



Australian Government  
Productivity Commission

Introducing Competition  
and Informed User Choice  
into Human Services:  
Reforms to Human Services

Productivity Commission  
Inquiry Report

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### Publications enquiries

Media and Publications, phone: (03) 9653 2244 or email: [maps@pc.gov.au](mailto:maps@pc.gov.au)

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The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website ([www.pc.gov.au](http://www.pc.gov.au)).



**Australian Government**  
**Productivity Commission**

***Melbourne Office***

Level 12, 530 Collins Street  
Melbourne VIC 3000

Locked Bag 2 Collins Street East  
Melbourne VIC 8003

Telephone 03 9653 2100

Facsimile 03 9653 2199

***Canberra Office***

Telephone 02 6240 3200

[www.pc.gov.au](http://www.pc.gov.au)

27 October 2017

The Hon Scott Morrison MP  
Treasurer  
Parliament House  
CANBERRA ACT 2600

Dear Treasurer

In accordance with Section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the Commission's final report into *Introducing Competition and Informed User Choice into Human Services*.

Yours sincerely

A stylized, handwritten signature in black ink, consisting of a large 'S' and 'K'.

Stephen King  
Commissioner

A handwritten signature in black ink, appearing to be 'R. Spencer'.

Richard Spencer  
Commissioner

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# Terms of reference

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

I, Scott Morrison, Treasurer, pursuant to Parts 2, 3 and 4 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission undertake an inquiry into Australia's human services, including health, education, and community services, with a focus on innovative ways to improve outcomes through introducing the principles of competition and informed user choice whilst maintaining or improving quality of service.

### **Background**

The Australian Government is committed to working in partnership with State and Territory Governments and non-government service providers to ensure that all Australians can access timely, affordable and high-quality human services, which are appropriate to their needs, and are delivered in a cost-effective manner.

The human services sector plays a vital role in the wellbeing of the Australian population. It covers a diverse range of services, including health, education and community services, for example job services, social housing, prisons, aged care and disability services. There are some features that are common across the range of services and models of service provision, while other features are unique in nature. Complexity arises from differences in the characteristics of the services, and of the individuals receiving the services, the objectives sought, and the jurisdiction and market in which the services are being supplied.

While governments have made progress in introducing competition, contestability and user choice to human services provision, the efficiency and effectiveness of the delivery of services within the sector varies significantly between jurisdictions. Service delivery frameworks in the human services sector that are inefficient and/or ineffective can result in significant costs to the economy and individuals, including poorer outcomes and reduced productivity.

Australia's human services sector is facing significant challenges, including increasing demand for services due to the ageing population, the effect of technology and cost increases associated with new and more complex service provision demands. Finding innovative ways to improve the efficiency and cost effectiveness of the human services sector, and to target services to those most in need, will help ensure that high quality service provision is

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affordable for all Australians and leads to improved outcomes for the economy and individuals.

## **Scope of the inquiry**

The Commission is requested to examine the application of competition and user choice to services within the human services sector and develop policy options to improve outcomes. These options should lead to improvement in the sector's efficiency and effectiveness and help to ensure all Australians can access timely, affordable and high quality services, which are appropriate to their needs, and are delivered in a cost-effective manner.

The Commission is to undertake the inquiry in two stages.

1. 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;
  - (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; and
    - (ii) international examples of best practice.
2. In the second stage, the Commission will undertake a more extensive examination and provide an inquiry report making recommendations on how to introduce greater competition, contestability and user choice to the services that were identified above.
  - (a) In providing its recommendations, the Commission's report should identify the steps required to implement recommended reforms.
  - (b) In developing policy options to introduce principles of competition and informed user choice in the provision of human services, the Commission will have particular regard, where relevant, to:
    - (i) the roles and responsibilities of consumers within the human service sector, and the service or services being considered;
    - (ii) the factors affecting consumer use of services and preferences for different models of service delivery, noting the particular challenges facing consumers with complex and chronic needs and/or reduced capacity to make informed choices;

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- (iii) the role of the government generally, and as a commissioner, provider and regulator, in the delivery of human services;
  - (iv) the role of government agencies in designing policy, commissioning and, in some cases, delivering human services in a client-centred way that encourages innovation, focusses on outcomes and builds efficiency and collaboration;
  - (v) the role of private sector and not-for-profit providers;
  - (vi) the benefits and costs of applying competition principles in the provision of human services, including improving competitive neutrality between government, private and not-for-profit service providers;
  - (vii) how best to promote innovation and improvements in the quality, range and funding of human services;
  - (viii) the challenges facing the provision of human services in rural and remote areas, small regional cities and emerging markets;
  - (ix) the need to improve Indigenous outcomes; and
  - (x) the development of systems that allow the performance of any new arrangements to be evaluated rigorously and to encourage continuous learning.

## **Process**

The Commission is to undertake appropriate public consultation processes including holding hearings, inviting public submissions, and releasing issues papers to the public.

The Commission will publish the initial study report within six months of receiving these Terms of Reference. The report will set out the findings from case studies and international experiences and identify which services within the human services sector are best suited to the application of competition, contestability and informed user choice principles.

The final inquiry report, including policy recommendations and a path and process to ensure sustainable, efficient and effective reform, will be provided within 18 months of receiving these Terms of Reference.

S. MORRISON  
Treasurer

**[Received 29 April 2016]**

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# Contents

Terms of reference	iv
Acknowledgments	x
Abbreviations	xi
<b>Overview</b>	<b>1</b>
<b>Recommendations</b>	<b>41</b>
<b>1 The Commission's approach</b>	<b>59</b>
1.1 What the inquiry is about	59
1.2 The roles of government	60
1.3 The objective of reform	64
1.4 Introducing greater informed user choice, competition and contestability	66
1.5 Assessing reform options	71
<b>2 Government stewardship</b>	<b>79</b>
2.1 Governments' role as stewards	80
2.2 Design	82
2.3 Delivery	100
2.4 Improvement	106
<b>3 End-of-life care in Australia</b>	<b>109</b>
3.1 What is end-of-life care?	110
3.2 Some end-of-life care is excellent	114
3.3 Too many Australians miss out on high-quality end-of-life care	116
3.4 Poor stewardship is hindering better end-of-life care	127
<b>4 Reforms to end-of-life care</b>	<b>129</b>
4.1 Improving acute care at the end of life	130
4.2 Enabling more people to be supported to die at home if they wish	135

---

4.3	Supporting end-of-life care in residential aged care	148
4.4	Advance care planning	156
4.5	Effective stewardship of end-of-life care	162
<b>5</b>	<b>Social housing in Australia</b>	<b>171</b>
5.1	The role of social housing	175
5.2	The broader housing market	184
5.3	Towards a better social housing system	186
<b>6</b>	<b>Choice and equity in social housing: a single system of financial support</b>	<b>191</b>
6.1	The importance of choice	192
6.2	Unlocking choice: A single system of financial assistance	194
6.3	Designing a single system of financial assistance	196
6.4	Transitioning to a single system of financial assistance	206
6.5	Enabling greater choice within social housing	206
<b>7</b>	<b>A better social housing system: improving user focus</b>	<b>211</b>
7.1	Improving government stewardship	212
7.2	Increasing contestability of tenancy management	220
7.3	Creating a more even playing field for providers	224
7.4	Improving services for users	227
<b>8</b>	<b>Commissioning family and community services</b>	<b>235</b>
8.1	Context and scope	237
8.2	Problems with the current arrangements	242
8.3	Reform directions	247
<b>9</b>	<b>Human services in remote Indigenous communities</b>	<b>265</b>
9.1	The opportunity for reform	268
9.2	Lessons from previous reforms	271
9.3	Toward a better model of service provision	274
9.4	Improvements to commissioning practices	280
9.5	Longer-term directions for service provision in remote Indigenous communities	288

