

Submission by the Tasmanian Government

Productivity Commission

Reforms to Human Services Issues Paper



Tasmania
Explore the possibilities

Productivity Commission Inquiry into Introducing Competition and Informed User Choice into Human Services

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Reforms to Human Services Issues Paper

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I Introduction

The Tasmanian Government is pleased to provide this submission to the second stage of the Productivity Commission's Inquiry into Introducing Competition and Informed User Choice into Human Services (the Inquiry).

The Tasmanian Government welcomes the development of evidence-based policy options to improve the efficiency and effectiveness of human services for Tasmanians, including, where appropriate, through increasing competition, contestability and user choice.

The Productivity Commission's *Reforms to Human Services Issues Paper*, December 2016, (the Issues Paper) contains a number of requests for information relating to potential reforms in the six priority areas identified by the Commission in Stage I of the Inquiry. The priority areas are social housing, public hospital services, end-of-life care, public dental services, commissioning family and community services and human services in remote Indigenous communities.

This submission builds on the Tasmanian Government's submission to Stage I of the Inquiry and does not attempt to address every request for information made by the Commission. It provides some general comments on how to increase user choice, introduce greater competition and contestability, and the role of Government stewardship.

The submission provides information on Tasmania's experience in the delivery of human services across the priority areas and comments on innovation and potential reform options for the Commission.

The submission also provides an explanation of some of the difficulties Tasmania's relatively small, dispersed population may present in increasing competition, contestability or user choice. These include:

- competition leading to an increase in turnover of service providers, resulting in a lack of continuity of care and personal connection with clients;
- competition acting as a barrier to cooperation and collaboration between service providers; and

- the potential that changes to the financial sustainability of non-government service providers will result in providers exiting the market with government needing to step in as a provider of last resort.

The Tasmanian Government Department of Health and Human Services (DHHS) plays a critical role in the delivery of human services in Tasmania across the Inquiry's priority areas. DHHS acts as a system manager – a steward and partner overseeing the provision of human services in the public, private and community sectors.

The Commission's objectives broadly align with the strategic direction outlined in recent DHHS strategies, including the *DHHS Corporate Plan 2016-2018* (which emphasises putting clients at the centre of what we do) and the *Healthy Tasmania Five Year Strategic Plan* (which seeks better health outcomes through informed communities).

Where required, the Commission has sought specific data or other detail directly from service delivery areas in DHHS – this information has been provided separately and is not included in this submission.

2 Increasing user choice

Underpinning the principle of increasing user choice is the need to ensure users have access to appropriate information that will allow them to make an informed choice. Tasmania continues to participate in reforms to improve data sharing and release, providing greater control for individuals over data that is collected on them.

Tasmania's rural and remote communities often have rapidly ageing populations, poor health status and lower levels of education. This can make choosing a provider or service (where they exist) difficult. However, in larger regional centres this may not be a problem where multi-clinician practice is standard.

One barrier to increasing user choice is health literacy. In 2006, the Australian Bureau of Statistics (ABS 4233.0 – Health Literacy Australia 2006) found that 59 per cent of Australian adults (63 per cent of Tasmanian adults) aged 15 – 74 years did not have adequate health literacy to meet the complex demands of everyday life. This has a significant impact on health outcomes, consumer rights and consumer participation in managing their access to health services – and this issue would likely apply equally in the human services space.

A high impact, sustainable approach to improving user choice in rural, regional and remote areas would be improving the health literacy of patients and consumers. A more health literate population can exercise greater judgement and understanding of the health system they interact with and the services they access and are referred to by clinicians.

There is also a need for innovation in service delivery. Telehealth consultations may support user choice, and are provided in some rural areas in Tasmania by both public clinicians and privately practicing providers. Telehealth options can work effectively, safely and efficiently when they are part of an integrated system, or where the patient has the literacy skills to successfully self-manage their care. The use of information technology can also support education, peer support and can be used to supplement other measures to maintain professional standards.

3 Introducing greater competition and contestability

Tasmania's small, dispersed population and remoteness creates a number of challenges to introducing competition and contestability. As in other states and territories, many of the human services identified for reform by the Commission – particularly social housing and family and community services – are outsourced to community sector organisations for delivery.

However, there are a relatively small number of community sector organisations established within Tasmania compared with mainland jurisdictions. It has proven difficult to attract new and established national community service providers to extend their service provision footprint and to establish their organisations in Tasmania. Limited supply of services is a particular issue in more rural and remote locations.

Experience in other countries (e.g. New Zealand) has found that competition and contestability can improve some areas of service provision in human and community services. Competition can determine an efficient price for service delivery, below which service quality would suffer. At the efficient point, price ceases to be a driver and service quality becomes the point of difference. Setting an efficient price may incentivise providers to compete with one another on the basis of service quality or attractiveness to niche groups, rather than price, to achieve the best outcomes.

Consideration should also be given to the impact of being required to compete for government contracts on a regular basis. Resulting changes to service providers may impact continuity of care, which is not always in the best interests of clients.

