



Australian Government
Productivity Commission

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

Productivity Commission
Inquiry Report
Overview & Recommendations

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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).

Contents

Key points	2
Overview	3
1 Why reforms to human services matter	3
2 Introducing greater user choice, competition and contestability	4
3 Governments as system stewards	7
4 Caring for people at the end of life	8
5 Social housing	13
6 Family and community services	21
7 Services in remote Indigenous communities	25
8 Giving patients greater choice	30
9 Public dental services	34
Recommendations	41

The full report is available from www.pc.gov.au

OVERVIEW

Key points

- This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will use human services in their lifetime and change is needed to enable people to have a stronger voice in shaping the services they receive, and who provides them.
- In the study report for this inquiry, the Commission identified six services for which the introduction of greater user choice, competition and contestability would improve outcomes for the people who receive them. These services are: end-of-life care services; social housing; family and community services; services in remote Indigenous communities; patient choice over referred health services; and public dental services. This final inquiry report sets out tailored reforms for those six services. There is no one-size-fits-all competition solution.
- Users should have choice over the human services they access and who provides them, unless there are sound reasons otherwise. Choice empowers users of human services to have greater control over their lives and generates incentives for providers to be more responsive to their needs.
 - Competition and contestability are means to this end and should only be pursued when they improve the effectiveness of service provision.
- A stronger focus on users, better service planning and improved coordination across services and levels of government is needed. Governments should focus on the capabilities and attributes of service providers when designing service arrangements and selecting providers — not simply the form of an organisation.
- Each year, tens of thousands of people who are approaching the **end of life** are cared for and die in a place that does not fully reflect their choices or meet their needs. Reforms are needed to significantly expand community-based palliative care services and to improve the standard of end-of-life care in residential aged care facilities.
- The **social housing** system is broken. A single system of financial assistance that is portable across rental markets for private and social housing should be established. This would provide people with more choice over the home they live in and improve equity. Tenancy support services should also be portable across private and social housing.
- **Family and community services** are not effective at meeting the needs of people experiencing hardship. Practical changes to system planning, provider selection, and contract management would sharpen focus on improving outcomes for people who use these services.
- Current approaches to commissioning human services in **remote Indigenous communities** are not working. Governments should improve commissioning arrangements and should be more responsive to local needs. This would make services more effective and would lay the foundation for more place-based approaches in the future.
- Patients should have greater choice over which healthcare provider they go to when given a referral or diagnostic request by their general practitioner. A simple legislative change would help. More **patient choice** would empower patients to choose options that better match their preferences. Public information is needed to support choice and encourage self-improvement by providers.
- **Public dental** patients have little choice in who provides their care and most services are focused on urgent needs. Long-term reform is needed to introduce a consumer-directed care scheme. This would enhance patient choice and promote a greater focus on preventive care.

Overview

The Australian Government's 2015 *Competition Policy Review* recommended that governments should, wherever possible, put user choice at the heart of human services delivery. In its response to the Review, the Australian Government asked the Commission to undertake this inquiry to examine policy options that apply the principles of informed user choice, competition and contestability to the provision of human services. Desirable though they may be, applying these principles has proven to be neither simple nor without cost.

1 Why reforms to human services matter

This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will access human services in their lifetime, including children, the elderly, people facing hardship or harm, and people who require treatment for acute or chronic health conditions. People who use human services can lose their autonomy, and with it their dignity, if they have too little control over decisions that affect them. Reforms to the way human services are provided are needed to enable and support people and their families to have a stronger voice in shaping the services they receive, and who provides them.

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

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

2 Introducing greater user choice, competition and contestability

The Commission’s task in this inquiry is to recommend reforms using the policy ‘tools’ set out in the inquiry terms of reference — the introduction of greater informed user choice, competition and contestability — to improve the effectiveness of human services. In doing so, the Commission’s objective is to improve outcomes for the users of those services and the welfare of the community. Not all areas of human services are amenable to the mechanisms we have considered. In the study report for this inquiry, the Commission found reform could offer the greatest improvements in outcomes for people who use:

- end-of-life care services
- social housing
- family and community services
- services in remote Indigenous communities
- public hospitals for elective care following a referral from their general practitioner
- public dental services.

In making its final recommendations to improve the effectiveness of these six services, the Commission has assessed whether: the likely benefits to the community of its proposed reforms would be expected to outweigh the costs; the incentives of providers and users would be aligned; and government objectives would be achieved.

The Commission also considered five *attributes* of effective service delivery in its assessment of the potential costs and benefits of reform options.

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

Each of the services the Commission has proposed for reform is different — in the type and number of users, their capacity and willingness to make choices, the setting and circumstances under which services are accessed, and the share of the cost of service provision that is paid for by users and by governments. The starting point for reform also differs across the services. In some cases, improving service effectiveness through the

application of competition principles would require major reform. In others, particularly those that currently operate well, service effectiveness can be improved with relatively minor reforms to introduce greater choice and competition. The Commission has tailored its proposed reforms to the unique circumstances of each service.

Informed user choice empowers people

Informed choice can improve outcomes for users because it:

- empowers people to have greater control over their lives
- enables people to make decisions that best meet their needs and preferences
- generates incentives for providers to be more responsive to users' needs and drives innovation and efficiencies in service delivery.

The Commission's starting point is that users should have choice over the human services they access and who provides them, unless there are clear reasons otherwise. These reasons include a lack of capacity to exercise informed choice and the inability of an agent to exercise choice on a user's behalf, or when decisions must be taken during a crisis, such as a medical emergency. Providing choice can also be expensive for governments, and the benefits of introducing greater choice need to be considered against its costs.

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

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

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

The Commission recognises that there are circumstances where user choice is not desirable. If not the user, someone — the government or the provider — will be making a choice as to which services a person should receive and who should provide them. In these cases, it is critical that the best interests of users, rather than governments or providers, remain at the heart of service provision. Yet even when user choice is not desirable, a focus on users can be achieved through other approaches, such as increasing 'user voice' and co-design so a person's (or community's) preferences are taken into account when others make decisions on their behalf.

Putting the focus on users through competition and contestability

Competition and contestability are a means to an end. Used well, competition and contestability can be a powerful mechanism for improving the effectiveness of service provision. But competition and contestability should only be pursued where they improve outcomes for service users and the community. For example, the Commission has concluded that introducing further contestability into the delivery of public hospital services is unlikely to deliver additional net benefits at this time.

Competition (as an adjunct to user choice) delivers strong incentives for providers to be more focused on people who use services. Efforts by a provider to attract users can include improving the quality of the service they offer, reducing the price that they charge or tailoring their services to better meet the needs of the people they serve — all of which are beneficial to service users. When competition between multiple service providers is not possible or desirable, contestability can deliver many of the same benefits as competition. Contestable arrangements, where providers are selected by governments through competitive processes such as tenders, are widely used in human services. Examples include the selection of providers of family and community services, and tenancy management services for social housing.

A number of participants questioned whether competition and contestability should have a place in the provision of human services. Anglicare Australia, for example, in its submission did not accept that competition is a driver of efficiency; that efficiency is an inherently good thing in human services; that the innovation that comes with competition between providers is of benefit to service users; or that it is appropriate to equate individual consumer choice with agency and wellbeing.

The Commission does not agree. Well-established markets for schools, optometrists, general practitioners and allied health professionals, for example, demonstrate the value that choice and competition can bring to people who use those services and the community as a whole.

Problems can emerge if competition and contestability are poorly implemented and Governments need to learn from the lessons of the past. Issues raised by participants included competition damaging collaboration between providers, funding uncertainty and providers focusing on writing tender applications at the expense of their core business. These issues emphasise the importance of good government stewardship.

Some participants stated that for-profit providers should be excluded from delivering human services arguing, among other things, that providers incentivised by profit are not suited to offer high-quality services to vulnerable people.

The Commission has a different view. Human services are currently provided by a mix of government, not-for-profit and for-profit organisations. Experience shows that no one type of provider has a monopoly over good service provision and each has had successes and failures. Governments should focus on the capabilities and attributes of service providers

when designing service arrangements and selecting providers — not simply the form of an organisation.

Costs and implementation

Governments have sound reasons to fully or partially fund many human services. Access to these services needs to be carefully managed to ensure that services flow to the intended beneficiaries and fiscal costs are outweighed by benefits to the community.

Eligibility arrangements for the human services covered by this inquiry vary considerably. In some cases, such as social housing and public dental services, clear eligibility criteria govern access. In others, such as family and community services, eligibility is governed more flexibly. The Commission did not reconsider the existing eligibility arrangements for the services covered by this inquiry. In particular, it has not commented on whether changes to eligibility criteria should be considered as a means of constraining fiscal costs.

Introducing greater choice, competition and contestability will involve additional fiscal costs to governments, especially in the early years of implementation. The nature and extent of these costs vary considerably. Additional costs in the delivery of one service may also be offset by lower costs in other areas of service provision. More effective end-of-life care and public dental services could, for example, reduce demand for some hospital services.

The Commission has outlined a broad reform timetable for each service that could guide implementation. These timetables provide information on the sequencing of reforms and the timing of implementation. Consideration will need to be given to how these reforms sit against existing reform priorities and activities.

All of the services considered in this inquiry involve the Australian, State and Territory Governments. There is evidence that uncertainty about the roles and responsibilities across different levels of government has led to policy inertia and, in some cases, conflict over responsibilities and uncertainty over how stewardship is shared and service provision is coordinated across different settings. Neither fiscal costs, nor the unequal distribution of fiscal effects, should be an insurmountable barrier to implementing reforms that would generate significant net benefits to the community. For successful reform to occur, collaboration across jurisdictions will be critical.

3 Governments as system stewards

Governments are heavily involved in the funding and provision of most human services. There are sound efficiency and equity reasons for this. Markets left to their own devices would not deliver the appropriate level, or distribution, of human services across the community. Governments' approach to filling these gaps can take a number of forms including funding universal access to a service, as is the case for emergency health care, and

fully or partly covering the cost of a service to targeted groups in the community, as is the case for public dental services. Governments also choose whether to provide services directly (as is the case for the management of some public housing tenancies) or commission other providers to deliver services.

Governments should always have the role of system stewards irrespective of how human services are provided, or by whom. Stewards are responsible for the range of functions that both determine what human services should be made available and the effectiveness of those services. These functions include policy design, regulation, oversight of service delivery, monitoring of provider performance, and system improvement. Planning to understand the population of service users is a key element of governments' stewardship role and an area in which the Commission has made several recommendations.

Stewardship is a core part of the reform and delivery process — the design and performance of these functions should be tailored to each service and to the settings in which it is provided. Stewardship arrangements are difficult to get right and, together with the need to place greater focus on the user, this inquiry has highlighted areas where governments need to improve. These areas include:

- *greater coordination*: government silos and poor planning have led to gaps and duplication, services with competing objectives and stewards losing sight of the users' overall wellbeing. Better planning and coordination are needed within and across governments. Greater efforts, for example, are needed to coordinate services for people with multiple and complex needs
- *more transparency*: Providing information to improve accountability and facilitate performance assessment can benefit all parties within the human services system. Equipped with improved information, users can assess providers, providers can plan their services, and governments can evaluate how providers or systems are performing
- *smoother transitions*: Policy reform in human services is a complex task. Reforms can be large, costly and disruptive to users and providers, take considerable time to fully implement, and affect the lives of many (sometimes vulnerable) users. Overly ambitious reforms and rollout schedules can lead to issues in implementation, particularly for large and complex reforms. Transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Governments should plan and prepare for change in order to preserve continuity of outcomes, and minimise any negative effects on users from the transition. Information and clarity about changes in advance can help.

4 Caring for people at the end of life

Too many people approaching the end of life cannot access end-of-life care that aligns with their needs and preferences. Service availability varies widely according to patients' diagnosis, age and location. Their end-of-life journey can be punctuated with avoidable, or unwanted, admissions to hospital with the confusion, loss of dignity and loss of control that

comes with it. Few of those who would prefer to die at home are able to do so. Developing end-of-life care services and improving access to high-quality care would enhance community welfare, by enabling people to have more choice about where they are cared for and where they die.

