



**Productivity Commission Issues Paper:
Reforms to Human Services**
Submission from the South Australian Government
February 2017

Introduction

South Australia welcomes the opportunity to make a further submission to the Productivity Commission on its inquiry into introducing further competition and user choice in human services ('Inquiry').

The ultimate purpose of any reforms to human services should be to raise the quality of life of all Australians, and in particular to improve outcomes for the most disadvantaged of our citizens.

Proposed reforms that introduce further competition, contestability and user choice in human services, and which may improve the efficiency and sustainability of services, are supported where it helps us achieve this purpose.

The South Australian Government notes that public sector service provision has some different aims than that of the private sector, in particular when it comes to the commercialisation of service provision. The South Australian Government will not pursue competition and increased user choice at the expense of equity and quality of outcomes, and does not support it to be used as a tool for budget cuts or cost shifting from the Commonwealth to the States or to low income households.

Considerations

Many of the factors to be taken into account when assessing potential reforms to human services are applicable across the board and the following comments are intended to have general application across all human services. Examples citing specific services (such as public hospitals, dental or homelessness) are illustrative of similar issues experienced across the range of human services under consideration.

Role of government

The South Australian Government considers its paramount duty to be that of improving the welfare of its citizens. Competition cannot be at the expense of this principle.

For instance, the provision of Australian public health services is based on the Medicare principles of universal access to medical services, pharmaceuticals and public hospital services. Public hospitals are therefore required to "take all comers" whereas other providers may have the option to refuse some users or set prices that may exclude some users.

In addition, the public hospital sector also has a significant role in teaching and training. This service is generally not a commercial activity and therefore not undertaken by other sectors to the same degree as government. However, it is a critical service undertaken by the public sector that is to the benefit of both private and not-for-profit organisations.

In some sectors, and particularly in rural and remote regions, government could be the only provider of services. In South Australia, a combination of salaried staff working in public dental clinics as well as private sector fee for service based outsourced models of care is used. In some rural locations, the private sector is the main provider of public dental care, while in other locations the public provider is the only provider, and in some locations private providers choose not to be involved in the treatment of public patients.

While some remote communities are undergoing a transition process that will result in greater control and responsibility for services such as housing at the local level by non-government organisations, citizens will always look to government at least as a provider of last resort.

Balancing costs and benefits

The Commission acknowledges that a key consideration is whether the reform can be introduced cost-effectively.

Publicly funded services need to balance choice, costs and outcomes at the community or population level and not just at the individual consumer level. In an environment of limited resources, increasing user choice (and ensuring that users are sufficiently well informed to exercise that choice) must take into account the distinction between what users need (to improve the wellbeing of users and welfare of the community as a whole) and what users want, or think they need (which also raises the importance of preventative actions and increased consumer knowledge in this area).

Balancing costs and benefits from a public sector perspective also involves ensuring that social policy objectives are met. For example, the SA Dental Service uses population based public oral health principles to underpin service provision (in simple terms, the underlying principle is about the greatest good for the greatest number). This principle sometimes results in a different service mix when compared with the private sector.

Choice is only one of many factors

There remains an underlying assumption in the Productivity Commission report that increased consumer choice will lead to improved outcomes. South Australia considers that the Issues Paper does not adequately separate issues relating to choice with that of outcomes and quality. All three issues are important but can have very different drivers. For example, access to health care includes physical and geographic access but improving physical and geographic access will not necessarily improve clinical outcomes or the cost efficiencies of care, or make care more affordable. Similarly, improving cost efficiency will not necessarily improve physical access or quality of care and may in fact have the opposite effect.

As has been noted in our previous submission, consumer choice principles do not necessarily fit well across all patient groups, such as patients receiving time-critical emergency care, Aboriginal people particularly people living in remote communities, vulnerable patients (those with cognitive impairment, or being treated for addiction), and highly complex cases.

Contestability and implications of short term funding arrangements

Short-term funding arrangements and delayed notification of ongoing funding have been a characteristic of Commonwealth-State funding arrangements, which has created difficulties in providing continuity and certainty in service delivery. This also compromises the ability to maintain an appropriately trained workforce in a range of important areas.

Continued changes and uncertainty in funding arrangements compromises the overall efficacy of providers and presents significant difficulties in future planning for services. The opportunity to engage with marginalised and vulnerable patients and community groups to improve their access to care becomes lost with short-term arrangements.