---

<b>10 Patient choice</b>	<b>295</b>
10.1 Introduction	296
10.2 Referral pathways	297
10.3 Giving patients greater choice	302
10.4 Key benefits and costs of the reforms	313
<b>11 Information to support patient choice and provider self-improvement</b>	<b>323</b>
11.1 Introduction	325
11.2 What information would support choice, provider self-improvement and contestability?	326
11.3 How well does current reporting support choice, provider self-improvement and contestability?	328
11.4 Proposed reforms	338
<b>12 Reforms to underpin more effective provision of public dental services</b>	<b>357</b>
12.1 The potential avoidable costs of oral disease	360
12.2 Establishing the basis for improvement	369
<b>13 User choice and contestability in public dental services</b>	<b>385</b>
13.1 Giving users choice through consumer-directed care	387
13.2 A better way to pay for public dental services	387
13.3 Better targeting high-risk children under the Child Dental Benefit Schedule	397
13.4 Allocating funding to patients	399
13.5 Improving contestability within public dental services	410
13.6 The reform pathway	415
<b>A Public consultation</b>	<b>423</b>
<b>References</b>	<b>451</b>

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# Abbreviations

AACQA	Australian Aged Care Quality Agency
ABF	Activity based funding
ACCC	Australian Competition and Consumer Commission
ACFI	Aged Care Funding Instrument
ACP	Advance care plan
ADA	Australian Dental Association
AHMAC	Australian Health Ministers' Advisory Council
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
CDA	Community Dental Agency
CDBS	Child Dental Benefits Schedule
CDDS	Chronic Disease Dental Scheme
CHC	COAG Health Council
COAG	Council of Australian Governments
CPI	Consumer price index
CRA	Commonwealth Rent Assistance
DEX	Data Exchange Framework
DHSV	Dental Health Services Victoria
DSS	Department of Social Services
FACS	NSW Department of Family and Community Services
GP	General practitioner
IAS	Indigenous Advancement Strategy
ICU	Intensive care unit
IHPA	Independent Hospital Pricing Authority
IPART	NSW Independent Pricing and Regulatory Tribunal
LASA	Leading Age Services Australia

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AACQA	Australian Aged Care Quality Agency
LSIC	Longitudinal Study of Indigenous Children
MHR	My Health Record
MRI	Magnetic resonance imaging
MUCHE	Macquarie University Centre for the Health Economy
NCOSS	NSW Council of Social Service
NDIS	National Disability Insurance Scheme
NEP	National Efficient Price
NFP	Not-for-profit
NHPF	National Health Performance Framework
NHRA	National Health Reform Agreement
NHS	National Health Service
NPA RSD	National Partnership Agreement on Remote Service Delivery
NRSCH	National Regulatory System for Community Housing
NSQHS	National Safety and Quality Health Service
NSW FHA	NSW Federation of Housing Associations
NYSCSRS	New York State Cardiac Surgery Reporting System
OECD	Organisation for Economic Cooperation and Development
PAF	Performance and Accountability Framework
PHN	Primary Health Network
POA	Patient Opinion Australia
PROM	Patient-reported outcome measure
RACF	Residential aged care facility
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians

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## OVERVIEW

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## Key points

- This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will use human services in their lifetime and change is needed to enable people to have a stronger voice in shaping the services they receive, and who provides them.
- In the study report for this inquiry, the Commission identified six services for which the introduction of greater user choice, competition and contestability would improve outcomes for the people who receive them. These services are: end-of-life care services; social housing; family and community services; services in remote Indigenous communities; patient choice over referred health services; and public dental services. This final inquiry report sets out tailored reforms for those six services. There is no one-size-fits-all competition solution.
- Users should have choice over the human services they access and who provides them, unless there are sound reasons otherwise. Choice empowers users of human services to have greater control over their lives and generates incentives for providers to be more responsive to their needs.
  - Competition and contestability are means to this end and should only be pursued when they improve the effectiveness of service provision.
- A stronger focus on users, better service planning and improved coordination across services and levels of government is needed. Governments should focus on the capabilities and attributes of service providers when designing service arrangements and selecting providers — not simply the form of an organisation.
- Each year, tens of thousands of people who are approaching the **end of life** are cared for and die in a place that does not fully reflect their choices or meet their needs. Reforms are needed to significantly expand community-based palliative care services and to improve the standard of end-of-life care in residential aged care facilities.
- The **social housing** system is broken. A single system of financial assistance that is portable across rental markets for private and social housing should be established. This would provide people with more choice over the home they live in and improve equity. Tenancy support services should also be portable across private and social housing.
- **Family and community services** are not effective at meeting the needs of people experiencing hardship. Practical changes to system planning, provider selection, and contract management would sharpen focus on improving outcomes for people who use these services.
- Current approaches to commissioning human services in **remote Indigenous communities** are not working. Governments should improve commissioning arrangements and should be more responsive to local needs. This would make services more effective and would lay the foundation for more place-based approaches in the future.
- Patients should have greater choice over which healthcare provider they go to when given a referral or diagnostic request by their general practitioner. A simple legislative change would help. More **patient choice** would empower patients to choose options that better match their preferences. Public information is needed to support choice and encourage self-improvement by providers.
- **Public dental** patients have little choice in who provides their care and most services are focused on urgent needs. Long-term reform is needed to introduce a consumer-directed care scheme. This would enhance patient choice and promote a greater focus on preventive care.

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# Overview

The Australian Government's 2015 *Competition Policy Review* recommended that governments should, wherever possible, put user choice at the heart of human services delivery. In its response to the Review, the Australian Government asked the Commission to undertake this inquiry to examine policy options that apply the principles of informed user choice, competition and contestability to the provision of human services. Desirable though they may be, applying these principles has proven to be neither simple nor without cost.

## 1 Why reforms to human services matter

This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will access human services in their lifetime, including children, the elderly, people facing hardship or harm, and people who require treatment for acute or chronic health conditions. People who use human services can lose their autonomy, and with it their dignity, if they have too little control over decisions that affect them. Reforms to the way human services are provided are needed to enable and support people and their families to have a stronger voice in shaping the services they receive, and who provides them.

Human services are essential for the wellbeing of individuals and their families, and underpin economic and social participation. Ensuring that everyone, regardless of their means or circumstances, has access to a minimum level of high-quality human services promotes equity and social cohesion, which in turn contributes to the welfare of the community as a whole.

The number of services provided each year in Australia is considerable, for example, there were more than 10 million admissions to public and private hospitals in 2015. Other services, such as homelessness services and social housing, are each used by hundreds of thousands of people every year. Public and private expenditure on human services is significant — over \$300 billion in 2014-15 — with demand for services projected to grow as more people live longer, incomes grow and technological advances increase the types of services that can improve a person's quality of life.

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## 2 Introducing greater user choice, competition and contestability

The Commission's task in this inquiry is to recommend reforms using the policy 'tools' set out in the inquiry terms of reference — the introduction of greater informed user choice, competition and contestability — to improve the effectiveness of human services. In doing so, the Commission's objective is to improve outcomes for the users of those services and the welfare of the community. Not all areas of human services are amenable to the mechanisms we have considered. In the study report for this inquiry, the Commission found reform could offer the greatest improvements in outcomes for people who use:

- end-of-life care services
- social housing
- family and community services
- services in remote Indigenous communities
- public hospitals for elective care following a referral from their general practitioner
- public dental services.

In making its final recommendations to improve the effectiveness of these six services, the Commission has assessed whether: the likely benefits to the community of its proposed reforms would be expected to outweigh the costs; the incentives of providers and users would be aligned; and government objectives would be achieved.

