rents set at a proportion of their income. The effect on State and Territory Government budgets would depend on how any high-cost housing payment is designed.

- Extending CRA to public housing tenants in Victoria would increase expenditure by the Australian Government by about $220 million annually (box 5.3) (Commission analysis; SCRGSP 2017).
- In addition, increasing CRA by 15 per cent for tenants in Victoria, as proposed by the Commission, would increase Australian Government expenditure by about $175 million annually (this assumes that everyone receiving CRA receives a 15 per cent increase, even if they currently do not receive the maximum payment) (Commission analysis; SCRGSP 2017).

Implementing reforms

Moving to the model of financial support proposed in this chapter would provide tenants with choice and significantly improve equity in social housing. Implementing the model would involve substantial changes to existing approaches and would require cooperation between the Australian, State and Territory Governments. Implementation could be done nationally or via bilateral agreements between the Australian Government and individual State and Territory Governments. The reform package should be taken as a whole, and changes to CRA should be contingent on State and Territory Governments implementing draft recommendation 5.2.

DRAFT RECOMMENDATION 5.1

The Australian Government should enhance Commonwealth Rent Assistance (CRA) by:

- extending CRA to cover tenants in public housing
- increasing the current maximum CRA payment by about 15 per cent to address the fall in the relative value of CRA caused by average rents rising faster than the consumer price index since 2007
- indexing the maximum CRA payment amount to reflect changes in rental prices nationally.

DRAFT RECOMMENDATION 5.2

State and Territory Governments should abolish the current assistance model for social housing where rents are set at a proportion of the tenant's income and enhance user choice by:

- providing a high-cost housing payment funded by State and Territory Governments for eligible tenants, such as those with a demonstrated need to live in a high-rent area
- delivering the high-cost housing payment to the tenant in a way that would enable it to be used in either the social or private rental markets
- offering existing tenants in social housing an option between continuing to pay rent set at a proportion of their income for up to ten years, or electing to move to the new assistance model
- charging market rents for tenants in social housing.

Tenancy rights

Aside from affordability, one of the key reasons that tenants are attracted to social housing is stability of tenure (Wiesel et al. 2014). In Australia's private rental market, tenancies are usually short term (often 12 months), and tenants can be evicted on short notice. Longer tenure for private properties would be particularly valuable for those who are currently seeking social housing.

Some jurisdictions have recently undertaken, or are currently undertaking, reviews of their tenancy laws. For example, a review of Victoria's tenancy law has identified that some tenants would like greater stability and certainty of tenure, and a key aspect of instability is the ability for landlords to evict tenants under 'no fault' termination provisions (Victorian Government 2017a). The review flagged several options for reform, which will be subject to further consultation. The Australian Government announced in its 2017-18 Budget that it will work with State and Territory Governments to standardise the use of long-term leases, and the Victorian Government intends to introduce reforms to encourage their use (Australian Government 2017b; Victorian Government 2017c). New South Wales is also planning to implement reforms to its tenancy act in 2017.

The Commission has not undertaken an analysis of the costs and benefits of reform to tenancy rights, and has not made draft recommendations in this area. While the Commission's draft recommendations are not contingent on reforms to improve tenancy rights in the private rental market, tenancy reform could improve the net benefits of the draft recommendations. If the stability of tenancies in the private market is improved, this would reduce the burden on social housing, and facilitate increased choice for tenants that require a stable tenancy.

5.3 The role of social housing

Social housing would focus on those who need stability and access to housing

The reforms to the model of financial assistance proposed in section 5.2 provide an opportunity for State and Territory Governments to focus the social housing system on those who are not well placed to enter the private rental market. As noted earlier, some tenants are unable to rent in the private market because they face discrimination, have a poor rental history, or are disruptive to neighbours. In addition, the stability offered by social housing is unique and is a key benefit for many tenants.

Reform of financial assistance would take some pressure off the social housing system. Some tenants who are currently in social housing could find it easier to move into private housing, while some applicants who would have entered social housing solely for affordability reasons could elect to remain in the private rental market. This could lead to more properties being available to allocate to people who need the stability or access to housing that social housing is in a unique position to provide.

Residualisation and neighbourhood segregation

Social housing tenants are sometimes co-located in large-scale housing estates. Approximately 40 per cent of social housing properties in New South Wales are part of a concentrated housing estate (NSW FACS 2016b). As social housing provides a safety net for people with high needs, this can create neighbourhoods where a high proportion of residents are disadvantaged. A social environment can develop that compounds the effects of disadvantage, and increases the chance that disadvantage is passed on from one generation to the next (Vinson 2009). Australian research has found that a child who resides in a lower-income neighbourhood has a higher chance of being unemployed in early adulthood as a result (Andrews, Green and Mangan 2002). Some social housing tenants are also negatively affected by the neighbourhood stigmatisation that comes with concentrations of disadvantage (Jacobs and Flanagan 2013; Pawson, Hulse and Cheshire 2015).

Several State and Territory Governments are taking steps to reduce the concentration of disadvantage in social housing estates. One way is to redevelop estates into 'mixed use' communities. Existing social housing is cleared, and in its place a mix of social, affordable and private housing is built. Due to higher property density the original number of social housing properties can be maintained, but within a neighbourhood that comprises a wider variety of households. The system of financial support proposed by the Commission would also open up more opportunities for social housing tenants to access private housing in less disadvantaged neighbourhoods.

Choice-based letting has had benefits internationally

Participants to several studies and inquiries have cited the need for, and benefits of, social housing tenants having more choice over the homes they are allocated. 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. The Council of Single Mothers and their Children (sub. 435) stated that the current placement model in social housing means that people receive housing that bears little or no relevance to their needs, and places further strain on households.

A change to market rents could be complemented with reforms to give social housing tenants more choice over their home. The rent that a tenant would be willing to pay would be another aspect of the property that the tenant could have choice over, based on their characteristics and the rental price they can afford.

An option to increase choice of home is choice-based letting, which has been implemented in several countries overseas, including the United Kingdom and the Netherlands. Choice-based letting allows households to apply for properties they are interested in, changing the allocation process from one driven by the housing provider to one driven by the preferences of households (box 5.5). Submissions were generally supportive of using a choice-based allocation scheme in Australia, noting that it could improve user choice and system efficiency (AHV, sub. PFR316; NSW FHA et al., sub 235; QShelter, sub PFR352).

Evaluations of choice-based letting schemes in the United Kingdom found a range of benefits (Marsh, Cowan and Cameron 2004; Pawson and Watkins 2007).

- Tenants reported feeling increased agency over their housing situation, and thought it was a more open and transparent allocation process.
- People were more likely to stay in the same area, invest in the local community, and have stable accommodation.
- There was evidence that choice-based letting can improve the efficiency and quality of the social housing system. For example, data collected through choice-based allocation schemes was used to identify the housing characteristics that tenants prefer, and to target areas of high demand and need.

Box 5.5 Choice-based letting in the United Kingdom

Choice-based letting schemes in the United Kingdom generally follow the same broad approach where they are used, although the exact details of the schemes can vary between local government areas. Available social housing properties are advertised in newspapers and online, along with eligibility requirements such as income level and household size. Eligible applicants apply for the listed property and are ranked against published selection criteria, such as waiting time, applicant age and time spent in their current premises. Applicants that may have difficulties using choice-based letting are identified, and direct assistance to navigate the system offered to these households.

The applicant with the highest ranking, based on factors such as waiting times and the needs of their household, is offered the property, and the qualifications of the successful tenant are published so that unsuccessful applicants can understand why they were not offered the property. Applicants are able to refuse the offer of a property, although in some cases there are penalties for refusal (such as not being able to apply for another property for a specified time period). 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.

Sources: Brown and Yates (2005); Marsh, Cowan and Cameron (2004); Pawson et al. (2006).

Overall, about 80 per cent of registered users preferred the choice-based system compared to allocation models where the choice of home was made by a government agency (Brown and Yates 2005). Despite the concerns of some providers of homelessness services, there was no indication that formerly homeless households were disadvantaged by choice-based letting schemes.

Several participants questioned whether all the benefits of choice-based allocation schemes enjoyed internationally can be replicated here, owing to our substantially smaller stock of social housing (AHV, sub. PFR316; National Shelter, sub. 232; NSW FHA et al., sub 235). The United Kingdom has a larger and more diversified stock of social housing than Australia, meaning that tenants have a wider range of property types, in a wider range of locations, to choose from. Moreover, there is a better chance that the tenant's preferred property will become available in a suitable timeframe.

Despite these differences, there could still be benefits to implementing choice-based letting in Australia. In each state and territory, about 10 per cent of all social housing properties are vacated each year — or approximately 40 000 properties Australia-wide (AIHW 2016i; Wiesel et al. 2014). The number and variety of properties that become available will vary between each region, but most tenants could be presented with more choice than is currently offered. Those tenants who are flexible with the location and type of home in which they live, or those that are able to wait longer for a more suitable property to become available, would likely benefit the most. Even for tenants who have limited flexibility, choice between four or five properties is an improvement over a choice of one or two that the current system provides. Importantly, choice-based letting would enable social housing tenants to choose a property with a suitable rent.

Choice-based letting has costs

Choice-based letting schemes have costs to implement and operate. Set up costs will vary depending on the requirements of each state and territory, including the number of properties that are covered by the scheme, among other factors. As a guide, if the cost per property of setting up a choice-based allocation scheme in Australia was the same as that of a medium-sized housing association in the United Kingdom, then they would range from $10 to $25 per property (Pawson et al. 2006). If set up costs are re-incurred every 5 years (due to depreciation), a benefit to tenants of $2 to $5 per property per year would be enough to cover this cost.

Ongoing operation costs of choice-based letting schemes in the United Kingdom were found to be similar to those for non-choice-based schemes (Pawson et al. 2006; UK Audit Commission 2006). Given the focus of social housing in Australia on providing shelter to high-needs households, these costs would likely be higher than in the United Kingdom. With choice-based letting, applicants are required to actively and continually apply for homes. This increases costs, both in terms of tenant time and effort, and the cost of providing information and support to those who are vulnerable.

Choice-based letting should be implemented with the contribution to rent payment model

The Commission considers that State and Territory Governments should introduce choice-based letting for tenants in social housing, as the benefits are likely to exceed the costs. The NSW Independent Pricing and Regulatory Tribunal (2017) has recommended that the NSW Government adopt a choice-based letting system with the existing social housing rent model kept in place, and other jurisdictions, including Victoria, are investigating choice-based letting using trials (Victorian DHHS 2016b).

The Commission's proposed system of financial support (draft recommendations 5.1 and 5.2) strengthens the case for choice-based letting, as it is likely to enhance the benefits. Some people who are currently in social housing will elect to move into a home in the private market, which could increase the number of homes available for social housing tenants to choose from. The new model of financial assistance would also create a price incentive for tenants to select a home that meets their requirements and preferences which, in conjunction with choice-based letting, could improve the efficiency of the social housing system.

DRAFT RECOMMENDATION 5.3

State and Territory Governments should introduce choice-based letting for tenants entering into, and transferring between, social housing properties.

Headleasing could give social housing tenants more choice of home

Headleasing is a tool that governments can use to give potential social housing tenants access to a wider choice of home (box 5.6). Providers of social housing already enter into headleasing arrangements, generally in cases where a suitable public housing property cannot be found (NSW FACS 2014b; Victorian DHS 2012). Headleasing is used in some states and territories to assist women escaping domestic violence, and as part of initiatives to find accommodation for the homeless (CHP 2016; NSW FHA et al., sub. 406).

Box 5.6 What is headleasing?

A headleased property is one that is owned by private individuals or corporations, and leased to a social housing provider. The social housing provider then selects a tenant, and enters into a separate lease with them. With a headlease, the private landlord is generally responsible for routine property maintenance, and the social housing provider responsible for tenancy management (such as collecting the rent, and passing on any maintenance requests). The social housing provider is usually liable (up to a cap) for any property damage after the application of the tenant bond and any insurance proceeds.

Both the government and community housing sector headlease properties from the private market, although it is more common in the community housing sector. About 20 per cent (12 500 properties) of all community housing properties are headleased from the private market. Some assistance is available to community providers to help them to headlease properties, such as the $76 million Community Housing Leasing Program in New South Wales. About 2 per cent (3000 properties) of NSW public housing properties are headleased.

Sources: AIHW (2016m); NSW FACS (2014a); NSW FHA (2014).

Headleasing can provide a flexible way to respond to housing need. Rather than building a new government-owned housing asset to provide stable accommodation to tenants, headleasing properties can replicate this benefit while providing flexibility over property type and location. This avoids one of the pitfalls of the current social housing system, namely, that the long-lived nature of housing assets combined with shifting demographics can result in a mismatch between the characteristics of the social housing stock and those receiving assistance. By headleasing properties outside of existing social housing estates, headleasing can help to reduce concerns about neighbourhood segregation outlined above.

Headleasing would have costs — in particular governments may need to pay additional rents to private landlords to encourage them to lease their property for an extended period of time. A detailed assessment of current and future demand for social housing (chapter 2) would help government to assess the need for headleasing arrangements, and enable them to weigh up the costs and benefits of entering into these arrangements.

5.4 Increasing contestability of tenancy management

A common theme of consultations was a desire, in particular from community housing providers, to increase the contestability of tenancy management services. Four out of five social housing properties in Australia are managed by government housing authorities, and service provision for these properties has generally not been subject to contestable arrangements. There are a large number of providers that could provide social housing services, whether they are not-for-profit, cooperatives and mutuals, or for-profit providers.

Governments have been transferring the management of social housing to not-for-profit organisations (in some cases, private sector organisations may have been part of a consortium of not-for-profit bidders (NSW FHA et al., sub. 406)), and some governments have a policy position of further transfers of public housing to non-government providers (NSW FACS 2016b; SA Government 2012). In 2009, the 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.

The benefits of contestable tenancy management

In principle, making the management of social housing contestable would lead to several benefits for tenants. Governments may not be best placed to provide tenancy management services — another provider may be able to offer better quality services, or provide services in a more efficient way. Contestability in social housing could offer many of the benefits of competition outlined in chapter 1, including incentives for providers to meet the needs of tenants and incentives to improve the efficiency and quality of service provision.

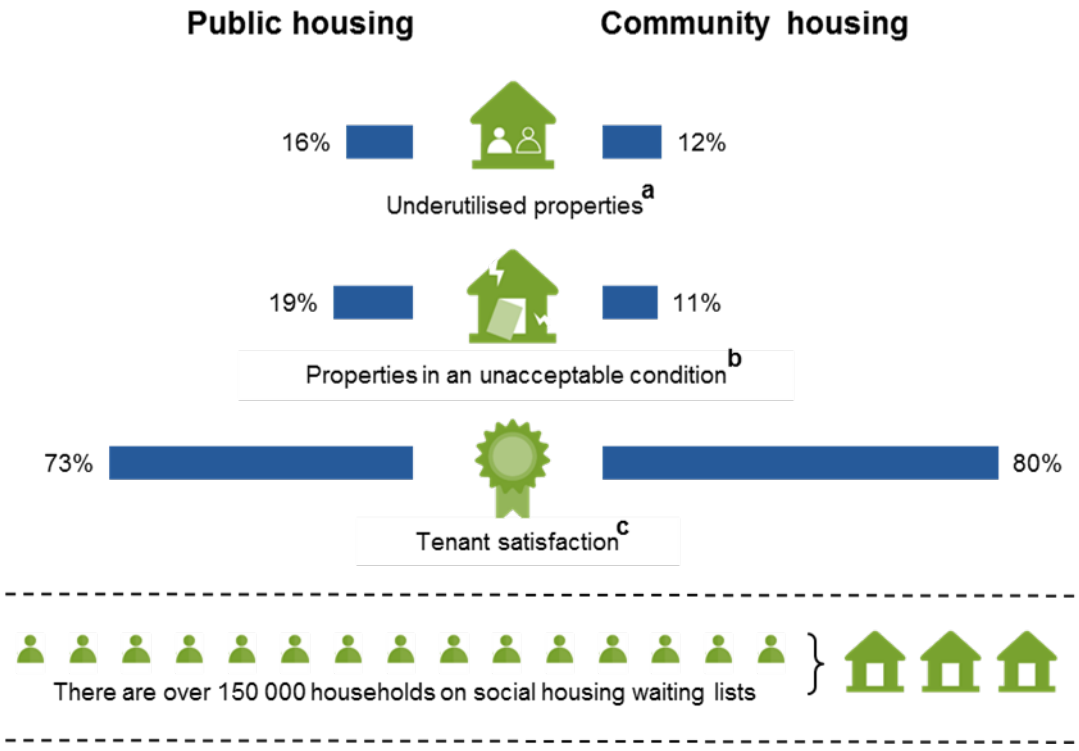
In Australia, contestability has been introduced most commonly through transferring the management of social housing to community housing providers. The NSW Federation of Housing Associations et al. (sub. PFR328) have expressed a desire for management transfers to continue, as have other providers through consultations. There have been several key drivers of management transfers in Australia. Most prominently, transfers seek to maximise the revenue available to State and Territory Governments for social housing — tenants in community housing are eligible for CRA, while those in public housing are not. Transfers of management, along with transfers of stock, have also sought to allow providers to leverage private finance to increase the stock of social housing. It is unclear whether this objective has been achieved (Pawson et al. 2013).

There is evidence in Australia that tenancy management transfers have led to better outcomes for social housing tenants. Community housing providers have a lower underutilisation rate and higher tenant satisfaction than public providers (figure 5.4). Participants noted that community housing providers have a more customer-focused approach to service delivery (Mission Australia, sub. 277; NSW FHA et al., sub. 235; NT DTF, sub. 261) and play a community development role (Anglicare Australia, sub. PFR391). QShelter (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. Cooperatives and mutuals can also be used to empower tenants (box 5.7).

This evidence should be treated with caution, as public and community providers are not placed on an equal footing. The extra income obtained through CRA can be used by community providers to improve the quality of their service, but this does not mean they are inherently better providers. Similarly, in some cases the stock transferred to community providers has been newer and of better quality than most homes in public housing, which may account for some of the improved outcomes.

Figure 5.4 **Indicators of public and community housing, 2016**



[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 (2017).

Management should be made contestable, but there is a need for proper evaluation

In light of the potential benefits outlined above, the Commission considers that the management of social housing should be made contestable. However, there is a need for evaluation frameworks to be established upfront, to allow for full evaluation of the benefits

and costs of transfers, and to inform future transfers. There have been gaps in data collections for previous transfers, for example, the Audit Office of NSW (2015, p. 2) has noted that, in relation to management transfers:

> It is unclear whether the Department has achieved its desired outcomes for tenants. For example, the Department wanted more flexible, tailored services for tenants and more resilient communities but it did not determine how it would measure these outcomes.

Chapter 6 discusses the data needed to support the reforms proposed by the Commission.

Competitive tendering is likely to be the best approach to determine the provider that is best placed to manage social housing. Competitive tendering can help governments choose the provider that can best meet the requirements of a tenancy management service at least cost by seeking and comparing proposals from a range of providers. When done through public processes, competitive tendering can improve government transparency and accountability (PC 2014b).

Box 5.7 Social housing cooperatives

Cooperatives are organisations that are owned by their members (which can include the users of the service, and the workers who provide it), who have a say in how the organisation is run and the services that it provides. Cooperative organisations have a unique way of placing service users at the heart of service delivery. Whereas competition and choice empower users by allowing them to make choices between services from different providers, cooperatives offer users a chance to own and control the services that they use.

A small proportion (for example, in Victoria, about three per cent) of social housing properties are managed by cooperatives. In its submission to this inquiry, the Business Council of Cooperatives and Mutuals (sub. 216) stated that tenants benefit from self-management through lower rent and administrative costs, and gaining managerial experience.

Sources: BCCM (sub. 216); CEHL (2016); Cooperatives Victoria (sub. PFR310); SCRGSP (2017).

Some inquiry participants have highlighted limitations and drawbacks of competitive tendering for social housing services, including the cost and complexity of responding to tenders, a disruption of services to users if the provider were to change, and an erosion of coordination between providers (National Shelter, sub. PFR369; Shelter WA, sub. PFR341). Steps can be taken to address other concerns. In part, tendering complexity is a result of unclear boundaries between tenancy management and tenancy support (chapter 6). Clear separation of these roles may help simplify the tender process. Other concerns can be addressed by careful contract design and through performance frameworks (chapters 2 and 7).

Tender processes should be open to all types of provider

Previous approaches that have sought to transfer the management of social housing have only been open to not-for-profit providers (including cooperatives and mutuals). The Commission does not consider that one provider type is inherently better placed than other

provider types to manage social housing. The NSW Federation of Housing Associations et al. (sub. 235) noted that there was no reason why for-profit providers could not manage social housing. Where a not-for-profit provider is better placed to manage social housing, it should win a tender, but this outcome should not be pre-determined at the outset.

Importantly, the Commission does not consider that non-government providers will always be better at managing social housing than government providers. The option of social housing management remaining with the government should not be excluded from the contestable process. Even where the management of housing remains with the government, increasing contestability would have had benefits, by increasing the pressure on the government provider to maintain and improve its performance.

Funding for non-government providers

In most property management transfers, community providers receive the (income-based) rent from their tenants. If draft recommendation 5.2 was adopted, community providers could charge market rents, and thus have a larger pool of funding than is currently the case — likely more than is needed to cover the cost of providing tenancy management services. State and Territory Governments would need to consider what to do with this additional funding pool.

- Governments often specify other objectives that they want providers to achieve with their funding, such as objectives for community renewal and the upgrading of properties. This approach has its drawbacks. Where the provider is expected to deliver multiple services or outcomes, providing a single source of untied funding can impede transparency and accountability. Targeting additional objectives aside from property management also complicates the tender process, and makes it harder for smaller organisations (who may be able to better provide tenant management services, but not provide other infrastructure services) to participate.
- Governments may want to retrieve some of this revenue, such as by charging providers a dividend for the properties they manage. This additional revenue could be used to fund the high-cost housing payment (draft recommendation 5.2).

DRAFT RECOMMENDATION 5.4

State and Territory Governments should continue to make the management of social housing properties contestable, on a staged basis. The management of social housing properties should be subject to a tender process that is open to all providers, including the government provider.

Title transfers

Community housing providers argued strongly for the need to transfer property titles (that is, the ownership of the property), citing several benefits (National Shelter, sub. PFR369; NSW FHA et al., sub. 406; Shelter WA, sub. PFR341). Most prominently, providers considered that having title of a property would facilitate cheaper finance for providers to construct additional social housing properties. Participants also stated that title transfers would provide a stronger incentive for providers to maintain the value of the house, and that providers would be better able to work at arm's length from governments (NSW FHA et. al., sub. 406).

Transferring title also has its drawbacks. Most significantly, once title has been transferred it becomes much harder for governments to replace an underperforming provider. This reduces the incentives that providers face to improve their service delivery, and limits the ability of governments to hold providers accountable for poor service. Once title has been transferred, it can also be difficult for governments to ensure that the properties are used for social housing over the long term (Tasmanian Government, sub. 485). Reduced asset holdings on behalf of the state government could also have an adverse effect on their credit rating, although this effect is likely to be small (NSW FHA et al., sub. 406; Pawson et al. 2013).

Transferring the title of some public housing properties to community housing providers could assist them to borrow more funds and build more stock, although the Commission is sceptical that transfers of title are the best way to achieve this outcome. Several providers have noted that the amount they can borrow depends primarily on the amount of income they have to make loan repayments, not the value of their assets (Pawson et al. 2013; VAGO 2010). Assessing a previous transfer of title to community housing providers, the Victorian Auditor-General's Office (2010, p. 15) found that 'the transfer of assets did not increase their rental income and hence does not provide any greater capacity to service interest and capital repayments for borrowings'. The Commission does not support transferring the title of social housing properties to non-government providers for the purpose of reducing a provider's cost of finance.

6 Social housing: tenancy support services and stewardship

Key points

- Tenancy support services are an often overlooked part of the social housing system, but these services are key to improving outcomes for tenants. About 2000 tenants were evicted from social housing in 2012-13 — support services that can stabilise these tenancies can lead to a large increase in tenant wellbeing. Support services can lead to flow-on effects on other areas of tenants' lives, such as improvements in health and community participation.
  - Tenants should not have to enter social housing to receive access to support services. Funding for support services programs to access the private rental market has sometimes been exhausted midway through the year, or where services do not provide the ongoing support that tenants need.
  - Community housing providers are often expected to deliver tenancy support services for their tenants, with no additional funding provided to deliver the services. This can lead to poor outcomes for tenants, both because funding is not allocated to provide those services, and because the provider of tenancy management may not be the best provider of tenancy support.
- Effective government stewardship arrangements are needed to support tenants to exercise choice of home and receive the services they need, and to help governments to select the best providers to offer tenancy management and tenancy support services.
  - In a model where users have greater choice over the home they receive, the demands on providers of intake and assessment services would be greater, and there is evidence that providers are unable to identify people with complex needs who would need additional support.
  - Data on the efficiency of social housing and on tenant outcomes could be improved, to allow governments to evaluate service providers and the performance of the social housing system as a whole.

In chapter 5, the Commission proposed several recommendations to introduce greater user choice and contestability into social housing, including:

- improving equity and increasing user choice by providing financial assistance that is portable between the private and social housing markets, coupled with a move to rent for social housing based on market rates
- enabling tenants in social housing to have more choice over the home they are allocated

- introducing greater contestability between government and non-government providers to deliver tenancy management services, so that the provider best able to deliver the service can do so.

This chapter outlines reforms that support those proposed in the previous chapter. Some tenants need support services, both to enable them to exercise their choice of home, and also to help them to sustain a tenancy and improve their economic and social participation (section 6.1). Reforms need to be backed by strong stewardship arrangements, so that government decision-making processes are sound, and so that tenants are provided with user-oriented information to make choices over the home they would like to live in (section 6.2). Table 6.1 summarises the Commission's draft recommendations on tenancy support services and stewardship.

Table 6.1 **The Commission's draft recommendations for social housing**
Tenancy support services and government stewardship

Reform direction	*Timeframe*	*Potential costs and benefits*
Draft recommendation 6.1 State and Territory Governments to: • separate the funding and commissioning of tenancy support services from tenancy management services • ensure that tenants renting in the private market have the same access to tenancy support as those in social housing.	As soon as practicable	Improve clarity about the role of tenancy support, and the funding dedicated to it. Improve the quality of tenancy support services. Improve access to tenancy support for those in the private rental market, which would facilitate choice and improve the capacity of private rental tenants to sustain a tenancy. Improve equity between tenants renting in the social and private housing markets. Budgetary costs due to increased funding for private rental tenancy support services.
Draft recommendation 6.2 State and Territory Governments to separate the regulation and management of social housing.	As soon as practicable	Improve the transparency and accountability of government decision making, particularly when selecting social housing providers.
Draft recommendation 6.3 State and Territory Governments to ensure that applicants for social housing receive an assessment of their eligibility for financial assistance and tenancy support, and are made aware of all of their options for assistance.	As soon as practicable	Provides tenants with support to make informed choices over the home they need, and matches them with the tenancy support service they need. Providers of intake and assessment services would need to spend more time with some tenants.
Draft recommendation 6.4 State and Territory Governments to: • improve data on tenant outcomes and the efficiency of housing providers • expand outcomes data to cover tenants receiving assistance in the private rental market.	As soon as practicable	Allow governments to make better decisions when making commissioning decisions. Allows for a full evaluation of the social housing system. Compliance costs on housing providers.
Draft recommendation 6.5 State and Territory Governments to publish information on waiting times by regions, provider performance, and provide information to facilitate choice-based letting.	As soon as practicable	Provides information for tenants to make better choices over the home they would like to live in. Improves the transparency and accountability of providers. As these data are already collected, the costs would be low.

6.1 Support services for tenants

Social housing provides accommodation for people with complex needs, who can often require support to establish and maintain their tenancy. About 4 per cent of people in social housing in 2014 also used drug and alcohol counselling services, about 19 per cent accessed mental health services, and about 10 per cent required support services for day-to-day living (AIHW 2014b). One estimate by Pawson et al. (2015) suggests that about 19 per cent of expenditure by community housing providers is on tenancy support and community services.

Participants emphasised the need for good support services in the social housing system. Jesuit Social Services (sub. 420) noted that long-term support is needed for people with complex needs, and that this support can have benefits in terms of reducing the burden on other human services. The Business Council of Cooperatives and Mutuals (sub. 470) encouraged the use of case management and support in social housing to help tenants to sustain their housing and improve their circumstances.

What are support services?

Tenancy support services are targeted at three key areas.

- Helping a tenant to sustain a tenancy. For example, the Social Housing Advocacy and Support Program in Victoria provides case management support to enable public housing tenants to establish and maintain a tenancy (box 6.1). Support to maintain a tenancy can range from help with budgeting through to referrals to other services and intensive support and supervision (Costello, Thomson and Jones 2013).
- Assisting tenants to improve their economic participation and providing skills to help tenants to exit the social housing system. For example, the NSW Future Directions for Social Housing strategy emphasises support to give tenants the choice to exit social housing (NSW FACS 2016b).
- Linking social housing with broader support services. For example, the Housing and Accommodation Support Initiative in New South Wales links accommodation supports with clinical care for people with mental health problems (box 6.2). Similar programs exist in most other states and territories.

Some support services are available for people in the private rental market, including services that offer support to some tenants to locate, establish and maintain a tenancy (these services are often referred to as private rental brokerage services).

Box 6.1 The Social Housing Advocacy and Support Program

The Victorian Social Housing Advocacy and Support Program (SHASP) provides tailored case management services and support for public housing tenants to maintain their tenancy. Services are provided by several non-government organisations and are funded by the Victorian Government. Tenants in community housing and the private rental market are not covered under the SHASP.

The type of support offered under the SHASP varies depending on the needs of the tenant. It can include support and advice, help with legal issues, financial counselling, skills training, or referrals to other services. There are two key focuses of the SHASP — helping people to transition from homelessness to being in public housing, and helping people whose tenancies are at risk. For about a third of people who were referred to the SHASP in 2014, their main issue was financial difficulty and rental arrears. Other reasons for being referred to the SHASP include mental health issues, anti-social behaviour, drug use and hoarding and squalor.

In 2014, the SHASP had a budget of $4.7 million and had a target of managing 2400 clients per year. Most people who engaged with the SHASP in 2014 either maintained their tenancy or were still working with their SHASP provider. About 2 per cent of SHASP clients were evicted from their property.

Source: SHASP Managers Network (2014).

Box 6.2 The Housing and Accommodation Support Initiative

The Housing and Accommodation Support Initiative (HASI) in New South Wales is a partnership between NSW Health, Housing NSW and providers of tenancy support. The scheme aims to provide people who have mental health problems with stable housing integrated with clinical and psychosocial rehabilitation services. Under the HASI, tenants receive:

- tenancy support services and rehabilitation services from non-government organisations
- clinical care services from specialist mental health services
- housing from social housing providers. Services under the HASI are also available for tenants in the private market.

In 2009, about 1000 people received support through the HASI. The (non-accommodation) costs of the HASI were about $11 000–$58 000 per person annually, depending on the level of support needed.

An evaluation of the HASI in 2012 found positive outcomes for service users. Outcomes included:

- a 59 per cent decrease in the average number of days spent in a mental health inpatient hospital per year
- improvements in life skills, an increase in community participation and a reduction in behaviour issues
- 90 per cent of users successfully maintained their tenancy.

Source: Bruce et al. (2012).

Tenancy support services are provided by different types of organisations. Governments directly provide some services, while other services, such as the Social Housing Advocacy

and Support Program, are provided by non-government organisations but funded in part or in full by governments. Community housing providers also offer support services, including referring tenants to other support providers, and preparing case management plans and managing tenancies at risk (Pawson et al. 2015). The NSW Federation of Housing Associations et al. (NSW FHA) (sub. PFR328) highlighted that community housing providers also offer a range of community-building activities, such as social outings and community events.

Improving the provision of support services

Enabling tenants to access support services is crucial for several reasons. Even within social housing, tenancies fail. In 2012-13, over 2000 tenants were evicted from social housing due to a tenancy breach (about 7 per cent of all tenancy exits) (Wiesel et al. 2014). The Queensland Mental Health Commission (2015) noted that tenants with a mental health condition often do not understand their tenancy obligations, and what may constitute a breach of their tenancy. For these people, social housing is often the last viable source of stable accommodation, and termination of their tenancy can result in homelessness, and increased risk of involvement in the child protection and criminal justice systems (QMHC 2015). Support services that can stabilise a tenancy are vital given the limited options some tenants have if they are evicted from social housing.

Support services can also increase the range of housing options available for tenants. Tenants can receive support to boost their economic and social participation, and allow tenants to access the private rental market when they may not otherwise have been able to. Support services can also have flow on benefits to other aspects of a tenant's life, such as improvements in health, and increases in community participation (box 6.2).

There is room for further improvement in the delivery of these services, particularly in the context of a system that seeks to provide people with genuine choice between social and private housing (chapter 5). Tenancy support services share many of the characteristics of family and community services, and some of the draft recommendations outlined in chapter 7 may also have relevance for tenancy support services.

Support for tenants in the private rental market

Access to support services for tenants that choose to rent in private housing is an important part of enabling choice, both to ensure that tenants in private housing are able to establish and sustain their tenancy, and to improve their economic and social participation. It is important that access to support services does not end if a tenant makes the choice to rent in the private market. NSW FHA et al. noted that:

> … tenant choice about housing tenure should not be distorted by rationed access to ancillary services. People should not need to be in social housing to access services such as tenant support, financial counselling or community mental health care. (sub. 406, p. 7)

As noted above, there are some supports offered to tenants who rent in the private market, but these are largely ad hoc and there are gaps. Many support schemes targeted at social housing tenants are not made available to those renting in the private market. Private rental support services generally require a tenant to be 'rental ready' before they will provide support to establish and maintain a tenancy. This reflects a view that it is nearly impossible to find stable accommodation for more complex tenants, and the high cost of assisting these tenants (Tually et al. 2016). Evaluations of some support services available overseas, such as the Private Rental Sector Access Development Program in the United Kingdom, found that tenancy support can help tenants with complex needs to sustain a tenancy in the private market (box 6.3).

Box 6.3 The UK Private Rental Sector Access Development Program

The Private Rental Sector Access Development Program was a program aimed at assisting single homeless people in the United Kingdom, who were not well served by existing services, into private rental accommodation. The program provided funding for about 150 organisations to deliver support services. The funded organisations varied in size and scope, but included, for example:

- a day centre that offered support for 'rough sleepers' and people with addiction problems, and was seeking to offer housing support for its clients
- an organisation focused on youth homelessness that provided help to sustain a tenancy and ongoing support
- an organisation that provided services to ex-offenders and was undertaking intensive resettlement work with its clients.

About 8000 tenancies were created over the lifetime of the Program, and 90 per cent of tenancies were sustained. The cost to governments was about £1000 per sustained tenancy.

Source: Rugg (2014).

The Royal Commission into Family Violence in Victoria (2016) highlighted several shortcomings of private rental support services. It noted that support often ceases once a person finds a home, and little support is offered over the long term. The Royal Commission into Family Violence in Victoria (2016, p. 85) stated that 'scant attention is paid to improving victims' ability to be resilient in the private housing market by helping them improve their status in the labour market and, as a consequence, their level of earned income'. Funding packages for private rental support are often exhausted quickly — one example was given of a regional provider who had used all of its allocated funding by halfway through the financial year.

There is likely to be an increase in fiscal costs associated with improving tenancy support services for tenants renting in the private market. This is because additional funding is needed to support tenants currently renting privately, and there may be diseconomies of scale involved in providing support services to people dispersed in the private market rather than those in clusters of social housing. For example, the UK Private Rental Sector Access Development Program cost about £1000 per sustained tenancy (box 6.3). Nonetheless, there

are clear benefits in providing such support, in the form of facilitating user choice, improving housing outcomes for tenants on low incomes, and reducing the burden on the social housing and homelessness systems.

The distinction between tenancy management and tenancy support

Inquiry participants raised concerns that the line between tenancy management and tenancy support was sometimes blurred, and the role of community housing providers in delivering services is unclear. Two concerns were raised.

- During consultations, participants noted that community housing providers are being asked to do too much with too few resources, and that the system is stretched to capacity. Launch Housing (2016) noted that, in Victoria, community housing providers are not able to deliver tenancy and additional support on current levels of funding. Similarly, Pawson et al. (2015) noted that it was unclear how additional support services would be funded by providers in a resource-constrained environment.
- Governments often do not make clear the role they want tenancy management providers to play in tenancy support. The NSW FHA et al. (sub. 406, p. 5) noted that tenancy support services 'along with community development and other non-housing outcomes, are different functions and need to be better specified in procurement arrangements'. Pawson et al. (2015) also noted that many of the objectives that governments want community providers to pursue are yet to be explicitly stated.

The Commission agrees that, where governments want additional services to be provided or outcomes to be achieved, these should be explicitly stated in funding agreements, and funding allocated where needed. This would make clear what objectives governments have for the delivery of support services, and ensure that providers have the resourcing available to deliver services to meet these objectives. Some governments are working toward developing outcomes frameworks for social housing (for example, NSW FACS 2016c; chapter 7), which, if designed and implemented well, could help to clarify the role of tenancy management providers, and the outcomes that governments want them to achieve.

The Commission supports a clear distinction being made between tenancy management services and tenancy support services in commissioning processes and funding agreements. Importantly, it should not be assumed that community housing providers will be best placed to provide tenancy support to the tenants in properties that they manage. Some participants advocated for a clear split between the provision of tenancy management and support — Jesuit Social Services (sub. 420, p. 12) stated that tenancy management should be distinct from tenancy support to help 'ensure that support is driven by a therapeutic and not tenancy management approach'. Queensland Advocacy Inc. (sub. 442, p. 7) noted that 'housing and support must go hand in hand for people with disabilities, but never from a single provider'.

Having one provider offering tenancy support and management services may have some benefits, such as better integration of services and, potentially, economies of scope. There will no doubt be a role for community providers to offer some support and refer tenants to

other services where appropriate. However, separation of management and support can also have benefits — it can make it easier to replace a provider of tenancy support or tenancy management that is underperforming, and it can make it easier for tenants to move home while retaining their existing relationship with their provider of tenancy support. The provider that is best placed to deliver these services is best decided on a case-by-case basis, through government commissioning processes.

DRAFT RECOMMENDATION 6.1

When commissioning tenancy support services, State and Territory Governments should:

- clearly separate the funding and commissioning of tenancy support services from tenancy management services
- ensure that tenants renting in the private market have the same access to support services as tenants in social housing.

6.2 Improving government stewardship

The Commission's proposed reform directions aim to put the user at the centre of service delivery by:

- increasing user choice to improve equity and enable tenants to choose homes that best suit their requirements
- providing tenancy support to meet the needs of tenants
- improving the contestability of tenancy management services so that providers best placed to improve outcomes for tenants manage social housing.

These reforms would require strong stewardship arrangements, so that households are supported to make choices, governments can select the best providers to deliver services, and providers are made accountable to users and governments.

Governance and transparency

In most states and territories, the housing authority responsible for managing social housing assets is contained within the department responsible for setting housing policy. There is a case for a separation of social housing policy and service provision. There may be conflicts of interest if the department setting criteria for tenders to manage social housing is also competing for the tender itself (chapter 5). Contestability requires that the government social housing provider faces a credible threat of replacement if they underperform, which would not be the case if that provider is responsible for monitoring their own performance.

The NSW Independent Pricing and Regulatory Tribunal (IPART) (2017) recommended that the New South Wales Government moves to a purchaser–provider model. The NSW Department of Family and Community Services (FACS) would be responsible for social housing policy and planning, and contracting with providers. Under IPART's model, social housing providers, including the public Land and Housing Corporation, would receive funding from FACS, and operate on a commercial basis. The Commission agrees that, to avoid conflicts of interest, policy and planning should be separate from provision, and jurisdictions that have not done so should seek to separate these roles, such as by having these responsibilities sit in different departments, or by establishing a new entity.

DRAFT RECOMMENDATION 6.2

State and Territory Governments should ensure that the entity responsible for managing social housing assets is separate from the entity responsible for social housing policy. The entity managing social housing assets should be subject to competitive neutrality policies.

Intake and assessment services

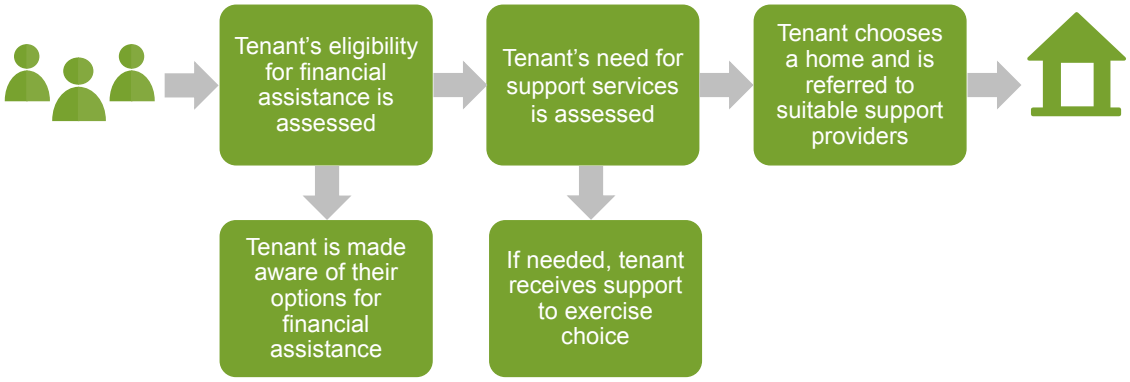
People that require access to social housing go through initial intake and assessment services, which determine a person's eligibility for social housing. These services often also determine a person's need for tenancy support services, including in some (limited) cases through triage services to match people to the services they need. Intake and assessment services vary across jurisdictions. Some jurisdictions have a centralised intake service, such as Tasmania, where most tenants will receive an initial assessment through the centralised service, while in other jurisdictions intake and assessment processes are more decentralised. For example, in Victoria tenants can access social housing through a local housing office, or through individual community housing providers.

A common theme in the Commission's consultations for this inquiry was that people's need for tenancy support services and support to exercise choice varies widely. Some social housing tenants need little to no support to maintain a tenancy, whereas others need intensive support. In some cases, providers may need to offer outreach services to ensure that a person receives the support they need, while in other cases tenants will approach the social housing system themselves. To assess the different support needed by tenants, there are several key roles to be played by the intake and assessment service in a system where users have a greater opportunity to choose their home (figure 6.1).

First, providers of intake and assessment services need to make sure that tenants are able to navigate the system — that they are aware of all of their options for housing assistance, and can make choices between these options, including the option of receiving financial assistance to rent in the private or social housing markets. Some State and Territory Governments have moved toward 'one-stop shops' for housing and homelessness assistance. For example, Tasmania introduced Housing Connect in 2013, which is managed by several

not-for-profit providers. It is a one-stop shop for housing and homelessness support, and provides an upfront housing and support assessment (Tasmanian DHHS 2017). Nonetheless, participants noted that in some jurisdictions the system remains fragmented — Jesuit Social Services (sub. 420) considered that reform is needed to improve access and enable easier navigation of the system. Wiesel et al. (2014) noted that some people were confused about the types of assistance available to them.

Figure 6.1 **Role of intake and assessment services**



Second, providers of intake and assessment services need to determine whether a tenant requires support to enable them to exercise choice over the home they live in. The Commission's proposed reforms would see a substantial increase in the scope for people to make decisions about the home they live in. Many people would be able to make these choices themselves, or have a family member, friend or guardian to make choices on their behalf. Other people would require support to make choices. The Penrith Homeless Institute (sub. 413) stated that 'vulnerable people including youth will require support in exercising their choice both in social housing and [the] private rental market'. Where a tenant is identified as needing additional support to make choices over the home they would like to live in, they could be referred to a tenancy support provider (this role is already played by some services in the private market (Tually et al. 2016)). If there is no trusted person or organisation that can support the tenant to make choices, then the government may need to make choices on behalf of the tenant by allocating them a social housing property.

Finally, providers of intake and assessment services conduct upfront assessments that could be used to refer tenants to support services that meet their needs. For many people, this assessment will be straightforward, as they are able to manage their tenancy on their own and have little need for support. For people with support needs, a more detailed assessment will be required. Alternatively, for people who access other services, their need for tenancy support could be apparent through assessments from other service providers, such as mental health providers.

There is evidence that the assessment of support needs for people entering social housing is currently deficient in some jurisdictions. The Queensland Mental Health Commission

(QMHC 2015, p. 18) noted that the Department of Housing and Public Works is 'unable to identify which of their social housing tenants, including those on the State Housing Register, are living with a mental illness, mental health difficulties or substance abuse problems'. In part this is because local housing staff do not have expertise in, for example, mental health issues, and may struggle to recognise people with mental illness. Similarly, the Royal Commission on Family Violence in Victoria (2016) noted that data from the Department of Health and Human Services appeared to dramatically underestimate the number of people waiting for social housing that were experiencing domestic violence.

Some governments are seeking to improve their approaches to triage and assessment. The Victorian Government is trialling a consistent approach to needs assessment and triaging by service providers in several locations in response to the recommendations of the Royal Commission into Family Violence. The Queensland Government has trialled a triaging service on the Gold Coast, although results from this trial are not publicly available. Results from these trials should be made public, so that they can be used to inform reforms in other jurisdictions.

Overall, providers of intake and assessment services would need to play a strong role, and any deficiencies in these services would need to be addressed. The Commission considers that State and Territory Governments should ensure that social housing applicants receive a comprehensive assessment of their eligibility for assistance and tenancy support, and are made aware of all of their options for assistance. Importantly, tenants should receive support to enable them to choose their home if required.

DRAFT RECOMMENDATION 6.3

State and Territory Governments should ensure that applicants for social housing assistance:

- receive a comprehensive up-front assessment of their eligibility for: a social housing placement; the high-cost housing payment (draft recommendation 5.2); and tenancy or other service support, including support to enable the tenant to choose their home
- are made aware: that the high-cost housing payment would be payable if they chose to live in either the private or social housing markets; and of the extent to which support services available in social housing would also be available in the private market.

Data to assess performance

Data are needed to allow governments to evaluate the effectiveness of service provision and implement reforms to improve service provision. There are several levels at which data can be collected, including data on user outcomes, provider performance, the performance of programs, and the performance of the system as a whole (chapters 2 and 7).

To support the Commission's proposed reforms, there are several key reasons why data are needed. Data are needed to support contestable approaches to selecting providers, including to allow governments to select the best provider to deliver a service, and to identify and replace underperforming providers. Data can also allow providers to benchmark their own performance and provide incentives to improve. Data can also be used to evaluate the effectiveness of the housing system as a whole, and to identify any areas where improvements are needed.

There are several sources of data on the effectiveness of service provision in social housing.

- The main data available on tenant outcomes are tenant satisfaction measures collated through the National Social Housing Survey, undertaken by the Australian Institute of Health and Welfare. The survey includes measures of overall tenant satisfaction, and tenant satisfaction with the amenity of the property they live in (such as its size and modification for special needs), with the location of the property they live in and with their housing provider. Some housing providers are also undertaking their own assessments of tenant outcomes, such as through the House Keys survey undertaken by the New South Wales Federation of Housing Associations (NSW FHA 2015). Data on tenant outcomes can also be used to assess the effectiveness of individual providers, as well as the effectiveness of the housing system.
- Data on individual provider performance are obtained through requirements under the National Regulatory System for Community Housing (NRSCH) (these data are not publicly available — discussed below). Under the system, providers must provide evidence to prove that they meet several performance criteria, including demonstrating that the provider manages its housing assets in a manner than ensures suitable properties are available now and in the future; and that the provider is fair, transparent and responsive in delivering housing assistance.
- Data on the overall performance of the social housing system are available through the Report on Government Services, compiled annually by the Productivity Commission using a range of data collected from State and Territory Governments. The report includes data on maintenance, (implicit) financial assistance provided to tenants, utilisation of properties and size of waiting lists.

There are gaps in social housing data. Pawson et al. (2015, p. 1) noted that 'Australia's existing suite of official social housing performance measures is seriously inadequate in this respect and lags well behind other service realms'. There are little data available to assess the effectiveness of tenancy support services across both the social and private sectors. In 2015, the Australian Housing and Urban Research Institute (AHURI) released a report examining ways to improve data collection for social housing across Australia (box 6.4). The NSW FHA et al. (sub. 406) noted that they supported the direction of these recommendations.

Box 6.4 AHURI study on the effectiveness and efficiency of social housing

In 2015, AHURI released a report on measuring the effectiveness and efficiency of social housing. The report noted that there were several gaps in the reporting on social housing across the public and community sectors, and made several recommendations to governments.

- Transparency on the costs of social housing provision and tenant outcomes should be a top priority for governments.
- The methodology for estimating the costs of providing social housing differs by jurisdiction. A new and consistent, metric for estimating social housing costs is needed, which breaks down social housing management costs into different categories, such as cost incurred in tenancy management and costs incurred in tenancy support.
- Alignment is needed between the national social housing survey and surveys undertaken by community housing organisations.
- Public housing authorities report on tenancy sustainment metrics, but community housing providers do not. This metric should be expanded to larger community housing providers.
- There is a need for additional tenant outcome measures, such as data on the effectiveness of a social housing landlord in aiding economic reconnection.
- Under the National Regulatory Scheme for Community Housing, provider level data on cost of provision, operational performance and outcomes metrics should be published.

Source: Pawson et al. (2015).

The costs of managing social housing

Data on the costs of managing social housing services across providers are needed for governments to make decisions about who should manage social housing (Tasmanian Government, sub. 485). During the course of this inquiry, participants were unable to tell the Commission whether housing is more cost-effectively managed by the public sector or the community sector, let alone determine the differences *between* individual government or community housing providers.

The Australian Institute of Health and Welfare produces a metric on the net recurrent cost of managing social housing. Pawson et al. (2015) outlined several reasons why this measure is inadequate. In particular, it is highly aggregated, and includes tenancy management and support, as well as property maintenance. Differences in costs can be strongly driven by the extent to which providers have older stock and need to undertake additional maintenance, or offer additional support for tenants. There are also differences in how jurisdictions estimate costs, which limits the comparability of the data across jurisdictions. Participants during consultations agreed that current metrics to estimate the costs of providing social housing are inadequate.

Improving metrics on the costs of managing social housing would improve the ability of governments to assess the performance of individual providers of tenancy management and to select managers of social housing if using contestable approaches, and also to improve the

transparency of the system. The methodology should be broken down into the costs of the various functions that social housing tenancy management providers deliver.

Measuring outcomes for tenants

Chapter 7 examines good practice in developing outcomes frameworks from the perspective of family and community services. Data collected on tenant outcomes can allow governments to monitor the performance of individual providers based on whether they are delivering a high-quality service and are achieving positive outcomes for their tenants. This can align the incentives of governments and providers, and allow governments to replace underperforming providers. Data on outcomes can also be used to evaluate individual programs and the social housing system as a whole, and help determine 'what works' (and what does not work) to improve outcomes for social housing tenants.

Data on tenant outcomes in social housing are largely limited to tenant satisfaction measures. These metrics can be powerful — improving the satisfaction of tenants is one way of determining whether services are improving outcomes — but they do not tell the whole story. Data on tenant outcomes, such as the sustainment of tenancies or a tenant's success in finding employment, are not consistently collected across public and community housing providers (Pawson et al. 2015).

As noted in chapter 5, the Audit Office of New South Wales (2015) stated that transfers of the management of social housing have not been supported with data collection to measure outcomes. The NSW Government defined intended outcomes for the transfers, including building stronger communities and supporting the self-sufficiency of individuals, but it is unclear whether these outcomes were met. On the whole, there is limited evidence, aside from broad tenancy satisfaction metrics, as to whether management transfers have led to net benefits for users, or for the community more generally.

Similarly, there is a lack of evidence and evaluation of tenant outcomes from tenancy support programs, particularly those for tenants in private rental properties. Tually et al. (2016, p. 96) noted that:

> Long-term evaluation of the work of [Private Rental Brokerage Programs] PRBPs has not been undertaken externally, although we understand that a number of evaluations have been prepared by individual agencies for internal use. Determining the value of, and outcomes from, PRBP initiatives is therefore difficult.

Costello, Thompson and Jones (2013) also noted that data are needed to inform the development of remedial solutions, and evaluations of existing innovative programs need to be undertaken.

The first step in developing an outcomes framework is to identify the outcomes that governments want the system, program or service provider to achieve (chapters 2 and 7). The outcomes defined would depend on government objectives, but could include measures such as the number of tenants transitioning from social housing into the private rental market,

employment outcomes, whether tenants sustain a stable tenancy, as well as improvements in tenant satisfaction. It could also include assessing whether service provision is equitable and responsive to the needs of tenants. Ultimately, the performance of the system, program or provider should all be linked back to the outcomes achieved for tenants.

There is a need for broader indicators of the wellbeing of tenants — such as their overall economic and social participation — to be measured and linked to the range of other services that tenants receive. The Commission has recommended that governments should develop indicators of wellbeing of people that are applied consistently across all family and community services (draft recommendation 7.3). These indicators could also form the basis of measuring wellbeing for tenants in social housing.

Once outcomes are defined, frameworks need to be put in place for outcomes to be measured. Measuring outcomes for tenants from social housing management and support services is complex, and there is no agreed approach that can be used to assess outcomes. Some State and Territory Governments are beginning to put in place frameworks to assess outcomes — for example, the Tasmanian Government (2015) requires providers to estimate their 'social return on investment' as part of the Better Housing Futures management transfers. The NSW Government is developing an outcomes framework for social housing focusing on health, social and community, empowerment, economic, safety and education outcomes (NSW FACS 2016c). These approaches are still in their infancy, and their success is unclear. It is important that the approaches are evaluated, and rolled out more broadly if they prove to be successful.

Data on outcomes for tenants receiving assistance to rent in the private market

To enable a full evaluation of the Commission's proposed reforms, data are needed on outcomes for tenants receiving assistance to rent in the private market (section 6.3). Currently, these data are limited — there have been some surveys of tenants deemed to be in 'rental stress' in the private market, but no data are available that could be used to assess the satisfaction of these tenants with their property, and with the support services they receive.

Data on tenant satisfaction should be expanded to cover tenants receiving assistance to rent in the private housing market. These measures could include the tenant's overall satisfaction with their property, the location they live in, as well as whether they have received sufficient support to ensure a stable tenancy (if applicable). When outcomes measures are developed for tenants in social housing, these should also be expanded to cover tenants receiving assistance in private rentals where feasible.

DRAFT RECOMMENDATION 6.4

State and Territory Governments, in conjunction with the Australian Institute of Health and Welfare, should improve the data that are collected on:

- the efficiency of social housing
- tenant outcomes, including high-cost housing payment and service recipients who choose to rent in the private housing market.

