

Submission

Productivity Commission, Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Draft Report.

<http://www.pc.gov.au/inquiries/current/human-services/make-submission#lodge>

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Little Company of Mary Health Care Limited, trading as Calvary, appreciates the opportunity to give feedback on the *Productivity Commission, Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Draft Report*.

Calvary is a charitable Catholic not-for-profit organization with more than 12,000 staff and volunteers, 15 public and private hospitals, 17 retirement and aged care facilities, and a national network of

Our Services

Australian Capital Territory (ACT)

- Calvary Public Hospital Bruce
- Calvary Public Hospital Bruce - Clare Holland House Campus
- Calvary Bruce Private Hospital
- Calvary John James Hospital
- Calvary Haydon Retirement Community
- Community Care Service Centre - Bruce

South Australia (SA)

- Calvary Adelaide Hospital
- Calvary North Adelaide Hospital
- Calvary Wakefield Hospital
- Calvary Wakefield Surgicentre
- Calvary Rehabilitation Hospital
- Calvary Central Districts Hospital
- Calvary Flora McDonald Retirement Community
- Calvary St Catherine's Retirement Community
- Community Care Service Centres - Adelaide, Port Augusta, Victor Harbor Goolwa

Tasmania (TAS)

- Calvary Lenah Valley Hospital
- Calvary St John's Hospital
- Calvary St Luke's Hospital
- Calvary St Vincent's Hospital
- Community Care Service Centre - Launceston



New South Wales (NSW)

- Calvary Riverina Hospital
- Calvary Riverina Drug and Alcohol Centre
- Calvary Riverina Surgicentre
- Calvary Mater Newcastle
- Calvary Health Care Kogarah
- Calvary Ryde Retirement Community
- Calvary Retirement Communities Hunter (12 locations including Muswellbrook)
- Calvary Cessnock Retirement Community
- Community Care Service Centres - Sydney, Taree, Wagga Wagga (also respite care), Newcastle (also respite care and a social centre), Lake Macquarie, Forster (respite care only), Albury (respite care only)

Victoria (VIC)

- Calvary Health Care Bethlehem
- Calvary Community Care Head Office
- Community Care Service Centres - Melbourne, Gippsland, Shepparton

Northern Territory (NT)

- Community Care Service Centres - Darwin, Alice Springs, Bathurst Island

Community Care centres. We operate across six states and territories within Australia.

Since the establishment of Calvary in Sydney in 1885, with the arrival of the Sisters of the Little Company of Mary in Australia, Calvary has provided health care to the most vulnerable, including those reaching the end of their life. We provide aged and community care, acute and sub-acute care, specialist palliative care and comprehensive care for people in the final years of their life.

In 2016/17 our hospitals recorded 199,518 admissions; we looked after 443,942 outpatients and managed 116,390 emergency department presentations. We cared for 20 residents over the age of 100 and 359 residents over the age of 90 with 770 *new* admissions to our retirement communities. We proved 1.2 million average annual hours of community or home-based care.

Please find attached our submission for your consideration.

Yours faithfully,

Mark Doran

National Chief Executive Officer

Little Company of Mary Health Care Ltd

PRODUCTIVITY COMMISSION INQUIRY INTO INTRODUCING COMPETITION AND INFORMED USER CHOICE INTO HUMAN SERVICES

Submission of Little Company of Mary Health Care Ltd in response to the Draft Report

Commission's Key Points (from the Draft Report)

- This inquiry is about finding ways to put the people who use human services, such as health care, social housing and family and community services, at the heart of service provision. This matters because everyone will use human services in their lifetime and change is needed to enable people to have a stronger voice in shaping the services they receive, and who provides them.
- Competition and contestability are means to an end and should only be pursued when they improve the effectiveness of service provision.
 - This report sets out the Commission's proposed reforms for: end-of-life care services; social housing; government-commissioned family and community services; services in remote Indigenous communities; public hospitals; and public dental services.
 - The Commission's proposed reforms vary according to the purposes of the services in question, the settings where they are accessed and, importantly, the users themselves.

Calvary Response

Thank you for the opportunity to make comment on the Productivity Commission Draft Report: *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, June 2017*.

In general we support the work of the Commission to improve access to high quality human services, regardless of their means or circumstances. We agree that this will lead to enhanced social cohesion, equity and improvement in the welfare of the community as a whole.

We would also like to applaud the Commission's focus on the most vulnerable in our communities – those approaching or reaching the end of life, those suffering social, family or financial hardship, and indigenous peoples, particularly those living in remote communities. These are areas where it is essential that systems are designed around the needs of users and the wider communities within which they live.

