



Australian Government  
Productivity Commission

## Reforms to Human Services

## Productivity Commission Issues Paper

December 2016

The Commission has released this issues paper to assist individuals and organisations to prepare submissions.

It contains and outlines:

- the scope of the inquiry
- the Commission's procedures
- matters about which the Commission is seeking comment and information
- how to make a submission.

## The Issues Paper

The Commission has released this issues paper to assist individuals and organisations to prepare submissions to the inquiry. It contains and outlines:

- the scope of the inquiry
- the Commission's procedures
- matters about which the Commission is seeking comment and information
- how to make a submission.

Participants should not feel that they are restricted to comment only on matters raised in the issues paper. The Commission wishes to receive information and comment on issues which participants consider relevant to the inquiry's terms of reference.

## Key inquiry dates

Receipt of terms of reference	29 April 2016
Due date for submissions	10 February 2017
Release of draft report	May 2017
Draft report public hearings	July/August 2017
Final report to Government	October 2017

## Submissions can be lodged

Online:	<a href="http://www.pc.gov.au/inquiries/current/human-services/make-submission">www.pc.gov.au/inquiries/current/human-services/make-submission</a>
By post:	Human Services Inquiry Productivity Commission Locked Bag 2, Collins Street East Melbourne Vic 8003

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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](http://www.pc.gov.au)).

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## 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 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.

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## 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
    - (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

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- (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
  - (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.

Scott Morrison  
Treasurer

[Received 29 April 2016]

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# 1 What this inquiry is about

## What has the Commission been asked to do?

The Commission has been asked to examine whether the effectiveness of human services could be improved by introducing greater competition, contestability and informed user choice. Commencing in April 2016, the inquiry followed a recommendation of the Competition Policy Review that governments should, wherever possible, put user choice at the heart of human service delivery as users are best placed to make choices about the services they need (Competition Policy Review 2015).

## The inquiry process

The terms of reference for this inquiry set out a two stage process — the first stage identified the human services that the Commission considers are best suited to greater competition, contestability and user choice. The Commission undertook an extensive consultation process, including stakeholder visits, the receipt of almost 400 submissions, roundtables and the release of a preliminary findings report. Marking the completion of stage one, the Commission released its study report in December 2016 which prioritised six areas where outcomes could be improved for people who use human services, and the community as a whole. The Commission found that well-designed reforms, underpinned by strong government stewardship, could offer the greatest improvements in outcomes for people who use:

- social housing
- public hospitals
- end-of-life care services
- public dental services
- government-commissioned family and community services
- services in remote Indigenous communities.

The study report sets out the Commission's reasoning for selecting these areas.

The Commission is commencing the second stage of the inquiry. In this stage, the Commission will make recommendations on how outcomes could be improved through greater competition, contestability and informed user choice in the provision of the services identified in stage one. The Commission's focus will be on improving outcomes by putting users at the heart of service delivery — competition, contestability and user choice are tools to achieve this, but will not always be feasible or desirable. The Commission will outline a path and process to achieve sustainable, efficient and effective reform.

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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 benefits and costs 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.

## **Opportunities to participate in this inquiry**

The Commission will consult widely through meetings with stakeholders, written submissions and public hearings.

The Commission is publishing this issues paper to assist participants to prepare a submission to the inquiry. It outlines areas where the Commission is seeking feedback across the six areas identified as priorities for reform. Information on how to prepare a submission can be found in attachment A. Submissions are due by 10 February 2017.

Submissions received during the preparation of the study report will inform the Commission's analysis in this second stage of the inquiry. Participants are also welcome to steer the Commission to relevant submissions that were prepared for other public reviews.

The Commission will release a draft report in May 2017, and will invite comments on that report. Public hearings will commence in July. The final report will be submitted to the Australian Government in October 2017.



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## 2 The framework for assessing reforms

### The objectives of human services provision

The objective of human services is to improve the wellbeing of users and the welfare of the community as a whole through the provision of effective services. Effectiveness is an overarching concept, incorporating the attributes of *quality*, *equity*, *efficiency*, *responsiveness* and *accountability* to determine whether the service is achieving its intended outcomes (box 1). The main focus of the Commission's analysis is to identify reform options that improve the effectiveness of service provision.

In addition to improving the lives of users and their families, the provision of human services can also provide social capital by improving social inclusion through, for example, the development of community networks (PC 2011). These broader benefits can be difficult to measure or attribute to particular services or funding streams, but should be taken into account when considering reform options.

#### Box 1 The attributes of human service provision

Several attributes of human service provision combine to determine the overall effectiveness of services in improving the wellbeing of users and the welfare of the community as a whole. Innovation can improve the effectiveness of service provision over time.

- The **quality** of a human service is the effect that the service has on a user's wellbeing, such as the reduction in pain from medical treatment, or the improvement in a child's literacy from school education.
- **Equity** is about the 'fairness' of the distribution of resources and services between different individuals and regions. Equity principles imply that equals are treated the same and are able to access the same level of support. There can be differentiation between types of users as long as those in need are able to access at least as much support as those with lower levels of need. 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 those who face the biggest challenges.
- Economic **efficiency** measures how well inputs are combined over time to provide human services that produce the outcomes the community values most highly.
- **Responsiveness** refers to how well an individual or organisation reacts to changing circumstances, including the needs and preferences of individual service users, and the way these preferences change over time.
- **Accountability** refers to the need to account for activities to those who fund human services (including taxpayers and service users) in a transparent manner.

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## Identifying reform options

The Commission's task in this inquiry is to develop reform options that would improve the effectiveness of human services and help ensure all Australians can access timely, affordable and high quality services. As required by the *Productivity Commission Act 1998* (Cwlth), the Commission will be guided by the need to increase the wellbeing of all members of the Australian community. An individual's wellbeing is influenced by many things and is difficult to define and measure but one thing is clear: the wellbeing of an individual, or the welfare of the community, cannot be reduced to a simple economic metric or fiscal cost.

Getting reforms to human services 'right' is a challenging task. The needs and preferences of users are diverse within and across the six areas identified by the Commission, as are the motivations and capabilities of service providers, making it essential that reform options are tailored to the characteristics of both. The following sections of this issues paper outline the information the Commission needs to identify policy options, and understand the costs and benefits of the alternatives. This information will enable the Commission to develop reforms in each of the six areas that would be expected to offer the greatest improvements in outcomes for users, and the community as a whole.

## Evaluating reform options

Once reform options have been identified, the Commission will evaluate their potential effects on service users, providers and the broader community. The Commission proposes to evaluate reform options based on the way they change the attributes of effectiveness outlined in box 1. This involves assessing the effect of reform options on:

- service quality, including whether the reform will lead to incentives for providers to produce services that lead to greater improvements in user wellbeing
- the equity of service provision, including the effects on different cohorts of people, such as those with different levels of income and wealth, younger and older Australians and people living outside of urban areas
- the efficiency of service provision, including whether there are incentives for providers to improve the cost-effectiveness of providing high-quality services, produce the type and quantity of services that users need and want.
- the incentives inherent in system design — the 'carrots and sticks' that influence the way service users, providers and governments behave — to ensure that service providers and governments will be responsive to the needs of service users and to changes in these needs over time, and are accountable to those who pay for services
- the incentives for service providers to innovate and improve the effectiveness of service provision over time.

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### 3 Tailoring reform options

There are many different ways to introduce greater competition, contestability and user choice. The characteristics of service users, providers and the role of government stewardship will influence how human services should be delivered (figure 1). The best model to deliver a particular human service will also be dependent on the objective of service provision and the different incentives inherent in alternate models of service provision. A key consideration will be whether reform can be introduced cost-effectively — taking into account the need for strong government stewardship arrangements to underpin reform, and the need for any complementary reforms.

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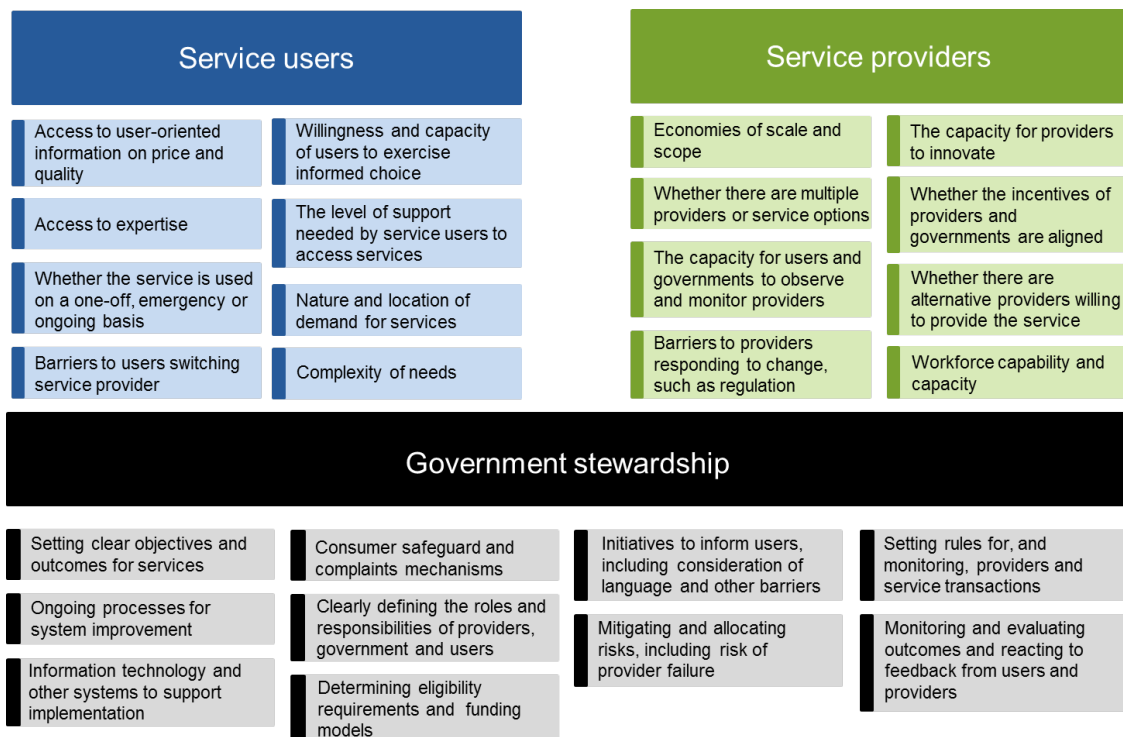
#### REQUEST FOR INFORMATION 1

*The Commission is seeking feedback from participants on whether figure 1 reflects the characteristics that should be taken into account when designing reforms to service provision for the six priority areas considered in this inquiry. What other characteristics should the Commission consider?*

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Figure 1 **Characteristics of human services**



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## Increasing user choice

There are many different forms of user choice. Users can make choices over the service they use, and who provides it, they can receive assistance to make choices, or delegate the choice to a trusted agent (such as a family member or friend). In some cases, choices will be restricted — for example, users may be able to choose the provider of their services, or the type of services they receive, but not both. Introducing user choice can be combined with approaches to build the capacity of users to make choices over time. Where user choice is not feasible or desirable, there may be other options for empowering users — such as governments and providers taking greater consideration of user preferences in decision making. Under some models of human service delivery, providers or a third-party (such as a regulator) make decisions on behalf of some — or all — users.