The Commission also considered five *attributes* of effective service delivery in its assessment of the potential costs and benefits of reform options.

- *Quality*: whether the reform option would lead to incentives for providers to offer high-quality services to users.
- *Equity*: who would be affected by the reform option and how.
- *Efficiency*: whether the reform option would lead to incentives for providers to reduce the costs of providing services while still maintaining quality, and for users to select the services that best meet their needs.
- *Responsiveness*: whether the reform option would result in service providers being more responsive to the needs of service users.
- *Accountability*: whether the reform option would result in service providers being more accountable to those who fund the services (taxpayers and users).

Each of the services the Commission has proposed for reform is different — in the type and number of users, their capacity and willingness to make choices, the setting and circumstances under which services are accessed, and the share of the cost of service provision that is paid for by users and by governments. The starting point for reform also differs across the services. In some cases, improving service effectiveness through the

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application of competition principles would require major reform. In others, particularly those that currently operate well, service effectiveness can be improved with relatively minor reforms to introduce greater choice and competition. The Commission has tailored its proposed reforms to the unique circumstances of each service.

## **Informed user choice empowers people**

Informed choice can improve outcomes for users because it:

- empowers people to have greater control over their lives
- enables people to make decisions that best meet their needs and preferences
- generates incentives for providers to be more responsive to users' needs and drives innovation and efficiencies in service delivery.

The Commission's starting point is that users should have choice over the human services they access and who provides them, unless there are clear reasons otherwise. These reasons include a lack of capacity to exercise informed choice and the inability of an agent to exercise choice on a user's behalf, or when decisions must be taken during a crisis, such as a medical emergency. Providing choice can also be expensive for governments, and the benefits of introducing greater choice need to be considered against its costs.

A common theme in submissions was a strong desire for people to have choice and the empowerment that comes with it. In its submission to this inquiry, Alzheimer's Australia stated:

Alzheimer's Australia is strongly supportive of the principle of user choice in human services. For people living with dementia, their families and carers, having a say in their everyday lives is a basic desire and underpins a sense of purpose and wellbeing. Many people living with dementia have expressed a desire to feel that they are participating in decision making regarding their care but also recognise that their ability to do so can be impacted by their diagnosis: capacity to make informed decisions may change from day to day or may decline rapidly.

Not everyone shares this view. A small number of inquiry participants considered that user choice should not be increased, pointing out that recipients of human services may not possess full knowledge of their preferences, have the capacity to act on their preferences, or have access to information that is necessary to make decisions.

The Commission recognises that there are circumstances where user choice is not desirable. If not the user, someone — the government or the provider — will be making a choice as to which services a person should receive and who should provide them. In these cases, it is critical that the best interests of users, rather than governments or providers, remain at the heart of service provision. Yet even when user choice is not desirable, a focus on users can be achieved through other approaches, such as increasing 'user voice' and co-design so a person's (or community's) preferences are taken into account when others make decisions on their behalf.

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## Putting the focus on users through competition and contestability

Competition and contestability are a means to an end. Used well, competition and contestability can be a powerful mechanism for improving the effectiveness of service provision. But competition and contestability should only be pursued where they improve outcomes for service users and the community. For example, the Commission has concluded that introducing further contestability into the delivery of public hospital services is unlikely to deliver additional net benefits at this time.

Competition (as an adjunct to user choice) delivers strong incentives for providers to be more focused on people who use services. Efforts by a provider to attract users can include improving the quality of the service they offer, reducing the price that they charge or tailoring their services to better meet the needs of the people they serve — all of which are beneficial to service users. When competition between multiple service providers is not possible or desirable, contestability can deliver many of the same benefits as competition. Contestable arrangements, where providers are selected by governments through competitive processes such as tenders, are widely used in human services. Examples include the selection of providers of family and community services, and tenancy management services for social housing.

A number of participants questioned whether competition and contestability should have a place in the provision of human services. Anglicare Australia, for example, in its submission did not accept that competition is a driver of efficiency; that efficiency is an inherently good thing in human services; that the innovation that comes with competition between providers is of benefit to service users; or that it is appropriate to equate individual consumer choice with agency and wellbeing.

The Commission does not agree. Well-established markets for schools, optometrists, general practitioners and allied health professionals, for example, demonstrate the value that choice and competition can bring to people who use those services and the community as a whole.

Problems can emerge if competition and contestability are poorly implemented and Governments need to learn from the lessons of the past. Issues raised by participants included competition damaging collaboration between providers, funding uncertainty and providers focusing on writing tender applications at the expense of their core business. These issues emphasise the importance of good government stewardship.

Some participants stated that for-profit providers should be excluded from delivering human services arguing, among other things, that providers incentivised by profit are not suited to offer high-quality services to vulnerable people.

The Commission has a different view. Human services are currently provided by a mix of government, not-for-profit and for-profit organisations. Experience shows that no one type of provider has a monopoly over good service provision and each has had successes and failures. Governments should focus on the capabilities and attributes of service providers

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when designing service arrangements and selecting providers — not simply the form of an organisation.

## **Costs and implementation**

Governments have sound reasons to fully or partially fund many human services. Access to these services needs to be carefully managed to ensure that services flow to the intended beneficiaries and fiscal costs are outweighed by benefits to the community.

Eligibility arrangements for the human services covered by this inquiry vary considerably. In some cases, such as social housing and public dental services, clear eligibility criteria govern access. In others, such as family and community services, eligibility is governed more flexibly. The Commission did not reconsider the existing eligibility arrangements for the services covered by this inquiry. In particular, it has not commented on whether changes to eligibility criteria should be considered as a means of constraining fiscal costs.

Introducing greater choice, competition and contestability will involve additional fiscal costs to governments, especially in the early years of implementation. The nature and extent of these costs vary considerably. Additional costs in the delivery of one service may also be offset by lower costs in other areas of service provision. More effective end-of-life care and public dental services could, for example, reduce demand for some hospital services.

The Commission has outlined a broad reform timetable for each service that could guide implementation. These timetables provide information on the sequencing of reforms and the timing of implementation. Consideration will need to be given to how these reforms sit against existing reform priorities and activities.

All of the services considered in this inquiry involve the Australian, State and Territory Governments. There is evidence that uncertainty about the roles and responsibilities across different levels of government has led to policy inertia and, in some cases, conflict over responsibilities and uncertainty over how stewardship is shared and service provision is coordinated across different settings. Neither fiscal costs, nor the unequal distribution of fiscal effects, should be an insurmountable barrier to implementing reforms that would generate significant net benefits to the community. For successful reform to occur, collaboration across jurisdictions will be critical.

## **3 Governments as system stewards**

Governments are heavily involved in the funding and provision of most human services. There are sound efficiency and equity reasons for this. Markets left to their own devices would not deliver the appropriate level, or distribution, of human services across the community. Governments' approach to filling these gaps can take a number of forms including funding universal access to a service, as is the case for emergency health care, and

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fully or partly covering the cost of a service to targeted groups in the community, as is the case for public dental services. Governments also choose whether to provide services directly (as is the case for the management of some public housing tenancies) or commission other providers to deliver services.

Governments should always have the role of system stewards irrespective of how human services are provided, or by whom. Stewards are responsible for the range of functions that both determine what human services should be made available and the effectiveness of those services. These functions include policy design, regulation, oversight of service delivery, monitoring of provider performance, and system improvement. Planning to understand the population of service users is a key element of governments' stewardship role and an area in which the Commission has made several recommendations.