The tools the Commission has been requested by the Australian Government to use to recommend reforms to human services in the six identified areas – that is user choice and competition and contestability – create both opportunity and risk. We are thankful for the opportunity to provide comment.

The principle of user choice.

Calvary supports any reform that starts with the principle of informed, inclusive choice. Quite rightly the Draft Report identifies the reality that some users may not be in a position independently to exercise that choice at an appropriate time. The current understanding of user choice has been

restricted to one that is based on autonomous decision making – and yet there are many examples where this has not been an effective mechanism to deliver quality care. The Draft Report’s acknowledgement of alternative mechanisms for inclusive service design, development and delivery offer an opportunity to address some of the barriers that have plagued attempts to move to more person-centred care models. In particular we support the suggestions for increasing ‘user voice’ and co-design methods to ensure that community preferences are at the centre of decision-making.

Competition and Contestability

Competition and contestability are only one means to the desired end point of improving service effectiveness. In the right circumstances these can be, as noted in the Draft Report, powerful market drivers. There can, however, be unintended consequences in the absence of equally strong and robust measures of quality and outcome. In the area of social reform the development of these measures is challenging and there are no universally accepted tools. For example, while we may describe the intended outcome as improved benefits we have only partial and immature understandings of what these benefits should be – and therefore inadequate or absent mechanisms to ensure that they are measured alongside more clearly defined measures of efficiency and cost.

Calvary has observed – following the introduction of Consumer Directed Care (CDC) in the home care sector – that the mere introduction of competition does not necessarily increase the quality of the service offered and performed nor guarantee an improved outcome for the individual.

Competition and contestability have led to some competitiveness with respect to price; but there is a risk that this competitiveness in price may result in a race to bottom with respect to the quality of care offered and in attaining an outcome of greater user well-being. For instance, a service provider may cut their price by eliminating case management fees and case management, a component that consumers don’t visibly value. Without an expert who helps them, how does a vulnerable person navigate, find and negotiate their way to acquiring the best services commensurate with increasing their wellbeing or other goals? A person in need of some home care might, for example, decide to buy several hours of cleaning, some help shopping and some help showering. In order to deliver this service, the provider is not required to offer any case management. Without case management, however, without looking at the needs of the whole person, the provider of home care will not detect that the same person is experiencing isolation and loneliness. The provider will not work with their client to resolve this problem, reconnect with family members or social groups and later help the client resolve other problems that may arise, for example reasonably priced nursing care.

The introduction of tools, like Consumer Directed Care, needs to be monitored and evaluated. What is happening to people? What impact does the tool have on consumers? Are they better off? Measures which draw on the principles of competition and contestability need to be tested. If there is no evidence that they have improved service provision, if those who use the human services are no better off, the appropriateness of competition and contestability, as the most apt means to achieve the end, needs to be reviewed.

We will explore some of the issues related to the use of these specific tools in our response to the Commission’s recommendations below.

End-of-life care

Commission’s Key Point

- Each year, tens of thousands of people who are approaching the end of life are cared for and die in a place that does not reflect their choice or fully meet their **end-of-life care** needs. Most people who die do so in two of the least preferred places — hospitals and residential aged care.
 - More community-based palliative care services are needed to enable more people who wish to die at home to do so.
 - End-of-life care in residential aged care needs to be better resourced and delivered by skilled staff, so that its quality aligns with that available to other Australians.

Calvary Comment

Calvary appreciates the Commission’s discussion of and acknowledgment of the distinctions between end-of-life, end-of-life care and palliative care in Section 3.1 of the draft report, *What is end-of-life care?*¹

Preferred places of death

There has been a great deal of work undertaken in Australia over the preceding three decades to definitively determine peoples’ preferred places of death. The reality is that despite these many attempts through research, policy and survey we have no clear universally accepted understanding of what choice people would make or what might influence their choice. We know that choices, and influencing factors change over time and with circumstances and that simplistic approaches, bounded by procedural or policy requirements, can be both ineffective and potentially harmful.

Choices about end of life care are often negotiated rather than independent, particularly when they relate to place of care and/or death. Family and social circumstances have to be taken into account and care-giver burden (and benefit) is a key consideration.

While the evidence that points to home as the preferred place of death appear to be preferentially accepted by policy makers and funders for reasons that address desired system rather than individual challenges and choices – there is a substantial body of evidence that suggests that a significant proportion of people with a life-limiting illness, their carers and families, who do not prefer home as their place of care.