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

Providing community-based palliative care instead of hospital care to those who would prefer it is potentially cost effective. Available evidence indicates that the savings from avoiding a single hospital admission for palliative care (costing about \$11 000) would more than cover the cost of providing community-based care over a period of months (costing between \$6000 and \$10 000). However, the net cost to State and Territory Governments of increasing the availability of community-based palliative care will ultimately depend (amongst other things) on the extent of unmet demand, which is currently unknown.

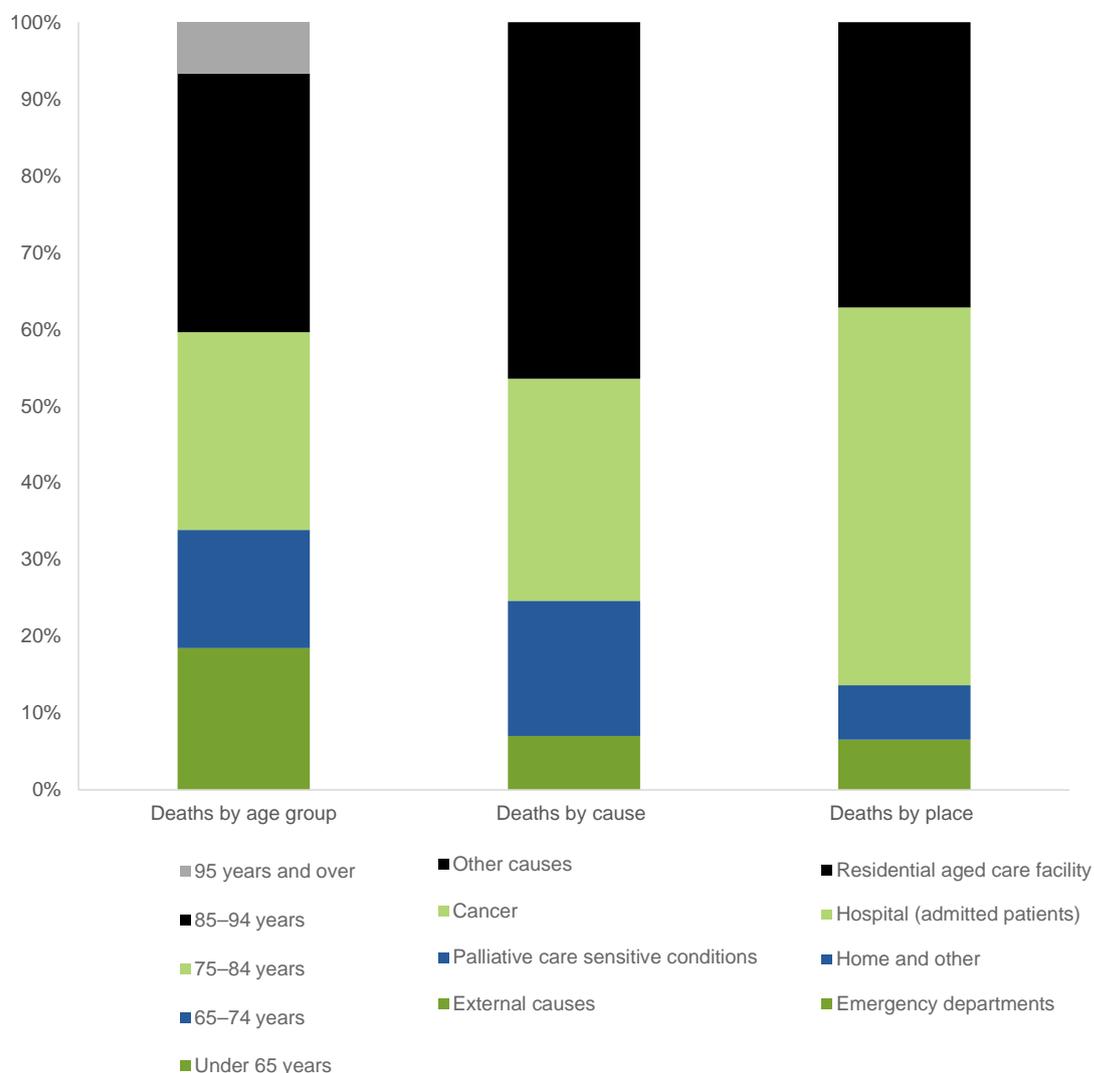
Effective end-of-life care recognises that the patient and clinicians are both essential participants in discussions and decision making about care options at the end of life. This shifts the emphasis of care delivery toward fulfilling each patient's choices, values and preferences, given the realities of their clinical condition and available treatments.

The quality of end-of-life care in Australia is among the world's best, but services are not available everywhere and to everyone who would benefit. People approaching the end of life in hospitals can find it hard to access care that is responsive to their preferences, and sometimes receive medical interventions that are not beneficial to them. Up to 70 per cent of Australians would prefer to die at home, but few do so (figure 1). Demand for end-of-life care in the community (community-based palliative care) far exceeds the availability of that care, particularly for those with illnesses other than cancer. Four out of five residents of aged care facilities die in them but the lack of palliative care expertise and qualified staff to administer pain relief mean residents often make traumatic (and costly) trips to hospital to receive medical care that could have been provided in surroundings that are familiar to them.

State and Territory Governments are primarily responsible for, and often provide, end-of-life care in public hospitals and in people's homes. The Australian Government is primarily responsible for end-of-life care in residential aged care and general practice. Coordination between these services is too often poor. Collaborative reform is needed to improve the effectiveness of end-of-life care across all settings where it is delivered, and to allow users more choice over their place of death and the services they receive.

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

Figure 1 Age, location and cause of death in Australia, 2015



The aim of reforms to end-of-life care should be to provide the growing number of people needing end-of-life care with services that better match their preferences. These reforms should ensure that Australians receive high-quality care across all major settings — hospitals, residential aged care facilities and at home.

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

preferences. Additional reforms are needed, however, to ensure high-quality care is available for people wishing to die at home and for those in residential aged care facilities.

Few people can access community-based palliative care

Tens of thousands of the people who die each year have a medical condition that is amenable to palliative care and have family and friends who are able to provide the considerable support needed for them to remain at home as they approach the end of life. Lack of access to the community-based palliative care that would enable them to be cared for and to die at home prevents them from fulfilling this preference. Better meeting this demand will require State and Territory Governments to **substantially increase the availability of community-based palliative care**, and to fund that increase. While offering service users choice of provider should be the long-term goal of governments, the first priority should be better meeting demand.

Increasing the availability of community-based palliative care requires careful stewardship. The Commission's proposed approach would require State and Territory Governments to better understand the needs of different regions and populations to determine priorities for service expansion. This assessment should inform decisions on how to select service providers. In many places, competitive processes could be run to select providers of additional community-based palliative care services. A lack of potential providers in some regional and remote areas will require governments to provide services directly or to commission a sole supplier.

Governments should establish standards for community-based palliative care services and fund the provision of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care. Users should be able to purchase additional services if they wish to do so.

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

All aspects of end-of-life care should be core business for residential aged care facilities. However, under current arrangements, many people miss out on the clinical care they need at the end of life. Intensive nursing and other end-of-life care services are only funded in the last week or days of life, and are not available to those with pre-existing high health care needs. Two main reforms are needed to address this.

First, residents require greater access to **services delivered by clinically qualified staff**. There are many possible staffing and contracting arrangements that could be used to increase these services. Residential aged care facilities could, for example, purchase services from community-based palliative care providers or employ additional skilled staff themselves, such as nurses or end-of-life care nurse practitioners. The increase in clinical services should be funded by the Australian Government and ensure that people living in an aged care facility receive end-of-life care that aligns with the quality of care available to other Australians.

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

Other measures to deliver better end-of-life care

Aligning care to people’s preferences is critical to the effectiveness of end-of-life services. Not everyone will be able to communicate their preferences at the time they receive care. Preparing an advance care plan (ACP) lets people have a real choice in the care they receive, even if they can no longer communicate that choice. ACPs can include anything from a formal directive to an entry in a patient’s medical record, and have been shown to improve end-of-life experiences for the patient, their family and their clinicians. Yet despite efforts to promote advance care planning, less than 15 per cent of Australians have an ACP. People who could be more likely to need an ACP, such as those aged over 65 years, are not more likely to have one. Reforms are needed to **provide more opportunity for people to develop a high-quality advanced care plan**. Primary care providers and residential aged care facilities are well placed to promote advance care planning and to facilitate the ongoing conversations that it requires. This will require training and supporting clinicians to hold advance care planning conversations and improving access to plans once they are made, including through electronic health records.

Improving stewardship of end-of-life care

The effectiveness of the proposed reforms will depend on governments implementing broader improvements to their stewardship of end-of-life care. The Australian, State and Territory Governments should, through the Council of Australian Governments (COAG) Health Council, ensure that there is **cross-jurisdiction co-operation** to:

- plan, fund and deliver end-of-life care so that patients receive integrated services across different settings and jurisdictions
- set standards for end-of-life care in each of the settings in which it is provided (such as those in the updated version of the National Safety and Quality Health Service Standards, which will apply to hospitals in all jurisdictions from 2019)
- monitor and evaluate end-of-life care services.

A comprehensive and coordinated approach to addressing gaps in data on end-of-life care will require the development and implementation of a **national data strategy**, overseen by the COAG Health Council. The data strategy should:

- establish a national minimum data set for end-of-life care (including collecting and publishing linked information on place of death, primary and secondary diagnoses and details of service provision at time of death)

-
- improve the accessibility of patient-level data (such as ACPs or hospital discharge summaries) so that they are used to deliver high-quality care
 - use system-level data to enable governments to plan, monitor and evaluate how well end-of-life care services are meeting users' needs across all settings and jurisdictions, and to drive improvements in end-of-life care.

In 2025, the COAG Health Council should commission an **independent review** of the effectiveness of end-of-life care across all settings in which it is, or should be, provided. This must include an assessment of consumer protection, such as the use of quality standards.

5 Social housing

Australia's social housing system is broken. Eligible tenants have little choice over the home they live in and can face a lengthy wait to access housing, and the type and amount of financial assistance available to households is inequitable. There is little transparency around the outcomes governments are seeking to achieve from the social housing system. The introduction of greater choice and competition could substantially improve the effectiveness of social housing but the cost would be significant.

Access to social housing properties for tenants is currently determined by the amount, location and composition of public and community housing properties. These properties have largely been built through an inflexible 'build and own' model, making it difficult for governments to respond quickly to changes in demand. As a consequence, people eligible for social housing are often unable to access it — over 150 000 households are on waiting lists to enter social housing and some households can wait 10 years or more. In addition, many people eligible for social housing have chosen not to apply and rent in the private market. About 850 000 households in the private rental market satisfy the income eligibility criteria for social housing.

The type and amount of financial assistance a household receives depends on the sector from which they rent their home, rather than their circumstances. Households that rent from the private market can receive a vastly different (often much lower) level of implicit financial assistance compared with households that rent social housing, even when their circumstances are otherwise similar (box 1). Even within social housing, rates of implicit assistance vary widely depending on the location and characteristics of the property. These arrangements are inequitable and result in many of the 400 000 or so households in social housing having a considerable financial disincentive to exit.

Box 1 **A two-tiered system of financial assistance**

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

Social housing

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

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

The social housing system covers the allocation of tenants to properties, the ownership and management of properties, and the provision of financial assistance to tenants. Tenants in social housing properties pay rent that is set at a proportion of their income (typically 25 per cent), or at the estimated market rent, whichever is lower. The implicit assistance that tenants receive is equal to the difference between the market rent for the property they live in, and the rent they actually pay. Tenants living in community housing can also receive CRA but this assistance is generally passed straight through to the housing provider. Public housing tenants are not eligible for CRA.

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

Commonwealth Rent Assistance

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

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

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

Introducing greater choice and competition

Unlocking user choice requires governments to rethink the way they meet the needs of tenants who are eligible for housing assistance — to shift the focus of social housing away from providing financial assistance and tenancy support services according to whether a

person lives in private, public or community housing toward a single system of financial assistance that can be accessed regardless of the type of housing a person chooses to live in.