Underpinning user choice is the principle that, with some exceptions, informed users are best placed to determine which services and providers best meet their needs and preferences. This is a fundamental principle underpinning markets — they facilitate the matching of service users to their preferred services or providers, putting users at the heart of service delivery through choice. This is how markets for cars and groceries work and is no different for some human services. For example, users choose which general practitioner (GP) or dentist to go to, students choose their university, and increasingly older people can choose their aged care provider. Recent reforms to disability support services are unlocking the ability of people with disabilities to determine what support is best for them.

The benefits of user choice have been well demonstrated. Where exercised under sound stewardship arrangements, choice raises living standards for the service user, both by giving them a greater sense of control over their own lives, and also by placing pressure on providers to understand and meet their needs.

User choice is not always desirable or feasible. Importantly, users must be willing and able to make choices, or have someone do so on their behalf. This will not always be the case. Some services are provided during an emergency or crisis, and it may be impractical to expect users to make choices in these situations. Very young people or people living with some types of mental illness, for example, may not be well placed to make choices. For some services, there is a lack of user-oriented information that would enable users to make choices, and implementing user choice in these cases can make users dissatisfied, overwhelmed, and confused about the implications of their choices. There are also circumstances when a user's agency is explicitly removed, such as when placed under a court order to attend drug rehabilitation.

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## REQUEST FOR INFORMATION 2

*The Commission is seeking information on the potential to introduce greater user choice to the six priority areas considered in this inquiry. This includes information on:*

- how user choice could lead to improvements in the quality, equity, efficiency, responsiveness and accountability of service provision*
  - lessons from previous reforms, in Australia or overseas, to introduce greater user choice in human services (specific examples outlining how user choice was introduced, the costs and benefits of the reform, and the ways in which the reform could be applied would be welcome)*
  - the supports needed for users to exercise informed choice (examples could include the provision of user-oriented information, access to third-party expertise or a system navigator)*
  - how to support users with complex needs, or a reduced capacity to make informed choice*
  - how to overcome the challenges of introducing greater user choice in regional and remote areas.*
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## **Introducing greater competition and contestability**

The provision of human services is dominated by government funding which is often allocated directly to the service provider. This breaks the normal provider–user relationship and makes it critical that both governments and providers focus strongly on the needs of users. Greater competition and contestability can be powerful tools to encourage governments and providers to make service provision more user-focused and effective (box 2). When designed and implemented well, competition and contestability can lead to a range of benefits, including increased innovation, better quality services, a greater range of services, and more cost-effective service provision.

Introducing more competition to provide human services is not always feasible or desirable. The market may be unable to support multiple providers in locations with low demand for the service, or where provision of the service is driven by economies of scale. Similarly, contestability will not be effective if there are not alternative providers (or management teams) willing to provide the service if the current provider underperforms. And those receiving services must be given the well-advised opportunity to act as consumers, not merely passive elements in an inevitable process.

Competition and contestability are not ends in themselves, and should only be introduced where they are likely to lead to more effective service provision. Several participants stated that previous reforms to introduce competition and contestability in services such as vocational education and training (VET), job services and homelessness services have not always improved the effectiveness of service provision. Participants' concerns included that the introduction of competition and contestability led to providers reducing costs

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rather than increasing quality, impeded opportunities for collaboration, and imposed unduly burdensome administrative and compliance costs on providers. These examples highlight that governments need to be careful when introducing competition and contestability to human services. Reform must be paired with strong government stewardship, including arrangements to monitor service providers and strong consumer protection arrangements.

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## **Box 2      What are competition and contestability?**

### **Competition**

Competition already exists, indeed can thrive, in human services. For example, Medicare funding for GP services follows users and recipients of support under the National Disability Insurance Scheme have individual budgets. Government and/or non-government providers of a service (or substitute services) strive against one another to attract service users. If competition is effective, service providers will attempt to attract users by reducing the price they charge, improving the quality of their service, offering new and innovative services, or otherwise tailoring their services to better meet the needs of users. Providers will have more incentive to provide services that users want, including packages of services. Where competition is introduced in markets for human services, it is often done through individual entitlements.

### **Contestability**

Contestable markets are those where there are no substantial barriers preventing a provider that is not currently supplying services to users from doing so now or in the future. Contestability in human services refers to a provider of human services, or the management team of that provider, facing a credible threat of replacement if they underperform. This could include the threat of replacing the management of a public provider with another public management team. The term contestability is used widely in the context of commissioning arrangements used by governments to select service providers — which can be from within or outside government. Contestability does not necessarily require the outsourcing of publicly provided services to the non-government sector.

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

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### REQUEST FOR INFORMATION 3

*The Commission is seeking information on the potential costs and benefits of introducing greater competition and contestability to the six priority areas considered in this inquiry. This includes information on:*

- whether, and how, greater competition or contestability could lead to improvements in the quality, equity, efficiency, responsiveness and accountability of service provision*
  - how reforms should be implemented and evaluated*
  - lessons from previous reforms in Australia and overseas to introduce greater competition and contestability in human services provision*
  - reforms to support competition and contestability, such as the need to provide user-oriented information to support choice and safeguard users*
  - how greater competition and contestability could promote innovations in the provision of human services, drawing on examples where possible*
  - consideration of the challenges of introducing competition and contestability in regional and remote areas*
  - ways to ensure that competition and contestability does not limit providers collaborating, formally and informally, where it would improve the effectiveness of service delivery.*
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## **Government stewardship**

Stewardship relates to the range of functions governments undertake that help ensure service provision is effective at meeting policy objectives. This includes responsibility for ensuring arrangements for providing human services are continually improving. Ultimately, stewardship recognises that the overarching responsibility for ensuring that human services contribute toward the wellbeing of the community remains with government, even where non-government providers are responsible for service provision. The role governments take, including the functions they perform themselves or delegate to other authorities, depends on the characteristics of the service and on the objectives and outcomes that governments set for service provision. For example, a human service may rely on general consumer protections administered through consumer protection agencies or it may require specific protections.

The stewardship role may be spread across different levels of government (and potentially include all three levels), or parts of a government, making coordination critical to ensuring service provision is effective.

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## Government funding for human services

Different funding models for human services have different incentives for providers and users. Governments can provide funding to the user of the service through budgets or vouchers, with funding following the user's decisions. User-directed funding can create strong incentives for providers to respond to the wishes of users. Governments can attempt to mimic these incentives by linking funding to provider performance ('outcomes-based funding'). These models can be difficult to design and may lead to 'gaming' if governments are unable to effectively monitor providers.

Block funding models do not create financial incentives for providers to respond to users' needs in the way user-directed funding does — these models rely heavily on providers being trusted or compelled (through rules and regulations) to act in the interests of users. Service users can feel disempowered when they have little or no say over the choice of service they receive, and have little redress if funding is allocated directly to providers. Some participants stated that block funding has positives, including the flexibility for providers to determine who should receive the service and how. Participants also considered that block funding enabled services to be delivered in markets that would be otherwise unviable (Australian Red Cross, sub. PFR325; National Disability Services sub. 262).

The terms of reference ask the Commission to consider factors affecting consumer use of services, which could include the use of user co-payments. The balance of government funding and user co-payments, as well as who is eligible to receive the service, will influence the level of demand for the service, and the incentives of providers and users of the service. On the one hand, co-payments can ensure that users focus more strongly on the consequences of their choices by giving them 'more skin in the game'. On the other hand, co-payments can mean that some users who need services do not receive them and, if not well-designed and targeted, they can be in conflict with objectives to improve equity of access to services.

## Selecting the service provider

Many different types of providers supply human services, including not-for-profit, for-profit, cooperative, sole trader and government providers. Indigenous organisations play a role in the delivery of many services to Indigenous Australians. Providers can be large or small, and have a different reliance on employed staff, volunteers and donations.

Each type of provider will have distinct capabilities and motivations. External benefits, such as social capital benefits, should be considered when selecting providers, but these benefits are not exclusive to one type of provider. Maximising community welfare from the provision of human services does not depend on adopting one type of model or favouring one type of service provider over others.



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## Setting the rules

Governments set rules covering how users and providers engage to help ensure services are high quality, safeguards are in place to protect users, and imbalances in information available to users and providers are addressed, among other things. Rules can either restrict some actions, or provide incentives for providers and users to take other actions. Governments set the rules that determine who makes the decision as to which service, or provider, a user can access.

A key feature of rule setting is establishing regulatory frameworks that may include eligibility criteria, pricing schedules, minimum standards of service quality, professional accreditation, and consumer protection mechanisms.

Explicit, written regulations have an important role to play in stewardship, but they are not the only way that governments can influence the behaviour of service providers and service users. Governments can indirectly influence behaviours through incentives that are built into the design of the system (for example, the potential to roll over a service contract for high-quality providers with a strong record of achievement). In some cases, less formal rules may be established. For example, providers may self-regulate, set standards and monitor the performance of their peers.

Models based on ‘trust’ (for example, the relationship between a patient and their GP), and outcomes-based contracting offer substantial flexibility to providers. Flexibility can allow providers to innovate and tailor services to users. These approaches rely on providers having the expertise and incentive to act in the interests of the user.

Ultimately, governments need a robust framework for deciding when (and how) to regulate, and when to rely on other means to influence the behaviour of service users and providers. A key factor will be who is best placed to manage risk inherent in the provision of human services (including the risk of harm and financial risk). In some cases, governments can best identify and manage risks. In other cases, users can manage some of the risk they face by, for example, acquiring relevant information to help them make decisions that are right for them and their circumstances. Similarly, providers can implement internal management processes to manage more effectively their own financial risks compared to explicit oversight from governments.

## Ongoing processes for system improvement

Stewardship of a human service is more than simply designing the system and ensuring compliance with the rules of the system. Governments need to monitor service provision on an ongoing basis to ensure it achieves the desired outcomes for users and the broader community. This monitoring and evaluation role can be used to identify effective practices, and make ongoing improvements to policies and programs to disseminate innovations and improve service outcomes.

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Governments need good processes for testing reforms, identifying good practices and problems, and implementing solutions to problems. These processes need to include opportunities to receive feedback from those in day-to-day contact with services — the providers and users of the service.