4 Government stewardship

The Tasmanian Government's *One State, One Health System, Better Outcomes* reforms have seen DHHS move away from a service provider role and instead solidify its role as system manager. As emphasised in the *DHHS Corporate Plan 2016-2018*, this role positions DHHS as both a steward and a partner in health and human services delivery across public, private and community sectors.

To facilitate governments performing the role of system manager in a changing human service marketplace, appropriate data should be available across all relevant services (including publicly funded private services). The provision of this data is essential if governments are to provide monitoring, evaluation, and feedback functions to ensure that standards of quality, sustainability and accessibility are met, and to inform ongoing improvement to services. Noting the need to support providers to report this information, appropriate resourcing would need to be available to allocate to the performance of these functions across a potentially increasing number of services in a growing market place.

Absence of established, standardised, mandatory reporting in certain areas of the health sector (such as private hospitals and private dental services - both subsidised by the Australian Government's Private Health Insurance Rebate) has been identified as a significant barrier to government's capacity to monitor, evaluate and feedback data to enable meaningful comparison between services.

A positive example of data sharing is demonstrated in the area of oral health (Chapter 8), with the majority of jurisdictions utilising the same client management system, which has enabled them to informally share operational data and benchmark against each other for a number of Australian Council on Healthcare Standards clinical indicators. This example further highlights the importance of having standardised data to enable comparison between like services, evaluate outcomes and foster continued improvement.

An outcomes framework can be used to measure and monitor the effectiveness of service delivery and reform, and should be supported by appropriate investment in information systems that support outcomes measurement and reporting. In 2014, DHHS introduced an Outcomes Purchasing Framework for all community sector services it funds. The Framework aims to achieve better outcomes by focusing on defining and measuring the changes to be achieved for clients and the community in grants administration and management. It is underpinned by a partnership approach to working with community sector organisations.

5 Social Housing

Increasing user choice

As the Commission notes in its Issues Paper, competition and user choice under any social housing model will be constrained by social housing supply. Demand for social housing currently exceeds supply across Australia, meaning many users face a significant wait to access social housing.

An Open Access Infrastructure model may be a viable model in Tasmania, given its alignment with reforms that are underway to integrate housing and homelessness systems. This approach may support improving user choice in the delivery of social housing. Under this model:

- applicants choose their tenancy manager;
- the tenancy manager accesses the asset by paying an access fee to the asset owner;
- the asset owner (State Housing Authority) maintains the asset and meets other ownership obligations by using this access fee payment;
- the tenancy manager charges rent to tenants that covers their costs and offers a margin; and
- lease agreements would be 12 months duration. The tenant has the choice to change their tenancy manager by offering notice prior to expiry of lease (e.g. three months).

For properties owned by state housing authorities, user choice could be improved by supporting applicants to make informed decisions about suburb preferences, bedroom numbers and other property requirements. Access to this information could be enhanced by an online self-service portal that enables applicants to enter their preferences. However, online access needs to be complemented by face-to-face and phone services to assist tenants with complex needs or reduced capacity to make informed choices.

Alternative models include:

- a Tenant Subsidy Payment model, where applicants would receive a payment which they can use to access social, affordable or private housing. This model needs further consideration and analysis given the supply constraints and the unknown funding risks to government. There is also a risk subsidies may have unintended consequences; and

- a Service Provider Competition model, where social housing service delivery is divested from state housing authorities to multiple community housing providers who operate across a number of areas and compete with each other. This model is already in part being delivered in Tasmania under the Better Housing *Futures* initiative, and is successfully delivering benefits to tenants and greater choice to applicants. However, the Open Access Infrastructure model could build on this and further increase choice and competition.

Introducing greater competition and contestability

The delivery of social housing in regional and remote areas of Tasmania can be challenging due to scale and availability of appropriate resources. It is inefficient for housing providers to operate across a dispersed area with small pockets of housing. This imposes significant costs on the organisation due to the distance and time it takes to manage inspections, allocations and maintenance services. It is also more difficult to attract and retain skilled staff and contractors to work in regional and remote areas.

In such areas, it may be more appropriate for services to be provided by a single organisation. Service quality, cost and equity of access can be overseen by government through both regulation and service agreements. Alternatively, government may be a service provider of last resort or provide a subsidy for an organisation to provide the services if they cannot be delivered sustainably.

Government stewardship

DHHS is introducing an Outcomes Framework for funded services, including homelessness and social housing providers to improve evaluation of these services and to foster collaboration.

In addition, significant reforms are underway to the national Specialist Homelessness Information Platform (SHIP) in Tasmania to integrate services across the housing and homelessness system and to report on performance indicators. The reforms being made to SHIP in Tasmania demonstrate the capacity of this system to be used as the central platform for service integration and performance-based delivery of housing and homelessness services.

Social housing supply

There are a number of issues that may make it difficult for community housing providers and the private housing market to provide social housing for those in need.

Community housing providers have had limited success in increasing supply to the level required to address shortages. Much of the supply owned and/or managed by community housing providers has been provided by state housing authorities through title/management transfer and other programs such as the Nation Building Economic Stimulus Program.