Calvary agrees with Commission that the delivery of high quality end of life care to people living in residential care facilities should be understood to be a core requirement.

¹ Calvary makes similar definitional distinctions.

End of life refers to that period of time when a person is living with an advanced, progressive, life limiting illness and likely to be in the last 6 to 12 months of their life.

End of life care is care provided to people who are approaching and reaching the end of their life. This care can be provided by all health and community care professionals, regardless of where they work in health, community, specialist palliative care or aged and retirement care services.

Palliative care refers to designated specialist services provided by an interdisciplinary team of specialist palliative care professionals whose substantial work is with patients who are approaching the end of their life.

DRAFT RECOMMENDATION 4.1

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

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

Calvary Response

As the projected proportion and absolute number of people approaching or reaching the end of their lives in our communities is expected to increase over the coming decades, there will be a need to continue to monitor the escalation rate and ensure that service funding and provision is able to meet those needs.

There is also a need to review current models of care to deliver better person-centred, integrated care. This needs to be established on the basis that regardless of previously expressed choices or preferences people approaching or reaching the end of life will continue to require access to **a range of home-based, community and hospital services**. The delivery of high quality, person-centred care at the end of life needs to be understood as a universal social not just health accountability. State and Territory Governments should be charged with the responsibility, in accordance with their stewardship functions, to ensure that people are able to move between the various care providers in accordance with their needs and changing preferences and choices.

Calvary has been involved in a number of jurisdictions with public sector, general practice and community representatives to establish co-designed integrated care models that facilitate needs based care delivery to people in the last year of life. These models create virtual service alliances that put individual patients and the families and carers in the middle and deliver highly responsive services based on person-centred, shared goals of care. *We are happy to share information about these models of care with the Commission.*

The Draft recommendations focus on only one component of the required integrated care system and may have an unintended consequence of degrading the required resources and capabilities in other parts of the health, social and aged care systems.

There have already been a number of initiatives that have attempted to improve community based access to care and increase the rate of home or out of hospital death. These have included multi-million dollar investments in the provision of home care packages and education programs. While helpful, these initiatives have failed to make any substantial shift in the rate of in-hospital death.

Simply continuing to increase resource inputs without a clear understanding of the actual needs and requirement (in terms of both quality and quantity) is likely to at best to delay hospital admission and potentially increase family and carer, and overall community, burden.

Calvary submits the most important principle is that people approaching or reaching the end of life have access to **a range of home-based, community and hospital services**. Then people can choose the care that is best for them at right time and in right place.

DRAFT RECOMMENDATION 4.2

The Australian Government should:

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

Calvary Response

Calvary supports this recommendation. Almost 40% of people admitted into a Residential Aged Care Facility will die within 12 months of admission (and almost half of these will die within 3 months). This means that at any given time, and despite the current system of resident needs classification (ACFI), 40% of the residents are in their last year of life. It is unacceptable that the needs of people living in residential care facilities are not addressed at the same levels as are those of people living in the community.

DRAFT RECOMMENDATION 4.3

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

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

Calvary Response

Calvary supports the notion that individuals should be assisted to consider and share their goals and preferences for care. Simplistic approaches to advance care planning such as that set out in Recommendation 4.3 have, however, been demonstrated, over many decades of work, to have made little impact.

What is understood is that people's preferences and plans change. What is central to the delivery of high quality care, in any circumstance – but particularly as people approach and reach the end of their life – is **communication, honesty and clearly understood purposes and goals**.

The introduction of any initiative that improves the opportunities for the general community, health, social or aged care staff to be empowered and resourced to initiate and support conversations that allow for honest and open sharing of information, communication of goals and preferences and development of shared understanding of approaches to care can only ever be supported.

DRAFT RECOMMENDATION 4.4

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

Calvary Response

End of life care as previously stated should be mandated as a core requirement of all residential aged care facilities and should be incorporated into the Quality of Care Principles.

More importantly Residential Aged Care Facilities should be required to ensure that facilities adequately resource and staff the provision of care. At a minimum this should require that all Residential Aged Care Facilities have a registered nurse rostered on duty 24 hours a day seven days a week.

There is a risk, if completion of an end of life care plan (or as more commonly practiced – directive) is mandated as an entry requirement, older people will feel pressured or coerced. This is particularly true if the focus of the advance care plan is on transfer to hospital or withholding withdrawal of treatment. In accordance with the comments in relation to Recommendation 4.3 above **the ongoing communication around goals of care, their clarification and/or amendment should be the focus of any recommendation and mandated requirement – rather than the completion of a document at any single point of time.**

DRAFT RECOMMENDATION 4.5

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

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

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

Calvary Response

Calvary supports this recommendation.