High-quality data, and effective use of these data, are crucial to government's evaluation and feedback role. Governments need to consider the data required to effectively monitor the provision of the service when designing systems to provide human services, noting that data collection can impose costs on users, providers and governments.

While governments can set objectives, design and fund systems to provide services, ultimately, service provision is about achieving outcomes for users. The users themselves need to have a say through feedback on existing services, and involvement in future service design processes. Many participants to the study report were attracted to the idea of governments 'co-designing' services with users of services — to collaborate on designing and improving human services over time. For example, the Federation of Ethnic Communities' Councils of Australia (sub. 25) stated that users should be a key consideration when designing a service rather than being treated as an afterthought.

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#### REQUEST FOR INFORMATION 4

*The Commission is seeking information on government stewardship arrangements for the six priority areas considered in this inquiry. This includes information on:*

- the role government stewardship should play to ensure services are user-centred when providers have discretion as to what services a user can access (measures to give users more say over the services they access when services are block funded could be an example)*
  - funding models that provide incentives for service providers to improve service quality, innovate, and respond to the needs of service users and funders*
  - the effects of user co-payments on the quality, equity, efficiency, responsiveness and accountability of human service provision, and on the incentives of users and providers*
  - how governments should account for the benefits to the broader community (such as the benefits from social capital) when allocating funding for human services*
  - rules that should be established to support effective service delivery, the design of these rules, and institutions needed to establish rules and monitor compliance*
  - processes that could be used to help users, providers and governments work collaboratively to evaluate the effectiveness of human service provision, and continually improve the provision of human services (approaches to co-design could be an example)*
  - the design of government's monitoring, evaluation and feedback functions, the data needed to support these functions and mechanisms for sharing these data across services and governments.*
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## 4 Social housing

### The current model of social housing provision

The social housing system provides a safety net for people who are experiencing homelessness, or who face high barriers to sustaining a tenancy in the private rental market. Eligibility criteria to enter social housing are usually based on household income. Time spent waiting before housing is allocated to eligible tenants can be considerable, stretching to several years in some cases, although households with complex needs can receive priority access. Households in social housing can receive three broad forms of assistance.

- Assistance with the financial costs of housing through discounted rents (or indirectly through Commonwealth Rent Assistance (CRA)).
- Assistance to access or maintain a tenancy (such as support for people with a mental illness or poor tenancy records, which make holding a tenancy difficult).
- Transitional assistance for people to move into the private housing market from social housing or the social housing waiting list.

A number of services, assets and processes make up the social housing system, including the ownership and management of properties, the allocation of tenants to specific homes, and some tenancy support services, such as alerting other service providers to potential concerns with tenants (for example, providers of mental health services). The Commission's focus in this inquiry will be on the effectiveness of services to people receiving support through the social housing system, and to those who require support but are currently unable to access it.

The Commission's study report identified several reasons why the social housing system is not as effective as it could be at improving outcomes for users.

- A shift in the demographics of people receiving support — from working families to households who face barriers to entering the private housing market — means that the social housing stock is no longer fit for purpose.
- Many social housing properties are in an unacceptable condition and are underutilised, and there is a lack of data to monitor service providers.
- The system produces inequitable outcomes. The social housing system is primarily the responsibility of state and territory governments, but the Australian Government provides funding for social housing and also CRA to households in private rentals or community housing. Households with the same income and characteristics can receive vastly different levels of assistance, depending on whether they are able to access social housing or receive assistance to rent in the private market.

Once in social housing, there is little incentive for tenants to exit the system, and many tenants receive permanent support. Over 40 per cent of tenants in public housing in 2015 had been there for over ten years (AIHW 2016b).

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Importantly, users have little choice over the home they are allocated, and there is little competition between government and non-government providers to manage social housing. The key question that the Commission is seeking to answer is whether introducing greater choice, competition and contestability could provide incentives for providers and governments to increase the effectiveness of the social housing system? In answering this question, the Commission will consider the characteristics of service users and providers (section 3).

Reforms will need to be tailored to account for the characteristics of different user groups and regions. For example, it could be more difficult to implement user choice and competition in regions where there are fewer providers willing to offer social housing. As noted by Aboriginal Housing Victoria (sub. PFR316), Indigenous Australians face additional barriers to access the private rental market that will need to be taken into account when designing reforms. People with a disability may also need social housing that is tailored to their needs.

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#### REQUEST FOR INFORMATION 5

*The Commission is seeking information on the current effectiveness of the social housing system in improving outcomes for tenants. This includes information on:*

- whether users are placed at the heart of service delivery and, if not, what could be done to address this*
  - whether current arrangements, including the eligibility criteria and the type and level of assistance, enable equitable access to social housing*
  - the roles and responsibilities of governments and non-government providers, including who is best placed to provide support to households to sustain a tenancy, and to exit the social housing system when they have the means to do so.*
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## **Giving users more choice over the home they live in**

The study report found that providing tenants with a greater choice of home could improve housing stability and lead to a more efficient social housing system. Implementing greater user choice will require consideration of the model used to allocate tenants a home, the supply of, and demand for, social housing, and the model used to provide financial support to households.

### **The model used to allocate tenants a home**

Governments and other social housing providers allocate households to social housing properties based on the household's characteristics, such as the number of bedrooms needed. The suitability of the property can be a question of timing and luck. There is scope for greater user choice to be included in an allocation model. For example, choice-based letting allows prospective households to 'bid' on social housing properties that they would

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like to live in. This approach has been used with some success in countries such as the United Kingdom, the Netherlands and Canada (City of Toronto 2016; Marsh, Cowan and Cameron 2004; Pawson and Watkins 2007).

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#### *REQUEST FOR INFORMATION 6*

*The Commission is seeking information on models used to allocate social housing that could increase choice of home for users, and the benefits and costs of these models. This includes consideration of:*

- whether increased choice would lead to better outcomes for users, both by allowing them to exercise their preferences over where they live, and by encouraging housing providers to be more responsive to their needs*
  - what information and other supports should be provided to tenants to enable them to exercise choice*
  - complementary reforms that would be needed to capture the benefits from increased user choice*
  - whether the allocation model may need to differ between regions and user groups*
  - international approaches to increase user choice of home, the applicability of these models in Australia and, where it would be beneficial, how they could be implemented here.*
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### The supply of, and demand for, social housing

Participants to the study report highlighted the lack of supply of social housing, relative to demand, as one of the key impediments to introducing greater user choice. Further, increasing the supply of social housing generally relies on governments building (or funding the build of) new properties. The time and cost associated with new builds reduces the ability of the system to respond to changing demographics and needs.

Some participants raised the potential for additional government investment, either in the form of new government construction or subsidies for the private sector to construct new homes, to boost the supply of social housing. Given the 200 000 households on social housing waiting lists, this could require a substantial boost in government funding for social housing — for comparison, the Social Housing Initiative funded about 20 000 homes at a cost of about \$5 billion (DSS 2013). There may also be reforms that could create incentives for the private sector to invest in social housing.

Construction of social housing is not the only option available to increase housing options for households in need of social housing. Unlocking the potential supply of homes available in the private rental market may be an option — either through governments leasing properties from the private market to use as social housing; by continually assessing the eligibility of people to enter, and remain in, social housing; or by providing

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social housing tenants with the assistance and the incentive to transition out of social housing.

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*REQUEST FOR INFORMATION 7*

*The Commission is seeking information on how best to address supply constraints in the social housing system to enable households to have a genuine choice of home. This includes consideration of:*

- whether eligibility criteria for entering, and remaining in, social housing are targeting those most in need of support*
  - the extent to which community housing providers can contribute toward increasing the stock of social housing (and, to the extent that this has already occurred, the factors underlying successful outcomes for eligible households)*
  - the role of the private housing market in providing homes for households in need of social housing, and the costs and benefits of reforms to unlock this potential (examples could include social housing providers leasing properties from the private sector or providing assistance to households to access the private rental market)*
  - the adequacy of current support provided to help tenants transition out of social housing, what could be done to improve this support, and who should provide this support.*
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## Financial support for households

Across all jurisdictions in Australia, the financial support that households receive in social housing is linked to incomes, rather than the market rent for the property. Most households in social housing pay about 25 per cent of their income in rent, which is often substantially less than what would be the market rent for the property. The value of the subsidy received by individual households lacks transparency.

Further, the support received by people in social housing is often much higher than that received by people who receive CRA and rent in the private market. This has implications for user choice, as households face less incentive to exit the social housing system, even where they have the capacity to do so.

IPART (2016) highlights other models that could be used in social housing to provide financial support to tenants. These include providing a fixed level of support based on household characteristics (such as the number of people in the household), or providing support based on a percentage of rent paid (which is the case under CRA). The model could differ between user groups and regions, and could taper over time as the length of tenure increases. Each of these models has different effects on tenant incentives to obtain or maintain employment, the level of certainty that households will avoid ‘rental stress’, equity of access across different households, the transparency of the subsidy, and the

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financial sustainability of the social housing system. The capacity of tenants to absorb change will also be important.

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*REQUEST FOR INFORMATION 8*

*The Commission is seeking information on models that could be used to provide financial support to social housing households. This includes consideration of :*

- how the level of support to social housing tenants should be set and the benefits and costs of each model, including its effects on incentives for households to obtain or maintain employment, fiscal implications for governments, and its effects on outcomes for service users*
  - the potential for support to differ across households, groups and regions, or to change depending on the length of tenure*
  - the equity implications of having different models of support applying across social and private housing.*
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## **Making the management of social housing more contestable or competitive**

About four in five social housing properties in Australia are managed by governments and have not been subject to contestable arrangements to select alternative providers (or demonstrate that the government provider is best placed to improve outcomes for tenants). Increasing the contestability of social housing could increase incentives for providers to respond to the needs of households, which could increase the effectiveness of social housing. Evidence suggests that community housing providers perform better than public providers on indicators relating to maintenance, utilisation and tenant satisfaction (SCRGSP 2016b). This evidence should be treated with caution, given that community providers are often responsible for managing newer, higher-quality properties.

Transferring the management of properties to the non-government sector is complex. Some participants to the study report had concerns with how non-government providers are regulated under the National Regulatory System for Social Housing, and the process for transferring the management of properties.