Financiers tend to take a risk averse approach to providing finance to community housing providers. Anecdotally, lenders do not want to be placed in a position where they become a mortgagee in possession and are forced to evict low income tenants. Subsequently the lending parameters set by financiers (including high loan to value ratios) make it difficult for community housing providers to access finance without significant equity or subsidies from government. It may also mean that community housing providers are better positioned to accommodate tenants on moderate rather than low incomes.

Allowing community housing providers access to low cost finance on long term tenure may support increasing supply. This is being explored under the Bond Aggregator model as discussed in the Affordable Housing Working Group¹'s Issues Paper (January 2016).

While private markets can be used to provide accommodation for social housing eligible households, the cost to subsidise these clients (i.e. the difference between the market rent and what a household can afford) tends to be higher than the comparative costs of direct social housing delivery. It can also be difficult to access the private rental market in an environment where vacancy rates are low and there is competition for residential supply, with demand for private rentals from more affluent households increasing private rental prices.

There are also supply constraints for people exiting social housing. The subsidies required to make private rentals affordable for many tenants are greater than Commonwealth Rent Assistance (CRA) payments.

¹ The Affordable Housing Working Group was established by the Commonwealth Treasurer under the Council on Federal Financial Relations to identify reform models and increase the provision of affordable housing.

Financial support models

Models to provide financial support for social housing households could focus on the demand side, supply side, or both.

Issues with demand side assistance include:

- that it does not in itself lead to more supply. Rental assistance can inflate overall rents and reduce the effectiveness of the assistance; and
- landlords in the private rental market may be resistant to rent their homes to low income earners.

Measures to ensure a demand side assistance scheme meets outcomes include:

- placing a cap on assistance, to avoid outcomes that arose in the United Kingdom where households received a benefit to meet the gap between their actual rent and an affordable rent, irrespective of how much that rent was. That scheme has now been tightened; and
- making assistance contingent upon the household achieving certain objectives (i.e. employment or training).

Given these issues, a subsidy model that deals with both the demand and supply side may be more effective. This may include landlord incentives to encourage the availability of lower rental stock for low income earners allied with a payment that bridges the affordability gap for tenants. Such an intervention may reduce the crowding out effect as caps could be placed on the level of rents that can be charged under such programs.

A key issue raised with respect to housing assistance is the apparent inequity of assistance between social housing tenants and those who are renting in the private market. CRA is a capped income supplement paid to eligible households, i.e. they must be in receipt of Centrelink income support. The amount of rent assistance payable is determined by household type, size, and rent payable. For every dollar of rent paid in excess of the relevant rent threshold for a household, 75 cents of rent assistance is paid, up to the applicable maximum rate. As CRA is capped, the amount of assistance may not be sufficient to make private rental affordable, indicating that perhaps CRA is capped inappropriately, particularly for some housing markets. A high proportion of private renters are still in housing stress, even after the benefit of CRA is accounted for.

Few households in social housing pay the market rate for their homes, as rent is calculated on income, i.e. capacity to pay. Households in social housing have their housing costs subsidised to a greater degree than CRA.

It should be noted however that entry into social housing is highly targeted - the profile of social housing tenants and private rental tenants in receipt of CRA is different. Due to their age, level of disability or other disadvantages, most people in social housing are totally reliant on income support. This contrasts to CRA recipients, who are less likely to be solely reliant on income support and more likely to have a greater connection with the labour market. While there is a discrepancy between the levels of assistance provided, that does not in itself suggest that social housing tenants are receiving too much assistance.

Provider selection

In selecting providers the following factors should be considered:

- Scale of organisation – organisations should be managing a minimum number of dwellings to be cost competitive;
- Policies and procedures demonstrating an ability to appropriately manage social housing tenants; asset management and maintenance capacity;
- Proper governance – organisations require skills based boards that offer a broad range of professional capabilities and experience; and
- Relationships with support organisations (providers, community groups) that can allow for referrals/opportunities for services to work closely together to benefit clients.

Evaluation of performance requires a broad range of data including information outlined in further detail under ‘data considerations’ below.

National Regulatory System for Community Housing

There is opportunity for the current National Regulatory System for Community Housing to work more seamlessly with organisations that operate across multiple jurisdictions. Jurisdictions may adopt a cautious approach to what providers do in other jurisdictions and how those activities may impact upon their own circumstances. Some providers have multiple registrations as a result.

A single system where providers hold national registration aligns with a recent report prepared by the Affordable Housing Working Group². The report outlines the benefits of such an approach.

Title Transfers vs Management Transfers

² Affordable Housing Working Group (2016) *Innovative Financing Models to Improve the Supply of Affordable Housing* Australian Government Council on Federal Financial Relations

Under the current system title transfers are used to facilitate the redevelopment and renewal of assets/communities. Issues with the use of title transfers include:

- ensuring assets can be used for social housing over the long term, preserving tenure security for residents;
- protecting the interests of financiers while ensuring that in the case of a default, assets are not lost to the social housing system;
- ensuring assets are used to meet the needs of the most vulnerable;
- loss of control from State to community housing providers whose objectives may not be completely aligned (i.e. they may sell down well located stock, allocate to middle income earners etc.); and
- ongoing subsidies are still required to retain assets as social housing.