Stewardship is a core part of the reform and delivery process — the design and performance of these functions should be tailored to each service and to the settings in which it is provided. Stewardship arrangements are difficult to get right and, together with the need to place greater focus on the user, this inquiry has highlighted areas where governments need to improve. These areas include:

- *greater coordination*: government silos and poor planning have led to gaps and duplication, services with competing objectives and stewards losing sight of the users' overall wellbeing. Better planning and coordination are needed within and across governments. Greater efforts, for example, are needed to coordinate services for people with multiple and complex needs
- *more transparency*: Providing information to improve accountability and facilitate performance assessment can benefit all parties within the human services system. Equipped with improved information, users can assess providers, providers can plan their services, and governments can evaluate how providers or systems are performing
- *smoother transitions*: Policy reform in human services is a complex task. Reforms can be large, costly and disruptive to users and providers, take considerable time to fully implement, and affect the lives of many (sometimes vulnerable) users. Overly ambitious reforms and rollout schedules can lead to issues in implementation, particularly for large and complex reforms. Transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Governments should plan and prepare for change in order to preserve continuity of outcomes, and minimise any negative effects on users from the transition. Information and clarity about changes in advance can help.

## 4 Caring for people at the end of life

Too many people approaching the end of life cannot access end-of-life care that aligns with their needs and preferences. Service availability varies widely according to patients' diagnosis, age and location. Their end-of-life journey can be punctuated with avoidable, or unwanted, admissions to hospital with the confusion, loss of dignity and loss of control that

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comes with it. Few of those who would prefer to die at home are able to do so. Developing end-of-life care services and improving access to high-quality care would enhance community welfare, by enabling people to have more choice about where they are cared for and where they die.

Between 80 000 and 140 000 of the 160 000 people who die each year in Australia could benefit from high-quality end-of-life care — the physical, spiritual and psychosocial services provided by health professionals and ancillary staff to people who are likely to die within the next 12 months.<sup>1</sup>

Providing community-based palliative care instead of hospital care to those who would prefer it is potentially cost effective. Available evidence indicates that the savings from avoiding a single hospital admission for palliative care (costing about \$11 000) would more than cover the cost of providing community-based care over a period of months (costing between \$6000 and \$10 000). However, the net cost to State and Territory Governments of increasing the availability of community-based palliative care will ultimately depend (amongst other things) on the extent of unmet demand, which is currently unknown.

Effective end-of-life care recognises that the patient and clinicians are both essential participants in discussions and decision making about care options at the end of life. This shifts the emphasis of care delivery toward fulfilling each patient's choices, values and preferences, given the realities of their clinical condition and available treatments.

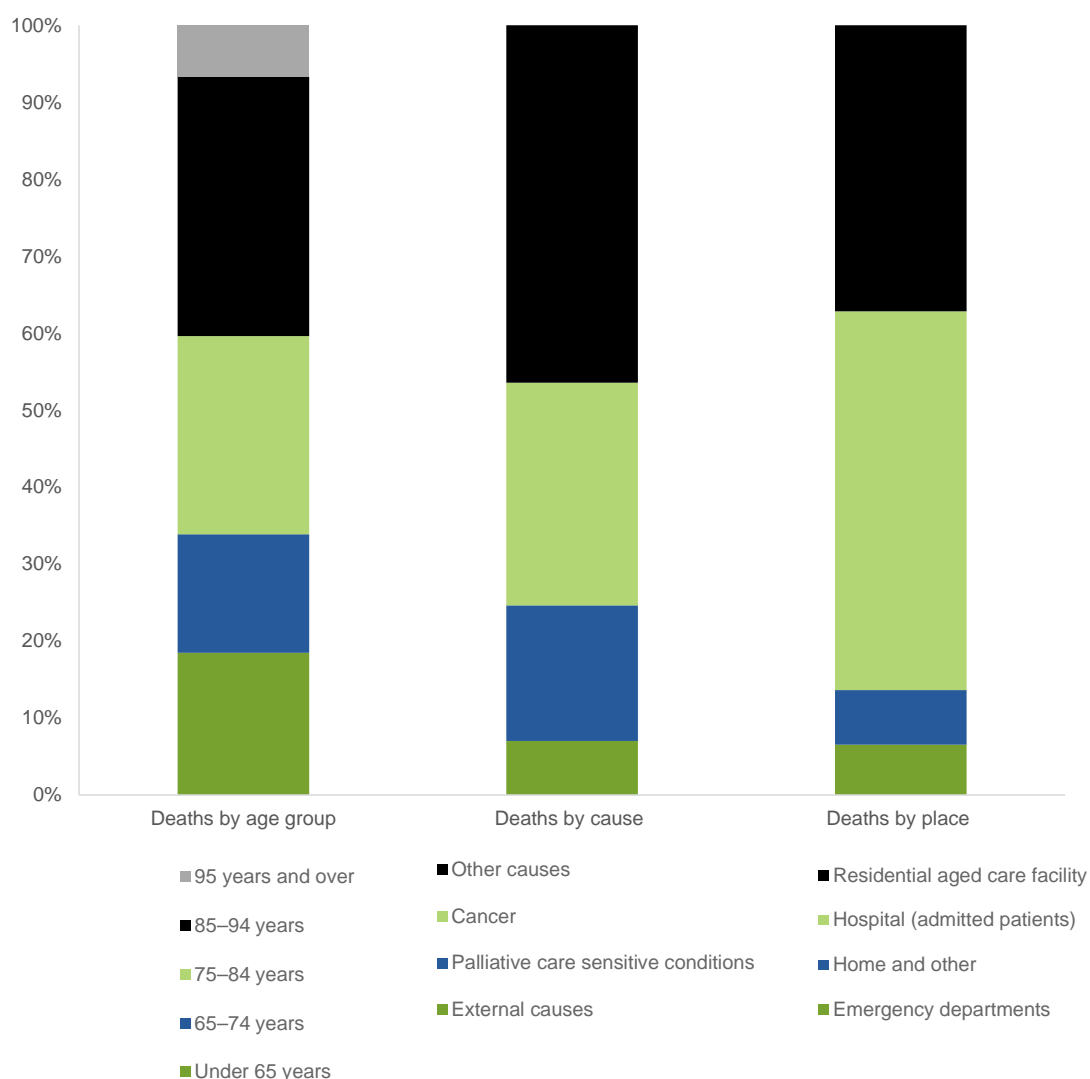
The quality of end-of-life care in Australia is among the world's best, but services are not available everywhere and to everyone who would benefit. People approaching the end of life in hospitals can find it hard to access care that is responsive to their preferences, and sometimes receive medical interventions that are not beneficial to them. Up to 70 per cent of Australians would prefer to die at home, but few do so (figure 1). Demand for end-of-life care in the community (community-based palliative care) far exceeds the availability of that care, particularly for those with illnesses other than cancer. Four out of five residents of aged care facilities die in them but the lack of palliative care expertise and qualified staff to administer pain relief mean residents often make traumatic (and costly) trips to hospital to receive medical care that could have been provided in surroundings that are familiar to them.

State and Territory Governments are primarily responsible for, and often provide, end-of-life care in public hospitals and in people's homes. The Australian Government is primarily responsible for end-of-life care in residential aged care and general practice. Coordination between these services is too often poor. Collaborative reform is needed to improve the effectiveness of end-of-life care across all settings where it is delivered, and to allow users more choice over their place of death and the services they receive.

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<sup>1</sup> End-of-life care does not include euthanasia, assisted suicide or voluntary assisted dying.

**Figure 1 Age, location and cause of death in Australia, 2015**



The aim of reforms to end-of-life care should be to provide the growing number of people needing end-of-life care with services that better match their preferences. These reforms should ensure that Australians receive high-quality care across all major settings — hospitals, residential aged care facilities and at home.