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#### REQUEST FOR INFORMATION 9

*The Commission is seeking information on the effectiveness of current arrangements to select community housing providers and whether greater contestability could improve the effectiveness of service provision. This includes information on:*

- the relative performance of community and public providers in delivering good outcomes for tenants, and in meeting policy objectives set by governments*
  - where the management of public housing has been transferred to the community sector, whether the arrangements for selecting providers have resulted in providers that are strongly focused on improving tenant outcomes, and if not, how these arrangements could be improved*
  - what factors governments should consider in selecting service providers, including the types of providers that can best provide social housing, and the minimum scale of provider needed to efficiently provide social housing*
  - what the role of community housing providers should take in addition to tenancy management — for example, whether community housing providers could offer services to help tenants maintain their tenancy or to improve the health and education outcomes of tenants, or whether this should remain a role for government*
  - the data needed to ensure that service providers are responsive to the needs of users and accountable to taxpayers*
  - the suitability of the National Regulatory System for Social Housing, and whether revisions are needed to this system to support contestability*
  - the benefits and costs of title transfers versus management transfers.*
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## Implementing reforms

Reform to the social housing system should only be introduced when it is paired with strong government stewardship arrangements. This includes what institutions are needed to oversee the system, what rules should be established to offer incentives to providers to improve outcomes, and the monitoring of providers (section 3). In addition, the timing of reforms is important — such as whether reforms should be phased in over time to give market participants capacity to adjust, or whether trials are needed to provide more evidence as to whether, and how, reforms should be introduced.



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#### REQUEST FOR INFORMATION 10

*The Commission is seeking information on the factors that need to be considered when implementing reforms to increase competition, contestability and user choice. This includes consideration of the:*

- roles of users and providers in the process of designing the social housing system and in informing ongoing improvements*
  - rules needed to support effective service provision, including the regulations needed to ensure service quality and to protect social housing households*
  - data needed by governments to evaluate the effectiveness of reforms and design ongoing improvements to the system*
  - costs of reform on users, providers and governments, and how reform could be implemented to minimise these costs*
  - role for policy trials in the reform process, including what reforms would be best suited to trialling before full implementation.*
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## **5 Public hospital services**

### **The current model of service delivery**

The term ‘public hospital services’ refers to healthcare that (mostly public) hospitals provide to public patients. Public hospital services are provided on the principle of universal access. That is, all people eligible for Medicare are entitled to receive services free of charge. State and territory governments have primary responsibility for public hospital services and the Australian Government provides about 40 per cent of the funding.

The Commission’s study report found that the effectiveness of service provision in Australian hospitals compares well to that in comparable countries in terms of quality, equity, efficiency, responsiveness and accountability. Nevertheless, there is scope to improve. Public patients are often given little or no choice over who treats them and where, and equitable access remains a concern for some groups, particularly those in remote areas. Benchmarking within Australia suggests that many public hospitals could increase their service quality and efficiency by matching best practice among their domestic peers. Greater public reporting of service quality could bolster accountability.

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#### REQUEST FOR INFORMATION 11

*The Commission is seeking information on the effectiveness of public hospital services, including:*

- *the responsiveness of public hospitals to patients' needs and preferences*
  - *the equity of access to public hospital services*
  - *the quality and efficiency of public hospital services, and how this differs across regions and jurisdictions*
  - *the scope to improve accountability through more public reporting, including on clinical outcomes and cost effectiveness*
  - *how greater competition, contestability and user choice could place users at the heart of service delivery and improve the quality, equity, efficiency, responsiveness and accountability of public hospital services.*
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As discussed above in section 3, the characteristics of service users and providers will influence how human services should be delivered. There is considerable heterogeneity in the types of services provided and patient populations treated. Services range from emergency care to hip replacements, and can be delivered in hospitals or even in patients' homes, and in metropolitan, regional and remote settings. This heterogeneity means that a one-size-fits-all approach to reform is unlikely to be appropriate. For example, user choice has little relevance to emergency care where the patient has no capacity to explore alternative providers.

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#### REQUEST FOR INFORMATION 12

*The Commission is seeking information on which types of public hospital services and patient populations are suited to greater:*

- *user choice over clinician or hospital*
- *competition between clinicians or hospitals*
- *contestability*

*as well as the benefits and costs of implementing such reforms, and who would capture the benefits and bear the costs.*

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## Giving patients more choice

The good health outcomes that Australia generally achieves compared with other countries indicate that, from a clinical perspective, public hospitals are responsive to patient needs. Still, giving public patients more choice would let them exercise greater control over their own lives and can generate powerful incentives for service providers to be more responsive to their needs. Overseas experience indicates that user choice can improve service quality and efficiency when hospital patients can plan services in advance and access useful

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information to compare doctors and hospitals. In England, patients have been given a legal right to choose their hospital or clinic and clinician-led team whenever their GP decides that referral to a specialist is necessary. Following these reforms, consumers sought out better-performing providers, and hospitals in more competitive locations improved service quality the most (Propper 2013).

The ability and willingness of patients to make informed choices (figure 1) is affected by their health literacy. Providing greater choice at the point where individuals are referred to a specialist by their GP might be one way of supporting choice for people with low levels of health literacy. As part of its input to the Commission's study report, the Royal Australian College of General Practitioners (sub. PFR337) cautioned that adopting such a model in Australia would increase the length of GP consultations and hence probably the cost of care.

A further issue is that patients in regional and remote areas could face barriers to choice because there are few alternative hospitals and health professionals close to where they live.

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#### *REQUEST FOR INFORMATION 13*

*The Commission is seeking information on the potential to introduce greater user choice to public hospital services. This includes information on:*

- what decisions patients should be given choice over (for example, the individual clinician or clinician-led team that treats them, and/or the hospital in which they are treated)*
  - at what point(s) patients should be given a choice (for example, when a GP refers a patient to a specialist)*
  - what support should be offered to patients in making choices and who should provide it (for example, GPs or independent advocates)*
  - who should bear the costs of greater user choice*
  - whether existing consumer protections are sufficient and, if not, how to address this*
  - how to deliver choice to patients in regional or remote areas with few nearby providers (for example, by funding patient travel to better-serviced areas)*
  - likely changes in the use of other parts of the health system (including services for private patients) and how to minimise unintended consequences*
  - whether there should be policy trials to test alternative approaches to introducing greater user choice, and a phased implementation of reforms.*
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## **Providing more information**

Patients cannot exercise informed choice without adequate user-oriented information. While they can currently access a website (MyHospitals) to compare individual hospitals,

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many of the indicators concern waiting times. There is almost no information on the outcomes from specific treatments, apart from average length of stay in hospital for a few conditions. Greater user choice in Australia would need to be supported by more user-oriented information than is currently available, particularly on the clinical outcomes achieved by individual hospitals and doctors. Overseas evidence suggests that some (but not all) patients would use such information to seek out better-performing providers (Propper 2013).

The Commission's concurrent inquiry into data availability and use is exploring some of the benefits and barriers associated with making data more widely available, including in the health sector (PC 2016a). A draft report was released in October 2016, which proposed giving individuals greater control over digitally held data about themselves (including their health records) and a mechanism for making it happen. This could include allowing individuals to direct a data holder to pass information on to a third party, such as a new service provider. The Commission has asked for feedback on whether such data transfers should be backed by a legislative presumption in favour of providing data in an application programming interface to enable different pieces of software to communicate with each other.

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#### REQUEST FOR INFORMATION 14

*The Commission is seeking input on:*

- *what information patients would need to make informed choices about public hospital services, how it should be presented and how this should vary for different patient populations (for example, people who are unable to access information provided on the internet or in English)*
  - *what level(s) of information should be available to patients (for example, information could be provided at the level of individual clinicians, clinician-led teams or hospitals)*
  - *how the information patients need to make informed choices differs from what is currently available publicly (including through the MyHospitals website), and what changes are required to address this*
  - *the mechanisms for assembling and communicating data to patients (for example, through the use of application programming interfaces, the MyGov website and mobile phone apps).*
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There is also evidence that hospitals and doctors would use publicly reported data to benchmark themselves against other providers and seek to improve when they fall below best practice. The opportunity for third parties, such as health academics, policy think tanks and consumer advocacy groups, to analyse publicly reported data would place further pressure on providers to improve outcomes.

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#### REQUEST FOR INFORMATION 15

*In addition to the information patients need to make informed choices, the Commission is seeking input on what further data should be published to facilitate improvements in public hospital services through benchmarking, including:*

- what additional performance indicators to publish*
  - how this information would support more effective public hospital services by improving quality, equity, efficiency, responsiveness and accountability*
  - who should be responsible for collecting and managing this information, and who should bear the costs.*
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### **Increasing contestability**

In most cases, public hospital services are provided by state and territory governments through local health networks. Funding arrangements with the Commonwealth require each local health network to have a (published) service agreement with its state or territory government for the purchase of health services, specifying the number and broad mix of services to be provided, how the network will be paid, service standards to be met, and how poor performance will be addressed. The agreements are renegotiated at regular intervals (usually annually). This provides an opportunity to trial more contestable approaches to commissioning services, which could be for individual services, subsets of services, or an entire hospital. For example, state and territory governments could consider alternative providers of specific types of healthcare at the time of renegotiation, or the local health network could do so for services that it plans to subcontract to others. This would not require switching to a non-government provider.

Reforms would need to be carefully designed and implemented. Lessons and difficulties from past attempts to commission non-government providers should not be forgotten.

Workforce arrangements pose particular challenges to changing providers under contestability. The relationships that a hospital builds with local specialists could be a barrier to new providers entering the market. Changing the employment arrangements for a hospital's employees, or replacing them with a new workforce, could be particularly disruptive. For government-operated hospitals, it may be feasible to implement contestability as a more transparent mechanism to only replace the management team (or board of the local health network). Current arrangements for replacing underperforming management teams could be more transparent, particularly the level of underperformance that would trigger replacement.

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#### REQUEST FOR INFORMATION 16

*The Commission is seeking information on the potential to introduce greater contestability for public hospital services. This includes information on:*

- when contestability should apply to individual services, subsets of services, or entire hospitals*
  - the design of tender processes and management of contracts (for example, contract duration, minimum market size for contracting to be worthwhile, and how to define services and monitor quality to avoid gaming)*
  - how government-provided hospital services could be made contestable without necessarily changing to a non-government supplier (for example, by having more transparent arrangements for replacing underperforming management)*
  - where public hospital services are already contestable, what works well and how could existing contestability arrangements be improved.*
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## Complementary reforms

There are a number of complementary reforms that the Commission could consider as part of a possible shift to greater user choice and contestability for public hospital services. This could include changes to how state and territory governments manage demand across different public hospitals and health networks, facilitate access to services for people living in regional and remote areas through initiatives such as telehealth, and manage the interaction with services provided to private patients.

There are also various relevant reforms in progress. For example, the Independent Hospital Pricing Authority (IHPA) and others are developing new payment models for public hospital services, including paying hospitals less when poor service quality leads to avoidable readmissions. The IHPA is also working on bundled payments across different episodes of care for the same patient that allows more flexibility in the services provided. The Australian Government has sought to facilitate more timely and effective primary care (and thereby reduce avoidable hospitalisations) by commissioning Primary Health Networks and trialling a Health Care Homes initiative for patients with chronic and complex conditions (Ley 2015, 2016).