State and Territory Governments should clearly define the outcomes they are seeking to achieve to support the commissioning of tenancy management and tenancy support services, and put in place frameworks to assess their success in meeting these outcomes over time. Outcomes data should, to the extent possible, be consistent and comparable to that developed for family and community services (draft recommendation 7.3).

Information for households to make choices

People need information to base their decisions on. Social housing is no different — information is needed to enable tenants to decide both the home and the provider (if renting in social housing) that they expect would best meet their needs. Exercising choice in social housing would not require a large amount of information as the characteristics of individual homes are usually readily available and observable to tenants. Social housing does not have the same information asymmetries that are prevalent in many other human services, although some asymmetries may exist in relation to the performance of providers of tenancy management services. Information needed for social housing can be placed into two categories — information needed to support choice-based letting, and information that should be made available irrespective of whether choice-based letting is implemented.

Information on social housing properties, similar to that available in the private rental market, would be needed to support choice-based letting. Governments could be guided by the experience of the United Kingdom when deciding what information is to be provided to tenants. Importantly, information needs to be disseminated across a range of mediums, so that tenants who, for example, do not have access to the internet can also receive information. In the United Kingdom, information on available properties, such as the number of bedrooms and location, is shared online and through bulletin boards and printed leaflets (Marsh, Cowan and Cameron 2004). In some cases, high-priority applicants receive information on available properties through targeted mail outs.

Irrespective of whether choice-based letting is implemented, tenants should receive information on the expected waiting times to enter social housing. Some jurisdictions, such as New South Wales, publish information on expected waiting times for social housing properties across regions, but most do not. Other jurisdictions publish the information in a format that is difficult for tenants to understand (NSW FHA et al., sub. 235). Better information on waiting times for particular locations would allow tenants to make informed trade-offs. A tenant can

choose to wait for an extended period of time for a social housing property in their preferred location, or seek to receive a property quicker in a different location.

There is little publicly available information on individual providers, and making this information available would enable tenants to make more informed choices over the home they would like to live in. Pawson et al. (2014) and the NSW FHA et al. (sub. 406) noted that information provided as part of the NRSCH on cost of provision, operational performance and service outcomes could be made publicly available. Under the NRSCH, housing registrars monitor compliance with the National Regulatory Code, and conduct annual or biannual compliance assessments of registered providers. Information and evidence collected can include:

- information on tenant satisfaction. Providers are required to demonstrate that they have maintained a satisfactory level of tenant satisfaction, and it is recommended that larger providers undertake a tenant survey of satisfaction at least every two years
- information on managing complaints. Providers are required to demonstrate that complaints and appeals are reviewed to ensure they have been handled fairly, and that there are no ongoing or repeated failures
- information on support services. Providers are required to demonstrate that they have in place arrangements to ensure tenants receive appropriate support to maintain tenancies where relevant
- information on property conditions. Providers are required to demonstrate that properties are well maintained and that they meet property condition standards.

Making regulatory reports on housing providers publicly available would enhance the transparency of the system and enable more informed choices by service users. As this information is already collected there appears to be few costs involved in making it available to tenants — any information that is considered commercial-in-confidence could be removed from the reports before publishing.

Providing information on waiting times and the performance of individual providers would have benefits beyond improving information to users, and should be pursued regardless of whether the reforms outlined in chapter 5 are introduced — although the benefits would be greater if the information was provided in combination with greater choice. Both sets of information would improve the accountability of decision makers and providers to the broader community. Underperforming providers would be more easily identified, and have strong incentives to improve their performance and their responsiveness to tenant needs.

DRAFT RECOMMENDATION 6.5

State and Territory Governments should:

- publish information on expected waiting times to access social housing, by region, in a format that is accessible to prospective tenants
- make publicly available the regulatory reports on the performance of community providers that are undertaken as part of the National Regulatory System for Community Housing.

To facilitate choice-based letting, State and Territory Governments should publish information on available social housing properties, such as the rent charged for the property, number of bedrooms and the location of the property. This information should be disseminated across a range of mediums, such as online and printed leaflets.

Regulation of providers

Community housing providers are regulated under the NRSCH (box 6.5). All states and territories — with the exception of Western Australia and Victoria — have joined the NRSCH. Registration under the NRSCH is voluntary, but State and Territory Governments often require that a provider be registered as a precondition to receiving funding for housing services.

A key concern with the NRSCH is that it does not cover all social housing providers. The NRSCH only applies to community housing providers, and several participants during consultations stated that it should be expanded to cover public housing. Participants stated that the NRSCH should be expanded to cover Victoria and Western Australia. The Tasmanian Government (sub. 485) noted that organisations that operate across multiple jurisdictions may still need to have multiple registrations.

In addition to its coverage, the NSW FHA et al. (sub. 406) raised other concerns with how the NRSCH has been applied.

- State and Territory Governments have significant scope to interpret how to implement the NRSCH in their jurisdiction, leading to inconsistent treatment between jurisdictions. This adds to the administration costs of providers operating across jurisdictions, and can create barriers to entry, as jurisdictions can restrict tenders for funding to locally operating organisations.
- Compliance costs under the NRSCH are high, which can be a particular burden for smaller providers.

Box 6.5 National Regulatory System for Community Housing

The National Regulatory System for Community Housing (NRSCH) is the national system of registration, monitoring and regulation of community housing providers that came into effect on 1 January 2014. The NRSCH seeks a clear separation between regulatory activities, and state and territory policy and funding activities. There is no obligation for a community housing provider to be registered under the national system, although governments can make registration a precondition for receiving funding for housing services.

Registration under the NRSCH is divided into three tiers, with different levels of regulatory scrutiny and monitoring applying to providers based on the scale and scope of their activities. Housing providers that engage in activities that involve a higher level of risk, such as property development or managing a large number of tenancies, are subject to higher levels of oversight. Registered housing providers must demonstrate a capacity to meet and achieve ongoing compliance with the National Regulatory Code, and have in place arrangements to manage their assets in the event of a business wind-up or deregistration.

National Regulatory Code

The code sets out the performance and outcome requirements that must be met by each tier of registered housing provider. It is outcomes focused, and does not prescribe how the provider should achieve each requirement. The code covers tenant services, housing assets, community engagement, governance, probity, business management and financial viability.

Sources: NRSCH (2014a, 2014b); Victorian Housing Registrar (2014).

The Commission considers that regulation should be consistent across providers with different organisational structures — whether they are government, not-for-profit, mutual and cooperative, or for-profit. This approach is taken in England, where the Homes and Communities Agency regulates all social housing providers, including government, not-for-profit and for-profit providers. Consistent regulation of providers would extend a set of rights and protections to all tenants, regardless of which sector is managing their tenancy. Consistent regulation would also help balance any competitive advantage or disadvantage experienced by a sector, and assist governments to select the provider best placed to deliver services. These benefits need to be weighed against costs. Public housing authorities would have to transition to the NRSCH, which may require investments in information technology infrastructure and staff training, among other costs.

The NRSCH was designed to regulate community housing providers, and it is unclear if it is flexible enough to regulate a range of providers with different organisational structures. Different types of provider face different incentives, and sometimes need different regulations to minimise the risk that they act in an undesirable way (chapter 2). The Commission is seeking additional information on whether changes to the NRSCH would be needed to account for different types of providers.

The Commission has insufficient information to assess whether other changes to the NRSCH to reduce compliance costs and increase tenant empowerment are warranted. The Commission is seeking further information from participants in these areas to inform its final report.

INFORMATION REQUEST

The Commission supports the principle of consistent regulation across different types of social housing providers. The Commission is seeking information and evidence on whether changes to the National Regulatory System for Community Housing (NRSCH) are needed to accommodate different types of providers. This includes information and evidence on:

- *whether the NRSCH is flexible enough to regulate different types of providers and, if not, the changes that are necessary*
- *the costs and benefits of extending the NRSCH to include different types of providers of tenancy management services*
- *the extent to which inconsistencies between jurisdictions add to administration costs and create barriers to entry (the Commission would welcome quantitative evidence on the costs incurred by providers)*
- *what changes to the regulatory system should be made to provide incentives for providers to improve outcomes for tenants, improve provider responsiveness to the needs of tenants and improve provider accountability to governments.*

6.3 Evaluating reforms

The Commission's reform path aims to put tenants at the centre of service delivery, both by offering them greater scope to make informed choices about where they live, and by providing them with necessary support services based on up-front (and ongoing) assessments of their needs (figure 6.2). The needs of people that enter social housing are diverse, and the Commission's reforms seek to allow people to take very different paths through the social housing system, depending on their needs.

Once a reasonable period of time has passed — five years after reforms have been implemented — the Commission's reforms need to be evaluated based on whether they have been successful in putting users at the centre, and at improving outcomes for users and the broader community. Each State and Territory Government has different objectives for social housing, and thus the indicators that they use to assess the effects of reforms will vary. Regardless, the Commission considers that there are several metrics that would need to be considered in the evaluation of reforms, based on the five attributes of human service delivery (chapter 1).

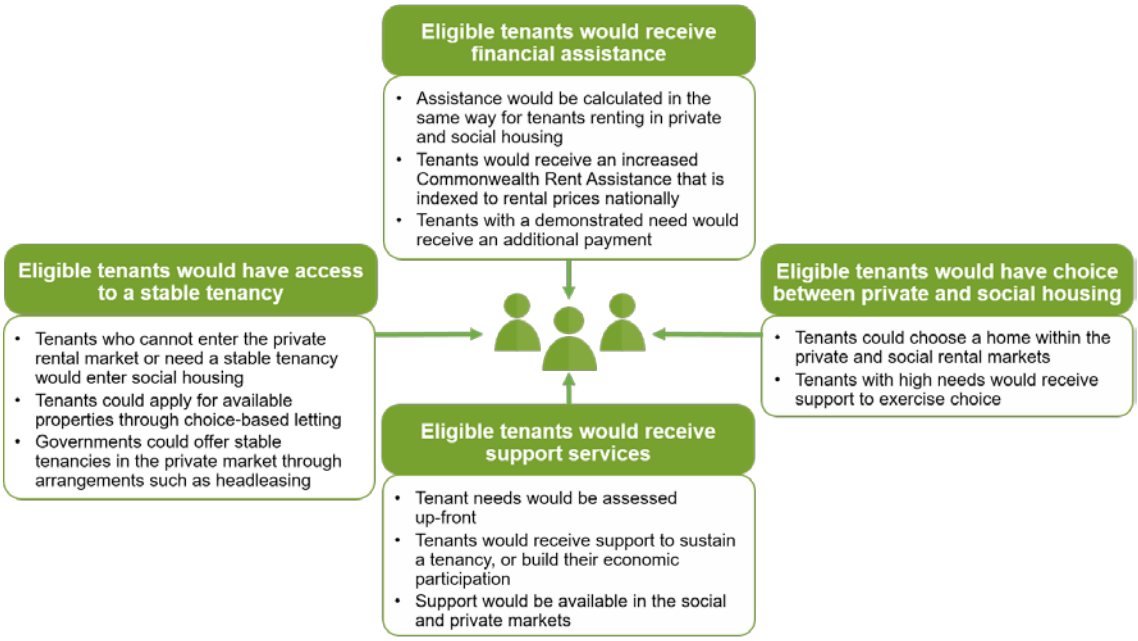
- The quality of housing assistance, including both assistance received to rent in social and private housing, should be based on whether tenants are receiving stable housing that meets their needs, and is affordable. Quality can be measured by tenant satisfaction measures — whether tenants are happy with the home they receive — as well as affordability measures based around self-reported financial stress. The quality of tenancy

support services could be assessed based on measures of economic participation and the stability of tenure, as well as broader measures of a tenant's wellbeing (section 6.2).

- Equity is a key driver of the reform path, and the effect of reforms across the groups of people eligible for social housing should be assessed.
- Assessing the efficiency of the social housing system can include use of both financial metrics, based around the costs of providing tenancy management and tenancy support, as well as utilisation metrics — whether social housing properties are underutilised or overcrowded.
- Responsiveness should be assessed based on whether tenants are able to exercise genuine choice of home, as well as whether the social housing system is able to identify tenant needs, and deliver appropriate services to them.
- Reforms should be evaluated based on whether they provide incentives for accountable and transparent decision making, including separating the key functions of housing authorities to ensure that there are no conflicts of interest.

Evaluation across these metrics should be used to inform continuous improvement in the delivery of social housing. Where some jurisdictions implement reforms before others, the evaluation can also be used to inform whether and how to proceed with reform in other jurisdictions.

Figure 6.2 **Putting the user at the centre of social housing — the Commission's draft recommendations**



7 Commissioning family and community services

Key points

- Governments fund and deliver a range of services that are intended to achieve improvements in the wellbeing of people experiencing hardship, including crisis support, ongoing support and support for communities. Many services are delivered by non-government organisations. Funding from all levels of government to not-for-profits delivering social services totalled $7.2 billion across over 5000 organisations in 2015.
- The processes that governments use to commission these services are haphazard, and designed to minimise risk and maximise convenience for governments. Poor commissioning is a barrier to service quality, efficient resource allocation, responsiveness to the needs of people experiencing hardship and effective accountability.
- The problems have come about because the service system has evolved without any coherent plan, government agencies make decisions about service provision in 'silos' and risk aversion drives an excessively prescriptive and government-centric approach to contract management.
- People who use family and community services are not always in a position to exercise informed choice. However, the system can and should put their interests at the centre of service provision.
- Governments could improve their understanding of user needs and what works, and unlock the potential of providers to achieve better outcomes by implementing a range of changes to commissioning processes, including:
  - investing in systematic service planning and developing service plans for each region
  - adjusting provider selection processes to identify service providers that are able to achieve outcomes for the people who use the services
  - establishing and using person-centred outcomes frameworks as the basis for information collection, performance evaluation and contract management
  - increasing standard contract terms and trialling relational approaches to contracting
  - aligning funding available to service providers with the cost of achieving outcomes.

Table 7.1 **Overview of proposed reforms to family and community services**

All reforms are directed at the Australian, State and Territory Governments

Proposed reforms	*Timeframe*	*Potential costs and benefits*
Systematic service planning		
Draft recommendation 7.1 Develop and publish maps of existing services; analysis of the characteristics and needs of the service user population; and service plans to address these needs.	12–24 months	Commissioning activities could better address user needs. Costs of data collection, stakeholder consultation and analysis.
Provider selection processes		
Draft recommendation 7.2 Design provider selection criteria that focus on the ability of service providers to improve outcomes for service users and not discriminate on the basis of organisational type.	12–24 months	Better outcomes for people using services; more efficient resource allocation. Costs of data collection and analysis.
Allow sufficient time for providers to prepare considered responses (including the development of integrated bids across related services).	As soon as practicable	Potential to increase collaboration between providers.
Performance management frameworks		
Draft recommendation 7.3 Develop outcome measures for family and community services, for use in provider selection and provider, program and system level evaluations.	24 months	More information about the effects of services on people's wellbeing would support system planning, provider selection and service quality. Governments and service providers would need to expand their capabilities in data management and analysis.
Draft recommendation 7.4 Monitor the performance of providers in achieving outcomes for service users, and evaluate service providers, programs and systems in ways that are commensurate with their size and complexity.	36 months	
Proactively support the sharing of data between governments and departments, and the release of de-identified data to service providers and researchers.	36 months	
Develop processes to disseminate the lessons of evaluations.	12 months	
Contract management practices		
Draft recommendation 7.5 Increase default contract lengths to seven years. (Exceptions could be made, such as for program trials but justification should be provided.) Ensure contracts contain adequate safeguards in any cases of serious failure by providers.	On expiry of existing contracts	Greater market stability facilitates investment by providers in service quality and gives users more continuity of service. Less flexibility for governments to change funding priorities.
Draft recommendation 7.6 Provide payments to providers for family and community services that reflect the efficient cost of service provision.	12–24 months	More equitable access and increased capacity for providers to invest in service improvement. Costs of data collection, analysis and contract design.
Draft recommendation 7.7 Trial relational approaches to contract management. Train staff to increase their capacity to implement outcomes-based approaches to commissioning and relational approaches to contract management.	12–24 months	Increased flexibility and incentive for providers to be responsive to users. Costs of investment in government expertise; costs of data collection and analysis by governments and providers.

7.1 Context and scope

What are family and community services?

Family and community services cover a range of activities targeted at achieving improvements in the wellbeing of individuals and families. Services address a range of circumstances, including crisis support, transitional support, building capability and early intervention and prevention. Examples include services for family support, homelessness, family and domestic violence, alcohol and other drugs and settlement support. The objective of these services is to achieve outcomes for service users — changes in knowledge, skills attitudes, values, behaviour, condition or status — that increase their wellbeing (PC 2010). Examples of outcomes that family and community services can contribute to include improved housing stability, reduced harmful behaviours and increased knowledge of and confidence to seek support services (DSS 2014).

Governments provide the majority of funding for family and community services, largely thorough a model of contestability where providers 'compete' periodically for funding to deliver services. Services are generally free to the user, and service provision is dominated by the not-for-profit (NFP) sector, although government remains a direct service provider in some areas. For-profit entities are sometimes specifically excluded from seeking government funding.

This inquiry's focus is on family and community services where governments select providers, user choice is limited and funding is often not linked to outcomes. Consistent with the terms of reference, recommendations in this chapter focus on services commissioned by the Australian Government and State and Territory Governments. However, local governments also commission family and community services and recommendations may be applicable to these governments also.

Changes over time: from charity to commissioning

Family and community services have developed in an ad-hoc way over time. This reflects, in part, the genesis of many services. Prior to the 1970s many of the services now funded by government were provided by charities, funded via donations. This led to services that were highly specific to a location, cohort or delivering organisation.

Since the 1970s, governments have substantially increased their focus on, and funding for, family and community services. However, decision making remains idiosyncratic rather than planned — decisions made by all levels of government about what services are commissioned, where and for whom, are siloed and uncoordinated. Decisions on funding are sometimes made without regard to how they interact with funding by other levels of government or other funding streams. Governments sometimes respond to emerging issues by creating a new funding stream, rather than adjusting the priorities and arrangements of the whole system.

The relationship between governments and providers too has changed. Since the 1980s, governments have moved away from general funding to support organisations to more competitive funding models, including 'purchase of service contracting', which involves 'government agencies contracting with a provider to deliver a service to an eligible group of clients in exchange for money' (PC 2010, p. 323). These changes recognise that governments, rather than individual service providers, are ultimately responsible for the outcomes of services delivery.

Changes to funding models have, however, created some tension between the mission-driven purpose of NFP organisations that deliver most services and the government-objective driven design of spending programs (box 7.1).

Box 7.1 Tensions in service delivery

The evolution of family and community services from a charity-driven model to one funded and driven by governments has created tension within the not-for-profit (NFP) sector. This was identified in the Commission's 2010 study of *The Contribution of the Not-For-Profit Sector*. Participants in that study identified 'inherent tensions between a market based approach to the procurement and funding of human services and the characteristics and motivations of community organisations' (p. 297). These included that 'purchase of service contracting' was:

- creating incentives for community organisations to take on the practices and behaviours of the government agencies they deal with (or so called 'isomorphism')
- distracting NFPs from their purpose thereby contributing to 'mission drift'
- creating a perception in the community that NFPs are simply a delivery arm of government
- eroding the independence of NFPs in ways that make it difficult for them to remain responsive and flexible to community needs
- being inherently biased in favour of large organisations and thereby contributing to a loss of diversity in the sector. (pp. 309–310)

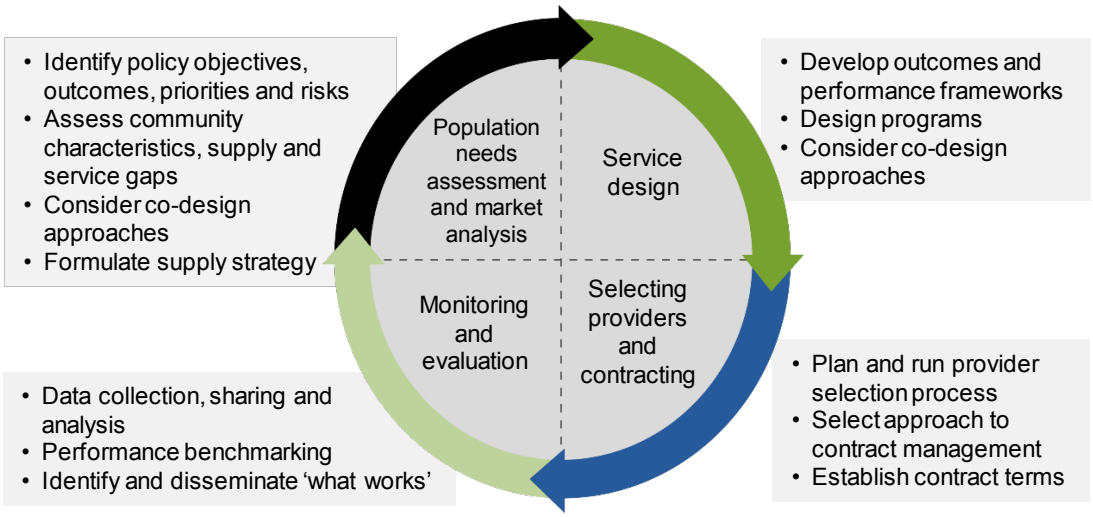
As the Commission noted in the study report, several submissions to this inquiry also identified a tension between the value of supporting not-for-profit organisations to pursue a positive (but often broad and unmeasurable) social mission, and funding models that are primarily focused on providing services to improve the wellbeing of individuals and their families (GSANZ, sub. 282; St Vincent de Paul Society National Council, sub. 285). In considering these issues, it is important to recognise that governments separately support the general value delivered by NFPs through a range of mechanisms, including the provision of tax incentives for donations and special arrangements for employee benefits.

Source: PC (2010).

Over time, the way governments manage their relationships with service providers has become increasingly sophisticated. Many governments have endorsed 'commissioning' as their preferred approach to designing, delivering and improving services, and as the process through which governments implement contestability in this sector. Commissioning is often conceptualised as a cycle that begins with planning the service system and moves through stages including designing services, selecting providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement (figure 7.1). Governments

can use contestable approaches in the provider selection stage of commissioning, although in some cases governments use closed or restricted tender processes.

Figure 7.1 **The commissioning cycle**



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

Governments have not always successfully translated the principles of commissioning into effective practice. Governments are still learning how best to set clear objectives and accountability arrangements for funding, while providing the flexibility needed for service providers to achieve good outcomes for service users. NFP service providers are still grappling with how best to reconcile the inevitable constraints that come with delivering government-funded services with the broader pursuit of an organisational 'mission'.

There has been some innovation in commissioning, including the development of social impact investment (box 7.2). The social impact investment approach has required governments and providers to carefully identify and articulate the effect funding is designed to achieve for individual service users. It has also required careful consideration of the extent to which outcomes truly reflect provider effort. Social impact investment models emphasise the importance of governments having a clear focus on, and understanding of, the service user.

The development of social impact investing is an important innovation. While there is scope for expansion, this approach will not take over from more traditional funding approaches by government. In the future, there would be great benefits in bringing into the broader commissioning system the focus that social impact investing has on the definition of outcomes. In the meantime governments can make several practical reforms to improve the commissioning of, and outcomes from, family and community services. Section 7.4 sets out draft recommendations to achieve improvements in the ways that governments commission services, and through these improvements to achieve more of the potential benefits of

contestability. The draft recommendations for family and community services are likely to have broader lessons for the commissioning of other human services, including those being considered in this inquiry such as social housing and services to remote Indigenous communities.

Box 7.2 Social impact investment

The Australian Treasury defined social impact investment as 'investments made with the intention of generating measurable social and/or environmental outcomes in addition to a financial return' (2017b, p. 8). The main forms of social impact investment include: social enterprises, social impact investment funds and social impact bonds. A social impact bond is a form of outcomes-based funding with a:

> … financing mechanism in which governments or commissioners enter into agreements with social service providers, such as social enterprises or non-profit organisations, and investors to pay for the delivery of pre-defined social outcomes. (Galitopoulou and Noya 2016, p. 4)

Use of social impact bonds for family and community services is growing in Australia. The NSW Government funds two social impact bonds for family support services (NSW Government 2017). Other bonds are being developed to reduce homelessness, over-representation of Indigenous children in out-of-home care and harmful use of alcohol and other drugs in South Australia, Victoria and Queensland (ABC News 2017; Donaldson 2017; Pallas 2016).

For example, under the NSW Government's Resilient Families social benefit bond, payment is calculated based on the number of children involved in the program that enter out-of-home care or have a risk assessment or a helpline report, relative to a control group of similar children that did not enter the program. Funding for the service is $10 million and returns to investors will be paid at the end of the five-year program in 2018.

Interim evaluation reports for the two NSW bonds have found that the Newpin bond is 'achieving a higher [family] restoration rate than other interventions' (Urbis 2016b, p. ii) and that the Resilient Families bond has had mixed success to date (ARTD Consultants 2016).

Social impact bonds are complex, and the design and implementation of bonds is costly.

> Rigorous methodological design for identifying measurable social outcomes and appropriate target groups is of utmost importance in order to avoid perverse effects, such as "creaming", "parking" or "cherry picking". (Galitopoulou and Noya 2016, p. 3)
>
> The upfront transaction costs for establishing a bond are high- not just in terms of the range of experts a not-for-profit organisation is required to contract in [order] to set up such a complex financial instrument (which in itself is considerable) — but also the level of meaningful engagement required between the parties to the transaction to fully understand all aspects of the arrangement. (Benevolent Society, sub. 457, p. 4)

Who uses family and community services?

Hundreds of thousands of people access family and community services each year. The number of programs and services makes it difficult to estimate the total number of people who use these services but public information is available for some services, including that:

- about 279 000 people received homelessness services in 2015-16, of which:

  - 106 000 were experiencing family and domestic violence
  - 72 000 had a mental health issue (AIHW 2017b, 2017e)
- about 284 000 people participated in Australian government funded Community Mental Health activities in 2014-15[1] (DSS 2016b)
- about 115 000 people received alcohol and other drug treatment in 2014-15 (AIHW 2016c)
- about 27 000 children commenced intensive family support services in 2015-16 (SCRGSP 2017).

People who use family and community services have a range of needs, and the costs of providing services vary significantly depending on their characteristics. Some people need assistance to address a temporary crisis or transition, others have complex needs and require multiple services and support over a long period. A small proportion of the service user population has very high service requirements and accounts for a large share of the total cost of some services. For example, in 2015-16, 26 per cent of specialist homelessness services clients received five days of support or less, 60 per cent of clients received between six and 180 days of support and 15 per cent of clients received over 180 days of support (AIHW 2017f).

The wide range of user needs creates some particular challenges in designing and funding services. Service effectiveness relies on the right people getting the right level of services for the right period. Most services seek to cater for the full range of client circumstances, from those with relatively straightforward needs to those with highly complex, long-term, needs. The challenge of getting the right services to the right people is reinforced by government funding models that generally rely on providers to assess needs and allocate resources between clients.

User choice

User characteristics need to be carefully considered when thinking about the potential for greater user choice in family and community services. User choice of service or of provider will not be appropriate in all circumstances (such as responding to emergencies) and for all people (such as people with severe cognitive impairment). This is already recognised in the way that services are delivered to some people who are unable to exercise choice (through, for example, outreach services) and to those who can exercise at least some choice (through walk-in services).

Although not everyone is able to, or wishes to, exercise choice over the services they receive, many can. Many service users already self-identify their need for a service and choose a provider to approach. Governments have developed phone and website-based service

[1] Some of the programs that make up these activities are transitioning to the National Disability Insurance Scheme (DSS 2016c).

directories to help these users navigate the service system, such as the Australian Government Department of Social Services' (DSS) Carer Gateway and the Queensland Government's oneplace (DSS 2016d; Queensland Government 2017).

For service users able to exercise choice, other barriers exist. One is that there is no entitlement to a level of service, let alone any entitlement to choose a provider — providers often have discretion over which clients they serve and what services they provide. Another barrier is the availability of services. As services are provided at no charge to service users (and, according to inquiry participants, because of chronic under resourcing) demand exceeds supply by a wide margin in many services. For example, in 2015-16 approximately 100 000 requests for specialist homelessness services were unable to be met (about half of the people unassisted received services later in the year) (AIHW 2017g).

Competition between service providers to 'win' service users is not a common feature of family and community services. User directed funding is also not widely used. There could be scope for increased application of user choice in some services in the future (some carer support services may be moving in this direction) but this model is unlikely to be feasible in most family and community services because users often need emergency assistance and many are making decisions at a time of great stress (CHP, sub. 434; NSW FACS, sub. 484). Instead, governments need to focus on practical reforms to improve the way they select providers on behalf of users, and to plan and commission services in a way that puts users at the centre of service provision.

Funding for services

Governments fund family and community services through several service models. For example, governments directly provide some mental health and alcohol and other drug services, commission non-government providers to deliver some services and fund some services through user-directed funding under the Medicare Benefits Scheme (AIHW 2016j; Ritter et al. 2014).

Annual funding of family and community services by the Australian, State and Territory Governments totals several billion dollars. The large number of programs and funding lines across jurisdictions and government agencies makes estimating a total very difficult. As at end of April 2017, two significant components of Australian Government expenditure — the DSS Families and Communities Programme and the Department of Health's grants for mental health programs — had active grants worth about $2.9 billion and $2.2 billion respectively (Department of Health 2017c; DSS 2017d). At the State and Territory Government level, two service areas — expenditure on family support services and homelessness (funded under the National Affordable Housing Specific Purpose Payment and the National Partnership Agreement on Homelessness) was $789 million and $764 million respectively in 2015-16 (SCRGSP 2017).

Government funding to NFP organisations whose main activities were in social services totalled $7.2 billion across over 5000 organisations in the 2015 reporting year (ACNC 2016).

(This figure includes some activities, such as disability services, which are outside the scope of family and community services.) Larger providers receive funding through many agreements with several governments. For example, 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.

7.2 Problems with the current arrangements

There is considerable scope to improve family and community services across the five attributes of effective service provision identified in chapter 1. Problems have largely come about because governments have not adequately discharged their stewardship functions in family and community services. The Commission identified many problems with the sector in its 2010 report on the *Contribution of the Not-for-Profit Sector* (box 7.3) (PC 2010). The Community Services Industry Alliance (sub. 410, p. 8) stated that problems identified in that study have persisted, including: 'extensive reporting', 'short term heavy handed contracts' and 'micro-management'.

Box 7.3 Issues raised by the not-for-profit sector in 2010 persist

In 2010, the Productivity Commission received extensive feedback from the not-for-profit (NFP) sector on how governments were commissioning services, including:

- [that] governments are not making the most of the knowledge and expertise of NFPs when formulating policies and designing programs (p. 309)
- excessively short-term contracts given the nature of the problems being addressed (p. LXI)
- tendering, contractual and reporting requirements that are disproportionate to the level of government funding and risk involved (p. 310)
- the sheer volume of contracts that community-based organisations have to manage. (p. J.6)

Source: PC (2010).

Understanding and planning for the user

Service effectiveness begins with a thorough understanding of the user. Although service providers generally understand the people they work with, governments have not devoted the effort needed to develop an understanding of user need and characteristics across the system as a whole. This lack of knowledge undermines governments' ability to plan services effectively and to prioritise between users. It contributes to duplication and uncoordinated service delivery that lead to inefficiencies and inequitable access, and are barriers to achieving the best outcomes for the largest number of people. Australia's federal system bears some responsibility — numerous agencies at all levels of government are responsible for commissioning family and community services, but there is no process for coordination between them. For example, the Brotherhood of St Laurence (sub. 479, pp. 19–20) stated:

> An incoherent patchwork of different funding priorities and commissioning arrangements creates barriers for providers, even those in the same service area, to develop closer working relationships, let alone integrate their service offers. A recent request for EOIs [expressions of interest] to deliver a new state government employment program nominated several sites, apparently unaware that the same locations were already served by another, almost identical, state-funded program.

History also plays a role — the system has emerged over decades with no guiding strategy for how it should operate. As a result, family and community services are much less sophisticated than other systems of human service delivery (such as health and education).

Selection processes

Processes for selecting service providers have a key role in delivering the benefits of contestability. Governments need to identify the provider most likely to achieve the user outcomes that they are seeking. This requires governments to have a thorough understanding of the capabilities and attributes needed by the provider. These need to be identified in the tender documentation and be at the centre of how governments select providers.

Participants have raised strong concerns that government selection processes fall short of this ideal. Many participants argued that, when selecting service providers, governments tend to focus on the cost of service delivery and the 'quality' of tender applications rather than the ability of providers to deliver outcomes for users. This creates incentives for service providers to direct their energies to a relevant but narrow issue (cost) and a more or less irrelevant issue (tender preparation), rather than focusing on achieving outcomes for service users (and demonstrating that they are able to achieve outcomes).

> Over recent years, the need for more professional tender writing has led to increased investment in submission preparation. Greater competition runs the real risk of this being taken to an even higher and more costly level. And that doesn't necessarily lead to more effective outcomes, just fancier, more detailed and more expensive tender submissions. (CEWA, sub. 403, p. 3)

> Rather than contestability leading to more choice and better tailored services it can, in the worst circumstances, lead to the reverse. The cost imperative, can have attendant consequences for the staffing of human services (instances leading to higher client-staff ratios). (MAV, sub. 443, p. 3)

Provider selection processes can always be improved, and the Commission has made draft recommendations in this chapter and elsewhere in this report that would strengthen tender processes. However, contestable selection processes remain an effective way to identify the best providers to achieve user outcomes.

Identifying what works

Government systems for collecting and harnessing information on 'what works' (and doesn't work) to achieve outcomes for service users remain underdeveloped. The lack of evidence is an impediment to planning the service system to achieve efficient resource allocation and

selecting the best service providers to deliver quality services to people experiencing hardship. Where governments have collected evidence for performance monitoring and accountability they have tended to focus on inputs and (in some cases) outputs, rather than outcomes for service users.

Inflexible contract management

One reason that governments are currently not reaping all of the potential benefits of contestable commissioning processes is that contract terms are excessively prescriptive and constrain providers from being responsive to the needs of users. The underlying causes are similar to the causes of the problems with provider selection processes: rigid approaches to accountability and risk aversion within governments. It is easier (and safer) for governments to focus on narrow, measurable indicators (such as average cost per output) in selection processes.

Attitudes to risk

Family and community services involve risks to service users, service providers and governments. As system stewards, governments manage risks in a way that minimises the risks to governments. This has the effect of passing on risks to service providers and service users, who are, in many cases, less well placed to manage them.

Sturgess (2017) noted that there is a culture of risk aversion among public servants that is driven by governments' audit focused approach to accountability. Although the Sturgess paper was based on research into government procurement practices in the United Kingdom, the problems he identified with commissioning in that country and his conclusions are relevant to Australia. Governments' risk aversion feeds into selection processes and contract management, and constrains innovation that would improve service quality and efficiency.

7.3 What would effective commissioning of family and community services look like?

The following sections set out the Commission's benchmarks for effective commissioning from the perspective of service users, service providers and governments.

Service users

People who use family and community services need a system that they can navigate and that helps them achieve sustainable improvements in their lives. The people who use the services should be at the centre of every commissioning decision — needs assessment, service system design, provider selection, contracting, monitoring and evaluation.

Governments and service providers must invest in understanding the people who use (or who could be helped by) family and community services and evaluate their own performance with reference to the effects they have on people's lives. This understanding should drive a system which maximises the positive effects services have on the long-term wellbeing of users.

People must have choice about services and providers as much as possible. When they cannot exercise choice there must be somebody who is in place to make decisions that are in the best interests of the person using the service.

Service providers

Service providers need to understand what they are being commissioned to provide and to whom, and be accountable for their performance. Service providers will be better placed to achieve positive outcomes if they have clear expectations of the intended outcomes of the services they are commissioned to deliver, adequate funding for sustainable service delivery and enough flexibility in their contracts to determine and implement the most effective approach for each person they serve. Service providers must be accountable for the way they spend government funds, including a genuine threat of replacement if another provider can do the job more effectively.

Governments

Governments are responsible for establishing the framework for the service system and the incentives that influence service provider behaviour. As system stewards with ultimate responsibility for ensuring that the system meets the needs of people experiencing hardship, governments need to:

- establish the objectives of the system as a whole and of each program they fund
- understand who needs assistance and the most effective ways to achieve outcomes for them
- select service providers and hold them to account for their performance
- manage a learning system to achieve continuous improvement
- provide some services where direct government provision is the most effective approach to service delivery and where there is a need for a 'provider of last resort'.

7.4 Reform directions

Currently the family and community services system is government-centric — the interactions between governments and providers dominate design and delivery considerations. Turning the system around to put the focus on the people who use the

services will require cultural change across all levels of government and service providers. Governments can begin the journey with some practical changes to processes and investment in information collection and use, including:

- developing a much stronger understanding of service users and using this to drive system design, delivery and improvement
- investing in systematic service planning
- adjusting provider selection processes to ensure that they give preference to providers that are able to achieve outcomes for users
- establishing and using person-centred outcomes frameworks as the basis for information collection, performance evaluation and contract management
- implementing contract management processes that focus the relationships between governments and service providers on achieving outcomes rather than on managing money.

Systematic service planning

Governments could take a more systematic approach to commissioning and service delivery by being clear about what services are being commissioned to achieve, for whom and where.

Identifying and articulating outcomes

As a first step in the commissioning process, governments must articulate what outcomes they are trying to achieve.

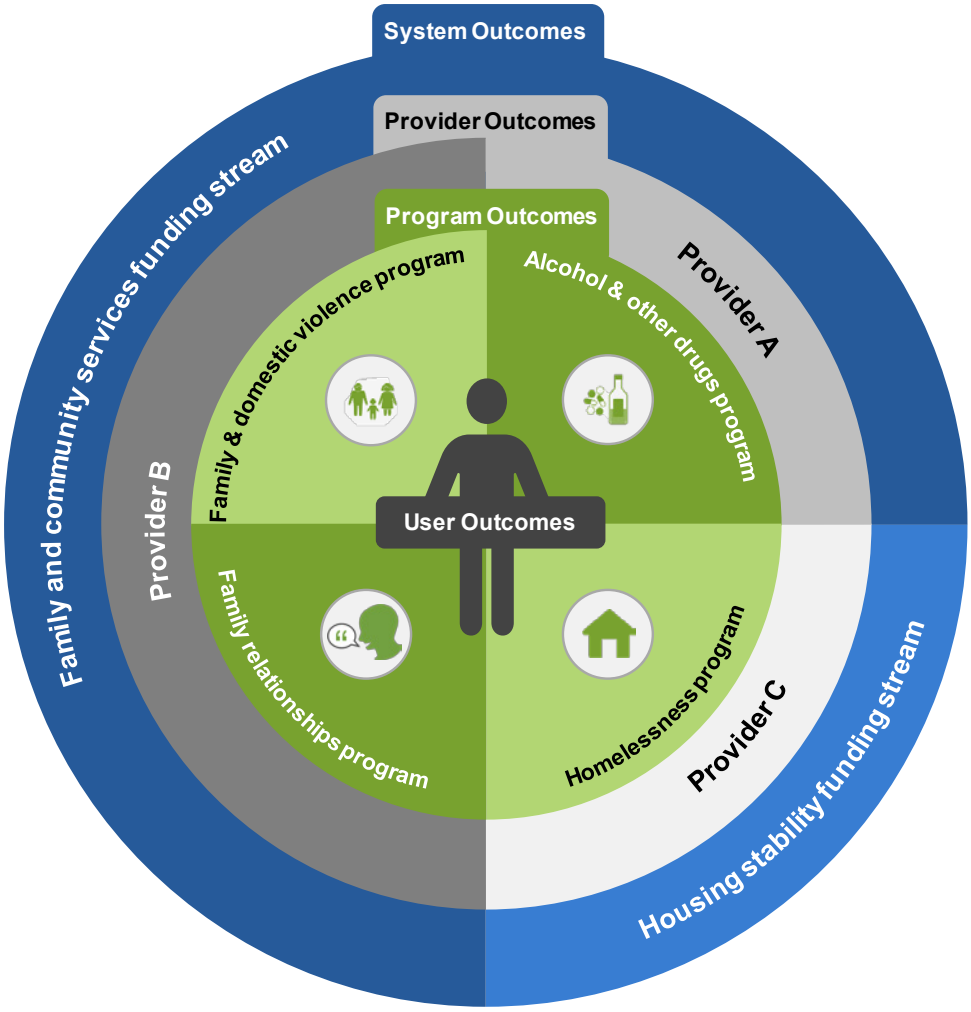
> Importantly, the first step for stewardship is agreement on outcomes sought from investment. Once outcomes are defined, systems and processes to support measurement, flexibility to respond to changing circumstances and business models and service design to support good client outcomes can be designed. (CSIA, sub. PFR395, p. 2)

Outcomes can be defined and evaluated at several levels — service user, service provider, program and system (chapter 2) (figure 7.2).

Governments often state the objectives of family and community services systems and programs, as well as specifying provider-level outcomes in contracts. However, the objectives are often very high-level or focus on service outputs — they rarely link to measurable changes in user wellbeing.

Figure 7.2 **How outcomes fit together**

A stylised example of a person who uses services across four programs that are delivered by three providers and funded through two funding streams.



The way objectives are expressed is more than a technical detail — it influences the way governments select providers and evaluate their performance, and hence the incentives that providers face. Governments could drive greater user focus by articulating outcomes at all levels that are based on achieving improvements in service users' wellbeing. Inquiry participants agreed with the importance of defining outcomes (box 7.4). Gruen (2016) noted that service providers and the people who use services should have input into developing outcomes.

> In all this, performance measures imposed from the top sound like a mistake waiting to happen. Bureaucracies have a terrible habit of role-playing their expertise, while in reality going through the motions and covering their arses. And this can occur whether service is delivered by lower levels of the hierarchy or by contractors. Yet our experience in TACSI [The Australian Centre for Social Innovation] tells us that progress occurs when we draw those we are trying to help into

the process, when we're intentional about the change we're trying to facilitate and about the process of learning.

Box 7.4 Participants agree: outcomes matter

Inquiry participants agreed that defining and measuring outcomes is an essential part of effective commissioning.

> In the absence of a coherent set of agreed outcomes towards which service providers can map their efforts, the focus will continue to be on measurement of inputs and activity, to the detriment of service users. (The Smith Family, sub. 469, p. 4)
>
> Outcomes must be clearly articulated in meaningful terms of improvements and changes for the intended beneficiaries of public policy, whether these beneficiaries are individuals, a particular group of citizens, or communities and the broader society. We need to be clear about our goals, set outcome targets and measures for tracking our performance towards those outcomes. (Family Life, sub. 57, p. 2)
>
> The Department advocates a focus on outcomes to provide a more holistic understanding of program performance and the impact specific interventions have on people's wellbeing. For example, measuring how many people complete a course on decision making (output) does not give an indication of whether people felt more in control, made better decisions, and had an improved sense of wellbeing as a result (outcome). (DSS, sub. 476, p. 12)
>
> Client outcomes should be defined early, through consultation with clients, providers and other stakeholders. (NSW FACS, sub. 484, p. 8)
>
> UnitingCare Australia strongly supports the commissioning of services against outcomes measurement (UnitingCare Australia, sub. 459, p. 7)

Identifying the service user population

Governments have limited resources to allocate among many competing demands in family and community services. They need to identify where those resources can make the biggest difference. Governments have taken steps to assess the needs of users and the potential to achieve outcomes in other policy areas, including preventive health services. To date governments have not undertaken similar work in family and community services, and as a result decisions about resource allocation are unfocused and lacking in transparency.

The DSS Australian Priority Investment Approach to Welfare is one example of how evidence about service user characteristics can be used to prioritise resource allocation decisions. This approach uses actuarial analysis to identify the characteristics of people who are likely to have a high reliance on welfare payments (DSS 2016a). This approach can support the planning and design of programs aimed at early intervention and support services that increase people's long-term capacity for self-sufficiency. More generally, a deeper analysis of the family and community services user population could inform better understanding of its characteristics and needs, and could feed into more effective targeting through commissioning. Some participants agreed that similar approaches have some promise for family and community services.

> [Under the NSW Government's Their Futures Matter reforms, an] investment approach will better target interventions to improve the outcomes of services and ensure the sustainability of

the child protection and OOHC [out-of-home care] system. This will involve undertaking actuarial analyses of the lifetime costs of children and young people in OOHC and families in the system. The investment approach ensures that effort and funding is focused on providing services which have the greatest social return as well as promoting a cost-effective system. (NSW FACS, sub. 484, p. 12)

Appropriately designed 'investment approaches' may however have the potential to improve outcomes for vulnerable service users. There is significant evidence that many identifiable cohorts amongst those experiencing homelessness are both currently underserviced compared to their needs, and at a greatly increased risk of experiencing homelessness in the future (and into the long-term). Appropriately designed 'investment approaches' developed in line with consumers' expressed needs, could improve outcomes for service users as well as deliver cost savings into the future, and are worth exploring. (CHP, sub. 434, p. 9)

A bias toward large providers?

Some inquiry participants suggested that smaller providers are disadvantaged by current commissioning practices.

The aim of government should be to maintain the diversity of expertise that exists in the sector. Unfortunately there is a tendency of large government departments to prefer working with large not-for-profits. (Yfoundations, sub. 438, p. 5)

Southern Youth and Family Services (sub. 436, p. 5) stated that competitive tendering gives rise to:

Disadvantage to small and medium NGOs [non-government organisations], who unlike larger NGOs, do not have access to tender writing teams and are more compromised by tight timeframes (i.e. length of notice and application time). It also disadvantages small to medium NGOs applying across multiple locations / programs and/or developing consortia based proposals, which need more time.

Larger providers may achieve economies of scale and scope that makes them more able to dedicate resources to provider selection processes and to invest in service improvement. However, smaller, niche providers may be more efficient at providing particular services, or servicing a part of the larger population of users. Some participants stated that processes that favour larger organisations can be an existential threat for smaller providers and can reduce the overall quality of service provision.

The Department has observed that competitive tender processes can have smaller organisations experience difficulties competing for funding, leading to mergers with larger organisations. This has reduced options for service provision. (WA CPFS, sub. PFR386, p. 4)

The Brotherhood strongly believes that a diversity of providers is necessary to deliver choice and accountability. However present trends in commissioning threaten diversity by placing undue pressure on smaller and mid-sized community sector organisations to merge in order to compete with larger providers (BSL, sub. 479, p. 10)

Some negative impacts result from the natural advantages accruing to bigger players in the market with the greater brand recognition and resources to put forward their case. This means

that the creativity and diversity generated within small 'outlier' services are lost. (GSANZ, sub. 282, p. 14)

Governments need to focus on selecting the mix of providers best suited to delivering the user outcomes they seek. In some instances this will involve selecting larger providers and in others smaller providers. The Commission's draft recommendations are designed to improve government decision making, including by providing more scope for providers to develop better proposals and to collaborate, for example, to extend their coverage or build on local connections.

Regional planning

Ensuring that service planning and delivery are coordinated is a major challenge for governments, due to Australia's system of federation, variations in local circumstances, and the size and complexity of service provision. One way to address poorly coordinated service provision would be for governments to undertake more regional service planning and commissioning.

A model that could provide lessons for better regional planning of family and community services is the process undertaken by Primary Health Networks (PHNs). PHNs were established in 2015 with the objectives of:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time. (Department of Health 2015a, p. 1)

Each of the 31 PHNs is responsible for commissioning medical and healthcare services in its region. As part of commissioning, each PHN undertakes 'strategic planning', which consists of two stages:

> … undertaking a needs assessment in order to identify and prioritise opportunities for activity, followed by the development of annual plans. The two components are closely linked, but distinct. Annual plans will be informed by factors other than the needs assessment such as cost, capacity and timing. (Department of Health 2015a, p. 3)

Currently, no bodies exist in family and community services that have analogous functions to PHNs. Several models of regional coordination have been tried in the past for particular services, with mixed results. The Communities for Children program has been cited as an effective model. This program targeted interventions for children up to five years old in 45 regions. In each region, a non-government organisation was funded as a 'Facilitating Partner' that would establish committees and 'oversee the development of community strategic plans and annual service delivery plans' (Muir et al. 2010, p. 35). Service providers were funded to undertake the activities specified in the community plans. The Benevolent Society (sub. 457, p. 8) stated that the Communities for Children program 'provides a good model for effective service coordination'.

There was some support for the idea of establishing regional coordination bodies for family and community services. The Community Council for Australia (sub. 193, p. 6) suggested that governments consider 'outsourcing government contracting of human services to non-government specialists who have the capacity to engage with potential clients and their communities'. Establishing such bodies could assist in the development of better regional planning of family and community services. An alternative would be for existing State and Territory Government departments to take responsibility for developing regional service plans, with the Australian Government using these plans to inform its own funding decisions. This approach could be lower cost than establishing new bodies, and may impose less of a burden on service providers. Collection of data on existing services (across funding streams) and publication of maps based on these data would also support better planning and could avoid inadvertent duplication of services by different levels of government.

Although the development of service plans for family and community services could lead to a more efficient and equitable allocation of resources, it would have costs. Improvements would need to be based on information and analysis of existing service availability and use (across government departments). Proposed changes to services and funding priorities should be tested with and informed by consultation with providers and users (ASU, sub. 480; Benevolent Society, sub. 457).

DRAFT RECOMMENDATION 7.1

The Australian, State and Territory Governments should work together to develop and publish:

- data-driven maps of existing family and community services
- analysis of the characteristics and needs of the service user population to assist with system and program design and targeting
- service plans to address the needs of people experiencing hardship.

Provider selection

Changes to provider selection processes could support governments to select the most effective providers — those most likely to improve outcomes for users. Governments can improve their approach to provider selection by developing and using evidence about how the attributes of service providers are related to achieving outcomes for service users. Relevant attributes could include the provider's connection to the local community, its size, whether it is a specialist service provider and governance. As noted in chapter 2, organisation type — such as whether a provider is for-profit, not-for-profit or a mutual enterprise — is not a good guide to a provider's performance. Discrimination in tender processes against particular types of organisations would not be consistent with effective service tendering.

Some service providers are specialised in particular services and/or for particular groups of people. Specialisation can have benefits when service users have specific needs

(Yfoundations, sub. 438). For example, participants in the Senate inquiry into the 2014 DSS tender rounds stated that some culturally and linguistically diverse clients choose ethno-specific providers and achieve better outcomes with them (SCARC 2015). Governments should plan to select the mix of providers that is most consistent with achieving intended outcomes, given the characteristics of the service user population.

Even without evidence on the overall relationship between the attributes of the service provider and service user outcomes, governments can make adjustments to provider selection processes that would increase the focus on outcomes. Some inquiry participants suggested that governments should place more emphasis on demonstrated performance in a service or region.

> Prior learning, research as to what works, and services that have been achieving excellent outcomes for consumers tend to be overlooked. (YFCC, sub. PFR293, p. 2)

> Factoring past performance should become more central to procurement because in many cases it would indicate there is no need to competitively tender. (SYFS, sub. 436, p. 5)

Timing of tender rounds to facilitate provider coordination

Family and community services could achieve better outcomes for people with complex needs if there were greater coordination between providers of complementary services.

> At a day-to-day, operational level cooperation fuels the planning, coordination and delivery of community services; and it will remain at least as important as competition in the design and delivery of human services into the future. In any extension of competition principles to community services, measures will need to be adopted to ensure that cooperation remains at the forefront of local service delivery systems and inter-agency relationships. (MAV, sub. 443, p. 3)

Several participants stated that their service agreements include clauses requiring that they coordinate with other providers, but do not provide any financial resources or organisational support for coordination. Service providers often work together despite the lack of systematic support. Relying on the goodwill of service providers is a haphazard way to achieve coordination. Governments could achieve better outcomes and more efficient use of resources by identifying regions and services where coordination is needed and allocating resources specifically to coordination between service providers.

More systematic approaches to the timing of provider selection processes could also create opportunities for service providers to develop joint venture arrangements, which could facilitate coordination in some services. The Commission noted in the study report that 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)

Leaving tenders open for longer could enable service providers to formalise consortium arrangements. Community Employers WA (sub. 403, p. 5) recommended 'longer timeframes for co-design, tender consultations, tender submissions and contracted arrangements'. Other participants agreed.

> Were sufficient time available during tendering, more collaboration would be evident in funding applications. (CHP, sub. 434, p. 6)
>
> The time between the announcement of a grant/tender round and the deadline for applications is often very short, making it difficult for organisations to explore possible opportunities for formal collaboration. Extending this period would allow greater opportunity for organisations to develop and agree upon a collaborative application. (FECCA, sub. 433, p. 2)

A further step would be to coordinate the timing of tenders so that contracts for related services were open simultaneously. For example, governments could agree to open all tenders for family support services in a region at the same time and hold them open for long enough to facilitate consortium bids by local providers.

DRAFT RECOMMENDATION 7.2

The Australian, State and Territory Governments should adjust provider selection processes in family and community services to reflect the importance of achieving outcomes for service users. Governments should:

- design selection criteria that focus on the ability of service providers to improve outcomes for service users
- not discriminate on the basis of organisational type (for-profit, not-for-profit and mutual for example)
- allow sufficient time for providers to prepare considered responses (including the development of integrated bids across related services).

Performance management frameworks

Governments need to develop systems for collecting information on service user outcomes, linked to their interactions with service providers.

Measuring user outcomes

Measuring service users' outcomes is the foundation of any performance management framework in a user-focused system (CSIA, sub. PFR395; UnitingCare Australia, sub. PFR313). 'Outcome measures' are data that quantify how activities contribute to user outcomes (chapter 2). An 'outcomes framework' identifies the outcome measures that are chosen for each outcome and how the data are to be collected.

The Australian and most State and Territory Governments have outcomes frameworks either in place or under development (box 7.5). This is a positive step but there is a considerable way to go before user outcomes are identified and measured across all areas of family and community services.

> Whilst a transition to an outcomes based approach is desirable and aligns with the Productivity Commission's discussion to date, there has been little work done to redesign systems, define community service outcomes and enable effective measurement. (CSIA, sub. 410. p. 1)

One example is the DSS Data Exchange Framework (DEX). The Department collects data on outcome measures that are reported by providers, through user surveys and are collected from research and government datasets. The measures are based on a five-point rating scale for outcomes relevant to the user, including:

- client circumstance outcome domains: physical health; mental health, wellbeing and self-care; personal and family safety; age-appropriate development; community participation and networks; family functioning; managing money; employment, education and training; material wellbeing; housing
- client goal outcome domains: knowledge; skills; behaviours; confidence to make own decisions; engagement with relevant support services; impact of immediate crisis (DSS 2014).

The DEX outcomes framework is based on measuring changes to user wellbeing over time. For example, consider the case of a person seeking assistance with homelessness. Suppose at the beginning of the period, the service provider reports that a user's circumstances align with score 1 for the housing domain, 'significant negative impact of poor housing on independence, participation and wellbeing', and score 2 for the behaviours goal domain. At the end of the case, the provider may report that the user's wellbeing aligns with score 3, 'progress towards housing stability', and score 4, 'moderate progress to date in achieving behaviour goals' (DSS 2014, pp. 25, 27).

