

Australian Unity

**Submission to the  
Productivity  
Commission Issues  
Paper: Human Services:  
Identifying sectors for  
reform.**

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## About Australian Unity

Australian Unity is a national healthcare, financial services and independent and assisted living organisation with over 6,000 employees providing services to nearly a million Australians including some 300,000 members nationwide. Australian Unity’s history as an independent mutual dates back 175 years.

As a provider of health insurance Australian Unity protects almost 200,000 Australians against the risks of costly and unexpected medical bills. Australian Unity’s retirement communities assist over 3,000 older Australians to continue to live as independently as possible in communities with friends and supports. The organisation also provides in-home care services to more than 50,000 clients across New South Wales after the recent purchase from the NSW government of the Home Care Service of New South Wales. These clients include older people and people with disability. Australian Unity’s investments and financial services divisions give Australian families the information they need to plan for a financially secure future.

Australian Unity contributed a submission to the 2015 Harper Review of Competition Policy, which was the catalyst for the Commission’s current inquiry, and supported both the broad tenor and many of the specific recommendations made by Professor Harper and his expert panel. We stand ready to assist the Commission in its consideration of human services reform in any way it can.

## Executive Summary

Australian Unity is a mutual organisation that has been providing social infrastructure for Australians for the past 175 years. By this, we mean both the hard infrastructure (aged and health care facilities) and soft infrastructure (workforce, models of care, business systems) that maintains and improves standard of living and quality of life within our community. We seek to enable millions to enjoy wellbeing, in its broadest sense, across their life course. This includes the provision of a range of services that fit into the Productivity Commission’s categorisation of “human services” - namely health, aged care and disability services. A number of Australian Unity’s businesses have been formed for this purpose.

Australian Unity has a deep and abiding policy interest in the issue of human services. Our submission to the 2015 Harper Review of Competition policy was cited in the final report as a call to action for the introduction of greater competition into the health and aged care sectors.

“As Australian Unity notes: Without fundamental change to the health and aged care systems, the ageing of Australia’s population will mean a future of greater government-managed care and increased rationing of health services. Fundamental change must revolve around the greater adoption of market economy ideals including a focus on consumer, rather than producer, interests. Competition reform is a critical component.” Harper Review final report p218

Broadly, Australian Unity agrees with the Commission that while the human services sector is both diverse and complex, it must, and can, be improved for the benefit of both individuals and the overall economy. Increasing demand, driven by an ageing population, the rise in chronic conditions and more expensive technological solutions in service provision creates an impetus for finding efficiencies in order to distribute services more equitably across those who need them.

Further, Australian Unity supports the Commission’s baseline contention that the delivery of the human services in which the organisation is involved – health care, aged care and disability care - can be improved through greater competition and informed user choice. More choice, however, will not of itself improve outcomes unless consumers *understand* the range of service options available and the differences between those options. And this is challenging particularly in the health system given the historically deep producer interests that continue to hold sway.

Australian Unity submits (and will expand on subsequently) that:

**Demand:** Health and aged care services have considerable scope for improved outcomes from the increased application of competition, contestability and user choice. The current level of demand for these services is increasing and likely to increase more rapidly into the future for demographic, population and technology-related reasons. Some policy steps have been taken to promote consumer-directed models, but gaps remain.

**Supply:** Given the depth of the supply challenge for the provision of health and aged care services, the greater the range of available delivery models, the better for the consumer. The public system is critical, but Australian Unity argues that the mutual form of business organisation should be an important part of the overall service delivery landscape. Mutuals can take pressure off government budgets through service delivery in important social infrastructure, yet aren't constrained by the short term profit-driven demands of shareholder companies. And suppliers should be looking for innovative service provision models that can deliver win/win benefits both to client outcomes and to sector costs. Australian Unity's MindStep program is an example.

**Effectiveness:** In health care, Australian Unity argues user choice and competition can play a role in improving human service delivery, provided consumers are informed of, and understand, the choices they are offered. But this will be no easy task. Producer interest runs deep in the health care system, and has done so for more than 200 years. There is asymmetry of health and medical information between clinician and patient. This is why informed consumer choice will be a challenge.

These points are examined in further detail below.

## Introduction

Australian Unity notes the Commission’s two part consultation process in respect of this issues paper, and will **limit the content of this submission to the scope of the inquiry’s first stage**, as per below. We will provide a subsequent submission in due course along the timeline proposed by the Commission.

### “Scope of the Inquiry

The first stage will deliver an initial study report identifying services within the human services sector that are best suited to the introduction of greater competition, contestability and user choice.

The Commission will examine:

- a. the current level, nature and future trends in **demand** for each major area of service delivery;
- b. the current **supply** arrangements and future trends, including the scope for diversity in provision and informed user choice, alternative pricing and funding models, and the potential for contestability in supply by government, not-for-profit and private sector providers; and
- c. the **effectiveness of previous reforms** intended to introduce greater competition and user choice, and the pathway taken to achieve those reforms, through investigating:
  - i. case studies of existing practices and trials in Australian jurisdictions
  - ii. international examples of best practice.”

