

Queensland Government Submission on the Productivity Commission Draft Report: *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*

Introduction

This submission provides a consolidated response of relevant Queensland Government agencies to the Productivity Commission's Draft Report, namely:

- Queensland Health (QH)
- Department of Aboriginal and Torres Strait Islander Partnerships (DATSIP)
- Department of Housing and Public Works (DHPW)
- Department of Communities, Child Safety and Disability Services (DCCSDS)
- Queensland Treasury (QT)

Access to high-quality human services, such as health, education, community services, social housing and justice, is vital for retaining a skilled workforce, improving labour productivity and ensuring social cohesion. Such services enable a stable and attractive investment environment, help to ensure discrimination and exclusion does not inhibit individuals attaining their full productive potential, and assist in addressing intergenerational poverty. Yet, greater levels of competition, contestability and informed user choice are not always appropriate frameworks to achieve these outcomes in human services and are only likely to improve outcomes in some human services — not in all of them.

The benefits of greater levels of competition, contestability and informed user choice can be substantial. Informed user choice improves the ability of the service user to make decisions about the services that meet their needs and preferences. Competition between service providers can drive innovation, reduce some costs, and create incentives for providers to be more responsive to the needs and preferences of users. Creating contestable arrangements amongst providers can achieve many of the benefits of effective competition.

However, such positives must be weighed against the potential risks and costs of greater competition and contestability in human services, including: the risk of a reduction in the quality of services; and for users of human services, difficulties in accessing the resources and support needed to exercise informed choice (particularly disadvantaged and remote groups).

The appropriateness of more contestable and competitive arrangements will vary on a case-by-case basis and depend on a range of circumstances. The transition to more contestable and competitive arrangements can involve significant change and risks for all parties involved. While some markets already have the underlying features for contestability to work, others may require further market design. The government may be required to overcome policy and transaction complexities, and ensure that legal, regulatory and financial structures develop well designed, reliable incentives for market participants. Even when a market is established, the appropriate governance arrangements will depend on the particular type of contestable arrangement.

Government stewardship of human services is critical, to ensure human services meet standards of quality, suitability and accessibility; ensure that appropriate consumer safeguards are in place (particularly for vulnerable populations); evaluate outcomes to identify effective practices; make continuous improvements to policies and programs to disseminate innovations; and encourage and adopt ongoing improvements to service provision. Indeed, information asymmetries can be a barrier to reform in human services, and access to information is crucial in the user choice model. To this end, high quality data is central. User-oriented information on the range of services that are available to

them allows people to make choices about the services they want. Data improves the transparency of service provision, making it easier for users to access the services they need, and increases accountability to those who fund the services. Finally, data increases the ability of governments to identify community needs and expectations, and make funding and policy decisions that are more likely to achieve intended outcomes.

Even in the presence of greater contestability, funding issues remain very important. While competition can lead to service improvement, it can also facilitate cost reductions to the community over time. Conversely, reforms can involve transitional costs and this is an area where the Commonwealth Government can assist States by providing incentive payments to cover these costs. In addition, greater user choice can lead to greater demand for services and pressure on Government budgets.

In short, the Queensland Government sees competition, contestability and user choice as instruments that may have the potential to drive better service outcomes in some cases, rather than ends in themselves.

Overarching comments on Chapters 5, 6 and 8 are provided directly below. Recommendations of Chapters 4 and 7-12 are addressed in turn in the table following.

Social Housing: Chapters Five and Six

The Draft Report states that the social housing system is broken and points to the two-tiered levels of assistance: Commonwealth Rent Assistance (CRA) into the private market and social housing. It recommends a move to a single model of assistance, with extension of CRA to social housing tenants, and a new high cost housing payment for eligible tenants to be funded by state governments. While the Queensland Government acknowledges the benefits of competition and choice principles, consideration of the full range of impacts of the recommendations of Chapters 5 and 6 is required before a view can be reached on these proposals.

At the outset, it should be acknowledged that reform of CRA is needed in order for this option to be able to deliver improved housing affordability for intended CRA recipients.

Extending CRA to public housing tenants and removal of National Affordable Housing Agreement (NAHA) and National Partnership Agreement on Homelessness (NPAH) funding was an option put forward under Reform of the Federation, with social housing authorities able to move to market-based rents. The Queensland Government strongly advocated for an alternative option to be presented to COAG, involving a comprehensive review of CRA to look at opportunities for CRA to better respond to increasing rental costs and local market conditions. Modelling undertaken by Queensland showed at then-current levels, CRA was insufficient to enable housing providers to charge market rents to social housing tenants, and would result in a funding gap of approximately \$118.6 million in 2014-15.