Another feature of the DSS DEX is the use of a statistical linkage key, which allows data on an individual to be linked within DEX across services, providers and over time, and for DEX data to be linked with other government datasets (DSS 2014). These features could support governments, providers and researchers to assess the effectiveness of different service models and to assess the performance of service providers, programs and the system as a whole.

Although measuring outcomes is desirable, several inquiry participants pointed out that doing so is challenging (South Australian Government, sub. 460).

> While service outputs are generally easy to measure in terms of: hours, service events, and time on waiting lists; services outcomes are less tangible though not necessarily outside the scope of measurement. (Baptist Care (SA) Inc., sub. 123, p. 1)

> There is a major difficulty in recognising what constitutes a positive outcome due to the highly individualised nature of human services and how these outcomes might be quantified. (Tweed Shire Council, sub. PFR311, p. 2)

A major challenge in measuring the effectiveness of services that address complex social problems is attribution. Outcomes can take many years to achieve and factors other than service provision contribute to changes in a person's wellbeing. Attributing such outcomes to services is not feasible in many cases. This can have implications for contract management (discussed further below).

Box 7.5 Outcomes frameworks in use or development

The NSW Government has at least four outcomes frameworks in use or under development, including:

- the NSW Human Services Outcomes Framework , which will first be applied to social housing before being adopted more broadly (NSW FACS 2016d).
- the Quality Assurance Framework, which has been designed to measure and improve outcomes for children and young people in out-of-home care (NSW FACS 2017)
- an outcomes framework for homelessness services (NSW FACS 2015)
- one for family support services and other initiatives that aim to reduce demand for out-of-home care (NSW FACS 2016f).

The Queensland Government uses the Social Investment Reform Performance Framework for monitoring the performance of family and community service providers and introduced outcome measures to the framework in 2014 (Queensland DCCSDS 2016).

The Victorian Government is testing an outcomes framework under its integrated services trial, Services Connect (Victorian DHS 2015).

The Western Australian Partnership Forum is developing an 'across sector joint outcomes framework to measure the impact of earlier intervention programs, services and policies' (WA CPFS, sub. PFR386, p. 4).

In 2014 the Tasmanian Government Department of Health and Human Services introduced an 'Outcomes Purchasing Framework' to apply to all the community services it funds. The Framework is intended to define and measure the changes that services achieve for service users. The Framework 'was designed to align with the Australian Department of Social Services' new approach to program performance reporting, Data Exchange' (Tasmanian Government, sub. 485, p. 28).

In South Australia, the Department for Communities and Social Inclusion uses 'Results-Based Accountability', an outcomes-based framework for quality improvement, in its programs (SA DCSI 2017a). The Department's Thriving Communities initiatives are based on a collective impact approach, and progress towards 'outcomes that reflect the community's priorities and needs' are measured to support ongoing learning and improvement (SA DCSI 2017b).

As part of its Better Services reforms, the ACT Government stated that an 'outcomes framework will be developed as a key accountability measure to support improved outcomes and ongoing improvement' (ACT Government 2014, p. 20).

Governments can evaluate service providers' contribution to achieving long-term outcomes by including 'interim and proxy measures of progress' (DSS, sub. 476, p. 13) in outcomes frameworks. Outputs can be useful proxies for outcomes where there is evidence of a strong causal link (such as the link between providing crisis accommodation and achieving

immediate safety for people fleeing domestic violence). Governments need information on service outputs to establish these causal links and to determine 'what works'.

DRAFT RECOMMENDATION 7.3

The Australian, State and Territory Governments should prioritise the development of user-focused outcome measures for family and community services — indicators of the wellbeing of people who use those services — and apply them consistently across all family and community services.

Governments should also identify outputs from family and community services that can be used as proxies for outcomes or measures of progress toward achieving outcomes.

In developing outcome measures and outputs, governments should define the indicators broadly so they can be used in provider selection, performance management and provider, program and system-level evaluations across the full range of family and community services.

Performance monitoring, evaluation and a learning system

Governments have not allocated adequate resources to monitoring and evaluating the performance of service providers, programs or systems. Nor have they established systems to identify and disseminate lessons about effective practices. Inquiry participants stated that evaluations of provider performance are generally based on the service activities, outputs and processes that service providers must perform to be paid. The contribution that service providers make to achieving outcomes is generally not part of the performance frameworks (Benevolent Society, sub. 457).

> … reporting systems usually favour simple counts of 'client throughput' and 'occasions of service' that are easily quantifiable and comparable. (St Vincent de Paul Society National Council, sub. 285, p. 23)

The Australian Centre for Social Innovation (sub. 155, p. 3) noted that it is common for existing systems (such as for child protection and employment services) to measure 'performance against delivery of output based contracts where there is little or no evidence, or underlying logic, of those outputs leading to long term outcomes'.

Program evaluations are currently not done frequently (or at all for smaller programs) and those that are completed often have inconclusive or qualified findings. A lack of system-level evaluation is a barrier to understanding how service systems work for users who participate in multiple programs, and to effective system planning. Inquiry participants recognised the importance of increasing the frequency and quality of evaluations. Jesuit Social Services (sub. 420, p. 4) called on government to 'evaluate and disseminate practice learnings amongst stakeholders in order to enable innovation and better outcomes'.

> … knowing what has been tried and what works is critical to improving service delivery. (CCA, sub. 193, p. 7)

> Embedding evidence-based practice is a vital component of building an effective and sustainable industry. Evidence-based practice must be underpinned by investment in research, sharing of learnings, and a culture of continued evaluation and assessment. (Deloitte Access Economics 2016, p. 31)

Monitoring and comparing provider performance based on outcomes can align the objectives of governments and providers. Information on performance can be used to determine whether to extend existing contracts, which providers to select to deliver services and the market share awarded to each provider. Data on outcomes could also support providers to continuously improve service delivery.

> A well designed transition to outcomes will provide more accountability for investment, demonstrate value for money, stimulate creativity, and create new client based and performance data to guide investor, provider and client decision making. (CSIA, sub. PFR395, p. 2)

Evaluating providers, programs and systems has costs as well as benefits, and the scope of an evaluation should be commensurate with the size and complexity of the program. However, the current level of evaluation is inadequate and governments should take steps to increase the number of programs that are evaluated and the quality of the evaluations.

As well as doing evaluations, governments need to make sure that they are released publicly and use them as inputs to every stage of commissioning. An effective system of family and community services would incorporate a learning system — findings from evaluations should inform changes to system planning and program design. Governments would also identify and disseminate the lessons from evaluations to increase the application of effective approaches to service delivery. The Commission recommended wider sharing of information in its 2010 report on the *Contribution of the Not-for-Profit Sector* (PC 2010, p. 237).

> Information and communication technology has the potential to enable more cost-effective and higher quality human services. With due considerations to protocols for protecting privacy, in specific service areas, Australian governments should explore the potential for selective sharing of client information between agencies and not-for-profit organisations and other providers, through the utilisation of enhanced information and communication technology.

Increasing the sharing of information could run up against some cultural challenges. In its inquiry report *Data Availability and Use* the Commission identified some cultural barriers within government that limit the usefulness of data.

> Despite recent statements in favour of greater openness, many areas of Australia's public sector continue to exhibit a reluctance to share or release data.
>
> The entrenched culture of risk aversion, reinforced by a range of policy requirements and approval processes, and often perverse incentives, greatly inhibits data discovery, analysis and use.
>
> The lack of public release and data sharing between government entities has contributed to fragmentation and duplication of data collection activities. This not only wastes public and private sector resources but also places a larger than necessary reporting burden on individuals and organisations. (PC 2017, p. 153)

Addressing these issues and implementing a more proactive approach to sharing or releasing more data on the outcomes of family and community services could contribute to significant ongoing improvement to the effectiveness of service provision.

DRAFT RECOMMENDATION 7.4

The Australian, State and Territory Governments should improve systems for identifying the characteristics of service delivery models, service providers, programs and systems that are associated with achieving outcomes for the people who use family and community services. To achieve this, governments should:

- monitor the performance of providers of family and community services in achieving outcomes for service users
- evaluate service providers, programs and systems in ways that are commensurate with their size and complexity
- proactively support the sharing of data between governments and departments, consistent with the Commission's inquiry report *Data Availability and Use*
- release de-identified data on family and community services to service providers and researchers
- develop processes to disseminate the lessons of evaluations to governments and service providers.

The benefits and costs of greater consistency

As noted above, the Australian Government and most State and Territory Governments have developed or are developing outcomes frameworks for family and community services (governments have multiple frameworks in development in some cases). In addition, some of the larger service providers have developed their own outcomes frameworks for internal purposes (UnitingCare Australia, sub. 459). These systems have been developed independently and for specific purposes and the way information is collected for each framework reflects their diverse purposes.

Some inquiry participants raised the idea of developing nationally-consistent approaches to outcomes frameworks. The Centre for Social Impact (sub. 448, pp. 5–6) stated that one way for governments to 'enable high quality outcomes, to protect and support vulnerable people and to minimise risk' is to support 'the development of shared outcomes measurement systems (including linked data) to help track whether and where outcomes are being achieved, for who and under what circumstances'.

The National Aboriginal Community Controlled Health Organisation (2017, p. 1) stated that inconsistent approaches to data collection can have costs for service providers.

> In every jurisdiction we see inconsistent data collection. In 2017, with such innovative information technology available, all governments should implement open, transparent, consistent data collection and reporting to ensure their accountability to the Australian people at large.

The Commission considered the issue of consistency in data collection in its inquiry into *Data Availability and Use* (PC 2017). It stated:

> The absence of, or inconsistencies in, data standards and management can significantly limit users' ability to compare, aggregate and link data. (PC 2017, p. 163)

However, the Commission also noted that the costs of implementing consistent data and metadata standards sometimes outweigh the benefits. Time spent aligning data to standards can delay data access, and mandating a specific data standard may be counterproductive if the sector is not consulted on design or if a 'one-size-fits-all' approach is not appropriate.

These issues apply in family and community services. Moving to a more consistent approach to defining and measuring user outcomes would have benefits and costs. Consistent outcomes frameworks could reduce the administrative costs of data collection for providers with several contracts. However, for some providers existing frameworks might be better tailored to their services. A highly-detailed national system might add to the administrative burden for some providers.

> It is vital that any enforced reporting requirements do not add another layer of time and labour-intensive activity for service providers, who may need to allocate significant human and financial resources. This may impact the actual task of providing adequate services. (JSS, sub. 420 p. 9)

Consistent outcomes frameworks for use across multiple programs could facilitate system-level evaluation and a comparison of provider performance across programs. However, developing such a framework would require significant co-operation and investment by governments. There could also be considerable costs for governments and service providers in developing information technology systems.

Many of the benefits of consistent outcomes frameworks are related to improved quality of life for service users, and cannot be quantified. The administrative costs are also difficult to quantify, and beyond the capacity of this inquiry — even cataloguing the number of programs and data standards and their technical differences would be a substantial undertaking. As a result, the Commission has not been able to estimate the balance of benefits and costs.

Given the number of outcomes frameworks currently in use and under development, consistency is unlikely to be achieved soon. Although nationally consistent approaches might be desirable in principle, the first and much more important task is for governments to implement outcomes frameworks. There is, however, a risk that inconsistent frameworks will add unnecessarily to provider costs and undermine the ability of governments to coordinate in the longer term. To avoid this, there is merit in the Australian Government and State and Territory Governments working together to maximise the complementarity of outcomes frameworks, with an eye to achieving consistency where this is possible.

Contract management practices

Governments could achieve better outcomes by following smarter approaches to contracting, including some simple changes to contract terms.

Longer and more certain contract terms

Many inquiry participants stated that contract lengths (which typically default to three years or less) are too short to provide certainty to service providers and users (box 7.6). They identified several disadvantages of short contract terms, including barriers to planning, collaboration with other providers, innovation, investment in staff and staff retention. As a result of short contracts, service providers spend too much time seeking short-term funding, which is a costly distraction from delivering and improving services. Short-term contracts can also result in governments slipping into contract management mode rather than adding value to the efforts of providers.

Box 7.6 Service providers' views on short contract terms

[O]rganisations delivering human services need longer-term secure funding, as the current short-term funding model has deleterious effect on service providers capacity to plan for and provide community services (St Vincent de Paul Society National Council, sub. 285, p. 25)

The practice of short-term contracts means that providers operate in a climate of constant uncertainty. Precarious funding militates against collaboration by making providers disinclined to invest scarce time and resources in the effort required to build networks and learn new ways of working. (BSL, sub. 479, p. 19)

Presently, organisations have little incentive to invest in training and skill development or create career opportunities for their staff as they have little certainty about future funding. This model hampers innovation, and the trial of new strategies and approaches.(ASU, sub. 480, p. 3)

Our main concern here is around funding levels limited contract terms and their inflexibility. Ultimately, these factors create uncertainty for not-for-profit providers, stifle innovation within the sector, and hinder service provision and outcomes. (JSS, sub. PFR336, p. 13)

Currently, inadequate and unstable funding means many services are unable to cover the true costs of their operation and this flows on to impact other vital elements of service delivery such as attracting and retaining experienced and appropriate workers. (YACSA, sub. 408, p. 2)

The Commission considered the issue of contract lengths in *Contribution of the Not-for-Profit Sector*.

> Excessively short-term funding can create uncertainty for providers and undermine their ability to plan and efficiently allocate resources. It can also create an administrative burden for those organisations that are reliant on multiple short-term funding agreements. These problems are particularly acute for Indigenous NFPs. As participants highlighted, at times even government agencies seem to struggle to keep up with the current cycle of short-term contract reviews and renewals. (PC 2010, p. 335)

The Commission made a recommendation about contract lengths.

The length of service agreements and contracts should reflect the length of the period required to achieve agreed outcomes rather than having arbitrary or standard contract periods.

Extended life service agreements or contracts should set out clearly established:

- processes for periodically reviewing progress towards achieving a program's objectives
- conditions under which a service may be opened up to new service providers or a provider's involvement is scaled back or terminated. (PC 2010, p. 347)

While, in theory, contract lengths should reflect the individual circumstances of each service, this may not be practical for governments operating many thousands of contracts across a wide range of services. In such circumstances, a 'default' contract term can be desirable. Setting a default term requires a balance between the advantages of longer contracts and the advantages of regular contestability.

Some stakeholders made suggestions about contract length. The Senate Community Affairs References Committee undertook an inquiry into the tender process used by the Australian Government DSS in 2014. It considered the issue of contract length and recommended five-year terms, where possible, 'to ensure stability so the sector can plan and deliver sustainable services' (Australian Government 2015a, p. 6). The Australian Government (2015a) stated, that it remained committed to this approach, where appropriate.

The Australian Institute of Company Directors (2017, p. 33) called for government to establish five-year cycles for service agreements with the not-for-profit sector 'on an "if not, why not" basis' and 'with 12 months' notice of termination'. Southern Youth and Family Services (sub. 234) also supported five-year contracts. The Australian Services Union (sub. 480) and Community Employers WA (sub. 403) supported terms of at least five years.

Moving to a five-year default terms would be an improvement, but is not long enough in the Commission's view. Five years may not allow enough time for new providers to establish themselves and build the relationships and connections needed to deliver effective services, or for a considered handover between providers at the end of a contract. A five-year term also provides too little time for providers to innovate and demonstrate the benefits (or not) of new approaches to service delivery.

The Commission considers that a default contract term of seven years for family and community services is likely to support high-quality service provision. A seven year default contract term would give providers a better opportunity to improve user outcomes while still retaining the benefits of periodic contestability. This would better recognise the time needed for setup (making the investments that are necessary to deliver effective services, including workforce capacity, and building relationships in the community) and the time needed for a smooth transition to a new provider at the end of the contract. In between, service providers should have a period of stability.

Seven year contract terms would also result in governments undertaking fewer grant rounds each year, freeing resources to be used in more productive activities, such as better service planning and the identification and dissemination of best practice. This would encourage a

greater focus from government on user outcomes and be a better use of public resources than the current tendency to micro-manage contracts.

Moving to a default term of seven years will require the introduction of safeguards to manage underperformance, including provisions to allow governments to remove providers in any cases of serious failure. Development of stronger outcome reporting at the user level will assist, by providing government (and the public) with a better understanding of how services are affecting users.

A default term of seven years may not be appropriate for every circumstance, and governments should retain the ability to set alternate terms; for example, when experimenting with a new service. It should be incumbent on government, however, to publicly justify departure from the default.

Problems with short contracts are being compounded by the chaotic conduct of some government funding processes. In consultations, inquiry participants have provided examples of cases where governments have given providers very short periods in which to submit proposals for funding only to have governments take much longer than planned to make funding decisions. This can result in governments rolling-over contracts for short periods, creating instability for providers and undermining service effectiveness. Although contestable processes do create some level of uncertainty, this type of instability is not necessary. A particular problem is the effect that funding uncertainty has on providers and their ability attract and retain staff, which in turn can negatively affect service users.

In consultations, inquiry participants stated that renewal of contracts is often uncertain until very close to contract end dates. Governments could provide more certainty by announcing forward schedules of commissioning processes and tenders, and committing to a clear timetable for decision making. Governments could further enhance accountability by publishing its performance in meeting the timeframes outlined in tenders, including for the delivery of final decisions.

DRAFT RECOMMENDATION 7.5

The Australian, State and Territory Governments should set the length of family and community services contracts to allow adequate time for service providers to establish their operations, have a period of stability in service delivery and for handover before the conclusion of the contract (when a new provider is selected).

To achieve this the Australian, State and Territory Governments should:

- increase default contract lengths for family and community services to seven years
- allow exceptions to be made, such as for program trials which could have shorter contract lengths
- provide justification for any contracts that differ from the standard term
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of serious failure.

Smarter contracts

Longer contacts would give service providers more certainty and stability to build relationships and invest in service provision. Smarter approaches to contract management would provide incentives for service providers to focus on achieving outcomes for service users. Three areas for improvement are:

- aligning payments levels with the efficient cost of provision
- outcomes-based commissioning
- adopting more 'relational' approaches to contract management.

Aligning payment with the efficient cost of provision

Current approaches to setting the level of payments for service providers are blunt and are rarely based on an assessment of the efficient cost of provision (chapter 1). Rather, payment levels appear to be either arbitrary 'carve ups' of an available funding stream, or a continuation of historic levels of funding. However, the costs of achieving outcomes varies across different service needs, user populations, and according to location and the scale of provision. Participants identified service areas where this is currently an issue.

> Current funding models for SHS [specialist homelessness services] are based on metropolitan assumptions, and fail to account for the significant time and travel costs associated with providing support services to regional and rural areas. (CHP, sub. 434 p. 6)

When payment is not based on the costs of achieving outcomes and service providers have discretion over who they serve, they have incentives to 'cherry pick' clients who are relatively low cost. The people who need the most help might face difficulties in identifying a service provider who will best assist them.

Funding and reporting arrangements can also constrain a provider's ability to invest and undertake other activities associated with service improvement.

> The delivery of quality outcomes for service users is dependent on providers being able to invest in quality management mechanisms. Pricing for disability services have failed to incorporate activities such as performance monitoring, quality assurance, continuous improvement and workforce training, development and planning. (CSIA, sub. 410, p. 8)

A smarter approach to contracting would align payment with the full costs of achieving outcomes for people and account for factors that cause costs to vary. It would include funding for investment in workforce capacity and equipment, coordination with other service providers and the costs of meeting regulatory requirements (such as data collection). This would improve equity of access and the capacity of providers to improve their services over time. However, the analysis required to estimate the costs of provision is likely to be complicated and costly. Governments should initially focus on making use of the data they already collect and identifying the information required to improve their estimates and contract design over time.

DRAFT RECOMMENDATION 7.6

The Australian, State and Territory Governments should provide payments to providers for family and community services that reflect the efficient cost of service provision.

Outcomes-based commissioning

Outcomes-based commissioning is a general term that encompasses several approaches to focusing on outcomes in commissioning and service delivery (box 7.7). The Brotherhood of St Laurence (sub. 479, p. 37) described how identifying outcomes and having them well understood by all involved in commissioning and delivering services has benefits in itself.

> As the commissioning process unfolded, as the stakes increased, as relationships were tested and nerves frayed, it was this shared belief in the goal of the endeavour that provided the incentive for all parties to develop workable compromises and 'work-arounds' to keep the project afloat.

Box 7.7 Outcomes-based commissioning

Outcomes-based commissioning encompasses a variety of approaches to commissioning, including:

- **outcomes-based funding** — the government collects data on outcomes and links a provider's funding with their performance against outcomes targets (also referred to as outcomes-based contracting)
- **outcomes-based provider performance management** — the government collects data on outcomes that it uses to monitor and compare provider performance
- **outcomes-based service evaluation** — the government collects data on outcomes that it uses to evaluate the effectiveness of programs and the service system
- **outcomes-based program design** — the government designs program guidelines, service agreements and provider selection processes to maximise intended outcomes by carefully specifying outcomes and minimising the specification of activities, outputs and processes, where appropriate
- **outcomes-based service delivery** — providers use data on outcomes to support case-management and to provide a tailored service response to their clients.

The benefits, costs and risks of having an outcomes focus to commissioning family and community services depend on which of these elements are applied.

Outcomes-based funding, which involves some or all funding being linked to the achievement of outcomes, is seen as the gold standard of outcomes-based commissioning. Social impact bonds are a subset of outcomes-based funding that incorporates third party funding, which have been implemented in several areas of family and community services in Australia, although, as noted earlier in this chapter, they are likely to have limited application overall (box 7.2).

Designing outcomes-based funding arrangements is costly and poses significant challenges for services as complex as many family and community services. One challenge is that linking payment to a small number of outcome measures can create incentives for providers to take a narrow focus (Tomkinson 2016). Another challenge relates to attribution of outcomes to services (discussed above). Outcomes-based funding can create incentives for service providers to 'park' or 'cherry-pick' people if outcomes can be more easily achieved for some service users. For example, the Council to Homeless Persons (sub. 434, p. 8) stated:

> Critically, those with multiple and complex needs are less likely to sustain a tenancy, and therefore less likely to achieve a positive outcome in a competitive model that rewarded successful sustainment of tenancies. Competitive contracts based on outcomes would create a situation whereby organisations would be more likely to be awarded future contracts or renewals by turning away those most in need.

In some cases governments have addressed these challenges through sophisticated contract design. Some social impact bonds control for differences in the characteristics of the people who use services by defining improved performance as the change in outcomes for people who participated in the program relative to the change in outcomes of a comparable group of people that did not participate (for example, the NSW Resilient Families bond, the Essex Children Support Services bond and the Peterborough Prison bond use this approach). However, the costs of establishing and monitoring such contracts is extremely high.

The potential application of outcomes-based funding is currently limited. For many family and community services, the data and expertise needed for outcomes-based funding to work well are currently not available. There could be scope to expand outcomes-based funding beyond current levels in cases where services can achieve measurable and tightly defined outcomes in a reasonable time frame, but it is likely to remain a relatively minor part of the overall service system. In 2017, the Australian Treasury began a consultation process on developing the social impact investing market that will provide further insight into the potential for the approach.

Relational approaches to contract management

Governments often use simplistic approaches to contract management. Sturgess (2017, p. 11) put it succinctly:

> … the procurement and contract management tools that are appropriate for buying 'paperclips' – highly commoditised, easily specified goods and services – are not appropriate for commissioning complex support services and front-line human services.

Anglicare Australia (sub. PFR391, p. 15) made a similar point.

> Services that meet complex needs are difficult to unpack as a series of 'transactions'.

An alternative approach is to adopt more 'relational' approaches to contract management, where the parties to the contract seek to maximise the effect of their joint efforts on improving user outcomes over time. Levasseur and Phillips (2004, p. 222) encapsulated the

elements of relational contracting that are most relevant to commissioning family and community services.

> Relational contracting rests on a basis of trust and a commitment to common goals. Although it can maintain a legal core, it emphasizes a long-term relationship rather than a one-off exchange and a specification process. This approach assumes that each party is motivated to maintain its credibility and reputation with the other, and it thus depends more on open communication and processes than on rules and more on maintaining flexibility than on pre-specifying detailed requirements.

The Commission recognised the potential benefits of this approach in *Contribution of the Not-for-Profit Sector*. (In that report the Commission described this approach as 'joint ventures' between governments and service providers.)

> Under the joint venture approach relatively more weight is given to achieving outcomes through relational rather than contractual governance. To be successful, these types of arrangements need a high degree of flexibility and trust based on each party having a good understanding of the other, an alignment of purpose in relation to the service being provided, and effective communication. (PC 2010, p. 326)

The relational contacting methodology is often used for civil construction and has been applied in human services. For example, the principles of relational contracting are consistent with principles adopted by the Western Australian Partnership Forum, which include:

- A collaborative approach to decision making and working together recognising the interdependence in the delivery of community services;
- A partnership based on mutual respect and trust, with openness and transparency in all activities. (CEWA, sub. PFR368, p. 4)

A similar approach has been used in New Zealand and was found to be consistent with effective service provision (box 7.8).

Taking a relational approach to contract management would pose some risks. For one, relational contract management could lead to a reduction in contestability if government developed close relationships with providers. The relational approach could also lead to (or be seen to lead to) a reduction in accountability, compared with more transactional approaches.

These risks are real, but they could be managed. The risks to contestability could be managed through 'triggers' for contracts to be put up for tender. For example, requiring all contracts to be re-tendered every seven years, as the Commission recommended above, would encourage contestability while providing incentives to build more relational approaches.

A key impediment to accountability relates to the lack of quantitative information available to assess providers' performance. In their absence, governments (and auditors) tend to focus on the hard data they do have, which is often related to money. Governments could build

accountability mechanisms into relational governance by implementing performance management frameworks to collect information on service user outcomes.

Box 7.8 Relational governance for health services in Canterbury

The District Health Board (DHB) for the Canterbury region of New Zealand has introduced reforms since the mid-2000s to improve the effectiveness of its health services, including the introduction of alliance contracting. For contracts with district nurses, allied health and laboratory services, the DHB abandoned fee for service funding arrangements that had penalties for under-performance in favour of collective contracts with 'pre-agreed gains and losses dependent on the overall performance of all the parties, rather than with penalties solely for whoever fails within it.' (Timmins and Ham 2013, p. 19).

Under the alliance approach, funding to the parties in each alliance is pooled and there is a reliance on informal processes over bureaucracy and litigation. Open book accounting allows for benchmarking, which creates the incentive for the providers to compete on quality but the collective responsibility for the contract fosters co-operation and the incentive to direct resources to areas of under-performance. There is greater certainty about funding and trust amongst the parties means that 'problems are aired rather than hidden from competitors and the funder.' (Timmins and Ham 2013, p. 20). Any 'profits' are invested in service improvement according to the preferences of the alliance members.

The alliance approach has involved the DHB surrendering some of its authority. However, New Zealand's Auditor General (2013, p. 19) found that service providers were working 'in an open and transparent manner with Canterbury DHB to actively address questions of service efficiency and consistent quality of service delivery'. Regarding high-trust contracting, the Auditor General's report (NZ OAG 2013, p. 19) highlighted the importance of 'transparency of decision-making processes', 'equity of treatment' and 'demonstrable value for money'.

Governments also need to recognise the risks of not changing the way they manage contracts. The current approach to contract management — rigid practice guides that define how providers must interact with service users — reduces the prospect of a service provider doing something that is not consistent with the practice guide. However, it creates a different type of risk: that the provider will follow a course of action that is not effective in achieving outcomes for a particular service user.

The risks of inertia leading to sub-optimal approaches to service delivery are not likely to end up on the front pages of a newspaper. The consequences are invisible — nobody knows how many people could be leading better lives today if services had been more flexible and more effective in the past — but they can be significant.

The balance that governments draw in risk management comes down to their attitudes to risk. What looks like excessive risk aversion to an outsider might seem reasonable to a government agency. The Commission's view is that the current approaches to risk management have led to excessive prescriptiveness around the behaviour of individual service providers, and that the prescriptiveness has increased the risks that the system as a whole will not achieve the intended outcomes. Governments should explore approaches to reduce the risk of inaction, including relational approaches to contract management.

For relational approaches to contract management to work, governments and service providers need to establish relationships based on trust. Performance management frameworks are an essential input into building trust. Governments and service providers would also need to invest in developing new capabilities to manage contracts (CEWA, sub. 403). Managing an ongoing relationship to achieve mutual benefits requires a different set of skills to managing prescriptive transactional contracts.

DRAFT RECOMMENDATION 7.7

The Australian, State and Territory Governments should:

- train staff to increase their capacity to implement outcomes-based approaches to commissioning and relational approaches to contract management
- trial relational approaches to contract management in family and community services.

8 Human services in remote Indigenous communities

Key points

- Indigenous Australians living in remote communities have significantly worse quality of life than other Australians. There are often limited economic opportunities and, in some remote Indigenous communities, the delivery of government services can be the main economic activity.
- Improving the effectiveness of human services in remote Indigenous communities could contribute to the wellbeing of Indigenous Australians living in these areas and should be a priority for governments.
- Service delivery in remote Indigenous communities faces challenges including isolation, time-consuming travel, and difficulty recruiting and retaining staff.
- Service providers that are responsive to community priorities tend to be preferred by service users and deliver more effective services. Expanding community voice in program design and decision making could increase service effectiveness.
- 'Place-based' approaches — service delivery models based on achieving outcomes for a place — are more likely to contribute to achieving community priorities than programs that align with jurisdictional, departmental or program boundaries. Many reforms have attempted to put these principles into practice and provide lessons for what has and has not worked.
  - Place-based models can be resource intensive to establish and require high levels of community support and major changes in government arrangements.
  - Place-based approaches should be expanded but are not practical everywhere.
- Different models have been proposed for moving to community voice and place-based approaches. No single model has universal support. The Commission has been considering an approach based on community-led plans that articulate community priorities and aspirations. Community plans could be used to hold governments and service providers to account for their contribution to outcomes for remote Indigenous communities.
- Significant improvements in service effectiveness can be achieved by reforming processes for selecting and managing service providers including establishing longer default contract terms (of ten years), improving the timing and alignment of tender processes, supporting the capacity of people and organisations in remote Indigenous communities, and improving provider selection.
- Planning, evaluation and feedback systems underpin effective service delivery. Outcomes could be improved by developing objectives for human services in remote Indigenous communities to inform service design and delivery and establishing systems to identify and share information on 'what works'.

This chapter sets out draft recommendations to improve arrangements for planning, evaluation, contracting and feedback systems for services in remote Indigenous communities, summarised in table 8.1. The Commission has also been considering a longer-term transition to a place-based approach to service planning, delivery and evaluation with community involvement in program design and decision making. One way to do this would be to use community plans to articulate community aspirations and incorporate community views in service planning and delivery. The Commission has not developed specific recommendations in this area, but may do so in its final report.

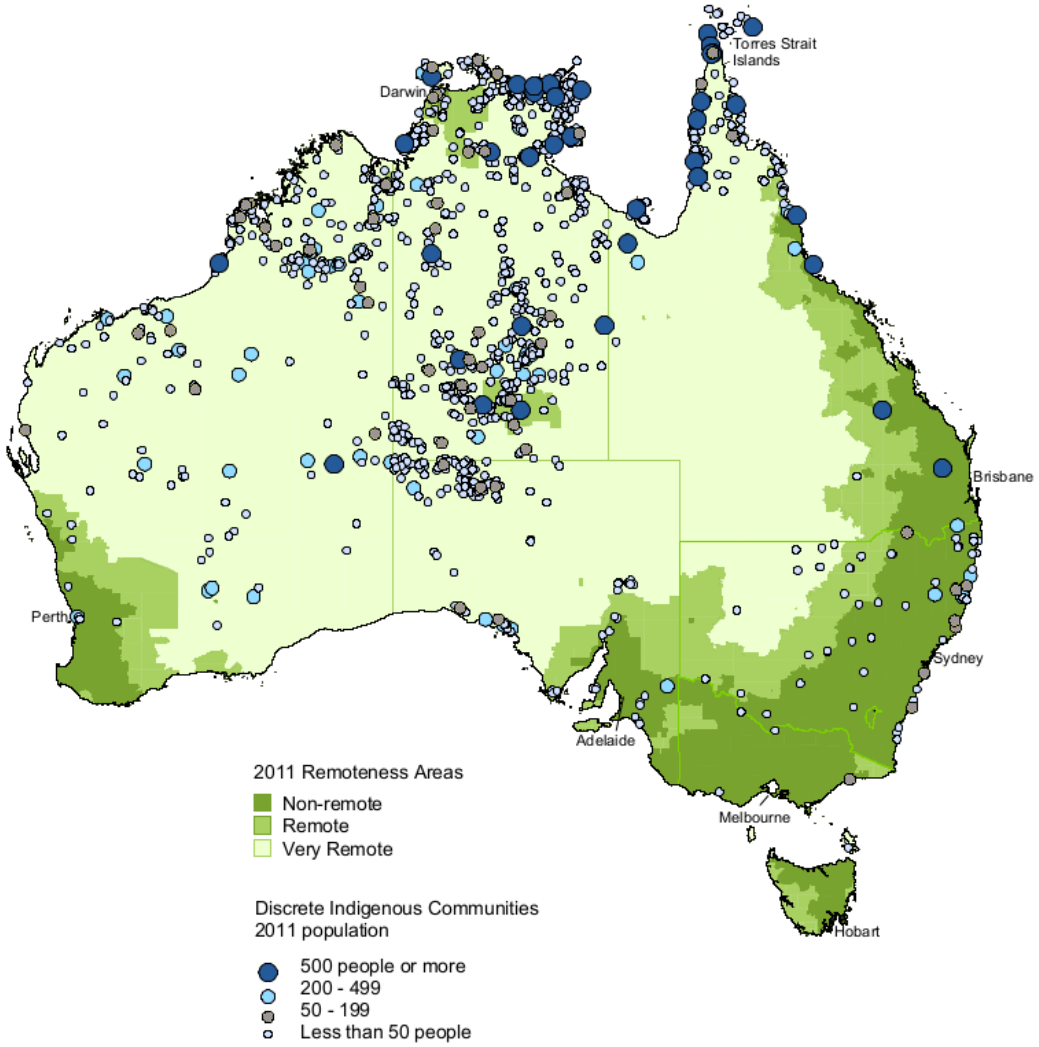
Table 8.1 **Overview of proposed reforms to services in remote Indigenous communities**

All reforms are directed at the Australian, State and Northern Territory Governments

Proposed reforms	*Timeframe*	*Potential costs and benefits*
Improved contestability arrangements		
Draft recommendation 8.1 Increase default contract lengths to ten years.	Short term, as contracts lapse.	Facilitate greater investment by providers in service quality, increased time to invest in relationships and build trust. Could increase consequences of selecting the wrong providers; less flexibility for government to change funding priorities.
Draft recommendation 8.2 Better align tender processes for related services, allow sufficient time for providers to prepare considered responses, notify providers of the outcome of tender processes in a timely manner and allow enough time for transition when new providers are selected.	Aligning contract terms should be rolled out gradually, commencing with a small number of communities. The other reforms should be implemented in the short term, as contracts lapse.	Create opportunities for communities and governments to identify a mix of providers that can coordinate delivery of related services. Potential risk of service gaps if contracts are not filled.
Draft recommendation 8.3 Ensure commissioning processes have a strong focus on transferring skills and capacity to people and organisations in communities.	Short term, as contracts lapse.	Community development; reduced travel costs. Potentially higher cost of service provision in the short term.
Draft recommendation 8.4 When selecting providers, take into account the attributes of providers that contribute to achieving the outcomes sought (including, for example, culturally appropriate service provision).	Short term, as contracts lapse.	Improved quality, responsiveness and efficiency of services. Small increase in administrative costs for governments. May lead to selection of higher cost providers, potentially offset by increased effectiveness.
Planning, evaluation and feedback systems		
Draft recommendation 8.5 Invest in better systems to underpin service delivery by developing objectives, conducting community assessments and establishing evaluation and feedback systems.	Short term for objective development and evaluation and feedback systems. Community assessments should be rolled out gradually, commencing with a small number of communities.	Improved efficiency and quality of services (better targeted to community need). Governments and service providers would face costs of data and information gathering, analysis and sharing.

About one in five Indigenous Australians live in a remote area (ABS 2013a). In 2011, there were over 1000 discrete Indigenous communities in remote areas (figure 8.1), of which more than three quarters had a population of less than 50 people (ABS unpublished data). Remote Indigenous communities are diverse, with different characteristics, capacity, resources, representative arrangements and culture. Communities are also not static — their circumstances and characteristics change over time.

Figure 8.1 **Discrete Indigenous communities by size and remoteness, 2011**



Source: ABS (Census of Population and Housing, unpublished).

Indigenous Australians as a group are amongst those most likely to experience deep and persistent disadvantage (McLachlan, Gilfillan and Gordon 2013). Where data are available, they suggest that Indigenous people living in remote communities have worse life outcomes than other Indigenous people. Since 2003, the Commission has published the *Overcoming*

Indigenous Disadvantage report of indicators of Indigenous people's wellbeing. Over that time, there has been evidence of improvement in some areas, but outcomes have stagnated or declined in others (SCRGSP 2016a).

The causes and consequences of disadvantage are complex and interrelated. Remoteness and scale play a role — they are often correlated with limited economic development, few opportunities for employment and diminished potential for positive life outcomes, relative to metropolitan and regional centres. Remoteness increases the costs of delivering human services. It can be an impediment to effective service delivery and in some cases prevents services from being delivered at all. Communities with small populations may not be able to support full-time services. There can be a lack of fit-for-purpose infrastructure in communities (such as buildings suitable for service delivery). Some communities are isolated for weeks or months each year and cut off from service delivery. Even when they are accessible by road, travel can be difficult, time-consuming and for some people, such as those who are frail or elderly, not possible. Access to e-services can also be difficult due to a lack of IT infrastructure and, in some cases, a lack of the skills required to utilise those services.

Recruiting and retaining staff with skills in service delivery and the necessary cultural competencies is a significant challenge to the delivery of human services in remote Indigenous communities (Tasmanian Government, sub. 485). Few small communities have local people with the professional skills to deliver the full suite of human services they need. Many human services rely on relationships of trust and staff turnover is a significant barrier to effective service provision.

Government spending on service delivery can be the main economic activity in some remote Indigenous communities. This spending plays a central role in defining how the community works and what opportunities are available to Indigenous people.

8.1 The need for reform

The models of human service provision that can be effective in larger population centres are not working in remote Indigenous communities. The reality of remote Australia is that not all services can be delivered everywhere. There is nonetheless considerable scope for improvement.

Governments have articulated high-level objectives for improving Indigenous outcomes, but do not have a clear vision of what they are trying to achieve at a community level. They have not invested enough in developing an understanding of the needs and existing service levels in communities, or a common set of objectives that governments and providers can work toward in service delivery.

The history of Indigenous policy has been characterised by instability, shifts between centralised and place-based approaches, between Indigenous-specific and mainstream

programs, and by overlapping and shifting responsibilities within and across different levels of government.

> [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)

Delivery arrangements for human services in remote Indigenous communities, like those in family and community services, are largely designed around a model of commissioning where providers 'compete' periodically for funding to deliver services. This can be a sound model if implemented well. However, current approaches are often not delivering the benefits of contestability (better outcomes, more innovation and greater efficiency) and are exacerbating its potential weaknesses (poor collaboration and a lack of service continuity). A number of participants argued that competition and contestability have contributed to fragmentation in human services in remote communities, and that moves to increase competition and contestability would worsen the situation (APO NT, sub. 478; CAAC, sub. 430; CMHA, sub. 399). For example, the Aboriginal Medical Services Alliance Northern Territory (sub. 477, p. 6) stated:

> The principal driver of the high levels of fragmentation seen recently in remote Aboriginal service delivery in the Northern Territory is the move to greater competition and contestability and the undermining of comprehensive needs based planning processes such as those established under the NTAHF [Northern Territory Aboriginal Health Forum], which could assess needs at a jurisdictional level and strategically allocate resources on that basis.

A widespread problem is that services are uncoordinated, both between and within governments, and between service providers. Governments make decisions about service provision on the basis of jurisdictional, departmental and program boundaries. Insufficient coordination can lead to duplication and inefficiency. For example, 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 Northern Territory 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.

Consultation with Indigenous people who live in remote communities is inconsistent and disjointed. Participants lamented the frequency of white Landcruisers full of people rolling

into town for meetings, often to discuss the same things as the car-load of people from another department who came for a meeting the week before. The frustrations are exacerbated when the people who come to the communities do not have the authority to act on the issues that community representatives raise with them.

Uncoordinated consultation imposes a burden on communities where resources are already stretched and leads to fatigue and disengagement. More broadly, the uncoordinated approach to decision making is an inefficient way to allocate resources, and leads to duplication of services and a lack of coordination between providers 'on the ground'. The lack of coordination is a barrier to service providers addressing the complex and entrenched problems faced by some Indigenous Australians in remote communities.

Governments have also largely failed to evaluate approaches to service delivery in remote Indigenous communities. The 2016 *Overcoming Indigenous Disadvantage* report, produced by the Commission on behalf of an intergovernmental Steering Committee, noted the lack of rigorously evaluated programs in the Indigenous policy area (SCRGSP 2016a).

8.2 Lessons from some previous reforms

Despite goodwill and significant resources, initiatives aimed at improving outcomes for Indigenous Australians have often fallen short at the implementation stage. Governments have trialled many approaches to achieving better outcomes in remote Indigenous communities, with little sustainable success.

> Australian governments have been testing 'new approaches' to addressing Indigenous disadvantage for more than ten years, particularly since the abolition of the Aboriginal and Torres Strait Islander Commission (ATSIC). Indigenous affairs is largely characterised by a litany of reports and strategies, but implementation failure. (Phillips-Brown, Reddel and Gleeson 2013, p. 255)

This section discusses some of the previous approaches to service delivery in remote Indigenous communities and identifies lessons for more effective implementation of place-based approaches with community engagement.

The Council of Australian Governments trials

The Council of Australian Governments (COAG) trials, announced in 2002, aimed to introduce a whole of government, co-operative approach in eight communities (including remote and non-remote communities). Over time the concept of place-based approaches was also incorporated in the trials. The trials aimed to tailor government action to identified community needs and aspirations, coordinate programs and services, work in partnership with communities, and build the capacity of governments and communities (Morgan Disney & Associates 2006). Each trial was led by one Australian Government agency and one State or Territory Government agency. The trials were intended to use a flexible approach, with

different arrangements implemented in each community. For example, the trials included joint planning, including through 'planning days, community forums, "100 day plans" and the adoption of Action Plans in a number of sites' (Morgan Disney & Associates 2006, p. 19). Over the period of the trials there were a number of changes in the broader Indigenous policy environment, including the abolition of the Aboriginal and Torres Strait Islander Commission, the establishment of the Office of Indigenous Policy Coordination and Indigenous Coordination Centres.

The COAG trials were evaluated, and the evaluations yielded several lessons, including:

- consistency of community committee membership and lead agency staff was associated with higher trust, and strong government partnerships (across all three levels of government) were associated with stronger relationships with communities
- place-based approaches appeared to work most effectively where there were clearly identifiable Indigenous communities with strong, representative leadership and where government agencies played a facilitative leadership role, engaging across government and with community leaders
- governments and communities need to be willing to understand and work respectfully with each other
- solutions need to be responsive to local circumstances through flexible (not one-size-fits-all) approaches
- whole of government, place-based initiatives require systemic changes at the local, community, state and national level (Morgan Disney & Associates 2006).

The National Partnership Agreement on Remote Service Delivery

The National Partnership Agreement on Remote Service Delivery (NPA RSD) (agreed by the Australian, New South Wales, Queensland, South Australian, Western Australian and Northern Territory Governments), commenced in 2009 and introduced a new remote service delivery model in 29 priority locations. The new model adopted a place-based approach, established a Single Government Interface in each community to coordinate services, developed Local Implementation Plans and collected baseline evidence to assist in monitoring progress (Australian Government 2013b). Bilateral plans were also developed between the Australian Government and the participating State and Territory Governments, setting out milestones, performance benchmarks and indicators for services, and identifying priority communities for the rollout of the new approach (ANAO 2012).

Also in 2009, the statutory office of the Coordinator General for Remote Indigenous Services was created to oversee the implementation of the NPA RSD, report twice-yearly on progress and work across agencies to cut through bureaucratic blockages and ensure services were delivered effectively (CGRIS 2009).

The evaluation of the NPA RSD noted a number of lessons from the reforms.

- There was a tension between addressing service issues and community engagement. In the NPA RSD there was pressure to finalise plans quickly (to address service issues) that may have affected community engagement.
- The focus on concrete changes (such as new government infrastructure and coordination and engagement mechanisms) may have come at the expense of less concrete aspirations such as enhancing governance and leadership capacity within communities.
- Some government stakeholders considered the NPA RSD involved a heavy reporting burden, which may have related to the Local Implementation Plans containing a large number of actions.
- Many stakeholders considered that responsiveness to community needs could be improved by greater devolution of decision making to regional and local levels (Australian Government 2013b).

The role of the Coordinator General for Remote Indigenous Services was abolished in 2014. In his final report the Coordinator General outlined a number of lessons, including:

- joint planning and engagement between communities and all levels of government is required with greater responsibility for communities built into decision-making processes
- effective community empowerment requires investment in strengthening community governance mechanisms
- there need to be agreed performance measures and standards for improved monitoring, evaluation and accountability at the local, jurisdictional and national level
- the skills of individuals and the collective capacity of both government and community need to be strengthened and supported (CGRIS 2014).

The Indigenous Advancement Strategy

The Indigenous Advancement Strategy (IAS) commenced on 1 July 2014 and replaced more than 150 Australian Government Indigenous-specific programs and activities with five broad programs, administered by the Department of the Prime Minister and Cabinet. The five programs are jobs, land and economy; children and schooling; safety and wellbeing; culture and capability; and remote Australia strategies. The strategy was designed to 'reduce red tape and duplication for grant funding recipients, increase flexibility, and more efficiently provide evidence based grant funding to make sure that resources hit the ground and deliver results for Indigenous people' (Australian Government 2014c, p. 4).

The Australian Government also established a new regional network, with staff located on the ground in communities. It was intended that 'staff in the PM&C [Prime Minister and Cabinet] Network will engage with communities to negotiate and implement tailored local

solutions designed to achieve results against government priorities' (Australian Government 2014c, p. 4).

The Australian Government's intention in designing the IAS was to achieve more efficient allocation of grants, and for Indigenous communities to have 'the key role in designing and delivering local solutions to local problems' (Australian Government 2014a, p. 36). To date this has not been the case in practice. Many inquiry participants raised the scheme as an example of failure (AMSANT, sub. 477; AHCWA, sub. 468; CAAC, sub. 430; NHLF, sub. 475; VACCHO, sub. 455). A common complaint was that the tender process disadvantaged Indigenous organisations. Another issue raised by inquiry participants was that the IAS was extremely centralised. The 2014 IAS grant funding round was the subject of both a Senate inquiry (SFPARC 2016) and an Australian National Audit Office performance audit (ANAO 2017). Identified issues included that:

- the IAS was not effectively implemented
- the timeframe for implementation was too short and key implementation stages and timeframes were not met
- the tender process resulted in gaps in service delivery that had to be filled through new contracts and adjustments to existing contracts
- Indigenous organisations were disadvantaged in the tender process
- grants were not assessed in a way consistent with the program guidelines
- some obligations under the *Commonwealth Grants Rules and Guidelines* were not met and records of key decisions were not kept
- the program design of the IAS lacked a clear evidence base
- the consultation strategy was not fully implemented, and community involvement was limited
- regional investment strategies (which were intended to map each region's profile against priority indicators, identify key policy and geographic areas that would have the greatest impact on improving outcomes, and reflect community-identified priorities) were not developed
- the ability to adopt the intended approach of the regional network (partnering with communities to design and deliver local solutions to local problems) was limited
- performance targets were not established for all funded projects.

The Department of the Prime Minister and Cabinet accepted the recommendations in the Australian National Audit Office audit, and noted that actions had already been taken or were underway to implement them (ANAO 2017).

8.3 Effective service provision in remote Indigenous communities

This inquiry is the latest of many recognising the unacceptable outcomes experienced by Indigenous Australians living in remote communities, and suggesting community voice and place-based approaches as a basis for a solution. The draft recommendations draw on the lessons from previous initiatives to improve services in remote Indigenous communities, and build on the principles for effective stewardship of human services (chapter 2) and effective commissioning of family and community services (chapter 7). The Commission has also taken into account the set of 'success factors' that the Steering Committee for the Review of Government Service Provision has identified in its series of reports on *Overcoming Indigenous Disadvantage*:

- cooperative approaches between Aboriginal and Torres Strait Islander Australians and government — often with the non-profit and private sectors as well
- community involvement in program design and decision-making — a 'bottom-up' rather than 'top-down' approach
- good governance — at organisation, community and government levels
- ongoing government support — including human, financial and physical resources. (SCRGSP 2016a, p. 3.18)

The following sections set out the overarching principles that are the basis of the Commission's draft recommendations.

Clearer outcomes

Governments must identify the outcomes that human services are intended to achieve for there to be any prospect of an effective service system (chapter 7). These should be outcomes for the user and the community. This means that in developing outcomes, governments need to understand Indigenous Australians' preferences, priorities and conception of wellbeing. Many inquiry participants drew attention to the holistic Indigenous Australian concept of health or wellbeing that encompasses:

> … not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being. (NACCHO, quoted in NHLF, sub. 475, p. 2)

Similarly, Aboriginal Peak Organisations Northern Territory (sub. 478, p. 3) raised concerns that the definition of service quality adopted by this inquiry may not be broad enough to apply to the Indigenous context.

> Of concern, firstly, is the way in which some of the objectives of human services have been framed (second Issues Paper, p 3). 'Quality' in an Aboriginal context must include broader measures of wellbeing, such as cultural or spiritual wellbeing, and not restricted to narrower conceptions of health outcomes. In this light, empowerment becomes a critical aspect of ensuring

that Aboriginal services are 'quality' services, because of the impact that empowerment has on Aboriginal people's sense of self-worth.

Mainstream service models and outcomes frameworks that focus on individuals (rather than communities or families) might not reflect the outcomes that are important to Indigenous people in remote communities. The report of the Yawuru Wellbeing Project (a research project that investigated the meaning of wellbeing to Yawuru people) noted that:

> Connections to family and community, to the land, to culture and traditions, are all fundamental to how Yawuru feel about themselves, and their sense of a good life. Yet all too often, the sorts of indicators of social and economic development used to inform policy-making, or to evaluate policy or community initiatives, fail to represent such values in any meaningful way.
>
> The problem here is not just the lack of consensus on how wellbeing for Indigenous communities should be conceptualised, but — more critically — that many of the indicators most commonly used to capture Indigenous peoples' wellbeing are drawn from western concepts that fail to reflect the essential elements of a good life that resonate with Yawuru people. (Yap and Yu 2016, p. 8)

Governments should establish opportunities for Indigenous Australians living in remote communities to articulate the outcomes they want to achieve and to be involved in program design, decision making and ongoing evaluation to improve the effectiveness of service provision.

Community involvement in program design and decision making

The characteristics of remote Indigenous communities (including their size and distance from other communities) mean that user choice through competition between providers is unlikely to be feasible for the services considered in this inquiry. Nonetheless, governments that provide services in remote Indigenous communities are making choices about who will provide which services and how. An alternative to user choice is 'community voice' — giving communities opportunities to express their preferences and priorities across the 360 degrees of the commissioning cycle — from needs assessment through to evaluation (chapter 7).

Increasing community involvement in program design and decision making in remote Indigenous communities could improve service effectiveness by empowering communities. Community involvement can result in services that are better tailored to the community and that are more likely to be used by the community.

> The Smith Family's experience of working in remote communities demonstrates that services that do not consider the unique cultural context of the specific community will not be utilised by community members. Community involvement in determining and designing appropriate services is paramount to service utilisation. (The Smith Family, sub. 469, p. 5)

The potential benefits of community involvement in program design and decision making have been recognised in previous initiatives. For example, in 2002 the Murdi Paaki Regional Council (2002, p. 3) proposed 'a new framework of regional governance and integrated

service delivery arrangements for Indigenous communities with a focus on community decision making'. It stated:

> The framework aims to ensure that communities play a central role in developing and implementing strategies and taking responsibility for their own improvement, and have an effective voice in all matters that affect individual and family well-being.
>
> Communities are best able to tell Government and non-government organisations what their needs are, whether the services they receive are adequate, and whether programs are meeting those needs. (Murdi Paaki Regional Council 2002, p. 11)

More recently, the Prime Minister's Indigenous Advisory Council (tasked with advising Government on practical changes which can be made to improve the lives of Indigenous Australians) also noted the importance of collaborative approaches.

> The Council reiterated to Government genuine partnership and collaboration with Aboriginal and Torres Strait Islander peoples will be critical to ensure policies coming forward to Government are driven and supported by aspirations and needs of local communities. (DPMC 2017)

The challenge for governments is to find ways of sustainably and successfully implementing the principle of community voice in a remote context.

Place-based approaches

Australia's federal system of government poses challenges to coordinating the planning and delivery of human services. Place-based approaches — programs designed and delivered with the intention of targeting a specific geographical location(s) and particular population group(s) in order to respond to complex social problems (Wilks, Lahausse and Edwards 2015, p. viii) — can cut across the government 'silos' that are a barrier to coordination. Place-based approaches are one way of improving the effectiveness of service delivery in remote Indigenous communities. Place-based approaches can be tailored to the needs of diverse communities and can be consistent with outcomes that are focused on community connections and community-wide wellbeing. Place-based models involve detailed ground-up service design and decision making, underpinned by high levels of community engagement. Existing placed-based approaches offer some promise, but are highly resource intensive and would not be appropriate everywhere.

As with community involvement in program design and decision making, the potential benefits of place-based approaches to human services are widely recognised. Phillips-Brown, Reddel and Gleeson (2013, p. 247) noted that:

> Within Australia, the shift towards whole-of-government service delivery to meet the needs of a geographically defined local community has been occurring since the 1970s.

A place-based approach was a guiding principle of the NPA RSD. More recently, the Indigenous Affairs Group of the Department of the Prime Minister and Cabinet (sub. 265, p. 2) cited the principle in its submission to this inquiry.

> 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.

There are signs that place-based approaches are gaining traction in policy making, including the Empowered Communities proposal, Local Decision Making in New South Wales, and Regional Services Reform in Western Australia (box 8.1). Initiatives like these hold promise, but will need time and patience from all stakeholders to achieve results.

Box 8.1 Some current examples of place-based and community voice reforms

Empowered Communities (EC) is a proposal for long-term reform of Indigenous policy, based on empowerment and development. The proposal is a place-based approach involving regional and community planning and priority setting. There are currently eight EC regions around Australia (in remote and non-remote areas). The Australian Government is supporting the EC model by sharing data and providing funding for 'backbone' organisations in seven of the EC regions. Work is currently underway in each region to identify first priorities and establish longer-term regional Development Agendas.