The collection of data has been predominately based on administrative coded data (AIHW) or specialist palliative care data (PCOC). Data collection approaches, methodology and definitions need to include whole of system data capture. The current absence of comprehensive population based data biases policy and funding decisions towards those problems which are visible through the acute hospital lens.

Social housing

Commission's Key Point

- The **social housing** system is broken. The current two-tiered system of financial assistance for people who live in social housing or the private rental market is inequitable, and limits tenants' choice over the home they live in. The system would be improved if a single model of financial assistance applied across social and private housing, based on an increase and extension to Commonwealth Rent Assistance.
 - Social housing should continue to provide a home for people who are not well placed to rent in the private market.

DRAFT RECOMMENDATION 5.1

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

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

DRAFT RECOMMENDATION 5.2

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

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

DRAFT RECOMMENDATION 5.3

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

DRAFT RECOMMENDATION 5.4

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

DRAFT RECOMMENDATION 6.1

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

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

DRAFT RECOMMENDATION 6.2

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

DRAFT RECOMMENDATION 6.3

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

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

DRAFT RECOMMENDATION 6.4

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

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

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

Calvary Response

Calvary generally supports the Commission's recommendations. Calvary provides home care to many people who simply can't afford to access housing through the private rental market and at the same time do not wish to live on government-funded properties. Recommendations 5.2 and 6.3 may be particularly attractive for them.

In relation to Recommendation 6.3, Calvary encourages the Commission to give some thought to two further areas. People's need for tenancy support services and support to exercise choice will also vary as they age and as they approach end-of-life. How do people who may be eligible for a high-cost housing payment (5.2) transition to a Residential Aged Care Facility, if this is their choice and need?

An additional reform, which may also benefit people who are living in aged care facilities, could be to remove the limitations in legislation like *Retirement Village Act* in each state which preclude people under 55 and people with disabilities living among the residents of these facilities. Multi-generational housing may reduce isolation aged cohorts experience and increase the housing choices available to those eligible for high-cost housing payments who have additional needs and/or assist families to remain closer together.

Family and community services

Commission's Key point

- **Family and community services** are not meeting the needs of people experiencing hardship. The system is designed for the convenience of governments, not people. Practical changes to system planning, provider selection and contract management could shift the focus to improving outcomes for people who use these services.

DRAFT RECOMMENDATION 7.1

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

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

DRAFT RECOMMENDATION 7.2

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

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

DRAFT RECOMMENDATION 7.3

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

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

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

DRAFT RECOMMENDATION 7.4

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

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

DRAFT RECOMMENDATION 7.5

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

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

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

DRAFT RECOMMENDATION 7.6

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

DRAFT RECOMMENDATION 7.7

The Australian, State and Territory Governments should:

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

Calvary response

Calvary generally supports these recommendations. While recognising that the services discussed by the Commission in this section address a range of circumstances, including crisis support, transitional support, building capability and early intervention and prevention (for example, services for family support, homelessness, family and domestic violence, alcohol and other drugs and settlement support), Calvary is mindful of Australia's burgeoning aging population between 2020-2050. The types of crisis and transitional support being offered will have to take account of this fact.

The focus in this section on user-focused outcome measures contrasts with some models of consumer directed care which do not encourage a focus on outcomes associated with user well-being nor require any accountability against indicators of well-being. As our population ages, the services offered need to change, with a focus on increasing well-being in the home.

Those who can afford and continue to have access to private health insurance should have more extensive access to services which promote enablement and well-being. The public would see a better return on their investment in this product as people who have access to private health insurance and use it to resolve challenges associated with drugs, alcohol, depression and mental health become more socially engaged and experience better health.

Calvary lauds the Commission's recommendations which support longer term contracts for service providers that allow them to do significant outcomes-driven work, free of the anxiety and paper-chase associated with one or two year renewal cycles.

Principles of competition and contestability may work well when there is a plenitude of high quality providers. This is not always the case in regional and rural areas. Governments need to invest in these communities over a sustained period. The risk with one provider models is a reduced focus on accountability, particularly to demonstrate achievement against indicators of greater health and well-being. Recommendation 7.5 is particularly important in this regard.