## DEMAND FOR HUMAN SERVICES

### Health and Aged Care Services

The current demand for human services in Australia is significant and future demand is almost overwhelming. Already we can see a huge workforce shift, driven by a demographic imperative that sees some 3,000 people a week across the nation turning 75.

This manifests in both the health and aged care sectors. For instance, within a decade there will be more Australians living with dementia than there are Tasmanians. These people will need intensive support from suppliers of human services. In terms of residential aged care, and even after factoring in Australians’ preference to “age in place” in their own homes, 70 new 100-bed facilities per year for the next decade are required to meet demand. Actual construction is nowhere near this level.

Even if such construction was to take place, there is little hope Australia would have a workforce ready and able to provide the necessary support. On the government's own figures, some 470,000 more workers will be required by 2050 to service the aged care needs alone of our population. Part of the reason for this is that the *informal* care workforce (often children or partners) is dwindling.

The widespread belief these care workers can be sourced, if necessary, from developing economies around the world may be misplaced, in our view. In the competition for such workers from across the developed world (the United States and Japan being just two examples), Australia may not be the most desirable option, in view of the potential financial and other benefits from workers pursuing other destination. Further, developing countries (such as The Philippines) are themselves looking to build programmes so that their citizens can strive for higher qualifications and more lucrative careers. Australia will have to compete on a global stage for a suitably qualified workforce to deliver the care needed by older Australians.

This shift in human services demand is reflected in the shifting foundations of the nation's economy. Over the past 10 years – which includes arguably the biggest mining boom in a century – the mining sector has created an average 9,690 jobs per year, according to Australian Bureau of Statistics figures. Last year it gained 2,800 jobs. The health and social assistance sector, over the same period, has created an average increase of 47,060 jobs per year. In the last year alone, the figure was 55,600 jobs.

Beyond workforce, these sectors are ripe for disruption to improve services. Currently they are beset with issues that don't allow optimum performance. Using the health sector as an example, this would include:

- Information asymmetries between providers and patients;
- Funding arrangements that support activity rather than outcome;
- Demarcation and boundary management issues;
- Training models that entrench boundaries;
- Government's conflicting role as funder, regulator and sometimes provider; and
- Cost and blame shifting between state and federal governments.

Already there has been some recognition, both within government and beyond, that these issues will require a greater focus on competition and market-based solutions. One example of current legislative thinking is the move to consumer-directed care in aged and disability care, with the client having control over the service that is funded, rather than the providers.

That said, health care, aged care and disability care are ripe for reform, as improving competition, contestability and user choice in these sectors can drive efficiencies and lower costs in the public sector and consequently allowing funding in these sectors to stretch further. Providing the private sector with a greater opportunity to play a role is one way of driving reform.

Further, Australian Unity strongly supports the Commission's view that well designed and implemented policies will be critical. This includes strong quality standards and consumer protections targeted at areas of greatest risk. Good regulatory frameworks will minimise the administrative burden on providers.

## **SUPPLY ARRANGEMENTS, DIVERSITY IN PROVISION AND FUTURE TRENDS**

### **Supply arrangements – Workforce built around patient need.**

The policy push for human services delivery to be focussed more on the patient than the provider is, in Australian Unity's view, welcome. But it means rethinking training and qualification models, and even working hours, so that practitioner skills are best utilised to support the maximum number of consumers.

In health care, highly qualified practitioners are too often required to perform simple tasks capable of being done by others, at no risk to the quality or safety of treatment to the patient. Both doctors and nurses regularly find themselves in this position.

In aged care, there is a generational shift occurring in the training of care workers. For those looking to become more employable in the aged care workforce, obtaining an industry competency qualification is often insufficient, and will increasingly fall short of what is desired in the market. More complex qualifications will be sought, for instance clinical competence in palliative care, and the current "siloes" training and qualification system will begin to fracture.

Further, the provision of aged care itself is becoming increasingly complex and fractured. There is no longer a template that can be applied to recipients of care, as their complex needs can differ widely. For example, some aged care facilities offer "pet friendly" areas of accommodation, at an additional charge. Providers of aged care will have to incorporate the capacity to deal with such individualised needs into training and workforce requirements.

In both health and aged care, the future workforce must also balance qualifications with 'soft skills' and ensure over-professionalism does not drive wage increases that are not commensurate with greater value and improved outcomes for clients.

The intersection of humans and emerging technologies will change forever the delivery of aged care. As aged care services increasingly concern delivering more than simply medical care and cleaning support, instead looking at the overall wellbeing of care recipients, technologies will be introduced to support that. And with this change, the role of workers will inevitably change. As an example, for regional and remote parts of Australia, some care will also become remote. The diagnosis and proposed treatment of the severity of a remote patient's wound or sore could be assessed by smart phone video by a relevant professional in an urban centre, or perhaps even by someone in another country. This notion of "borderless health" and global innovation hubs is rapidly becoming a reality. The very character of the workforce will shift accordingly as this type of situation becomes increasingly prevalent.