Local Decision Making in New South Wales aims to place Indigenous Australians at the centre of service design, planning and delivery, thereby enabling a staged devolution of decision making and accountability to the local level. This is done through the negotiation of accords between regional alliances and the New South Wales Government, which outline agreed priorities and projects, and decision-making processes.

Regional Services Reform in Western Australia aims to bring about long-term systemic change to improve the lives of Indigenous Australians in regional and remote Western Australia. The reforms have an initial focus on the Pilbara and Kimberley. Strategic Regional Advisory councils bring together governments, communities, service providers and industry, while District Leadership Groups are implementing change at a local level.

Sources: Aboriginal Affairs NSW (2015, nd); DPMC (2016); Empowered Communities (2017); WA RSRU (2016).

Learning systems

Governments, service providers and communities need to learn 'what works' in human services in remote Indigenous communities. Governments have tried many approaches to service delivery in remote Indigenous communities and many of them have been reviewed. However, governments seem to cherry-pick the lessons from history. For example, as they did with the NPA RSD.

> The road that the Council of Australian Governments travelled to get to the National Partnership Agreement on Remote Service Delivery had many clear sign posts from previous interventions

> and experiences of what works in place-based and community strengthening approaches for remote communities. As often seems to be the case, some lessons were firmly embraced in both the policy and implementation of the new approach, whereas others have been left to languish by the road side. (Phillips-Brown, Reddel and Gleeson 2013, p. 245)

An effective service system would incorporate ongoing service monitoring, evaluation and continuous improvement. Explicitly requiring that programs are monitored and evaluated with input from communities can enhance community voice and improve service implementation and ongoing provision. Evaluations that are carried out after programs have concluded are not adequate — evaluation needs to be an ongoing process embedded in program design. Evaluation should lead to ongoing discussions between governments, service providers and communities about the effectiveness of services, and be integrated with mechanisms to adjust contracts to improve outcomes.

8.4 Toward a better model of service provision

While it is easy to point to failures in service delivery for Indigenous people living in remote communities, these failures are not due to a lack of intent, effort or resourcing. Improving service delivery in remote Indigenous communities is hard and change will come slowly. Governments and the community need to be patient. This requires a recognition that, while governments play a critical role in creating and maintaining the conditions for improving outcomes, the actions of Indigenous people themselves will also play a major role in determining outcomes.

The Commission is conscious that a major issue for remote Indigenous communities has been the rapid shifts in policy over time. It is proposing reforms that can be implemented as existing arrangements lapse and that would promote longer-term stability and underpin improved service delivery and a focus on service outcomes in remote Indigenous communities.

The Commission has developed draft recommendations for changes in contracting arrangements for human services in remote Indigenous communities (section 8.5). These changes address participants' concerns about the effect of current contracting arrangements on users and providers. The proposed reforms address many of the same issues that arose in the Commission's consideration of family and community services (chapter 7), with adjustments to accommodate the unique circumstances of remote service delivery. The Commission's view is that these reforms have the potential to significantly improve service effectiveness over time.

Many stakeholders have pointed to the potential of place-based approaches and the need for Indigenous people living in remote communities to have more voice in influencing the services they receive. Different models have been proposed. Some people favour providing Indigenous people with more control over the funding and design of local services at a community level. Others promote a regional governance approach. Others stop short of

passing on control and promote greater engagement instead. No single model has universal support.

The Commission has not developed specific recommendations in the area of greater community engagement and input, but may do so in its final report. It has been considering ways to empower communities, including using community plans to articulate community aspirations and incorporate community views in service planning and delivery. The following sections set out some of the considerations around introducing community planning processes. Between this draft report and the final report the Commission will seek further feedback on community planning approaches, including through submissions, roundtables and participation in public hearings.

Purpose and potential content of community plans

The purpose of community planning would be to establish a process for Indigenous Australians living in remote communities to express their preferences and priorities, and to make governments and service providers more responsive to each community. Plans would be developed by the community, with governments offering support. Plans would be designed to articulate the long-term aspirations of the community and how community members, governments and providers would work together to achieve these long-term outcomes. The plans would not be 'funding plans' for government, but would define common priorities and the basis for future actions.

Although this inquiry is focused on human services, there are often no distinct boundaries between these and many other services such as infrastructure services (IT infrastructure or suitable buildings, for example). Minimum criteria would need to be developed, but communities would have flexibility in how the plans were developed and what they involved.

The process of developing plans would need to accommodate the diversity of remote Indigenous communities. Previous initiatives that have incorporated planning processes have fallen short because they have applied a 'template' approach. The onus would be on governments to support communities to develop their plans, and to understand and help communities achieve their priorities, not on communities to fit their priorities into a standard template.

Once developed, governments would be obliged to: take each plan into account when funding services for the relevant community; and report publicly (to Parliament and to the community) on whether, and if so how, funding and other government actions have supported the community plan. Although community plans would enhance the role of communities in decision making, governments would retain ultimate responsibility for funding decisions and stewardship (including consumer protections around service provision).

Supporting community capacity

Successful implementation of community plans would depend on the capacity of both government and the community to fully engage in more localised approaches. This capacity does not exist everywhere and would take time and effort to build. Governments should support remote Indigenous communities to build their capacity — including institutions, skills and governance arrangements. Capacity-building activities should be decided on a community-by-community basis, and be informed by an understanding of the community's existing strengths and preferences. As Tsey et al. (2012, p. 9) observed:

> Measures to improve governance by imposing a one-size-fits-all approach to addressing Indigenous governance are unlikely to be workable or sustainable.

Some capacity-building arrangements currently exist, and could be built on. The Office of the Registrar of Indigenous Corporations provides resources and training programs to increase corporate governance knowledge, skills, efficiency and accountability within organisations. Jawun, a not-for-profit organisation, places people from the private sector, government and philanthropic organisations into Indigenous organisations to build the capacity of Indigenous people. These bodies, and others, have experience and skills that governments and communities could learn from.

Government structures and processes need to support reform

Governments would need to change their structures and processes, and change the way they work — with communities, across departments, and with other governments — for a place-based approach with community involvement to succeed. Changing the way governments make decisions would be a gradual process that must evolve from governments' current approaches to service delivery and be compatible with the fundamentals of the Australian system of government.

In the past, the risk appetite of governments has been a barrier to moving from rhetoric to reality on community empowerment. Governments must be willing to transfer some control from centralised decision making in government. To be effective, implementation requires ongoing bottom-up consultation and engagement. Indigenous communities will only develop trust in governments if they see that there is genuine commitment to taking their views into account when decisions are made.

It is inevitable that some changes will fail and some communities will show little or no sign of improvement, at least initially. Governments must adopt constructive responses if initiatives begin to falter. Governments have a role as stewards of the system to intervene in any cases of 'serious' failure, but to do so in a proportionate way. Program failings in remote Indigenous communities have often been met with overreaction from governments when a more measured approach could have achieved better results and maintained community trust. The response to failure should be to learn from the experience and adjust.

Governments would also need to develop the skills to work with remote Indigenous communities, to support meaningful engagement and to design programs and commission services that meet the diverse needs of these communities. The former Coordinator General for Remote Indigenous Services noted that:

> Cultural competence of government is imperative to working effectively anywhere in Indigenous Affairs and specific local knowledge is vital for community engagement. (CGRIS 2014, p. 4)

Considerations around timing and rollout of community plans

The Commission is keenly aware of the disruption that constant changes to policy have caused to remote Indigenous communities. Any significant changes to services in remote Indigenous communities would take time. Governments and communities must have realistic expectations about what changes can be implemented and how quickly change can occur. Governments would need to make careful decisions about priorities and resources for implementation. Reforms to services in remote Indigenous communities should be implemented in ways that minimise any negative effects of the transition on service users.

Community plans would not be appropriate for all remote Indigenous communities. Governments would need to make clear decisions about which communities would be eligible for a community planning approach. Governments should roll out reforms when communities are ready, rather than adhering to a prescriptive timetable. The Commission considers that the lessons of the past caution against over-reach and over-promising. Expanding too far, too fast is a significant risk, and the rollout of community plans should be careful, focusing on community readiness. One approach would be for community planning to be rolled out incrementally, starting with a small number of communities (say, ten or fewer). Allowing enough time for rollout would assist in building community trust that the approach would be allowed to evolve as communities, service providers and governments adapt to the new way of working together.

One way to commence the planning process may be for governments to make judgments, in discussion with local communities, about which communities are ready to participate and which bodies have the status to represent their communities, drawing on lessons from similar initiatives. In New South Wales, as part of Local Decision Making (an initiative to devolve decision making and accountability to the local level), the New South Wales Government established good governance principles that must be met before communities progress through each phase of the initiative (Aboriginal Affairs NSW 2016).

Another approach might be to consider the development of a community plan to be a demonstration of community capacity. A number of Indigenous communities already have plans or planning processes in place (for example, Empowered Communities and the Murdi Paaki Regional Assembly). Where there are existing arrangements these should be built on, not discarded.

8.5 Improvements to commissioning practices

In chapter 7 the Commission made several draft recommendations for improvements to the way governments commission family and community services. Many of these reforms could be applied to human services in remote Indigenous communities, with some adjustments to account for the unique circumstances in those communities.

Longer contract terms

Many inquiry participants argued that uncertainty around funding arrangements is an impediment to effective service provision and that contract terms are too short (AHCWA, sub. 468; Anglicare Australia, sub. 445; CAAC, sub. 430; DSS, sub. 476; South Australian Government, sub. 460). This was also raised in relation to family and community services (chapter 7). The Senate inquiry into the IAS recommended that 'where possible and appropriate, longer contracts be awarded to ensure stability so that organisations can plan and deliver sustainable services to their communities' (SFPARC 2016, p. 64).

Increasing certainty by increasing default standard contract lengths could improve outcomes by improving the stability of service provision for users (for whom trusting relationships with providers are important). It would also provide scope for service providers to improve service quality by planning investments (such as staff development and new approaches to service provision) over a longer cycle. Short contracts, contracts with uncertain end dates, and uncertainty around contracts due to policy changes make it difficult to attract providers in remote areas, where, if the contract ends they may have no other work.

Longer contracts would also pose risks, including by reducing the flexibility of governments to change their funding priorities and potentially exacerbating the negative consequences of selecting 'poor' providers. It is particularly important, then, that governments retain safeguards for withdrawing contracts and ensuring continuity of service provision (through provider of last resort arrangements) in the event of a provider failure (chapter 2).

In drawing a balance between the benefits and risks of longer contracts, the Commission has built on its discussion of contract terms in family and community services (chapter 7). In those services the Commission's draft recommendation is for default contract terms of seven years. In remote Indigenous communities there is a case for longer contracts, to allow extra time to establish community trust and invest in staff, capital and delivery models. Increasing the contract length would increase the risks associated with locking in ineffective service providers. Those risks would need to be managed through contract terms that build in the potential for early termination of the contract if the service provider is not effective.

The Commission's view is that ten-year default contract terms, incorporating potential early termination for poor performance, is the right balance. As with family and community services, there should be some flexibility around the default contract length. For example, a

shorter contract term could be warranted for the trial of a new service type. Governments should provide justification for any contracts that differ from the standard term.

DRAFT RECOMMENDATION 8.1

The Australian, State and Northern Territory Governments should set the length of human services contracts in remote Indigenous communities to allow adequate time for service providers to establish their operations, have a period of stability in service delivery and for handover before the conclusion of the contract (when a new provider is selected). The contract period should take into account the additional challenges of service delivery in remote communities.

To achieve this the Australian, State and Northern Territory Governments should:

- increase default contract lengths for human services in remote Indigenous communities to ten years
- allow exceptions to be made, such as for program trials which could have shorter contract lengths
- provide justification for any contracts that differ from the standard term
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of serious failure.

Tender processes

Currently there is little coordination of the start and end dates of contracts within remote Indigenous communities. Aligning the start and end dates of contracts for related services could create opportunities for communities and governments to identify the mix of providers that is likely to achieve the best outcomes. For example, service providers and communities might consider joint-venture arrangements if several contracts became available simultaneously. A more coordinated approach to contract timing could also focus communities and governments on future opportunities to change service provision in a community. Changes to contract alignment also carry risks if not managed well. There is a risk that communities could be left with large service gaps if several contracts are unfilled at the same time.

When conducting provider selection processes, governments should also allow sufficient time for providers to prepare a considered response, to notify providers of the outcome in a timely manner ahead of the commencement of the contract and allow enough time for transition when new providers are selected.

DRAFT RECOMMENDATION 8.2

When conducting provider selection processes for services in remote Indigenous communities, the Australian, State and Northern Territory Governments should:

- better align tender processes for related services
- allow sufficient time for providers to prepare considered responses (including the development of integrated bids across related services)
- notify providers of the outcome of tender processes in a timely manner
- allow enough time for transition when new providers are selected.

Supporting community skills and capabilities

The provision of government-funded human services is a large part of the economy in remote Indigenous communities and is an opportunity for governments to invest in building local capacity. In designing services and selecting providers, governments should include a focus on skills transfer and building the capacity of people and organisations in the community. Difficulty recruiting and retaining staff has been identified as an issue in remote Indigenous communities, and building a local skills base could ameliorate this over time. For example, a service agreement for housing services could include specific funding to provide training for local people to learn how to maintain properties.

Building and utilising a local skills base could have additional costs initially. However, it would contribute to the development and resilience of the community and, over time, could lower the cost of service provision (such as through lower transport costs).

DRAFT RECOMMENDATION 8.3

The Australian, State and Northern Territory Governments should ensure that commissioning processes for human services in remote Indigenous communities have a strong focus on transferring skills and capacity to people and organisations in those communities.

Provider selection

Many inquiry participants argued that competitive tendering arrangements tend to disadvantage Indigenous organisations. (The IAS was commonly raised as an example.) One reason given for this was that large non-Indigenous organisations have greater resourcing for and experience in responding to calls for tender.

> Competitive tender processes also tend to favour large-scale NGOs which have the skills and capabilities to develop effective grant applications. Though some larger organisations offer brokerage or subcontracting to local communities, as discussed above, others implement a 'one

> size fits all' approach that doesn't reflect the diversity and complexity of local communities. The Department [of Social Services] tries to counter this when assessing funding applications and requires applicants to demonstrate how they will service the local community. (DSS, sub. 476, p. 8)

Another issue raised by inquiry participants was that tender processes do not always take into account the advantages Indigenous organisations offer over 'mainstream' organisations. Aboriginal Medical Services Alliance Northern Territory (sub. 477) argued that, compared with mainstream primary care, Aboriginal Community Controlled Health Organisations provide greater health benefits, improve access for Indigenous people, deliver culturally appropriate services, are more likely to be committed to processes of clinical governance and evidence-based medicine and employ more Indigenous people (and develop their skills and career path). They also argued that Aboriginal Community Controlled Health Organisations are instrumental in developing and supporting innovative models of care (including through partnering with mainstream providers).

This is consistent with the situation described by participants in family and community services: that governments focus disproportionately on the financial cost of services and the 'quality' of tender applications (chapter 7). This is inconsistent with a user-focused approach to human services. In such a system, governments undertaking tender processes would select providers based on their ability to achieve outcomes for users, taking into account all the attributes of providers that contribute to this.

Taking into account the capacity of service providers to achieve outcomes in remote Indigenous communities would increase the quality, responsiveness and efficiency of services. Governments might face higher administrative costs for assessing tender applications, and potentially higher costs of service. However, the potential for better outcomes means that the benefits are likely to exceed the costs.

DRAFT RECOMMENDATION 8.4

When selecting providers of human services in remote Indigenous communities, the Australian, State and Northern Territory Governments should take into account the attributes of providers that contribute to achieving the outcomes sought. This may include:

- culturally appropriate service provision (specific to the region where the service is being delivered)
- community engagement and governance (including through considering communities' feedback on provider performance)
- collaboration and coordination with existing service providers, and community bodies
- employment and training of local and/or Indigenous staff.

Planning, evaluation and feedback systems

Systems to support service planning, evaluation and the identification and sharing of best-practice approaches underpin better service delivery.

A fundamental requirement to move from the current system to effective place-based service delivery in remote Indigenous communities is an understanding of the current situation in each community, to inform service planning. Ongoing assessments of the characteristics of each community would provide information about communities' needs and capacities. This information should be published so that it can be used by communities and providers. The assessments would cover:

- community characteristics (including demographics and service user characteristics)
- community organisations and forums (including representative organisations and service providers)
- community strengths and capacity (including successful organisations and programs)
- the services that are delivered in the community, who provides them, who they are provided to and who funds them
- infrastructure available in the community (including IT infrastructure that can support technological innovations such as telehealth)
- trends and drivers influencing the above characteristics (recognising that community circumstances are not static) – for example trends in the expected future demand for services due to demographic change.

The assessments could identify gaps and overlaps in service provision that could be taken into account in commissioning and could increase the quality and efficiency of services through better targeting community needs. The information gathered could also assist in determining what capacity building support could assist communities. It could contribute to service coordination and accountability, and could also feed into community planning arrangements, if they were adopted.

Governments would need to draw on the knowledge of communities and service providers in the community assessments. Community views on their characteristics should be taken into account. For example, communities may have a different view to government on their strengths, or on the drivers influencing community needs. The Commission recognises that collecting this kind of information can be resource intensive. Governments should draw on existing information where possible. For example, information on services gathered as part of the Western Australian Regional Services Reform process. Governments should also conduct the assessments with a clear understanding of what the information will be used for, and this should inform the types of information collected. This process would only result in better service delivery to the extent that the information gathered is used to inform service planning and design.

Evaluation and an understanding of 'what works' also underpins better service delivery. Explicitly requiring that programs are evaluated with input from communities can enhance community voice and improve service implementation. Evaluations that are carried out after programs have concluded are not adequate — evaluation needs to be an ongoing process embedded in program design. There are different ways to conduct evaluations, and evaluations can be tailored to the program and knowledge, skills and resources of the local community. Evaluating providers, programs and systems has costs as well as benefits, and the scope of an evaluation should be commensurate with the size and complexity of the program (chapter 7).

Governments should also gather information on 'what works' and share it across governments, providers and communities. This would then feed back into service commissioning and delivery. This should be done with the understanding that approaches that work in one community may not work in another.

DRAFT RECOMMENDATION 8.5

The Australian, State and Northern Territory Governments should invest in better systems to underpin service delivery by working together to:

- develop objectives for human services in remote Indigenous communities
- conduct and publish ongoing assessments of the characteristics and needs of Indigenous Australians living in remote communities, including mapping the existing services delivered in communities
- establish systems to identify and share information on 'what works' in human services in remote Indigenous communities.

The Australian, State and Northern Territory Governments should involve communities at all stages of this process.

9 Patient choice

Key points

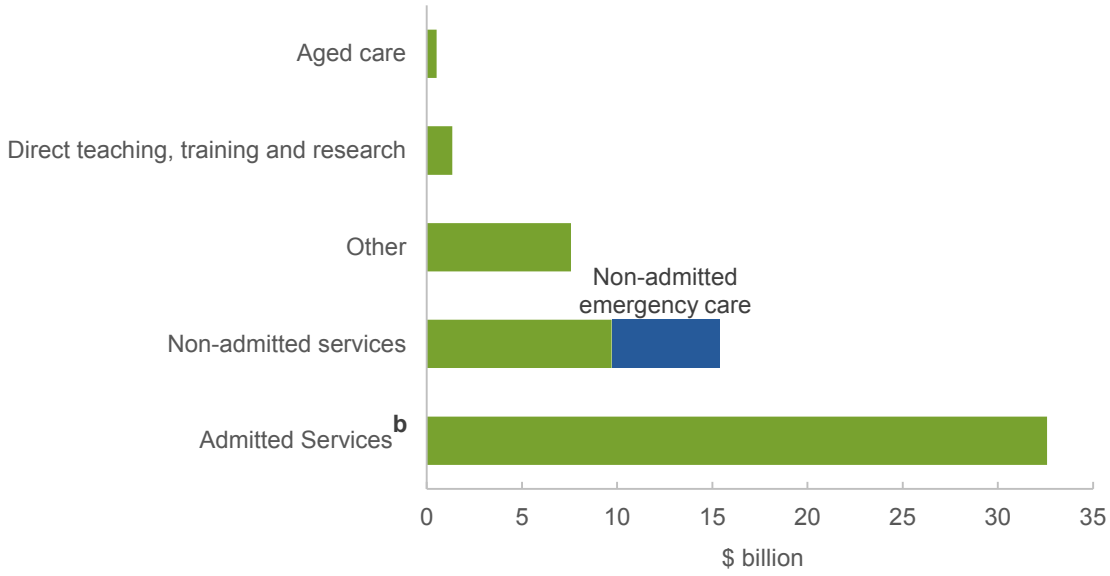
- Greater choice could improve outcomes for the many Australians who will be admitted to a public hospital at some stage of their lives for elective (planned) care.
  - There are more than 2.3 million elective admissions to public hospitals each year, most of which are preceded by a specialist referral from the patient's general practitioner (GP).
  - Specialist referrals are provided in almost 10 per cent of GP consultations, amounting to about 14 million referrals annually, with the most frequent including those to orthopaedic surgeons, dermatologists and cardiologists.
- The Commission proposes that, when patients are given a referral for an initial specialist consultation, they are always given an opportunity (following support from their GP) to choose either the:
  - public outpatient clinic they attend (with the specialist chosen by the clinic)
  - private specialist they see (usually in private rooms and possibly involving out-of-pocket charges).
- Patients currently face barriers to exercising these choices because:
  - individuals referred to a public outpatient clinic are often given no choice but to attend the clinic nearest to their home
  - patients wishing to see a private specialist may be constrained by their GP's knowledge of alternative specialists and efforts to satisfy patient preferences, as well as a common misconception that referrals must name a specific specialist.
- Giving individuals greater choice at the point of referral would lead to more patient-centred provision of public hospital services and improve patient wellbeing by:
  - empowering patients to have more control over their health care
  - giving patients greater scope to choose options that match their preferences, such as a public clinic further from home with a shorter waiting time
  - driving improvements in the quality, efficiency, accountability and responsiveness of public hospital services.
- Implementing greater choice will require:
  - best-practice guidance for GPs on how to support choice
  - removing geographic restrictions on which public outpatient clinic a patient can attend
  - amending regulations to make it clearer that patients can choose an alternative to a specialist named in their referral.
- More published information on alternative hospitals and specialists would increase the benefits from choice but is not a prerequisite for the reform.

9.1 Introduction

The term 'public hospital services' is used in this report to refer to health care that specialists and hospitals provide to public patients. This covers many different types of health care and can be provided in a range of settings, including in public outpatient clinics, private outpatient rooms[1], hospitals and as hospital-in-the-home care.

Total public hospital expenditure was about $57 billion in 2014-15 (AIHW 2016c). About $33 billion of this (almost 60 per cent) was on services provided to patients admitted to hospital ('inpatients') (figure 9.1). The vast majority of admitted services aim to cure a condition, alleviate symptoms or manage childbirth. Other admitted services aim to optimise the patient's functioning and quality of life, for example through rehabilitation or palliative care (chapters 3 and 4 discuss end-of-life care). Non-admitted services include specialist outpatient services — where specialists consult with patients, and perform diagnostic and other procedures — and most emergency department services.

Figure 9.1 **Public hospital expenditure by type of service, 2014-15[a]**



a Recurrent expenditure including depreciation. Excludes private outpatient services. **b** 42 per cent of separations for admitted services were coded as an emergency admission.

Sources: AIHW (2016a, 2016h).

A guiding principle of this inquiry is that service users (patients) should be at the centre of human services. Increasing patient choice can help place patients at the centre of public hospital services and improve patient outcomes by empowering patients, letting them decide

1 Private outpatient rooms refers to all private outpatient settings, including private consultations in public outpatient clinics where the specialist is exercising a right of private practice.

how to satisfy their preferences, and driving improvements in public hospital services (these benefits are discussed in section 9.4).

The Commission's proposed reforms focus on the referral pathways to elective care as a public hospital patient. These pathways are detailed further in section 9.2 but in summary they cover:

- specialist outpatient services (which may be provided at a public clinic attached to a public hospital or in private rooms)
- elective care[2] that patients could subsequently receive as a public inpatient in a public hospital.[3]

Reforms are proposed on the basis that patients should be offered choice only in situations where the benefits are likely to outweigh the costs. Where this condition is met, reforms should be implemented in the way that maximises the net benefits to the Australian community as a whole. The Commission considered, but ruled out, reforms to other types of public hospital services, either because the patients receiving them already have significant choice (for example, women giving birth) or because increasing patient choice could interfere with patient safety or impede efficiency (for example, patients receiving emergency services).

In developing draft recommendations to increase patient choice, the Commission has considered what effective provision of specialist outpatient services and public hospital elective care would look like from the perspective of patients, providers, and governments.

- All patients would be able to choose their provider, to the extent that choice does not interfere with the quality or efficiency of services. Patient choice would be supported by the best-placed healthcare professionals and by ongoing improvements in user-oriented information. This support would let patients with differing levels of health literacy exercise choice.[4]
- Providers (specialists and hospitals) would be able to attract patients by improving service quality and being more responsive to patients' preferences. Providers' established work processes would not be disrupted by patient choice. Providers would be able to benchmark the quality and efficiency of their services against their peers.

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2 Elective care is care deemed necessary — elective here does not mean optional — but admission can be delayed for at least 24 hours. Emergency care is when hospital admission is desirable within 24 hours (AIHW and RACS 2012).

3 Most public hospitals are run by governments but not-for-profit bodies also provide a sizeable share of services, including in major facilities such as St Vincent's Hospital (Sydney); Mercy Hospital for Women (Melbourne); Mater Adult, Children's and Mothers' Hospitals (Brisbane); St John of God Midland Public Hospital (Perth); and Calvary Public Hospital (Canberra). Few public hospitals are run by for-profit operators and they tend to be relatively small facilities located outside capital cities, apart from Joondalup Health Campus (Perth).

4 The Australian Commission on Safety and Quality in Health Care (2014c, p. 2) defines individual health literacy as 'the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action'.

- Governments would help healthcare professionals to understand and support patient choice, and would publish comparative information for both patients and providers. Governments would monitor the operation of patient choice to facilitate ongoing improvement and to increase the accountability of healthcare professionals.

The Commission's draft recommendations are summarised in table 9.1.

Table 9.1 **Overview of proposed reforms to patient choice**

Reform actions	*Timeframe*	*Potential benefits and costs*
Increasing choice for referred patients		
Draft recommendation 9.1 Australian Government to amend the Health Insurance Regulations 1975 to make it clear that patients can choose which public clinic or private specialist they go to when given a referral.	As soon as practicable	Empower consumers and support them to make choices that better satisfy their needs and preferences. Increase competition among specialists, reduce power of referral networks. Additional cost of GP time where supporting choice requires longer consultations.
Draft recommendation 9.2 Australian Government to develop, with GPs, best-practice guidelines on how to support patient choice, as part of a strategy to help healthcare professionals to implement choice at the point of referral.	As soon as practicable	Increase patient choice. Make choice work better for patients, GPs and specialists. Helps GPs to support patient choice. Cost of strategy.
Draft recommendation 9.3 Public outpatient clinics to accept any patient with a referral letter for a condition the clinic covers, regardless of where the patient lives.	As soon as practicable	Increase choice for public patients. Reduce administration costs involved with re-routing patients to a different clinic.
More flexible travel assistance		
Draft recommendation 9.4 Eligible patients to be able to access patient travel assistance schemes regardless of which provider they choose to attend.	As soon as practicable	Increase choice for eligible patients. May be a small increase in number of patients accessing the scheme.
Evaluation of reforms		
Draft recommendation 9.5 Australian Government to evaluate patient choice reforms.	5 years after implementing reforms	Cost of evaluation. Identify further beneficial improvements.

9.2 The referral pathways to specialist elective care

Patients typically need a referral for an initial specialist consultation before they can access any government-funded elective care, and general practitioners (GPs) are the 'primary source of referrals' (Department of Health 2017d, p. 15). In 2015-16, GPs made almost 10 specialist referrals for every 100 consultations — about 14 million specialist referrals in total (although some of these referrals were not for initial consultations) (Commission

estimate based on Britt et al. 2016). The types of specialists that GPs referred to most frequently include orthopaedic surgeons (about 9 per cent of specialist referrals), and dermatologists and cardiologists (each about 8 per cent) (Britt et al. 2016).

Patients referred to a specialist can go to either a public outpatient clinic or a private specialist who works at private outpatient rooms. Both options are covered in this chapter because they can ultimately lead to the patient receiving elective care as a public patient in a public hospital (discussed below) and are largely government-funded.

Patients do not pay for either public outpatient services, or services received as a public inpatient in hospital. State and Territory Governments fund the bulk of these services, although the Australian Government makes a significant contribution. Patients may pay some 'out-of-pocket' costs for a private outpatient appointment if the specialist charges more than the government contribution (box 9.1).

While this chapter mainly discusses referrals made by GPs, specialist referrals can also be made by doctors in hospitals, by other specialists in outpatient settings, and by some other health professionals (optometrists, dentists and some midwives and nurse practitioners). Much of the analysis in this chapter is relevant to specialist referrals made by health professionals other than GPs. The draft recommendations should apply to all specialist referrals (except for those parts of draft recommendations 9.3 and 9.4 that are explicitly aimed at GP practice).

Specialist consultations leading to an elective hospital admission

An initial specialist outpatient appointment may be followed by further outpatient consultations, usually with the same specialist or at the same public clinic. For many patients, the entire course of their treatment occurs in an outpatient setting. However, some patients need to be admitted to hospital.

In 2014-15, there were more than 2.3 million admissions to public hospitals for elective care (and more than 3.4 million elective admissions to private hospitals). In the same year, about 700 000 patients were admitted to public hospitals for elective *surgery* (about 1.4 million were admitted to private hospitals). The most common elective surgeries in public hospitals were cataract surgery (just under 10 per cent of surgeries) and removal of skin cancers (just under 5 per cent) (AIHW 2016a).

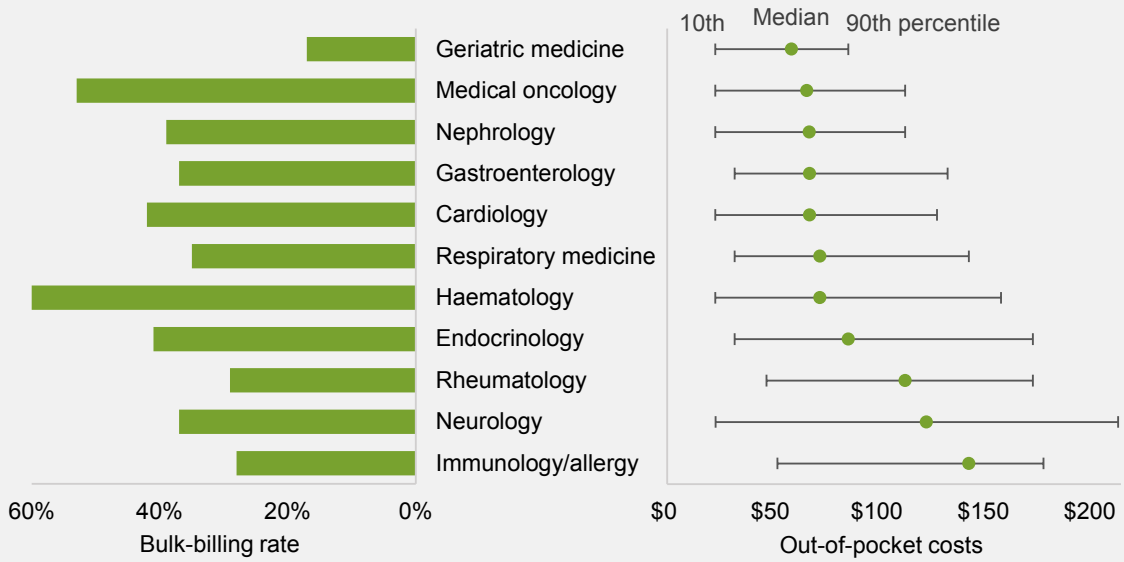
Box 9.1 How much do private outpatients pay for consultations?

Specialists set their own prices for private outpatient consultations, but the Australian Government (through Medicare) contributes 85 per cent of the 'schedule fee' for private outpatients (and 75 per cent for private inpatients). As at May 2017, schedule fees were $150.90 for an initial consultation with a consultant physician (a non-surgical specialist – item 110) and $85.55 for an initial consultation with other specialists (item 104) (Department of Health 2017d). Other schedule fees apply to different types of consultations or treatments with different specialists.

Specialists can choose to charge 85 per cent of the schedule fee, so that the patient pays nothing ('bulk-billing'), or can charge a higher price, in which case the patient must pay the difference ('out-of-pocket' costs). Private health insurance cannot be used to pay for private outpatient services. In 2015-16, about 30 per cent of private specialist consultations were bulk-billed (not including procedures). Of those that were not bulk-billed, about a third were billed at the schedule fee, and the average patient contribution was about $70 (Department of Health 2016a).

Bulk-billing rates and out-of-pocket costs vary a lot — between and within specialties (figure below) and between jurisdictions. In 2015-16, the Northern Territory had the highest bulk-billing rate for private specialist consultations (47 per cent) and Western Australia the lowest (17 per cent) — other jurisdictions had rates between 25 and 35 per cent (Department of Health 2016a). Many specialists charge more to high-income patients than to low-income patients (Johar et al. 2016). The Commission has proposed that the out-of-pocket charges of private specialists be published as part of a shift to systematic public reporting on individual specialists (chapter 10).

Bulk billing rates and out-of-pocket costs for initial consultations, 2015[a]



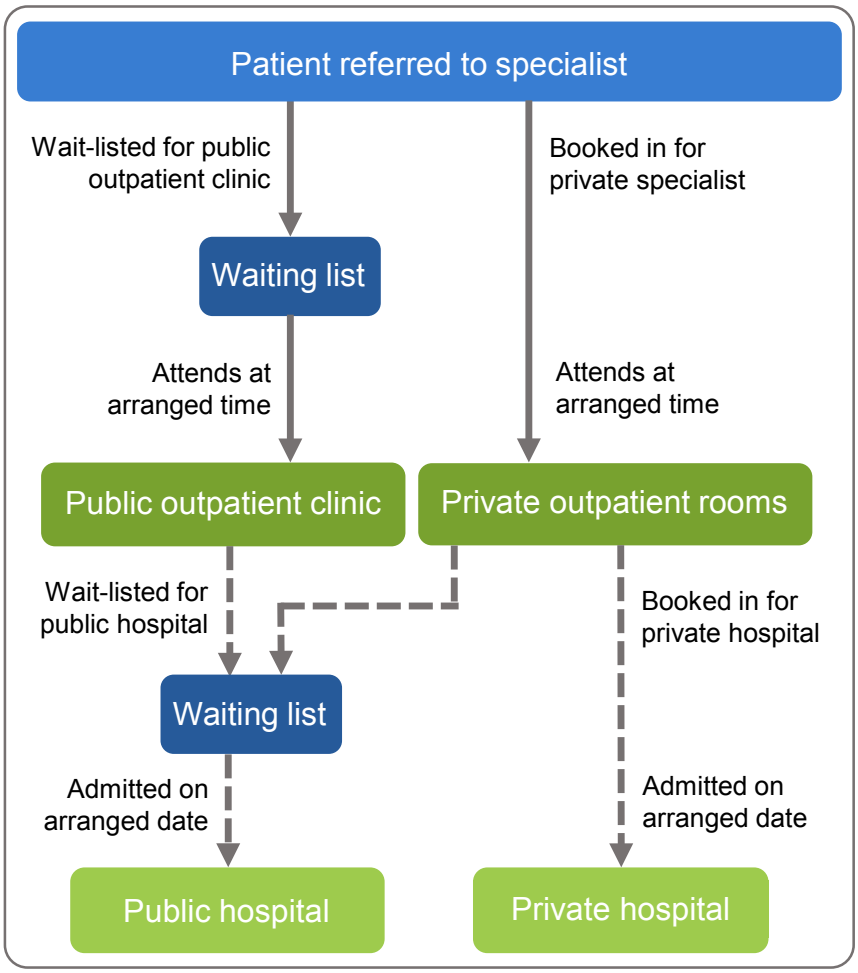
[a] Private consultations with a consultant physician. Excludes (bulk-billed) consultations with no out-of-pocket charge.

Source: Freed and Allen (2017).

Figure 9.2 shows three common pathways from specialist consultation to elective hospital admission (indicated by dotted lines in the figure):

- public outpatient–public inpatient
- private outpatient–public inpatient
- private outpatient–private inpatient.

Figure 9.2 **Pathways to elective hospital admission**



Public outpatients that need to be admitted to hospital are by default wait-listed at the hospital attached to the public outpatient clinic they have attended (the public outpatient–public inpatient pathway). This may not be the case if the hospital is unable to treat the patient, for example if the patient has complicating co-morbidities.

Some private outpatients may be able to be treated as a public inpatient (the private outpatient–public inpatient pathway) if the specialist they have seen has admitting

rights at a public hospital.[5] This is restricted in Queensland by a requirement that individuals must have a public outpatient consultation before being placed on a public hospital surgery waiting list (Queensland Government 2015). The number of people following the private outpatient–public inpatient pathway varies a lot between jurisdictions but precise numbers are not known.

The private outpatient–public inpatient pathway raises equity issues. Patients following this pathway are able to access public inpatient services without first queuing on a public outpatient waiting list (box 9.2). Additionally, patients' access to the private outpatient–public inpatient pathway is likely dependent on where they live, which GP refers them and whether they are willing to pay any out-of-pocket costs for a private outpatient consultation. Increasing patient knowledge about this pathway and supporting patients to make informed choices about which pathway they wish to follow would reduce this inequity.

Private outpatients that need to be admitted to hospital and elect to be treated as a private inpatient are usually booked in for elective admission at a private hospital (the private outpatient–private inpatient pathway). These patients are typically admitted under the specialist they saw as a private outpatient.

5 Specialists can work across both public and private sectors. Just under half work across both sectors, one third work only in public practice and about 20 per cent work only in private practice (Freed, Turbitt and Allen 2016).

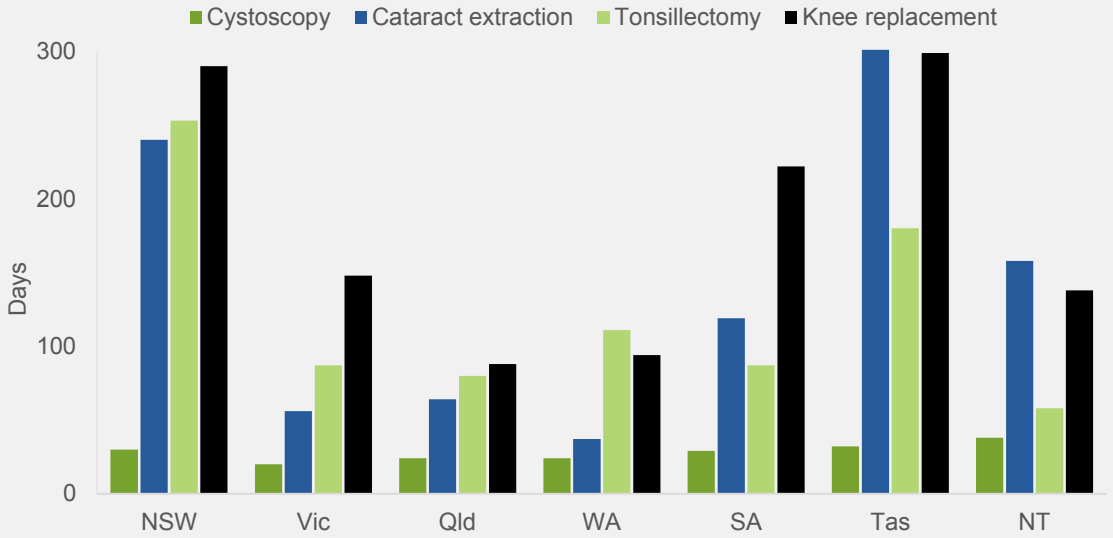
Box 9.2 Waiting times for elective care

Waiting times for initial **public outpatient** appointments vary a lot depending on clinic resources and the urgency of the patient's condition. Patients with urgent conditions may be able to make an appointment immediately. Other patients (with less urgent conditions) are placed on a waiting list, and may face very long waiting times (up to several years). For example, of patients attending a public 'general surgery' clinic in the first quarter of 2017 in Queensland, 10 per cent of patients with the *most* urgent conditions had waited longer than 35 days, while 10 per cent of patients with the *least* urgent conditions had waited longer than 438 days (Queensland Health 2017c).

Private outpatients may not be able to see a particular specialist for a consultation immediately, but waiting times are usually shorter than for public outpatients (especially for less urgent conditions). Instead of being added to a waiting list, private outpatients are more likely to be asked to make an appointment a few weeks or months in the future. There are limited data on waiting times for private outpatient consultations. One study found that patients in Melbourne waited an average of 33 days for a private paediatric outpatient appointment (Kunin et al. 2017).

Elective surgery waiting times for **public inpatients** also depend on clinical urgency. In 2015-16, the median waiting time for elective surgery in a public hospital was 37 days. However, many patients faced much longer waiting times — 10 per cent waited longer than 260 days (AIHW 2016f). Waiting times varied by procedure, and across States and Territories (figure below). The median waiting time for elective surgery in public hospitals is longer for patients residing in more disadvantaged areas (AIHW 2016a). There are limited data on waiting times for elective inpatient care other than surgery.

Median waiting times for common elective surgeries in public hospitals, 2015-16



Source: AIHW (2016f).

9.3 Increasing referral choices for patients

As discussed above, referral is the key decision point for not only an initial outpatient consultation but also which hospital the patient is admitted to if they need such care.

The Commission proposes that patients should be offered 'referral choice'. In particular, when patients are given a referral for an initial specialist consultation, they should always be given an opportunity (following support from their GP) to choose either the:

- public outpatient clinic they attend (with the specialist chosen by the clinic)
- private specialist they see (usually in private rooms and can involve out-of-pocket charges).

The Commission is not proposing that public outpatients or public inpatients be able to choose which specialist treats them. Providing such choice, while inherently desirable, cannot be justified on the basis of the high cost. In public clinics and hospitals, doctors work in teams. Allowing doctors to allocate work within these teams is important for efficiency and for the education of trainee doctors. The Royal Australasian College of Physicians cautioned that:

> Introducing patient choice at the specialist level would therefore have significant potentially negative implications for teamwork and workload allocation at public hospitals. (sub. 473, p. 4)

Well-established clinical norms dictate that (where possible) public outpatients are admitted to the hospital attached to the public outpatient clinic they attend, and private outpatients are admitted to a (private or public) hospital where the specialist they saw for their outpatient consultation has admitting rights. The Commission does not propose changing these norms, as doing so could interfere with patient safety and impede efficiency.

Once admitted to hospital (public or private) patients may be referred to other doctors within the hospital, or may even be transferred to another hospital — depending on clinical need and resource availability. The Commission has determined that the benefits of increasing choice for public inpatients *once they have been admitted* do not justify the potentially very large costs — such as a patient occupying a hospital bed while waiting for a bed at their 'chosen' hospital to free up.

GPs are best placed to support patients' referral choices

Several participants stressed the importance of supporting the healthcare decisions of patients (Australian Healthcare and Hospitals Association sub. 427; Jeanette Sheridan sub. 451; the Victorian Healthcare Association sub. 464).

GPs are uniquely well placed to provide this support for patients' choosing which public clinic or private specialist they go to for an initial outpatient appointment. GPs understand the circumstances of the referral best, they are with patients at the point of referral, they often know the patient well, and patients trust their opinion. 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 and patients are currently supported to choose a provider or service'.

Patients' ability to make referral choices, and GPs' ability to support these choices, would be improved by better access to information on individual specialists and hospitals (such as their clinical outcomes and specialists' out-of-pocket charges). The Royal Australian College of General Practitioners (sub. PFR337, p. 1) stated that 'sufficient information to support patient choice is often unavailable to both the patient and GP'. The Australian Medical Association was also concerned about the resources available to GPs to support patient choice.

> Overall, GPs are not currently funded or equipped to provide the types of services and information needed to make the full range of patients health literate, informed and skilled to make their own choices. (sub. 481, p. 5)

In addition to the reforms proposed in this chapter to increase choice, the Commission has recommended changes to information provision in chapter 10 to support choice. However, patient choice should not be postponed until information provision improves. Patients can already access some information to help them make choices on alternative hospitals and specialists, such as the advice of their GP, published waiting times for hospital admissions, and the views of the patient's family and friends. GPs collect information — such as from nearby specialists and other GPs — to inform their referrals. They should share this information with patients to support choice, where they do not already do so.

The extent to which GPs currently support patients to make referral choices is not clear. The Commission heard of GPs that consistently support their patients' referral choices (when desired by their patients), and of GPs that usually make referral decisions on behalf of their patients. Where most GPs are along the spectrum between these extremes is not known.

GPs generally draw on patient input when referring patients. For example, the GP may gauge from the patient whether they have private health insurance, their willingness to pay out-of-pocket costs, where they live, how important timeliness and quality of care are to them, or other relevant information (such as a preference for a specialist they have seen previously).

GPs may limit the options they provide to patients for good reason. Evidence suggests that patients do not like being overloaded with options. Patients given too many options may be overwhelmed, and therefore more likely to avoid choosing or to remain with the default choice, such as the nearest hospital (Dixon et al. 2010). Overwhelming patients with choices disempowers them, rather than empowering them. Some patients may wish to rely on their GP to make choices for them (Tricia Damé, sub. 449).

Where GPs make referral decisions on behalf of their patients, they may default to the easiest option (such as referring to a specialist they know) or base their decisions on incorrect assumptions about patients' preferences. Scott, Yong and Mendez (sub. 87, p. 5) suggested that current GP referral behaviour may be 'dominated by referral networks and preferred

specialists, rather than factors important to patients such as the lowest price, waiting time, or quality of care'.

The Macquarie University Centre for the Health Economy (MUCHE) recently surveyed one thousand Australians aged 50–75 and found that many patients would prefer to make referral choices with their GP, rather than have their GP make decisions on their behalf (Cutler, Gu and Olin 2017). In particular, 85 per cent of those surveyed said they would prefer their GP to discuss with them the options for choosing a hospital. Only 5 per cent wanted their GP to choose a hospital without any input from the patient.

In sum, patients should always be given the option to make referral choices, and should receive assistance from their GP to choose the referral pathway that best suits their circumstances and needs. If they wish, patients can leave their GP to make referral decisions for them, but the expectation is that GPs will support patients' referral choices. This includes patients with low health literacy, who may require more support from their GPs.

To help GPs support patients' referral choices, the Australian Government should:

- develop best-practice guidelines for GPs on how to support patient choice, as part of a broader strategy to inform and assist GPs, specialists and other health professionals to implement the reforms
- amend regulations governing referrals to make it clearer that patients can choose an alternative to a specialist named in their referral (discussed below).

Some participants suggested a possible role for 'system navigators' to support patient choice (Australian Healthcare and Hospitals Association, sub. 427; Diana Voss, sub. 450; Tasmanian Government, sub. 485). System navigators already play a role supporting some patients with cancer or diabetes to make more complex treatment decisions. The Commission's view is that GPs are uniquely well placed to support patients' *referral* choices. Additionally, it would likely be very expensive to duplicate GPs' role by providing system navigators — even if only to some patients. With GPs better placed to support patients' referral choices, this cost is difficult to justify.

Choice reforms in England included a national online booking system that allows patients to book their outpatient appointment online, either while in the GP's office or by themselves after receiving a referral. The Commission considered such a system, but found the potential costs difficult to justify at this time. It would likely be expensive and complex to implement across states and territories. The National Health System in England spent £280 million on its 'Choose & Book' system between 2002 and 2012 (Dusheiko and Gravelle 2015). The Queensland Government (2016) has announced a more modest plan to provide online booking for public outpatient appointments by 2020.

Clarifying and amending referral regulations

The Health Insurance Regulations 1975 set out conditions that referrals need to satisfy so that specialist consultations qualify for Medicare payments. The Australian Department of Health advised the Commission that under the regulations:

- referrals do not need to name a particular clinic or specialist
- any specialist can accept a referral to a specialist of their type, irrespective of whether another person is named as the specialist in the referral.

However, the regulations are not clear and are often misinterpreted — they should be amended for clarity. The Commission has heard that patients often (unnecessarily) contact their GP's office to get the name of the specialist on a referral letter changed. Clarifying the regulations would remove this burden from patients and GPs.

Amending the regulations would also make it clearer that, after receiving a referral and associated advice from their GP, patients have the right to independently choose which private specialist to go to for their initial consultation. This includes going to a specialist (of the same specialty) other than the private specialists or public clinic named in the referral. This could increase competition among private specialists, by reducing the importance of established referral networks. The Commission has proposed changes to how public outpatient clinics handle referrals so that patients can also independently choose which public clinic they go to (discussed below).

GPs would still have a vital role to play in supporting patients at the point of referral, including patients who wish to choose by themselves after leaving the GP's office. GPs could provide these patients with a short list of recommended options and information about these options; advise them of specialists, public clinics or hospitals to avoid; and direct them to useful sources of information. Patients would still be able to rely on their GP to make decisions on their behalf, if they wish.

DRAFT RECOMMENDATION 9.1

The Australian Government should amend the Health Insurance Regulations 1975 to make it clearer that patients referred to a specialist can choose the public outpatient clinic or private specialist they attend for their initial consultation. This includes clearly specifying that:

- referrals do not need to name a particular clinic or specialist
- any specialist can accept a referral to a specialist of their type, irrespective of whether another person is named as the specialist in the referral
- when making a referral to a specialist, general practitioners (GPs) must explain to patients that they can attend a specialist or public outpatient clinic other than the one named in the referral, and patients can choose independently after receiving support and advice from their GP at the time of referral
- referral letters should clearly indicate that patients must be offered choice by their GP, can attend a specialist or clinic other than the one named in the referral, and can choose independently after receiving the referral.

DRAFT RECOMMENDATION 9.2

The Australian Government should develop, with general practitioners (GPs), best-practice guidelines on how to support patient choice. These should form part of a broader strategy — designed with the relevant professional bodies — to help GPs, specialists and other health professionals implement the amendments to the Health Insurance Regulations 1975 in draft recommendation 9.1.

Removing restrictions on choice of public outpatient clinic

GPs almost always refer public outpatients to the public clinic nearest their home, although some GPs in regional areas may instead refer patients to a clinic in the nearest city.

In most States and Territories, GPs can refer patients to any public outpatient clinic, although clinics sometimes refuse a referral if there is another clinic nearer the patient's home (Cutler, Gu and Olin 2017). For example, Victorian guidelines specify:

> If a referral is received for a service that could be provided at a facility closer to the patient's home, specialist clinic staff may contact the referrer and ask them to redirect the referral. However, … [p]rovided there are valid reasons why the patient should be seen at the original hospital, the referral should not be refused on the basis of the patient's location. (Victorian Department of Health 2013, p. 13)

In practice, uncertainty about whether a referral will be refused encourages GPs to refer to the clinic nearest the patient's home.

In some areas, GPs may not refer patients directly to a public outpatient clinic — the GP may send the referral to a local hospital network,[6] which then refers the patient on to a clinic (typically the nearest to the patient's home). In Perth, non-urgent GP referrals to public clinics are required to be sent to the WA Central Referral Service, which identifies the catchment area in which the patient lives, and sends the referral on to the clinic for that catchment area.

Restrictions on choice of public outpatient clinic may have worthwhile aims, such as ensuring patients are not unknowingly referred to a clinic further away than necessary, and preventing patients from joining waiting lists for multiple clinics (with the intention of going to the clinic that offers them the earliest appointment). However, these aims could be achieved in ways that do not impinge on patients' referral choices.

Several State and Territory Governments have suggested that there may be significant administrative costs associated with patients who join the waiting lists at multiple public outpatient clinics, and then opt to be treated at the clinic that gives them the earliest appointment. This behaviour may also make it more difficult to assess demand for services and to predict waiting times. The Commission considers that patients should only be allowed to join one waiting list. State and Territory Governments could monitor waiting lists to identify patients on more than one (as some States already do). Public outpatient clinics could also publish more timely and accurate information on their expected waiting times, to reduce the incentive to join multiple waiting lists and inform referral choices.

All State and Territory Governments should remove restrictions on which public outpatient clinic a patient can attend, including by directing public outpatient clinics to accept any valid referral for a patient whose condition they cover. As well as increasing choice, this may reduce the administrative burden of re-routing a patient whose referral has been refused by a clinic. Where a local hospital network or the WA Central Referral Service processes referrals, these referrals should be able to specify which public outpatient clinic the patient has chosen to attend.

State and Territory Governments should direct all public outpatient clinics in their jurisdiction to accept valid referrals directly from patients. Where a local hospital network or the WA Central Referral Service is responsible for processing referrals, they should similarly be directed to accept referrals from patients.

Currently, a GP referring a patient to a public outpatient clinic usually sends the referral directly to the clinic. The clinic then contacts the patient to make an appointment or let them know they are on the waiting list. GPs should instead give patients the option to submit the referral to the clinic (or local hospital network). If patients wish, these changes would allow them to independently choose which public clinic to go to, after receiving a referral and advice from their GP.

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6 The term 'local hospital network' is used in the National Health Reform Agreement to refer to regional bodies that can go under a different label in individual jurisdictions, such as local health district (New South Wales), hospital and health service (Queensland), or Tasmanian health organisation (AIHW 2013b).

DRAFT RECOMMENDATION 9.3

State and Territory Governments should direct their public outpatient clinics to accept any patient with a referral letter for a condition that the clinic covers, regardless of where the patient lives. Where a local hospital network or the WA Central Referral Service processes referrals, that service should be directed to:

- allow patients to lodge requests for an initial outpatient appointment when they have received a referral
- give patients the option of specifying the public outpatient clinic they will attend.