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#### REQUEST FOR INFORMATION 17

*The Commission is seeking information on how greater competition, contestability and user choice in public hospital services could be complemented by:*

- *innovative payment models, such as those that incorporate quality indicators, bundle payments across services, or make capitation payments to providers*
  - *changes in demand management by state and territory governments*
  - *measures to facilitate coordination between primary and tertiary healthcare*
  - *improved access to services in regional and remote areas through reforms such as greater use of telehealth, expanding the scope of practice of nurses, and more fly-in-fly-out arrangements for health workers*
  - *changes in how governments manage the interaction of public hospital services with those provided to private patients.*
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## 6 End-of-life care

### The current model of service delivery

The Australian Commission on Safety and Quality in Health Care has defined end-of-life care as including a range of health and community services for people who are likely to die in the next 12 months, including services that support their families and carers (ACSQHC 2013, 2015).<sup>1</sup> End-of-life care is provided in a variety of generalist and specialist settings in hospitals, residential aged care facilities and patients' homes.

It is, in principle, difficult to envisage end-of-life care as a single service. Yet for individuals suffering from a life-limiting illness, their set of complex needs could be bundled as a tailored service.

The Productivity Commission's study report concluded that there was scope to improve the effectiveness of end-of-life care. In particular, it could be more responsive to patient preferences and differences in access to high-quality services within and across jurisdictions could be reduced. The consistent application and publication of indicators that quantify how well providers are performing could enhance service quality and accountability, and enable benchmarking across providers.

End-of-life care is often funded by taxpayers, with a state or territory government sometimes providing services directly or commissioning them from a non-government supplier. In some cases, individuals (at least partly) contribute to funding their care, both directly and via health insurance premiums. In 2013-14, around 16 per cent of

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<sup>1</sup> End-of-life care does not include euthanasia or assisted suicide.



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palliative-care-related hospitalisations occurred in private hospitals, with the majority of this funded through private health insurance (AIHW 2016a).

Eligibility for services varies. End-of-life care received as a public patient in a hospital or from a GP in the community is provided on a universal access basis under Medicare. In practice, people with a life-limiting illness other than cancer are under-represented among users of government-funded services, such as specialist palliative care (Currow et al. 2008; LSIC 2016). There are also concerns about the range and quality of services available across jurisdictions, variability in access to services between urban and non-urban areas, inadequate access to 24-hour services, and under-servicing of Indigenous Australians, people from culturally and linguistically diverse backgrounds and people with disabilities.

Introducing greater competition, contestability and user choice to end-of-life care services is complex. The trajectory of each patient's illness, their preferences for the type and setting of care, and their capacity to make choices will be different. The person who is best placed to make choices may change over time. High-quality end-of-life care will often involve coordinating diverse services, some of which may be non-medical, across a range of settings. This raises questions as to who is best placed to take on the coordination role, and what supports are needed to ensure patients remain at the centre of service provision (for example, how is information about patient preferences for care communicated between providers). The availability of services varies across regions and jurisdictions, due in part to location and low levels of demand, as well as variation in eligibility criteria for government-funded services.

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#### REQUEST FOR INFORMATION 18

*The Commission is seeking information on the potential for greater competition, contestability and user choice in end-of-life care. This includes information on:*

- what types of services and settings to include in the definition of end-of-life care*
  - current government funding and eligibility criteria*
  - how eligibility for end-of-life care should be defined, and who should have responsibility for determining whether a person is eligible for care*
  - whether care services should be considered as a 'bundle' or individually, and who should determine which services a person can access (the patient's GP or the service provider, for example)*
  - how best to coordinate care across different settings and the supports needed to ensure patients remain at the centre of service provision*
  - the feasibility of offering users greater choice of service, or of provider, and how this differs between regions*
  - the potential for greater contestability, particularly for services and regions where choice is not practical*
  - the likely costs and benefits of greater choice or contestability, and how they should be distributed among users, their families and the wider community.*
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## Choosing and planning for care

The Commission's study report identified that patient preferences regarding the setting and timing of end-of-life care are not always well satisfied, and access to high-quality care is variable. Most Australians would prefer to die at home but end up dying in hospital instead. End-of-life care could be improved by providing patients with greater choice about the care they receive and the setting in which that care takes place.

Choices about end-of-life care often take place during periods of high emotion and stress. Unless given simple and well-designed choices, patients may lack the capacity to make decisions about their end-of-life care at the time when specific services are required and this can mean that patients do not receive the care they need in the setting they prefer. Holding early and ongoing conversations about end-of-life care (to accommodate changing preferences as an illness progresses, for example) and undertaking advance care planning (to document user preferences to be followed by doctors, carers and families) would help. However, taboos about discussing death can be a barrier to this occurring. Moreover, patients often rely on medical professionals to initiate conversations about end-of-life care, many of whom are inadequately trained about, and intimidated by, holding such conversations.

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### REQUEST FOR INFORMATION 19

*The Commission is seeking information on ways to improve the implementation of choice in end-of-life care, including how:*

- *patients and carers could be better supported to plan for care in advance*
  - *patients could be better informed about the end-of-life care options available to them and how to access that care*
  - *healthcare professionals could be better trained, assisted or incentivised to identify people who would benefit from end-of-life care, and to initiate and guide end-of-life conversations*
  - *patient preferences for end-of-life care could be better documented and communicated across healthcare settings*
  - *barriers to implementing patients' expressed preferences (including those in advance care plans) could be overcome.*
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## Improving commissioning and funding arrangements

Providing services that better support people who want to die at home could require more high-quality, community-based end-of-life care. These services are provided by GPs, residential aged care facilities, generalist in-home care services and specialist palliative care services, and draw on a mix of federal and state government funding.

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At the state and territory level, funding and commissioning models for community-based specialist end-of-life care vary, as do the range of services available. There are some reasonable justifications for these differences (such as the level of demand for services in a given region) but they also reflect the different paths that jurisdictions have taken over time to reach their current policy approaches.

The Commission is interested in further exploring how improvements to commissioning and funding arrangements could contribute to the capacity of end-of-life care to satisfy patient preferences while providing high-quality care. This could include more flexible funding arrangements that better accommodate patient demand across different care settings.

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*REQUEST FOR INFORMATION 20*

*The Commission is seeking input on:*

- *the costs and benefits to the community as a whole of providing end-of-life care in different settings (such as hospitals, aged care facilities and homes)*
  - *commissioning and funding arrangements for end-of-life care that have proven most effective in Australia and abroad, both in urban areas and in less densely populated regional and remote areas*
  - *how existing commissioning and funding arrangements could more closely reflect population needs, better satisfy patient preferences, incentivise improved patient outcomes and provide governments with better value for money.*
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## **Reforms to support greater user choice**

Changes to consumer protection may be required to support greater contestability or choice, including possibly strengthened accreditation or licensing of providers of community-based care.

There is a need for improved data collection and reporting on patient activity, expenditure and outcomes; coordination of end-of-life care between different settings; integration of end-of-life care into primary care and aged care; and support for informal carers. The matters that the Commission has raised in its concurrent inquiry on data availability and use are relevant in this regard (discussed above with respect to public hospital services). In particular, giving patients a right to direct holders of their health records to pass the data on to other service providers could facilitate better integration of care across services.

The Commission is open to considering improvements in these and other areas that complement user choice, provided that there is a strong, evidence-based case for reform.

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#### REQUEST FOR INFORMATION 21

*The Commission is seeking information on complementary measures to support greater user choice in end-of-life care (and the associated costs and benefits), including how:*

- consumer protection may need to be improved (for example, strengthened accreditation or licensing of providers of community-based care)*
  - collection and publication of data on end-of-life care could be improved to support user choice and improve the planning, delivery and evaluation of services*
  - key performance indicators and associated benchmarks should be specified to monitor whether services are high quality and enable benchmarking across providers*
  - end-of-life care could be better integrated into primary care and aged care*
  - transitions between end-of-life services, providers and settings could be improved to minimise disruption for patients and carers (and thereby ensure that patient preferences travel with them)*
  - informal caregivers could be better supported to provide care at home*
  - other measures could support user choice and improve outcomes for patients, carers, families and the broader community.*
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## 7 Public dental services

### The model of public dental service delivery

Unlike many other forms of healthcare, governments only fund a small proportion (around 14 per cent) of dental expenditure in Australia and, when they do, the service is also often provided by government itself. This is in contrast to, for example, eye tests and GP services, where the vast majority of funding comes from the Australian Government via Medicare, but services are almost always provided by the private sector.

Public dental services are not open to all through universal access arrangements, as is the case with public hospitals. Adults with a concession card and most children are eligible to receive public dental services funded by state and territory governments. Children in families receiving Family Tax Benefit Part A are eligible for services funded by the Australian Government. Reflecting their role as a safety net, public dental services are funded to provide basic dental care.

Governments also manage demand for public dental services through waiting lists, with patients triaged based on their clinical need. Dr Martin Dooland (sub. PFR 300) estimated that, among adults eligible to receive public dental care, 20 per cent receive public dental services in a given year, but a further 30 per cent are treated in the private sector and pay for it themselves. Demand is also influenced by co-payments that users of public dental

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services are sometimes required to make to partly fund their care. Governments therefore employ a range of tools — including eligibility criteria, limiting the scope of provided services, waiting lists and co-payments — to manage demand and control the fiscal cost of public dental services.

The Commission's study report identified scope to improve the effectiveness of public dental services. The responsiveness of service providers to user preferences over the timing and location of treatment can be constrained if public patients have no option other than receiving care in a public dental clinic. State and territory governments regularly publish some information on public dental services, however there remains considerable scope to improve accountability through greater public reporting, including on patient outcomes and cost effectiveness.

Equitable access is also a concern for groups such as Indigenous Australians and people living in remote areas. Difficulties accessing dental services that cause people to leave dental problems untreated can lead to more costly treatment, particularly if the patient requires hospitalisation. In 2013-14, people in remote areas were about 40 per cent more likely than those in major cities to be hospitalised for conditions that could have potentially been avoided if timely and adequate dental care had been provided, after controlling for age differences between regions (AIHW 2015).<sup>2</sup> Indigenous Australians were more than twice as likely to experience an acute potentially preventable hospitalisation for a dental condition if they resided in a remote area (SCRGSP 2014).