A COAG paper on this reform option noted 40 per cent of CRA recipients across Australia were in housing stress even after receiving the payment. Increasing CRA by 15 per cent is unlikely to be sufficient to reduce housing stress, considering 41.5 per cent of income units receiving CRA in Queensland were experiencing housing stress in 2016 (Report on Government Services 2017).

The Draft Report's recommendations for significant reform of the current models of social housing and private housing assistance would likely have significant impacts for State Budgets and Housing agency service and funding models and community housing providers. There are likely to be

significant impacts on rental affordability and broader social and economic wellbeing outcomes for the most vulnerable Queenslanders, including reduced affordability for some social housing tenants.

Full financial and impact modelling of the recommendations for a high cost housing payment funded by the Queensland Government to eligible social and private housing tenants should be undertaken. Extension of CRA to public housing tenants and a move from income based rents to market rents should also be re-examined (following the review under the Reform of the Federation) using current data. The review of CRA should examine the reforms required in order for the CRA to deliver improved housing affordability.

It is also unclear whether the high cost housing payment is intended to replace current Commonwealth funding under the NAHA, NPAH and National Partnership on Remote Housing. This would have significant impacts on funding arrangements between the Australian and State and Territory Governments.

Service delivery in remote and discrete Indigenous communities

Queensland's Productivity Commission (QPC) is undertaking an inquiry into service delivery in remote and discrete Aboriginal and Torres Strait Islander communities. The QPC's consultation paper was released in March 2017 with the draft report due on 31 August 2017 and the final report due for release on 30 November 2017.

There are strong parallels between Chapter 8 of the Draft Report of the Australian Productivity Commission's inquiry and the work currently being undertaken by the QPC.

Approximately twenty per cent of Queensland's 155,824 Aboriginal and Torres Strait Islander people live in remote and discrete Aboriginal and Torres Strait Islander communities. These communities are some of the most economically and socially disadvantaged communities and make up seven of the top ten most disadvantaged locations in Australia (Census 2011).

DATSIP acknowledges that there are a range of historical and contemporary barriers that impact on service delivery into these communities. DATSIP agrees with the Productivity Commission's assertion that effective delivery of services alone will not overcome the disadvantage and dysfunction existing in communities however significant improvement in the way services are delivered will, over time, lead to improved community and economic wellbeing.

DATSIP supports the view that communities should be involved across the 360 degrees of the commissioning cycle – from needs assessment through to evaluation and the recognition that while governments play a critical role in creating and maintaining the conditions for improving outcomes, the actions of Indigenous people themselves will also play a major role in determining outcomes (PC Draft Report page 23). The draft report notes at page 24 that there are obvious limitations in providing great options for service delivery and consumer choice in some remote communities, but also correctly identifies that ensuring investment aligns with priorities and preferences of the community is critical. This cannot be under-estimated, and is a priority for the Queensland Government.

The Queensland Government is implementing community inclusive and place-based approaches that draw on the skills and experience of local community members, support Aboriginal and Torres Strait Islander community controlled service organisations, and utilises local networks to integrate service delivery. Through these initiatives, the Queensland Government is increasing community voice in service design and delivery and delivering opportunities for economic participation.

For example, the Government is investing \$150 million for Aboriginal and Torres Strait Islander Family Wellbeing Services to be delivered by Aboriginal and Torres Strait Islander community controlled organisations. These organisations will lead the design and delivery of the new services to ensure support and responses and culturally safe and responsive, reflect community and family strengths, local needs and aspirations, leadership and cultural knowledge.

DATSIP supports the view that for services to be effective, place based approaches are required which give greater priority to community-led-and-owned needs assessment and planning, decision making and accountability, and should be tailored to the situation of each community (Productivity Commission draft report page 24). The draft report also highlights that greater community ownership will help assist in enhanced coordination of existing services which is also supported. Funding models have an important role to play in this regard.

Queensland Consultation Opportunities

It is noted that no consultation session is planned for Queensland. The Queensland Government recommends that a public consultation session be extended to Queensland to allow the Queensland social services sector the same opportunity as other jurisdictions to participate in consultation sessions on the draft report. It would also be appropriate for the Productivity Commission to provide Aboriginal and Torres Strait Islander communities the opportunity to engage fully with the draft report.