Making patient travel assistance schemes more flexible

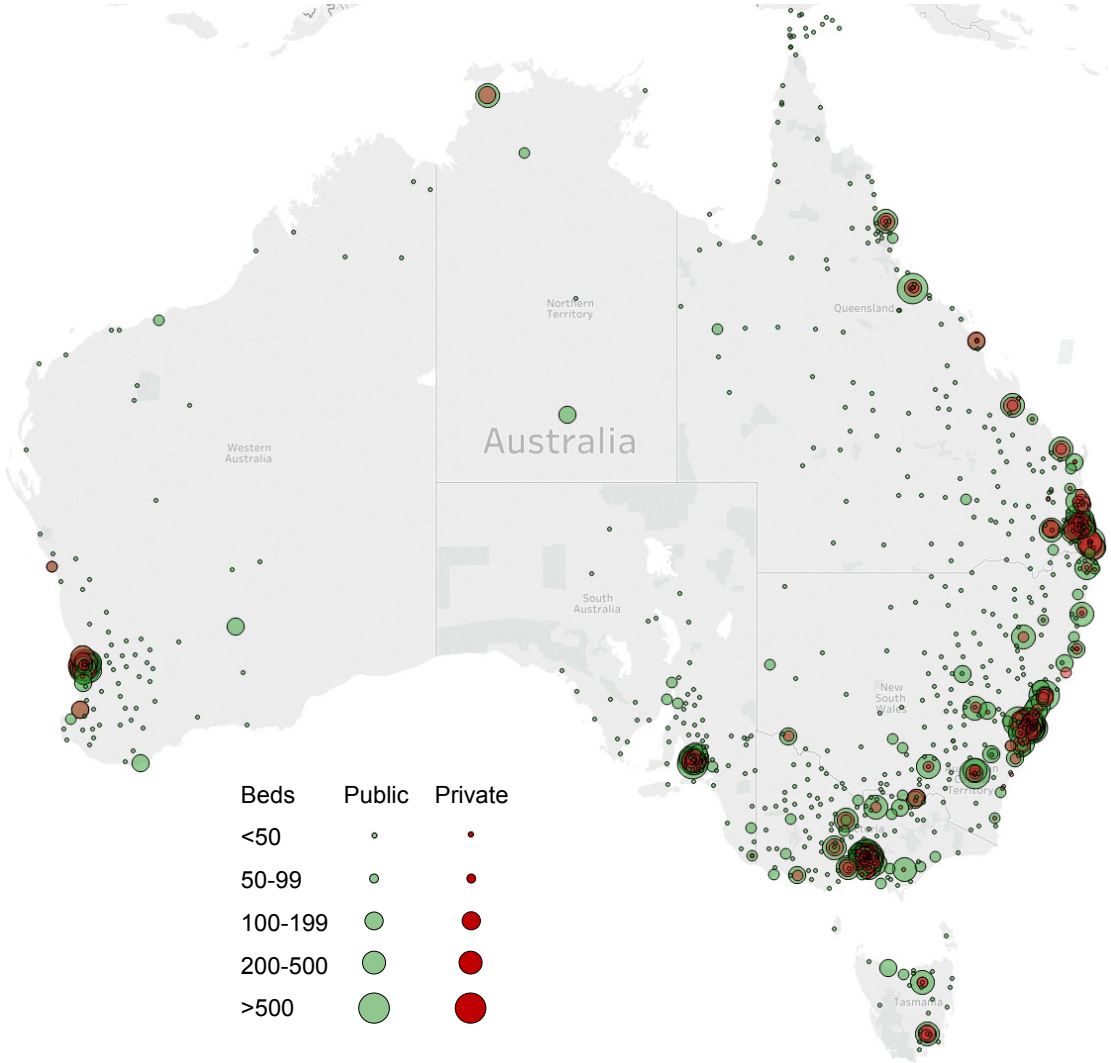
Patients living outside major cities tend to have less access to elective care. Over 87 per cent of all specialists locate their practices in major cities and only 3 per cent decide to provide their services in outer regional, remote and very remote areas (Scott, Yong and Mendez, sub. 87). Hospitals are clustered around major cities (figure 9.3) — particularly larger public and private hospitals, where most elective surgery is performed.

As getting to alternative providers may involve significant travel (with its associated time and financial costs), it may be more difficult for patients in regional and remote areas to exercise referral choices. The Australian Healthcare and Hospitals Association noted that:

> For many consumers there is no practical alternative public hospital that can be selected (e.g. if the nearest geographic alternative involves an unreasonable travel burden) … (sub. 427, p. 5)

Nonetheless, there is evidence that those living in regional and remote areas may be more willing to consider, and travel further to, alternative providers. The MUCHE survey found that respondents living outside major cities were more willing to travel longer distances (up to 60 kilometres) to attend a better quality hospital (Cutler, Gu and Olin 2017). Similarly, a survey of more than 2000 English patients found that those living outside of urban centres were more likely to choose to attend a non-local hospital (up to two hours away) (Dixon et al. 2010).

Figure 9.3 **Location and size of hospitals, 2016[a]**



[a] Data are for July 2016. Bed counts include chairs for same-day admissions.

Sources: AIHW (2016k) and Productivity Commission estimates of bed numbers where AIHW data are not available.

All State and Territory Governments run patient travel assistance schemes which give financial assistance to patients who must travel long distances to access specialist medical treatment (National Rural Health Alliance 2014). The level of assistance is based on the cost of getting to the nearest provider and in most jurisdictions is only available to patients that go to the nearest provider.[7] Allowing eligible patients to claim assistance regardless of which healthcare provider they choose to attend, while still basing the level of assistance on the cost of getting to the nearest provider, would increase patients' referral choices without costing governments significantly more.

7 Assistance may be paid to patients (often on return of receipts) or directly to providers of transport or accommodation, depending on the patient's preference (and jurisdiction).

DRAFT RECOMMENDATION 9.4

State and Territory Governments should change patient travel assistance schemes so that assistance is available to eligible patients regardless of which healthcare provider they attend. The level of assistance should continue to be based on the cost of getting to the nearest provider.

Monitoring the effects of reforms

The Australian Government should monitor the effects of these reforms to identify where fine tuning is warranted. This could include surveying patients to establish to what extent, and in what way, GPs are supporting patients' referral choices, and whether patients require other support. The Australian Government could also survey GPs or specialists to establish that they understand the referral guidelines, and whether (and how) the Government should further assist GPs to support patients' referral choices. Five years after introducing the reforms, the Australian Government should undertake a comprehensive evaluation to assess the costs and benefits, and whether further changes are needed.

DRAFT RECOMMENDATION 9.5

The Australian Government should undertake an evaluation of the referral choice reforms five years after they commence operation.

9.4 Benefits and costs of increasing referral choices

This section discusses the key benefits and costs of the draft recommendations.

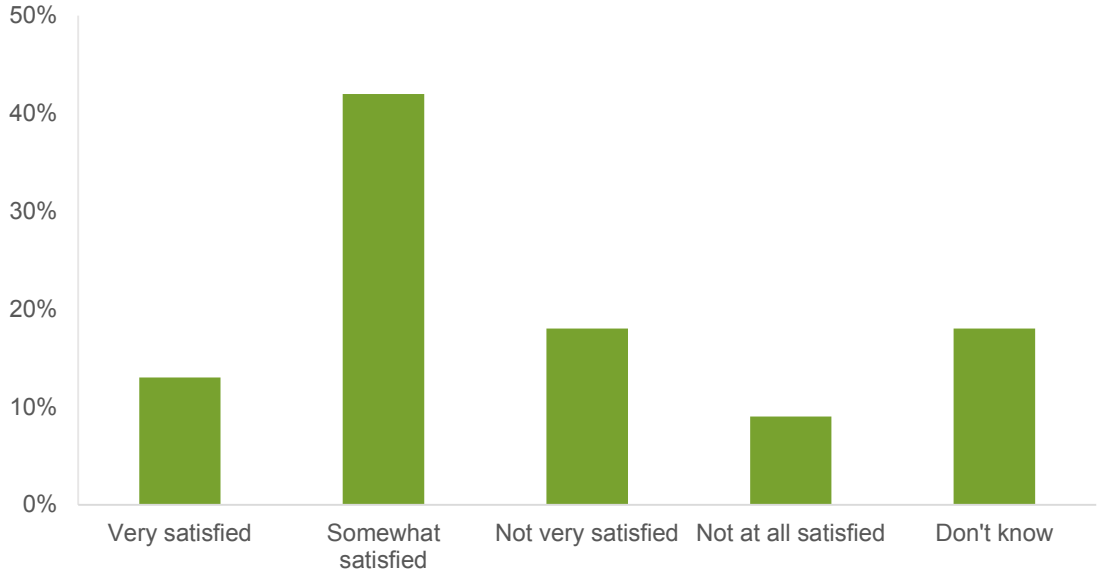
Intrinsic value of referral choices

As discussed in chapter 1, choice has intrinsic value by empowering people to have greater control over their lives. By supporting patients to make decisions about their own health care, these reforms aim to benefit patients through empowering them. Reviewing choice in the English public health system, Dixon et al. (2010, p. 13) argued that choice of hospital is justified by its intrinsic value, citing a link between providing a choice and 'positive psychological indicators such as perceived control, intrinsic motivation, task performance and life satisfaction'.

The limited Australian evidence also suggests that most public patients would like more choice. The MUCHE survey found that about 70 per cent of respondents were either somewhat satisfied, not very satisfied or not at all satisfied with the amount of choice

available in the public hospital system (and a further 18 per cent responded 'don't know') (figure 9.4). This is comparable to survey results from other countries (Coulter 2004). For example, 75 per cent of patients in an English survey said that being offered a choice of hospital was either important or very important to them (Dixon et al. 2010). Patients' desire for choice may reflect its intrinsic value or other benefits (discussed below).

Figure 9.4 **Satisfaction with choice in the public hospital system[a]**



[a] Based on a survey of one thousand 50- to 75-year-old Australians in December 2016.

Source: Cutler, Gu and Olin (2017).

Referral choices let patients satisfy their individual preferences

Patients differ in many ways, including where they live, their ability (or willingness) to pay out-of-pocket costs, and preference over the timing of their care. Increasing patients' referral choices would allow them to choose providers that better match their individual preferences, such as choosing a public clinic further from home with a shorter waiting time (box 9.3).

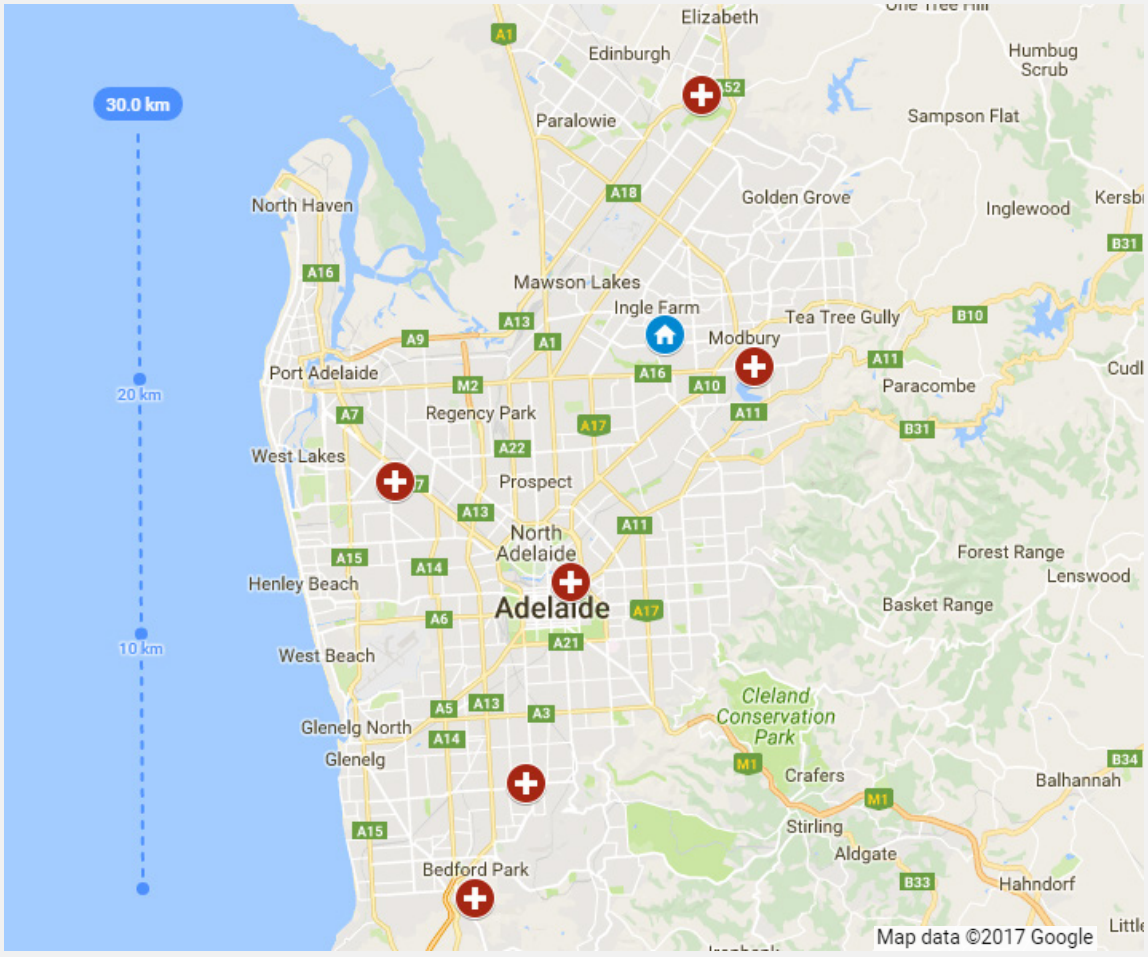
When patients in England were given more choice in the mid-2000s, they became more likely to bypass the nearest hospital in favour a more distant alternative. The share of patients attending their nearest hospital fell from three-quarters (in 2002-03) to one-half (in 2012-13) (Moscelli, Siciliani, Gutacker and Gravelle 2016).

Box 9.3 Case studies: potential benefits of proposed reforms

Jess lives in Ingle Farm, a suburb of Adelaide (the blue house on the map below). Her GP decides to refer her to a neurologist. Jess tells the GP she does not have private health insurance and does not want to pay any out-of-pocket costs. The GP tells her there are six public neurology clinics around Adelaide (red crosses on the map — at Modbury Hospital and Lyell McEwin, each about 15 minutes' drive), Royal Adelaide Hospital and Queen Elizabeth Hospital (each about 30 minutes' drive), and Repatriation General Hospital and Flinders Medical Centre (each about 45 minutes' drive).

The GP gives Jess a brief rundown of what he knows about each of the clinics. He explains to Jess that she can take the referral and do some more research before choosing which clinic she would like to go to, which Jess agrees to. Jess speaks to her brother, who is a nurse, and looks up some information on hospital waiting times on the MyHospitals website. She decides to send her referral to the clinic at Royal Adelaide Hospital in central Adelaide.

Jess has benefited from being able to make an informed choice in line with her preferences, and being able to attend a public clinic other than the one closest to her house. She also felt empowered in gathering her own information on the six options and choosing between them.



(Continued next page)

Box 9.3 (continued)

Adam lives in Thirroul, about 20 minutes' drive north of Wollongong. His GP decides to refer him to a dermatologist. The GP asks Adam whether he has private hospital insurance and discusses Adam's choice to be treated as a public or private outpatient. Adam decides he would like to be treated as a private outpatient as he wants to be seen straight away, although his condition is not urgent. The GP tells Adam there are numerous private dermatologists in Wollongong and offers to discuss a few with Adam, but Adam says he is happy to go to any local dermatologist the GP recommends. The GP gives Adam a referral, and the details of three dermatologists — thinking that at least one will be able to see Adam immediately — for Adam to call to make an appointment.

Through discussion with his GP, Adam has satisfied his preference for an immediate appointment, without being overwhelmed with choice. Without the referral regulations being clarified, Adam may have had to contact the GP's office to get the name of the specialist on the referral changed. Both he and the GP's office have avoided this complication.

John lives in Emerald, in Queensland. His GP decides to refer him to an orthopaedic surgeon for a problem with his elbow. When asked, John tells his GP he does not have private health insurance and prefers to not to go to a specialist that has out-of-pocket charges. John also says that he prefers not to travel more than necessary. The GP explains to John there is no orthopaedic clinic at Emerald Hospital and that, as the nearest orthopaedic surgeon is more than 50 km from Emerald, John qualifies for assistance under Queensland's Patient Travel Subsidy Scheme.

The GP tells John that there are orthopaedic clinics attached to both Rockhampton Hospital (about 3 hours' drive) and Gladstone Hospital (about 4 hours' drive) where John can go and not pay any out-of-pocket costs. The GP gives John her opinion on the two options and explains to John that he can take the referral and go away and think further about the choice before sending the referral to the clinic of his choice — John likes this idea. Over the next few days, John looks up information on each hospital on the MyHospitals website, and speaks to a friend who has recently been to Gladstone Hospital, before choosing to send his referral to the Gladstone clinic.

John has benefited from being able to make an informed choice that meets his needs and receiving travel assistance towards the cost of this attendance. Additionally, he felt empowered in taking control of the decision between the two public clinics.

Precisely how Australian patients would respond to greater choice is uncertain, given that there is limited information on the service characteristics they value when choosing a specialist, clinic or hospital. In the MUCHE survey, respondents choosing between (hypothetical) hospitals cared most about quality of care — as indicated by average health gains, rates of readmission and adverse events. Respondents' choices indicated they would be willing to travel further and wait longer to access better quality hospitals (Cutler, Gu and Olin 2017).

Evidence from other countries suggests that many patients choose the nearest hospital by default, although they also care about other hospital characteristics such as quality of care and waiting times (Kolstad and Chernew 2009). Patients that have had a bad experience at the nearest hospital are more likely to choose one further afield, while patients with poor mobility are less likely (Dixon et al. 2010). The Royal Australian College of Physicians (sub. 473) noted that English studies have found that older patients, those having chronically

poor health, and those reliant on public transport are less likely to choose an alternative to the local hospital.

Patients' referral choices can drive service improvements

More patient choice over provider — specialist, clinic or (implicitly) hospital — can drive these providers to compete for patients, by increasing service quality and becoming more responsive to patients' needs and preferences (such as by improving hospital amenities). Competition for patients can also drive providers to improve efficiency, in order to free up resources that can be used to attract or service more patients. Private specialists can also attract patients by reducing out-of-pocket costs (box 9.1).

There is limited Australian evidence on the effects of competition between healthcare providers. Two studies of public and private hospitals in Victoria have produced mixed findings. Palangkaraya and Yong (2013) found that greater competition was associated with fewer unplanned readmissions for cardiac patients but also a slight increase in mortality. Chua, Palangkaraya and Yong (2011) found an ambiguous relationship between competition and hospital efficiency. A recent study of Australian GPs — which, like private specialists, set their own prices — found that more competition leads to more bulk-billing and lower out-of-pocket charges, without affecting consultation length (which is associated with quality of care) (Gravelle et al. 2016).

There is extensive evidence from other countries (mostly from England and the United States) on the effects of competition between hospitals. Where hospitals are not able to set prices — as with public clinics and public hospitals in Australia — greater competition among hospitals is generally associated with higher quality (box 9.4; Gaynor 2006). There is limited evidence on the effects of competition between specialists (Gaynor and Town 2012).

Considering the available evidence, and the structure of Australia's health system, the Commission considers it unlikely that the proposed reforms to patients' referral choices would alone drive dramatic improvements in public hospital services. However, these reforms are likely to sharpen the incentives to hospitals and specialists to establish or maintain a good reputation, to be responsive and provide high-quality care to patients, and (for private specialists) to keep their prices competitive.

Box 9.4 Patient choice in England

In England, a range of reforms were introduced from 2006 to increase patient choice. Prior to 2006, GPs referred public patients needing elective care to a clinic at the nearest hospital. In 2006, patients were given some choice over which hospital they attended, and from 2008 they have been able to choose any public or private hospital covered by the English National Health Service. Patients also have access to a useful website to compare alternatives (chapter 10) and an online booking service (Choose and Book).

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 (Gaynor, Moreno-Serra and Propper 2013). Among people seeking a coronary artery bypass graft, choices made by sicker patients were more sensitive to reported mortality rates (Gaynor, Propper and Seiler 2012)
- hospitals in more competitive locations generally improved service quality the most — death rates for patients admitted after a heart attack fell the most in hospitals that had more nearby competitors (Cooper et al. 2011). Hospitals located in more competitive areas also had larger declines in mortality from other causes and lower lengths of stay for elective surgery (Gaynor, Moreno-Serra and Propper 2013). However, one study found that the reforms increased emergency readmissions for patients who had hip or knee replacements, and had no effect on hospital quality for coronary bypass patients (Moscelli, Gravelle and Siciliani 2016).

The cost of GPs' time to support patient referral choices

GPs receive funding from the Australian Government through Medicare according to the length of their consultation (table 9.2). Both the Royal Australian College of General Practitioners (sub. PFR337) and the Australian Medical Association (sub. 481) stated that giving patients more choice would increase the length of some GP consultations and hence their cost. The Commission agrees.

As noted, some GPs already support their patients' referral choices, and so these GPs are already reimbursed for supporting choice through existing Medicare consultation rebates. The *additional* cost to the government of GPs providing *additional* support for patients' referral choices would depend on the likelihood that a consultation extends into a longer consultation category (and is charged at a higher rate). However, data limitations make it difficult to estimate this likelihood accurately.

Beyond the existing Medicare consultation rebates, the Commission does not consider that any additional payments should be made to GPs for supporting patients' referral choices. The benefits to patients of having their choices supported (if they desire it) are likely to outweigh the additional cost to the Australian Government of additional GP time (namely, the cost of some consultations being charged at a higher rate).

In 2015-16, patients paid out-of-pocket charges for about 15 per cent of GP consultations (the rest were bulk-billed) (Department of Health 2016a). These patients could face higher

out-of-pocket charges if their consultations lengthen due to the GP spending more time supporting their referral choices. If this is likely to be the case, the GP should tell the patient so that the patient can decide whether they want the consultation to continue.

Table 9.2 **Medicare schedule for GP consultations**

Consultation type	*Current rebate*[a]	*Per cent of consultations*[b]	*Definition*
Level A	$16.95	3.0	Consultation for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
Level B	$37.05	81.2	Consultation **lasting less than 20 minutes**, including any of the following that are clinically relevant: taking a patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Level C	$71.70	14.4	Consultation **lasting at least 20 minutes**, including any of the following that are clinically relevant: taking a **detailed** patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
Level D	$105.55	1.3	Consultation **lasting at least 40 minutes**, including any of the following that are clinically relevant: taking an **extensive** patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.

[a] As at May 2017. Rebates shown are for consultations at consulting rooms. Other rebates apply for consultations in nursing homes or elsewhere. [b] In 2015-16.

Sources: Department of Health (2017d); DHS (2016).

The clinical and economic costs of low volume

If increasing referral choices for patients leads to a particular hospital or specialist providing fewer services, the volume of patients served by these providers could fall below the necessary minimum levels for clinical or economic scale. Clinical scale refers to the volume–outcome trade-off that exists for some hospital services — as the volume of services being provided falls, the quality of outcomes from those services also falls. For example, for some types of surgery, those hospitals where more operations are performed in a year provide better outcomes for their patients on average (Luft, Bunker and Enthoven 1979).

Economic scale refers to the ability to spread fixed costs among a sufficiently high number of services, so that the services can be provided at reasonable cost. For example, a hospital may need to perform a sufficiently high number of magnetic resonance imaging (MRI) scans to spread the high fixed costs of an MRI machine (and justify its purchase). More generally,

a hospital may need to have a sufficiently large number of patients to spread the fixed costs of running the facility.

Specialists, clinics and hospitals that are operating at relatively low service volumes — including in regional and remote areas — may be more susceptible to scale issues. The Australian Healthcare and Hospitals Association stated:

> If consumers respond strongly to increasing public hospital competition by seeking out higher performing clinicians or hospitals, with reduced demand for what is perceived as lower quality services, the risk profile and efficiency of each facility will be altered, and may well result in services or hospitals becoming operationally and financially unsustainable. Of concern is the impact this would present for public hospitals in remaining accessible and responsive to local community need, particularly for smaller regional services. (sub. 427, p. 5)

Similar views were put by the Australian Medical Association (sub. 481) and the Tasmanian Government (sub. 485).

The Commission considers that scale issues are not a sufficient reason to restrict patients' referral choices. Apart from the benefits to patients of having choice, the risk of patients choosing an alternative provider is one way in which providers may be driven to improve (discussed above). A fall in a provider's patient volumes is a signal that the:

- provider may need to make its services more attractive to patients, such as by improving service quality or (for private specialists) reducing prices
- State or Territory Government or local hospital network may need to reconsider the allocation of resources within the jurisdiction and/or remedial action to improve service quality.

Would the private health system be affected?

Some participants argued that increasing choices for public patients could reduce demand for private health insurance, and increase the burden on the public health system (for example, Australian Medical Association, sub. 481; National Rural Health Alliance, sub. 428). Catholic Health Australia noted that:

> … offering choice of provider may risk undermining one of the key benefits of private health insurance – which could ultimately lead to adding further demand on the public hospital system. (sub. 440, p. 5)

The effect of the proposed reforms on the private health system depends on their effect on both the decision to take out private hospital insurance (on which there are some data), and the decision to access private outpatient or hospital services (on which data are limited).

Just under half of all Australians held private hospital insurance in March 2017 (APRA 2017). A 2014-15 ABS survey found that, on average, people had private hospital insurance for three or four reasons. The most commonly cited reasons were security or protection or peace of mind; allow treatment as private patient in hospital; and shorter

waiting times. About one-third of those with private hospital cover gave 'choice of doctor' as one of their reasons (ABS 2016c).

The Commission considers that its proposed choice reforms are unlikely to have a significant effect on the take up of private hospital insurance, or on the private–public balance of hospital services in Australia. They would not affect the advantages of being admitted to hospital as a private (rather than public) patient, such as being able to choose the treating specialist and avoid waiting times in the public system by choosing to be treated in a private hospital. Patients who initially attend a public outpatient clinic would still be treated by specialists chosen by managers in the public system.

10 Information to support patient choice and provider self-improvement

Key points

- Patients are given almost 14 million referrals annually for specialist health care and can already draw on some information to choose between alternative providers, such as published waiting times and the experiences of family and friends.
- However, more information could be publicly reported to facilitate comparisons between alternative providers, including on clinical outcomes and the wide variation in out-of-pocket charges for private specialist outpatient consultations.
- Other countries have shown that it is possible to publish more information on individual service providers to further empower patients and help general practitioners (GPs) to support them.
- In addition to the benefits for patients, there is also evidence that publishing more information would prompt service providers to engage in greater self-improvement activity.
- To better inform patients and their GPs, and encourage more self-improvement by service providers, the Australian, State and Territory Governments should commit to:
  - releasing all data they hold on individual hospitals and specialists unless it would clearly harm the interests of patients
  - disseminating the information nationally through an improved MyHospitals website
  - allowing non-government organisations to use the data in advisory services they provide
  - phasing-in public reporting on individual specialists, possibly beginning with their registration details, followed by process data (such as location, levels of activity and out-of-pocket charges), user ratings and reviews, and, in the longer term, whether clinical outcomes are within an acceptable range.
- The Commission's recently completed inquiry on data availability and use recommended a package of broader reforms to make data already gathered by governments and others more accessible. These would complement the health care-specific information reforms proposed in this report.

The Commission is proposing a number of reforms to improve published information on hospitals and specialists to better support choice for patients and self-improvement by service providers (hospitals and clinicians) (table 10.1). Central to the reforms is strengthening and expanding the commitment to public reporting that the Australian, State and Territory Governments made in the 2011 National Health Reform Agreement.

The Commission also considered what additional information governments would need to make public hospital services more contestable (detailed later in this chapter). In summary, history has shown that it can be very challenging for governments to sufficiently codify and

measure required performance, as demonstrated by safety and quality breaches in public hospitals and failed attempts to outsource entire hospitals. While this remains the case, policy makers should be cautious about considering more contestable approaches that delegate the provision of public hospital services to an external provider. The Commission is therefore not recommending changes to make public hospital services more contestable than currently.

Table 10.1 **Overview of proposed health information reforms**

Proposed reforms	*Timeframe*	*Potential costs and benefits*
Strengthened government commitment to public reporting		
Draft recommendation 10.1		
Australian, State and Territory Governments to adopt a general policy of publicly releasing any data they hold on individual hospitals and specialists unless clearly demonstrated that it would harm the interests of patients	12 months	Cost of renegotiating health funding agreement but publishing information would support choice and improve patient outcomes by encouraging self-improvement by health care providers
Australian, State and Territory Governments to make data on individual hospitals and specialists available in a format that other organisations can readily include in advisory services they provide	As soon as practicable	Wider dissemination of information that supports choice and facilitates provider self-improvement
State and Territory Governments to require all specialists serving public patients to participate in public information provision (as specified by the Australian Institute of Health and Welfare)	12 months	Extra compliance costs for specialists and data processing costs for governments, but would facilitate patient choice and provider self-improvement
Australian Government to require specialists to participate in public information provision (as specified by the Australian Institute of Health and Welfare) in return for being eligible to provide Medicare-funded services to outpatients	12 months	Cost of amending legislation Extra compliance costs for specialists but will facilitate self-improvement and support choice
Improve the MyHospitals website		
Draft recommendation 10.2 Australian Institute of Health and Welfare to transform the MyHospitals website into a vehicle that better supports choice by patients, and encourages self-improvement by individual hospitals and clinicians. Australian, State and Territory Governments to provide relevant data and other assistance	Phase-in as data become available	Cost of data development and website redesign Better informed patients and will encourage provider self-improvement

10.1 Introduction

This chapter considers how reforming published information on individual hospitals and specialists could support greater patient choice, provider self-improvement, and contestability. There is a case for information provision in health care because suppliers typically have a significant information asymmetry over the patients they serve and governments that regulate and fund them (Arrow 1963).

Information provision is particularly important for contestability because governments should only contemplate a contestable model for public hospital services in cases where they are able to codify and measure required performance. It is also necessary to publish the collected information to make service commissioners and individual providers more accountable.

A further potential benefit from publishing information on individual providers is that it could prompt improved outcomes through two channels:

- patient choice (informed patients seeking out better performing providers)
- self-improvement by providers (through benchmarking against their peers).

Much of the research on the effects of publishing information on individual health care providers has focused on performance indicators — such as mortality rates — which are often not presented in a consumer-oriented format, cover only a small subset of service characteristics that patients value, and may not be sufficiently specific to a particular illness or treatment to be seen as relevant by individual patients.

This could explain why studies typically find that published performance indicators have rarely influenced choices made by patients (for example, Devlin and Appleby 2010; Dixon et al. 2010; Faber et al. 2009; Fung et al. 2008; Marshall and McLoughlin 2010; NZHQSC 2016a; Totten et al. 2012; Werner and Asch 2005). Other information sources have tended to be more widely used by patients, such as the views of their general practitioner (GP), friends and family (Day and South 2016; Victoor et al. 2012). Further research is required on whether there are more consumer-oriented approaches to public reporting which would encourage patients to make greater use of performance indicators (Boyce et al. 2010; Hibbard 2003). There could also be scope to make indicators more specific to the circumstances of individual patients and provide better support to interpret the information.

There is evidence that public reporting encourages service providers to engage in self-improvement activity, particularly at the hospital level, possibly because of a peer-pressure effect (Bevan 2013; Cacace et al. 2011; Campanella et al. 2016; Chen 2010; Fung et al. 2008; Lamb et al. 2013; Smith et al. 2009; Totten et al. 2012). This suggests that, even if patients do not use performance indicators, it is in the interests of patients to publish the data to encourage service providers to deliver more effective services in terms of quality and efficiency, as well as to make them more responsive and accountable.

10.2 What information would support choice, provider self-improvement and contestability?

If information is to support greater patient choice, provider self-improvement and contestability, it has to describe service characteristics that are valued by patients (as consumers) and governments (as system stewards). Its usefulness will also depend on whether

the amount of information, and its presentation, is tailored to the varying capacity and willingness of patients, their supporting GPs, service providers and governments to use it.

This section gives a broad of overview of the types of information that would support greater choice, provider self-improvement and contestability. It is not intended to be a detailed guide or to nominate specific indicators for a particular service characteristic.

Supporting patient choice

GPs would continue to play an important role in supporting patients under the choice model recommended in chapter 9 and so information needs to be accessible and useful to both groups. In some cases, patients may wish to rely solely on their GP to access and interpret the information but patients should, after an initial discussion with their GP, have the option of using available information to make choices independently.

The Commission's proposed choice model would provide scope to choose between different hospitals and/or specialists, depending on whether the patient initially goes to a public or private outpatient clinic. To support this model, information would therefore be needed on both individual hospitals and specialists (particularly if the specialist conducts outpatient appointments in a private clinic).

There are many service characteristics that patients can value, including:

- convenience (such as opening hours and distance from a patient's home)
- waiting time to receive the service
- out-of-pocket payments (for patients attending a private outpatient clinic)[1]
- courtesy of staff and clinicians
- amenity of facilities
- clinical outcomes.

Studies of hospital choice have found that distance from home is a major determinant of which provider is chosen, with patients tending to select the nearest hospital by default (Boyce and Browne 2013; Dixon et al. 2010; Kolstad and Chernew 2009). However, there is also evidence that patients will bypass the nearest hospital when its clinical or other outcomes are significantly worse than other providers (Beckert, Christensen and Collyer 2012; Gaynor, Propper and Seiler 2012; Moscelli, Siciliani, Gutacker and Gravelle 2016).

Patients have bypassed hospitals with worse outcomes despite (as noted above) rarely making choices based on published performance indicators. Studies have found that patients instead tend to rely on their own experience (particularly a bad experience with the nearest

[1] Out-of-pocket charges often vary significantly between specialists providing the same service (chapter 9).

hospital), that of friends and family, and the advice of their GP (Day and South 2016; Dixon et al. 2010). In Australia, these sources can provide information that is more relevant to a given patient's illness or treatment options than the (limited) performance indicators that governments currently publish (detailed below). A recent survey showed that Australians have less trust in the information published by governments compared to their own experiences, those of family and friends, and a GP's opinion (Cutler, Gu and Olin 2017).

Patients may wish to trade off different characteristics, such as choosing a closer facility with lower amenity, which suggests that they should be given information on as many traits as possible. However, there is a risk that the amount of information could far exceed what patients are able or willing to process, possibly facilitating indecision rather than choice. A balance therefore has to be struck that provides information with sufficient breadth and detail to assist patients but does not overwhelm them.

A further challenge is to accommodate the possibility of marked differences between patients in their ability and willingness to use information, including because of differences in health literacy (ACSQHC 2014b; Barber et al. 2009; Tasmanian Government, sub. 485). As noted above, making the information accessible and useful to GPs will help them to support patients to choose.

One way of accommodating the varying ability and willingness among patients to use information is to have an interactive website that has a limited number of headline indicators, possibly with visual aids such as infographics, but with the ability to drill deeper into the data as desired by an individual patient or their supporting GP. As detailed below, there are already websites in Australia that provide some information on individual hospitals and specialists but they have significant limitations in their current form.

Supporting provider self-improvement

To ensure alignment with patient preferences, the service characteristics reported for the purpose of encouraging provider self-improvement should be largely the same as those for supporting choice. The key difference is in how the information should be presented, with providers requiring detailed data to benchmark effectively, rather than more consumer-oriented summary measures. As noted above, consumer-oriented measures and the underlying data could be built into a single website, but this is not essential. What is critical is that the data intended for benchmarking are publicly available, rather than being restricted to service providers, and that they name individual providers so as to maximise the incentive to undertake self-improvement.

Supporting contestability

Compared to information that supports user choice, contestability will tend to require greater emphasis on performance indicators that measure clinical and other outcomes, so that governments can monitor whether policy objectives are being met. The indicators are likely

to need to be more detailed and technical than those designed for consumers. Timely reporting is also more important so that governments can intervene promptly when underperformance occurs.

A further difference is that governments are more interested than patients in accountability measures, such as levels of expenditure, to understand how well resources are being used to deliver health outcomes. As noted above, patients are largely influenced by convenience (particularly distance from home) but clinical and other outcomes are also influential when the nearest provider is considered to be significantly worse than more distant options.

The next section of this chapter identifies weaknesses in how State and Territory Governments currently monitor a range of performance indicators in their role as system stewards, and give public hospitals access to data gathered from their peers to encourage self-improvement.

10.3 How well does current reporting support choice, provider self-improvement and contestability?

The Commission's recent inquiry on data availability and use detailed how a large amount of information is collected on the health system for a variety of purposes, including to track activity and expenditure, process insurance claims and maintain electronic patient records (PC 2017). The Commission has also previously found that the collected data often have limited usefulness due to deficiencies in collection methods, restrictions on who can access the data, and because useful types of information are missing (PC 2015a). As a result, many potential benefits from health data are being forgone (table 10.2).

This section focuses on health data that are relevant to patient choice, provider self-improvement and contestability. Recent reviews of such data (discussed below) have found that the large amount of information gathered from hospitals and clinicians does not always give patients the information they need to be fully informed about choices, service providers to engage in self-improvement, and governments to undertake timely monitoring.

Table 10.2 **Types of health data, users, benefits and gaps**

Type of information	*Potential users and benefits*	*Key gaps*
Performance of individual health care organisations and clinicians (quality, safety, outcomes, costs)	Helps consumers to choose where to obtain treatment Enables governments, taxpayers and insurers to assess value for money and hold providers to account Encourages providers to compete to improve performance Helps organisations to identify good practices and ways to improve quality or reduce costs	Cost data and quality measures are not reported for all hospitals Measures of patient experience in hospitals vary across jurisdictions, and are not always timely or comprehensive No performance data currently reported for hospital clinicians, individual general practitioners or other professionals Information on the characteristics of patients treated is not always complete

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Table 10.2 (continued)

Type of information	*Potential users and benefits*	*Key gaps*
Patient health records	Improves the coordination of care by allowing health professionals to access and share data on individual patients Reduces risk of medical errors or duplicated testing Facilitates clinical and epidemiological research (using de-identified data)	Take up of national electronic health records has been modest, in part due to concerns over quality of included information
Other administrative data	Facilitates clinical and epidemiological research (using de-identified data) Enables research into policy impacts Supports development of an evidence base for improving medical practice, developing clinical guidelines or evaluating health treatments and technologies	Many data are collected, but it has been difficult for researchers to access or link datasets

Source: PC (2015a).

National reporting by governments

At a national level, patients can access information on individual specialists and other health professionals on a website maintained by the Australian Health Practitioner Regulation Agency (AHPRA). However, the website is essentially confined to providing a practitioner's registration details so that patients can check that they are dealing with a licensed professional.

There is a significant amount of national reporting on public hospitals, typically under the auspices of the Council of Australian Governments (COAG), but it is not well suited to supporting patient choice, provider self-improvement or contestability. Few of the reported indicators measure patient outcomes, and what is reported is often not disaggregated below state or territory level.

A further problem is that it is difficult to navigate the data because they are built on a complex system of frameworks and reports. There are currently three main reporting frameworks:

- National Health Performance Framework (NHPF)
- Performance and Accountability Framework (PAF)
- Report on Government Services (ROGS).

A recent review undertaken for the Australian Health Ministers' Advisory Council called for reporting arrangements to be rationalised because:

> … the purposes of the current frameworks are unclear and overlap. In addition, the specific audience and beneficiaries of the frameworks are undefined. (Nous Group 2017, p. 10)

The review recommended a single overarching framework based on the NHPF, with elements of the PAF incorporated as appropriate. Other existing frameworks would be linked and subordinate to the overarching framework.

The review also recommended a shift in emphasis to reporting outcomes because:

> Many of the current indicators focus on throughput or output rather than measuring the change or improvement of patient's experience or clinical outcome. This does not provide insight to the effectiveness of the health system at either a patient or population level. (Nous Group 2017, p. 11)

The current specification for the PAF already includes a large number of outcome indicators but many of these are not actually reported due to ongoing data and methodological problems. The PAF is also unusual in being designed to allow reporting at the level of individual hospitals (but not clinicians). For this reason, it was the framework adopted for the MyHospitals website, which is supposed to be a national vehicle for informing patients (box 10.1). In reality, the limited number of indicators currently reported under the PAF has meant that MyHospitals is largely confined to reporting waiting times and other process measures for public hospitals (table 10.3). MyHospitals is even more limited in the information it provides on private hospitals due to their participation being voluntary and, for those that do participate, fewer indicators tend to be reported than by public hospitals.

Box 10.1 The MyHospitals website

MyHospitals was established in late 2010 by the Australian Institute of Health and Welfare to provide greater public access to information on hospital performance. The Australian, State and Territory Governments had committed to set up the website as part of the National Health and Hospitals Network Agreement. Their commitment to this initiative was reiterated in the succeeding National Health Reform Agreement in 2011, which described the website as a vehicle for patients to compare available services and performance at different hospitals. It could also be used by GPs to help patients choose a hospital.

The website currently has information on more than 1000 public and private hospitals. Users can search for a hospital by state or postcode, view the hospital's profile and the services it offers, see data for some performance indicators, and compare to other hospitals. All public hospitals are listed on the website but only around half of all private hospitals are covered (about 300 establishments) because their participation is voluntary.

In late 2011, COAG endorsed the Performance and Accountability Framework as the basis for performance reporting on individual hospitals. The framework has 17 performance indicators for hospitals but only seven of these are currently reported on MyHospitals (table 10.3). The indicators that are reported largely concern waiting times and other process measures. There is almost no information on the outcomes from specific treatments, apart from average length of stay in hospital for a few conditions. Private hospitals listed on the website tend to report even fewer indicators than public hospitals.

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Box 10.1 (continued)

In February 2016, a progress report on two of the indicators not yet reported by public hospitals — the hospital standardised mortality ratio and in-hospital mortality rate for specific conditions — stated that it would not be meaningful or helpful to report them until there was greater national consistency in the data. The report identified inconsistent coding practices between hospitals, differences in admission policies between jurisdictions, and an inability to track patients who are transferred between hospitals. It noted that resolving the problems would require a concerted effort by agencies such as the Australian Commission on Safety and Quality in Health Care, and the Australian Institute of Health and Welfare, working with national committees responsible for coding standards, and also with state and territory system managers to align coding practices with national standards.

Sources: AIHW (2016l); NHPA (2012, 2016).

Table 10.3 **MyHospitals does not report every indicator it is meant to**

Indicator	*Reported on MyHospitals?*[a]
Safety and quality	
1. Hospital Standardised Mortality Ratio	✗
2. Deaths in low-mortality Diagnostic Related Groups	✗
3. In-hospital mortality rate for selected conditions[b]	✗
4. Unplanned readmission rate for selected conditions[c]	✗
5. Health care-associated *Staphylococcus aureus* infections	✓
6. Health care-associated *Clostridium difficile* infections	✗
7. Rate of community follow-up within 7 days of discharge from psychiatric admission	✗
Patient experience	
8. Measures of patient experience with hospital services	✗
Access	
9. Access to services by type of service compared to need	✗
10. Emergency Department waiting times by urgency category	✓
11. Percentage of Emergency Department patients transferred to a ward or discharged within 4 hours, by triage category	✓
12. Elective surgery patient waiting times by urgency category	✓
13. Waiting times for cancer care	✓
Efficiency and financial performance	
14. Relative Stay Index for multi-day stay patients	✓
15. Day of surgery admission rates for non-emergency multi-day stay patients	✗
16. Cost per weighted separation and total case weighted separations	✓
17. Financial performance against activity-funded budget	✗

[a] Indicators reported by public hospitals. Private hospitals listed on the website tend to report fewer indicators than public hospitals. [b] Acute myocardial infarction, stroke, fractured neck or femur, and pneumonia. [c] Acute myocardial infarction, knee and hip replacements, depression, schizophrenia, and paediatric tonsillectomy and adenoidectomy.

It will take some time for officials from all jurisdictions to collectively develop a response to the review's recommendations, gain the approval of Ministers, and implement reforms. The Commission understands that no firm timeframe has been set for this task. The detail of how to implement a new national framework, including which indicators to include and how to rationalise existing frameworks, is likely to be the subject of much further debate. Past efforts to improve health information have foundered or at least proceeded at a glacial pace. Governments need to address the political and technical barriers. Development of better performance information should be a higher priority for the future.

Reporting at a state and territory level

The hospital indicators published at a national level are typically derived from detailed information that State and Territory Governments gather to fulfil their responsibility to oversee the provision of public hospital services.[2]

Among other things, public hospitals are required to report on a large number of performance indicators embedded in service agreements and associated performance frameworks. Targets are set for many of the indicators, which if not met can lead to a graduated system of intervention by the relevant health department (for example, NSW Ministry of Health 2013, 2016b).

State and Territory Governments sometimes give public hospitals access to data gathered from their peers to encourage self-improvement. An example of this is an activity-based management 'portal' developed by NSW Health (Damato 2015). In Queensland, public hospitals have access to a graphical tool — termed variable life adjustment displays — which plots differences in actual and predicted outcomes for various clinical indicators and compares to the statewide average (adjusted for patient characteristics) to flag when internal review is required (Duckett, Coory and Sketcher-Baker 2007; Queensland Health 2016d).

Governments also contribute to the funding of some clinical quality registries, which gather outcomes data on a specific illness or treatment to facilitate improved practice (box 10.2). Moreover, some public hospitals have access to international benchmarking data from the health care analysis company Dr Foster.

Data collection on individual clinicians occurs as part of self-improvement initiatives in particular specialities. For example, the Royal Australasian College of Surgeons (2017; sub. PFR374) facilitates ongoing improvement through audits of surgical mortality in each jurisdiction in collaboration with the relevant State or Territory Government. Medibank Private and the Royal Australasian College of Surgeons (2016a, 2016b, 2016c, 2016d,

[2] The data that State and Territory Governments supply for national reporting are specified in a series of National Minimum Datasets, with the data provided to the Australian Institute of Health and Welfare. This is done in accordance with the National Health Information Agreement, which also specifies a nationally agreed set of performance indicators to be reported. The agreement also commits State and Territory Governments to providing various datasets to the Independent Hospital Pricing Authority to assist its calculation of the Australian Government's funding contribution for public hospitals.

2016e, 2017) have used data on services provided to private patients to inform surgeons about variation in surgical practice and out-of-pocket charges.

Box 10.2 Clinical quality registries

Clinical quality registries are organisations that systematically monitor the quality of health care within specific clinical domains by routinely collecting and analysing health-related information. They use the data to identify benchmarks and variation in clinical outcomes and feed this information back to clinicians for self-improvement. Reports may also be provided to hospital management, health care funders, clinical colleges and researchers.

There is significant heterogeneity across registries. Some monitor the quality of care for a specific service, such as blood transfusions or cardiac surgery, while others focus on a particular disease, such as lung or prostate cancer, and some target a range of conditions and services, such as those associated with major trauma. Reporting arrangements vary, with participation sometimes voluntary and coverage limited to a single state or subset of hospitals, while others cover both Australia and New Zealand. Some registries are partly funded by governments but most are managed by a non-government organisation.

There is evidence that clinical registries can facilitate improved quality and safety by both providing feedback to service providers and by publishing performance data on individual providers. Publication is likely to create additional impetus for providers to engage in self-improvement, rather than prompting consumers to seek out higher-performing providers, given that the information generated by registries can be difficult for patients to interpret.

Publishing performance data can encourage self-improvement by not only hospitals and clinicians but also providers of prosthetic devices. 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.

Registry data could also be a useful resource for State and Territory Government monitoring of service quality and safety. However, the data are not routinely included in datasets assembled by governments as part of their stewardship role. For example, a 2016 review of hospital safety and quality assurance in Victoria found that many registries did not provide their data to the state health department, even in cases where the registry was partly funded by the Victorian Government. The review recommended that the Victorian Government make its funding of registries conditional on all performance metrics being provided to the state health department and relevant hospital management at the same time as they are fed back to clinical units.

Sources: ACSQHC (2014a, 2016); AIHW (2016q); Duckett, Cuddihy and Newnham (2016); Larsson (2012).

Some jurisdictions have been developing patient-reported outcome measures (PROMs), which are emerging as a useful addition to indicators traditionally used to monitor the performance of health care providers (box 10.3).

Much of the data gathered by State and Territory Governments are not published, particularly clinical outcomes at the level of individual hospitals or practitioners. However, some jurisdictions do publish more data on individual hospitals than available nationally. For example, the NSW Government regularly publishes hospital-level data online on elective surgery, emergency departments and patient experience (NSW BHI 2017; box 10.3).

Similarly, the Queensland Government maintains a website that provides detailed information on its public hospitals (Queensland Health 2017a). The Victorian, SA and WA Governments also make some hospital-level information available online (SA Health 2017; Victorian DHHS 2017a; WA Department of Health 2017). However, the data published by State Governments have similar limitations to the MyHospitals website, particularly an almost exclusive focus on process measures such as throughput and waiting times.

Box 10.3 Patient-reported experience and outcome measures

Public hospital patients have been surveyed about their experiences for many years, with varying approaches and transparency across jurisdictions. For example, the NSW Bureau of Health Information regularly publishes results for emergency departments, admitted services, outpatient clinics, small hospitals and maternity units. In Victoria, public hospitals are given survey results each quarter. Providers in Queensland have in recent years been given survey results for emergency departments, small hospitals, maternity units and orthopaedic outpatient clinics.

A drawback of patient experience surveys is that they focus on processes rather than health outcomes. There is an emerging trend to address this by using patient-reported outcome measures (PROMs), which ask patients about their health and health-related quality of life. They are the only way to measure some symptoms (such as pain and nausea) and a patient's judgment of their functioning. They can therefore be a useful complement to clinical outcome measures reported by service providers, such as readmission and mortality rates.

The countries most advanced in implementing PROMs at a systemwide level are England, the Netherlands, Sweden and United States. England was a leader in 2009 when it began to require routine collection and publication of PROMs for patients before and after varicose vein, groin hernia, and hip and knee replacement surgery. In the United States, the focus has been on a number of chronic conditions. In the Netherlands and Sweden, PROMs collection is undertaken as part of clinical registries for specific diseases or conditions.

In Australia, the NSW Agency for Clinical Innovation and the Cancer Institute NSW have been leaders in PROMs. Several NSW local health districts have implemented demonstration projects that include small-scale PROMs collections. In Victoria, some providers already collect PROMs and the Agency for Health Information is developing a pilot for a statewide collection. There is also a trend for clinical registries to use PROMs as part of their measurement of outcomes.

To date, evidence on the benefits of PROMs is mixed. Studies have found strong evidence that PROMs have improved patient-provider communication and patient satisfaction but have yet to be widely used by providers as a tool to improve clinical outcomes.

Sources: ACSQHC (2012); Boyce and Browne (2013); Chen (2015); Chen, Ou and Hollis (2013); Devlin and Appleby (2010); Duckett, Cuddihy and Newnham (2016); Kyte et al. (2016); NSW BHI (2016); Queensland Health (2016b); Thompson et al. (2016); Victorian DHHS (2016a, 2017d); Williams et al. (2016).

Weaknesses in current reporting limit the scope for greater contestability

In the study report for this inquiry, the Commission observed that there may be scope for State and Territory Governments to test more contestable approaches to commissioning public hospital services when they regularly renegotiate service agreements with local hospital networks (PC 2016a). Another option mentioned in the study report was to make

senior management positions in public hospitals more contestable through increased transparency about the level of underperformance that would trigger the replacement of managers.

Several inquiry participants cautioned that there had been a series of failed attempts in the 1990s to make public hospital services more contestable, with the poor outcomes partly due to governments being unable to adequately codify and monitor required performance (ACTU, sub. 100; Duckett (2013); Illawarra Forum, sub. 444; NSW Nurses and Midwives' Association, sub. 247; Queensland Nurses' Union, sub. 405). A key issue for this inquiry is whether improvements in performance reporting to State and Territory Governments since the 1990s, combined with a more rigorous approach to commissioning, provides scope for making services more contestable.

There are now well-developed systems for reporting levels of hospital activity and expenditure, particularly for acute in-patient services, and so it would be more straightforward to specify and monitor these variables in a contestable service agreement.

Safety and quality is more challenging to codify and enforce in a timely way as part of a service agreement. There are often methodologies to address such issues but they require an investment of time and resources to develop and maintain. Examples include efforts to measure mortality rates (box 10.1) and survey patients using PROMs (box 10.3).

The findings of a 2016 review of hospital safety and quality assurance in Victoria suggest that State and Territory Governments have a lot more work to do before they can be confident that underperformance will be quickly identified and acted on.

> … most states monitor only a narrow range of safety indicators, and over-rely on individual incident reports rather than analysing trends. As a result, many health departments in Australia do not know the true rate of complications in their hospitals, how safety varies across the different hospitals they oversee, or whether safety is improving over time. They mostly lack the information required to identify concentrated risks to patient safety, and even the knowledge of whether their existing safety policies are working. (Duckett, Cuddihy and Newnham 2016, p. 8)

A further concern is that State and Territory Government monitoring of private hospitals is less extensive than the reporting requirements that public hospitals are required to adhere to (Australian Healthcare and Hospitals Association, sub. 427; Duckett, Cuddihy and Newnham 2016; Tasmanian Government, sub. 485).

Until governments can sufficiently codify the safety and quality they require, and ensure compliance through timely monitoring, there remains a risk of incomplete contracts. While this remains the case, policy makers should be cautious about considering more contestable approaches that delegate the provision of public hospital services to an external provider. It is also doubtful that performance data at the hospital level are sufficiently robust to be the basis for making senior management positions in government-operated hospitals more contestable.

The Commission is therefore not recommending changes to make public hospital services more contestable than currently. Governments are already able to utilise private sector providers, at least for some services, when they wish to. For example, governments sometimes commission private hospitals to reduce elective surgery waiting lists for public patients (Tasmanian Government, sub. 485) and government-operated public hospitals use private providers for pathology and radiology testing. Government-operated public hospitals are already subject to performance frameworks that include some quantitative targets but the frameworks do not set prescriptive rules on when these would trigger the replacement of a hospital's senior management. The Commission has not seen any evidence that going beyond current arrangements at this time would deliver more effective services.

Non-government initiatives to inform choice

Patients have always drawn on the experiences of family and friends when considering alternative providers of health care. As a trusted source of advice, this can have a significant influence on choices. The advent of the internet has created an opportunity for individuals to broaden this to drawing on the experiences of a wider group, although consumers should not rely solely on this source due to the possibility of being misled by fake reviews and websites that give a biased impression by deleting unfavourable posts.[3]

Patient Opinion Australia (POA) operates a website where individuals can search reviews that others have posted on the health care they have received. The relevant service provider can post a response, and this may be followed by a published dialogue between the patient and provider. The website is moderated by POA to ensure published material is not defamatory. If patient feedback is very critical, POA may contact the individual to check that it is sent in good faith.

The POA website was established in 2012 and is modelled on a similar UK website that has operated since 2005. POA is run on a not-for-profit basis. It earns revenue by offering a subscription service to service providers, which gives them access to tools and support to help staff make the most of patient feedback. Subscribers can also compare how they are doing and generate reports. Over 150 organisations subscribe to POA.

In 2013, health insurer NIB also established a website, called Whitecoat, where people can search and compare health care providers based on user reviews. A number of other insurers now also contribute to funding the website. It is focused on services other than admitted care in hospitals, such as from GPs. Unlike the POA website, it does not include responses from service providers.

Another website, called Healthshare, allows individuals to search for health professionals in a particular speciality and region. The resulting information can include the hospitals where

[3] Section 29(1) of the *Competition and Consumer Act 2010* (Cwlth) prohibits false or misleading representations through testimonials but this depends on timely detection of the behaviour. The ACCC (2013) has published a guide on how businesses and review platforms can comply with the law.

a specialist has admitting rights and whether they charge out-of-pocket costs to members of the health insurer HCF.