A single system of financial assistance that is *portable* across rental markets for private and social housing would serve two purposes. One, it would enable a person to choose where they live based on their *preferences* — their access to financial assistance (and tenancy support services) would ‘follow them’. Two, it would address current inequities by targeting the type and amount of financial assistance a person receives to their *circumstances*, rather than the type of housing they live in.

The proposed reforms summarised in figure 2 present the Commission’s approach to a single system of financial assistance — an approach that would place the user at the centre of the social housing system. The reforms also recognise the significant variation in local housing market conditions in each state and territory, including the variation in the affordability and nature of housing across and within jurisdictions. Importantly, the design of the reforms is flexible enough to enable each State and Territory Government to tailor implementation to meet the outcomes it seeks from the social housing system, given these variations.

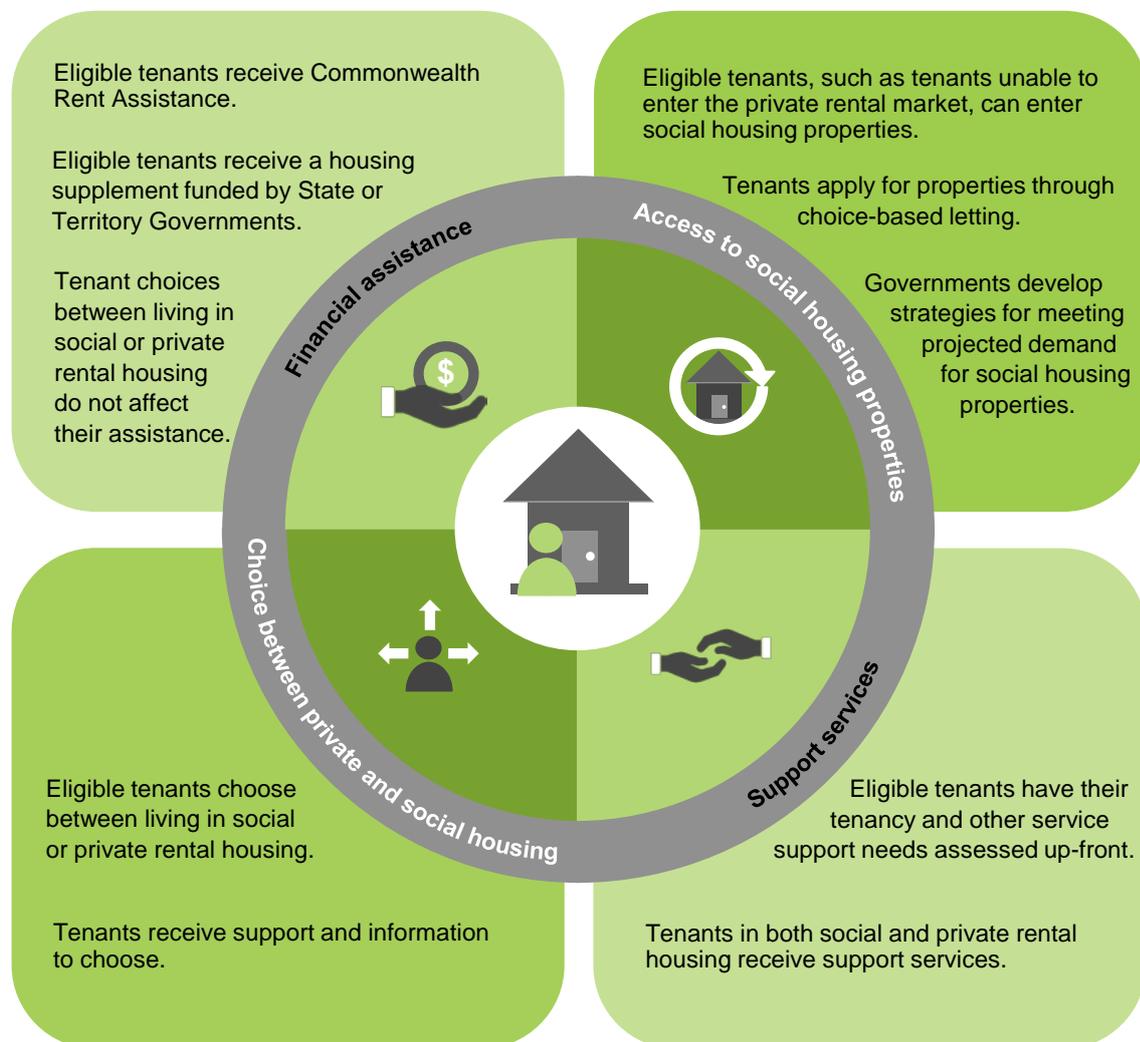
A single system of financial assistance

The current two-tiered system of financial assistance must be replaced for choice and competition to address the problems in the social housing system. Reforms to enable people to have a genuine choice over where they live would improve the responsiveness of the social housing system to the requirements of tenants by increasing competition between housing providers.

The establishment of a single system of financial assistance hinges on reforms being undertaken at both the national and state and territory level so assistance can be provided as a package (box 2).

- **The Australian Government should extend Commonwealth Rent Assistance to tenants in public housing** so that it is available to all eligible tenants in social housing properties. People who live in private and community housing already receive Commonwealth Rent Assistance (CRA), but people in public housing do not. This change would provide a consistent baseline level of support.
- **State and Territory Governments should provide and fund an additional housing supplement.** The supplement should target eligible tenants in areas with acute rental affordability problems for whom CRA is insufficient.

Figure 2 **Putting the user at the centre of the social housing system**



Eligibility for, and the level of, the housing supplement would be a matter for State and Territory Governments, but should be calibrated to the demographics and housing market characteristics of their jurisdictions. The supplement should:

- be provided to eligible tenants in areas with acute rental affordability problems
- be set at a level (or levels) where eligible tenants can afford housing that meets their requirements, but provides incentives for them to choose the housing they most value given their needs and financial circumstances
- be portable — tenants eligible for the supplement should be able to use it in either private or social housing
- recognise that a tenant’s need (and eligibility) for financial support can change over time. For example if a person’s employment situation changes and they are earning a higher (or lower) level of income, then the amount of assistance that they receive should adjust.

These adjustments should be calibrated with those applying to income support payments to avoid financial disincentives to employment, and introducing new inequities between recipients of income support payments.

State and Territory Governments should **charge new social housing tenants market rents**. The Commission notes that about 60 per cent of people who currently receive CRA pay less than 30 per cent of their income in rent — an often used (but imperfect) indicator of ‘rental stress’. For transitional reasons, people who are currently living in social housing properties should continue to pay rents set as a proportion of their income for up to 10 years before being required to pay market rents, unless they elect to move to the new system of financial assistance earlier.

The reforms proposed by the Commission would require a new agreement between the Australian, State and Territory Governments. The Australian Government should only extend CRA to public housing tenants in a jurisdiction if that State or Territory Government agrees to implement reforms to introduce a well-focused housing supplement to address affordability concerns for people on low incomes and charge market rents for all tenants in social housing.

Improving the support that tenants receive

Financial assistance that is portable across rental markets for private and social housing should be complemented with portable tenancy support.

People eligible for social housing vary widely in their need for (non-financial) tenancy support services. For some, these services play an important role in stabilising tenancies, preventing evictions and connecting tenants to other supports, such as treatments for a mental health condition. In 2012-13, over 2000 tenants were evicted from social housing due to a tenancy breach (about 7 per cent of all tenancy exits) — bringing with it increased risks of homelessness and involvement in child protection and criminal justice. Some tenancy support programs have cited 80–90 per cent success rates in supporting people with experiences of homelessness to sustain tenancies.

Many support services targeted at social housing tenants are not made available to those renting in the private market. The support services that are available to people renting in the private market primarily focus on assisting tenants to find a home, and little long-term support is provided to sustain the tenancy. Improved access to tenancy support services could help to further enhance the benefits of user choice of home.

Delivery of support services for tenants eligible for social housing is, and should remain, a responsibility of the State and Territory Governments. These governments should **improve their contracting of tenancy support services** to clarify the support available for tenants and who should provide it.

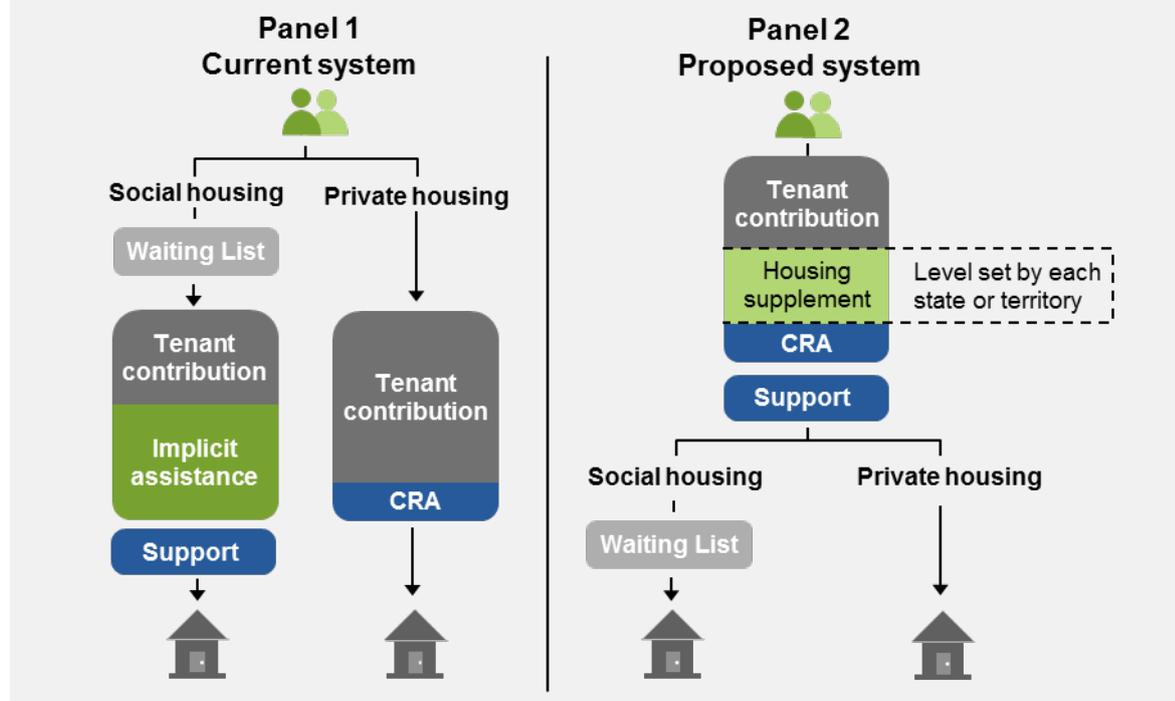
Box 2 A single system of financial assistance

The figure below illustrates the financial assistance and tenancy support received by a household under the current and proposed systems of assistance. In the example, the household is assumed to be a couple with no children that lives in an area with acute rental affordability problems.

Panel 1 of the figure shows the level of financial assistance and tenancy support the couple receive under the current system. The couple receive a different level of assistance and support depending on whether they live in private or social housing.

- In private housing they receive Commonwealth Rent Assistance (CRA) and pay market rents.
- In social housing they generally face a wait to be allocated a property. Once allocated a property, they pay a rent set at a proportion of their income (usually 25 per cent) and receive implicit assistance equal to the difference between the rent they pay and the market rent. They also have access to tenancy support services. If the couple lives in community housing some of their implicit assistance is funded through CRA.

Panel 2 shows the financial assistance the couple would receive under the Commission's proposed single system of assistance. The couple would receive a package of assistance that is portable between rental markets for private and social housing. This would include CRA and, because they live in an area with acute rental affordability problems, a housing supplement. Eligibility for, and the level of, the housing supplement would be a matter for State and Territory Governments. The couple would have access to tenancy support services regardless of whether they live in private or social housing. If they choose social housing they may continue to face a wait to be allocated a property, but would receive their assistance package during this waiting period. Social housing properties would be allocated through choice-based letting, giving the household more choice of home. Social housing properties would continue to offer more secure tenancies than generally available in the private rental market.