Response to draft recommendations

DRAFT RECOMMENDATIONS

	Draft Recommendations	Position	Comments
4.1	<p>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:</p> <ul style="list-style-type: none"> • 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. 	Supported in part	<p>In general, giving patients access to better support from community-based palliative care services to enable those who wish to die at home or in a home-like environment is supported.</p> <p>This recommendation is generally consistent with Queensland Health’s Statewide strategy for end of life care 2015 which requires Hospital and Health Services (HHSs) to undertake a needs/gap analysis of the population and plan their health services (and funding requirement) to meet needs and ensure services are staffed to the appropriate Clinical Services Capability Level. A national requirement to include appropriate end-of-life services planning is supported.</p> <p>The report focuses on the provision of community palliative care services which are a necessary component of system service delivery. However, access to ‘home like environments’ in the community does not negate the need for specialist palliative care services in acute settings/hospitals. It is more important that people have control over their location of care and death as much as possible (whatever equates to quality care to them) rather than assuming people want to die at home. For some people, an acute setting or hospice is the preferred choice and it is highly likely additional inpatient specialist palliative care services are also required to support choice.</p> <p>The report recommends that State and Territory governments should undertake a detailed assessment of current and future needs for community-based palliative care services, and to determine the current gaps in service provision.</p> <p>The report then recommends that State and Territory governments should tender out services to community-based palliative care services and should resource providers accordingly. The report claims that this could be a cost effective solution as home-based care generally costs less than its hospital alternative.</p> <p>In Queensland, the HHSs determine service delivery models and approaches differ between HHSs to meet needs across Queensland. A one-size fits all approach to commissioning is unlikely to be accepted or practical.</p> <p>It is not clear that community-based palliative care would necessarily be more cost effective. The lower cost may be due to the relatively lower level of care provided in the community compared with hospital (fewer nurse-patient hours, fewer medications and consumables etc.). Or it may be that patients receiving palliative care in the community have lower care needs and those with higher care needs (and associated cost) remain in the hospital. Moving some of these high needs, higher cost patients out of the hospital into the community may cost more in community end of life care provision. However, inadequate community care can lead to unplanned presentations to acute hospital settings. A key factor for good care is the quality of service linkages and integration between acute and community settings.</p> <p>Where services are commissioned from non-government providers it is also important to focus on quality as well as cost and to set clear performance standards that are used in monitoring and evaluation.</p>
4.2	<p>The Australian Government should:</p> <ul style="list-style-type: none"> • 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. 	Supported	

	Draft Recommendations	Position	Comments
4.3	<p>The Australian Government should promote advance care planning in primary care by:</p> <ul style="list-style-type: none"> 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. 	Supported	<p>The promotion of advanced care planning in primary care is supported.</p> <p>Encouraging the development and ongoing update of advance care plans is supported. However, it should not be a requirement to have an advanced care plan as this is voluntary. Payments to primary care providers should not be linked to the patient having an advanced care plan.</p>
4.4	<p>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.</p> <p>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.</p>	Supported	<p>The introduction of a requirement for residential aged care facilities to ensure that clinically trained staff hold conversations with residents about their future care needs is supported.</p> <p>The second component of the recommendation would need to be implemented with caution as completing a common or statutory advance care plan is entirely voluntary. However, it is agreed that it is appropriate for clinicians in all settings to have discussions and document outcomes of discussions to inform and identify patient choices and assist medical management.</p> <p>Implementation should focus on having discussions about goals of care and having a clear care plan for deterioration/provision of high quality care at the end of life rather than having an advance care plan.</p>
4.5	<p>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:</p> <ul style="list-style-type: none"> 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. 	Supported in principle	<p>This recommendation is supported from a contemporary policy perspective. The collection and provision of data which will help assess the type, availability and quality of end-of-life care services is supported. The identification of known advance care plans may reduce the volume of 'unwanted' care provided when patient choices and preferences aren't known.</p> <p>It needs to be recognised that the development of the minimum linked data set is likely to be both a costly and lengthy process to implement.</p> <p>At present there is no standardised and reported data on palliative care provided by consultation liaison services, non-specialist palliative care health professionals or palliative care provided in the community by government or NGO services. Data is limited to 'in-patient palliative care beds', which does not capture all admitted specialist palliative care activity, and potentially outpatient clinic activity.</p> <p>Palliative Care Outcomes (PCOC) data is available but is opt-in for specialist palliative care services i.e. a limited sub-set with respect to the system.</p>