The Commission is seeking information on whether reforms to increase competition, contestability and user choice in public dental services could place users at the heart of service delivery and improve outcomes. In examining potential reform options, the Commission will consider the need to tailor reforms based on the characteristics of users and providers (section 3). Notably, the scope for user choice and competition is likely to be limited in remote areas of Australia where there are fewer dental professionals and public dental services play a relatively large role.

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<sup>2</sup> A potentially preventable hospitalisation is one thought to have been avoidable if timely and adequate non-hospital care had been provided. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14, accounting for around 64 000 (2.7 separations per 1000 population) potentially preventable hospitalisations.

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#### REQUEST FOR INFORMATION 22

*The Commission is seeking information on the effectiveness of public dental services in improving outcomes for patients, including:*

- whether existing eligibility criteria and the level of assistance for public dental services enable equitable access to care, including for people living in remote areas*
  - the extent to which the current emphasis on government provision of public dental services limits the responsiveness of services to user preferences over the timing and location of treatment, and the type of services provided*
  - the scope to improve accountability through more public reporting, including on patient outcomes and cost effectiveness*
  - the quality and efficiency of public dental services, and how this differs across public and private providers, regions and jurisdictions.*
- 

## **Giving users greater choice**

Responsiveness to user preferences over the timing and location of treatment could be improved for some segments of the population by enabling users to choose between competing dental practices through, for example, the greater use of vouchers. Vouchers have already been used to some extent in all jurisdictions to improve access to dental care and manage waiting lists. However, this has often been driven by short-term arrangements, rather than to be more responsive to user preferences.

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#### REQUEST FOR INFORMATION 23

*The Commission is seeking information on the potential to give public dental patients greater choice between competing providers. This includes information on:*

- whether increased choice would lead to better outcomes for users, and how this would differ between patient populations and regions*
  - lessons from current and past voucher schemes in Australia and other countries, and how they could be redesigned to put greater emphasis on placing users at the heart of service delivery rather than as a means to utilise short-term funding to reduce waiting lists*
  - mechanisms other than voucher schemes that could give users greater choice between providers*
  - whether additional regulations and monitoring arrangements are required to protect consumers*
  - the costs and benefits of giving public dental patients greater choice, and their distribution between users and governments.*
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## Understanding differences in the cost and mix of services

Some study participants observed that publicly funded dental services are more costly when provided by the private sector and attributed this primarily to private clinics providing more services per patient (Dr Martin Dooland, sub.PFR300, attachment A, Dental Health Services Victoria, sub. PFR366). Participants also suggested that there are differences in the mix of services provided due to the public sector taking a more targeted, risk-based approach to care. Other factors could also be at play, including cross-sector differences in economies of scale and the way costs are measured. For example, governments may be able to observe the fees paid to private providers but not the true cost of providing services themselves. Indeed, greater availability of information to benchmark services (discussed below) may be needed to effectively monitor and evaluate providers.

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### REQUEST FOR INFORMATION 24

*The Commission is seeking information on differences in public dental services provided by the public and private sectors, including:*

- differences in the unit cost, number and mix of services provided to public patients, and the causes of such differences*
  - issues that would need to be addressed to ensure that clinically- and cost-effective services are delivered to public patients if there were greater private sector provision of public dental services.*
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## Greater access to information

When introducing greater user choice, governments would need to ensure that they support users of public dental services to make informed choices. Governments already do this to some extent under current voucher schemes, although additional support may be needed for disadvantaged users, people with high dental fear and those with low oral health literacy.

In addition to supporting users, more information is needed to monitor and evaluate service providers and the treatments they provide to public patients. Greater access to information would enable the benchmarking of services, improve accountability to those who fund public dental services and support continuous improvement in the sector. While state and territory governments regularly publish information on public dental services, the Commission's study report identified considerable scope to improve consistent public reporting of clinical and other patient outcomes. Moreover, detailed information on expenditure, including on the cost effectiveness of public dental providers, will be important to introducing greater competition and contestability in a way that improves outcomes for users.

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#### REQUEST FOR INFORMATION 25

*The Commission is seeking input on the information needed to facilitate greater competition, contestability or user choice in public dental services, including:*

- the information users would need to make informed choices, how this varies by user group, and how the data should be presented and provided*
  - how barriers to greater public reporting on patient outcomes and cost effectiveness could be overcome, including changes needed to collect and provide relevant information to users*
  - the information needed to monitor and evaluate service providers and the treatments provided to public patients.*
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### **More contestable provision of public dental services**

Introducing greater user choice may not be feasible for certain populations or locations as there may not be multiple providers who can provide suitable services. While state governments sometimes contract private dentists to provide services in remote locations, there may be scope for more contestable commissioning of public dental services to improve outcomes for service users.

There are many different models of contestability that could be applied to public dental services. Such models could include opening the management of public clinics to government and non-government providers, tendering the supply of dental professionals in government-operated clinics, or tendering the management and operation of the whole clinic.

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#### REQUEST FOR INFORMATION 26

*The Commission is seeking information on whether and how public dental services could be made more contestable, including:*

- lessons from past commissioning of public dental services*
  - the models of tendering that would best suit different services, patients and settings*
  - the design of tender processes and management of contracts, such as the length of contracts, the coverage of services, and how to adequately define services and monitor outcomes*
  - the costs and benefits of more contestable arrangements, and their distribution between users and governments.*
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## Implementing reforms

Reforms to public dental services will need to consider how alternative delivery models affect the incentives facing users and service providers (section 3). Importantly, consideration will need to be given to the payment models used to fund providers and the resulting financial incentives. Under current arrangements, government-operated providers typically employ dentists on a salary basis and can receive a mix of block funding, co-payments from users, and reimbursement of some services on a fee-for-service basis from the Australian Government. Private dentists providing public dental services through voucher schemes are typically paid on a fee-for-service basis. However, governments have explored alternative payment models. Capitation payments, for example, have been used in South Australia to pay private dentists to provide school dental services to children in remote areas. In addition, changes to how the demand for public dental services is managed (including through measures such as waiting lists and the scope of eligible treatments) will also need to be considered.

Workforce reform may be needed to successfully implement greater competition, contestability and choice in public dental services. Dr Martin Dooland (sub. PRF300, Attachment A) and the Australian Dental and Oral Health Therapists' Association (sub. 99) suggested that some dental professionals working in the private sector face barriers to using their skills effectively. Consideration may need to be given to a more flexible approach to using the skills of the dental workforce, such as a greater role for practitioners other than dentists. Participants also stressed the role of public dental services in giving dental students a range of clinical experience. The implications for the training of dental professionals would need to be factored in to any reforms that introduced greater private sector provision of public dental services.

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### *REQUEST FOR INFORMATION 27*

*The Commission is seeking information on the implementation of reforms to increase competition, contestability and user choice in public dental services, including:*

- the role of alternative payment models for providers, such as capitation payments, and how different models affect incentives for users and providers*
  - changes in how demand is managed*
  - whether workforce reforms are needed to enable more effective use of dental professionals in the private and public sectors*
  - changes in training arrangements for dental professionals, including possible alternative models of training.*
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## **8 Commissioning family and community services**

### **The model of provision for family and community services**

All levels of government fund services to support people who are in crisis or are experiencing persistent hardship. Services are funded through a range of programs — examples include emergency payments, and services for family support, homelessness, family and domestic violence, and alcohol and other drugs.

Eligibility criteria vary across the services and by jurisdiction. For the most part, eligibility is determined by a person's circumstances (for example, a person is 'sleeping rough' or suffering severe financial hardship). Some services are available universally (for example, family relationship centres can provide information, support and referral services to any family). The eligibility criteria for some services are broad and give providers discretion over who to support and how much support should be provided. Consequently, it is not clear whether services are provided equitably across the community.

Much of the government funding for family and community services is allocated to not-for-profit organisations through contestable processes. There is no coherent system for identifying overall community need across the range of services as a whole, the intended outcomes of family and community services, or the most effective ways of delivering those outcomes. Where there is a focus on outcomes, it tends to be on a program-by-program basis.

Some users of family and community services have complex needs and require access to a range of services. Evidence presented to the Commission suggests that funding streams do not always facilitate the coordination of services, leaving vulnerable users to navigate a complex system with little support.

In the study report, the Commission concluded that there is scope to improve the effectiveness of family and community services through processes that better capture the benefits of contestability — these benefits could include better outcomes for individuals and their families, and more cost-effective use of government funds.

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#### REQUEST FOR INFORMATION 28

*The Commission is seeking information related to how commissioning arrangements influence the effectiveness of service provision. This could be related to any specific service in the suite of family and community services and includes information on whether:*

- users are placed at the heart of service delivery, including the extent to which service providers facilitate user choice and, if not, how commissioning arrangements could be improved to address this*
- there are cost-effective ways of helping users navigate the system of service delivery, with particular regard to users with complex needs who require access to multiple services*
- arrangements enable equitable access to services, including for people living in remote and regional areas, and how this could be improved through changes to commissioning arrangements*
- arrangements are cost-effectively selecting providers that are most likely to improve outcomes for users*
- arrangements enable service providers to co-operate (formally or informally) to provide higher-quality services to users (including by providing a 'bundle' of services), or to lower costs to governments and others who fund those services through the benefits of larger scale or scope*
- there are barriers faced by providers seeking to innovate and improve service quality and responsiveness, and how they could be overcome.*

*To support its analysis, the Commission is seeking information on:*

- data on funding for commissioned family and community services including the value, purpose and duration of funding agreements.*
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## Introducing greater user choice

As discussed above, providers often have discretion over who should receive family and community services. On the one hand, providers service a variety of users, many of whom would be capable of exercising some level of choice. On the other hand, it will not always be the case that users are well-placed to make decisions on their own. Sometimes the provision of information or an agent to act on behalf of a user may help but in other cases it will not be possible or desirable for users to make choices over the service they receive or who provides it. Families in crisis, for example, may simply want access to a provider they know they can trust rather than the burden of evaluating and choosing between multiple providers. People with multiple needs who require support through a combination of services are likely to fare differently under a user choice model to those who require one-off support to get back on their feet.

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Similarly, there is considerable diversity in the type of family and community services, as well as variation across providers, including size, organisational purpose (for example, social mission, for-profit) and structure (cooperatives or sole traders, for example), the range and number of services offered by a provider or in a location, and funding sources (government, self-generated revenue, donations). These factors add considerable complexity to developing reform options to introduce greater user choice.