Making social housing work for tenants

Even with greater choice between social and private housing, there would remain a strong role for social housing properties to provide a home for people who have limited opportunity to rent in the private market. For example, people can enter social housing because landlords in the private market are reluctant to rent to them, or because they value the stability offered by greater security of tenure.

State and Territory Governments should do more to assess the future demand for social housing and **develop strategies for meeting that demand into the future**. Tenants entering social housing properties should also have more choice of home. This should be achieved through the introduction of **choice-based letting of social housing properties**.

Continuing to make the **management of social housing properties contestable** would provide incentives for managers of social housing to improve the effectiveness of service provision, and increase the pressure on them to provide well maintained properties that meet the requirements of tenants. Governments have transferred the management of some social housing properties to not-for-profit providers, and some have a policy position of further transfers. Nonetheless, four out of five social housing properties remain managed by government housing authorities.

Management of social housing properties should be **open to all types of providers**, and these providers should compete on a level playing field. This includes **applying consistent regulation across different types of provider**, and ensuring that the government housing provider is not managing tender processes or responsible for monitoring its own performance.

The benefits of reform are expected to exceed the costs

The Commission's proposed reforms would address key shortcomings of the social housing system. The proposed reforms provide for a greater choice of home for eligible households, and would improve equity between households across rental markets for private and social housing. They would also remove a disincentive for tenants currently living in social housing properties to adjust to changing circumstances. Many tenants would benefit from the reforms.

- About 13 per cent of public housing tenants surveyed in 2013 — equivalent to over 50 000 households in social housing — expressed a desire to leave public housing in the short term. Concerns raised by tenants included rowdy and unsafe neighbours, poorly maintained or undersized properties, or properties that were unsuitable for a person with disability. Many of these tenants are deterred from leaving social housing because, under current policies, they would receive less financial assistance in the private rental market.
- People who need to quickly change their housing situation could benefit from a flexible approach to housing assistance. For example, social housing rarely offers the flexibility to provide a rapid response to people at risk of or experiencing family violence.

-
- Choice-oriented reforms could increase the availability of social housing properties by making it easier for tenants to move into, or remain in, private housing. Some of the more than 150 000 households on waiting lists to enter social housing properties could benefit as they would be able to access social housing sooner. Once assessed, people waiting for social housing could potentially use their supplement in the private market immediately.
 - There are about 850 000 households eligible for, but not in, social housing. The proposed State- and Territory-funded housing supplement could benefit these households where they are in areas with acute rental affordability problems.

The benefits of exercising choice go beyond tenants' increased satisfaction with their home. Tenants empowered with greater choice are more likely to engage with their local community, and can locate closer to any services they need, including schools and hospitals. Better housing outcomes have also been linked to improved health outcomes.

There would also be broader improvements to the effectiveness of the social housing system. Governments could use information gained about tenant preferences to inform their planning processes and better allocate tenants to properties. Making the financial assistance received by tenants more explicit would increase transparency and improve government decision making. Social housing providers may receive additional revenue, which could be used to construct additional properties, or improve existing properties.

These reforms do not rely on an increase in the supply of properties that are affordable to households on low incomes, nor on greater rental security of tenure in the private market, desirable though these may be.

The Commission notes that the relative value of CRA compared with rental prices has declined over time. While desirable, addressing this decline is not essential to the design of greater choice and competition in the social housing system.

Fiscal implications and implementation

Delivering choice in social housing will involve costs. The Commission estimates that the Australian Government would be required to increase its expenditure on CRA by about \$1.2 billion each year to extend CRA to public housing. This is similar in magnitude to existing Australian Government payments under the National Affordable Housing Agreement, which has a broader remit including homelessness.

State and Territory Governments would receive additional rental revenue over the long term from social housing properties. They would also be required to fund the housing supplement for eligible tenants in areas with acute rental affordability problems. Actual costs to State and Territory Governments of the supplement would depend on its design and, in particular, how tightly each government targets the supplement, making any estimates of cost hypothetical. Given this, the Commission has not provided estimates of the potential cost of the supplement to State and Territory Governments — it has no basis to make a selection

from the range of the possible combinations of eligibility and supplement design that are available to those governments.

6 Family and community services

Governments fund family and community services, such as services for homelessness, and family and domestic violence, to improve the wellbeing of people at risk of hardship or harm. These services are not delivering the best possible outcomes for the people who use them, their families, or for governments that fund them. Poor coordination between and within governments has resulted in a patchwork of funding priorities, gaps in service provision in some places, duplication in others, and barriers to accessing services that are made even higher due to the difficulties of navigating a complex system of service delivery.

Many family and community services are delivered by not-for-profit organisations that are contracted by governments. In 2015, governments provided \$7.2 billion in funding to more than 5000 not-for-profit organisations whose main activities were in social services.

Processes for selecting and managing service providers are hindering the delivery of effective services. Contracts with short terms and excessively prescriptive conditions reflect governments' overly cautious attitudes toward risk. Short contracts and uncertainty about when services will be put to tender prevent service providers from planning ahead, innovating and investing in their workforce.

Unlike some of the other services considered in this inquiry, family and community services are *not* well-suited to the widespread introduction of greater user choice at this time. Instead, governments should focus on practical reforms to stewardship to improve the way they:

- plan the system of services
- select providers on behalf of users
- contract services so that users are at the centre of service provision.

Re-setting the system to focus on service users

Governments use 'commissioning' to steward family and community services. Commissioning is a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement (figure 3). Governments have not always successfully translated the principles of commissioning into effective practice.

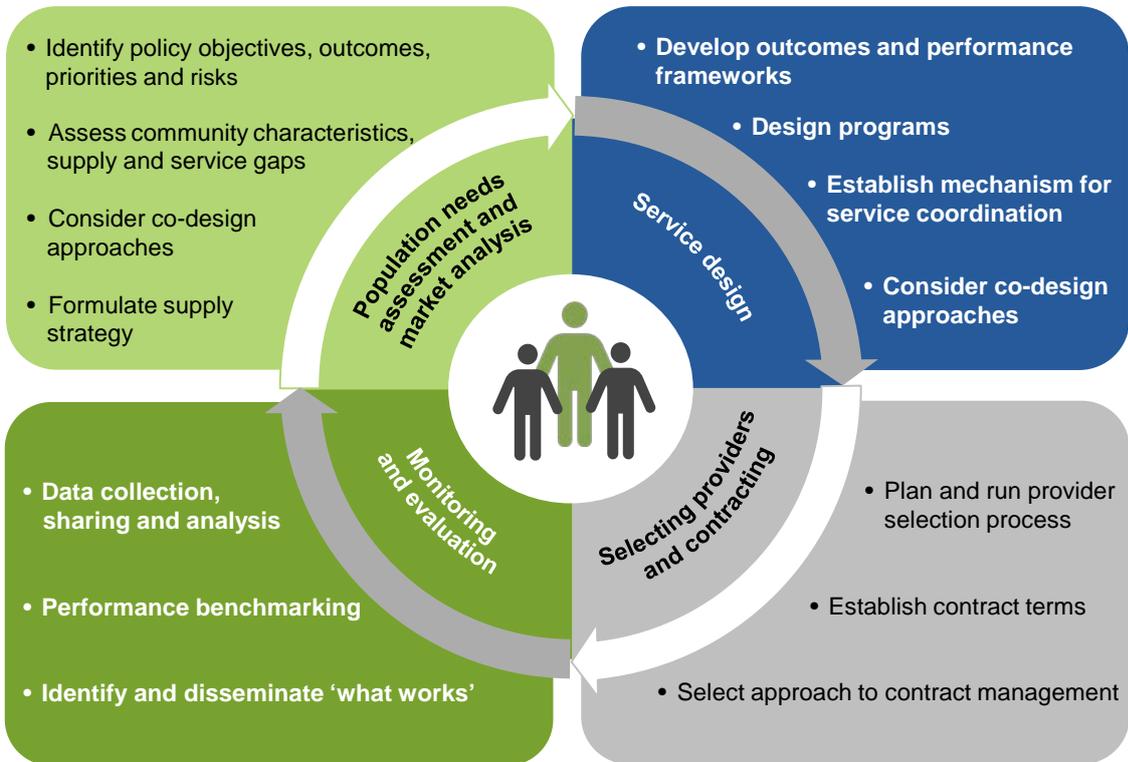
Understanding the service user population

Understanding the population and the services it needs is essential to making sound decisions about what services should be provided, where and to whom. This includes understanding

the number of people that are facing hardships that could be addressed through family and community services, their characteristics, and the distribution of needs within the service user population — from straightforward, one off assistance through to ongoing coordinated assistance.

New data and analytical techniques are opening up possibilities for **better population analysis**. The analysis underpinning the Australian Government’s Priority Investment Approach to Welfare provides one example where a more detailed understanding of the level and intensity of need across the community as whole, and in particular regions and cohorts, can provide a basis for targeting investment in family and community services. Population analysis, coupled with on-the-ground evidence drawn from service providers and others with local experience or an understanding of particular cohorts, could be used to build a more detailed picture of the needs of people experiencing hardship. Population analysis should build on existing initiatives and data to underpin stronger service design and planning, particularly for people with complex needs who require multiple services on an ongoing basis.

Figure 3 The commissioning cycle



Development of ‘user’ outcomes

Governments that commission family and community services typically define outcomes for specific funding programs in a manner that is not consistent with a focus on service users. The system would be more effective if governments developed cross-program outcomes frameworks that articulate outcomes at all levels — service user, service provider and program — and can be used to track changes in wellbeing at an individual level consistently across services. Family Life captured this in its submission:

Outcomes must be clearly articulated in meaningful terms of improvements and changes for the intended beneficiaries of public policy, whether these beneficiaries are individuals, a particular group of citizens, or communities and the broader society. We need to be clear about our goals, set outcome targets and measures for tracking our performance towards those outcomes.

Particular priority should be given to developing an outcomes framework focusing on assessing user wellbeing that can be used across programs (and potentially across departments and levels of government). Progress has been made in this direction in some jurisdictions, such as by the Department of Social Services in the Australian Government. This progress needs to be built on to provide a more consistent focus on user outcomes.

Selecting providers to achieve outcomes for service users

Governments should improve the way they select service providers, as current processes are often designed for the convenience of governments rather than the benefit of service users. The Commission is recommending reforms that offer greater certainty to potential service providers, give more time for the development of high-quality collaborative proposals, and provide confidence that governments are focused on selecting providers whose attributes are most likely to improve outcomes for users.

Governments should develop a **better understanding of how the attributes of service providers relate to achieving outcomes** for service users and make these a core part of the selection process. These attributes could include a provider’s experience delivering a particular service, its local presence and established connections in communities, and its workforce capability and capacity.

Publishing **rolling schedules of upcoming tender opportunities** well in advance would create more certainty as to when contracts will come up for renewal, and when a decision on the outcome of the tender will be made. This would allow providers to better plan their activities or handover. Governments also generally only allow four to six weeks for service providers to respond to selection processes. This is not long enough to develop a high-quality proposal, or for providers to formalise collaborative arrangements to take advantage of synergies. Much longer periods should be allowed in tenders for potential providers to develop bids (three months should be the default).

The need for longer contract terms

Currently, contracts for the provision of family and community services generally default to a term of three years or less. Brotherhood of St Laurence described some of the effects of short-term contracts:

The practice of short term contracts means that providers operate in a climate of constant uncertainty. Precarious funding militates against collaboration by making providers disinclined to invest scarce time and resources in the effort required to build networks and learn new ways of working.

Short-term contracts can also be detrimental to service users because service providers spend too much time seeking short-term funding, which is a costly distraction from delivering and improving services. Short-term contracts can also be an impediment to service providers developing stable relationships with service users, hindering service provision and the achievement of outcomes for users.