Management transfers are used to improve the amenity of the portfolio and provide alternative management arrangements. Many issues with management transfers are associated with shorter term transfer periods, and may be resolved by having longer transfer periods (30-40 years). Identified issues include:

- the length of tenure for the organisations needs to encourage investment in the assets and be of sufficient length for financiers to lend on;
- ability to develop new supply can be limited by the length of tenure and access to land;
- tenure for tenants may be limited by the tenure period held by the provider;
- ensuring appropriate asset management plans are in place to avoid assets being returned to the State in poor condition; and
- commitment to undertake major upgrades or modifications may be restricted as the provider does not own the asset.

Data considerations

When implementing reforms to increase competition, contestability and user choice, data needed by governments to evaluate the effectiveness of reforms and design ongoing improvements includes:

- tenant satisfaction;
- allocations to those in greatest need;
- occupancy rates (including under occupancy) - to ensure assets are being utilised;
- cost of service per dwelling, to allow evaluation of whether costs are being well managed and competitive;
- condition of dwellings;

- asset amenity – that the amenities (e.g. kitchens, bathrooms etc.) are being upgraded and modified as required;
- location – to assess proximity to services;
- rental affordability;
- reasons for ending tenure, to assess the rate of evictions for poor behaviour etc; and
- tenant engagement with employment and training.

6 Public hospital services

Increasing user choice

System navigator roles can be effective in increasing user choice. However, experience suggests that these roles should be provided by an independent body that is not subject to service delivery and other organisational requirements and constraints – combining this role with service delivery creates significant complexity.

Cultural liaison services can also provide significant benefit to Aboriginal people. Liaison workers are particularly valuable in bridging knowledge and information gaps when they are embedded in teams working with patients and can help to build effective relationships between all those providing care and assistance to patients (e.g. public hospital services, patients receiving end-of-life-care).

In the case of ‘culturally and linguistically diverse’ communities, interpreting or liaison services are likely to fulfil an important role in ensuring people know about the options that are available to them.

The experience in Tasmania is that health care workers are frequently placed in the position of making judgements about whether capacity to make a health care decision is present using legislated criteria, while also recognising that a person’s choices (outlined in advance care plans or otherwise communicated) should be supported. Where capacity to make a health care decision is not present, the person who makes decisions for that person is required to act from a best interests position with the proviso that decisions made in advance directives are upheld.

In Tasmania, the Guardianship Board plays an important role where patients lack capacity to make a health care decision and where family and treatment providers cannot agree on what is in that patient’s best interests.

Tasmanian patients living in these rural, regional or remote areas often have to travel to regional service centres. To facilitate access to patients in such areas, Tasmania has a state-funded Patient Transport Access Scheme (PTAS) that provides financial help with travel and/or accommodation costs to Tasmanian residents who need to travel from their permanent residence:

- More than 50 km (one way) to the nearest oncology or dialysis treatment centre

- More than 75 km (one way) to the nearest appropriate specialist medical service or to access lymphoedema treatment.

The PTAS also assists with the travel and/or accommodation costs of an escort for patients under 18 or those who require assistance during treatment or while traveling.

Introducing greater competition and contestability

While there would be benefits to introducing competition and contestability in the delivery of public hospital services, it should also be noted that increasing competition can lead to a loss of economies of scale and the critical mass of procedures, with the result that efficiency gains can be lost in the delivery of health services. This would reduce opportunities to provide more services from a given health budget.

In Tasmania, introducing competition and contestability in respect of public hospital services would be challenging without specific rural remote funding incentives for service providers. This might also include funding to support smaller established and existing services to broaden their service provision in local areas.

In addition there is also the ever present challenge of the recruitment and retention of appropriately skilled staff to rural and remote areas in Tasmania. Incentives have been found to be useful in overcoming these workforce challenges.

In a purchaser/provider relationship, service agreements may be used to ensure competition and contestability does not limit collaboration between providers. The agreement between DHHS and the Tasmanian Health Service (THS - Tasmania's sole provider of public hospital services in Tasmania) seeks to encourage collaboration between the THS and alternative private providers where services can be delivered more effectively and efficiently.

However, from the purchaser's perspective (DHHS), the service agreement must make it clear that whether services are provided within the public or private system, the THS is expected to meet key performance measures in relation to the quality and effectiveness of these services. In relation to elective surgery, for example, if those performance measures cannot be met, DHHS can utilise private sector capacity directly through established contractual mechanisms (such as interstate private and public hospitals accessed through the Tasmanian Elective Surgery Panel, as discussed below).

In September 2015, DHHS undertook an initiative to address elective surgery waiting lists and introduce greater contestability by establishing a new Panel arrangement for purchasing elective surgery services from private hospitals in Tasmania and interstate (following an extensive competitive procurement process).

All previous initiatives had relied solely on increased funding of public hospitals and had not achieved the desired reduction in waiting times. The policy objective in this instance was not only to deliver additional activity directly through the private sector, but also to leverage improved performance from public hospitals via competitive pressure.