End-of-life care in acute hospitals will improve when hospitals implement a range of new practices to identify, and deliver higher quality care to, patients approaching the end of life. This includes an updated version of the National Safety and Quality Health Service (hospital accreditation) Standards, which will commence in 2019 and contain new end-of-life care standards. Provided clinical governance systems include end-of-life care, and hospital clinicians are trained to engage patients (and their families and carers) in shared decision making, the new standards will help to ensure that patients are encouraged and supported to express their preferences about end-of-life care, and receive care that is responsive to those

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preferences. Additional reforms are needed, however, to ensure high-quality care is available for people wishing to die at home and for those in residential aged care facilities.

## **Few people can access community-based palliative care**

Tens of thousands of the people who die each year have a medical condition that is amenable to palliative care and have family and friends who are able to provide the considerable support needed for them to remain at home as they approach the end of life. Lack of access to the community-based palliative care that would enable them to be cared for and to die at home prevents them from fulfilling this preference. Better meeting this demand will require State and Territory Governments to **substantially increase the availability of community-based palliative care**, and to fund that increase. While offering service users choice of provider should be the long-term goal of governments, the first priority should be better meeting demand.

Increasing the availability of community-based palliative care requires careful stewardship. The Commission's proposed approach would require State and Territory Governments to better understand the needs of different regions and populations to determine priorities for service expansion. This assessment should inform decisions on how to select service providers. In many places, competitive processes could be run to select providers of additional community-based palliative care services. A lack of potential providers in some regional and remote areas will require governments to provide services directly or to commission a sole supplier.

Governments should establish standards for community-based palliative care services and fund the provision of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care. Users should be able to purchase additional services if they wish to do so.

## **Residential aged care is ill equipped to meet end-of-life care needs**

All aspects of end-of-life care should be core business for residential aged care facilities. However, under current arrangements, many people miss out on the clinical care they need at the end of life. Intensive nursing and other end-of-life care services are only funded in the last week or days of life, and are not available to those with pre-existing high health care needs. Two main reforms are needed to address this.

First, residents require greater access to **services delivered by clinically qualified staff**. There are many possible staffing and contracting arrangements that could be used to increase these services. Residential aged care facilities could, for example, purchase services from community-based palliative care providers or employ additional skilled staff themselves, such as nurses or end-of-life care nurse practitioners. The increase in clinical services should be funded by the Australian Government and ensure that people living in an aged care facility receive end-of-life care that aligns with the quality of care available to other Australians.

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Second, consumers and their families need more information to help them select aged care facilities that deliver high-quality end-of-life care. A good first step would be for the Australian Government to ensure that all of its aged care publications — both for consumers and for policy makers — explicitly acknowledge that one of the core roles of residential aged care is to provide end-of-life care.

## Other measures to deliver better end-of-life care

Aligning care to people's preferences is critical to the effectiveness of end-of-life services. Not everyone will be able to communicate their preferences at the time they receive care. Preparing an advance care plan (ACP) lets people have a real choice in the care they receive, even if they can no longer communicate that choice. ACPs can include anything from a formal directive to an entry in a patient's medical record, and have been shown to improve end-of-life experiences for the patient, their family and their clinicians. Yet despite efforts to promote advance care planning, less than 15 per cent of Australians have an ACP. People who could be more likely to need an ACP, such as those aged over 65 years, are not more likely to have one. Reforms are needed to **provide more opportunity for people to develop a high-quality advanced care plan**. Primary care providers and residential aged care facilities are well placed to promote advance care planning and to facilitate the ongoing conversations that it requires. This will require training and supporting clinicians to hold advance care planning conversations and improving access to plans once they are made, including through electronic health records.

## Improving stewardship of end-of-life care

The effectiveness of the proposed reforms will depend on governments implementing broader improvements to their stewardship of end-of-life care. The Australian, State and Territory Governments should, through the Council of Australian Governments (COAG) Health Council, ensure that there is **cross-jurisdiction co-operation** to:

- plan, fund and deliver end-of-life care so that patients receive integrated services across different settings and jurisdictions
- set standards for end-of-life care in each of the settings in which it is provided (such as those in the updated version of the National Safety and Quality Health Service Standards, which will apply to hospitals in all jurisdictions from 2019)
- monitor and evaluate end-of-life care services.

A comprehensive and coordinated approach to addressing gaps in data on end-of-life care will require the development and implementation of a **national data strategy**, overseen by the COAG Health Council. The data strategy should:

- establish a national minimum data set for end-of-life care (including collecting and publishing linked information on place of death, primary and secondary diagnoses and details of service provision at time of death)

- 
- improve the accessibility of patient-level data (such as ACPs or hospital discharge summaries) so that they are used to deliver high-quality care
  - use system-level data to enable governments to plan, monitor and evaluate how well end-of-life care services are meeting users' needs across all settings and jurisdictions, and to drive improvements in end-of-life care.

In 2025, the COAG Health Council should commission an **independent review** of the effectiveness of end-of-life care across all settings in which it is, or should be, provided. This must include an assessment of consumer protection, such as the use of quality standards.

## 5 Social housing

Australia's social housing system is broken. Eligible tenants have little choice over the home they live in and can face a lengthy wait to access housing, and the type and amount of financial assistance available to households is inequitable. There is little transparency around the outcomes governments are seeking to achieve from the social housing system. The introduction of greater choice and competition could substantially improve the effectiveness of social housing but the cost would be significant.

Access to social housing properties for tenants is currently determined by the amount, location and composition of public and community housing properties. These properties have largely been built through an inflexible 'build and own' model, making it difficult for governments to respond quickly to changes in demand. As a consequence, people eligible for social housing are often unable to access it — over 150 000 households are on waiting lists to enter social housing and some households can wait 10 years or more. In addition, many people eligible for social housing have chosen not to apply and rent in the private market. About 850 000 households in the private rental market satisfy the income eligibility criteria for social housing.

The type and amount of financial assistance a household receives depends on the sector from which they rent their home, rather than their circumstances. Households that rent from the private market can receive a vastly different (often much lower) level of implicit financial assistance compared with households that rent social housing, even when their circumstances are otherwise similar (box 1). Even within social housing, rates of implicit assistance vary widely depending on the location and characteristics of the property. These arrangements are inequitable and result in many of the 400 000 or so households in social housing having a considerable financial disincentive to exit.

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## Box 1      **A two-tiered system of financial assistance**

Currently, two types of financial assistance are potentially available to people who have low incomes — assistance received by tenants in social housing who have their rent set at a proportion of their income, and the provision of Commonwealth Rent Assistance (CRA) to tenants currently renting in the private market. The type of assistance a household is eligible for depends on whether they rent private, public or community housing.

### **Social housing**

There are two main types of social housing in Australia, both of which are rationed using (what are often very long) waiting lists.

- **Public housing** — properties managed by State and Territory Government housing authorities, such as Housing SA or Housing NSW.
- **Community housing** — properties managed (and in some cases owned) by non-government providers.

The social housing system covers the allocation of tenants to properties, the ownership and management of properties, and the provision of financial assistance to tenants. Tenants in social housing properties pay rent that is set at a proportion of their income (typically 25 per cent), or at the estimated market rent, whichever is lower. The implicit assistance that tenants receive is equal to the difference between the market rent for the property they live in, and the rent they actually pay. Tenants living in community housing can also receive CRA but this assistance is generally passed straight through to the housing provider. Public housing tenants are not eligible for CRA.

Many people in the private rental market who receive CRA would also be eligible to apply for social housing.

### **Commonwealth Rent Assistance**

A household renting in the private rental market or in community housing is eligible for CRA if they pay more than a minimum rent threshold, and are receiving a qualifying social security payment (such as Newstart Allowance, Youth Allowance and the Age Pension).

CRA is payable at the rate of 75 cents for every dollar of rent above the rent threshold, up to a maximum amount. The rent thresholds and maximum amount vary depending on household characteristics, such as the number of children they have, and increase with the consumer price index.