The Australian Medical Association (sub. 481) noted that it publishes a public hospital report card, which identifies hospitals that have not met their targets for treatment and waiting times in emergency care and elective surgery.

10.4 Proposed reforms

The Commission's recent inquiry on data availability and use recommended a number of reforms to improve access to, and utilisation of, data across the economy (PC 2017). This included a new Data Sharing and Release Act, National Data Custodian, and sectoral Accredited Release Authorities to streamline access to datasets. These would complement the health care-specific reforms proposed in this section, which focus on driving better public reporting to support patient choice and provider self-improvement.

There is clearly scope for better information provision. Current gaps in available data can leave consumers (and their GPs) in the dark about what they are choosing. Service providers and governments can be unaware of prolonged safety breaches — such as occurred at Djerriwarrh Health Services in Bacchus Marsh, Victoria — due to gaps in performance data needed to undertake timely monitoring and give feedback to clinicians and hospital managers (ACSQHC 2015c; Duckett, Cuddihy and Newnham 2016).

A number of inquiry participants supported publishing more information on public hospital services.

> CHA [Catholic Health Australia] supports greater provision and transparency of appropriately risk-adjusted performance information. In doing so, we note that the publication of such information often prompts providers to compare their performance with their peers which results in performance improvement — even where consumers themselves do not change provider in response to the provision of performance information. (Catholic Health Australia, sub. 440, p. 4)

> While the MyHospitals website currently provides hospital-level data on waiting times and average lengths of stay for limited conditions, it may be more appropriate to provide patient outcome data at the clinical service level or at the level of the clinician-led hospital team. This enhanced public reporting would allow individuals to identify those services or teams with better performance, and may encourage hospitals, services and teams to improve performance and patient outcomes. (AHHA, sub. 427, p. 5)

> The reality remains that most health consumer choices are made in a vacuum of relevant and important data. Consumers are just not appropriately supported to make data-driven health choices … Transparent data drives culture change, and culture change is at the heart of all the intransigence in the health sector to delivering patient-centred care. (Health Consumers' Council (WA), sub. 447, p. 2)

> To make informed choices about clinician and/or hospitals services, consumers need access to all levels of information i.e., individual clinician performance, clinician led-team outcomes, and hospital outputs compared with peers. (Jeanette Sheridan, sub. 451, p. 6)

While there is a case for better information provision, it should not be used as a reason for postponing the introduction of greater choice in public hospital services. As noted in chapter 9, there is intrinsic value for patients in being given a right to choose. Moreover, patients already have access to information on some of the service characteristics that they value, like location and waiting times. They can also have less formal means for accessing other information, such as checking with their GP, family and friends.

However, more user-oriented reporting (including on out-of-pocket payments, courtesy of staff and clinicians, amenity of facilities, experiences of other patients, and clinical outcomes) is desirable to further empower consumers. The extensive information available to patients in England through the National Health Service (NHS) website provides an example of how Australia could improve (box 10.4).

Box 10.4 Information provision in England

In England, a large amount of consumer-oriented information about health care providers has been made available online. Patients are able to search the National Health Service website for hospitals and specialists in their area, and compare performance indicators for individual:

- hospitals, divided into various reporting categories (including key facts, efficiency, safety, food, friends and family test, patient-reported outcome measures, reporting culture, cleanliness and infection control, complaints and parking facilities)
- consultants in 14 specialities, with the number of indicators varying between speciality (they can include mortality rates, readmissions, average number of days that patients stay in hospital, and number of procedures performed in the past year).

Indicators are often presented in an easy-to-understand format, such as a tick or star rating, but with scope to drill down into the data to see quantitative results, definitions and data sources.

To give a broader perspective on performance, the hospital indicators include information reported by staff (such as whether they would recommend the facility) and patients (including their perceived health improvement, user ratings and written reviews, and whether they would recommend the hospital to friends and family).

Patients can also see an overall rating that England's health care regulator — the Care Quality Commission (CQC) — has given to individual hospitals. On the CQC website, this can be disaggregated into ratings for individual objectives (safety, effectiveness, caring, responsiveness or well-led) and specific service areas (such as surgery or end-of-life care). By law, hospitals must display their ratings where patients can easily see them (such as the main entrance) and on their website (if they have one).

There are also other websites that patients can turn to for information, including one hosted by the Society for Cardiothoracic Surgery in Great Britain and Ireland, which provides additional detail on the performance of individual surgeons and surgical units.

It is widely recognised that there are weaknesses in current reporting. There has been some movement to improve information, including in response to safety incidents.[4] However, progress is often slow, such as with the development of safety and quality indicators supposed to be on the MyHospitals website.

A number of barriers have impeded the progress of public reporting in Australia. There are often complex issues associated with measuring clinical outcomes, such as linking data collected in different settings and controlling for differences between patients. There can also be a reluctance among health departments, hospitals and clinicians to be exposed to public scrutiny. This is despite the literature showing that it is in patients' interests for performance data to be published because of its positive effect on provider self-improvement. Paternalism may also be a factor, with patients viewed as being incapable of interpreting information if they were allowed to see it (Mead 2017). Data perfectionism can be another possibility, with data withheld from the public on the grounds that it would not be helpful or meaningful to release information that has limitations.

At a national level, there is also the challenge of getting agreement on consistent approaches across multiple jurisdictions. National approaches are arguably more important for measuring clinical outcomes (which is where much of the work needs to be done) because there can be economies of scale in developing methodologies, and a consistent approach across jurisdictions provides a greater sample of providers to benchmark against. There may be scope for individual states or territories to move ahead of the pack in the short term, but only if it does not close off options for national reporting in the longer term.

Strengthen cross-jurisdiction commitment to public reporting

The system of national reporting for individual hospitals outlined above is based on commitments made by the Australian, State and Territory Governments in the 2011 National Health Reform Agreement. Specifically, as part of their funding agreement for health care, the governments committed to a national system of public performance reporting on every individual public hospital, to use the MyHospitals website as the online vehicle for such reporting, and for the website to allow performance to be compared between hospitals.

The hospital-level data are provided by State and Territory Governments to the Australian Institute of Health and Welfare (AIHW) to process and publicly report an agreed set of indicators.[5] A number of other agreements and technical documents, and cross-jurisdiction committees, support the reporting arrangements. This includes the previously mentioned

[4] For example, the Victorian Government (2016) committed to implement a package of improvements to the collection, use and publication of data on health service delivery following safety breaches at Djerriwarrh Health Services in Bacchus Marsh.

[5] This task was previously assigned to the (now abolished) National Health Performance Authority.

Performance and Accountability Framework, which details the indicators that jurisdictions have agreed will be reported (listed in table 10.3 above).[6]

The National Health Reform Agreement provides the broad architecture through which the Australian, State and Territory Governments could agree to improve information provision to support greater choice and contestability. Specific initiatives are discussed below, but in summary the Commission is proposing an increase in the information publicly reported on individual hospitals and an expansion of reporting commitments to include individual specialists. These changes would be in the interests of patients, facilitate more self-improvement by service providers, and help to strengthen State and Territory Government oversight of service provision.

Publicly release as much data as possible

As a general principle, the Australian, State and Territory Governments should commit to publishing as much as possible of the data they hold on individual hospitals and specialists, unless it is clearly demonstrated that releasing the data would harm the interests of patients.

As noted above, some states already publish a large number of process measures online for individual hospitals, such as waiting times and number of services provided. In New South Wales, this is done centrally by the Bureau for Health Information, with the data presented in a user-oriented format online with a search facility. The central website could be expanded to publish all hospital-specific performance data gathered by the NSW Government.

It may be less straightforward to do this in the smaller jurisdictions because they do not have as well-developed arrangements for publishing information on individual health care providers. The MyHospitals website is likely to be a more cost-effective vehicle for disseminating the information across all jurisdictions and so should be used for this purpose (specific actions on MyHospitals are discussed below).

Make data available to other information providers

In addition to publishing information through existing channels, including the MyHospitals website, the Australian, State and Territory Governments should commit to making published data available in a format that enables other organisations to readily incorporate it into advisory services they provide.

For example, providers of software used by GP clinics could include the information in their software to help GPs support patient choice during a consultation. There may also be scope to include it in regional Health Pathways services, which are web-based portals being

[6] Other supporting elements include the National Health Information Agreement, Australian Health Ministers' Advisory Council, National Health Information and Performance Principal Committee, and National Health Information Standards and Statistics Committee.

developed to help GPs and other health professionals identify the best pathway for a particular patient, including guidance on referring patients to local specialists.[7]

Phase-in public reporting on individual specialists

The choice model proposed in chapter 9 would give patients the option of choosing between specialists as well as hospitals. Governments (and private health insurers) already collect some data on specialists but patients are denied access to all but the most basic information. This is in contrast to England, where patients can access a single website to search for a specialist in a particular discipline near the patient's home and view various indicators of the specialist's performance (box 10.4).

In Australia, the MyHospitals website should be expanded to provide a similar information service on individual specialists to that already available in England. The AIHW, in consultation with other bodies, would have to determine what information to report. The arrangements should be underpinned by a joint Australian, State and Territory Government commitment in the National Health Reform Agreement that there will be public reporting on individual specialists.

State and Territory Governments would need to ensure that all specialists treating public patients are obliged to participate in public information provision. For specialists who see clients in private outpatient rooms, the Australian Government should add public information provision to the eligibility criteria that the specialist has to satisfy in order to be authorised to provide services that attract Medicare benefits.

Reporting would need to be phased-in as specific indicators are developed and associated data assembled and processed by the AIHW. Box 10.5 outlines a potential sequence for doing this.

A longer-term goal should be to publish information on the clinical outcomes achieved by individual specialists, such as their mortality, revision and unplanned readmission rates. The slow progress in publishing such indicators on the MyHospitals website at even a hospital level suggests that there will be a number of technical issues to address (box 10.1). Resistance to greater transparency will be another barrier.

While there will be barriers to public reporting on individual specialists, Australians should not be denied access to information which has been available to patients in other comparable countries for many years. Several US states have publicly reported the performance of individual cardiac surgeons since the early 1990s. In England, the mortality rates of individual cardiac surgeons have been publicly reported since 2005. Reporting has since expanded on the NHS website to include a range of indicators for individual consultants in 14 specialities.

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7 Health Pathways is modelled on an approach first used in Canterbury, New Zealand, in 2008 (Timmins and Ham 2013).

Box 10.5 How reporting on individual specialists might be phased-in

The phasing-in of public reporting on individual specialists could be done in the following order.

- Provide each specialist's registration details using information currently published by the Australian Health Practitioner Regulation Agency — including where and when the specialist trained, and any conditions, undertakings or reprimands attached to their registration — but with a search function that makes it easy for patients to search for clinicians in their region by speciality.
- Add process data on the specialist, such as:
  - location, contact details, opening hours and available parking at the specialist's outpatient clinic(s)
  - out-of-pocket payments (for patients attending a private outpatient clinic)
  - number of relevant procedures the specialist performed in the last year
  - hospitals where they have admission rights.
- Allow patients to post (moderated) user ratings and write reviews, with an option for specialists to post responses, as currently occurs on the Patient Opinion Australia website.
- In the longer term, report the clinical outcomes achieved by individual specialists, such as whether patient-reported outcome measures, mortality, revision and unplanned readmission rates are within an acceptable range.

Governments and health professionals in England and the United States were initially reluctant to support public reporting on individual specialists. Resistance to releasing data on individual surgeons in England was eventually overcome by the combination of a 2001 public inquiry, which highlighted a lack of transparency regarding a notorious case of malpractice in cardiac surgery, and the subsequent introduction of freedom-of-information legislation enabling *The Guardian* to force the release of mortality data for individual heart surgeons in 2005 (Bridgewater et al. 2007; Guardian 2005; Kennedy et al. 2001; NZHQSC 2016a, 2016b; Street 2016; UK Department of Health 2002). Similarly, the longest-running US reporting program — the New York State Cardiac Surgery Reporting System (NYSCSRS) — was forced to begin releasing data on individual surgeons in 1991 when it lost a freedom-of-information lawsuit initiated by the publication *Newsday* (Barua and Esmail 2011; Harlan 2001; NZHQSC 2016a, 2016b).

Ideally, public reporting on the performance of individual specialists in Australia would be developed and implemented in collaboration with the professions. The Royal Australasian College of Physicians (sub. 473) and Royal Australasian College of Surgeons (sub. PFR374) stated that they currently oppose such reporting. Its usefulness was also questioned by other inquiry participants in roundtables and meetings with the Commission.

The key concerns raised by participants were that:

- public reporting is not warranted because patients do not use the information to exercise choice and publishing it does not lead to greater self-improvement by specialists

- specialists will 'cherry pick' the lowest-risk patients and avoid more complex cases to improve their published performance indicators
- the typical caseload of specialists is too small to have enough statistical power to identify differences in performance between clinicians
- hospital services are provided by teams, making it difficult to isolate a specialist's impact from that of other professionals caring for the patient.

The Commission has concluded that, while there may be some basis for these concerns, they can be managed and do not justify continuing to conceal information on specialists. The reasoning is outlined below.

Is public reporting warranted?

There is little evidence that patient choices have been influenced by the performance indicators that have been published to date on individual specialists (Henderson and Henderson 2015; Jha and Epstein 2006; Schneider and Epstein 1998). Like hospital-level reporting, the evidence points to the impact being on the behaviour of service providers.

Most studies focus on the US experience with reporting on cardiac surgeons, particularly a significant decline in risk-adjusted mortality following the introduction of the NYSCSRS. The extent to which this decline can be attributed to public reporting, rather than a general trend of improving outcomes from cardiac surgery, has been the subject of much debate. However, there is evidence that the overall decline in mortality rates in New York was partly due to the NYSCSRS (Jha and Epstein 2006; Oakley 2011; Peterson et al. 1998; Smith et al. 2009). Moreover, exposing the mortality data to public scrutiny prompted efforts to address major deficiencies in collection and reporting methods, which would have facilitated more effective stewardship (Harlan 2001).

There has also been a downward trend in risk-adjusted mortality for cardiac patients in England since the introduction of public reporting. While publishing mortality data is not the only possible cause, there is little evidence that it led to worse outcomes and the observed overall improvement suggests that it was beneficial (Bridgewater et al. 2007; Shaw, Taylor and Dix 2015). Like the US experience, publishing the data highlighted deficiencies in collection and reporting methods, thereby adding impetus to strengthen information also relevant to stewardship (Bridgewater et al. 2013; Radford et al. 2015; Williams 2013a).

The limited available evidence of benefits from specialist-level reporting needs to be weighed against the cost associated with collecting and publishing the data. However, much of the data are already collected in Australia, or should be, for stewardship purposes, and so the additional cost of public reporting could be relatively small. For example, audits of surgical mortality already gather data on surgeons in each state and territory of Australia (RACS 2017; sub. PFR374). Publishing the data could, like other countries, also generate a benefit by giving added impetus to address data deficiencies which hamper the stewardship role of governments.

Cherry picking and risk avoidance

A common argument against specialist-level reporting is that it encourages clinicians to cherry pick low-risk patients and avoid more complex cases (Chen 2010; Chou et al. 2015; Hannan et al. 1997; Pearse and Mazevska 2010; Radford et al. 2015; Royal Australasian College of Surgeons, sub. PFR374; Werner and Asch 2005). Most research on this topic is based on surveys of providers, with specialists sometimes stating that they were more reluctant to treat high-risk cases following the introduction of public reporting (Bridgewater et al. 2007; Narins et al. 2005; Schneider and Epstein 1996; Smith et al. 2009; Walker et al. 2013). However, there is little evidence of reporting actually resulting in widespread avoidance of high-risk patients.

It is common for clinical outcomes to be reported in risk-adjusted terms, which controls for differences in the mix of treated patients and largely removes the incentive for cherry picking. This approach is now well established in England and implemented in collaboration with the professions (box 10.6). The NYSCSRS also publishes risk-adjusted data for individual specialists (NY DOH 2016).

Box 10.6 The journey to risk-adjusted reporting in England

England began a shift to publicly reporting risk-adjusted clinical outcomes for individual specialists in the mid-2000s. Specialists had previously opposed public reporting, partly due to concerns that like-for-like comparisons were not possible. Professor Andrew Street (Centre for Health Economics, University of York) observed that this argument became outdated with the development of risk-adjustment techniques, which in England are now being implemented in collaboration with specialists, but the argument is still used to resist public reporting in Australia.

> The excuse no longer holds: like-for-like comparisons are now perfectly possible, as recent experience in England testifies … The Society for Cardiothoracic Surgery in Great Britain and Ireland led this initiative, collecting data about individual surgeons and devising its own approach to adjusting risk between surgeons … The Society also evaluated what happened next. Doctors weren't forgoing more risky operations to protect their outcome data, because they were confident the risk-adjustment was correct. And survival rates following surgery improved across the board because doctors compared and questioned their performance relative to their peers. They've published the data annually for hospitals and individuals ever since … Following this experience, publication of performance data has since been rolled out across the NHS, starting in 2013 with the publication of activity and death rates for hospital doctors in ten specialities … (Street 2016)

The Royal College of Surgeons of England shifted its position to supporting the release of surgeon-level data from 2013 and stated that:

> The objective of publishing the data is to drive forward improvements in care and enable patients to understand far more about the nature of a surgeon's work and their recovery after an operation … It is believed that, by revealing what others have achieved in their clinical area, surgeons are more likely to reflect on their practice and be inspired to improve while providing patients with accurate information on their surgeon's outcomes. (RCS 2017)

(continued next page)

Box 10.6 (continued)

The President of the Royal College of Surgeons from 2011 to 2014, Professor Norman Williams (2013b, p. 1), backed the change because patients 'have a right to know of doctors who are not meeting the standards expected of them' and observed that almost all surgeons in England had consented to releasing their surgical audit data.

> This occurred despite many misgivings concerning the accuracy of the risk adjustment, team versus individual performance, risk-averse behaviour … Despite the drawbacks and the criticisms I have no doubt that the exercise has been a success … this was a watershed moment for the profession and I am sure that in years to come we will all look back with great pride that we … adopt[ed] this transparency agenda as a means to drive up standards and inform the public … Transparency is a potent means of driving up standards for both delivery of care and training … (Williams 2013a, pp. 250-1)

As detailed in box 10.7 for mortality rates, risk-adjustment methodologies are already used in Australia to monitor clinical outcomes but the resulting performance indicators are almost never published. The box also illustrates how funnel plots can be used to present risk-adjusted data in a way that facilitates accurate interpretation. The NHS website in England uses an alternative, more consumer-oriented, approach to address concerns about how the data could be misinterpreted. Mortality, revision and unplanned readmission rates are simply presented as being 'OK' if they are within an acceptable range, rather than publishing precise rates which may differ between specialists but not by so much as to be statistically significant. The underlying data are available for those who are interested.[8]

Box 10.7 **Measuring risk-adjusted mortality rates**

Mortality rates are often used as a measure of clinical performance because there is a clear outcome (death) to measure. However, without risk adjustment, much of the variation in this indicator over time and between providers could be due to differences in patient characteristics, rather than the performance of service providers.

Risk-adjusted mortality rates are now regularly calculated in several jurisdictions using routinely collected data, including Queensland, Canada, England, the Netherlands, and Scotland. Moreover, the Australian Commission on Safety and Quality in Health Care has developed national coefficients to assist jurisdictions within Australia to risk-adjust two measures of mortality (the hospital standardised mortality ratio and condition-specific mortality for four conditions). However, mortality rates are rarely published at a service provider level in Australia.

A key step in risk adjustment is to use a logistic regression model to estimate coefficients for various risk factors — such as patient age, gender, comorbidities and type of admission — that quantify how the probability of mortality has varied with each factor across a population of service

(continued next page)

[8] In contrast, the US Hospital Compare website only publishes a qualitative rating for (hospital-level) mortality (possible ratings are worse than, no different than, or better than the national average). Joynt et al. (2016) noted that this limits the peer-pressure effect of public reporting (especially because few hospitals are rated as different from the national average) and so could explain why a downward trend in mortality rates did not accelerate after public reporting began in 2008.

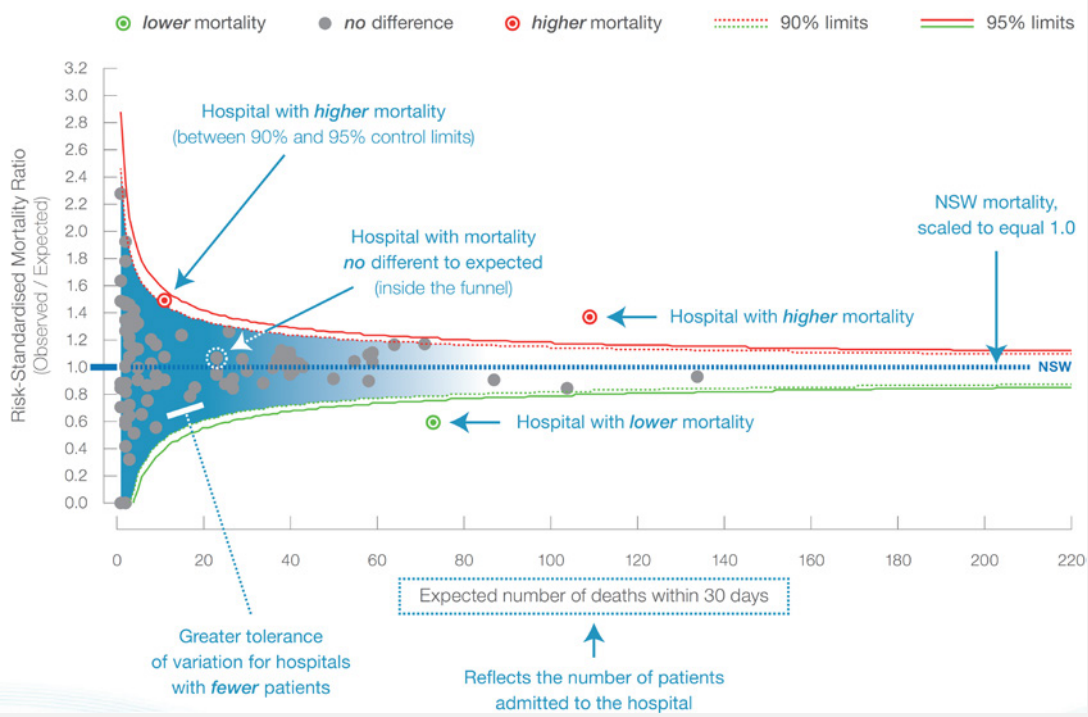
Box 10.7 (continued)

providers. The results are then used to estimate an *expected mortality rate* for each provider, based on the characteristics of its patients.

The risk-adjusted mortality rate for each provider is often presented as the ratio of its actual to expected deaths. In essence, this ratio compares actual outcomes for the provider's set of patients with the outcomes expected if its patients had been treated by the average provider. Hence, each provider is compared with a hypothetical average provider treating the same patients, not another actual provider that treated different patients. For this reason, it can be misleading to compare risk-adjusted rates between providers.

An Australian example is the 30-day risk-standardised mortality ratio published by the NSW Bureau of Health Information for hospitals treating five clinical conditions (acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip-fracture surgery). If this ratio is less than one, it indicates that a hospital has lower than expected mortality compared to the hypothetical average NSW hospital that treated the same group of patients. However, small deviations from one are not considered to be meaningful. Funnel plots (illustrated below) are used to show when there is a high level of confidence that a hospital's mortality ratio is greater than expected.

Hospitals with fewer patients (appearing towards the left-hand side of the figure) tend to have greater variability in deaths simply by chance and so the funnel's 90 and 95 per cent confidence limits are wider. A mortality ratio above the 90 per cent limit of the funnel is interpreted as the hospital having higher than expected mortality, based on the patients it treated. If a hospital is outside the 95 per cent limits, there is greater confidence about its outlier status.



Sources: ACSQHC (2014d, 2015b); AHRQ (2014); Ben-Tovim et al. (2009); Brand et al. (2013); CMS (2017a, 2017b); Dr Foster (2014); Flowers et al. (2010); NHPA (2012, 2016); NHS Digital (2016); NHS Scotland (2011, 2016a, 2016b); NSW BHI (2013, 2015b); NY DOH (2016); Taylor and Aylin (2014); YNHHSC and CORE (2017).

No risk-adjustment methodology is perfect because it can only control for risk factors that are measured and depends on the quality of data and modelling (AHRQ 2014). However, as the support of specialists and their associations in England demonstrates, public reporting of risk-adjusted indicators has gained acceptance over time as publication has driven improvements in methodologies and associated data.

Small caseloads and statistical significance

In some cases, a clinician's reported performance may differ from the average for his or her peers, but not by a sufficiently large amount to be statistically significant in the sense that there is a high probability that the difference is due to more than chance. To identify performance differences that are statistically significant, it is common to publish a confidence interval around the peer average, beyond which there is a high probability (usually 90 or 95 per cent) that a provider's performance is truly above or below the peer average. An example is illustrated in box 10.7 for hospital-level reporting of mortality rates.

For specialists, the confidence interval will tend to narrow as the frequency of the relevant procedure (such as cardiac surgery) and measured outcome (such as mortality) rises, thereby increasing the indicator's statistical power to identify genuine differences in performance.

The Royal Australasian College of Surgeons (sub. PFR374) noted that a 2016 NZ Government review had decided not to support specialist-level reporting partly because overseas experience had shown that the typical caseload of specialists is unlikely to be sufficiently large to provide the statistical power needed to identify real differences in performance (NZHQSC 2016b).

This conclusion was largely based on a study by Walker et al. (2013), which analysed the statistical power of mortality rates for four types of surgery in England.[9] However, in the case of cardiac surgery, the authors concluded that the number of procedures undertaken by individual clinicians was 'sufficient to allow the process of detection [of poor performance] to operate with reasonable statistical power' (Walker et al. 2013, p. 3), although this was based on a relatively low bar for defining poor performance and an acceptable rate of detection.[10] A similar result was found for hip-fracture surgery but the likelihood of identifying poor mortality rates in the other two types of surgery was much lower. To achieve an acceptable level of statistical power, the authors recommended:

- using data for a longer period (such as three years) to increase the number of procedures for a given specialist, although this reduces the timeliness of reporting
- measuring only outcomes that occur frequently for the relevant procedure

[9] Adult cardiac surgery; oesophagectomy or gastrectomy for oesophagogastric cancer; bowel cancer resection; and hip-fracture surgery.

[10] Poor performance was defined as a 95 per cent probability that the surgeon's mortality rate was twice the national level. It was estimated that 69 per cent of cardiac surgeons did enough procedures over a three-year period to be detected in seven out of ten cases when they truly met this definition of poor performance.

- only reporting at a team or hospital level when the detection rate for individual surgeons with poor performance would be less than 60 per cent.

The mortality rates reported for cardiac surgeons in England and New York are based on data over three years. Moreover, Walker et al. (2013) concluded that mortality is sufficiently common to be a useful indicator for cardiac surgery. This is not always the case for other specialities and so consideration would have to be given to measuring other outcomes. Indeed, the clinician-level performance indicators published in England vary between the 14 specialities where reporting occurs. Whether reporting would have insufficient statistical power even after pooling data over a longer period and measuring more frequent outcomes is a matter that can be judged on a case-by-case basis for individual specialities.

Effect of teams on outcomes

The Royal Australasian College of Surgeons (sub. PFR374) said that it supported the release of performance data at the team level, but not individual specialists, because medical interventions in public hospitals are provided by teams and serious failures in health care are often related to systemic issues rather than individual competence. The NZ Government review that the college referred to went further by arguing that publishing the results of individual surgeons seems likely to promote individualistic behaviour and that, if it is team-based medicine that is to be encouraged, it does not seem sensible to publish data based on one team member (NZHQSC 2016b).

However, the Commission has not seen any evidence that specialist-level reporting in England, the United States or other countries has led to a systemic problem with individualistic behaviour undermining teamwork. The fact that such reporting is supported by the Royal College of Surgeons of England and the Society for Cardiothoracic Surgery in Great Britain and Ireland (box 10.6) suggests that the benefits far outweigh the negative impacts, if any, on teamwork. In Australia, the audits of surgical mortality that the Royal Australasian College of Surgeons oversees in each jurisdiction in collaboration with State or Territory Governments gather information on the outcomes of surgeons and provide feedback to them on their performance.

The Commission accepts that clinical outcomes in hospitals are often the result of teamwork which can include, among others, surgeons, anaesthetists and nurses. Moreover, there may be value in reporting performance at a team or unit level, particularly when the caseload of individual clinicians in a particular speciality is too low to provide much statistical power. However, claims that specialist-level reporting conveys no useful information and undermines teamwork are overstated.

Improve the MyHospitals website

The Commission supports the concept of a national website to inform patients and their GPs about individual providers of health care.[11] It could also be a source of information for hospitals and clinicians to benchmark themselves for self-improvement.

A national website should not exclude the development of alternative information services, such as those targeted at GPs, given the Commission's above proposal that governments make their data available in a format that other organisations can readily incorporate in advisory services they provide.

The current national website, MyHospitals, should be seen as a work-in-progress with significant potential for improvement. The breadth of information available to patients in England through the NHS website, and its consumer-oriented presentation, provides an example of what to aim for (box 10.4).

MyHospitals has been active for more than six years, so now is an opportune time for the AIHW to consider how to improve it. This should include market research on who uses the website currently, who would in the future, their varying needs and health literacy, what indicators are useful to them, and best-practice approaches to presenting health information online.

There may be potential to redesign the website so that it is more user-friendly and intuitive, providing a small number of headline indicators in a format such as infographics but with scope for patients, their GPs and others to drill much deeper into the data as they wish. The AIHW could draw on lessons learned with the NHS website and those in other countries.

The AIHW should identify gaps in the indicators currently available on MyHospitals and how to address them. Future information provision could include PROMs, user ratings and reviews, and results from staff surveys. The lack of progress in reporting clinical outcome measures, such as mortality rates, would also have to be addressed.

[11] For patients who are blind or vision impaired, information would also have to be accessible in a format such as audio, large print or braille (Australian Blindness Forum, sub. 412; Vision Australia, sub. 421).

DRAFT RECOMMENDATION 10.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the National Health Reform Agreement to better support patients and their general practitioners to exercise patient choice, and encourage performance improvement by hospitals and specialists. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare (AIHW) to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in draft recommendation 10.2
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals and specialists unless it is clearly demonstrated that releasing the data would harm the interests of patients
- make the information that a jurisdiction publicly releases on hospitals or specialists available in a format that other organisations can readily incorporate in advisory services they provide.

To facilitate reporting on individual specialists, there should also be a commitment by:

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that medical specialists are required to participate in public information provision, as specified by the AIHW
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision, as specified by the AIHW.

DRAFT RECOMMENDATION 10.2

The Australian Government should, in consultation with State and Territory Governments, direct the Australian Institute of Health and Welfare to transform the MyHospitals website into a vehicle that better supports choice by patients and encourages self-improvement by hospitals and specialists. The changes should:

- draw on lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England
- be based on market research on who would use an improved MyHospitals website, how their needs and health literacy vary, what indicators are useful to them, and how they could be informed by using best-practice approaches to presenting health information online
- put greater emphasis on reporting outcomes, such as by publishing patient-reported outcome measures, user ratings and reviews, and clinical outcomes such as readmission rates
- include the phasing-in of reporting on individual specialists as data become available, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges), user ratings and reviews, and, in the longer term, whether clinical outcomes are within an acceptable range.

11 Reforms to underpin more effective provision of public dental services

Key points

- Public dental services have not been a major focus for governments.
- Ad hoc use of fee-for-service vouchers has not resulted in a systemic improvement in user choice, and has done little to improve the effectiveness of public dental services over time.
- People who receive public dental services in government operated clinics have little choice in who provides their care, when and where.
- Oral disease can give rise to significant costs:
  - for individuals these include pain, discomfort and infection, as well as detrimental effects on their broader health and wellbeing
  - for governments, complications can lead to higher costs through more costly treatments and increased demand in other parts of the health system
  - for the community more broadly, costs include productivity lost through reductions in a person's capacity for economic and social participation.
- Many of these costs are preventable and can be avoided with timely access to care. Conversely, delays to accessing care can lead to increasing costs and complications.
  - Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015–16.
  - Time to treatment is therefore an important metric. *Public performance reporting* of patients treated within clinically-acceptable waiting times (benchmarked by risk category) would improve accountability and encourage more effective service provision.
- To move beyond the short-term focus on the urgent needs of those suffering from oral disease, governments need to measure and track the oral health outcomes of users.
  - Developing an *oral health outcomes framework* would not only improve information on the quality of services provided to public patients, but would also underpin more comprehensive reforms to promote targeted preventive care.
- Public dental services largely exist in a silo, with little integration with the broader health system, and little linkage between the public and private dental sectors.
  - Adopting *digital oral health records* would assist in tracking patients over time and across services, improve triaging processes and facilitate user choice with portability of a person's dental records.
- The Commission's proposed reforms to improve data collection and reporting are prerequisites that should be completed before the next stage of broader reforms to public dental services (chapter 12) can proceed.

Access to high quality, timely dental care can alleviate oral health problems, reduce pain and improve a person's quality of life. The most common barriers to accessing dental care are cost, including dental fees, and the location of a dental practice, particularly for people living in remote areas. Limited access to dental care can result in dental problems going untreated, giving rise to a range of other costs, including increasing pain and difficulty eating, and potentially avoidable hospital admissions. Indeed, dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015-16 (AIHW 2017a).

Public dental services provide safety net access to basic dental care for people who face financial and other barriers to accessing care, such as some people with a disability.

State and Territory Governments are primarily responsible for delivering public dental services, with funding support from the Australian Government through the Child Dental Benefits Schedule (CDBS) and National Partnership Agreements. In 2014-15, State and Territory Government expenditure on dental services was $713 million and Australian Government expenditure was $788 million (AIHW 2016g). Australian, State and Territory Governments have developed a National Oral Health Plan that is intended to provide a strategic direction and a framework for collaborative action (COAG Health Council 2015a). While the National Oral Health Plan outlines guiding principles for improvements to the oral health system, it does not contain policy recommendations to translate the Plan into practice.

Unlike, say, hospital care, public dental services are not open to all through universal access arrangements, but are delivered as safety net services to eligible users. People with low-incomes are able to access public dental services with eligibility leveraging off criteria for other government services.[1] In March 2014,[2] there were approximately 5.3 million adults holding relevant concession cards (unpublished data from the Department of Social Services), representing about 23 per cent of the Australian population. Eligibility is somewhat wider for children.[3] As at 1 January 2014, there were approximately 3.1 million children eligible for the CDBS (Australian Government 2016c), representing an additional 13 per cent of the population. Hence, in the most recent comparable year, 2014, approximately 36 per cent of the population was eligible for publicly funded dental services.

The remaining approximately two thirds of Australians are ineligible to receive publicly funded dental services. They access dental care through the 13 100 private dental providers

1 Eligibility for adults is determined through holding a concession card (a Commonwealth Health Care Card or Pensioner Concession Card, and in New South Wales and Queensland a Commonwealth Seniors Health Card which has a broader eligibility criteria). These concession cards are typically issued to those receiving Commonwealth social security income support payments such as the Age pension, Disability Support Pension or Newstart allowance.

2 More recent data are available for adult concession card holders. In March 2017 there were 5.5 million card holders, representing a similar proportion (23 per cent of the population) to that observed in March 2014 (DSS 2017c). More recent public data on the number of children eligible for the Child Dental Benefits Schedule are not publicly available.

3 All children are eligible for public dental services in New South Wales, South Australia, Tasmania and the Northern Territory. Various age limits apply in the other states and the ACT. The Australian Government's CDBS is a means-tested program for children.

who operate throughout Australia (ABS 2016b). These providers usually operate in small, sometimes single dentist, clinics, although this is changing with the emergence of larger practices often associated with health insurance companies. Patients pay for the dental care they receive, sometimes with contributions from their private health insurance covering all or part of the cost.

Public dental services are provided predominately through public dental clinics. These clinics are owned and operated by State and Territory Governments, using salaried dental professionals.

The current emphasis on government provision of public dental services can limit the ability of patients to choose their dental professionals and the time and location of treatment. For people who access services, this can mean an appointment that requires a commute (rather than one near work or home), or one that fits with the clinic (rather than being able to choose a time that does not conflict with, for example, school pick-up).

High levels of demand and government funding constraints mean that public dental services focus on seeing the most urgent cases first and place other patients on a largely 'first come, first served' waiting list. At the end of March 2017, there were some 100 000 adults in New South Wales alone waiting for general dental care in the public system. Of those adults on the waiting list for general care in New South Wales, about one third were not seen within the clinically-accepted benchmark time (Centre for Oral Health Strategy 2017). While waiting times for non-urgent public dental care vary across jurisdictions and over time (with variations in funding), public patients can be waiting up to two to three years to receive care (SCRGSP 2017).

Compared with some other parts of the health system, public dental services have not been a major focus for governments. Public dental services face difficulties in tracking patients over time, and exist in a silo, with little integration with the broader health system. Performance reporting is limited, not comparable between jurisdictions, and does not include patient outcomes. There is therefore considerable scope to improve accountability to those who fund public dental services (governments and users).

This chapter sets out a proposed framework for reform in public dental services by considering the desirable features of an effective system of service delivery (section 11.1), examining the potential to avoid the costs of oral disease through more targeted early intervention (section 11.2), and setting out some initial priorities for reform that should be completed before the next stage of broader reforms (section 11.3). The following chapter examines ways to introduce greater user choice through long-term reforms to introduce consumer directed care, and, for those areas where this is not feasible, alternative reforms to introduce greater contestability.

11.1 What would an effective public dental system look like?

In an effective system, public dental programs would provide access to clinically-effective services to the target population in a cost-effective manner.

Governments would strive to improve outcomes for users using available resources, including — where it would be beneficial to users and the community more broadly — utilising the large number of private sector dental providers in many parts of the country. In formulating draft recommendations to improve public dental services, the Commission has considered what an effective system of service provision would look like from the perspective of users, providers and governments.

Service users

People that use public dental services would have choice over who provides their dental services (public or private), and receive user-oriented information on which to base those decisions. These people would be able to access clinically- and cost-effective treatments at a time and place that suits their needs.

For people that may find choice challenging, or need additional support to access services, there would be additional strategies to improve their oral health that go beyond simply including them as eligible for public dental services. For example, people living in remote areas would have timely access to basic oral care from, say, a combination of visiting dental professionals and locally based allied-health workers who are trained to undertake some types of diagnoses and care.

For people at a higher risk of poor oral health there would be a targeted package of services that work to avoid the need for (and cost of) drastic interventions. Patients would have access to advice and promotion materials in an accessible format. People unable to travel to the public dental provider would have dental providers come to them, such as to their home. People that seek care for oral health problems from their general practitioner (GP), or any other health service, would not just have their immediate symptoms addressed, but would be referred to the public dental system to treat their underlying condition.

Service providers

Service providers would understand the needs of their target population and how to be responsive to them. Providers would be able to draw on available data to improve their services, including benchmarks with other providers and, importantly, outcome measures for users.

Providers would face clear incentives that are aligned with government objectives to provide clinically- and cost-effective treatments and to focus on users' outcomes. Rather than being paid based on the number of services provided, providers would be rewarded to invest in prevention and early intervention treatments that promote better oral health outcomes for the people they serve.

Service providers and governments would have integrated data systems and providers would track and report on the services provided and outcomes for users.

Governments

Governments would know the populations that face significant barriers to accessing dental services, and for whom access would make the greatest difference. Governments would know what the barriers to access are, and be informed about ways to overcome them. Governments would understand who is presenting for dental emergencies and who is turning up to other health services (such as GPs or hospital emergency departments) with dental problems.

Governments would provide access to services for the eligible population through systems that align the incentives of providers with the outcomes for the people they serve. Governments would monitor the quality and efficiency of providers through an outcomes framework. Governments would take into account the characteristics of the users and markets when selecting the providers best able to deliver services that improve outcomes for users.

Governments would benchmark outcome measures to improve accountability, which would drive service improvements and reward innovation. In addition to the outcomes for users, this may allow governments to more efficiently target their investments in public dental services. Governments would share learnings and best practices between providers.

11.2 The potential avoidable costs of oral disease

Oral disease costs individuals through pain, discomfort and infection, and has a detrimental effect on their broader health and wellbeing. Oral disease reduces a person's capacity for economic and social participation, and imposes costs on the broader community through increased demand in other parts of the health system and decreased productivity (figure 11.1).

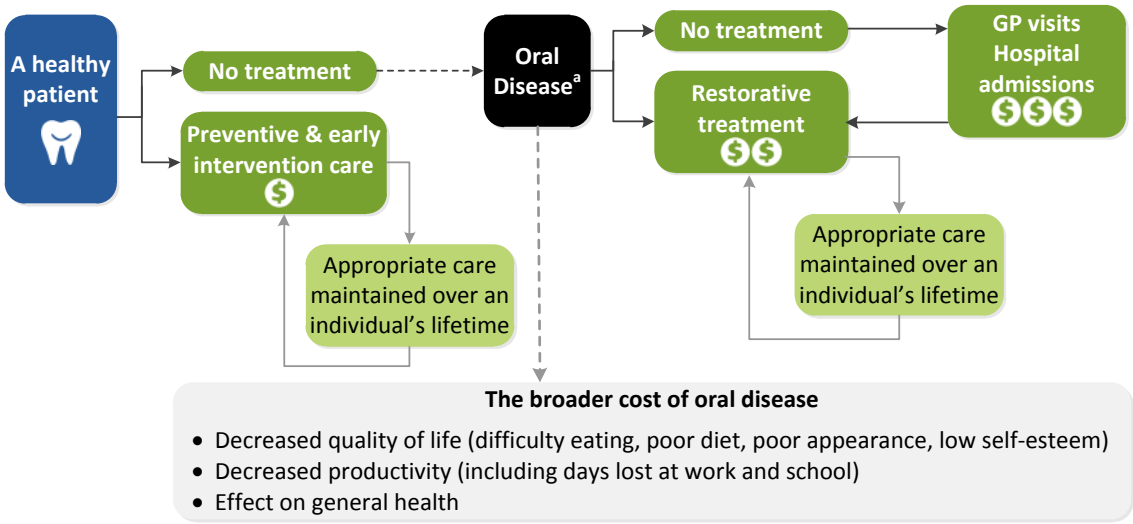
Many dental conditions are preventable (VAGO 2016). Ensuring timely access to dental care can address conditions at an early stage and avoid the onset of oral disease. Several studies have shown that a targeted preventive approach to dental care that is based on an individual's risk profile can be clinically- and cost-effective (box 11.2).

However, the way governments currently manage their waiting lists (on a 'first come, first served' basis) means that, for those at high risk of developing oral disease (box 11.1), their

oral health deteriorates while waiting to receive care, resulting in potentially large avoidable costs to public dental users, governments and the community (discussed below).

The avoidable cost of oral disease has two important implications for the effective delivery of public dental services. First, the time to treatment is an important metric for service effectiveness (discussed in the next section). Second, reforms to public dental services that shift the focus from treating existing conditions to delivering targeted preventive care and early intervention, may improve the oral health of the eligible population. Reforms to give public dental users greater choice over their dental provider can generate incentives for providers to be more responsive to patients' needs — to provide the right treatment at the right time. (Long-term reforms to introduce consumer directed care and encourage the delivery of preventive care to public dental patients are discussed in chapter 12.)

Figure 11.1 **A stylised pathway of dental health care and the costs**



[a] Oral disease covers a range of disorders, from mouth ulcers and oral cancer to teeth and mouth trauma. The two main forms of oral disease are dental caries (tooth decay) and periodontal (gum) disease, which are largely preventable and reversible if treated early. AIHW (2002) noted that about 90 per cent of all tooth loss can be attributed to untreated dental caries and periodontal disease.

The costs to quality of life and general health

Poor oral health can lead to difficulties with eating, sleeping, socialising and working without pain or embarrassment. Dental conditions with cosmetic, but not necessarily painful, symptoms can also have serious effects on a person's wellbeing:

> Dental disease can affect the way a person looks and sounds, with a significant impact on wellbeing – a person whose appearance and speech are impaired by dental disease can experience anxiety, depression, poor self-esteem and social stigma which in turn may inhibit opportunities for education, employment and social relationships. (NACDH 2012, p. 15)

Box 11.1 Who is at high-risk of developing oral disease?

Oral health is influenced by:

- behavioural factors, such as smoking and alcohol consumption, diet, stress, and hygiene
- biological factors, such as the shape and vulnerability of teeth to external influences, and other genetic conditions such as cleft lip and palate
- medical conditions, including taking medications that can alter the flow of saliva and increase the risk of dental caries (tooth decay)
- environmental factors, such as policies to support access to services and water fluoridation
- cultural factors
- socioeconomic factors, which affect an individual's ability to access dental treatment and preventive care, and have been linked to behavioural factors like sugar, tobacco and alcohol consumption.

The interaction of these factors determine an individual's risk of developing particular conditions and their oral health needs. The risk of developing common forms of periodontal (gum) diseases, for example, has been associated with: age, smoking, infrequent dental visits, low education and income levels, and some medical conditions (including diabetes and osteoporosis).

Sub-population groups may face multiple risk factors and, as a result, experience a high burden of oral disease. Based on survey and administrative data, de Silva et al. (2016) identified a range of risk indicators to identify communities at high risk of developing oral disease including, for example, personal behaviours of the population, use of services and disease outcomes. The authors also suggested that these population level indicators could be used to develop a framework for assessing community level risk to use as a basis for allocating public dental services.

Screening and individual risk assessment can play an important role in improving the oral health of the population. To help address oral health inequalities, the National Oral Health Plan identified four priority populations that experience the greatest burden of poor oral health and most significant barriers to accessing care. The identified populations were:

- people who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander people
- people living in regional and remote areas
- people with additional and/or specialised health care needs (including people living with mental illness, people with physical, intellectual and developmental disabilities, people with complex medical needs, and frail older people).

The plan also suggested that the frequency of check-ups and oral health care should be determined through individual risk assessments.

Sources: AIHW (2002); COAG Health Council (2015b); DHSV (2011); de Silva et al. (2016).

Poor oral health can affect an individual's overall nutrition and has been associated with a number of other diseases, such as heart and lung infections and stroke. Poor oral health can also cause complications when interacting with other conditions. For example, gum disease can affect a person's blood sugar intake and increase the risk of diabetic complications (COAG Health Council 2015b).

These costs to individuals' wellbeing are difficult to quantify, but very real.

In 2013, about one quarter of surveyed adults reported feeling uncomfortable about their dental appearance (AIHW 2015c). In the same year, one fifth of surveyed adults reported avoiding eating certain foods because of problems with their teeth (AIHW 2015c). These issues were more prevalent among adults eligible for public dental care, with one third reporting feeling uncomfortable with their dental appearance and 29 per cent avoiding eating certain foods.

The costs to the economy from reduced productivity

Oral disease can have a negative effect on productivity through time that would otherwise be spent in the workforce and education lost due to dental conditions and related treatments.

Using self-reported survey information on the number of days missed from work or study and days of reduced activity, the Australian Research Centre for Population Oral Health (ARCPOH 2012) estimated that:

- there were approximately 2.4 million occasions per year of people taking half a day or more from work or study. Assuming that individuals were away on average for three quarters of a day, the average cost to the economy in lost productivity was estimated to be approximately $453 million annually
- in addition, there were approximately 1.6 million occasions per year of people cutting down on their usual activity. Assuming that lost time for these individuals accounted for on average one quarter of their day, the average cost to the economy in lost productivity was estimated to be approximately $103 million annually
- the combined cost to the economy from lost productivity was estimated to be approximately $556 million annually.

Getting a handle on the true productivity lost from a lack of publicly-funded preventive care is difficult. On the one hand, not all of the estimated self-reported productivity costs will be for oral conditions that were avoidable, and not all will be attributable to those within the eligible population for public dental services. On the other hand, as noted by the Australian Research Centre for Population Oral Health (ARCPOH 2012), the analysis does not include the value of missed time and reduced activity for people not in paid employment or study.

The costs to the health system

People who have untreated dental conditions may seek treatment for pain and infection from other health services, including GPs and hospitals. GPs and emergency departments are, however, generally unable to provide comprehensive urgent dental treatment, requiring patients to seek further care from a dental provider (Cohen 2013).

With little integration with the broader health system, public dental services face difficulties in tracking the health outcomes of their patients over time. The true cost to the health system from treating public patients for preventable oral disease is, therefore, not well understood. The limited information that is available tends not to distinguish the population eligible for public dental services. For this reason, care is needed not to overstate the potential cost savings to the health system from publicly-funded preventive care.

Potentially preventable GP visits

In 2011, over 750 000 GP visits were estimated to be for dental problems and complaints, for which GPs usually provided prescriptions for painkillers and antibiotics, referred patients to dentists, or provided advice on dental hygiene (NACDH 2012). Under the 2017 Medicare Benefit Schedule, the cost to the Australian Government of 750 000 visits to the GP for dental problems could be close to $28 million annually.[4] The demand for prescribed antibiotics also has cost implications for the Pharmaceutical Benefits Scheme, the size of which is unknown (NACDH 2012).

Potentially preventable hospitalisations

People who have untreated dental conditions also seek treatment for pain and infection in hospitals. As noted above, dental conditions were the second-highest cause of acute potentially preventable hospitalisations — accounting for about 67 000 admissions in 2015–16 (up from approximately 64 000 admissions in 2013–14) (AIHW 2017a). These are hospitalisations for conditions that could have potentially been avoided if timely and adequate non-hospital care had been provided. These conditions include dental caries, periodontal disease, cysts and other disorders of teeth and supporting structures (Rogers 2016).[5]

Using data from the Victorian Admitted Episode Dataset, Rogers (2016) found that in 2013-14, hospitalisation rates for potentially preventable dental conditions were highest among young children (particularly children aged 5 to 9 years), for whom the main cause was dental caries (or tooth decay).

Rogers (2016) estimated that expenditure in public and private hospitals for approximately 15 000 potentially preventable dental hospitalisations was close to $56 million in Victoria in 2013-14 — that is, an average cost of $3733 per patient. Assuming that the average cost of

4 This highly indicative estimate of the cost to the MBS assumes that each visit to the GP would take place at the GP's consulting rooms for less than 20 minutes and, therefore, would be eligible for benefit of a $37.05 per appointment in 2017 (Department of Health 2017d).

5 Hospitalisation for dental conditions that are not considered to be preventable — such as, for impacted teeth, cleft lip and palate conditions, and disorders of tooth development — are excluded (Rogers 2016).

each potentially preventable dental hospitalisation was $3733, the estimated cost of the roughly 64 000 admission that year would have been about $240 million.[6]

Public patients accounted for one third of all potentially preventable hospitalisations in Victoria (Rogers 2016). Extrapolating Rogers' (2016) results further, if one third of all potentially preventable dental hospitalisations were for eligible public patients, then the cost of treating public patients for acute potentially preventable hospitalisation could have been in the order of $80 million in 2013-14.

The costs of oral disease occur over a lifetime

After the onset of oral disease, the cost of treating it continues over a lifetime:

> Oral disease (even when treated by fillings or periodontal treatments) will have irreversible lifetime effects and results in a cycle of treatment need. Furthermore, the initial treatment will often result in a cycle of retreatment and repair with further irreversible damage and so carry a lifetime financial cost. The practice of dentistry is largely constructed around this cycle of repair and replacement. The major benefits from managing risk and preventing disease are not immediate but accrue over a lifetime. (Steele 2014, p. 33)

Poor oral health can track strongly from childhood to adulthood (de Silva-Sanigorski et al. 2012). Early detection and prevention may have lifetime benefits for individuals and, potentially, for the health system.

Targeted preventive care can avoid the larger costs of oral disease

Preventive care has been generally accepted as a cost-effective way to deliver services as it can 'avoid' the onset of some oral diseases and the subsequent costs for individuals and the community (figure 11.1).

However, driven by high levels of oral disease and high demand for services, the public dental sector is largely focused on delivering urgent care (particularly for adults).

> The current public dental system struggles to address the lifestyle and broader health issues affecting oral health and although an immediate dental problem can usually be alleviated, it can often be through the unnecessary removal of tooth structure, which invariably leads to other health and quality of life problems. (Calache, Hopcraft and Martin 2013, p. 17)

This surgical or 'drill and fill' approach to the management of symptoms of dental caries may not lead to the management of the disease itself and the disease may continue to progress further. In turn, this approach can increase the demand on public dental programs, leading

[6] Based on 2008-09 data on the average cost per admission, Richardson and Richardson (2011) estimated that the direct cost of 50 000 potentially preventable dental conditions admissions was approximately $233 million annually.

to longer waiting times, and the ineffective use of public resources (Calache, Hopcraft and Martin 2013).

There is evidence that targeted preventive dental care that is based on an individual's risk profile can be a cost-effective approach to delivering dental services (box 11.2). Minimal intervention dentistry, for example, departs from the traditional surgical approach to focus on the risk assessment of individual patients and the early detection and prevention of oral disease. By focusing on early care, Calache, Hopcraft and Martin (2013) argued that adopting minimum intervention dentistry in Australia's public dental system could help to reduce the need for complex restorations and improve the oral health of public dental patients.

The National Health Service (NHS) in England is progressively introducing a risk-based preventive dental care pathway. The pathway focuses on managing risk, creating a healthy oral environment through providing preventive care, encouraging healthy behaviours, and engaging in continuing care. An initial oral health assessment informs a 'traffic-light' system indicating whether patients are at high (red), medium (amber) or low (green) risk of oral disease, and to tailor the care provided (including recall intervals). Evidence from the initial pilot suggested that the pathway was effective in reducing risk and improving patients' oral health (Steele 2014), but further research is needed to determine the cost-effectiveness of the approach (Hulme et al. 2016).

Targeted investment in preventive dental care is likely to have long-term benefits to individuals, governments and the wider community from preventing the onset of oral disease. The Victorian Auditor-General's Office (VAGO 2016) suggested that shifting the focus of services from treatment to prevention would represent a more cost-effective way to deliver public dental services. However, it also noted that there is a backlog of people with oral disease who require treatment, and getting the balance right between prevention and treatment is a longer-term objective. This highlights the need for a considered and long-term approach to reform.

Box 11.2 The cost-effectiveness of preventive dental care

The costs and benefits of preventing and treating oral disease occur over a lifetime, and the effect of interventions to prevent oral disease may occur with a long lag time, or be confounded by other factors that influence oral health. Estimates of the long-term costs and benefits of prevention measures are therefore challenging, and relatively few evaluations in the oral health literature consider both the outcomes and costs of an intervention (Morgan et al. 2012). Further, to date results have come from small-scale trials with differences in the types of preventive services provided and, as a result, are not necessarily generalisable to the broader population.

However, some clinical studies (outlined below) provide evidence that a targeted preventive approach to dental care can be clinically- and cost-effective. These studies tend to find that the benefits of preventive dental care are greatest for patients at high risk of oral disease, and are potentially *not* cost-effective for those at low risk.