It is difficult to identify an ideal contract length. What is clear, however, is that current contracting terms are too short. To address this, the Commission is recommending that governments move to a **seven-year default contract term**. Seven-year default contracts would allow for time for setup (making the investments that are necessary to deliver effective services, including workforce capacity and building relationships in the community) and time for a smooth transition to a new provider at the end of the contract. In between, service providers would have a much needed period of stability and, when combined with a stronger focus on user outcomes, would provide the basis for more effective service provision. At the end of this period, contracts should be retendered to find a balance between providing continuity and retaining the benefits of periodic contestability. As with any default, exceptions should be allowed where justified. For example, shorter contracts could be used to trial new programs.

Longer contracts would open the door for governments and service providers to adopt more ‘relational’ approaches to contract management. Relational contracting involves the parties to the contract seeking to maximise the effect of their joint efforts on improving user outcomes over time. This recognises that governments and service providers both have contributions to make to the effective delivery of services.

Increasing default contract lengths will emphasise the importance of strong selection processes and good contract management. A ‘set and forget’ approach by governments will not deliver outcomes for service users — provider performance must be monitored and poor performance remedied. This could include the removal of a provider in cases of failure. Incorporating formal reviews of service effectiveness into contracts should help to manage the risk of poor provider performance.

7 Services in remote Indigenous communities

Human services should be making a greater contribution to improving the wellbeing of Indigenous people living in remote communities. Despite goodwill and significant resources, current approaches to commissioning human services in remote Indigenous communities are not delivering the benefits of contestability and are exacerbating its potential weaknesses.

About one in five Indigenous Australians live in a remote area. In 2011, there were over 1000 discrete Indigenous communities in remote areas of which more than three-quarters had a population of less than 50 people (figure 4). Indigenous Australians living in these communities have significantly worse quality of life than most other Australians. From 2003, the Steering Committee for the Review of Government Service Provision has published the *Overcoming Indigenous Disadvantage* report of indicators of Indigenous people's wellbeing. Over that time, there has been evidence of improvement in some areas, but outcomes have stagnated or declined in others. Improving the effectiveness of human services for Indigenous Australians living in remote communities should be a priority for governments.

The causes and consequences of disadvantage in remote Indigenous communities are complex and interrelated. Few remote communities have a mainstream economic base and the provision of government services is the dominant economic activity in many. The way services are designed and provided needs to reflect the circumstances of communities — the Commission's recommendations take account of this context.

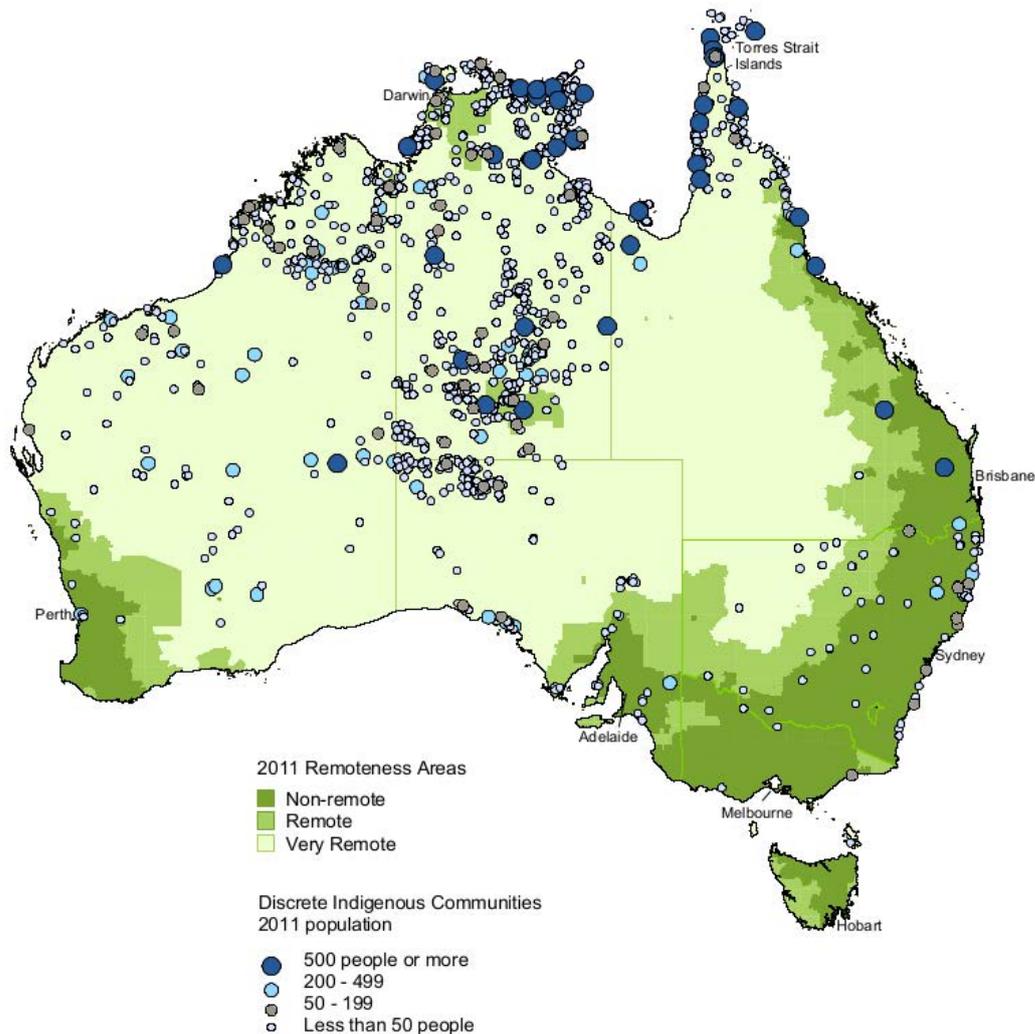
Competition between service providers is not commonplace in remote Indigenous communities, even where there are multiple providers, and user choice of service or provider is limited. The provision of human services in remote Indigenous communities, like family and community services, is largely designed around a model of commissioning where providers compete periodically through tender processes for funding to deliver services. For example, the Australian Government provides Indigenous-specific grants across a range of service areas through the Indigenous Advancement Strategy. State and Territory Governments also commission human services through tendering processes, such as housing for remote Indigenous communities.

Remoteness poses a number of challenges for service provision. It increases the costs of delivering services and prevents some services from being delivered at all. The size and remoteness of these communities means that they may not be able to support full-time services. Isolation also poses challenges, with some communities cut off from services for weeks or months each year. Even when they are accessible, travel can be difficult, costly, time-consuming and for some people, such as those who are frail or elderly, impossible. Access to online service alternatives can also be challenging due to a lack of IT infrastructure and, in some cases, a lack of the skills required to utilise those services.

Recruiting and retaining staff with skills in service provision and the necessary cultural competencies is an enormous challenge. Few small communities have local people with the

professional skills to deliver the suite of human services they need, and provider and staff turnover can be significant barriers to effective service provision.

Figure 4 **Discrete Indigenous communities by size and remoteness, 2011**



The opportunity for reform

Initiatives to improve outcomes for Indigenous Australians through the provision of human services have often fallen short at both the design and implementation stages. Indigenous policy has been characterised by high levels of instability, with shifts between Indigenous-specific and mainstream programs, and by overlapping and shifting responsibilities within and across different levels of government. This was captured by Empowered Communities.

[Likewise,] Indigenous leaders and communities trying to take responsibility for improving the future of their peoples are too often stuck in a morass of red tape and policy churn associated

with the political cycle and the all-too-temporary whims of successive governments and their ministers. While we have the knowledge about our lives and communities, government holds nearly all the power.

Greater policy stability would support providers to build trusting relationships with communities, underpin continuous improvement and innovation in service provision, and improve the ability of governments to attract providers and staff to remote communities. Constant changes by governments at all levels have created uncertainty and confusion for communities and service providers and have undermined the effectiveness of service provision. Most communities and services will struggle to succeed in this environment. Governments must exercise patience and consistency while maintaining the capacity to act to address high levels of dysfunction and harm when they arise.

Services in remote Indigenous communities are often poorly planned and uncoordinated. Decisions about service provision are made on the basis of jurisdictional, departmental and program boundaries, and this may come at the expense of a focus on achieving outcomes for users. The inefficiency created by poor planning and coordination is stark. The Aboriginal Medical Services Alliance Northern Territory gave an example of a remote community in Central Australia where about 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. The Alliance described what happens on the ground.

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

Toward a better model of service provision

Much has been written about the successes and failures of initiatives to improve service provision in remote Indigenous communities. These lessons are often overlooked by governments and few formal evaluations have been undertaken — this needs to change. The Commission has identified a set of principles that would improve the effectiveness of service provision in remote Indigenous communities. These principles draw on lessons from previous initiatives to improve services in remote Indigenous communities, and on the ‘success factors’ that have been identified in the *Overcoming Indigenous Disadvantage* reports.

- *Greater community voice* — Giving communities opportunities to engage with governments to express their preferences and priorities could result in services that are better tailored to the community, are more likely to be used by the community and hence more effective. This is a way of enabling service users to have more say about the services they receive, and who provides them, in communities that are too small or

remote to support competition between service providers. Increasing community voice is not a simple task and any expectation that Indigenous people should speak with one voice is unrealistic as well as unhelpful. Like other Australians, people living in remote communities often have strongly differing views about what is best, and not all communities have well-functioning representative bodies that are able to harness these views. This complicates engagement and service delivery.

- *Clearer outcomes* — Governments should work with communities to clearly identify and measure the outcomes that human services are intended to achieve. Policy makers need to take into account both the broad objective of improving Indigenous Australians' wellbeing, and also Indigenous Australians' preferences, priorities and conception of wellbeing.
- *Effective government structures and processes* — Governments should tailor the way they operate to the circumstances in remote communities. Putting people at the centre of service delivery in remote Indigenous communities would require more tailoring of service delivery to local circumstances. Achieving this requires a shift towards government structures and processes that support regional and local engagement, planning and decision making.
- *Building community capacity* — Building community capacity would support community involvement in service design, provision and evaluation. Too often, opportunities have been missed to connect the provision of services with the building of local capacity, including the capacity of Indigenous service delivery organisations and individuals.
- *Effective learning systems* — Building community and government capacity and service design and provision should be informed by effective learning systems that help to identify 'what works' (and for whom and in what context) in delivering human services in remote Indigenous communities.

Better commissioning arrangements would improve service effectiveness

There is significant scope to improve the provision of human services to Indigenous people living in remote communities. The Commission is recommending changes to commissioning arrangements to promote longer-term stability for service users and providers, and to increase community involvement across the commissioning cycle. The proposed reforms address many of the same issues that arose in relation to family and community services, with adjustments to accommodate the different circumstances of remote communities, and take into account the principles for effective service provision outlined above.

Longer **default contract terms of ten years** for human services in remote Indigenous communities should be established to improve the continuity of service provision and contribute to better outcomes. In remote Indigenous communities there is a case for even longer contract terms than in family and community services, to allow extra time to establish

community trust and invest in staff, capital and delivery models. Continuity has benefits for users for whom trusting relationships with providers are important. For providers, greater continuity would improve their ability to attract and retain staff and allow them to improve service quality by planning investments over a longer cycle. Longer contract terms might also make it easier for governments to attract more providers to remote areas.

Longer contract terms will need to be supported by a more relational approach to contract management. Communities, governments and providers should engage in collaborative reviews of contracts to assess progress and align effort with emerging priorities. This approach should complement mechanisms to ensure that providers are meeting performance standards.

Improving the scheduling and timing of tender processes would better facilitate coordination and the ability of providers to work together through, for example, forming consortiums or less formal forms of collaboration. Government should publish a schedule of upcoming tenders, align tenders for similar services in a particular community and provide more time for providers to develop their proposals. A benefit of this approach is its potential to encourage more partnerships between mainstream providers and local Indigenous organisations. Aligning tenders would also create opportunities for communities and governments to identify the mix of providers that is likely to achieve the best outcomes for the community.

Governments should **improve processes used to select service providers** to take into account all the relevant attributes of service providers that can contribute to outcomes for service users. In remote Indigenous communities, this should include attributes that are valued by the community such as on-the-ground connections and the ability to provide culturally appropriate services.