The two types of financial assistance lead to a two-tiered system. Tenants in social and private housing can receive vastly different levels of financial assistance, even though their circumstances are similar, except for the tenure of their housing. The Commission estimates that households in public housing in Victoria, for example, receive on average about \$50 per week more in financial assistance than if they received CRA.

## **Introducing greater choice and competition**

Unlocking user choice requires governments to rethink the way they meet the needs of tenants who are eligible for housing assistance — to shift the focus of social housing away from providing financial assistance and tenancy support services according to whether a

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person lives in private, public or community housing toward a single system of financial assistance that can be accessed regardless of the type of housing a person chooses to live in.

A single system of financial assistance that is *portable* across rental markets for private and social housing would serve two purposes. One, it would enable a person to choose where they live based on their *preferences* — their access to financial assistance (and tenancy support services) would ‘follow them’. Two, it would address current inequities by targeting the type and amount of financial assistance a person receives to their *circumstances*, rather than the type of housing they live in.

The proposed reforms summarised in figure 2 present the Commission’s approach to a single system of financial assistance — an approach that would place the user at the centre of the social housing system. The reforms also recognise the significant variation in local housing market conditions in each state and territory, including the variation in the affordability and nature of housing across and within jurisdictions. Importantly, the design of the reforms is flexible enough to enable each State and Territory Government to tailor implementation to meet the outcomes it seeks from the social housing system, given these variations.

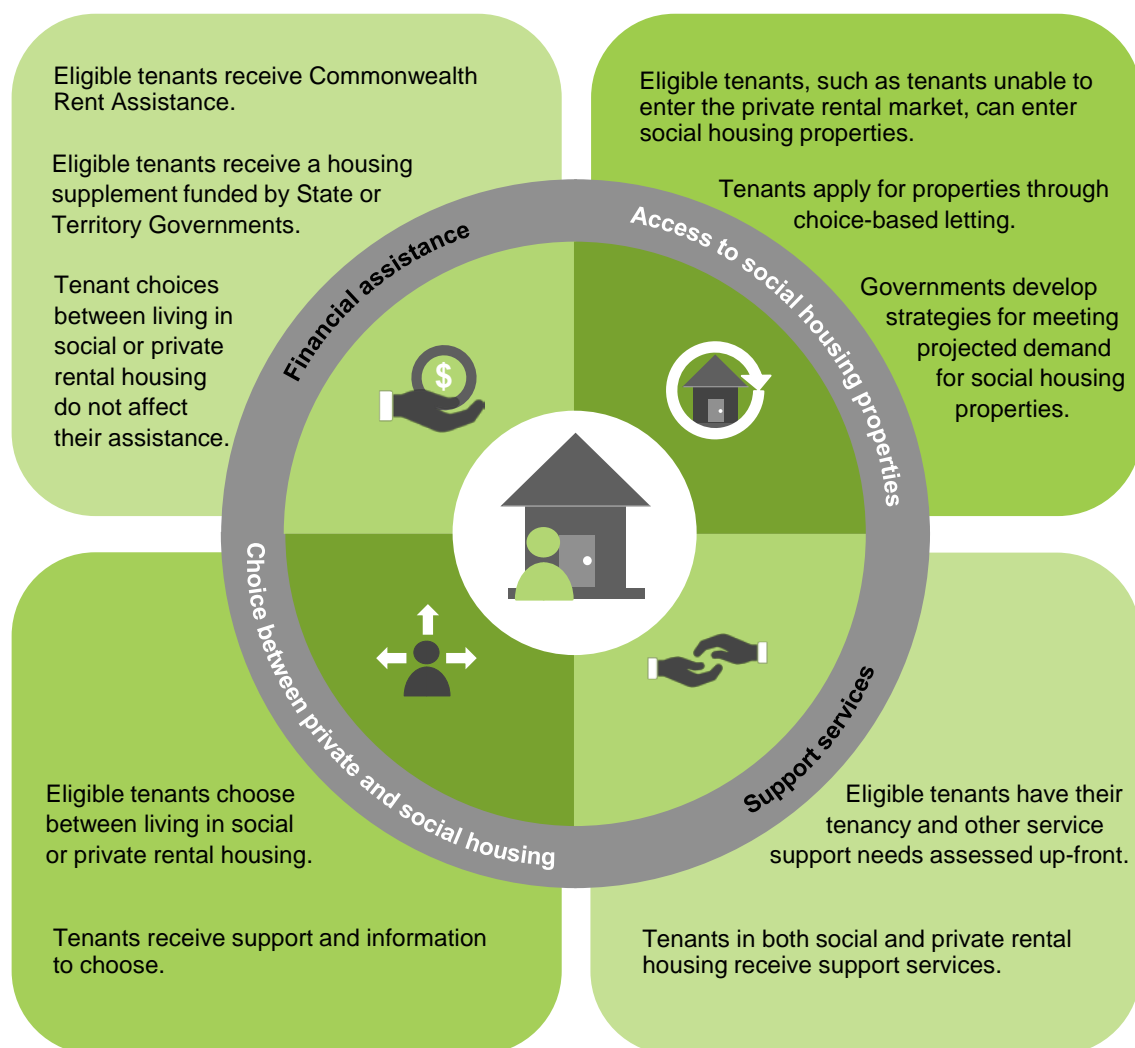
### A single system of financial assistance

The current two-tiered system of financial assistance must be replaced for choice and competition to address the problems in the social housing system. Reforms to enable people to have a genuine choice over where they live would improve the responsiveness of the social housing system to the requirements of tenants by increasing competition between housing providers.

The establishment of a single system of financial assistance hinges on reforms being undertaken at both the national and state and territory level so assistance can be provided as a package (box 2).

- The **Australian Government should extend Commonwealth Rent Assistance to tenants in public housing** so that it is available to all eligible tenants in social housing properties. People who live in private and community housing already receive Commonwealth Rent Assistance (CRA), but people in public housing do not. This change would provide a consistent baseline level of support.
- **State and Territory Governments should provide and fund an additional housing supplement.** The supplement should target eligible tenants in areas with acute rental affordability problems for whom CRA is insufficient.

Figure 2 **Putting the user at the centre of the social housing system**



Eligibility for, and the level of, the housing supplement would be a matter for State and Territory Governments, but should be calibrated to the demographics and housing market characteristics of their jurisdictions. The supplement should:

- be provided to eligible tenants in areas with acute rental affordability problems
- be set at a level (or levels) where eligible tenants can afford housing that meets their requirements, but provides incentives for them to choose the housing they most value given their needs and financial circumstances
- be portable — tenants eligible for the supplement should be able to use it in either private or social housing
- recognise that a tenant's need (and eligibility) for financial support can change over time. For example if a person's employment situation changes and they are earning a higher (or lower) level of income, then the amount of assistance that they receive should adjust.

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These adjustments should be calibrated with those applying to income support payments to avoid financial disincentives to employment, and introducing new inequities between recipients of income support payments.

State and Territory Governments should **charge new social housing tenants market rents**. The Commission notes that about 60 per cent of people who currently receive CRA pay less than 30 per cent of their income in rent — an often used (but imperfect) indicator of ‘rental stress’. For transitional reasons, people who are currently living in social housing properties should continue to pay rents set as a proportion of their income for up to 10 years before being required to pay market rents, unless they elect to move to the new system of financial assistance earlier.

The reforms proposed by the Commission would require a new agreement between the Australian, State and Territory Governments. The Australian Government should only extend CRA to public housing tenants in a jurisdiction if that State or Territory Government agrees to implement reforms to introduce a well-focused housing supplement to address affordability concerns for people on low incomes and charge market rents for all tenants in social housing.