The cost-effectiveness of the Caries Management System

Warren et al. (2010) evaluated the long-term cost-effectiveness of a three year randomised clinical trial of the preventive approach underpinning the Caries Management System (CMS) in private dental practices in New South Wales and the ACT. The CMS is a non-invasive program designed to prevent cavities arising from dental caries, to stop the progression of existing lesions, and reduce future needs for restorative care.

After adjusting for the baseline incidence of dental caries, the authors found the CMS significantly reduced the incremental number of decayed, missing and filled teeth (DMFT) over the three year study period. Extrapolating the cost and outcomes beyond the study period, the incremental cost per DMFT avoided was estimated to be $1795 over a patient's lifetime.

The cost-effectiveness of the CMS was found to be highly dependent on the patient's risk of dental caries:

> When compared with standard dental practice in Australia, the CMS is most cost-effective in patients who have a high underlying incidence of developing dental caries. The CMS is unlikely to be cost-effective in patients with a low risk of developing dental caries unless the costs associated with the program can be constrained (for example, by assuming that the monitoring of caries activity is performed by a dental hygienist rather than a dentist). (Warren et al. 2010, p. 759)

Cost-effectiveness of a telephone program in disadvantaged communities

Pukallus et al. (2013) examined the oral health outcomes for children living in low socioeconomic areas in Queensland who received a telephone delivered education program to prevent early childhood caries. Early childhood caries are a significant problem in low socioeconomic populations, and can be costly to treat as young children may need to be treated under general anaesthesia or sedation. The costs of early childhood caries are compounded by higher caries rates in later childhood and adulthood.

The program provided oral health instruction to parents when their children were aged around 6, 12 and 18 months. Outcomes were compared to a usual care group of children from the same district who received care in the public dental system. By age 6 years, the telephone intervention program was estimated to have prevented 43 carious teeth and saved approximately $113 000 in healthcare costs per 100 children.

Pukallus et al. (2013) concluded that a preventive intervention by telephone is likely to generate considerable and immediate patient benefits and cost savings to the public dental services in low socioeconomic areas.

11.3 Establishing the prerequisites for reform

As the Commission's study report (PC 2016b) found, public dental services do not support users to seek timely treatment for oral health problems. The reforms to introduce greater user choice and contestability proposed in chapter 12 are intended to achieve this goal. However, before these proposed reforms can proceed, it is important that governments have a greater understanding of who needs more timely access to care, and to have systems in place to measure the outcomes for users.

As an initial step, access to public dental services for higher risk users in an appropriate timeframe can be encouraged through benchmarking of wait times. There is, at present, no way to compare the timeliness of access to public dental services between jurisdictions, because they are not measured on a comparable basis. Average wait times are included in the annual *Report on Government Services* (SCRGSP 2017), but are not comparable between jurisdictions (and New South Wales does not participate).

Outcome measures are not routinely published for public dental services. Some jurisdictions report some quality indicators, but on the whole performance measures for public dental services are not well developed. As the South Australian Government observed, 'there is at present no nationally consistent framework for reporting and accountability for public providers of dental services' (sub. 460, p. 4).

In addition to laying the path for long-term reform, benchmarked wait time and outcome measures would be beneficial in their own right. Developing and publishing these two measures would improve the accountability of public dental services to those who pay for them (governments and users through co-payments), assist in systematic service planning (chapter 2) and assist targeting of those at high risk of oral disease.

Benchmarking wait times

In addition to the patient's pain, there are a number of costs if oral conditions go untreated that could potentially be avoided with more timely access to dental care (section 11.2). With that in mind, it is the *time* on the waiting list that is of interest and not the length of the waiting list. Since demand and the availability of resources can fluctuate over time, 'waitlists may not be inherently bad as long as the eligible patients are able to access the required care within desirable time frames' (Dudko, Kruger and Tennant 2016, p. 278). It would therefore be of much value if public performance reporting included benchmarked wait times. These benchmarks should be based on the maximum clinically-acceptable timeframe for treatment.

The risk of escalating harm while awaiting treatment, and therefore the clinically-acceptable timeframe, will vary by patient. To use resources efficiently, public dental services should ensure that care is received by those that need it the most, and will benefit to the greatest degree. As such, there should not be a single benchmark, but rather a range of benchmarks

by risk (or triage) groups. Dental Health Services Victoria (DHSV) outlined how such an approach could work, and its role in monitoring the system:

> An alternative approach to comparative waiting time performance metrics would be to further develop response time targets for patients of different triage categories. Triaging is already done for emergency public dental services with targets to treat within defined times. However, risk is not currently categorised when people go onto the waiting list – so their condition may deteriorate over time, rather than preventing the worsening of the most serious conditions.
>
> As is done in other parts of the health system (notably, for elective surgery patients) dental patients — both hospitalised and in the community — should be prioritised in accordance with risk triage categories and with guidelines for such prioritisation and triaging. This would enable assessment and monitoring of waiting time targets, together with relative funding levels between jurisdictions, per risk-weighted patient. (sub. PFR366 p. 21)

All public dental services triage and prioritise access for patients in need of urgent care (box 11.3), but not all publicly report whether they meet their triage goals. For example, in Tasmania there are five triage categories with recommended appointment timeframes, but the only public reporting is on the urgent triage category (Tasmanian Health Service 2016). In contrast, Queensland publishes monthly reports for every clinic on the number of adults waiting or seen within clinically-acceptable benchmark times for all its priority categories (table 11.1). For example, in January 2017, 85 per cent of 'priority 2' category patients seen in the Toowoomba dental clinic had been waiting less than the clinical benchmark time of 3 months (Queensland Health 2017b).

Publication of monthly data allows thorough analysis to be conducted, such as comparisons across the State or over time, improving the usefulness of the data in assessing system performance, and is an essential element of good government stewardship (chapter 2). For users, improvements in accountability can encourage governments and service providers to better allocate their resources, improving the responsiveness, and thereby the effectiveness, of service provision.

The triaging systems used in Queensland and New South Wales go some way toward that recommended by DHSV. In New South Wales, access to dental assessment and treatment is based on medical and dental needs as well as socio-economic and other risk factors. Adults can be classified as 'high oral health need' based on two clinical criteria: having three or more extensively decayed (or 'carious') teeth or scoring 3 or higher on an index of gum disease (Centre for Oral Health Strategy 2008). The recommended treatment time for adults with high oral health need is 12 months from initial assessment. Children with decay in any permanent teeth are recommended to be treated within 6 months. Pregnant women with poor oral health requiring treatment are recommended to be seen within 3 months.

Box 11.3 How patients are triaged by public dental services

Public dental services in all jurisdictions triage patients with urgent oral problems. While each jurisdiction is different, all use an initial telephone assessment. Some jurisdictions make efforts to prioritise access to general care. Victoria, for example, prioritises specific population groups that are at greater risk of poorer oral health than the general population, including children, homeless people, and Aboriginal and Torres Strait Islander people.

Telephone triaging

In Tasmania, for example, telephone triaging is conducted by trained receptionists using triage software. Patients are asked questions about their symptoms, such as whether they have pain that wakes them during the night, or whether they have any swelling of the mouth or face. The triage software determines the severity of the complaint and determines the patient's priority for accessing care. There are a number of possible priorities, including 'see today', see in 2 days, see in 3 weeks, see in 6 weeks and add to the waiting list for general care (which, in Tasmania, could be up to three years) (SCRGSP 2017).

A Relative Needs Index

South Australia and New South Wales have developed a telephone triage questionnaire, the Relative Needs Index (RNI). To develop the RNI, researchers tested whether a questionnaire of patient reported symptoms could approximate a dentist's clinical judgment around the urgency of treatment. Some indicators were good predictors of dentists' treatment recommendations. For example, patients that had pain in their jaw when opening their mouth wide were 2.4 times more likely to be clinically assessed as requiring treatment within 48 hours compared to those who did not have pain. The largest statistically significant effect was for patients that reported difficulty sleeping all the time because of pain or discomfort. The study found it was also possible to determine levels of priority for general dental care using the RNI. Victoria began using the RNI to triage urgent care in 2016, but no jurisdiction uses the RNI to triage access to general care.

Jones (2012) reported on a trial of the RNI at four clinics in South Australia that found it was successful in shifting efforts away from urgent care toward more preventive, general care. Using the RNI resulted in the proportion of staff hours spent on urgent care falling from 60 per cent pre-implementation to 40 per cent post-implementation, with a proportionate increase in the time spent on general, preventive care.

A tiered approach

In Queensland, patients are given an initial assessment over the phone, with three possible outcomes: being provided an appointment for urgent care; being placed on the general waiting list; or being referred for a clinical assessment. A clinical assessment is a brief examination that is used to prioritise patients based on their clinical needs. All patients seeking treatment for a problem (that are not immediately given an appointment for urgent care) will undergo a clinical assessment. Additionally, patients that meet certain criteria will be given a clinical assessment, including Aboriginal and Torres Strait Islanders, those with denture related concerns, those with a disability, children aged 0 to 3 and refugees and asylum seekers. A clinical assessment can result in a patient being given access to urgent care, being placed on the general or priority waiting lists, or being advised that they do not require dental care.

Sources: DHSV (2016); Luzzi et al. (2009); Ponnusamy et al. (2013); Queensland Health (2015); VAGO (2016).

Table 11.1 **Clinical benchmarks for waiting times in Queensland**

Clinical category	*Benchmark waiting time*
Seeking clinical assessment: a brief examination to prioritise patients clinical needs and allocate patient to an appropriate waiting list	1 month
Priority 1: condition may deteriorate to become emergency, or dental care is delaying other urgent treatment	1 month
Priority 2: condition causes some pain or dysfunction but is not likely to deteriorate quickly or become an emergency	3 months
Priority 3: condition causes minimal or no pain or dysfunction, is unlikely to deteriorate quickly or become an emergency	12 months
General: non-urgent dental care, e.g. a check-up	24 months

Source: Queensland Health (2015).

The frequency of publication, as well as the level (clinic, region, or jurisdiction) should match the purpose for which the data are intended. For example, publication would need to be frequent and at the lowest level available, preferably for individual public dental clinics, to support increased user choice. As the Victorian Auditor-General's Office observed, while 'wait time data is accurate only at a point in time, making this data publicly available could assist patients in making decisions about accessing public dental services, as they could compare wait times at different [community dental agencies] in their region' (VAGO 2016, p. 28).

For performance monitoring it may be more appropriate to report on longer timeframes and at a higher level. This should be at least annually at the jurisdiction level, similar to the reporting in the *Report on Government Services*. Publishing these data would also be consistent with the Commission's *Data Availability and Use* report (PC 2017), which recommended that governments release all non-sensitive publicly funded datasets. In particular, the Commission recommended that, subject to risk assessment and mitigation efforts, low risk data that could be used for program or agency performance management purposes should be released.

While the publication of waiting time performance brings transparency itself, benchmarking also has other benefits. Waiting time performance measures can be used by a public dental service to monitor trends in demand and guide future decisions about system design, including whether the service is meeting its objective, whether eligibility criteria are capturing the intended users, and resource allocation. In particular, rather than aggregate data, more detailed data on a clinic-by-clinic basis could be used (in combination with other data such as demographic trends) for service planning within a jurisdiction about where to

invest future efforts, as well as understanding those areas that have managed their waiting list well or poorly.

At present, published waiting time performance metrics are not reported on a consistent basis across jurisdictions. This impedes accountability. If waiting time performance were comparable, public dental services in different jurisdictions could look to the better performers for ways to improve their system. For example, jurisdictions could have compared the effects of the different ways they used the additional funding provided under the 2013 National Partnership Agreement. While there may be some initial difficulty in coordinating a consistent set of benchmarks across jurisdictions, as well as potential short-run transition costs for clinics to change their reporting practices, the Commission considers the ongoing benefits outlined above to be significant enough to warrant these efforts.

DRAFT RECOMMENDATION 11.1

State and Territory Governments should report publicly against a consistent benchmark of clinically-acceptable waiting times, split by risk-based priority levels.

Once data systems are developed, provider-level reporting should be published monthly and aggregate measures included in public dental services' annual reporting processes.

A need to develop outcome measures

A fundamental requirement for an effective public dental system is the ability to assess the performance of service provision on the basis of outcomes, rather than just outputs or inputs. Outcome measures would show the quality of the services provided by the public dental system, and how they are improving the oral health of users. Outcome measures could be used in a variety of ways to improve the delivery of public dental services.

Outcome measures can create the framework for contestable contracting of public dental services. Box 7.7 in chapter 7 outlines the forms of outcomes-based commissioning, including outcomes-based program design, monitoring, evaluation and funding.

For public dental services, an outcomes framework would provide the basis for governments to choose providers that can improve oral health in a cost-effective way. Once the government has selected providers, it would be able to monitor performance over time, to see if providers' actions are improving outcomes for users. Governments could also use outcome measures to compare different providers, that could highlight best practices to disseminate through the network of providers. Publication of outcome measures would also help to keep governments accountable for provider performance, reinforcing their stewardship role and providing extra impetus to disseminate best practices.

If governments, as stewards, held providers accountable for outcomes, providers would have an incentive to prioritise activities that are proven to be clinically- and cost-effective, such

as targeted preventive care. If outcome measures were published, providers could use the data to benchmark themselves to see if there are service improvements from other providers they could adopt. An outcomes focus may also lead providers to be more responsive to the needs of users. For instance, providers could work more closely with other types of services such as transportation, education or translation services.

A further step beyond reporting outcomes would be to link them to funding. The Victorian Auditor-General's Office noted that the current output-based funding model rewards more complex and time intensive treatments and does not encourage providers to carry out preventive activities (VAGO 2016). DHSV recommended that the funding of public dental services be based on outcomes:

> Regardless of whether the government implements greater competition and contestability in the dental industry, the payment system should be focused on providing performance based reimbursement. (DHSV, sub. 465, p. 11)

Specifically in the context of improving user choice to public dental services (chapter 12), consumer directed care could incorporate outcome measures in the payment structure for providers. The potential use of outcome measures in payment models is discussed further in chapter 12.

All governments have previously acknowledged the need for continuous improvement in the safety and quality of oral health services and endorsed benchmarking programs incorporating clinical outcomes and other quality indicators (COAG Health Council 2015b). DHSV has observed that there is a need for public dental services to apply a 'value based health care model' that aims to achieve the best outcomes for users in a cost effective way. It 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, to be completed by the end of 2017 (DHSV, sub. 465). Dental Health Services Victoria is aiming to use outcome measures to analyse the effectiveness of its services and prioritise high-value care (that contributes to patient oral health) while eliminating low-value care.

What types of measures should be used?

Some clinical outcome measures are already collected, such as rates of tooth decay and gum disease. However, an important area for further work is to measure health outcomes from the patient's perspective. Patient experience measures can give important insights into not only the level of oral disease experienced but also whether that disease had been treated in a timely fashion (AIHW 2015c). Some measures, already reported at the national level, include toothache experience and whether people avoid eating certain foods.

Patient-reported outcome measures

Patient-reported outcome measures (PROMs) are increasingly being used in the broader health sector. For example, in England, the NHS has collected PROMs on four types of elective surgery since 2009 (chapter 10 discusses PROMs in a public hospital context). These data are used by providers to evaluate potential improvements to services, and recently have been linked to payment incentives in pay-for-performance schemes (Gomes et al. 2016). Starting 1 July 2017, the Victorian Department of Health and Human Services plans to collect PROMs data on an ongoing basis from Victorian health services (including hospitals). Victoria is trialling incentive payments based on patient experience surveys for health services that effectively manage the transition of patients from hospital back to the community. Victorian health services are eligible for incentive payments based on the responses from patient experience surveys (Victorian DHHS nd).

Box 11.4 Dental Quality Indicators in England

The National Health Service (NHS) in England is trialling a system that rewards dental providers for good performance. The UK Department of Health (2015, p. 31) acknowledge that quality indicators, and in particular outcome indicators, are 'relatively new in the NHS and even more so in dentistry'.

The quality indicators used in the trials were based on clinical outcome measures of dental decay and gum health. They also included patient function and experience measured by patient surveys. Providers are scored against a Dental Quality and Outcomes Framework (DQOF) that covers 5 domains:

- clinical effectiveness (which represents 50 per cent of the DQOF score) — that is, maintaining or improving a patient's condition. It includes indicators such as the percentage of patients with decayed teeth, and adults that improved or maintained their gum health.
- patient experience (30 per cent of the DQOF score), which includes indicators such as the percentage of patients reporting that they are able to speak and eat comfortably
- safety (10 per cent of the DQOF score), which is measured by the percentage of patients whose medical history is kept up-to-date
- data quality (10 per cent of the DQOF score), which includes indicators such as the timeliness of data submissions to the NHS Dental Service.

The trial began in 2011 with 70 practices. The trials provided information on designing viable indicators and ensuring reasonable data quality. As at January 2015 the data were still not considered robust and complete enough to provide a fair basis for remuneration for providers.

Source: Steele (2014).

Patient reported outcomes are, by their nature, subjective — they capture an individual's experience and outcomes relating to changes in, say, pain levels and their ability to conduct day-to-day tasks (such as eating) (chapter 10, box 10.3). This informs the ways these data can be used.

- First, they can directly measure whether dental services are improving patients' wellbeing.

- Second, while each user's experience may vary, public reporting of outcome measures in simple, user-driven categories ('pain went down', 'gave good advice') could inform user choice more directly than complicated clinical measures. As Tan Nguyen, president of the Australian Dental and Oral Health Therapists Associated noted, clinical information may not be relevant to the majority of users of public dental services (sub. 398). However, outcome-related information can be translated to metrics that would be of use to individuals, such as star ratings reporting performance against select criteria (the choice of criteria should be informed by their usefulness for patients and the reliability of simplified measures).
- Finally, as PROMs are based on users' perception, when combined with other data, they can provide insights into which elements of service provision drive behavioural change (for example, over time the data could reveal that those dental services that 'gave good advice' or 'made it easy to get an appointment' saw greater long-term reductions in oral disease). As noted in chapter 10, provider self-improvement based on published performance data can be a powerful driver of improved outcomes.

The level of reporting

Outcome measures could be collected and reported for individual dental professionals or at the clinic level. Chapter 10 outlines the Commission's view that public reporting on performance of individual specialists within the hospital system should be phased in. For some dental clinics, there will be only one dental professional, so any data reported will cover the clinic and the clinician. In 2013, approximately one-third of private sector dentists worked in a sole practice (AIHW 2015c). Larger dental clinics may employ a range of dental professionals — including dentists, oral health therapists and dental therapists — in different mixes to provide bundles of services. This can lead to complications in understanding how the work of one dental professional affected a patient's outcomes.

Initially, outcome reporting should take place at the clinic level until complications such as these can be worked through. The experience in hospitals, particularly in England and the United States (chapter 10), suggests that moving to an individual level is possible over time. This will require the support of the profession, who could benefit from information that would support learnings of clinical best practice and efforts to compare their work to their peers.

Existing concerns can be addressed

As outlined in chapter 10, a common argument against provider or clinician-level reporting is that it encourages 'cherry picking' of lower risk patients. However, there is little evidence of widespread avoidance of high-risk patients for hospital specialists. In addition, there are a number of ways to address potential concerns.

- First, measuring the relative change in a patient's oral health (comparing their pre- and post-treatment status), rather than reaching a given absolute level (a disease-free mouth)

could ensure that the focus is on the outcomes that arise as a result of the service provided, not the underlying characteristics of the users.

- Second, appropriate risk-adjusted benchmarks could be developed to ensure that any comparisons are robust. The benchmarks could be developed and implemented in collaboration with the dental profession to ensure its support, and would need to take into account differences in the mix of patients for robust comparisons.
- Third, results could be presented in a way that does not overemphasise minor differences. For example, 'funnel plots' are used to illustrate risk-adjusted hospital mortality rates (box 10.7 in chapter 10). Additional protection could be provided by safeguards that accompany the data, with the appropriate safeguards depending on the intended audience. For example, providers could be given more detailed benchmarking reports that show their performance relative to their peers, while users could have access to more aggregate data that only reports whether the provider is meeting a certain threshold.

Implementation

So that outcome measures will have their desired effect of driving service improvements, governments need to ensure they are relevant, measureable and implementable. Central to developing desirable outcome measures is to engage with those with implementation skills, knowledge and experience during their development. Part of the development process could involve some initial test sites, with relevant stakeholders closely engaged, to identify success factors and gain acceptance of the measures. The development process could also include the gathering of baseline data from some demographically and geographically distinct sites. These data could inform the development of benchmarks that can provide the basis for comparisons of relative performance of providers.

Governments could still consider more context-specific measures when they commission services. Some output or activity measures may be good proxies or predictors of health outcomes and could be used in the short term where there is strong evidence of a relationship (DHSV, sub. PFR366).

DRAFT RECOMMENDATION 11.2

State and Territory Governments should establish outcomes frameworks for public dental services that focus on patient outcomes and include both clinical outcomes and patient reported measures.

State and Territory Governments should assess Dental Health Services Victoria's work to date on outcome measures, once implemented, with a view to identifying and commencing implementation of a nationally consistent outcomes framework.

A digital oral heath record

Public dental services face difficulties in tracking patients over time, following patients between public clinics (or between hospitals and clinics) and following patients treated in the private sector (even when they are publicly funded). There is little integration with the broader health system. A digital oral health record would support user choice, assist service planning and could support more coordinated care for patients.

The Commission's *Efficiency in Health* research paper outlined some of the benefits of electronic health records:

> Electronic health records offer the potential to improve patient care and care coordination by facilitating the sharing of information between health care providers, including on patients' diagnoses, tests and medications, and by reducing duplication in tests and procedures. A single, centralised health record would also help consumers to keep track of — and exercise control over — their own care, while simultaneously being a valuable information source for researchers. (PC 2015a, p. 79)

In the National Oral Health Plan, governments endorsed the inclusion of oral health information in electronic health records:

> Effective integration of health information systems supports improved capacity to plan and deliver care and to assess service quality, efficiency and health outcomes. Shared health information and records support increased consumer focus and enable more coordinated care. (COAG Health Council 2015b, p. 33)

Some State Governments have begun introducing digital oral health records. For example, in 2016 the Queensland Government introduced a system that allows public dental clinics to enter and store all clinical information in a state-wide database. Information recorded includes patient's medical history, tooth charting, treatment planning, clinical notes, referrals and medication lists (Queensland Health 2016). Costs in Queensland have included upgrades to IT infrastructure, adapting local business practices, training staff in each dental clinic and providing on-site support.

A centralised, state-wide electronic information system to capture clinical activity is used in New South Wales. Paper records are used for patient's medical history, diagnosis and test results as the electronic system does not have the capacity to record full medical histories. A study of a random sample of clinical records found the electronic records to be more reliable than the paper records (Masoe et al. 2015).

Government initiatives to improve oral health records within their public dental systems will not, on their own, provide the link to the broader health system or the private sector. The link could be provided by the Australian Government's My Health Record (MHR), which is a web browser-based electronic health record that contains a summary of a patient's health information. As at 23 December 2016, approximately 65 per cent of public hospitals and health services were connected to the MHR system (although connection does not imply actual use) (Digital Health Agency nd). If more public dental services began using MHR it could improve their connection with the wider health system.

Currently, participation in MHR is voluntary for patients and providers. The COAG Health Council (2017) has agreed to a national opt-out model for the MHR system, with the Australian Government confirming its commitment to the opt-out model in its 2017-18 budget (Australian Government 2017a).

Digital oral health records may also enhance the benefits of user choice. A portable dental history would enable a patient to switch providers more easily as they can be assured that the new provider will have the same information as their previous provider. Such a record would be consistent with the comprehensive right for individuals over their own data, as recommended in the Commission's *Data Availability and Use* inquiry (PC 2017). Portable records could avoid duplication of initial diagnostic processes (providing existing diagnoses are sound and recent) and tests like x-rays. This would require private providers that treat public patients to also participate in digital oral health record systems.

The Australian Dental Association (ADA 2016) has supported an opt-out system for patients for MHR but cautioned that electronic health records could create administrative burdens for dental practices. The Australian Dental Association argued that many dental practices have limited resources to deal with security and data quality requirements that governments may impose. The Australian Dental Association advocated for dental practices to receive financial assistance to adopt the changes required to implement electronic health records.

Notwithstanding the potential benefits from the widespread use of MHR, there are some limitations to the system. At present, it:

- does not contain a full health record, with much information (including hospital data) retained on local systems
- is not fully interoperable with existing software used by many health practitioners.

These limitations, if not addressed, could restrict the ways MHR could be used. For instance, ideally the MHR could be used to assist identifying high-risk patients when they make contact with public dental service, but this would depend on both the completeness of a patient's medical history and interoperability between MHR and dental triaging systems.

The full potential of MHR may be realised over time, with some improvements already underway. By May 2018, registration processes for health providers will be online and fully automated (Department of Health 2017e). As the system becomes easier to use for health professionals, and more patients enrol in it, MHR could be considered the vehicle for portable oral health records.

In the first instance, public dental services should work to digitise their own oral health record systems, and ensure linkage between jurisdictions. (The Commission notes that some jurisdictions have already commenced this process.) This should be done with a view to the longer-term goal of incorporating oral health records within the MHR system.

DRAFT RECOMMENDATION 11.3

State and Territory Governments should develop comprehensive digital oral health records for public dental services. Once developed, these systems should be incorporated within the My Health Record system.

12 User choice and contestability in public dental services

Key points

- Consumer choice in public dental services could be improved by the introduction of a consumer directed care model. This model could lead to improvements for users, and the system, by:
  - giving users choice over their dental provider
  - making better use of dental professionals in the public and private sectors
  - shifting the focus of the system to preventive care, which could avoid some of the costs of letting conditions worsen, and reduce demand for some hospital services.
- Compared with the current system, the consumer directed care model proposed by the Commission could improve outcomes for users by:
  - triaging patients according to their risk of oral disease (while retaining governments' ability to control the costs of service delivery)
  - providing access to top-up payment arrangements that, with consumer safeguards, could allow patients to pay a top-up fee to access a wider range of treatments
  - providing patients with consumer-oriented information (clinic locations and outcomes, prices, waiting times) to enable their choice of provider.
- In addition to the benefits to patients, the proposed approach represents a more efficient and sustainable use of government funds than fee-for-service vouchers.
- Consumer directed care would not be feasible where people are not able to choose between alternative competing providers, for example, in remote areas. In these circumstances, governments could improve outcomes for patients by commissioning services.
  - Governments need to take a more systematic approach to selecting providers that can best meet users' needs. Using an outcomes framework to monitor provider performance would promote a stronger focus on the long-term improvements to people's oral health.
- Reforms to introduce greater user choice and contestability require a fundamental shift in the way that public dental services are funded and overseen, and a staged long-term implementation path.

For people who access public dental services, choice and outcomes could be improved over the long term by the introduction of a consumer directed care model, coupled with a focus on targeted preventive treatments. Reforms to improve data collection and the performance framework (chapter 11) are necessary to underpin greater user choice and contestability. Table 12.1 provides an overview of the Commission's proposed reforms to public dental services.

Table 12.1 **Overview of proposed reforms to public dental services**

Reform direction	*Timeframe*	*Potential costs and benefits*
Improved data collection and reporting		
Draft recommendation 11.1 State and Territory Governments to report publicly against a consistent benchmark of waiting times.	As soon as practicable, completed within 3 years	Increases accountability. Costs could include the difficulty in coordinating across jurisdictions, and administration costs for providers.
Draft recommendation 11.2 State and Territory Governments should develop and progressively roll out means to **measure the outcomes for patients**.	Development is already underway	Increases accountability and promotes efficiency and quality improvements in services. Time is needed to develop measures that are meaningful, so a staged roll out is recommended.
Draft recommendation 11.3 State and Territory Governments should **adopt digital health records** that follow patients in the public and private dental sectors, and wider health system.	As soon as practicable	Improves the quality and efficiency of the system, particularly in providing additional information for triaging. Costs could include adopting new data systems, and costs for users and providers to create and maintain records.
Improving commissioning		
Draft recommendation 12.5 State and Territory Governments should **establish effective commissioning system**s to enable contestability for public dental services.	As soon as practicable, following the implementation of benchmarking and outcome measures	In settings where competition is not feasible (including remote provision and other outreach services), introducing greater contestability would improve the quality and efficiency of services.
Transition to a consumer directed care model		
Draft recommendations 12.1, 12.2, 12.3 and 12.4 Sate and Territory Governments should introduce a **consumer directed care** model using a blended payment model. Access to consumer directed care should be based on **triaging according to risk**. This should provide patients access to: • those treatments required to have a disease-free mouth • the option to pay 'top-up' fees to access a broader range of treatments • tailored information to support them to choose a provider.	Initial test sites to commence following the completion of outcome measures, with large scale roll-out within 5 years after completion of the first tests	Patients would have choice over participating providers (public or private clinics) who will care for them for an enrolment period. This can generate incentives for providers to be more responsive to patients' needs — to provide clinically- and cost-effective treatments. Shifting the focus from treating existing conditions to rewarding targeted preventive care and early intervention, would improve the oral health of users and avoid the larger costs from the onset of dental disease. Changes to financial incentives can produce large and abrupt changes in professional behaviour. To manage this initial test sites should evaluate new blended payment models and allocation systems before a staged roll out.

12.1 Giving users choice through consumer directed care

The current emphasis on providing services in the relatively limited number of government-operated clinics constrains user choice over the timing and location of treatment. Under a consumer directed care approach, it is the user's choice that determines which provider receives the funding allocated to them, and in some cases which services they receive and where and when they are delivered. A consumer directed care approach to public dental services could make greater use of private and public dental professionals, enabling users to have choice over a greater range of providers. Giving users greater choice over their dental provider can also generate incentives for providers to be more responsive to patients' needs as they are only funded when users choose them (chapter 2).

While beneficial, increased user choice is not the sole intent of this reform. As discussed in chapter 11, most dental conditions are preventable. Timely access to dental care can avoid the larger costs (to users, governments and the community) that arise when oral health conditions are left untreated. Several studies suggest that preventive dental programs targeted to individuals at high risk of developing oral disease can be clinically and cost effective (box 11.2). As such, the Commission considers that users' outcomes could be improved further if the implementation of consumer directed care also focuses on providing access to treatments that are assessed to be clinically and cost effective, and to encourage targeted investment in preventive treatments.

A consumer directed care approach would deliver benefits for users, governments and the community by:

- using a capitation payment for clinics to provide ongoing care for patients over an enrolment period, and enabling providers to invest in preventive and early intervention care
- weighting payments based on the treatment needs of different patient groups, countering any incentive for providers to 'cherry pick' by accepting only patients with straightforward needs
- rewarding providers for improving the oral health of their patients by paying them for achieving clinical and patient outcomes
- introducing top-up payment arrangements, with consumer safeguards, to give users access to a wider range of treatments
- using a centralised waiting list, prioritised and benchmarked based on risk categories, to target preventive and early intervention care to those most at risk of developing oral disease.

Under the Commission's proposed reforms, the user's chosen provider would care for them over an enrolment period, with provisions for patients to change providers in certain circumstances. The proposed use of an enrolment period does not offer the same level of choice as a fee-for-service voucher scheme. However, by rewarding preventive and early

intervention care (rather than payments for the number of treatments provided), consumer directed care could offer greater benefits to the oral health of the eligible population.

Improving user choice through a consumer directed care approach would require a fundamental shift in both the way that public dental services are funded and the stewardship arrangements that are needed to support the proposed reforms. These reforms, therefore, require a staged long-term reform path.

This chapter examines the case for, and details of, these proposed reforms.

12.2 The role of payment models in aligning incentives

The services delivered by health professionals, including dental professionals, are influenced by a range of factors such as medical ethics, professional codes of conduct and monitoring. Clinical guidelines based on robust and up-to-date evaluations, for example, can be an important way to promote best practice in delivering clinical- and cost-effective health care (PC 2015a).

Allowing users to choose who receives government funds (by choosing a provider), in combination with the payment model, can also help to align the incentive of providers with governments to deliver clinical- and cost-effective services at least cost (chapter 2). The dominant payment models for public dental services in Australia are salaried professionals working in public clinics and fee-for-service vouchers paid to private practices.

Each payment model has advantages and disadvantages (chapter 2).

- Salaried payments are simple to administer (dental professionals are paid the same salary regardless of the number of patients seen or the number of treatments provided), and gives funders more control over expenditure. However, salaried payment models have no explicit (financial) incentive to improve outcomes for patients by improving the quality or lowering the cost of care.
- A fee-for-service payment model rewards dental professionals for activity or work undertaken. The issues with fee-for-service models in primary care settings, however, are well recognised. Providers have a financial incentive to increase the number of services delivered or tests performed, reduce consultation times and recommend follow-up appointments, potentially leading to costly 'over servicing'. Unless preventive treatments are specially paid for (with a sufficient margin), providers are not incentivised to prevent future diseases.

In practice, these two models appear to have resulted in different service patterns for public patients treated in the public relative to the private sector.

For example, comparing the Dental Weighted Activity Units (DWAUs) provided during a course of care, Dental Health Services Victoria (DHSV, sub. PFR366) found that Victorian public patients treated at a private practice (using a fee-for-service 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 in the study report also argued that the relatively high level of servicing contributed to higher costs for treating public patients in the private sector. Dooland (sub. PFR300) suggested that the cost of a course of general dental care was, on average, 30 per cent higher for adults treated in the private sector compared with the public sector.

Participants in the study report raised concerns about the quantity and types of treatments provided to public patients under fee-for-service vouchers and questioned the added benefit to consumers of these treatments, particularly under the Chronic Disease Dental Scheme (CDDS). The expansion of the CDDS in 2008 (when the range of eligible services broadened to include reconstructive services and the spending cap was increased to $4250 per patient), led to an unsustainable increase in expenditure (Lam, Kruger and Tennant 2015). The growth in expenditure was largely attributed to the increase in aesthetic crown treatments (porcelain fused to metal crown), for which Lam, Kruger and Tennant noted there was limited evidence of the disease-control benefits. The CDDS saw significant waste and over-servicing and was closed in 2012 (Plibersek 2012).

Fee-for-service vouchers — used across jurisdictions often as short-term arrangements to manage capacity constraints in the public dental system — have provided recipients with greater choice over the timing and location of treatment. However, they have not been cost effective as incentives have focused on the numbers of services and not their outcomes.

In the Commission's view, sole reliance on fee-for-service arrangements to improve user choice and competition in public dental services could pose systemic risks to the ongoing sustainability of the scheme (as was the case with the closure of the CDDS). As such, exploration of other payment models that provide incentives for preventive and early intervention care is warranted.

Using capitation payments in dental care

Capitation payment models, where health professionals are paid a periodic payment for each enrolled patient, can overcome some of the problems with 'over servicing' under a fee-for-service model (chapter 2). By providing a *fixed budget* over time for each enrolled patient, well-designed capitation arrangements can incentivise providers to reduce costs through providing fewer, or less costly, treatments and 'investing' in cost-effective preventive and early intervention care.

Capitation payments do have drawbacks. A weakness of the capitation model is the incentive for providers to *cherry pick* low cost patients. A *risk-based* capitation payment, that compensates providers for the additional cost of caring for patient groups with relatively high treatment needs, could help overcome issues with cherry picking. Importantly, the risk adjustment needs to be based on factors that cannot be manipulated by the treating dental professional (risk factors for developing oral disease are discussed in box 11.1). If scope for manipulation is present, it is possible for practitioners to focus more on capturing the

payments than patients' outcomes. For example, evidence from the United Kingdom suggested that some general practitioner (GP) practices manipulated reporting data to increase their measured performance, in order to increase payments (Gravelle, Sutton and Ma 2010).

In dentistry, designing a payment system with the 'right' incentives is confounded by the lack of consensus over what is an appropriate and beneficial course of care. Steele (2014, p. 34) noted that:

> Although it is not particularly intuitive, most dentists would agree that the boundaries between when to treat and when to observe are far from clear cut, and the risk of a capitation contract in dentistry is what is sometimes described as 'supervised neglect', in other words a bit too much observation and not enough intervention, leaving patients at risk of progressive untreated disease.

An important limitation of relying on capitation arrangements (with a fixed fee per enrolled patient) alone is the incentive to undertreat (or lower the quality of treatments for) patients to save costs, potentially leaving dental conditions untreated. Overseas studies of capitation arrangements in dental and other primary care settings have found that while patients cared for under capitation payments receive less treatments, these arrangements have not led to 'supervised neglect' (box 12.1). Moreover, these studies suggest that capitation payments can promote the provision of preventive care.

In Australia, the Teen Dental Plan, which operated between 2008 and 2013,[1] was a means-tested voucher scheme for teenagers that provided a fixed payment (originally for a value of up to $150 per patient per year) toward the cost of a preventive dental check.

Based on the 2010 National Dental Telephone survey, the Australian Research Centre for Population Oral Health (2011) found that overall there were few differences in the services received by eligible and non-eligible teens. However, eligible teens that used a voucher were more likely to report having one or more fissure sealant treatments (a preventive treatment) than non-eligible teens (16 per cent compared with 7 per cent in 2010). While this result, to some extent, may be driven by the higher risk status of teens eligible for the scheme, it also highlights the potential value of a capitation payment model in focusing on delivering preventive dental services.

The incentive for providers to invest in preventive care under a capitation model will depend in part on the length of the enrolment period for the capitation payment. A short enrolment period, such as one year, is not sufficiently long for providers to realise the benefits to them of savings arising from preventive care. In this case, providers may have a strong incentive to reduce their costs by lowering the quantity or quality of treatments provided (Marshall, Charlesworth and Hurst 2014). A longer enrolment period would strengthen incentives for providers to prevent the onset of avoidable oral disease. A disadvantage of a longer enrolment period is the limits it could place on user choice.

1 The Teen Dental Plan was superseded by the Child Dental Benefit Schedule (CDBS).

Box 12.1 Capitation models: less treatment but more prevention

UK trial of capitation payments for treating children

Based on a three year clinical trial of children in the General Dental Service in Britain, Holloway et al. (1990) examined differences in treatments received and outcomes for children treated under a fee-for-service model and under a capitation payment model. For children treated under a capitation model, dentists carried out fewer fillings and extractions, took fewer radiographs and saw their patients less frequently than their fee-for-service colleagues. The trial found no evidence of systematic neglect under the capitation model, but concluded that dentists did not restore established carious lesions as readily as their fee-for-service counterparts.

The trial also found that dentists provided relatively more preventive care under capitation (Lennon et al. 1990). In particular, dentists were more likely to provide advice to parents on controlling dental disease — 36 per cent of children treated under capitation compared with 25 per cent of children treated under fee-for-service arrangements.

Norwegian natural capitation experiment in the public dental sector

Grytten, Holst and Skau (2013) examined outcomes six years after the introduction of a combined per capita and fixed salary remuneration contract for publicly funded and managed public dental services in Østfold in Norway in 2000. Compared to a salary model, they found that no evidence of a fall in the quality of dental care provided from transitioning to combined per capita remuneration — specifically, the transition did not lead to under-diagnosis of carious lesions, under-treatment or less preventive care for patients.

The authors noted that their results indicated that per capita remuneration is compatible with a dental health promotion paradigm. However, in 2006 the capitation component only accounted for, on average, 20 per cent of gross income. As the incentive effect of the per capita contract was relatively weak, caution must be used on generalising the findings to the private sector.

Canadian mixed payment models

Kantarevic and Kralj (2011) compared the short-term outcomes from the introduction of a blended capitation payment model in Ontario, Canada in 2007. Under this model, for a set of core services, physicians received an age-sex adjusted capitation payment plus 10 per cent of the fee-for-service payment for each enrolled patient.

The authors found that under the blended payment model, physicians provided fewer services and visits, but were more likely to reach preventive care targets. They concluded that, relative to an enhanced fee-for-services model, the blended capitation approach may reduce quantity and improve the quality of health care.

Toward a blended model with payments for outcomes

Concerns with potential under-servicing under pure capitation arrangements could be addressed, at least in part, by measuring and reporting on consumer outcomes at the provider level. The development of benchmarks can be used to measure the relative performance of providers (chapter 11), and to help safeguard minimum standards for consumers. Linking a proportion of provider payments to outcome measures could further strengthen incentives

for providers to focus on improving patient outcomes, rather than the use of particular treatments.

In a review of the influence of payments systems on the provision of oral health care, Woods (2013) concluded that the optimal payment model paid providers a 'blended' payment consisting of a capitation component, fee-for-service component and an allowance related to performance (with defined and measurable quality goals).

The National Health Service (NHS) in England is taking a blended approach to payment models in reforming remuneration in dental contracts (box 12.2). Pilots commenced in 2011 and employed a payment model that included a:

- capitation element that rewarded providers for the number of patients they cared for
- performance based element that rewarded providers for the quality of care provided.

In reviewing the NHS dental pilots, the UK Department of Health (2015) noted that there was no evidence that patients were undertreated in the pilots. Nonetheless, the Department raised concerns about the perverse incentive to provide less treatment in a capitation model and the difficulty in developing capitation prices for expensive and less predictable procedures. The Department concluded that the:

> … level of safeguarding needed at least initially in a full capitation system which replaced a full activity system, would be both unrealistic financially and also operationally. Any system requiring heavy policing is by definition not one where financial and clinical drivers are aligned. (UK Department of Health 2015, p. 17)

Following on from the pilots, NHS re-designed the payment model in a new prototype contract (box 12.2). Under the prototype contract, a blended payment model was introduced to balance the activity and capitation drivers and support the prevention and treatment needs of patients.

Activity payments were applied to various treatments in the different prototype models. These include activity payments for either: routine treatments (such as fillings, extractions and root canal treatments) in addition to complex treatment (such as crowns, dentures and bridges); or to complex treatment only. In Australia, activity-based payments are used to fund public hospital services (including some dental procedures that take place in a hospital setting), and are set by the Independent Hospital Pricing Authority (IHPA). Activity-based funding, which is a form of fee-for-service where payments cover a bundle of services instead of one, rewards providers for reducing costs below the funding payment.

Box 12.2 The NHS dental contract trials

Currently the National Health Service's (NHS) dental contracts in England are a wholly activity-based payment — paying dentists for the treatment and repair rather than for preventing future disease.

However, this is changing. The NHS has begun developing a new approach to dental services that could shift the focus of dental services from treatment and repair, towards prevention and oral health, by introducing: a clinical pathway focused on managing risk, providing preventive care and encouraging healthy behaviours; measurement and remuneration for quality of care; and a payment model that supports continued care and a focus on prevention as well as treatment (UK Department of Health 2015).

The pilot contracts

The initial pilots commenced in 2011. Rather than being paid based on the units of dental activity, providers were paid a weighted capitation payment, where for some providers the capitation payment was adjusted for a patient's age, gender and the deprivation status of their postcode.

- Practices were responsible for patients (routine and urgent care) for the duration of their capitation funding (UK Department of Health 2015). The experience in the pilots suggested that formalising the duty of ongoing care carried no particular risks, however issues around the length of registration were not tested in the pilots (UK Department of Health 2015).
- A small element of the payment was based on the quality of care provided (as measured against the Dental Quality and Outcomes Framework (DQOF) (box 11.4)). However, problems with the robustness of the clinical data meant that performance payments were not included in the initial two years of the project.

Moving from an activity-based system to a capitation approach was expected to lead to a fall in treatments per patient and an increase in the number of patients seen (when providers are rewarded to take on more patients). However, the NHS pilots saw both the number of treatments per patient and the number of patients fall. This was attributed to a range of factors including 'initial learning curve' factors, clinical and administrative (including data systems) issues, and potentially the fact that under the pilot, contract payments for some providers were not dependent on the number of patients cared for (UK Department of Health 2015).

The prototype contracts

The second stage of reforms developed a prototype payment model which is intended to form the basis of a new system for NHS dental contracts. While still including payments for capitation and quality to drive continued care with a focus on prevention, the prototype model also includes activity payments (for particular procedures) (UK Department of Health 2015). Two contract types are being prototyped:

- blend A where *capitation payments* are used as the basis of remuneration for oral health reviews and preventive care and *activity payments* are used for all treatments
- blend B where *capitation payments* are used as the basis of remuneration for oral health reviews, preventive care and routine treatment, and *activity payments* are used for more complex treatments.

A *quality* remuneration adjustment, based on relative performance against the DQOF, is included in both contract types. Urgent care for a *capitated patient* does not count towards a practice's activity level.

The blended NHS prototype models may offer potentially significant benefits to the delivery of public dental services in Australia. Specifically, the inclusion of activity-based payments for complex and hard to define dental procedures may encourage a range of providers to participate in a consumer directed care scheme. Under the Teen Dental Plan (which provided a fixed payment towards a preventive check-up), Lam, Kruger and Tennant (2015) suggested that one reason for low take-up rates may have been patients' awareness that they were unable to return for more expensive restorative treatments. As noted above, designing a capitation payment for more complex and unpredictable denture services, for example, is likely to be difficult. Activity-based payments may also be suitable for new patients requiring urgent care, where it would similarly be difficult to design a capitation payment.

The proposed consumer directed care model

The Commission's preliminary view is that public dental users, and the community more broadly, would benefit from transitioning away from the salary and fee-for-service models to a consumer directed care approach that gives users more choice over their provider.

Based on available evidence and analysis to date, the Commission proposes a consumer directed care model that introduces a blended payment model that rewards providers for improving outcomes for users rather than the number of treatments provided. This section outlines the features of the proposed blended payment model. The Commission is seeking feedback on the design of the proposed delivery model and how it could be implemented.

Drawing on the experience with dental contracts in England, the Commission's preliminary view is that under consumer directed care, participating providers (public or private clinics) should be paid a combination of:

- risk-weighted capitation payments, for preventive and restorative services, to provide continued care for a public patient over a defined enrolment period
- performance based outcome payments to reward providers for the quality of care provided
- activity-based payments for complex and hard to define procedures (including for example, for urgent dental care and for dentures).

Patients should be offered choice of a provider who will care for them for a defined enrolment period. As discussed above, the enrolment period should be long enough to ensure that providers can benefit by realising savings from investing in preventive and early intervention care to improve the oral health of their patients. An effective enrolment period is, therefore, likely to line up with the time period needed to measure clinical outcomes. A three year enrolment period, for instance, could allow sufficient time for:

- the dental team working in a clinic to see the benefits of care provided to patients

- stewards to measure the (benchmarked) effect of care on the oral health of a patient.[2]

Under the proposed consumer directed care model, users could benefit most when receiving ongoing care from their chosen provider over the entire enrolment period. In some cases, however, it may be necessary and appropriate for patients to change provider — such as, when the patient moves cities. Therefore, there will need to be provisions made for patients to change providers in certain circumstances.[3] In these circumstances, users will need to weigh-up the benefits from receiving ongoing care over the enrolment period with the benefits of changing provider.

Going beyond measuring and reporting on patient outcomes, to paying providers for achieving outcomes could address some of the weaknesses of a pure capitation payment; but adds complexity to the payment model. At this stage, the Commission considers that, in the long term, the use of outcome payments better aligns the interests of patients and providers.

As noted in chapter 2, the choice of performance measure is important, particularly when they are tied to provider's remuneration as proposed under consumer directed care reforms. Providers may focus on meeting measures as part of their monitoring requirements to the detriment of user outcomes. This can be controlled for, in part, through including patient-reported outcome measures (PROMs) in the outcomes framework (chapter 11). Under consumer directed care, governments as stewards of the system would be responsible and accountable for setting the outcomes framework, monitoring the activities and performance of providers, and the outcomes for public dental patients.

By making greater use of private and public dental practices, the proposed consumer directed care model can help to overcome any capacity constraints in the public dental sector, and represents a more cost-effective use of government funds than fee-for-service vouchers. That said, under the proposed model, access to public dental services could be managed through a waiting list. Section 12.3 outlines the proposed centralised waiting lists that take into account the urgency of care required and the risk level of developing or worsening oral disease for patients.

The efficient price of service delivery

Introducing consumer directed care to public dental services in Australia will require that State and Territory Governments give consideration to how the efficient cost of providing services varies for different population groups, and in different settings. For example, children are likely to have very different treatment needs from adults. If payments to providers are not weighted to reflect such variations, there is a risk that providers will avoid high-cost patients

2 For example, in a review of clinical trials of primary school-based behavioural interventions for preventing caries (tooth decay), Cooper et al. (2013) suggested that a follow-up period of two to three years was needed to measure the long-term outcomes of dental interventions.

3 For example, in New York State in the United States, patients sign up for a one year enrolment period with their chosen Medicaid managed care provider. This includes a 90 day grace period during which they can change providers for any reason (New York State Department of Health 2015).

where capitation-based payments would not cover their costs. This can give rise to equity concerns, and undermine the effectiveness of schemes intended as a safety net.

Payments to providers under consumer directed care should reflect the efficient cost of provision (chapter 1). As noted earlier, this practice is already established for activity-based funding in public hospitals where IHPA determines the National Efficient Price (NEP) for services.[4] Similarly, IHPA should set efficient prices (including risk-weighting) for public dental services, drawing on dental expertise through consultations with funders and providers. IHPA should be funded by the Australian Government to perform this function.

IHPA will need to consider a separate efficient price for activity-based payments and capitation payments. Outcomes payments could be set separately by State and Territory Governments. The precise blend (mix of capitation, activity-based and outcome payments) would appropriately be examined in the initial test sites before a wider roll out (below).

Efficient prices need to account for the cost of necessary care, plus a margin, based on effective and efficient administrative and clinical processes (Porter and Kaplan 2016). Efficient prices would also need to take account of the cost of capital to maintain competitive neutrality (a 'level playing field') between public and private providers (chapter 2). The cost of teaching and training activities, and the means of remunerating for these costs, should also be given consideration. Such concerns are not unique to public dental services. In the context of public hospital services, IHPA is currently developing a teaching and training classification system which is expected to be completed in 2017-18.

Transitioning to a new payment model

The Commission's proposed consumer directed care model represents a fundamental shift in how public dental services are funded and provided, and involves several elements that would need to be carefully designed. (The full timeline for implementing the proposed reforms to data, user choice and improved commissioning in public dental services is outlined in section 12.5.)

Following the completion of outcome measures and improved data collection, consumer directed care should, as in England, be first implemented at initial test sites using different 'blends' of the payment model. This stage should test the effect of specific elements within the blended payment model, such as what level of outcome payments would be needed to incentivise providers' behaviour and the length of the enrolment period. The number of activity-based treatments should also be monitored during this stage to ascertain whether initial payment levels provide poor incentives or result in limited delivery of more complicated treatments. For example, one blend could pay a relatively large share of the overall payment through a risk-weighted capitation payment, and a small outcome payment

[4] The NEP for hospitals is based on the average cost of an episode of care (which is a set of services). Each episode is weighted according to its complexity. The efficient price is then multiplied by the weighting to calculate the payment for each specific episode.

over a three year enrolment period; a second test site could invert this blend (using a small capitation payment and a larger outcome payment).

Once evidence from these sites has been evaluated and a desired payment model finalised, State and Territory Governments should progressively roll out the scheme.

Should the Child Dental Benefit Scheme be included?

In addition to the State- and Territory-run public dental schemes, the Australian Government funds a separate Child Dental Benefit Schedule (CDBS). The CDBS contributes to the cost of dental services, up to a cap of $1000 of benefits over two years for basic dental services for children in families receiving Family Tax Benefit Part A.

Parents of children eligible under the CDBS are able to choose their provider, either from the public or private sector, who is paid on a fee-for-service basis. Almost 80 per cent of CDBS claims have been for services provided in the private sector (Australian Government 2016c). The CDBS is a demand-driven system and, therefore, does not require any allocation mechanism to determine when an eligible user can access publicly-funded dental services.

Transitioning to a blended payment model (as proposed by the Commission) that measures and rewards providers for patient outcomes, rather than the number of treatments provided, could improve the efficiency of the CDBS and outcomes for users. A risk-weighted capitation payment may also better target the treatment needs of individual children (compared with having one cap for all eligible children as is currently the case). In 2014, of those children commencing treatment under the CDBS, the majority (71 per cent) used less than half of their cap in the first year. However, 8 per cent of those children reached or were close to reaching their payment cap (Australian Government 2016c).

As a demand-driven system with a cap per child, the interaction of the Commission's proposed payment model with the existing CDBS requires further consideration. For example, for children with complex needs, an appropriate course of care may reach the $1000 cap within the two years. The question then arises if the care should continue (as would be the case for an adult under the Commission's proposal) and, if so, what funding implications this may have for the CDBS.

The Commission intends to further consider the application of the consumer directed care payment model to the CDBS in its final report, and welcomes feedback on this, in addition to the broader implementation matters relating to the consumer directed care model.

DRAFT RECOMMENDATION 12.1

State and Territory Governments should introduce a consumer directed care approach to public dental services. Under the new approach, participating providers should be paid based on a blended payment model that incorporates:

- risk-weighted capitation payments for preventive and restorative services for enrolled patients that incentivises the provision of clinically- and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)
- performance based outcome payments, incorporating payments for clinical and patient outcomes
- activity-based payments for complex and hard to define procedures (such as dentures). The dental treatments that would be eligible for activity-based payments should be determined by governments based on available evidence on the clinical- and cost-effectiveness of treatments.

State and Territory Governments should ensure that under the scheme:

- patients are offered choice of provider (public or private clinic) who will care for them for a defined enrolment period
- the enrolment period aligns with the time required to effectively measure outcomes
- users are able to change provider in certain circumstances (such as, when moving city).

DRAFT RECOMMENDATION 12.2

The Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, should be funded by the Australian Government to determine the efficient prices for consumer directed care payments.

DRAFT RECOMMENDATION 12.3

State and Territory Governments should transition to a consumer directed care approach by first establishing initial test sites to evaluate new blended payment models and allocation systems, before a staged roll out.

12.3 Allocating funding to patients

Consumer directed care enables users to choose their provider. However, as noted in chapter 2, the presence of constrained funding necessitates the use of an *allocation model* to determine when an eligible user can access publicly-funded dental services.

Prioritising access to care based on risk

Consumer directed care reforms could shift the focus of the public dental system towards preventive and early intervention for:

- eligible users requesting and waiting for care — by identifying and targeting access for those users at high risk of developing oral disease (box 11.1). That is, those users whose oral health stands to benefit most from earlier access to preventive care.
- users who have accessed care — by introducing a blended payment model that rewards the delivery of preventive treatments over the enrolment period (discussed above).

Currently, despite having different risk levels, public patients on the waiting list for general care are largely treated on a 'first come, first served' basis:

> Triaging is already done for emergency public dental services with targets to treat within defined times. However, risk is not currently categorised when people go onto the waiting list — so their condition may deteriorate over time, rather than preventing the worsening of the most serious conditions. As is done in other parts of the health system (notably, for elective surgery patients) dental patients — both hospitalised and in the community — should be prioritised in accordance with risk triage categories and with guidelines for such prioritisation and triaging. (DHSV sub. 465, p. 10)

In a general health context, waiting lists — where they take into account the urgency of care required and the risk level of developing or worsening conditions for patients — can be an efficient way to ration access to services (Gravelle and Siciliani 2008, 2009). The same is true for dental services. In a public dental context, waiting times should not result in the significant deterioration of the oral health of patients while they wait to receive care. While actual waiting times are largely driven by funding levels, public performance reporting of patients treated within clinically acceptable waiting times (benchmarked by risk category) would improve accountability and encourage more effective service provision (chapter 11).