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#### *REQUEST FOR INFORMATION 29*

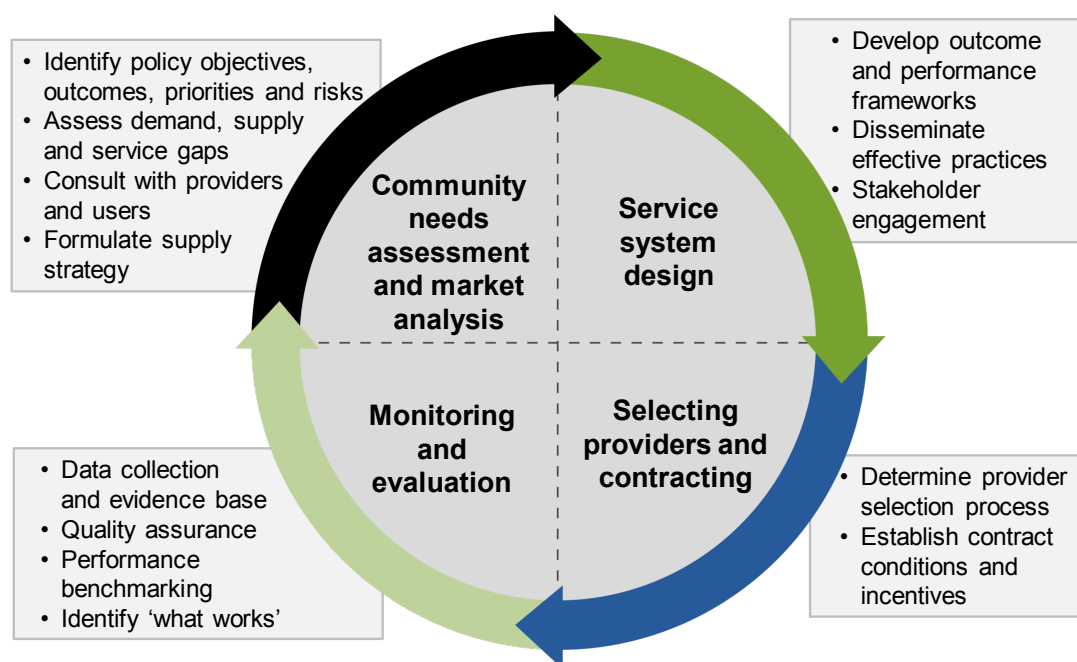
*The Commission is seeking information on the potential for greater user choice in any relevant individual family or community service, including:*

- examples of services that could be suited to greater user choice (of service and/or provider) and the factors underlying their suitability (such as the presence of multiple providers and sufficient time and information for a user to research and understand their choices)*
  - the extent to which greater user choice could lead to improved outcomes for service users by, for example, encouraging providers to be more responsive to their needs or improving accessibility of services for those most in need*
  - changes to commissioning arrangements needed to support greater user choice (such as changes to funding arrangements)*
  - the costs and benefits to users, service providers and governments*
  - changes to government stewardship arrangements (such as changes to accountability and compliance processes, or the need for additional consumer safeguards).*
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## **Increasing the benefits of contestability**

Participants argued strongly that the current arrangements for commissioning family and community services are not achieving the best outcomes for users, nor are they enabling providers and governments to cost-effectively deliver services. In submissions and roundtables, participants identified shortcomings with current government commissioning processes at each stage of the commissioning cycle (figure 2). These shortcomings included the fragmented nature of programs across and within governments, the prescriptive nature of program guidelines, and a tendency for performance management frameworks to rely on inputs, outputs and processes to assess providers, rather than the achievement of outcomes for users. Participants to the inquiry have described some of the costs to providers of current commissioning arrangements, and how administrative and compliance costs can disproportionately affect smaller providers.

Figure 2      **The commissioning cycle**



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

Consultations have revealed that governments have been trying to improve aspects of commissioning for many years but that progress has been slow. Examples of recent progress include:

- improvements to the design and implementation of outcomes frameworks (such as the Services Connect outcomes framework (Victorian DHS 2015a))
- efforts to improve engagement between governments and providers (such as the WA Government's Partnership Forum (WA Government 2016))
- pilot programs in Victoria, Tasmania and the ACT that allow for better coordination of services to people with complex needs (ACT Government 2015; Tasmanian DHHS 2016; Victorian DHS 2015b).

Governments have also been developing ways of better using data to identify groups of people who are susceptible to long periods of government support, and searching for ways to design and provide more individualised approaches to service provision. The Australian Government's *Priority Investment Approach* uses algorithmic and actuarial data to identify priority groups in need of support, and to evaluate the effectiveness of programs funded to address their needs (Porter 2016).

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#### REQUEST FOR INFORMATION 30

*The Commission is seeking information on how to improve government processes for commissioning family and community services. The Commission welcomes information from stakeholders on any relevant service covering the following areas:*

- the scope to identify and provide more effective services to people who are likely to need long-term support from multiple providers or services (examples could include the scope to improve commissioning arrangements through applying an 'investment approach' to service provision)*
  - how co-design and evaluation could contribute to improved decision making within governments*
  - ways governments could better balance their requirements for providers to be accountable for allocated funding against affording providers more flexibility to deliver services in a way that best achieves outcomes for service users*
  - how governments could improve commissioning arrangements to better align the incentives of users and providers, while ensuring government objectives are met (examples could include changes to provider selection processes, contract terms or quality standards, or the introduction of outcomes-based commissioning)*
  - how governments could better account for the benefits and costs associated with different types of providers, and identify those that are best placed to achieve outcomes for service users*
  - how to better balance the benefits and costs of contestability, for example, the factors that should determine whether agreements with providers are 'rolled over' for another contract period*
  - the factors that should determine the choice of funding arrangements (block funding or outcomes-based funding are two examples)*
  - lessons from Australia or overseas that could inform recommendations on improving commissioning arrangements to ensure services achieve the intended outcomes for users (this could include lessons on 'what not to do').*
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## **Implementing reforms to commissioning arrangements**

Any reforms to commissioning arrangements will need to take account of the diversity and number of users, providers, policy objectives and funders within family and community services. Models of service provision should be tailored, for example to ensure that user groups (such as users in regional and remote areas, or from culturally and linguistically diverse backgrounds) are not 'left behind'.

At a broader level, evidence presented to the Commission suggests that governments have tended to focus on a service by service approach to assessing needs for family and community services. While governments are seeking to undertake a more holistic approach to assessing need across the community to better provide the mix of services that might

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produce better outcomes, more could be done. For example, there may be merit in stronger joint planning within governments, as well as across different levels of government, as the basis for a more coordinated system of service provision.

Reforms will have costs. Governments may need to devote additional resources to build their capacity and expertise in service design, tender management and service evaluation. Similarly, attempts to develop more holistic approaches to service planning and provision will have costs. Understanding how the existing costs of commissioning can be reduced and who would bear the costs of changes to commissioning practises will be important in developing reform recommendations.

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*REQUEST FOR INFORMATION 31*

*The Commission is seeking information to support the implementation of reforms to improve arrangements for commissioning family and community services. This includes information on:*

- how governments could improve the planning and delivery of human services, including ways to better coordinate assessment of community needs across and within governments, and how to incorporate these improvements in commissioning arrangements*
- how reform recommendations should be tailored to ensure outcomes are improved for all users, including people with complex needs, those in remote and regional areas, those from different backgrounds and those who have difficulty navigating a complex system of service delivery*
- impediments to improving commissioning arrangements, such as the 'siloed' nature of service provision within and across governments, and how they could be overcome*
- how users and different types of providers would be affected by changes to commissioning arrangements (examples could include the costs to users when their service provider changes or if the compliance burden falls disproportionately on a specific type of provider, as well as the costs of performance monitoring and evaluation)*
- the data that governments need to collect to evaluate services and the success of reforms*
- the potential benefits to users, providers and governments from the use of policy trials to experiment with different approaches to commissioning family and community services, examples of services that might be well-suited to policy trials, and measures to evaluate the success of any trial.*

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## 9 Human services in remote Indigenous communities

### The current model of service provision

About one in five Indigenous Australians live in remote areas (ABS 2013). In 2011, there were over 1000 discrete Indigenous communities<sup>3</sup> in remote areas, of which more than three quarters had a population under 50 (ABS unpublished data). Small communities, combined with large distances between those communities, make service provision difficult and costly. This is compounded by difficulties accessing infrastructure, and the challenges providers face in recruiting and retaining staff. There may be potential for existing and emerging technologies to overcome some of these challenges and enable new ways of providing services (for example, telehealth can be used for consultations between patients and their medical specialists; and wearable technologies can allow remote monitoring of a patients' vital signs, such as heart rate and blood pressure, and alert health practitioners if a problem arises).

Physical isolation is a key reason why remote communities typically cannot access the range of human services that are provided elsewhere, but it is not the only reason. Indigenous Australians living in these communities may also interact with services differently to other Australians, reflecting a combination of factors, including culture and past experiences with government services. For example, about 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared with 2 per cent of Indigenous Australians living in non-remote areas (ABS 2016).

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#### REQUEST FOR INFORMATION 32

*The Commission is seeking information on service delivery challenges in remote Indigenous communities, including:*

- how service providers could overcome the challenges associated with distance such as the high cost of service provision and difficulties accessing infrastructure (for example through the use of technology)*
  - examples of the costs faced by service providers in remote areas and how they differ to those for similar services in regional and urban areas (cost data would be particularly welcome)*
  - strategies to address the challenges of recruiting, training and retaining staff*
  - ways service delivery could be adapted to better meet the needs and preferences of Indigenous Australians living in remote communities (for example, how service delivery could better respond to the higher mobility of Indigenous Australians).*
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<sup>3</sup> Discrete Indigenous communities are defined as being inhabited predominantly by Indigenous Australians with housing or infrastructure that is managed on a community basis.



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The service delivery arrangements for people living in remote Indigenous communities are complex. Funding and responsibility for service provision and outcomes are split across governments, departments, programs and providers. Eligibility criteria vary across the services delivered in remote Indigenous communities, and by jurisdiction. Like the broader community, access to some services, such as school education, is universal. Others, such as disability support services, have eligibility requirements. Moreover, access to services can also vary across communities, as not all services are delivered in all communities.

Many economic and social factors lead to Indigenous Australians living in remote communities experiencing worse outcomes than other Australians across many indicators of quality of life (such as life expectancy, educational attainment and imprisonment). Since 2003, the Steering Committee for the Review of Government Service Provision has been producing regular reports on indicators of Indigenous disadvantage. The most recent report found that while outcomes have improved in some areas (child mortality rates, year 12 completion rates and income from employment), there has been little or no change in others (family and community violence, and risky long-term alcohol use), and worsening results in yet others (psychological distress, self-harm, substance misuse and imprisonment) (SCRGSP 2016a).

The funding and provision of human services has been a key part of governments' strategies to improve outcomes for Indigenous Australians. However, inquiry participants have argued strongly that current approaches to delivering services in remote Indigenous communities are impeding the achievement of better outcomes. In its study report, the Commission found that:

- greater responsiveness to community needs through user choice, place-based service models or greater community engagement could improve outcomes
- redesign of commissioning arrangements and better coordination between governments could improve the effectiveness of service provision
- more stable policy settings and clearer lines of responsibility could increase government accountability for service outcomes.