### Improving the support that tenants receive

Financial assistance that is portable across rental markets for private and social housing should be complemented with portable tenancy support.

People eligible for social housing vary widely in their need for (non-financial) tenancy support services. For some, these services play an important role in stabilising tenancies, preventing evictions and connecting tenants to other supports, such as treatments for a mental health condition. In 2012-13, over 2000 tenants were evicted from social housing due to a tenancy breach (about 7 per cent of all tenancy exits) — bringing with it increased risks of homelessness and involvement in child protection and criminal justice. Some tenancy support programs have cited 80–90 per cent success rates in supporting people with experiences of homelessness to sustain tenancies.

Many support services targeted at social housing tenants are not made available to those renting in the private market. The support services that are available to people renting in the private market primarily focus on assisting tenants to find a home, and little long-term support is provided to sustain the tenancy. Improved access to tenancy support services could help to further enhance the benefits of user choice of home.

Delivery of support services for tenants eligible for social housing is, and should remain, a responsibility of the State and Territory Governments. These governments should **improve their contracting of tenancy support services** to clarify the support available for tenants and who should provide it.

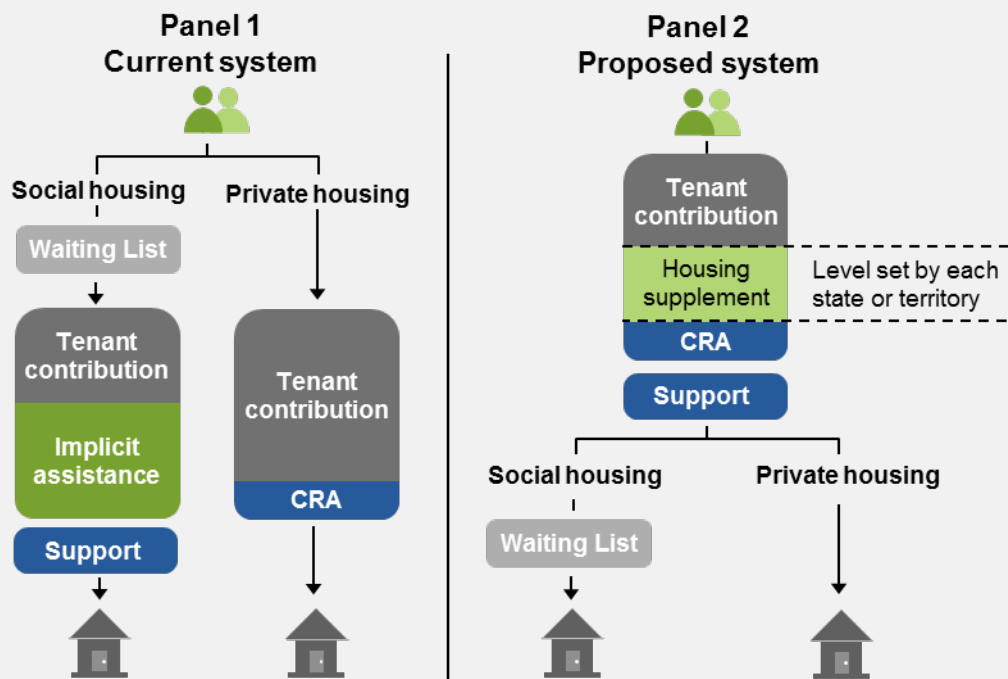
## Box 2 A single system of financial assistance

The figure below illustrates the financial assistance and tenancy support received by a household under the current and proposed systems of assistance. In the example, the household is assumed to be a couple with no children that lives in an area with acute rental affordability problems.

Panel 1 of the figure shows the level of financial assistance and tenancy support the couple receive under the current system. The couple receive a different level of assistance and support depending on whether they live in private or social housing.

- In private housing they receive Commonwealth Rent Assistance (CRA) and pay market rents.
- In social housing they generally face a wait to be allocated a property. Once allocated a property, they pay a rent set at a proportion of their income (usually 25 per cent) and receive implicit assistance equal to the difference between the rent they pay and the market rent. They also have access to tenancy support services. If the couple lives in community housing some of their implicit assistance is funded through CRA.

Panel 2 shows the financial assistance the couple would receive under the Commission's proposed single system of assistance. The couple would receive a package of assistance that is portable between rental markets for private and social housing. This would include CRA and, because they live in an area with acute rental affordability problems, a housing supplement. Eligibility for, and the level of, the housing supplement would be a matter for State and Territory Governments. The couple would have access to tenancy support services regardless of whether they live in private or social housing. If they choose social housing they may continue to face a wait to be allocated a property, but would receive their assistance package during this waiting period. Social housing properties would be allocated through choice-based letting, giving the household more choice of home. Social housing properties would continue to offer more secure tenancies than generally available in the private rental market.



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## Making social housing work for tenants

Even with greater choice between social and private housing, there would remain a strong role for social housing properties to provide a home for people who have limited opportunity to rent in the private market. For example, people can enter social housing because landlords in the private market are reluctant to rent to them, or because they value the stability offered by greater security of tenure.

State and Territory Governments should do more to assess the future demand for social housing and **develop strategies for meeting that demand into the future**. Tenants entering social housing properties should also have more choice of home. This should be achieved through the introduction of **choice-based letting of social housing properties**.

Continuing to make the **management of social housing properties contestable** would provide incentives for managers of social housing to improve the effectiveness of service provision, and increase the pressure on them to provide well maintained properties that meet the requirements of tenants. Governments have transferred the management of some social housing properties to not-for-profit providers, and some have a policy position of further transfers. Nonetheless, four out of five social housing properties remain managed by government housing authorities.

Management of social housing properties should be **open to all types of providers**, and these providers should compete on a level playing field. This includes **applying consistent regulation across different types of provider**, and ensuring that the government housing provider is not managing tender processes or responsible for monitoring its own performance.

## The benefits of reform are expected to exceed the costs

The Commission's proposed reforms would address key shortcomings of the social housing system. The proposed reforms provide for a greater choice of home for eligible households, and would improve equity between households across rental markets for private and social housing. They would also remove a disincentive for tenants currently living in social housing properties to adjust to changing circumstances. Many tenants would benefit from the reforms.

- About 13 per cent of public housing tenants surveyed in 2013 — equivalent to over 50 000 households in social housing — expressed a desire to leave public housing in the short term. Concerns raised by tenants included rowdy and unsafe neighbours, poorly maintained or undersized properties, or properties that were unsuitable for a person with disability. Many of these tenants are deterred from leaving social housing because, under current policies, they would receive less financial assistance in the private rental market.
- People who need to quickly change their housing situation could benefit from a flexible approach to housing assistance. For example, social housing rarely offers the flexibility to provide a rapid response to people at risk of or experiencing family violence.

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- Choice-oriented reforms could increase the availability of social housing properties by making it easier for tenants to move into, or remain in, private housing. Some of the more than 150 000 households on waiting lists to enter social housing properties could benefit as they would be able to access social housing sooner. Once assessed, people waiting for social housing could potentially use their supplement in the private market immediately.
  - There are about 850 000 households eligible for, but not in, social housing. The proposed State- and Territory-funded housing supplement could benefit these households where they are in areas with acute rental affordability problems.

The benefits of exercising choice go beyond tenants' increased satisfaction with their home. Tenants empowered with greater choice are more likely to engage with their local community, and can locate closer to any services they need, including schools and hospitals. Better housing outcomes have also been linked to improved health outcomes.

There would also be broader improvements to the effectiveness of the social housing system. Governments could use information gained about tenant preferences to inform their planning processes and better allocate tenants to properties. Making the financial assistance received by tenants more explicit would increase transparency and improve government decision making. Social housing providers may receive additional revenue, which could be used to construct additional properties, or improve existing properties.