	Draft Recommendations	Position	Comments
7.1	<p>The Australian, State and Territory Governments should work together to develop and publish:</p> <ul style="list-style-type: none"> • 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. 	Supported	<p>DCCSDS supports this recommendation and has invested in statewide stocktakes of family support (available on Open Data). In addition, DCCSDS' investment portal includes the locations of all funded community services.</p> <p>DCCSDS continues to use a range of tools to analyse the characteristics and needs of service users and demand for services, including:</p> <ul style="list-style-type: none"> • the Community Services Information System (COMSIS), which is available to the human services sector and includes a wide range of demographic and economic data and maps to help identify need • the Need and Services Analysis (NASA) method, which provides an evidence-based decision-making process for the department to identify the most effective locations for service investment and implementation • the department's forthcoming new commissioning approach, which will include investment schedules and plans to address the needs of vulnerable cohorts of Queenslanders • mapping application to analyse location-based data • supporting place-based (including collective impact) projects, such as Logan Together and EveryChild CQ, which employ a whole-of-community approach to achieving outcomes for individuals and families. <p>DCCSDS welcomes the opportunity to work with other levels of government to collaboratively analyse and plan responses to address the needs of vulnerable Queenslanders.</p>
7.2	<p>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:</p> <ul style="list-style-type: none"> • 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). 	Supported	<p>DCCSDS supports the proposed reforms to the commissioning and procurement of community services. The department is leading the cross-government Social Services Category Council to maximise benefits from cross-agency procurement of social services. This includes understanding client and community needs, the market and suppliers and increasing the capability to deliver better outcomes. A Commissioning Board will be established to oversee DCCSDS' service investment, including alignment to strategic priorities, performance and engagement with service providers and other government investors.</p> <p>DCCSDS is shifting towards a more outcomes-oriented investment approach. This will include more clearly identifying the outcomes to be achieved by investments, and developing commissioning strategies and investment plans to guide the department's investment. This increased outcomes focus will inform selection criteria of service providers.</p> <p>DCCSDS welcomes the opportunity to work with the community services sector to improve the effectiveness of provider responses to funding opportunities, including integrated responses.</p> <p>DHPW notes the recommendation for a new approach to commissioning family and community services (which includes specialist homelessness services) could provide an opportunity to be more responsive to community needs, improve service provider performance and deliver stronger client outcomes. However, it must be recognised this represents systemic change and would have considerable impacts for DHPW and homelessness service providers, including significant implementation costs. If adopted, timeframes for implementing such a reform would also be challenging in the context of developing the new NHHA.</p>

	Draft Recommendations	Position	Comments
7.3	<p>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.</p> <p>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.</p> <p>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.</p>	Supported	<p>DCCSDS is developing, and has developed, a number of user-focused outcomes frameworks and measures. These include:</p> <ul style="list-style-type: none"> • Out-of-home Care Outcomes Framework • an Aboriginal and Torres Strait Islander child and family wellbeing outcomes framework (an action in Changing Tracks: An action plan for Aboriginal and Torres Strait Islander children and families 2017-2019) • participation on the Outcomes Framework Working Group of the Child and Family Secretaries to develop a national approach to a Child, Youth and Family Wellbeing Outcomes Framework. <p>The department welcomes working collaboratively with other government agencies and the community services sector to further embed consistent outcome measures (or proxies) consistently across community services.</p>
7.4	<p>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:</p> <ul style="list-style-type: none"> • 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. 	Supported	<p>The Queensland Government supports the release of de-identified data on family and community services to service providers and researchers, and developing processes to disseminate the lessons of evaluations to governments and service providers, subject to any legislative provisions regarding privacy and confidentiality. This is in line with a need identified through Queensland Government consultation to strengthen the community services industry’s evidence base and apply the results of relevant research to community services to improve client outcomes.</p> <p>DCCSDS has a large evaluation program, including implementation, impact and outcomes evaluations of a range of child, family and domestic and family violence initiatives. Findings will continue to be shared and improvements undertaken to the processes for dissemination of learnings and lessons.</p> <p>DCCSDS shares a range of performance data on the Our Performance website.</p>

	Draft Recommendations	Position	Comments
7.5	<p>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:</p> <ul style="list-style-type: none"> • 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. 	Supported in principle	<p>DCCSDS supports the use of fit-for-purpose, responsive, flexible contracting arrangements. DCCSDS has five-year service agreements in place with funded service providers, where appropriate. DCCSDS supports the use of longer-term contracts where appropriate; the length should be based on particular circumstances, including to support trials or place-based projects.</p> <p>Greater attention should be afforded to other contract related reforms, such as client centred, outcomes-oriented, community-led contracts and associated practice around effectively managing these types of contracts; models of commissioning that deliver on the benefits of contestability; and strengthening risk mitigation strategies to ensure that government can cease or realign funding direction in line with policy change and evidence based need.</p> <p>The DCCSDS has multiple safeguards, including the Human Services Quality Framework, ensuring the quality of human services delivered by funded providers. In addition, service agreements (contracts) contain multiple provisions to suspend or stop funding due to breach of terms of the service agreement, becoming insolvent and conflict of interest.</p>
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	Supported in principle	The Queensland Government recognises the important role that providers for family and community services undertake. Further analysis is needed to determine an efficient cost of service provision relative to existing funding arrangements before any changes are made. Funding arrangements must be matched to service delivery and align with outcomes achieved. Any potential changes in funding policy would need to be considered and agreed upon by the Queensland Government.
7.7	<p>The Australian, State and Territory Governments should:</p> <ul style="list-style-type: none"> • 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. 	Supported	DCCSDS is continuing to upskill its workforce to undertake outcomes-oriented investment and procurement planning, implementation and monitoring. A more outcomes oriented investment approach will also enable a different approach to contract management that focuses on achieving jointly agreed outcomes rather than delivering outputs. In addition, DCCSDS is developing and implementing an IT-based integrated investment analysis and contract management tool that will enable better service provider access to data.