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#### REQUEST FOR INFORMATION 33

*The Commission is seeking information on the current service delivery model for human services in remote Indigenous communities, including:*

- *areas where outcomes for users are not being met (for example, particular programs, services, communities or user groups), the drivers behind this, and how they could be addressed through reforms to the way services are provided*
  - *areas where arrangements are currently working well and do not require major change, the drivers behind this, and how similar arrangements could be applied in other areas*
  - *whether services are well-targeted in terms of both the type and mix of services provided and the eligibility criteria that determine who can access the services.*
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## Evaluating reforms to increase competition and user choice

Reforms introducing greater user choice are already underway in disability services and the outcomes of these changes are important sources of evidence for this inquiry.

The National Disability Insurance Scheme is introducing greater choice and control for people with a disability. Under the scheme, participants can exercise choice around the package of supports they receive (which services and which providers) and they are also able to choose to self-manage their plan if they wish. The Barkly region in the Northern Territory was chosen as a trial site to test the scheme in remote Australia and with Indigenous communities. The trial identified the importance of providing services in a culturally appropriate way, including through building relationships and trust, and providing tailored information to those accessing support.

Western Australia has been progressively introducing self-directed supports for people with disability over many years.

The Commission will draw on the experience of users and providers of disability support services (and others services where relevant, including aged care) when considering if user choice initiatives could improve the effectiveness of service provision in remote Indigenous communities.

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### REQUEST FOR INFORMATION 34

*The Commission is seeking information on the experience of users, providers and governments with the implementation of reforms to introduce greater user choice and competition, such as disability support services, including:*

- whether Indigenous Australians in remote communities where these reforms have been implemented have access to a variety of service options and providers*
- whether the reforms have increased the effectiveness of service delivery in remote Indigenous communities, particularly the responsiveness of services to the needs and preferences of users and the quality of services*
- the experience of new providers entering the market and existing providers transitioning to the new arrangements*
- lessons from the implementation of these reforms, particularly where arrangements needed to be tailored to the circumstances of remote communities*
- whether similar reforms would be feasible (and desirable) for other services and why.*

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## Increasing user choice and community voice

Currently user choice of human services providers and competition between providers is limited for most services in remote Indigenous communities. A common refrain through

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consultations in the first stage of this inquiry was that governments ‘do services to’ remote Indigenous communities, rather than with communities.

The characteristics of remote communities mean that user choice models based on competition between providers are unlikely to be feasible for many services or in many communities. A more practical approach to increasing the responsiveness of services to user needs might be to provide more choice at the community level. This could involve communities, and community organisations, playing a larger planning role in identifying service needs and objectives, and strategies to improve community-level outcomes.

Many participants mentioned the Aboriginal Community Controlled Health Organisation (ACCHO) model giving some control to the local community and achieving very good outcomes. Co-design and place-based approaches were also raised as potential options for improving the responsiveness of service providers to the preferences of users. The Commission is aware of overseas examples (such as place-based initiatives in Canada) and is interested in the applicability of these types of initiatives in Australia (noting that the context in other countries is different).

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*REQUEST FOR INFORMATION 35*

*The Commission is seeking information on ways to improve the effectiveness of human services provision in remote Indigenous communities, including:*

- the scope for greater individual choice in remote Indigenous communities and whether there are particular services or user groups where greater individual choice would be feasible and desirable*
- how governments can support users to make informed choices*
- ways governments can improve how they engage with communities*
- the scope for greater community-level involvement in service planning and in ensuring there are ongoing improvements in provision (for example, through co-design approaches where communities collaborate with government and providers to design services)*
- how approaches to greater community-level involvement might be implemented (including the governance structures that would be required to support the proposed approach)*
- what support communities (particularly smaller communities) would need in order to have a greater role in service planning (such as capacity building)*

*(continued on next page)*

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REQUEST FOR INFORMATION 35 (continued)

- *how place-based approaches could be used to improve the effectiveness of service delivery in remote Indigenous communities (including examples of where place-based approaches have been successfully implemented in Australia and overseas)*
  - *whether and why Indigenous organisations (such as ACCHOs) have been successful at achieving intended outcomes for people living in remote communities (information on governance arrangements, workforce capacity and capability, or the characteristics of the organisation, service or users that are most often associated with effective service provision would be welcome)*
  - *factors that should be considered when balancing responsiveness of services to communities with accountability to those who fund the services.*
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## **Increasing the benefits of contestability**

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

Many of the issues discussed in the previous section on commissioning family and community services will also apply in remote Indigenous communities. However, the context in remote Indigenous communities can be different, and understanding these differences will be important in making recommendations to improve commissioning of services delivered in remote Indigenous communities.

Many participants in the inquiry pointed to service fragmentation and lack of coordination (between the Australian, state and territory and local governments, departments, programs and providers) as key issues in the delivery of human services in remote Indigenous communities. Evidence to support this view included examples of small communities where the number of different services being provided, as well as the number of providers, was very high relative to the population served.

The fragmented nature of services means providers often rely on funding from a variety of sources and programs. These separate sources of funding come with their own compliance requirements, placing a burden on providers.

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Integrated service delivery could be one way of improving service coordination. The level of integration can vary from, for example, information sharing to pooled funding and complete merging of service delivery (delivering previously separate services through a single provider).

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*REQUEST FOR INFORMATION 36*

*The Commission is seeking information on ways to improve commissioning arrangements for human services in remote Indigenous communities, including:*

- how processes for commissioning services (including specification and measurement of outcomes and selection of providers) could be changed to improve the quality, equity, efficiency, accountability and responsiveness of services*
  - how commissioning arrangements could be adjusted to reduce the administrative burden on providers without jeopardising accountability to those who fund the services*
  - characteristics of remote Indigenous communities relevant to service commissioning that differ from elsewhere in Australia*
  - the drivers behind the high levels of service fragmentation observed in remote communities, particularly in cases where the number of services and providers are very high relative to the population*
  - what steps governments could take to improve coordination of both policy and service delivery (across the Australian, state and territory, and local governments, departments and programs)*
  - the potential for more integrated services to improve service effectiveness, including particular services that would benefit from integration, and the level of integration that would be suitable (for example, information sharing or merging of service providers)*
  - other approaches to improving the coordination of services (across governments, departments, programs and providers)*
  - the barriers to effective service coordination and how they might be overcome.*
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## **Implementing reforms**

How reforms are implemented contributes to their success or failure. The frequency of policy change and the disruption this causes to services and communities were raised by many participants. Policy instability makes it difficult for providers to form relationships and establish trust with people in remote Indigenous communities; to collect, disseminate and act on evidence about what works; and to innovate and improve service delivery. Many participants cautioned against one-size-fits-all approaches, and stressed the diverse nature of communities, users and services. The need to better gather, share and use

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evidence on what works (including the learnings from previous programs) was also raised by a number of participants.

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*REQUEST FOR INFORMATION 37*

*The Commission is seeking information on the implementation of reforms to human services in remote Indigenous communities, including:*

- barriers to and drivers of success of reform processes (including examples of previous reforms, their rationale and why they did or did not lead to improved outcomes)*
  - whether existing structures and organisations (including governments, providers and community organisations) could be used to minimise disruption and churn as a result of policy changes*
  - how evidence could be better gathered, shared and used to support service allocation, commissioning and delivery (by both governments and providers), including improvements to the conduct and use of program evaluations*
  - how recommendations could be adapted to communities with differing needs and characteristics*
  - complementary policy measures that would support the introduction of greater competition, contestability or user choice in remote communities (for example, the provision of culturally appropriate information to allow users to exercise informed choice)*
  - the costs and benefits of reform*
  - stewardship considerations when implementing reforms to services in remote Indigenous communities (for example, feedback and complaints mechanisms, and processes to make ongoing improvements to policies and programs).*
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## **Attachment A: How to make a submission**

### **How to prepare a submission**

Submissions may range from a short letter outlining your views on a particular topic to a much more substantial document covering a range of issues. Where possible, you should provide evidence, such as relevant data and documentation, to support your views.

#### **Generally**

- Each submission, except for any attachment supplied in confidence, will be published on the Commission's website shortly after receipt, and will remain there indefinitely as a public document.
- The Commission reserves the right to not publish material on its website that is offensive, potentially defamatory, or clearly out of scope for the inquiry or study in question.

#### **Copyright**

- Copyright in submissions sent to the Commission resides with the author(s), not with the Commission.
- Do not send us material for which you are not the copyright owner — such as newspaper articles — you should just reference or link to this material in your submission.

#### **In confidence material**

- This is a public review and all submissions should be provided as public documents that can be placed on the Commission's website for others to read and comment on. However, information which is of a confidential nature or which is submitted in confidence can be treated as such by the Commission, provided the cause for such treatment is shown.
- You are encouraged to contact the Commission for further information and advice before submitting confidential material.
- The Commission may also request a non-confidential summary of the confidential material it receives, or the reasons why a summary cannot be provided.
- Material supplied in confidence should be clearly marked 'IN CONFIDENCE' and be in a separate attachment to non-confidential material.

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## Privacy

- For privacy reasons, all **personal** details (for example, home and email address, signatures, phone, mobile and fax numbers) will be removed before they are published on the website. Please do not provide these details unless necessary.
- You may wish to remain anonymous or use a pseudonym. Please note that, if you choose to remain anonymous or use a pseudonym, the Commission may place less weight on your submission.

## Technical tips

- The Commission prefers to receive submissions as Microsoft Word (.docx) files. PDF files are acceptable if produced from a Word document or similar text based software. You may wish to research the Internet on how to make your documents more accessible or for the more technical, follow advice from Web Content Accessibility Guidelines (WCAG) 2.0 <<http://www.w3.org/TR/WCAG20/>>.
- Do not send password protected files.
- Track changes, editing marks, hidden text and internal links should be removed from submissions.
- To minimise linking problems, type the full web address (for example, <http://www.referred-website.com/folder/file-name.html>).

## How to lodge a submission

Submissions should be lodged using the online form on the Commission's website. Submissions lodged by post should be accompanied by a submission cover sheet.

Online\*      [www.pc.gov.au/inquiries/current/human-services/make-submission](http://www.pc.gov.au/inquiries/current/human-services/make-submission)

Post\*        Human Services Inquiry  
                Productivity Commission  
                Locked Bag 2, Collins Street East  
                Melbourne Vic 8003

\* Please contact the Administrative Officer if you do not receive notification of receipt of your submission.

## Due date for submissions

Please send submissions to the Commission by **10 February 2017**.