### **Diversity in provision – the Mutual Business Model:**

As a private sector provider of human services in the health, aged care and disability sectors, Australian Unity brings a diverse perspective to the Commission's policy discussion. And our corporate structure – a mutual organisation – offers a further point of difference in the search for ideas.

Australian Unity believes that as the Commission examines the scope for user choice, diversity in provision and contestability in the supply of human services, consideration of the mutual as an important corporate form to be nurtured as part of the overall supply mix is a critical consideration. It is vital our economic settings encourage diversity of corporate form.

Because mutuals' members are typically their customers, they offer a vastly different corporate dynamic than shareholder companies. There is no competition between the interests of customers and the interests of shareholders. Mutuals have the capacity to take a longer term perspective.

Promoting this diversity in service provision through diversity of corporate form can, in our view, lead to stronger outcomes for customers/clients/patients, and buffer them from the economic cycles that can ripple through the share market, with a consequent impact on service delivery.

At a personal level, a mutual's propensity for longevity and stability also enables long-term relationships with clients, some of whom will be dependent on carers for much of their life.

We argue the mutual corporate form can continue to complement the public sector as it faces providing human services in the growing sectors of health, aged care and disability care. It is arguably more trusted than a full privatisation of public services as profits are reinvested into products and services for members, rather than being distributed to private shareholders as dividends.



### **Future Trends: Mental Health and MindStep.**

Policymakers must focus on driving competition and contestability into human service areas where efficiencies will create a more equitable system. Preventative health initiatives will lower the rate of expensive hospital stays, nipping significant costs in the bud. One of the fastest growing, yet severely underfunded, areas of health utilisation is in the area of mental health.

People admitted to hospital with severe anxiety and depression stay on average more than 20 days, compared to just under five days for someone who has suffered a heart attack. And they often return to a hospital setting multiple times a year. In both the public and private health systems, this is becoming a critical strain on budgets.

In an attempt to drive better patient outcomes and reduce hospitalisation, Australian Unity's preventative healthcare business Remedy Healthcare has recently introduced a mental health program, MindStep. It is designed to play a role in the overall care of someone suffering severe anxiety and depression, alongside GPs and mental health specialist. The program, developed in conjunction with Flinders University, delivers telephone-based low intensity cognitive behaviour therapy for clients with depression and anxiety, which they seem to prefer to having to meet with mental health practitioners face to face.

Already it is demonstrating strong results. The overall recovery rate of clients completing the MindStep program in its first seven months of operation is 58 per cent. Most of these clients would have previously been hospitalised with anxiety and depression.

I felt I had a coach helping me deal with my low moods and self-sabotaging thoughts. This unobtrusive contact was helpful at a time when I had isolated myself from most people for several months. The materials are particularly insightful and encouraging. – Feedback from MindStep client

[The coach] made me aware of the need to prioritise my worries into hypothetical and actual problems. Realised early on that most thoughts are only hypothetical. I can look at things and handle how I work out what I need to do to overcome my anxious thoughts. – Feedback from MindStep client

MindStep is one small example of a future trend in human services provision which can be done outside of government, driving efficiencies across both the public and private systems. It is arguable that only a mutual organisation could make the long-term investment necessary to take this program from inception to operation, given the long lead times (from building relationships with the academics investigating this form of care through to the training of staff).

## EFFECTIVENESS OF PREVIOUS REFORMS

### Effectiveness

The notions of “client directed care” or “patient-centred care” are in principle laudable in human services delivery. The recipient of care should be at the centre of planning of the system. Their decisions can drive competition between providers and improved efficiency across the health, disability and aged care systems in which Australian Unity operates.

The key to the effectiveness of putting the person at the heart of human services provision is transparency of information. Patient or client information (subject to appropriate privacy controls) should be available to them and their agents and providers at all points in the system. This will ensure information can be best used for his or her long term interest, particularly in cases of managing chronic conditions.

Part of this will involve closer cooperation and information-sharing between the primary care sector and private health insurers. MyHealth records are a partial answer to this, and need to be supported further to succeed.

But there is no reason why a patient should not be entitled to information about a surgeon’s success rate, or a hospital’s rate of avoidable admissions. Australian Unity notes the excellent recent work of the Australian Commission on Safety and Quality in Health Care, and believes more such reporting is needed. Perhaps an investment in updating Ross Wilson’s seminal 1995 “Quality in Australian Healthcare Study” would benefit the nation’s knowledge base in this area.

To deliver effective “client-directed” care, the system must give the consumer the right tools to make informed decisions. Otherwise they will be tempted to leave decisions in the hands of service providers to act as “gatekeepers” of their care. This leaves open the question of whether providers, likely to be GPs, have the time to effectively prosecute this obligation.

One of the more efficient methods of achieving positive outcomes in this regard is to shift funding incentives to patient outcomes, rather than provide funding for activity.

### Ends