Using a centralised waiting list in each jurisdiction, rather than a clinic-by-clinic approach, would facilitate more effective triaging of patients according to their escalating risk of oral disease across the eligible population in an area.

Under the Commission's proposed consumer directed care reforms, a patient's risk of developing or worsening oral disease would need to be clinically assessed. Clinical assessments would serve three purposes:

- first, to more accurately identify patients at high risk of developing oral disease
- second, to assign patients to the most appropriate risk-weighted capitation group
- third, to create a baseline record of the patients oral health status to measure clinical outcomes at the end of the enrolment period.

An initial assessment could be conducted over the telephone by the public dental services centralised call centre when patients first request (or are referred for) care (this would be independent of any particular provider of dental services). Following the initial telephone

triage, potentially high risk patients (or where the patient's level of risk is unclear) could be sent for a clinical assessment (for example, by an oral health therapist). A similar process already occurs in Queensland, where patients are filtered through an initial assessment over the phone, with three possible outcomes: being provided an appointment for urgent care; being placed on the general waiting list; or referred for a clinical assessment (box 11.3).

Requiring patients to attend a clinical assessment that is independent of their provider would provide integrity to the proposed scheme by ensuring that patients are correctly assigned into risk categories. However, without additional funding independent clinical assessments would draw resources away from the overall provision of public dental services. Ultimately, in deciding whether to refer patients for independent clinical assessments, governments must balance the associated costs for the public dental system (and time and inconvenience for patients) with the need to ensure system integrity.

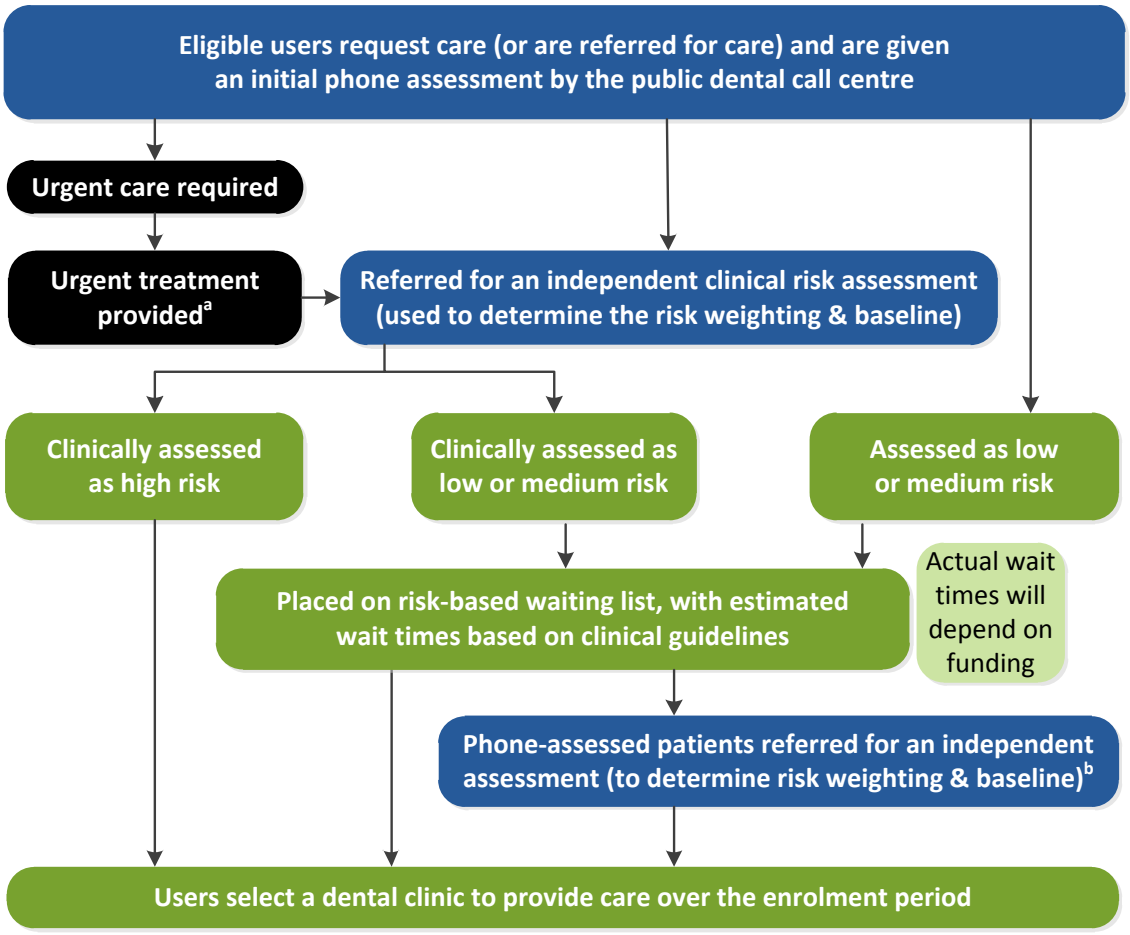
Investing in improvements to the information available at the time of the initial phone assessment — by drawing on patients' existing dental records, information from referrals from other health professionals and methods used to triage urgent patients — could potentially reduce the need for independent clinical assessments. A digital oral health record that follows patients across the public and private dental system and is incorporated within wider health system records (chapter 11) could assist in the identification and triaging of high risk patients. Digital health records that include information from other parts of the health system — for example, admissions to hospital for dental related conditions or diagnosis for chronic disease (such as diabetes) — would also assist in triaging public dental patients. This broader information could be particularly useful for those patients with no pre-existing records from the public dental system.

The Commission's preliminary view is that, under consumer directed care, all patients should receive an independent clinical assessment at some stage before being enrolled with their chosen provider (figure 12.1). This differs from the model used in Queensland. The Commission's allocation model would ensure that the system would be able to effectively target the oral health of those most at risk in the eligible population, create a baseline record of patients' oral health status to later measure clinical outcomes, and retain governments' ability to constrain the costs of service delivery. Box 12.3 provides an example of how the proposed reforms would work in practice for users under this allocation model.

Alternatively, patients' risk of developing or worsening oral disease could be assessed solely through a telephone assessment — where eligible users requesting care are screened based on population level risk indicators, but also provided an individual risk assessment based on patient-reported symptoms, existing digital health records and information from referrals. Similar to the Commission's proposed allocation model, telephone triaging would retain governments' ability to constrain the costs of service delivery, but may not be as accurate at triaging patients according to their true risk level or setting a baseline (to later measure clinical outcomes).

The Commission is seeking feedback on the accuracy, cost and practicality of an independent clinical assessment (including those used in the Queensland public dental system) relative to sole reliance on a telephone assessment.

Figure 12.1 **How could consumer directed care funding be allocated**
For eligible users under the State and Territory public dental schemes



[a] Under the proposed consumer directed care reforms, public dental patients would receive urgent care at either dental hospitals or participating public or private clinics (where providers will be paid an activity-based payment). [b] To assign patients to the most appropriate risk-weighted capitation group and to set a baseline of their oral health status (to later measure clinical outcomes) before commencing with their chosen provider, phone-assessed patients (as well as some patients whose initial assessment has lapsed) could be referred for an independent clinical assessment when coming off the waiting list.

In addition to waiting lists, co-payments can be used as a means to manage access to a service (chapter 2), or to supplement available funding. The allocation model for consumer directed care (above) provides a means to manage access to services on both clinical and funding grounds. As such, the use of co-payments is not an intrinsic feature of the consumer directed care model proposed by the Commission. Nonetheless, co-payments for public dental services are currently used in some jurisdictions and could continue under the proposed model. This is a matter that is appropriately dealt with by each jurisdiction.

Box 12.3 What consumer directed care would mean for users

Jane wakes up with a mildly sore tooth

Under the current model of provision, Jane rings her local public dental service, describes her symptoms and, as she is not in need of urgent treatment, she is placed on a waiting list. Jane does not know how long she will wait for treatment, but might be advised of the average wait time to access dental care. Nine months later, when eating one day her pain worsens and she starts to avoid certain foods and struggles to sleep, affecting her performance at work. She calls the local public dental service again and is given an urgent appointment. Jane travels to the public clinic 10 km away, and is seen by a different dentist to the one she had seen on a previous visit.

Under the Commission's proposed system, Jane would telephone the public dental service call centre (the central manager of the waiting list) and describe her symptoms. Jane would be asked to attend a clinical assessment, where they would inform her that her oral health is unlikely to deteriorate quickly, that the clinically benchmarked time for her condition is 6 months and that she would be placed on the waiting list. When Jane reaches the top of the waiting list for her risk level, she would receive a call from the service informing her: that she is now able to book an appointment at one of the nearby providers; of possible treatments; and likely co-payments (if any).

Using the information provided to her by the public dental service, in this example, Jane would be able to choose between two clinics — one clinic close to her work, the other further away from her work and home, but with slightly better reported outcomes. Upon making her choice, Jane would be informed that she would be cared for at her chosen dental clinic for the enrolment period. In addition to dealing with the immediate problem, this care could also include advice on ways to prevent any further tooth decay and any follow-up appointments in the enrolment period.

After one year with her choose provider, Jane would be invited to complete a survey about her patient experience and the quality of her care.

John has no dental pain, but is at high risk of tooth decay and gum disease

John has been prescribed medication that causes dry mouth as a side effect. He also smokes, and does not visit the dentist regularly. His doctor recommends he see a dentist, in case the dry mouth is affecting his oral health. Under the current system, John contacts the public dental service and is placed on a general care waiting list, possibly waiting up to 3 years for an appointment.

Under the Commission's proposed scheme, John would contact the public dental service call centre, who would ask John some simple questions that reveal his multiple risk factors. John would be asked to attend an independent clinical assessment immediately. Following the risk assessment, John would be informed that he is at high risk of tooth decay and gum disease and to expect a follow-up phone call from the public dental call centre with information on how he can make an appointment with a participating provider of his choice.

In this example, John could call three clinics and choose the one that can offer an appointment on his day off. When John visits the clinic he would be seen by an oral health therapist, who would clean his teeth and give him some advice on how to care for his teeth better.

The scope of eligible providers and services

Consumer directed care should be open to public and private providers

The Commission's proposed consumer directed care should be open to providers (both private and public) who opt-in to the scheme. Providers would need to satisfy a number of conditions to participate in the scheme, including (at a minimum) holding a Medicare provider number (to facilitate payment) and being registered with the Dental Board of Australia (as all providers must be). Providers would also need to be willing to accept the blended payment model and the efficient price as set by IHPA (section 12.2). Importantly, providers would need to be set up and willing to report on the services provided to public patients in their care over the enrolment period.

As noted earlier, governments as stewards of the system are responsible and accountable for setting the outcomes framework, monitoring the activities and performance of providers, and the outcomes for public dental patients. To participate in the proposed consumer directed care scheme, providers would therefore need to track and report the treatment provided to individual patients, their oral health status and any co-payments charged.

Participating providers would need digital data systems that can 'talk' to the government systems. As discussed in chapter 11, digital oral health records including the Australian Government's My Health Record (MHR) can be used for this purpose. The current Health Care Homes trials for treating patients with chronic and complex conditions, for example, will require all participating services to register and connect to the MHR system and to contribute up to date clinical information to their patients' MHR (Department of Health 2016c).

Payments for the ongoing costs of caring for enrolled patients would be covered by the efficient price, which the Commission proposes would be set by IHPA (section 12.2). Participants have argued that the traditional single-person private practice does not enjoy the economies of scale that the public sector does, and as such have higher costs than the public sector (DHSV sub. 465). If this was the case, then many private dental practices may not opt-in to the consumer directed care scheme.

That said, the private dental sector appears to be evolving and moving from a delivery model typically comprising one dentist and one assistant per practice, to a larger practice with a more diverse group of dental professionals (Solomon 2015). Private health insurers and chains are increasingly setting up and running large dental practices. Bupa, for example, owns and operates over 140 dental clinics across Australia (Bupa nd). In 2015 the Pacific Smiles Group, which provides fully serviced surgeries to independent dentists, operated 42 Pacific Smiles Dental Centres and 7 nib Dental Care Centres across Australia (Pacific Smiles Group 2015).

This shift away from the traditional single dentist practice means that, increasingly, private dental practices may achieve cost savings from economies of scale (including by employing a greater number of dental and oral health therapists).

As discussed above, the Commission's preliminary view is that consumer directed care should be based on the efficient cost of provision. Private providers that find the scheme beneficial can opt-in to the scheme. As the share of group and corporate dental practices grow in Australia, the number of private practices willing to participate in a consumer directed care scheme may also grow.

In the extreme case where only public providers opt-in, measuring and paying providers for the quality of care provided and rewarding preventive care would still improve the effectiveness of the public dental system, and the oral health of users.

Eligible services should be limited to clinically- and cost-effective treatments

Not all dental treatments are clinically and cost effective. Given the information asymmetries common to many medical treatments, expert analysis of which procedures should be included in funding is more likely to balance the funding needs of one patient against another.

In the past, the inclusion of treatments in public dental voucher schemes has not been based on a comprehensive review of clinical evidence to determine the *value for money* of these treatments (Nguyen sub. 398). In contrast, publicly subsidised medical services must undergo a cost-effectiveness analysis through the *Medical Services Advisory Committee* to be listed on the Medicare Benefits Schedule. Only those treatments proven to be both clinically and cost effective and required for a patient to have a disease-free mouth should be eligible under the payment model. Identifying these treatments could be informed by a process similar to that undertaken for the Medicare Benefits Schedule — expert analysis of effectiveness on a procedure by procedure basis. As the list of effective treatments changes over time in response to changes in clinical methods, so too should the schedule of eligible services available to users of public dental services.

It is important to note that treatments that are clinically and cost effective will vary between patients and over time. An effective and efficient public dental system would identify which user groups can benefit from treatment and at what frequency. The incentive structures within a blended payment model could assist in focusing providers on those clinically- and cost-effective treatments that would have oral health benefits for the patients in their care.

Giving users more choice over treatments they receive

Not all dental treatments will be eligible for public funding. If other treatment options are available (and justified), arrangements where patients could pay extra (a 'top-up' fee) to the provider could allow patients to choose a wider range of treatments beyond those necessary for the patient to have a disease-free mouth (that is, beyond the set of eligible services). For example, these arrangements could allow individuals to choose to pay a top-up fee for a more expensive filling that better matches the colour of their teeth.

'Dental conditions are relatively easy to diagnose, giving patients more time to plan treatment decisions' (Woods 2013, p. 1). When supported with adequate and effective safeguards and consumer-oriented information so that they can weigh up the costs and benefits to them, consumers should have some control over the treatments they receive. Achieving the benefits of greater user choice over the treatments they receive would require that:

- patients pay the difference in treatment costs (the 'top-up' fee) directly to the provider
- the more costly treatments are at least as clinically effective as the basic treatment
- patients are informed of the costs and benefits of different treatment options.

Top-up arrangements for the hearing services scheme vouchers allow patients to choose to be fitted with a hearing aid with additional features beyond those necessary to achieve a satisfactory rehabilitation outcome. Under the scheme, patients pay the difference in cost to the provider. The provider's contract and deed states that they must not encourage a patient to select a top-up device where there is no benefit for the patient (mpconsulting 2012). Stakeholder feedback to a 2012 review of the regulation for hearing services raised concern over the risk that vulnerable clients were being encouraged to purchase more expensive hearing aids when there was little or no clinical need for such devices (mpconsulting 2012). However, there were varying views from stakeholders to the 2012 review of hearing services on the extent to which this risk was playing out in the scheme.

More recently, the Australian Competition and Consumer Commission (ACCC) sought evidence relating to issues around the sales of hearing aids. Information provided to the ACCC identified practises in the industry aimed at selling more expensive hearing aids, including sales performance measures based on, among other things, the number of 'top ups' for consumers with vouchers under the scheme:

> Some hearing clinics encourage clinicians to sell more expensive hearing aids by setting sales targets, paying commissions to clinicians, having arrangements that favour certain brands or are owned by companies that manufacture hearing aids. (ACCC 2017a)

The ACCC released guidance material to assist with informed choice and requested that operators review their programs and performance measures (ACCC 2017b).

Careful monitoring of patient outcomes and of top-up payments could assist in ensuring that exploitation of consumers does not occur. The experience of the hearing services scheme stresses the importance of not only developing effective consumer safeguards and consumer-oriented information in the system (discussed below), but also of incorporating outcome measures in the payment model. In particular, the payment models should incorporate, among other outcome measures, patient-reported outcome measures to better align the incentives of the provider with the patient.

Information needs

Information for the eligible population

To get the full benefit from the Commission's proposed reforms, the eligible population needs to know that they are eligible to receive publicly-funded dental services, and that they would benefit from preventive and early intervention care.

Evidence suggests more effort is needed on both fronts. A 2016 online survey of 417 people living in New South Wales and experiencing (or at risk of) poverty found that:

- about 38 per cent of respondents were not able to afford dental treatment. This was much higher than the share of respondents (17 per cent) who reported being unable to afford medical treatment.
- of those families with dependent children responding to the survey, about 42 per cent reported not being able to afford a dental check-up for their child (NCOSS 2016).

All children (under 18 years old) are eligible for public dental services in New South Wales. As such, the NSW Council of Social Services (NCOSS) concluded that an underlying issue for children was awareness of, not eligibility for, programs. To address this, NCOSS (2016, p. 18) recommended that 'the NSW Government should invest in communication efforts to ensure all families are aware of the dental health services available for their children'.

Issues with a lack of promotion and low take up have also been identified under the CDBS — only 30 per cent of eligible children accessed services in 2014 (ANAO 2015; Australian Government 2016c). A review of the CDBS chaired by the Commonwealth Chief Medical Officer found that, by relying on the *myGov* website, the scheme had not been promoted effectively (Australian Government 2016c). The review recommended that hard copy notifications also be sent to eligible families, with hard copy follow up notifications for eligible families that have not accessed services.

In addition to issues with the promotion of public dental services, many eligible users simply do not seek timely access to dental care. This can also be observed across the population. For example, in 2013 one quarter of people living in high income households[5] last visited a dentist to receive treatment for a dental problem (rather than for a check-up) (AIHW 2015c). This supports the case for providing users with information on the benefits of preventive and early intervention care.

The COAG Health Council identified a lack of integration with the broader health system as a barrier to the effective promotion of oral health prevention. Many members of the non-oral health workforce have more regular contact with the population than dental practitioners do. The COAG Health Council noted that these workers have a role in providing oral health information and referral for dental care in general health and wellbeing checks (COAG

[5] High income households refers to those households with an annual income of $140 000 or higher in the National Dental Telephone Interview Survey.

Health Council 2015b). Some progress has been made on better integrating dental services with the broader health system. The 'lift the lip' initiative, for example, provides GPs, nurses and other childhood and health professionals with a simple screening and referral tool to identify young children with early signs of tooth decay (Tasmanian DHHS nd).

Greater promotion of public dental services would have direct upfront costs, as well as stimulating demand that needs to be managed. However, by providing care to high risk users before the onset of oral disease, the long-term benefits would include avoiding larger costs when people present in the dental system, or other parts of the health system, requiring more complex and costly treatment (chapter 11).

There are some parts of the population with particular characteristics where information is not the sole barrier to accessing services. For these, specialist outreach services may be required (discussed below).

Information for users

As with many other medical professions, patients rely on the expert advice of the dental professional to make decisions regarding their oral health. Warren et al. (2010) noted that it could be argued that, in a private practice setting, many treatment decisions are more likely to be based on a patient's willingness to pay rather than evidence on the cost effectiveness of treatments. This highlights the need for user-oriented information to support patients to make an informed choice.

Information on what to expect (in required services and their general costs) and where to find a provider could be delivered through pamphlets and online. The *NHS Choices* website in England allows users to look up a range of information about dentists in their area. Some of the information reported includes whether the dentist is accepting new patients and accessibility information (such as whether there is a hearing induction loop available). The site also allows users to leave star ratings across a number of domains, such as satisfaction that the user was involved in decisions about their treatment, and write a review. Chapter 10 recommends that the MyHospitals website be transformed, drawing on the example of the NHS in England. Public dental services should do the same. As the outcomes framework is developed, selected information could be included about the performance of dental clinics.

This information should be presented in a form that is clear and understandable for the eligible population for public dental services. The information presented on such a website forms a broad basis for users, but more specific forms may also be required.

As noted in the study report, some groups may have particular difficulty in making choices and could need another person to support their decision making. As such, in addition to a website, information in other forms (for example, pamphlets for community workers targeted at particular groups of the population) could be required to target particular groups. Useful and timely information that is specific to an individuals' needs could also be delivered through the initial triaging telephone conversation when patients are allocated funding.

Under the proposed consumer directed care model, public dental patients would benefit from being provided with information on the local participating providers (such as clinic locations and any published outcome measures), the enrolment period with their chosen provider and any co-payments.

DRAFT RECOMMENDATION 12.4

State and Territory Governments should provide access to consumer directed care through a centrally managed allocation system. Under the allocation system, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease.

Governments should ensure that, when allocated funding, a patient has access to:

- clinically- and cost-effective treatments that are necessary for the patient to have a disease-free mouth
- payment arrangements where patients can choose to pay extra to the provider to access a range of clinically-effective treatments beyond the basic treatments
- consumer-oriented information on participating providers including, for example, clinic locations and published outcome measures, to enable their choice of provider.

Consumer protection

Consumer protection can operate from the top down (establishing a system where those that run it safeguard the interests of the consumers), and/or the bottom up (providing avenues for recourse for individual consumers).

Under the proposed system, performance reporting required from participating private and public providers gives stewards the necessary data to run the system. This would allow stewards to monitor any trends in quality or cost of services within the scheme.

Most government-operated dental clinics are required to gain accreditation against the National Safety and Quality Health Service (NSQHS) Standards, which encompass six areas where it is known that people have been harmed as a result of health care and there is good evidence on how to achieve better outcomes. In contrast, NSQHS accreditation is voluntary for private dental practices. The registration requirements for dental professionals in Australia provide for a base minimum standard of care. In addition, the outcome measures in draft recommendation 11.2 (and their link to payments) would provide quality signals to users, providers and system stewards.

Nonetheless, there remains a risk of 'bad apples' in any profession. Consumers would benefit from being informed at the time of being allocated funding that they have access to recourse if they have complaints about their service provider to their relevant State or Territory authority. The outcome of any complaints should also be monitored by governments.

12.4 Improving contestability within public dental services

For many users in metropolitan areas, the presence of private dentists could provide choice under a consumer directed care model. However, this is not the case for all those eligible for public dental services. For instance, one estimate is that about 4 per cent of the population eligible for public dental services that live outside metropolitan areas are located more than 50 km from a public or private dental clinic (Dudko, Kruger and Tennant 2017). Even in metropolitan areas there may be populations with additional needs that require specialised services that can only be accommodated by a small number of providers. Victoria, Western Australia and South Australia provide services in a patient's residence if they are homebound due, for example, to disability or dementia (DHSV nd; SA Health nd; WA Department of Health and Human Services nd).

A direct application of the consumer directed care model proposed by the Commission would not have the same expected benefits where a choice of dental provider is not feasible. Instead, a better way to improve service provision is to establish more effective commissioning systems for public dental services. To do this, governments need to improve their practices in two fundamental ways:

- obtain a better understanding of the different barriers that people face in accessing care
- take a more systematic approach to selecting providers and monitoring their performance.

In the longer term, more effective commissioning practices will provide more opportunities for contestable provision of public dental services.

Understanding the barriers to dental care

Different people face a range of different barriers to accessing dental care. Higher rates of oral disease among some population groups could indicate that they have additional needs that are not being addressed effectively within the current system. The challenge for governments is to determine the degree to which a lack of suitable services is hampering access.

Governments should also seek to gain a better understanding of the population's needs. The complexity in identifying barriers directly means governments could first look at broad population groups that are *not* seeking to use public dental services. In their audit of access to public dental services in Victoria, the Victorian Auditor-General's Office observed that, while only a small proportion of the eligible population seeks to access public dental services in that state, the government had no mechanism to identify the specific barriers that result in this low take up (VAGO 2016). Governments themselves have identified the need for more data to enable better planning in the National Oral Health Plan (COAG Health Council 2015b).

Governments could also improve their understanding of population needs by making better use of data they already hold. The Commission's (PC 2017) report on data availability and use identified health data as an underutilised resource due to impediments and distrust around data use, and recommended a new framework for granting access to publicly funded datasets. Researchers in Victoria are developing a model to assess the oral health risk at the community level by drawing on existing datasets (de Silva et al. 2016). The researchers identified a range of existing survey and routinely-collected data that can be used to identify communities at high risk of developing oral disease.

Draft recommendation 11.1 identifies performance benchmarks for waiting times that should be published. These measures should contribute to understanding of population needs and therefore service planning. For instance, consistent failure to meet benchmarks could indicate higher than expected demand (relative to existing supply). This could prompt an investigation into the causes of the high demand, which might suggest that there is population group that needs some additional assistance. This process could identify where greater choice would be of benefit, but an understanding of the needs and barriers of particular groups could also suggest the need for commissioning of particular services (for example outreach or translation services). The outcome measures developed in draft recommendation 11.2 could, when aggregated, also track areas of need, and patient-reported measures may provide some insights as to reasons behind outcomes (for example, responses of 'I couldn't understand the dentist' could indicate need for translation services).

The digital oral health records created in response to draft recommendation 11.3 could collectively create a dataset that would assist planning and allow ongoing monitoring of areas of oral heath need.

In addition to the use of data, a better understanding of people's needs could be achieved by adopting elements of co-design (chapter 2). South Australia's Access to Oral Care Program, that commenced in 2013, is one example of the kind of work needed to identify specific barriers for diverse groups. The program aimed to increase access to SA Dental Service care for eligible people from culturally and linguistically diverse backgrounds, people with mental illness and those in rural locations (SA Health 2016). The SA Dental Service worked with non-government organisations and cultural associations to raise awareness of how dental services can be accessed, including providing information sessions to community groups about oral health and the public dental service. The SA Dental Service also met with key organisations to discuss the oral health needs of their communities and provided oral health training and information to community workers and clients (SA Health 2016).

Provider selection and contract management

Using a mix of providers

Governments currently commission public dental services from non-government providers in some locations, but could seek out further opportunities to do so. In some places, the best

use of resources will be to use a mix of public and private settings. Governments have already acknowledged this in the National Oral Health Plan:

> Although separate services delivered by government, non-government and private providers may target specific groups within the population, there is limited capacity to sustain multiple providers in regional and remote locations. Services can be made more sustainable and affordable when developed and managed using collaborative models that involve the private, public and non-government sectors. Such models can incorporate aspects of resource sharing, training education and research integration, clinical governance and workforce support and mentoring across sectors and regions. (COAG Health Council 2015b, p. 61)

In practice, governments have used a range of providers to deliver services to remote communities. For example, Western Australia has used fly-in-fly-out services (box 12.4), while DHSV and the Royal Flying Doctor Service Victoria jointly fund a mobile dental clinic that is staffed with assistance from the Australian Dental Association Victoria Branch (DHSV 2016). The Tasmanian dental service has lease agreements in place for private dentists to utilise spare capacity on King Island and in Queenstown (Tasmanian Government, sub. 458), improving the flexibility of the private dental workforce and the utilisation of public dental assets.

The scope to use private settings could be constrained by the smaller number of private providers outside the major capital cities. That said, over time it may be more sustainable for a private provider to operate in some regional or remote locations if they were able to expand their client base to include eligible public patients. As others have pointed out, allowing private practitioners to see public patients (and paying them to do so) can result in efficient use of available resources:

> In areas that do not have a large enough population to warrant building a public dental clinic, the level of subcontracting of public dental services to private clinics should be increased. This approach, although more expensive, could potentially have an added bonus of providing more favourable terms for private practitioners to set up practice in country towns, offering additional benefits for the rural and remote communities. (Dudko, Kruger and Tennant 2016, p. 281)

It is not only populations in remote areas that could benefit from the use of a wider range of providers. Using primary health workers to deliver oral health promotion, for example, could be an effective way to reach people in metropolitan areas that may not have a history of seeking preventive oral care.

As noted above, there are examples of approaches to partnering with the private sector already in use across the country, but they are not widely adopted. In the first instance, governments could undertake more systemic service planning (to understand patients' needs and existing resources within the market). Following this, contestable delivery arrangements could be used to encourage innovative approaches (including tele-health technology, or training other healthcare workers in dental diagnosis and care). These initiatives are not reliant on the development of an outcomes framework, and can commence immediately.

Box 12.4 Delivery of dental services in Remote Western Australia and the Northern Territory

Western Australia

Western Australia funds a visiting oral health program for five communities in outer regional, remote and very remote areas of the state. The services operate in partnership with Aboriginal medical services and use the local clinics. Dental professionals visit for around a week at a time, with visit frequency determined by clinical need and other community factors. The team comprises a visiting dentist and a local Aboriginal health worker, who acts as both the dental assistant and as patient liaison. Services comprise mostly restorations and extractions to alleviate pain and discomfort.

The Northern Territory

From 2009, the Australian Government has funded a series of oral health programs for Indigenous children in the Northern Territory. Implemented by the Northern Territory Government, the programs have been delivered in a variety of clinic types, including community dental clinics, school clinics and mobile dental trucks. Outreach dental teams consist of either a dentist or a dental/oral therapist and an assistant, who travel to communities for 1 to 3 weeks at a time. To promote preventive dental care in remote settings, primary health workers (such as Aboriginal health workers and remote nurses) can complete a certificate course in oral health promotion. The course trains them to incorporate oral health screening and education into health checks for children up to 5 years old. The primary care workers are also trained to apply fluoride varnishes, and to be able to refer children to the visiting oral health professionals.

The programs have had a strong focus on preventive services, with full mouth fluoride varnishes and fissure sealants being provided, in addition to other clinical services (such as fillings or extractions).

The children accessing services have high oral health needs: in 2009 more than 90 per cent of 7 and 8 year olds had tooth decay. Over time, the oral health of children accessing the program has improved. The proportion of 1 to 3 year olds with tooth decay fell from about 73 per cent in 2009 to about 42 per cent in 2015. Most other age groups experienced a reduction in the rate of tooth decay, albeit not as large as the improvement observed for the youngest age group.

Sources: AIHW (2017c); Dyson, Kruger and Tennant (2012, 2014).

Contract management

As is the case for consumer directed care, commissioning of public dental services would need to be underpinned by the development of an outcomes framework. Once this framework is in place, the government's relationship with providers could become less prescriptive. Contracts could instead focus on the needs of the people using the service and their oral health, and could incorporate (risk-adjusted) payments that reward good patient outcomes. The government's role can becoming more about 'value adding' to the system, including providing advice on best practices and benchmarking providers' performance (and indeed the whole jurisdiction's performance). This flexibility for providers, alongside the outcomes focus, can allow innovation. The government's stewardship role would remain important, including to manage underperformance and protect users.

The commissioning agency should have some oral health expertise, so that it can effectively evaluate outcomes, and an understanding of community needs so that it seeks out providers than can deliver the right services. The commissioning agency would also be in a position to encourage service improvements by offering advice to providers. More sophisticated analysis of outcomes across the whole system would be a key role for the commissioning agency.

Moving to a system that focuses on outcomes, rather than outputs, would require evaluation periods to be long enough for providers to have an incentive to invest in programs that may take time to pay off, such as a greater focus on preventive care. It would be difficult to establish sufficiently long timeframes for evaluation with recent policy and funding uncertainty (box 12.5).

Box 12.5 Dental funding: a case of fillings and extractions

In late 2012 and early 2013 the Australian Government and the States and Territories signed the *National Partnership Agreement on Treating More Public Dental Patients*. This National Partnership Agreement provided $344 million over three years to reduce public dental waiting lists. Another National Partnership Agreement was announced in 2013, and was to provide an additional $1.3 billion over four years to 2017-18. This announced National Partnership Agreement was delayed by a year and then cut substantially, ultimately only providing $155 million in one year, 2015-16.

In the 2016-17 Budget, the Australian Government announced that it would be abolishing the Child Dental Benefits Schedule (CDBS) and combining adult and child funding in a new National Partnership Agreement, to be worth $1.7 billion over four years from 2016-17. In December 2016, the Australian Government abandoned this plan, announcing that the CDBS would remain and that another National Partnership was planned, this time to provide $320 million over three years.

Sources: Australian Government (2013a, 2014b, 2015b, 2016a); COAG (2013); Ley (2016).

DHSV is the only dedicated dental commissioning agency in Australia. It contracts services from Community Dental Agencies (CDAs), which can be independent entities or can sit within larger community health services or hospitals. There are 50 CDAs, with 20 established as independent non-profit companies and 30 established as health services or hospitals. The contracts are for one year (DHSV, pers. comm., 13 April 2017).

The approach that DHSV takes to monitoring performance involves a high degree of communication with CDAs. Each CDA meets with DHSV's agency relationship team every month to discuss performance against targets and regional and state benchmarks (VAGO 2016). Each CDA is provided with monthly, quarterly and annual reports measuring their performance against the indicators in the contract.

There are a number of ways that DHSV passes on best practice to CDAs. Regional conferences let CDAs share learnings and practices with each other, while annual 'innovation workshops' are organised to discuss new ways to reach priority groups (DHSV 2015). These conferences and workshops aim to both promote service improvements

and provide professional development for the workforce. Despite these initiatives, the Victorian Auditor-General's Office (2016) advised DHSV that it needs to take a more active role in coordinating initiatives by CDAs to address barriers to access.

It is not necessary for all State and Territory Governments to adopt the model of a dedicated dental commissioning agency. In the other jurisdictions there are, at present, broadly two models of service provision:

- government dental services, such as the SA Dental Service, where the health department decides policy and also runs dental clinics (possibly through a service delivery agency)
- regional health districts, such as the Local Health Districts in New South Wales, which are contracted by the health department to provide health services, including public dental services, for a region.

Effective commissioning can be incorporated into any of these existing organisational arrangements. The role for governments and commissioning agencies would be to:

- identify needs, including user groups that would have difficulty exercising choice
- develop the outcomes framework
- select providers to deliver services for these users, using a contestable approach and the outcomes framework
- monitor and evaluate, including dissemination of effective practices.

The commissioned providers may be public sector (the local health districts in New South Wales), private, or a mix (the CDAs in Victoria). They would be responsible for the delivery of services, in line with any requirements set out in their contracts.

It may take time to fully implement effective commissioning for public dental services. As noted above, the first stage is reliant on the completion of an outcomes framework (chapter 11). Upon completion of the framework, governments could, at first, commission services in areas where choice is not feasible.

As the full implementation of consumer directed care is a long-term process, there may also be a role for the broader application of contestability to some general public dental services in the interim. The finalised application of consumer directed care is essentially a standard-form contract for services, obviating the need for specific contestable processes. As such, if consumer directed care is implemented, contestable services would only be needed in those instances where choice is not feasible.

In the event that consumer directed care is not implemented, there would be benefit from wider application of contestability for public dental services.

DRAFT RECOMMENDATION 12.5

State and Territory Governments should establish outcomes-based commissioning systems for public dental services. Once systems are established, State and Territory Governments should examine opportunities for introducing greater contestability in public dental services.

At first, greater contestability should be introduced in those settings where it is clear that competition is not feasible, including remote provision and other outreach services.

12.5 The pathway to reform

Public dental services provide care to people in need of it. Just as consumer directed care seeks to put the user at the centre of public dental services, the transition to reform should take account of the existing users, ensuring there is continued care for those already accessing (or waiting for) public dental services.

Managing risk through staged implementation

An important first step is to establish the prerequisites for reform identified in chapter 11. These will assist in targeting new services and, by measuring outcomes for users, refining the payment model. As the DHSV noted, outcome measures are key to delivering an effective service for users:

> If greater contestability is implemented without outcomes measures we could end up with a more costly, less effective system. Hence great care is needed in designing the next steps for reform. (DHSV sub. 465, p. 9)

The NHS is currently undertaking a staged 'evolutionary not revolutionary' approach to reforming the dental payment models in England (UK Department of Health 2015). The payment model there has moved from pilots (which commenced in 2011), to prototype models (from 2016) and, depending on the results of evaluations, will proceed to progressive roll-out from 2018-19. Examining the change in treatments delivered by NHS dentists before and after the introduction of activity-based funding in 2006, Tickle et al. (2011) concluded that changes to financial incentive structures can produce large and abrupt changes in professional behaviours. Tickle et al. (2011) also emphasised the need for giving consideration to incentive structures to mitigate their unintended consequences. Indeed, in one instance in the United Kingdom, pre-implementation modelling would have allowed policy-makers to identify, and correct for, unintended (but predictable) consequences from the introduction of an incentive payment for GPs (Guthrie, McLean and Sutton 2006).

The introduction of the proposed dental reforms should be implemented in a staged manner to reduce the likelihood of unintended consequences.

- Benchmarking should be implemented relatively quickly and should guide public dental services delivery and improve outcomes for users.
- Contestability through the use of private providers in certain settings should commence once State and Territory Governments have completed systemic service planning within their jurisdictions (informed by benchmarking).
- Outcome based measures should be developed. In the first instance, they can be used to evaluate the effectiveness of public dental services. They can also be used in contracts for specific contestable services.
- Once the outcome measures are in use, development of the consumer directed care scheme should be implemented:
  - first, as in England, different 'blends' of payment model should be used at initial test sites
  - second, once evidence from these sites has been evaluated and a desired payment model finalised, the scheme should be progressively rolled out. Roll-outs could initially occur in public dental clinics (giving governments greater control to further refine the system); after which the system should be opened to all prospective providers.
  - after one full enrolment period has been completed, the initial outcomes (centred on user outcomes but also including costs, take up and changes in service and provider mix) should be assessed and any changes made to the scheme
  - contestability would continue to apply in those settings where choice is not feasible.

Completing the implementation of this reform package will take time. If done properly, these reforms represent a considered, long-term and systemic approach to the introduction of user choice in a manner that benefits users.

In the interim, the Commission expects the public dental system, including the use of vouchers, to continue to operate as it does now, but enhanced by the information available through benchmarking, outcome measures and digital oral health records.

Public dental services could implement the reforms to commissioning (section 12.4) once performance benchmarking and outcome measures have been developed. This process should start with selected remote areas, before a wider application of commissioning for public dental services.

Monitoring and evaluation

Initial stages of the reforms to public dental services should be set up to allow the evaluation of results. In particular, the data systems (to collect, manage and analyse information) should

be created such that information can be used for both payment and performance monitoring, as well as longer-term evaluations (chapter 2). Specifically, these evaluations should consider the effect of new consumer directed care models on the overall cost of the scheme, the mix of treatments provided and patient outcomes. These learnings should inform any re-design of the scheme (such as the inclusion or exclusion of treatments or changes in payment blends) in the next phase of the roll-out.

Data and evaluation systems were put in place as part of the NHS dental contract reforms. The NHS established an *Evidence and Learning Reference Group*, responsible for gathering evidence and lessons from the pilot models.

Evaluations will require data systems that can track users over time. This highlights the need for all participating providers to have data systems that can 'talk' to the government data systems (section 12.3), as well as the need for digital oral health records (chapter 11).

In the context of commissioning, evaluation would help commissioning agencies identify effective practices, disseminate innovations and promote ongoing service improvements.

A Public consultation

The Commission has actively encouraged public participation in this inquiry. This appendix outlines the consultation process for both the first stage (the study report) and the second stage (the inquiry report) of the 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 June 2016 to assist those wishing to make a written submission to the study. 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.
- The final study report was released on 5 December 2016 and a circular was sent to interested parties. This release marked the conclusion of the first stage and the commencement of the second stage of the inquiry.
- On 12 December 2016, an issues paper was released to assist those wishing to make a written submission to the inquiry. Following the release of the issues paper, 91 submissions were received (table A.1). These submissions are available online at www.pc.gov.au/inquiries/current/human-services/reforms/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 throughout the inquiry (table A.3).

The Productivity Commission thanks all participants for their contribution to the inquiry and now seeks additional input for its final report. The Commission welcomes further submissions to discuss the content of the draft report, including responses to the information request and draft recommendations.

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

Participant	*Submission number*
Aboriginal Health Council of Western Australia (AHCWA)	PFR393, 468
Aboriginal Housing Victoria (AHV)	PFR316
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	274, PFR384, 477 #
Aboriginal Peak Organisations Northern Territory (APO NT)	275, 478 #
Access Ministries	242
ADJ Consultancy Services	PFR356#*
Adult Learning Australia (ALA)	439
Aged & Community Services Australia (ACSA)	243, 411
Aged Care Crisis (ACC)	273, PFR387, PFR392 *
Aged Care Guild	219 #
Aitkenhead, Wendy	78
Alzheimer's Australia	431
Andrew, Dr Jane and Baker, Dr Max	140 #
Anglicare Australia	217, PFR391, 445
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, 412 #
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, 429
Australian Dental and Oral Health Therapists' Association (ADOHTA Inc.)	99, PFR318, 415 #
Australian Dental Association (ADA)	230
Australian Dental Association (ADA) NSW Branch	PFR339, 454
Australian Education Union (AEU)	224 #
Australian Government Department of Social Services (DSS)	221, PFR378, 476 #
Australian Healthcare and Hospitals Association (AHHA)	134, PFR306, 427
Australian Medical Association (AMA)	481
Australian Nursing and Midwifery Federation (ANMF)	202, 474
Australian Private Hospitals Association (APHA)	PFR381
Australian Red Cross	203, PFR325 #
Australian Services Union (ASU)	85, PFR326, 480
Australian Unity	94
Azzopardi, Donna	180
Baensch, Dr Allison	48

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Table A.1 (continued)

Participant	*Submission number*
Baptist Care (SA) Inc.	123 #
Barnes, Dr Richard	26
Barry, Laurie	113
Bartlett, Francine	215, PFR354 *
Barwon Health	PFR355 #
Becker, Elizabeth	212
Benevolent Society	129, 457
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
Brisbane Housing Company (BHC)	486
Broadbent, Dr Russel	423 #
Brotherhood of St Laurence (BSL)	286, 479
Bupa	258, PFR380
Burrows, Matt	206
Business Council of Australia (BCA)	PFR371
Business Council of Co-operatives and Mutuals (BCCM)	216, PFR302, 470
Butterworth, Matilda	22
Cabrini Palliative Care	PFR343
Cameron, Dr David	162
Campbell, Steven	290
Carers Australia	259
Case Health	251 #
Catholic Health Australia (CHA)	236, PFR350, 440
Catholic Social Services Australia (CSSA)	226, PFR315
Catholic Social Services Victoria (CSSV)	272
Central Australian Aboriginal Congress (CAAC)	PFR382, 430 #
Central Queensland Financial Counselling Service (CQFCS)	119
Centre for Excellence in Child and Family Welfare (CFECFW)	PFR383
Centre for Policy Development (CPD)	124 #
Centre for Social Impact (CSI)	448
Churches of Christ in Queensland (CofCQ)	PFR357
Churches of Christ in Qld, CSIA, The Services Union, Qld Community Alliance, QCOSS and UnitingCare Qld	446
Clarke, Prof. Rufus	400
Cluney, William	112

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Table A.1 (continued)

Participant	*Submission number*
Cochrane, Dr Fiona	169
CoHealth	240
Collins, Isabell	199
Combined Pensioners and Superannuants Association (CPSA)	121, PFR364
Commisso, Rosanna	209
Commonwealth Ombudsman	PFR314, 402 #
Community and Public Sector Union (CPSU) and State Public Services Federation Group (SPSF)	253, PFR375, 416
Community Colleges Australia	264
Community Council for Australia (CCA)	193
Community Employers WA (CEWA)	126, PFR368, 403
Community Housing Providers for Queensland (CHPs for QLD)	PFR359
Community Mental Health Australia (CMHA)	PFR304, 399 #
Community Services Industry Alliance (CSIA)	192, PRF395, 410 #
Consumer Action Law Centre (CALC)	260
Co-operatives Victoria	PFR310, 396
COTA Australia	456
Council of Private Higher Education (COPHE)	280
Council of Single Mothers and their Children, Victoria (CSMC)	435
Council to Homeless Persons (CHP)	270, PFR349, 434 #
Cox, Dr Kevin	482
Crain, Dave	165
Damé, Tricia	449
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, 465 #
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

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Participant	*Submission number*
Egerton, Thorlene	117
Electrical Trades Union of Australia (ETU)	229, PFR324
Elliott-Rudder, Megan	63
Equality Rights Alliance (ERA)	PFR346, 471
Esots, Jenny	73
Family & Relationship Services Australia (FRSA)	PFR370
Family Life	57
Federation of Ethnic Communities' Councils of Australia (FECCA)	25, 433
Financial Counselling Australia (FCA)	PFR372
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, 407 #
Hanscombe, Norman	82
Health Care Consumers' Association (HCCA)	239
Health Consumers' Council (WA)	447
Health Performance Council (HPC) SA	437
Health Workers Union (HWU)	472
Heilbronn, Stan	53
Hendrickx, Leonardus	150
Henry, Gabrielle	146

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Table A.1 (continued)

Participant	*Submission number*
Hill, Dr Christine	89
Hills, Dr Ian	88
Hobart District Nursing Service Inc.	419
Hogg, Elizabeth	39
Home Modifications Australia (MOD.A)	228
Homelessness Australia (HA)	149
Homelessness NSW	175, 452
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, 444
Incerti, Kate	141
Independent Hospital Pricing Authority (IHPA)	PFR322
Independent Planning & Coordination Services Pty Ltd	PFR358
Independent Schools Council of Australia (ISCA)	179, 426
Independent Schools Victoria (ISV)	58
Indigenous Affairs Group - Department of the Prime Minister and Cabinet (DPM&C)	265
Indigenous Eye Health, The University of Melbourne	425 #
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, 420
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

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Participant	*Submission number*
Kyd, Michael	171
Launch Housing	PFR373
Lavery, Anne	59
Leading Age Services Australia (LASA)	177, 463
Little Haven Palliative Care	458 #
Local Government NSW (LGNSW)	PFR338
Lochner, Sheri	93
Lodge, Teresa	164
Luckie, Paris	76
MacKenzie, Colin	75
Macular Disease Foundation (MDF) Australia	95, PFR335, 424
Maddocks, Prof. Ian	116
Mallee Track Health and Community Service (MTHCS)	PFR294, 397 #
Mamalis, Elle	18
Marsh, Prof. Ian	288 #
Marshall, Linley	195
Martin, Paula	66
Mascarenhas, Dr Lester	184
Massage & Myotherapy Australia	409
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, 418
Mid North Coast Human Services Alliance (MNC HSA)	220
MIGA	432
Miller, Dr David	83
Miller, James	62
Mission Australia	277

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Participant	*Submission number*
Mitchell, Leigh	97
Morgan, Craig	108
Morley, Dr Tom	49
Municipal Association of Victoria (MAV)	256, 443
Muswellbrook Shire Council	PFR365
Name Withheld	24
Name Withheld	37
Name Withheld	38
National Aboriginal Community Controlled Health Organisation (NACCHO)	227
National Council of Single Mothers & their Children (NCSMC)	441
National Disability Services (NDS)	262, PFR363
National Health Leadership Forum (NHLF)	475
National Mental Health Consumer and Carer Forum (NMHCCF)	PFR389
National Rural Health Alliance (NRHA)	269, PFR385, 428
National Seniors Australia	PFR360
National Shelter Inc.	232, PFR369, 466
Nayler, Tracey	98
Nepean Community & Neighbourhood Services (NCNS)	191
Neyland, Nita	42
Nguyen, Tan	398
Nicholls, Taraeta	148
North Richmond Community Health (NRCH)	PFR320 #
NSW Department of Family and Community Services (FACS)	484
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, CHPs for QLD, Shelter Tas and QShelter	406
NSWFHA, CHCSA, CHFV, CHIA, PowerHousing Australia and Shelter Tas	235
NT Department of Treasury and Finance (NT DTF)	261
O'Donnell, Carol	PFR301 #
O'Reilly, Stuart	91
O'Dowd Austen, Lee	453
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

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Table A.1 (continued)

Participant	*Submission number*
Palliative Care Australia (PCA) and Palliative Care Outcomes Collaboration (PCOC)	417
Pande, Dr Divya	158
Parkes, Vanessa	136
PeakCare Queensland Inc.	128
Penrith Homelessness Interagency (PHI)	413
Penrith Youth Interagency	PFR362
Pickard, Dr Marion	102
Power to Persuade	PFR390
Pike, Bradley	483
Powles, Anne	196
Prader-Willi Syndrome Association of Australia (PWSAA)	PFR348
Q Shelter	PFR352
Qld Advocacy Inc. (QAI)	442
Queensland Network of Alcohol and other Drug Agencies (QNADA)	PFR312
Queensland Nurses' Union	405
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
Royal Australasian College of Physicians (RACP)	473
Royal Australasian College of Surgeons (RACS)	PFR374
Royal Australian College of General Practitioners (RACGP)	8, PFR337
Royal Flying Doctor Service of Australia (RFDS)	174
Rumbalara Aboriginal Co-operative (RAC)	401
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

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Table A.1 (continued)

Participant	*Submission number*
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, 422
Shelter WA	PFR341
Sheridan, Jeanette	451
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, 414
South Australian Government	281, 460
Southern Migrant and Refugee Centre (SMRC)	263
Southern Youth and Family Services (SYFS)	234, PFR327, 436
Spicer-Wensley, Merriwyn	138
St Vincent de Paul Society National Council	285
St Vincent's Health Australia (SVHA)	207
Steen, C	10
Stephenson, Una	86
Stevens, Natalie	205
Strahan, Merinda	17
Strutt, Sue	198
Swain, Paul	404
Tasmanian Government	PFR297, 485 #
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, 461
The Centre for Independent Studies (CIS)	152, PFR347 #
The Fred Hollows Foundation	467

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Participant	*Submission number*
The Smith Family	257, 469
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, 459
van Kessel, Sister Susan (Lucy)	69
van Someren, Rachel	109
Varkey, Shobha	151, PFR291
Vaughan, Andrea	132
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	455 #
Victorian Alcohol and Drug Association (VAADA)	248, PFR305
Victorian Allied Health Professionals Association (VAHPA)	PFR361
Victorian Healthcare Association (VHA)	PFR376, 464
Victorian Multicultural Commission	120 #
Villis, Angela	43
Vision 2020 Australia	462
Vision Australia	28, PFR321, 421 #
Voss, Diana	450
WA Regional Services Reform Unit (WA RSRU)	PFR351
Wall, Terry	110
Walshe, Sue	54
Warwick, Anne	131
Western Australian Department for Child Protection and Family Support (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, 438
Youngcare	PFR323
Youth Affairs Council of South Australia (YACSA)	408
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)
Centre for Social Impact (CSI)
Collaboration for Impact
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)
Independent Pricing and Regulatory Tribunal (IPART)
Mission Australia
NSW Bureau of Health Information
NSW Department of Family and Community Services (FACS)
NSW Federation of Housing Associations (NSWFHA)
NSW Government
NSW Health
NSW Health Pathology
Social Ventures Australia (SVA)
Sturgess, Prof. Gary; Australia and New Zealand School of Government
TAFE Directors Australia (TDA)
WentWest PHN
Western Sydney Local Health District (WSLHD)
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)
Dental Health Service Victoria (DHSV)
Disability Advocacy Network Australia (DANA)
Duckett, Prof. Stephen, Grattan Institute
Grattan Institute
Healthscope
Independent Schools Victoria (ISV)

(continued next page)

Table A.2 (continued)

Participant
Victoria (continued)
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)
Brisbane North PHN
Brisbane Youth Services
Community Services Industry Alliance (CSIA)
Head, Prof. Brian; Institute for Social Science Research (ISSR)
Logan Together
Memmott, Prof. Paul; Institute for Social Science Research (ISSR)
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
Dooland AM, Dr. Martin
Health Performance Council (HPC) SA
National Centre for Vocational Education Research (NCVER)
SA Dental Services
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
Oral Health Services Tasmania
Tasmanian Government

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Table A.2 (continued)

Participant
ACT
ACT Government
ACTCOSS
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 and Youth (ARACY)
Catholic Social Services Australia (CSSA)
Chaney AO, Hon Frederick Michael
Council of Private Higher Education (COPHE)
Council on the Ageing Australia (COTA)
Empowered Communities
Federation of Ethnic Communities' Councils of Australia (FECCA)
Gray AM, Bill
Group of Eight Australia
Independent Schools Council of Australia (ISCA)
National Aboriginal Community Controlled Health Organisation (NACCHO)
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

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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

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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

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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
User choice and competition in healthcare – 28 February, Melbourne
ACSQHC
Australian Government Department of Health
Australian Healthcare and Hospitals Association (AHHA)
Australian Private Hospitals Association (APHA)
Beauchamp, Dr. Alison - Faculty of Health, Deakin University
Bupa
Byrne, Dr. David - University of Melbourne
Catholic Health Australia
Clarke, Prof. Phillip - University of Melbourne
Commonwealth Bank
Consumers Health Forum
Cutler, Dr. Henry - Macquarie University Centre for the Health Economy
Gravelle, Prof. Hugh - Centre for Health Economics, University of York
Gu, Dr. Yuanyuan - Macquarie University Centre for the Health Economy
Lambert, Peter - Monash University
Medibank Private
Mendez, Dr Susan - Melbourne Institute
Payne, Prof. Abigail - Melbourne Institute
Private Healthcare Australia
Propper, Prof. Carol - Imperial College, London
Royal Australasian College of Physicians (RACP)
Royal Australasian College of Surgeons (RACS)
Royal Australian College of GPs (RACGP)
Scott, Prof. Anthony - Melbourne Institute
Sivey, Assoc Prof. Peter - RMIT
St Vincent's Health Australia
Victorian Agency for Health Information
Woods, Prof. Mike - Centre for Health Economics and Research Evaluation, UTS
Yong, Assoc Prof. Jongsay - Melbourne Institute

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Table A.3 (continued)

Participant
Social housing – 16 March, Sydney
Achieve Australia
Bridge Housing
Common Equity
Evolve Housing
Homelessness NSW
Housing Plus
National Affordable Housing Consortium (NAHC)
NSW Federation of Housing Associations (NSW FHA)
PowerHousing Australia
SGCH
Shelter NSW
Southern Youth and Family Services
UNSW
Wesley Mission
Women's Housing
Services in remote Indigenous communities – 2 May 2017
Chaney AM, Hon Frederick Michael
Department of Social Services (DSS)
Empowered Communities
Gray, Bill – Former Secretary of the Department of Aboriginal Affairs and former CEO of ATSIC
Gray AM, Bill
Queensland South Native Title Services

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