	Draft Recommendations	Position	Comments
8.1	<p>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.</p> <p>To achieve this the Australian, State and Northern Territory Governments should:</p> <ul style="list-style-type: none"> • 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. 	Supported in principle	<p>DATSIP supports an extension of contract lengths. As noted in this recommendation, an extension of contracts would require provisions to allow for exceptions such as pilots and trials; justifications for contracts that differ from the standard term; inclusion of safeguards to removal of providers in cases of failure.</p> <p>DCCSDS supports the use of fit-for-purpose, responsive, flexible contracting arrangements. DCCSDS has five-year service agreements in place with funded service providers, where appropriate. DCCSDS supports the use of longer-term contracts where appropriate, but contract length should be based on particular circumstances, including to support trials or place-based projects.</p> <p>Greater attention should be afforded to other contract-related reforms, such as client-centred, outcomes-oriented, community-led contracts and associated practice around effectively managing these types of contracts; models of commissioning that deliver on the benefits of contestability; and strengthening risk mitigation strategies to ensure that government can cease or realign funding direction in line with policy change and evidence based need.</p>
8.2	<p>When conducting provider selection processes for services in remote Indigenous communities, the Australian, State and Northern Territory Governments should:</p> <ul style="list-style-type: none"> • 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. 	Supported	<p>DATSIP is supportive of the view that communities should be involved across the 360 degrees of the commissioning cycle. Greater involvement by community leaders can assist with achieving this aim.</p> <p>DCCSDS supports improvements to provider selection processes in remote Aboriginal and Torres Strait Islander communities. For example, under the <i>Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037</i> strategy, the DCCSDS will lead the establishment of a Queensland First Children and Families Board, which will help provide a community voice and place-based approach to priority setting and investment strategies over the next 20 years.</p>

	Draft Recommendations	Position	Comments
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.	Supported	<p>DATSIP recommends that contracts include a provision for providers to build local capacity to allow for the transfer of service provision (where appropriate) to community control.</p> <p>DCCSDS will be working with partner agencies to analyse current investment in sector capacity and workforce capability to help inform future investment to build the child and family sector, including in discrete / remote communities.</p> <p>The <i>Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037</i> strategy outlines a commitment to increase capacity and build capability through service procurement, service mapping and integration of services delivered through greater engagement. Key actions to achieve this reform include investing \$150 million over five years in Aboriginal and Torres Strait Islander community-controlled organisations to support family wellbeing and developing an Aboriginal and Torres Strait Islander cultural capability strategy with mainstream child and family service organisations.</p> <p>Additionally, the Queensland Government's <i>Moving Ahead Strategy</i> also includes the implementation of a whole-of-government Indigenous Procurement Strategy to significantly increase and grow Indigenous businesses.</p> <p>The transfer of skills and capacity to local people and organisations needs to be genuinely supported through funding arrangements between the Australian and Queensland Governments.</p>
8.4	<p>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:</p> <ul style="list-style-type: none"> • 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. 	Supported	<p>DATSIP supports this recommendation including an approach where investments are better aligned with and support local priorities and preferences. To achieve this outcome, DATSIP would include community in the identification of priorities and preferences.</p> <p>DCCSDS is currently undertaking a range of relevant initiatives, including culturally appropriate service provision, community engagement and governance, collaboration with service providers, and employment and training of local Aboriginal and Torres Strait Islander staff.</p> <p>For example, the recent rollout of Aboriginal and Torres Strait Islander Family Wellbeing services in Queensland represents the department's single largest investment in community controlled organisations (approximately \$150 million over five years) and an additional \$1 million in one-off funds over two years to support a trial of packages of support to increase positive outcomes through targeted case planning activity supported through discretionary spending managed by the community-controlled organisations.</p> <p>In addition, through the recently released <i>Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037</i>, a number of different actions are being undertaken to move to community driven and place-based approaches. This includes partnering with three discrete and/or remote communities to build a coordinated, place-based universal and secondary system.</p> <p>The <i>Our Way</i> strategy is supported by enabling actions to support shared power, self-determination and accountability, including establishing mechanisms to hear and incorporate the voices of children in policy and service design, and enable services to be more responsive, culturally capable and safe.</p> <p>DCCSDS will also lead the development of an Aboriginal and Torres Strait Islander cultural capability strategy with mainstream child and family service organisations.</p> <p>Other initiatives include:</p> <ul style="list-style-type: none"> • First 1000 Days – partnering with Indigenous communities and adopting a culturally relevant, holistic approach to health and wellbeing during the first 1000 days of a child's life, initially in Townsville and Moreton Bay • EveryChild CQ - a whole of community approach to life outcomes for every child in Central Queensland, including in Woorabinda.