Contestable tender processes are often hampered by short term funding commitments. For instance, South Australian homelessness services, incorporating dedicated domestic and family violence providers, are funded by approximately \$60 million per annum in grants while also having access to hundreds of properties at sub-market rents. South Australia undertook a significant reform of the homelessness sector between 2009 and 2011 following the initial National Partnership Agreement on Homelessness (NPAH). This included a contestable tender process for services across the State. The term of the initial agreement allowed for

medium term contracts to be offered that, in turn, incentivised new partnerships between providers and supported new service models. Subsequent NPAHs of only one or two years, often finalised a few months prior to the expiration of funding, have created significant uncertainty and seen a shift from a focus on innovation to simply staying open and retaining staff (who have little or no job security).

The paper acknowledges that governments can indirectly influence behaviours through incentives built into system design and there needs to be a good understanding of the intended and unintended consequences of incentives on users, markets and contestability. This is a significant issue particularly in the delivery of services to Aboriginal communities in remote locations.

Tailoring reform options

Equity of access to services does not necessarily achieve equity of outcomes for individuals. Alternative commissioning arrangements should be considered for particular population cohorts, such as Aboriginal people, newly arrived migrant communities or specific geographical areas (such as remote Aboriginal communities) which either do not or cannot access community services at the same rate as other consumers of these services.

Community organisations representing these groups may be best placed to deliver culturally and linguistically appropriate, flexible and responsive services to their own communities but often find it difficult to compete with larger, more sophisticated and better-resourced organisations in competitive tendering processes. This is a particular issue for Aboriginal-controlled service providers competing with larger, more highly-resourced non-Aboriginal organisations.

Direct allocation processes have previously been used successfully by the SA Department for Communities and Social Inclusion to fund services to specific population groups. The risks associated with funding smaller organisations with limited governance and business management experience can be mitigated to some extent through requirements to participate in both formal (for example quality assurance accreditation) and informal (for example mentoring, corporate volunteering) programs.

Data, Outcomes and Evaluation

Any move to increase competition in human services needs to be matched with an investment in data systems to help people navigate the system. The challenges of creating appropriate data and information systems for consumers that go side by side with increasing competition cannot be underestimated. The cost of ensuring users are genuinely informed, imposing data collection and reporting requirements on providers, and providing incentives to influence supply and demand, must be taken into account.

The South Australian Government is supportive of the use of good data to drive evidence-based reforms and evaluation. The State Government is currently pursuing initiatives to make sharing data between government agencies and with research entities more efficient and effective and has recently passed the *Public Sector (Data Sharing) Act 2016*. This legislation, modelled after the New South Wales *Data Sharing (Government Sector) Act 2015*, provides the authority for agencies to share their data, including a framework for ensuring that this occurs in safe circumstances and only for purposes supporting government policy-making, program management, service planning and delivery.

However, for data to be useful as an evaluation tool, it needs to be collected and reported in a consistent and comparable manner.

For instance, the overlapping and intersecting housing assistance systems across different levels of government present significant challenges in ensuring comparable data. Such challenges are likely to increase as market concentration is reduced through greater contestability and as barriers to entry are removed to encourage more providers into the market. Any degradation in data quality or consistency has flow-on impacts to market stewardship, sector planning and informed procurement decisions. Parallel to any consideration of stewardship roles and resourcing, careful consideration must be given to the medium and long term data needs of the sector and responsibility for collection, analysis and reporting.

Similarly, there is at present no nationally consistent framework for reporting and accountability for public providers of dental services, leading to difficulties in comparing the efficacy of each jurisdiction's efforts.

National leadership is required to increase national consistency across a range of measures and activities. This includes policy and the coordination of programs across governments to ensure maximum benefits are achieved as well as nationally consistent data collection and evaluation of programs. A national system might even expand on the capabilities of existing infrastructure to develop a single system for records management, where appropriate. Issues around resourcing and the data collection and reporting burdens for jurisdictions would need to be addressed.

Ongoing efforts and opportunities for further reform

The Human Services reforms must be cognisant of other significant reforms occurring in parallel at the national level, including in the areas of disability, aged care and health. The Commonwealth Government and the States and Territories are currently negotiating a three-year schedule to the National Health Reform Agreement which not only includes public hospital funding arrangements but also includes reforms to reduce avoidable demand on public hospitals. In particular, measures will be introduced to better co-ordinate care for patients with chronic and complex conditions and incorporate quality and safety into hospital pricing and funding. These measures are expected to lead to increased innovation, better quality services for patients and more cost effective service provision – the principles of competition reform. There may also be opportunities through these reforms for a wider range of public reporting on clinical outcomes and comparison of peer hospitals which would lead to patients seeking out the best performing hospitals. Competition reform should guard against potentially hindering these reforms or minimising their impact.