A **greater focus on skills transfer and capacity building** should be included in contracts. This would improve community development and resilience over time, could encourage providers to recruit and retain local staff, and lead to more service delivery by local people and organisations.

Improvements to planning, evaluation and feedback systems are essential underpinnings of better service provision. Governments should work with local communities to develop outcome measures for human services in remote Indigenous communities; conduct and publish community assessments to develop an understanding of community characteristics and needs; and gather and share information on ‘what works’ (including for whom and in what context).

Longer-term directions for service provision in remote Indigenous communities

In its draft report, the Commission outlined a possible longer-term transition to a place-based model of service provision centred on community plans. These would be developed by

communities and would inform governments' decisions about human services funding and delivery.

Following the release of the draft report, the Commission consulted with Indigenous community representatives, service providers and governments about this proposal. The consultations confirmed that there is merit to place-based approaches, but that a large-scale systemic rollout of place-based approaches across remote Indigenous communities is not feasible. Successful implementation of place-based approaches would depend on the capacity of both governments and communities. This capacity does not exist everywhere and would take time and effort to build. As discussed above, the Commission is mindful that persistent change has caused ongoing disruption to remote Indigenous communities. Expanding too far, too fast is a significant risk, and has been identified as a contributing factor to problems in previous reform processes.

The Commission considers that its recommendations on the provision of services to remote Indigenous communities would form a solid foundation on which to base a longer-term transition to place-based reforms, on a case-by-case basis, as government and community capacity is built.

While a large scale move to place-based approaches is not recommended, governments should not stand still. Governments should be willing to adopt more place-based approaches where communities can demonstrate that they are ready and government capacity exists (or can be readily built), taking into account the differing circumstances, needs and preferences of communities. A variety of models have merit and an approach that works in one community may not work in another. A number of Indigenous communities already have models in place (for example, Empowered Communities and the Murdi Paaki Regional Assembly). Where there are existing arrangements these should be built on, and learned from.

Governments will need to adjust their structures and processes and build the capabilities of their staff to implement more localised (including place-based) approaches. This will require governments to shift the balance away from centralised decision making toward greater regional capacity and authority. To do this governments should **give local staff more authority over local planning, engagement and service implementation**. Governments would need to support this transition by authorising, resourcing and building the capacity and capability of staff working on the ground. A more regional and localised approach would foster better understanding of communities and their needs, and would facilitate greater linkages between government decision makers and communities. It would also lay the foundation for more place-based approaches in the future.

8 Giving patients greater choice

A combination of rules and common practices limit patients' choice of healthcare provider when they receive a referral or a diagnostic request. These barriers to choice should be

removed. Patients differ in their needs and preferences, and providers differ in their locations, performance, waiting times and out-of-pocket charges. All patients should be given the opportunity to choose the provider that best meets their needs, after receiving a referral and support from their GP (general practitioner). Better public information should facilitate this choice and drive provider self-improvement, such as adopting practices that have enabled a provider's peers to achieve superior clinical outcomes.

Each year, millions of Australians are referred by a GP to more specialised healthcare providers. In a year, GPs make about:

- 15 million referrals to specialists, most often to orthopaedic surgeons and dermatologists
- 9 million referrals to allied health professionals, chiefly to physiotherapists and psychologists
- 91 million requests for pathology tests and 15 million requests for radiology tests.

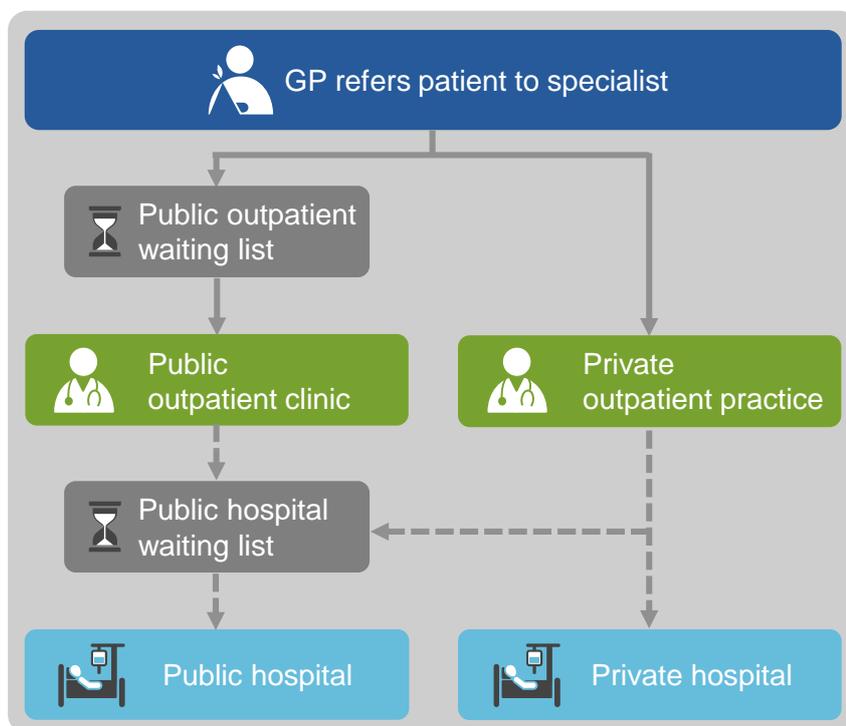
Patients referred to a specialist may go to a public outpatient clinic or a specialist working in private practice for their initial consultation. Which public clinic or private specialist they go to will also determine which hospital they are admitted to if they require inpatient care (figure 5).

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

Patient choice is also limited by a common misperception among patients and providers that a named referral for a specialist or allied health professional, or a branded diagnostic request form, cannot be accepted by an alternative qualified provider. As a result, specialists sometimes refuse to see a patient because a different specialist is named in the referral, and the patient has to contact their GP's office to request that the name in the referral is changed.

These restrictions limit choice without delivering any significant benefit for either the patient or the community more generally. Patients who are given a specialist referral should have the opportunity to choose the public outpatient clinic they attend (with the specialist chosen by the clinic) or the individual specialist they see in private practice. Similarly, when patients are referred to an allied health professional, or pathology or radiology provider, they should have the opportunity to choose which one they go to.

Figure 5 Pathways to elective hospital admission



To give patients greater choice, the Australian, State and Territory Governments should:

- direct **public outpatient clinics to accept any patient with a referral** for a condition that the clinic covers, regardless of where the patient lives
- amend referral regulations to make it clearer that patients can **choose their private specialist**
- require a **clear patient advisory statement on all referrals and diagnostic requests** highlighting patients' right to go to an alternative provider to any named
- work with professional bodies to develop best-practice guidelines on how to **support patient choice**.

GPs would continue to be responsible for making referrals and requesting tests, and would play a vital role in supporting patient choice. Patients would still be able to rely on their GP to make decisions on their behalf, if they wish. Patients should also have the option, following support from a GP, to choose their provider independently after leaving the GP's practice. This would give patients the chance to do their own research, consider their options and perhaps consult others before making a decision.

Greater choice empowers patients to have more control over their lives. This in itself is likely to improve the wellbeing of patients. Choice also allows patients to make trade-offs between options to better match their preferences — such as choosing a public clinic that has a shorter waiting time but is further from home. Overseas studies have shown that greater patient

choice, together with public information to support choice, can lead to better clinical outcomes — including fewer deaths — because it encourages some patients to seek out higher-performing hospitals and importantly prompts service providers to move closer to best practice among their peers.

Information to support patient choice and provider self-improvement

The information available to patients to help them make choices on alternative hospitals, specialists and allied health professionals is limited. Information on the MyHospitals website, for example, largely relates to waiting times and other process measures, with almost no information on outcomes from specific treatments or measures of patients' experience with hospital services.

Experience in other countries has shown that publishing more information would further empower patients and help GPs to support them. There is also evidence that public reporting encourages healthcare providers to engage in self-improvement activity, particularly at the hospital level, possibly because of a peer pressure effect. To unlock these benefits, **more information should be publicly reported** to facilitate comparisons between alternative providers, including on clinical outcomes and the wide variation in out-of-pocket charges for private specialist outpatient consultations.

Governments in Australia already collect a large amount of information about individual hospitals but much of it is withheld from public view. The Commission's 2017 inquiry on data availability and use identified this as a common problem across the economy and recommended reforms to make data more accessible. This included a new Data Sharing and Release Act, National Data Custodian, and sectoral Accredited Release Authorities to streamline access to datasets. These would complement the healthcare-specific information reforms proposed in this report.

The current commitment to public reporting that the Australian, State and Territory Governments made in the National Health Reform Agreement should be strengthened and expanded. In particular, jurisdictions should, as **part of their health funding arrangements**:

- adopt a general policy of **publishing all data** they hold on individual hospitals, specialists and allied health professionals, unless it would clearly harm the interests of patients or breach privacy protections
- make the published data available in a **format that other organisations can readily incorporate** in advisory services they provide, such as in software used by GP clinics and in mobile applications used by consumers
- transform the MyHospitals website into a national **vehicle that better supports choice** by patients, and encourages self-improvement by individual hospitals, specialists and allied health professionals, including by reporting more outcome indicators such as patient-reported outcome measures

-
- phase-in **public reporting on individual specialists and allied health professionals**, possibly beginning with their registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.

The Australian, State and Territory Governments should review progress in implementing these reforms three years after the new health funding arrangements come into force.

9 Public dental services

People who receive public dental services have little choice in who provides their care, when and where. Public dental services do not focus sufficiently on preventive care and early intervention. Left untreated, patients with preventable conditions often require complex — and costly — emergency and restorative treatments. Long-term reform of public dental services to shift the system’s focus from treating emergencies to targeted prevention and greater user choice has the potential to improve outcomes for people who are eligible for public dental services, and generate net benefits for the community as a whole.

Publicly funded dental services provide safety net access to basic dental care for people who face financial and other barriers to accessing care, such as some people with disability. Approximately 5.3 million adults and 3 million children are eligible for public dental services — about a third of Australia’s population. Public dental services operate alongside a substantial user-pays private sector.

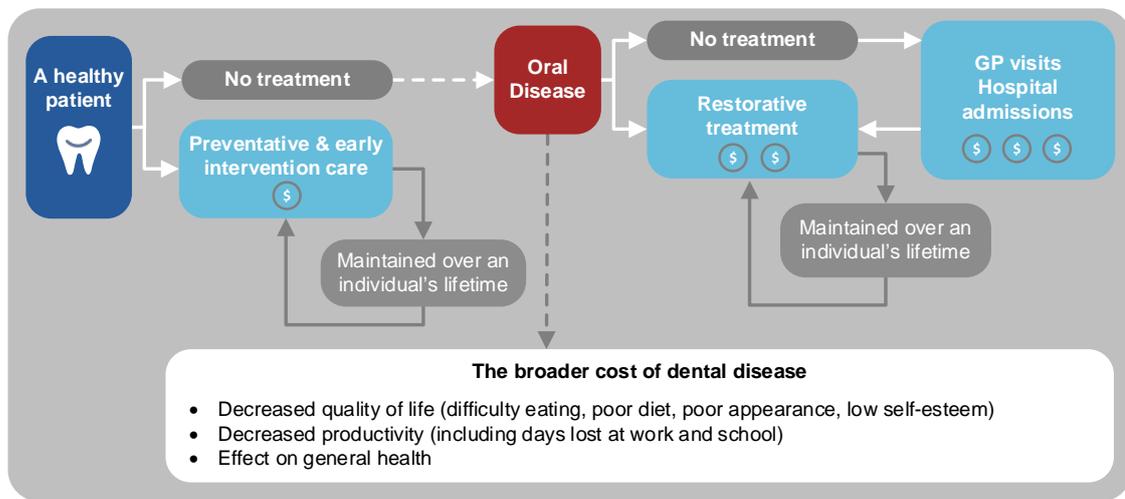
Introducing greater user choice and improving outcomes for users requires fundamental reform. To do so, governments should introduce a **consumer-directed care** approach that focuses on targeted preventive care. Under this approach, it is the user’s choice of dental clinic that determines where their funding is allocated. Improved choice would enable users to make decisions that suit them and generate incentives for providers to be more responsive to patients’ needs (providing the right treatment at the right time). Where user choice would not be feasible, governments should commission services that can best meet users’ needs. Changes to government stewardship arrangements, including improved public performance reporting and the development of oral health outcome measures, should be implemented to underpin these reforms.