Services in remote Indigenous communities

Commission's Key Point

- Human services are not making the contribution they should be to improving the wellbeing of **Indigenous people living in remote communities**. Increasing contract lengths for service providers, developing better planning, evaluation and feedback systems, and improving processes for selecting and managing service providers would contribute to improving outcomes for Indigenous people living in remote communities.

DRAFT RECOMMENDATION 8.1

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

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

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

DRAFT RECOMMENDATION 8.2

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

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

DRAFT RECOMMENDATION 8.3

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

DRAFT RECOMMENDATION 8.4

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

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

DRAFT RECOMMENDATION 8.5

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

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

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

Calvary Response

Calvary generally supports the Commission's recommendations, particularly Recommendation 8.3.

In relation to Recommendation 8.5, Calvary emphasises the importance of communities' ownership of and identification with the service outcomes to be achieved but also the importance of a sound, methodology for measuring progress towards outcomes together with highly visible mechanisms of mutual accountability. Quality systems do not necessarily equate with outcomes. A brilliant ISO accreditation result does not mean that efforts to improve outcomes should not be increased.

Public hospital services

Commission's Key point

- **Public hospital** patients should be given greater control over the pathway leading to planned admissions. This requires removing barriers to patients choosing the outpatient clinic or specialist they initially attend when given a referral by their general practitioner. Improved public reporting on individual hospitals and specialists would support greater user choice and encourage performance improvements in hospitals.

DRAFT RECOMMENDATION 9.1

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

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

DRAFT RECOMMENDATION 9.2

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

DRAFT RECOMMENDATION 9.3

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

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

DRAFT RECOMMENDATION 9.4

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

DRAFT RECOMMENDATION 9.5

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

DRAFT RECOMMENDATION 10.1

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

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

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

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

DRAFT RECOMMENDATION 10.2

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

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

Calvary response

Calvary generally supports these recommendations. Health and well-being is enhanced when information is accessible and available. As a public patient it is not currently always possible to have choice. Many are unaware that they may go to any hospital and can choose a specialist other than the specialist to whom the GP has referred them.

The distinction between public and private patients can be kept. The key is the ability to be informed and to have access to meaningful, reliable information about the safety and quality of care and the financial implications arising from one's choices.

Calvary notes the potential strain on public hospital systems in jurisdictions arising from the recommendations because of the way in which current funding models operate. Without corresponding adjustments, there is a risk that a particular local health district's waiting lists may burgeon because the money is flowing to another local health district.

In addition, there is a risk that public patients may gravitate towards a doctor who is working at a new facility outside their local area, putting pressures on that particular hospital when there are similar or even better quality services available in the older facility close to where they live.

Our society is not homogeneous. Health and financial literacy skills vary between generations and across social groups. Many people who have experienced significant social disadvantage are now aging and facing significant and complex health challenges. Many refugee and migrant populations are not financially mobile. Clinics and GPs who work with these groups have particular roles to play in respect of helping people understand and gain access to information. The skills required from and time commitment needed by clinics and GPs will vary from the investment required when working with more literate, independent and informed groups.

Given the proportion of the population requiring health services that is aging, attention needs to be given to incentives, programs and funding to ensure effective, safe and sustained transitions from hospital to home. How can this transition become seamless? How, for example, will we assist people to make choices between receiving rehabilitation services in their home and/or transitioning through a rehabilitation facility? It is important to reduce the need for re-admission and incentivise the attainment of quality outcomes after people have been discharged from hospital. As noted earlier, there is a need to review current models of care to deliver better person-centred, integrated care. This needs to be established on the basis that people who are aging and people who are approaching or reaching the end of life will continue to require access to **a range of home-based, community and hospital services**.

Public dental services

Commission's Key Point

- **Public dental** patients have little choice in who provides their care, when and where, and most services are focused on urgent needs. Patients' choice and outcomes could be improved by a new payment and care model, with a focus on preventive treatments.

DRAFT RECOMMENDATION 11.1

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

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

DRAFT RECOMMENDATION 11.2

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

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

DRAFT RECOMMENDATION 11.3

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

DRAFT RECOMMENDATION 12.1

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

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

State and Territory Governments should ensure that under the scheme:

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

DRAFT RECOMMENDATION 12.2

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

DRAFT RECOMMENDATION 12.3

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

DRAFT RECOMMENDATION 12.4

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

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

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

DRAFT RECOMMENDATION 12.5

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

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

Calvary Response

Calvary supports these recommendations. As the Commission notes, oral health is a key indicator of general health and well-being. Greater and more effective investment in making dental services accessible will ultimately reduce acute potentially preventable and expensive hospitalisations.