South Australia is also pursuing its own productivity reforms. In housing, South Australia has trialled or implemented various initiatives consistent with the Inquiry's focus on competition, choice and contestability, including property transfers to community housing; a trial of Choice Based Letting for public housing in a regional town; and competitive tender processes for services. South Australia provides the largest private rental support program in Australia; was the first jurisdiction to introduce inclusionary zoning for affordable housing; and is one of only two jurisdictions with a government-backed mortgage lender that helps low-income households into home ownership.

To support further competition and user choice, South Australia has previously suggested investigating an improved Commonwealth Rent Assistance (CRA) model across all housing options to create a "tenure neutral" payment, and continues to support this reform opportunity, contingent on ensuring funding adequacy across jurisdictions. One initial approach consistent

with this direction could include bringing forward a portion of future expected CRA payments to assist with upfront home purchase costs with the potential for these to be recouped, in part or in whole, upon sale of a home or other triggering event.

Maintaining the financial viability of social housing for remote Indigenous communities, coupled with factors inherent to remote service delivery, somewhat restricts the ability to further promote user choice. However, user input to home design during construction has provided for user voice while maintaining economies of scale. Tender processes for maintenance of assets in remote communities translates to competitive opportunities for Aboriginal business enterprises and includes local Aboriginal employment targets.

The priority for reform remains the development of an effective mechanism for community participation in planning and design of place-based service systems that respond to local conditions. This is particularly important in Aboriginal communities and requires genuine engagement and participation by Aboriginal people in decisions about community services. These require established, agreed Commonwealth-State funding arrangements that can support tailored service delivery systems (commonly siloed both across and within different levels of government) across a range of domains, including health, housing, education, justice, transport and employment.

The COAG Remote Service Delivery trials provide a strong basis for identifying opportunities and barriers to achieving reform. If funded and supported adequately, current trials in place-based/collective impact approaches, such as Empowered Communities and the South Australian Ceduna Service Reform Project, could also inform new models. The absence of a mechanism for Commonwealth, State and local governments to jointly consider and respond to systemic barriers is an ongoing risk. This would be a useful issue for consideration by the Commission.

The Commission should also consider that competition policy reforms may not be the only way to achieve improved productivity and service outcomes. For example, South Australia is currently embarking on the biggest-ever transformation of its health system through the Transforming Health initiative. Transforming Health is clinician-led, data driven and based on improving quality to deliver the best care, first time, every time, to all South Australians.

Through the Transforming Health process, South Australia's doctors, nurses, midwives, and allied and scientific health professionals developed over three hundred quality standards for the health system. To meet these quality standards, the state's health services are being reconfigured to ensure South Australians are provided consistent, safe, quality and patient-centred care.

South Australia recognises that high quality health care is less expensive to deliver than poor quality health care and most importantly, produces better health outcomes, allowing the state's health funding to be used to do the most good, in the most effective and efficient way.

Transforming Health is also about building capacity and fostering productivity in the system through, for example, implementing improvements in the flow of patients through Emergency Departments and other initiatives such as conducting more day surgeries.

The Transforming Health initiative is a clear example of an alternative way to reform public health service delivery to achieve better health outcomes in a sustainable manner.

Finally, South Australia has also commenced the first social impact bond in Australia with a focus on homelessness and would welcome support from other levels of government for trialling new financing or payment arrangements. Our experience to date indicates that the success of a single program may take five or more years to become apparent and a robust

assessment of the various policy areas in which these approaches may be useful is likely to take more than a decade. Our experience has also demonstrated the ease with which simple references to “inputs/outputs/processes” may be replaced with references to “outcomes”, contrasting with the difficulty in specifying these outcomes and an evaluation lag that necessarily occurs when measures require assessment over time.

Conclusion

It is clear from the 37 Productivity Commission “requests for information” that there are still many unanswered questions and that the task ahead is significant. An initial focus should be on establishing the right environment for contestability and user choice (i.e. providing information that enables users to make informed decisions; ensuring that providers are operating on a level playing field; acknowledging that equity of access does not equal equality of outcomes; and undertaking required analysis so that the needs of users are well understood).

It is also important to bear in mind that there are well documented examples (e.g. VET reforms) where increased competition has had unintended consequences. Further investigation to increase the breadth and depth of understanding about the benefits and risks of increased competition is required before any policy changes are implemented.

Most critically, any proposed reform to human services must aim to achieve improved outcomes for all citizens while balancing the costs to governments and society at large.