Measuring the effectiveness of public dental services

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

The time spent waiting to receive care means that the oral health of people at high risk of developing or worsening oral disease deteriorates — resulting in larger costs to them, to governments and the community for largely preventable conditions (figure 6). Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015-16. The time to treatment is therefore an important metric for improving the effectiveness of public dental services. **Public reporting of performance** in treating patients within clinically-acceptable waiting times (by risk category) would improve accountability and identify areas for performance improvement in the sector.

Figure 6 **A stylised pathway of dental health care and the costs**



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

Performance benchmarks and outcome measures should be developed and implemented as soon as practicable. Governments could also use these new data sources to better understand the population's needs which, in itself, would improve the effectiveness of service provision. They are also a necessary first step in introducing consumer-directed care, and shifting the system's focus to targeted preventive care.

Improving choice and outcomes for users

Enabling people to have more choice over their dental provider is an important reform but further benefits could be achieved if this choice was coupled with a greater focus on preventive care. One way to achieve this is for dental clinics to be responsible for the care of a patient for a defined period. This requires balancing a user's ability to choose a different provider against the benefits derived from continuity of care by a single provider. The Commission's proposed consumer-directed care reforms strike this balance by giving users the choice over their provider (either public dental clinics or a participating private clinic) for a three year enrolment period.

Under the proposed model, users would present to public dental services (as is currently the case). Patients with urgent care needs should continue to be prioritised for treatment. People presenting for care would be enrolled in the Commission's consumer-directed care scheme once any urgent care needs have been met and subject to any waiting period. Once enrolled, patients would choose their preferred dental clinic for the enrolment period. Over time, this will increase the focus of public dental services on preventive care. The pace of transition will depend on levels of government funding.

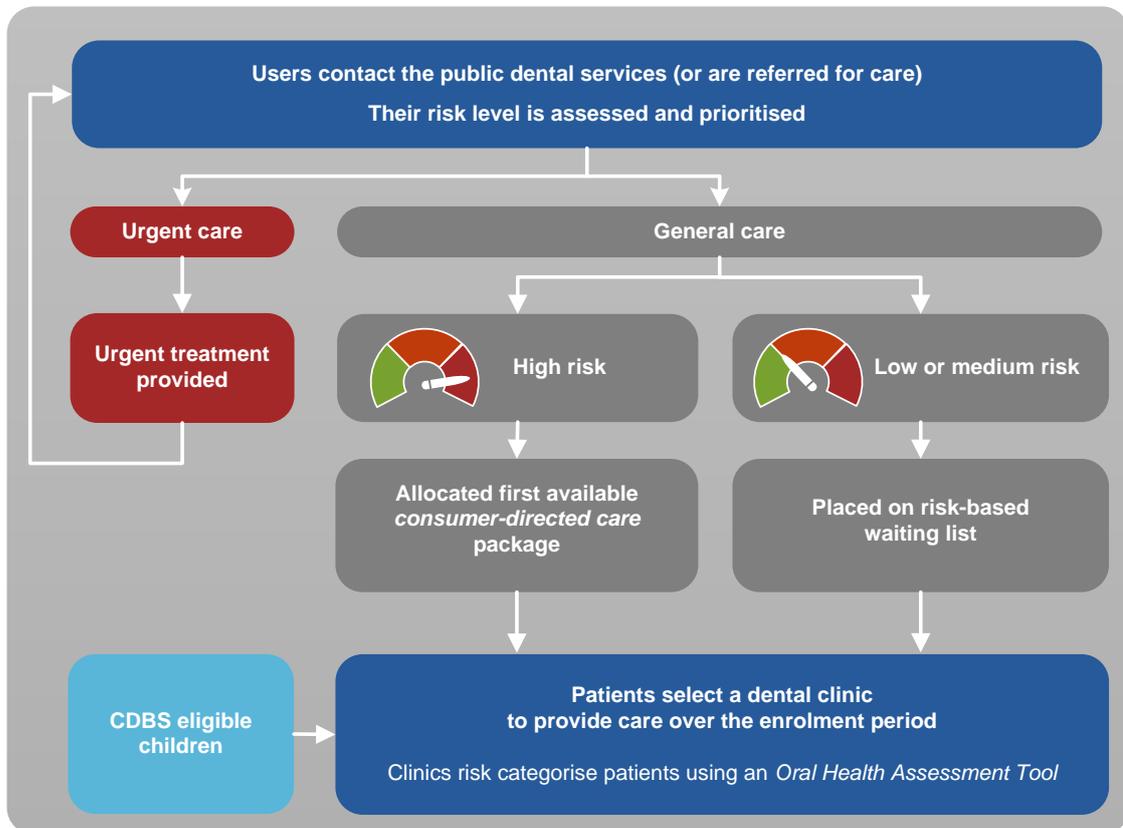
Implementing choice and obtaining the benefits of a targeted focus on prevention through consumer-directed care requires the development of a:

- **risk-based allocation model** that targets services to users at high risk of developing or worsening oral disease, providing access to services based on risk rather than the date that a user joined the waiting list (figure 7)
- **blended payment model** where governments pay providers a combination of payment types designed to reward preventive care and the overall quality of care, rather than the number of treatments provided (as occurs under fee-for-service arrangements) (figure 8).

Developing a risk-based allocation model will require governments to triage patients according to their risk of developing or worsening oral disease and would be used to target the oral health of those most at risk in the eligible population. Incorporating a **digital oral health record** into the My Health Record system could improve linkages with the broader health system (including GPs and hospitals), assist in the identification and triaging of patients at high risk of developing or worsening oral disease, and support user choice by ensuring a person's records are portable between providers.

Information from performance reporting, outcome measures, and digital oral health records would enable governments to more systematically identify those cohorts within the user population at high risk of oral disease. These stewardship changes would allow governments to make evidence-based decisions about how best to engage with people at high risk of oral disease, including the many users who only present to the public dental or health system when they require urgent care.

Figure 7 **How eligible users would access consumer-directed care**



Development of a blended payment model will require governments to pay providers for each enrolled patient. This payment should be risk-weighted to reflect the treatment needs of different population groups. In addition, outcome payments should be introduced to reinforce incentives for providers to focus on prevention. Activity payments should be retained for urgent and complex treatments where the need for treatment is less predictable and, therefore, cannot be readily brought within the capitation payment (figure 8).

The Commission has drawn on overseas experience to develop the blended payment model. Evidence from clinical studies in Britain, Canada, Norway and Sweden indicate that an enrolment payment encourages providers to invest in preventive and early intervention care for their patients. ‘Blending’ the enrolment payment with outcome payments rewards clinics for the quality of care provided and, thereby, better aligns the interests of patients and providers.

Blended payment models are commonly used in health care across OECD countries to balance the incentives of different payment types. A similar blended payment model is being progressively trialled and rolled out for public dental contracts in England.

Figure 8 **How providers would be paid under consumer-directed care**



Poor oral health can track strongly from childhood to adulthood. Targeting of services for children therefore could have lifetime benefits for individuals and, potentially, for the health system. Adopting the proposed blended payment model for the Child Dental Benefit Schedule (CDBS), including the use of risk-weighted payments, would both encourage preventive care and provide children at high risk of oral disease with individual funding that reflects their care needs. Therefore, the CDBS should be amongst the first elements of the rollout of the Commission’s proposed payment model.

Governments should also provide patients with improved consumer-oriented information. This information should focus on enabling choice of provider (such as the locations, waiting times, and published outcome measures of clinics) and highlighting the availability and benefits of dental care. The preventive care benefits of the proposed reforms would potentially be enhanced by outreach to people at high risk of oral disease who may not otherwise engage with dental services.

Providing services to users where choice is not feasible

There are some circumstances where introducing greater user choice is not feasible, such as in remote locations with small populations that may not be able to support multiple dental providers (or even a single provider all year round). Even in metropolitan areas there may be populations with complex and special needs that require services that can only be accommodated by a small number of providers. For example, in some jurisdictions services are provided in a person's residence if they are homebound due to disability or dementia. Improvements to governments' commissioning processes, including the need for a more **systematic approach to service planning, selecting providers and monitoring their performance**, would improve the provision of services for these users.

Governments should use the **oral health outcomes framework** to design contracts and select providers that focus on promoting the oral health of the people they treat. Outcomes-based commissioning of public dental services will focus governments and providers on understanding and addressing population needs and lowering barriers that may make some of the eligible population reluctant to seek out dental services.

A staged implementation

Taken together, the Commission's recommendations represent a long-term and systemic reform pathway for public dental services.

The Commission's reforms should be implemented in a staged manner, starting with reforms to improve the stewardship of the system. Following the development of outcome measures, governments should improve their commissioning processes and examine opportunities for introducing greater contestability in public dental services. These reforms on their own would improve the effectiveness of public dental services in Australia.

Once the outcome measures are in use, the consumer-directed care scheme should be developed and trialled at a range of test sites. Results from the test sites should inform a staged rollout process.

Recommendations

End-of-life care

RECOMMENDATION 4.1

State and Territory Governments should increase the availability of community-based palliative care so that people with a preference to die at home can access support to do so. To achieve this, State and Territory Governments should:

- assess the need for additional community-based palliative care services
- design services to address identified gaps in service provision
- establish standards for community-based palliative care services and fund the provision of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care
- use competitive processes to select providers (or a single provider) to deliver additional community-based palliative care services
- monitor and evaluate the performance of community-based palliative care services against the specified standards
- ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.

RECOMMENDATION 4.2

End-of-life care should be core business for aged care facilities, and the quality of end-of-life care in residential aged care should align with the quality of that available to other Australians. To achieve this the Australian Government should:

- remove current restrictions on the duration and availability of palliative care funding in residential aged care
- provide sufficient funding for this additional clinical care.

RECOMMENDATION 4.3

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

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

RECOMMENDATION 4.4

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

RECOMMENDATION 4.5

The Australian, State and Territory Governments should, through the Council of Australian Governments (COAG) Health Council, ensure that there is cross-jurisdiction co-operation to:

- plan, fund and deliver end-of-life care so that patients receive integrated services across different settings and jurisdictions
- set standards for end-of-life care in each of the settings in which it is provided (such as those that will apply to end-of-life care in hospitals in all jurisdictions from 2019)
- monitor and evaluate end-of-life care services.

The COAG Health Council should oversee the development and implementation of a data strategy for end-of-life care that:

- establishes a national minimum data set for end-of-life care (including collecting and publishing linked information on place of death, primary and secondary diagnoses and details of service provision at time of death)
- improves the accessibility of patient-level data (such as advance care plans or hospital discharge summaries) so that they are used to deliver high-quality care
- uses system-level data to enable governments to plan, monitor and evaluate how well end-of-life care services are meeting users' needs across all settings and jurisdictions, and to drive improvements in end-of-life care.

The COAG Health Council should, in 2025, commission an independent review of the effectiveness of end-of-life care across all settings in which it is, or should be, provided.

Social housing

RECOMMENDATION 6.1

The Australian, State and Territory Governments should work together to introduce greater user choice, and improve the equity and responsiveness of the social housing system, by introducing a single system of financial assistance for eligible tenants. This system should be portable across rental markets for private and social housing.

- The Australian Government should extend Commonwealth Rent Assistance to tenants in public housing so that it is available to all eligible tenants in social housing properties.
- State and Territory Governments should each design and fund a housing supplement for eligible tenants in areas with acute rental affordability problems.

State and Territory Governments should abolish the current model of financial assistance in social housing by:

- charging market rents for tenants in social housing properties rather than rents set at a proportion of income
- providing existing social housing tenants the option of moving to the new system of financial assistance or continuing to pay rent set at a proportion of income for up to ten years after the single system of financial assistance is introduced.

The Australian Government should only extend Commonwealth Rent Assistance to public housing tenants in a jurisdiction if that State or Territory Government implements this recommendation in full.