	Draft Recommendations	Position	Comments
8.5	<p>The Australian, State and Northern Territory Governments should invest in better systems to underpin service delivery by working together to:</p> <ul style="list-style-type: none"> 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. <p>The Australian, State and Northern Territory Governments should involve communities at all stages of this process.</p>	Supported	<p>DATSIP supports this recommendation and notes that:</p> <ul style="list-style-type: none"> Mapping existing services delivered into communities is imperative to improving service delivery, eradicating service duplication and promoting collaboration. The current inquiry being undertaken by the Queensland Productivity Commission may also significantly assist with this process (final report due later 2017). <p>DCCSDS is working with DATSIP, Family Matters Queensland and the Queensland Family and Child Commission to design a holistic Aboriginal and Torres Strait Islander child and family wellbeing outcomes framework and investment plan.</p> <p>DCCSDS will also work with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak to examine the case to establish a Queensland First Children and Families Centre for Excellence. In addition, the department will work with other Queensland Government agencies to build an evidence base about what works in preventing entry and re-entry into the child protection and criminal justice systems.</p> <p>The forthcoming Queensland Productivity Commission Inquiry report into Service Delivery in Queensland's Remote and Discrete Indigenous Communities will provide recommendations relevant to this reform area, including interactions between investment by all levels of governments; identification of duplication and coordination issues across programs; and the need for evaluation of what works. The final report is scheduled to be delivered to the Queensland Treasurer by 30 November 2017.</p>
9.1	<p>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:</p> <ul style="list-style-type: none"> 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. 	Supported in part	<p>In general, giving patients greater choice of specialist is supported. However, as noted under draft recommendation 9.3, it may not be appropriate or feasible to enable patients to choose any public outpatient clinic regardless of where they live.</p>

	Draft Recommendations	Position	Comments
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.	Supported	
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: <ul style="list-style-type: none"> 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. 	Not supported	<p>While enabling patients to choose any public outpatient clinic regardless of where they live may increase patient choice, it may also have unintended adverse impacts for the public hospital system.</p> <p>A general principle of the Queensland public hospital system is that as much as possible, Hospital and Health Services (HHSs) should be responsible for the health service needs of their population catchment. Enabling patients to choose a public outpatient clinic outside their HHS where the service is available within the HHS would not be consistent with the “closer to home” principle. This principle allows HHSs to appropriately service plan based on the population. The majority of HHSs are applying “closer to home” and not accepting out of catchment referrals because it increases the wait lists and leads to associated long waits.</p> <p>Enabling patient choice of any public outpatient clinic could result in an increase in demand for specialist outpatient services in tertiary centres, which would have workforce ramifications. Increasing services in tertiary centres could also result in a reduction in specialist services offered in regional and rural centres.</p> <p>We note that in Queensland there is already some flexibility under the Queensland Health Specialist Outpatient Services Implementation Standard (SOSIS) in that referral decisions must be patient orientated and consideration is given to patients requesting referral out of catchment for personal reasons (e.g. families in different catchments).</p> <p>To mitigate some of the issues raised by the PC around constrained GP knowledge, Queensland has purchased a statewide licence for HealthPathways. This is a web based application that contains assessment, management and information on local providers for General Practitioners. This enables GPs and their patients to have an informed conversation around treatment options and locations.</p> <p>Enabling patient choice of any public outpatient clinic may also give rise to perverse incentives. For instance, it would limit the incentive for HHSs to reduce waiting times, as HHSs with shorter waiting times are likely to attract patients from HHSs with longer waiting times, thereby increasing demand and putting greater pressure on service delivery in the HHS of treatment.</p> <p>If such a policy were introduced, it would be necessary to change the funding model to ensure that funding follows the patient. This would require substantial system level implementation investment and may lead to increased transaction costs and financial uncertainty for HHSs.</p> <p>One of the benefits of user choice identified in the report is that patients can make an informed choice of public outpatient clinic based on a various factors including an understanding of expected waiting times. Queensland Health currently has no ability to display “real-time” waiting times. A significant investment would be required to enable this.</p>
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.	Not supported	See response to draft recommendation 9.3
9.5	The Australian Government should undertake an evaluation of the referral choice reforms five years after they commence operation.	Supported	