Experience and analysis indicated two problems associated with relying purely on the Tasmanian private hospital sector to deliver additional activity. Firstly, spare capacity for elective surgery in local private hospitals was limited; large volumes of procurement would quite quickly fill this capacity, and run risks of overheating the local market. Secondly, there is a very significant overlap between the individual surgeons operating in both public and private hospitals in Tasmania. This posed complex risks of conflict of interest and the potential for gaming of outcomes. As a result, establishing contracts with interstate hospitals or hospital chains was regarded as an essential objective of establishing the Panel. No competitive procurement of clinical services had previously been undertaken on this scale by DHHS.

Improving access and encouraging use of competitive purchasing arrangements (either through private sector contracting or the Panel) helped Tasmania achieve record levels of elective surgery in 2015-16, with the waiting list the lowest it has been since record collection began in 2005. Over the 12 months to 31 October 2016, the number of patients on the waiting list fell by 33 per cent from 8 836 to 5 908. Over the same period, the number of patients on the waiting list who had waited longer than clinically recommended fell 69 per cent from 3 706 to 1 138.

Increasing activity within the private sector increases short term surgical capacity within the public sector, in parallel with rebuilding capacity of public hospitals to undertake more activity, including complex surgeries that cannot be outsourced competitively. Rebuilding public capacity remains the focus for Tasmania in its elective surgery reform program. The aim is to ensure that patients do not wait longer than clinically recommended for their procedures.

Government Stewardship

Current information collection and monitoring systems, and publication platforms for performance data focus on traditional, state-run public hospital services. As a minimum, efforts to introduce greater contestability and competition into a market for publicly-funded hospital services will require extensively enhanced, mandated data collection, monitoring and reporting on private hospitals, with significantly greater transparency in the mandatory publication of performance and quality data on private health care providers. These enhancements would be essential to bring private hospital reporting to a level comparable to current public hospitals reporting, and to provide more meaningful comparative performance measures.

Current arrangements focus on reporting out-sourced work from the public system, rather than examining holistically the performance of the private hospitals undertaking this outsourced activity. This would need to change significantly if users are to be offered any meaningful informed choice between providers.

Experience elsewhere would also suggest that 'commercial in confidence' clauses on finance, performance or clinical information may not be appropriate where efforts are being made to increase competition in public hospital services. Provision of extensive transparency on all aspects of outcomes from private provider operating in a publicly financed hospital market would be essential.

With regard to gaining data on patient experience/user choice it is currently hard to see any alternative to extensive surveys of patients as a means of ascertaining:

- whether patients received any choice of care; and
- whether they valued this choice.

To evaluate the benefits of choice or competition to patients, it is therefore essential that more (and more sophisticated) surveying of patient experience be undertaken, and that resources are available to do so.

7 End-of-life care

Increasing user choice

There can be unpredictable and rapid changes in health status towards the end of life, creating stress for both patients and family members and impacting the system's ability to support user choice.

Tasmania is guided by the Australian Government's *National Palliative Care Strategy 2010 – Supporting Australians to Live Well at the End of Life*. This Strategy is scheduled for review in 2017, which presents an opportunity for policy development to support more informed user choice in end-of-life care.

States and territories have also endorsed the 2015 Australian Commission on Safety and Quality in Healthcare's *National Consensus Statement: Elements for safe and high-quality end-of-life care*, which provides recommended practices to support individual patient needs and preferences, such as place of care.

To support user choice, consideration may be given as to whether the best form of 'choices' might be offering different basic care models (e.g. hospice at home versus admission to a hospice facility), rather than asking patients and carers to try to choose between organisations providing only subtly different care offerings.

Although many health and community care providers are actively involved in the delivery of home and community care services and packages, at this time there are no dedicated palliative or end-of-life care packages.

Community palliative care packages have been trialled in Tasmania under the Australian Government funded Better Access to Palliative Care Program (Hospice@HOME). These arrangements are not for the provision of Specialist Palliative Care Services but are brokerage arrangements to 'top-up' existing service arrangements. The Australian Government is undertaking an independent evaluation of the success of this program in achieving its objectives to improve patient care through better access to in-home, community based end of life services.

Under the previous Home and Community Care Program and current Commonwealth Home Support Scheme, palliative care or end-of-life care is not prioritised for access to services under the existing eligibility criteria.

There is also limited access to funding to support the delivery of end-of-life care in residential aged care facilities. Under the current residential aged care service

provider arrangements with the Australian Government, funds are allocated for terminal care (usually the last few weeks of care). There are no incentives or arrangements in place to support and facilitate end-of-life care planning and service delivery in these settings.

Introducing greater competition and contestability

In introducing greater competition and contestability in the delivery of end-of-life care in Tasmania, it is important to avoid development of more service locations and providers than is necessary. Instead, competition might be provided by training more health care providers (doctors, nurses or allied health workers) in end-of-life care, noting this could improve user choice by providing access to a greater number of providers. However in some areas with few providers it remains unlikely competition would feature strongly.

If competition and contestability is increased, collaboration may be supported through funding incentives that promote initiatives such as shared care plans and case conferencing.