RECOMMENDATION 6.2

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

RECOMMENDATION 7.1

State and Territory Governments should each publish a 10-year strategy for the supply of social housing properties in their jurisdiction. These strategies should include:

- an assessment of how many people will likely require social housing into the future, and analysis of their characteristics
- an analysis of types of properties tenants would likely require, such as number of bedrooms and disability supports, and where they should be located
- how governments plan to meet projected demand for social housing properties.

These strategies should be updated at least every five years.

RECOMMENDATION 7.2

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

- tenant outcomes, including the outcomes of tenants renting in the private market that receive a housing supplement or tenancy support services
- the cost of managing social housing.

State and Territory Governments should clearly define the outcomes they are seeking to achieve through tenancy management and tenancy support services, and put in place frameworks to assess their success in meeting these outcomes over time. Outcome measures should, to the extent possible, be consistent and comparable to those developed for family and community services (recommendation 8.3).

RECOMMENDATION 7.3

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

RECOMMENDATION 7.4

State and Territory Governments should ensure that the entity responsible for managing social housing assets is separate from the entity responsible for social housing policy.

RECOMMENDATION 7.5

State and Territory Governments should amend the National Regulatory System for Community Housing to cover public housing so that all providers of social housing face consistent regulatory requirements, regardless of whether they are government or non-government providers.

RECOMMENDATION 7.6

State and Territory Governments should:

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

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

RECOMMENDATION 7.7

State and Territory Governments should ensure that applicants for social housing assistance receive a comprehensive up-front assessment of their eligibility for:

- a social housing placement
- the housing supplement (recommendation 6.1)
- tenancy or other service support, including support to enable the tenant to choose their home.

Applicants should also be made aware:

- that the housing supplement would be payable if they chose to live in either the private or social housing markets
- of the extent to which tenancy support services available in social housing would also be available to eligible tenants renting in the private market.

RECOMMENDATION 7.8

State and Territory Governments should improve the commissioning of tenancy support services by:

- ensuring that tenants renting in the private market have the same access to support services as tenants in social housing
- clearly separating the funding and contracting of tenancy support services from tenancy management services
- considering the application of recommendations contained in this inquiry to improve the commissioning of family and community services.

Family and community services

RECOMMENDATION 8.1

The Australian, State and Territory Governments should build on existing initiatives and data to:

- analyse the characteristics and needs of the service user population to assist with system and program design and targeting
- develop and publish data-driven maps of existing family and community services
- identify outcomes for family and community services that articulate the improvements in service users' overall wellbeing that governments are seeking to contribute to through service provision
- develop plans to coordinate services for people who have complex needs
- develop and publish regional service plans to address the needs of people experiencing hardship.

These actions will require ongoing commitment from governments, working in consultation with service users and service providers.

RECOMMENDATION 8.2

To improve processes used to tender family and community services, the Australian, State and Territory Governments should:

- publish a rolling schedule of upcoming tenders over (at least) the next twelve months
- allow sufficient time (a default of three months) for providers to prepare considered responses, including the development of integrated bids across related services
- notify providers of the outcome of tender processes in a timely manner
- design selection criteria that focus on the ability of service providers to improve outcomes for service users
- not discriminate on the basis of organisational type (for-profit, not-for-profit and mutual for example).

RECOMMENDATION 8.3

The Australian, State and Territory Governments should, within 24 months, agree on indicators of the wellbeing outcomes of people who use family and community services and apply them consistently across all such services.

Where it is not feasible to define or collect data on service user outcomes, governments should identify outputs from family and community services that can be used as proxies for outcomes.

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

RECOMMENDATION 8.4

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

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

RECOMMENDATION 8.5

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

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

- increase default contract lengths for family and community services to seven years
- allow exceptions to be made, such as for program trials, which could have shorter contract lengths
- publish the justification for any contracts that differ from the default term
- initiate collaborative reviews (involving government and providers) to assess progress, adjust priorities as needed and identify opportunities for improvement
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of failure.

RECOMMENDATION 8.6

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

Services in remote Indigenous communities

RECOMMENDATION 9.1

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

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

- increase default contract lengths for human services in remote Indigenous communities to ten years
- allow exceptions to be made, such as for program trials, which could have shorter contract lengths
- publish the justification for any contracts that differ from the default term
- initiate collaborative reviews (involving communities, government and providers) to assess progress, adjust priorities as needed and identify opportunities for improvement
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of failure.

RECOMMENDATION 9.2

To improve processes used to tender human services in remote Indigenous communities, the Australian, State and NT Governments should:

- publish a rolling schedule of upcoming tenders over (at least) the next twelve months
- allow sufficient time (a default of three months) for providers to prepare considered responses, including the development of integrated bids across related services
- notify providers of the outcome of tender processes in a timely manner
- allow enough time for transition when new providers are selected.

The Australian, State and NT Governments should also gradually work to align tender processes for related services in communities, commencing with a small number of communities.

RECOMMENDATION 9.3

The Australian, State and NT Governments should ensure that commissioning processes for human services in remote Indigenous communities incorporate skills transfer and capacity building for people and organisations in those communities.

RECOMMENDATION 9.4

The Australian, State and NT Governments should take into account the attributes of providers that contribute to achieving outcomes for people living in remote Indigenous communities. These attributes may include:

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

RECOMMENDATION 9.5

The Australian, State and NT Governments should invest in better planning, evaluation and feedback systems to underpin service provision by working together — and with local communities — to:

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

These actions will require ongoing commitment from governments, working in consultation with communities, service users and service providers.

RECOMMENDATION 9.6

The Australian, State and NT Governments should adopt more regional and localised approaches to decision making and engagement with remote Indigenous communities, to underpin the greater use of place-based approaches to the design and provision of human services. To achieve this, the Governments should:

- give local staff more authority over local planning, engagement and service implementation
- provide capacity building support (such as cultural training) for staff working in remote Indigenous communities.

The Australian Government and State and NT Governments should work together to engage with communities on a coordinated basis.

Giving patients greater choice

RECOMMENDATION 10.1

The Australian Government should amend the Health Insurance Regulations 1975 (Cwlth) to make it clearer that patients with a specialist referral can choose to have their initial consultation with any private specialist practising the relevant specialty. This includes clearly specifying that:

- referrals do not need to name a particular specialist
- any specialist practising the relevant specialty can accept a referral, irrespective of whether another person is named as the specialist in the referral.

RECOMMENDATION 10.2

The Australian Government should amend the regulations for referrals and diagnostic requests to require:

- general practitioners and other referrers to advise patients that they can use an alternative to any provider mentioned in a referral or request
- all referrals to specialists and allied health professionals, and requests for pathology and radiology services, to include a prominent and easy to understand statement advising patients that they can use an alternative to any provider mentioned in the referral or request.

RECOMMENDATION 10.3

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

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

RECOMMENDATION 10.4

State and Territory Governments should change patient travel assistance schemes so that assistance is available to patients who must travel long distances to access specialist medical treatment, regardless of which provider they attend. The level of assistance should continue to be based on the cost of getting to the nearest provider.

RECOMMENDATION 10.5

The Australian Government should develop best-practice guidelines on how general practitioners (GPs) and other referrers should support patient choice when making a referral or diagnostic request. These guidelines should be designed with the relevant professional bodies, and form part of a broader strategy to help GPs and other healthcare providers implement recommendations 10.1 to 10.4.

RECOMMENDATION 10.6

The Australian Government should undertake an evaluation of the choice reforms proposed in recommendations 10.1 to 10.5, five years after they commence operation.

Information to support patient choice and self-improvement by healthcare providers

RECOMMENDATION 11.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the (soon to be negotiated) successor to the National Health Reform Agreement, with the aim of better supporting patients and their general practitioners to exercise patient choice, and encouraging performance improvement by service providers. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in recommendation 11.2
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals (including outpatient clinics), specialists and allied health professionals, unless it is clearly demonstrated that releasing the data would harm the interests of patients or breach requirements to protect privacy
- make the information that a jurisdiction publicly releases on hospitals, specialists and allied health professionals available in a format that other organisations can readily incorporate in advisory services they provide.

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

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that specialists are required to participate in public information provision in order to be eligible to provide any service that attracts a Medicare benefit
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision.

RECOMMENDATION 11.2

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

- draw on lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England
- be based on market research on who would use an improved MyHospitals website, how their needs and health literacy vary, what indicators are useful to them, and how they could be informed by using best-practice approaches to presenting health information online
- put greater emphasis on reporting outcomes, such as by publishing patient-reported outcome measures and clinical outcomes such as readmission rates
- include reporting on waiting times at individual public outpatient clinics and ratings for the quality of end-of-life care and other services in hospitals (similar to ratings published by England's Care Quality Commission)
- phase-in reporting on individual specialists and allied health professionals as data become available, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.

RECOMMENDATION 11.3

The reforms detailed in recommendations 11.1 and 11.2 should be reviewed by the Australian, State and Territory Governments three years after the successor to the current National Health Reform Agreement comes into force.

Public dental services

RECOMMENDATION 12.1

State and Territory Governments should report publicly against a set of benchmarks of clinically-acceptable waiting times for public dental services, split by risk-based priority levels. Reporting should commence as soon as possible. Governments should also make these benchmarks consistent across jurisdictions as soon as practicable.

To facilitate user choice, provider-level reporting should be published monthly. To facilitate performance monitoring, aggregate measures should be included in public dental services' annual reporting processes.

RECOMMENDATION 12.2

The Australian, State and Territory Governments should establish outcome measures for public dental services that focus on patient outcomes and include both clinical outcomes and patient-reported measures.

Governments should build on the work done by Dental Health Services Victoria on outcome measures, with a view to developing and implementing a nationally consistent outcomes framework.

RECOMMENDATION 12.3

State and Territory Governments should implement comprehensive digital oral health records for public dental services as soon as practicable. Once implemented, these systems should be incorporated within the My Health Record system.

RECOMMENDATION 13.1

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

- risk-weighted capitation payments for preventive and restorative services for enrolled patients that incentivises the provision of clinically- and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)
- outcome payments, incorporating payments for clinical and patient-reported outcomes
- activity-based payments for urgent and more complex treatments (such as dentures). The dental treatments that would be eligible for activity-based payments should be limited to those that cannot be readily brought within the capitation payment.

State and Territory Governments should ensure that under the scheme:

- patients are offered choice of provider (public or private clinic) who will care for them for a defined enrolment period of three years
- users are able to change provider in certain circumstances, such as when moving city.

RECOMMENDATION 13.2

The Australian Government should direct the Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, to immediately commence development of:

- a costing standard for public dental services
- efficient prices for consumer-directed care payments.

RECOMMENDATION 13.3

The Australian Government should introduce a new blended payment model for the Child Dental Benefit Schedule once the consumer-directed care scheme has been finalised. As described in recommendation 13.1, under the blended payment model participating providers should receive:

- risk-weighted capitation payments for preventive and restorative services for enrolled children
- outcome payments, incorporating payments for clinical and patient-reported outcomes
- activity-based payments for urgent and more complex treatments that cannot readily be brought within the capitation payment.

The Australian Government should replace the existing capped benefit with a capitation payment that is weighted to reflect the oral health care needs of eligible children.

RECOMMENDATION 13.4

State and Territory Governments should provide access to consumer-directed care through a risk-based allocation model.

Under the allocation model, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease.

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

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

RECOMMENDATION 13.5

State and Territory Governments should establish effective commissioning processes for public dental services for those population groups who are not able to choose between alternative providers. This would include introducing:

- service planning aimed at addressing users' needs
- greater contestability where a consumer-directed care approach is not feasible
- an outcomes framework which focuses on users' oral health.

Reforms should commence as soon as practicable following the development of outcome measures (recommendation 12.2).

RECOMMENDATION 13.6

The Australian, State and Territory Governments should transition to a consumer-directed care approach to providing public dental services by first establishing initial test sites before a staged rollout.

- Test sites should commence following the development of outcome measures (recommendation 12.2), and evaluate new blended payment and allocation models.
- Transfer of the Child Dental Benefit Schedule to the blended payment model should be an early priority of the rollout.