	Draft Recommendations	Position	Comments
10.1	<p>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:</p> <ul style="list-style-type: none"> 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. <p>To facilitate reporting on individual specialists, there should also be a commitment by:</p> <ul style="list-style-type: none"> the Australian Government to amend the <i>Health Insurance Act 1973</i> (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. 	Supported in part	<p>Queensland agrees in principle to the concept of providing additional data where it provides genuine information that can be used to improve patient choice. However, public dissemination of data needs to be done carefully. The following factors would need to be considered:</p> <ul style="list-style-type: none"> There would need to be agreement (including consultation with specialists) on exactly what data should be collected and displayed. The recommendation suggests that the AIHW would have the power to determine the data requirements. However, data requirements would need to be agreed by the States and Territories. There would need to be strict data standards agreed to ensure that effective comparisons could be made between hospitals and specialists, both within Queensland and between States. Safety and quality of care and experience and outcomes for patients is by no means solely a function of the performance of specialists. Experience and outcomes are affected by the system as a whole, including nursing care, diagnostic imaging, medications management, as well as administrative functions such as scheduling and communications. Raw data can be easily misinterpreted, particularly where clinical outcomes can be impacted by factors such as patient complexity. For example, specialists operating in a tertiary centre are more likely to treat patients with a high complexity (such as those with chronic disease) which may impact upon clinical outcomes. <p>With regard to the last point above, the PC notes that risk-adjustment processes are well developed, and that risk-adjusted data has been provided publicly in England since the mid-2000s. However, we note that risk adjusting data is highly complex, as demonstrated by the Independent Hospital Pricing Authority’s work developing a risk adjustment model for pricing for safety and quality reforms.</p> <p>Queensland Health suggests that the following recommendation that all jurisdictions should, “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 interest of patients” is too broad. This should be changed to:</p> <p>“adopt a general policy of publicly releasing data that a jurisdiction holds relating to the performance of individual hospitals and specialists unless it is clearly demonstrated that releasing the data would harm the interests of individuals or is contrary to legislation.”</p> <p>Queensland also considers that the MyHospitals website should include the same information for private hospitals as for public hospitals, in order to support patient choice and provider self-improvement.</p>

	Draft Recommendations	Position	Comments
10.2	<p>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:</p> <ul style="list-style-type: none"> 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. 	Supported in part	Per the response to recommendation 10.1, data that is subject to misinterpretation may not support informed choice by patients and may result in worse patient outcomes. In addition, the MyHospitals website should include the same information for private hospitals as for public hospitals.
11.1	<p>State and Territory Governments should report publicly against a consistent benchmark of clinically-acceptable waiting times, split by risk-based priority levels.</p> <p>Once data systems are developed, provider-level reporting should be published monthly and aggregate measures included in public dental services' annual reporting processes</p>	Supported in principle	<p>Queensland currently publishes monthly updates of waiting times for almost every public dental clinic in Queensland, by urgency/priority level, on the Queensland Health Hospital Performance website (this has been in place for approximately 3 years). The report uses Queensland as an example for public reporting.</p> <p>There may be opportunities to improve this public reporting by making the information more user-friendly and more accessible to eligible patients so that the information can support their decisions regarding accessing dental care.</p> <p>The Australian Institute of Health and Welfare, with oversight by the National Health Information Standards and Statistics Committee (NHISSC), has been working with state and territory public dental services to develop a national minimum dataset (NMDS) for public dental waiting lists in order to publish comparable information on waiting times for non-urgent public dental care.</p> <p>Queensland has contributed dental waiting list data to the NMDS for the last three financial years, with publication of public dental waiting times in the Report of Government Services (RoGS).</p> <p>There is currently no public reporting of waiting times for urgent/emergency dental care for public dental patients, either in Queensland or nationally.</p>

	Draft Recommendations	Position	Comments
11.2	<p>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.</p> <p>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.</p>	Supported in principle	<p>Queensland currently publishes internal reports on dental treatment outcomes using a national suite of indicators developed by the Australian Council on Healthcare Standards (ACHS).</p> <p>Queensland is also improving reporting of dental decay for public dental patients, initially for children through survey data collected by public oral health staff. With the implementation of the electronic oral health record, regular reports on levels of dental decay for all child and adult public dental patients will be possible using routinely collected data. It is envisaged this will commence over the next one to two years.</p> <p>Queensland does not currently collect data on patient-reported outcomes, so there is an opportunity to investigate the work of DHSV.</p>
11.3	<p>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.</p>	Supported	<p>The Information System for Oral Health (ISOH) is a Queensland wide system that has deployed a comprehensive digital oral health record for public dental patients to a majority of Hospital and Health Services adult clinics around the state. The rollout to adult clinics is expected to be complete by 30 June 2018.</p> <p>With a state-wide database and unique identifier for each patient, this system allows a single record per patient that can be accessed, updated and reviewed from any public dental clinic in Queensland.</p> <p>Queensland has commissioned a project that will provide integration functionality to enable automatic transfer of data through the Department's integration platform that will enable data transfer to the My Health Record. This platform would require further investment and a determination on funding and priority would be made in the future.</p>