Government stewardship

Outside of the acute care setting there are currently no established standardised, mandatory data sets or reporting requirements in place for end-of-life care. This issue could be addressed through the development and implementation of an end-of-life care or palliative care National Minimum Data and Performance Reporting Framework. This could be included in service agreements and linked to funding arrangements. Information systems developed or utilised to support end-of-life care delivery would need to include data capture and reporting capacity.

8 Public dental services

Increasing user choice

It is well recognised that those at highest risk of poor oral health are least likely to access preventive dental care. Therefore public dental services expend significant resources trying to reach these clients, who have complex needs or a reduced capacity to make informed choice.

For example, using the Socio-Economic Indexes for Areas (SEIFA) and Index of Community Socio-Educational Advantage (ICSEA) ratings, Oral Health Services Tasmania (OHST) provides outreach screening and preventive programs to schools in identified communities. Through these programs, services can be provided to children who have not previously accessed care, or who have not accessed for some time. In some instances, OHST partners with other community workers to try to ensure the children are brought for care (e.g. Child and Family Centres, Salvation Army).

Resources are put into providing training, education and support for those most likely to be regularly interacting with clients with complex needs, e.g. midwives, GPs, pharmacists, aged care workers, school nurses, child and parenting service staff and students in those fields.

In an environment where high risk individuals are required to identify the need for care and put in place the actions required to access it, there is a risk that many will not receive necessary treatment in a timely manner leading to increased health impacts and cost (e.g. need for general anaesthetic for young children to receive extractions).

The Australian Government funded Dental Relocation and Infrastructure Support Scheme which aims to encourage private dentists to relocate to regional and remote areas has seen dentists relocate to Brighton, Cape Barren Island, Claremont, Deloraine, Flinders Island, Kings Meadows, Moonah, New Norfolk, Shearwater and Sorell (according to the Rural Health Workforce website). OHST also has lease agreements in place for private dentists to utilise spare surgery capacity on King Island and in Queenstown.

Practice viability remains a challenge in these small communities, therefore enabling private providers to lease public clinics where there is scope to do so benefits both those eligible for public dental care (as the private provider can see public patients under outsourcing arrangements when they are visiting, increasing

their practice viability) and those seeking private treatment. In an environment based on competition, it would be important not to remove the incentive to continue such arrangements.

Introducing greater competition and contestability

Maintaining a viable practice within the more remote areas of Tasmania is a significant challenge. Within the public sector, the size of the service and the imperative to provide care to the entire eligible population means that services in remote locations can be 'cross subsidised' in the interest of providing equitable access.

Many of Tasmania's smaller, more remote communities would appear be of insufficient size and income level (i.e. they have a higher proportion of low income earners) to support a viable stand-alone private dentist practice.

In Tasmania, private dentists offering remote services tend to provide outreach services from their primary practice, utilising infrastructure owned by either the public dental service or, in some instances, local governments through lease agreements. These private providers avoid a capital outlay and generally supplement their private practice income by accepting public patients under contracted outsourcing arrangements.

The cost of establishing practices that cannot maintain a full time client load may prohibit greater competition in some areas.

There currently exists some collaboration amongst private dental providers in the provision of rostered after-hours services. However, increased competition may act as a disincentive for providers to collaborate.

Government stewardship

Public dental services collect a wealth of data, with almost all jurisdictions utilising the same client information management system thus readily enabling data sharing. Through regular national Dental Directors' networks, all jurisdictions already informally share operational data and benchmark against each other for a number of Australian Council on Healthcare Standards (ACHS) clinical indicators.

All jurisdictions also provide data to a dental National Minimum Data Set and have participated in the collection of data for the National Child Oral Health Survey (published in February 2017) and the National Adult Oral Health Survey (new data collection about to commence). Most jurisdictions also provide clinical indicator data to ACHS which is published in a de-identified form (although jurisdictions share the data with each other).

The Australian Government collects data from state and territory jurisdictions in relation to the minority share of public dental services that they fund. However, a large gap exists in data collection, monitoring, and evaluation in relation to services delivered in the private sector subsidised by the Australian Government through the Private Health Insurance Rebate.

With regard to consumer involvement in service design and evaluation in the public dental sector, mandatory accreditation against the National Safety and Quality Health Service Standards requires public dental services to demonstrate how they partner with consumers in the planning and evaluation of services (private dental providers are not required to undergo accreditation). Additionally, the National Oral Health Monitoring Group (which reports to the Council of Australian Governments and is tasked with monitoring progress against the National Oral Health Plan) includes consumer membership.

Access to care

To ensure equitable access to care, including for people living in remote areas Tasmania has implemented a statewide triage process and waiting list demand management strategies. OHST measures the proportion of the eligible population that accesses services by Local Government Area and at Area (suburb) level to ensure that access is equitable across the state for both children and adults.

Collaborative arrangements are also in place to utilise existing private practices to provide care to public patients. Despite the Commission's suggestion that these arrangements are short term efforts to reduce waiting lists, these are often long standing arrangements aimed at providing timely care as close as possible to a client's place of residence. OHST has contracts in place with around 60 private providers statewide and spends around \$3 million per annum in outsourcing.

If there were greater private sector provision of public dental services, mechanisms would need to be put in place to limit the potential for over-servicing and limit the provision of services for which there is little evidence of improved health outcomes.

For example, children accessing public services are currently 'risk assessed'. Recall timeframes are based on the child's individual risk status and range from six to 18 months, while private dentists routinely recall patients at six or 12 months regardless of risk.

Similarly, within the public sector, a range of clinical protocols exist to limit inappropriate and/or potentially wasteful provision of limited resources. For

example, dentures are not provided (other than for aesthetics if front teeth are missing) if a patient has functioning dentition; root canal therapy is only provided where there is likelihood of good prognosis (and clinical data regarding failure is collected and benchmarked against other jurisdictions); and the service operates a Minimum Intervention Dentistry model (an approach based on prevention, conservation of demineralised enamel and dentine, remineralisation, early arrest of disease, and minimisation of invasive intervention). High end or purely aesthetic services (such as teeth bleaching, veneer, and implants) are not generally provided within the public sector.

It is also important to avoid the potential for 'cherry picking' by providers, either through the choice of patients and/or treatments. There is a risk that some providers may provide only 'routine' treatments to the level of a cap and then leave the public sector 'safety net' to complete outstanding 'complex' treatment. Similarly, clients with additional complexities (those with disabilities, chronic conditions etc.) who are potentially more difficult and/or time consuming to treat (and therefore more costly) may be less likely to receive care from some providers.

Voucher schemes

Despite the Commission's assertion that these schemes are largely in place to utilise short term funding to reduce waiting lists, outsourcing is a key part of the OHST (and many other jurisdictions') service model. OHST has contracts in place with around 60 private providers (dentists and prosthetists) and currently expends around \$3 million per annum on outsourcing; prior to receiving Commonwealth funding, OHST expended around \$1 million per annum. Participation in the outsourcing schemes is available to all private providers who are willing to enter into a contractual agreement with OHST.

The Child Dental Benefit Schedule (CDBS), under which eligible children receive a capped entitlement to dental services which can be accessed in either the public or private sectors – is an example of an alternative mechanism that gives user greater choice between providers. In Tasmania, 76.8 per cent of CDBS benefits in 2015-16 were paid to the public sector (OHST), in contrast to the Commission's quote that 'almost 80 per cent of CDBS claims have been for services provided in the private sector' across Australia.

Dental workforce

The Commission's Study Report of November 2016 (p126) demonstrates the greater use of the broad oral health workforce within the public sector. As more Oral Health Therapists qualify with a full adult scope of practice, public

sector services will adjust their models of care to make even greater use of these professionals. The vast majority of children's services within the public sector are already provided by dental or oral health therapists with referral to dentists only for treatments outside their scope whereas the majority of services delivered within the private sector are provided by dentists.

There exists the potential to make greater use of the VET trained dental assistant workforce (and other non-dental health workers such as Aboriginal health workers, aged care workers, child and family nurses) in the delivery of some oral health promotion and prevention activities. With legislative change and additional training dental assistants would be well placed to provide some basic preventive treatments such as fluoride varnish programs.

It is also noted that despite Tasmania having no dental school, approximately 10 per cent of graduating dentists in Australia undertake placements in Tasmania in their final year.

The public sector has a significant role in the training of the professional dental workforce through providing traineeships to dental assistants, dental technicians, and prosthetists.

At present, graduating Oral Health Therapists have significantly different scopes of practice depending on the University at which they trained. Incorporating these professionals into a model of care is complicated by this issue and greater consistency (without limiting scope of practice) would be welcome.

9 Commissioning family and community services

Increasing user choice

In selecting approved providers in regional and remote areas, consideration of a range of factors (other than price) can ensure the needs of the local community are taken into account and that services represent value for money. Funding for rural services may require development of a specific funding model. Modelling should also consider the possibility that providers may be unwilling or unable to cover some areas, and there may not be choice.

Introducing greater competition and contestability

The shortage of service providers in Tasmania means that demand exceeds supply, allowing some providers to 'cherry pick' their clients – typically clients with less complex needs are chosen (this has been experienced in aged care and employment assistance programs). This can impact overall service availability to clients with more complex needs or those in remote locations.

The requirement to compete for government contracts on a regular basis also presents some challenges, including:

- increased burden on smaller providers, who become overwhelmed with the process and withdraw services – resulting in reduced community access; and
- maintaining continuity of care – changes to the organisation/staff dealing with intimate services or highly complex health care on a regular basis is not a situation that works well for client outcomes.

The implementation of the National Disability Insurance Scheme (NDIS) in Tasmania has shown that competitive markets can be difficult to achieve. It also highlights an emerging trend in Tasmania towards less diversity in the provision of some services, with some fields characterised by a few large service providers.

It is also worth noting that small, specialised providers have an important place in the market. A small provider providing a niche service can often be achieving impressive client outcomes, which may not be as readily reached if a large provider took over responsibility for the same service.