	Draft Recommendations	Position	Comments
12.1	<p>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:</p> <ul style="list-style-type: none"> 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. <p>State and Territory Governments should ensure that under the scheme:</p> <ul style="list-style-type: none"> 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). 	Supported in part	<p>While, in principle, a 'blended payment model' would appear to balance the limitations and benefits of capitation, outcome and activity-based payment models, it may result in a complex system that is difficult to implement.</p> <p>Clinical and patient outcomes are important indicators. However, they are difficult to measure within the timeframes that providers expect payment for their services.</p> <p>Queensland does not currently collect data on patient-reported outcomes, so there is an opportunity to investigate the work of DHSV and other jurisdictions.</p> <p>While a consumer directed care approach may improve patient choice, the extensive use of dental vouchers in recent years suggests that giving public patients the option to access a private dentist is likely to increase demand for public dental services. This would make it increasingly difficult to ensure timely access to care within current funding. The effect is likely to draw eligible patients away from services funded through private health insurance or funded privately into the public dental system, placing a further burden on the health budget.</p> <p>While it is clear that timely access to early intervention and preventive care potentially avoids larger costs, providing this level of service at a provider that patients choose, would likely increase costs through greater patient numbers (or increase waiting times if costs were contained).</p> <p>Offering public dental patients a choice of public or private provider may also have major implications for the viability of HHS oral health services if patients elect to seek care through local private dentists rather than established public dental clinics. There would also be significant risks to sustainability of services. If consumer choice led to the closure of a public clinic in a rural or remote community, but the private practice later closed, the community would be left with no service.</p> <p>Conversely, if a public dental clinic commenced seeing fee paying patients, it may threaten the viability of private practices, resulting in less patient choice.</p> <p>As stated in the key points of section 12: <i>Reforms to introduce greater user choice and contestability require a fundamental shift in the way that public dental services are funded and overseen, and a staged long-term implementation path.</i></p>
12.2	<p>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.</p>	Supported in principle	<p>There would be benefits in the Independent Hospital Pricing Authority developing an efficient price and price weights for dental services. This work would need to also consider loadings for services in rural and remote locations and Indigenous patients. Such work would be of potential benefit to both the states and territories and to the Commonwealth in refining funding models for public dental services.</p> <p>At the same time, there would need to be close consultation with states and territories and with clinical groups to minimise the additional burden for data collection. Unlike for public hospital services, costing data for public dental services is currently available only at the aggregate level rather than the patient level. A significant investment would be required to develop and refine patient-level costing systems.</p>
12.3	<p>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.</p>	Supported in principle	<p>As noted above, while in principle, a 'blended payment model' would appear to balance the limitations and benefits of capitation, outcome and activity-based payment models, it may result in a complex system that is difficult to implement.</p> <p>It should also be noted that blended payment models for public hospital services are still at a relatively early stage, even though we have had patient-level costing data for public hospital services for many years and this has been standardised and refined significantly in recent years through the national activity based funding model. It may be appropriate to focus on improving costing data for public dental services and on monitoring and evaluating the use of blended payment models for public hospital services before rolling out blended payment models for public dental services.</p>

	Draft Recommendations	Position	Comments
12.4	<p>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.</p> <p>Governments should ensure that, when allocated funding, a patient has access to:</p> <ul style="list-style-type: none"> • 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. 	Supported in part	<p>Most Queensland HHS oral health services already have centrally managed allocation systems through a call centre, which triages patients over the phone and determines whether each patient requires an appointment for urgent care or can be allocated to a waiting list for routine care.</p> <p>Under current outsourcing arrangements (via dental vouchers), private dentists can provide care from a defined schedule of dental treatments at no cost to eligible patients. Patients are able to arrange other treatment with the private dentist outside this schedule on a fee-for-service basis.</p>
12.5	<p>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.</p> <p>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.</p>	Supported in part	<p>As noted above, clinical and patient outcomes are important indicators but are difficult to measure.</p> <p>In addition, the introduction of greater contestability needs to be approached with caution for the following reasons:</p> <ul style="list-style-type: none"> • Giving public patients the option to access a private dentist is likely to increase demand for public dental services, making it increasingly difficult to ensure timely access to care within current funding. • Offering public dental patients a choice of public or private provider may also have major implications for the viability of HHS oral health services if patients elect to seek care through local private dentists rather than established public dental clinics. • There would also be significant risks to sustainability of services, particularly in rural and remote communities. <p>Introducing contestability in public dental services would also need to take into account the unique role currently fulfilled by the public sector in training and supervising undergraduate dental practitioners, such as dental, oral health therapy and dental prosthetist students, who undertake final year placements in public dental clinics.</p>