The *State of Tasmania's Community Services Sector 2015* report (Cortis and Blaxland 2016) highlights that the human services sector includes a number of

small niche organisations making specialist, localised contributions. Some organisations surveyed as part of this report felt that competition and competitive funding models have undermined the sector's collaborative ethos. However, competition and contestability may provide incentives for smaller organisations to collaborate to allow them to compete on a more equal footing with larger providers.

Government Stewardship

Monitoring, evaluation and feedback functions need to collect and report not only on service activity, but more importantly, on client outcomes. Data measurement and collection needs to evolve to place client outcomes at the centre of government and provider performance, while also maintaining current activity level data collection.

Tasmania's experience implementing an outcomes framework has validated experience elsewhere that indicates outcome measurement requires cultural and practice change and significant attention is required to enable and support change. There also needs to be investment in appropriate information systems to support outcomes measurement and reporting. Information about outcomes needs to be accessible to service users and the broader community to support greater user choice.

Even nationally agreed measurements are interpreted differently by different states and territories and different institutions; these points of potential departure could be identified and form part of a national moderation process.

When designing any monitoring, evaluation and feedback mechanism, government needs to consider the increasing reporting burden on service providers and the need for consistency across different government funding bodies. The DHHS Outcomes Purchasing Framework was designed to align with the Australian Department of Social Services' new approach to program performance reporting, Data Exchange, launched in July 2014.

Involvement of providers and clients early and throughout the policy and program design process will better inform governments. This process should involve stakeholders in the co-design of policy and program evaluation methods, including the collection of evaluation data post program and policy implementation. Experience in Tasmania highlights the need to improve this approach. Lack of support for people with complex needs has been experienced in implementing aged care reforms, and it is noted that this could potentially have been addressed at the system design stage.

Options to improve commissioning arrangements to ensure services achieve intended outcomes for users include:

- Exemptions from the tendering model for services providing highly complex care. In such cases it can be difficult to transfer between services and transfer the client's history. Breaking relationships and trust between clients and providers and their staff who are involved in intimate and/or complex care because a contract has been lost is not an optimal outcome for the client.
- Ensuring that fee for service funding does not incentivise providers to undertake activity where it is not needed in order to gain income.
- Investment in resource and education in governance to enable small providers to respond to the rigours of the market approach to service provision.
- Ensuring services set up for complex clients should not have to compete with services catering to the majority of clients who will not be complex to support. Focusing only on one group of service requirements to the detriment of another when building a commissioning framework can result in a deterioration of service access in transition phases. The framework should include both sets of need – not be designed for one need and adjusted for the other.

Duplication of set up costs and the reduced investment in infrastructure as a result of uncertainty occur where the future of an organisation is not predictable – these divert funding and quality outcomes away from service delivery.

Larger nationally focused organisations have not always invested in Tasmania when contracts have been awarded to them. For example, the rollout of the aged care reforms have resulted in some (not all) nationally based providers who have won contracts in the State seeking to manage services without a local presence and this has impacted on the availability of services and their quality. There is a risk of this extending to other areas of community service delivery as contestability increases.

10 Human services in remote Aboriginal communities³

Tasmania's Aboriginal and Torres Strait Islander population resides in all regions of the State. The most rural and remote Aboriginal communities are located on the Bass Strait islands and in the north-west of the state. They tend to be communities within larger rural and remote communities, with the exception of Cape Barren Island, which is a very small and very remote community.

Increasing user choice

It is noted that in rural and remote areas of Tasmania, the State acts as a provider of last resort across a range of service areas. As a result, there are few opportunities for users to exercise informed choice.

Tasmania's remote communities require considerable support from outreach services, including fly in/fly out (FIFO) clinicians to the Bass Strait islands. However, unless effort is put into ensuring integration with local service systems and the THS, FIFO has the potential to fragment the patient experience of the health system and increase costs to the public system if the patient is referred to a hospital interstate.

In addition, follow-up care and referral may require that the patient travel to mainland Tasmania or interstate for high-level services or hospital services, adding significantly to the cost of health care for those individuals and families, even when subsidies are available for patient travel. Time away from employment, sick leave and lost productivity also contribute to the cost of health care.

Initiatives to support user choice through improving health literacy may work well in the Tasmanian context. Greater choice and contestability can also be achieved in a sustainable way and with high impact by supporting the agency of people in remote communities, including the Aboriginal population. Providing remote community members a greater role in how clinicians or hospital management are appointed or renewed is important but to be successful requires strong ability in health literacy for the requisite decision-making. Attempts at improving health literacy are currently fragmented and generally target specific conditions or aspects of health services.

³ The Tasmanian Aboriginal community prefer to be referred to as Aboriginal people rather than Indigenous or Indigenous and Torres Strait Islander people. As a result the Tasmanian Government uses the term Aboriginal rather than Indigenous.

Introducing greater competition and contestability

The recruitment of appropriately skilled staff to rural and remote areas in Tasmania is an ongoing challenge and restricts the potential for competition and contestability. Incentives have been found to be useful in overcoming these challenges. Increasing the scope of practice for some professions in remote communities may provide an opportunity to increase competition. The use of information technology for education and peer support can also be used to supplement other measures to maintain professional standards in the delivery of services in remote communities.