These reforms do not rely on an increase in the supply of properties that are affordable to households on low incomes, nor on greater rental security of tenure in the private market, desirable though these may be.

The Commission notes that the relative value of CRA compared with rental prices has declined over time. While desirable, addressing this decline is not essential to the design of greater choice and competition in the social housing system.

## Fiscal implications and implementation

Delivering choice in social housing will involve costs. The Commission estimates that the Australian Government would be required to increase its expenditure on CRA by about \$1.2 billion each year to extend CRA to public housing. This is similar in magnitude to existing Australian Government payments under the National Affordable Housing Agreement, which has a broader remit including homelessness.

State and Territory Governments would receive additional rental revenue over the long term from social housing properties. They would also be required to fund the housing supplement for eligible tenants in areas with acute rental affordability problems. Actual costs to State and Territory Governments of the supplement would depend on its design and, in particular, how tightly each government targets the supplement, making any estimates of cost hypothetical. Given this, the Commission has not provided estimates of the potential cost of the supplement to State and Territory Governments — it has no basis to make a selection

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from the range of the possible combinations of eligibility and supplement design that are available to those governments.

## 6 Family and community services

Governments fund family and community services, such as services for homelessness, and family and domestic violence, to improve the wellbeing of people at risk of hardship or harm. These services are not delivering the best possible outcomes for the people who use them, their families, or for governments that fund them. Poor coordination between and within governments has resulted in a patchwork of funding priorities, gaps in service provision in some places, duplication in others, and barriers to accessing services that are made even higher due to the difficulties of navigating a complex system of service delivery.

Many family and community services are delivered by not-for-profit organisations that are contracted by governments. In 2015, governments provided \$7.2 billion in funding to more than 5000 not-for-profit organisations whose main activities were in social services.

Processes for selecting and managing service providers are hindering the delivery of effective services. Contracts with short terms and excessively prescriptive conditions reflect governments' overly cautious attitudes toward risk. Short contracts and uncertainty about when services will be put to tender prevent service providers from planning ahead, innovating and investing in their workforce.

Unlike some of the other services considered in this inquiry, family and community services are *not* well-suited to the widespread introduction of greater user choice at this time. Instead, governments should focus on practical reforms to stewardship to improve the way they:

- plan the system of services
- select providers on behalf of users
- contract services so that users are at the centre of service provision.

### Re-setting the system to focus on service users

Governments use 'commissioning' to steward family and community services. Commissioning is a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement (figure 3). Governments have not always successfully translated the principles of commissioning into effective practice.

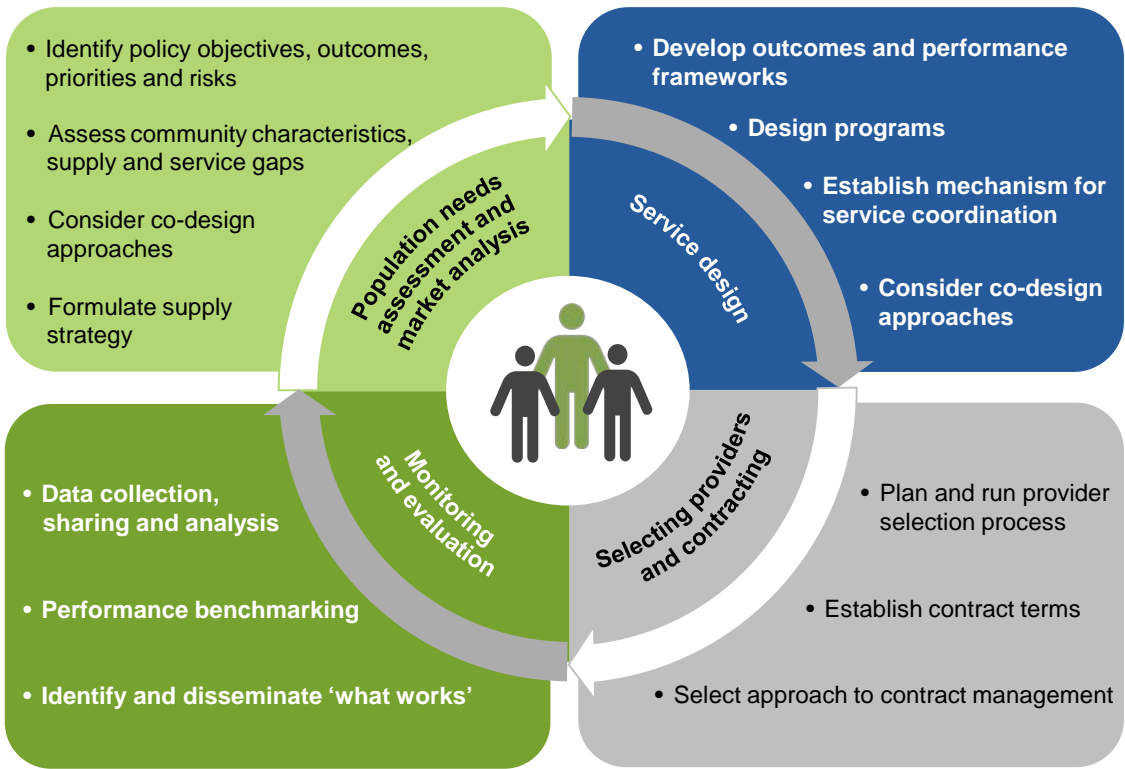
#### Understanding the service user population

Understanding the population and the services it needs is essential to making sound decisions about what services should be provided, where and to whom. This includes understanding

the number of people that are facing hardships that could be addressed through family and community services, their characteristics, and the distribution of needs within the service user population — from straightforward, one off assistance through to ongoing coordinated assistance.

New data and analytical techniques are opening up possibilities for **better population analysis**. The analysis underpinning the Australian Government’s Priority Investment Approach to Welfare provides one example where a more detailed understanding of the level and intensity of need across the community as whole, and in particular regions and cohorts, can provide a basis for targeting investment in family and community services. Population analysis, coupled with on-the-ground evidence drawn from service providers and others with local experience or an understanding of particular cohorts, could be used to build a more detailed picture of the needs of people experiencing hardship. Population analysis should build on existing initiatives and data to underpin stronger service design and planning, particularly for people with complex needs who require multiple services on an ongoing basis.

Figure 3      **The commissioning cycle**



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## Development of ‘user’ outcomes

Governments that commission family and community services typically define outcomes for specific funding programs in a manner that is not consistent with a focus on service users. The system would be more effective if governments developed cross-program outcomes frameworks that articulate outcomes at all levels — service user, service provider and program — and can be used to track changes in wellbeing at an individual level consistently across services. Family Life captured this in its submission:

Outcomes must be clearly articulated in meaningful terms of improvements and changes for the intended beneficiaries of public policy, whether these beneficiaries are individuals, a particular group of citizens, or communities and the broader society. We need to be clear about our goals, set outcome targets and measures for tracking our performance towards those outcomes.

Particular priority should be given to developing an outcomes framework focusing on assessing user wellbeing that can be used across programs (and potentially across departments and levels of government). Progress has been made in this direction in some jurisdictions, such as by the Department of Social Services in the Australian Government. This progress needs to be built on to provide a more consistent focus on user outcomes.

## Selecting providers to achieve outcomes for service users

Governments should improve the way they select service providers, as current processes are often designed for the convenience of governments rather than the benefit of service users. The Commission is recommending reforms that offer greater certainty to potential service providers, give more time for the development of high-quality collaborative proposals, and provide confidence that governments are focused on selecting providers whose attributes are most likely to improve outcomes for users.

Governments should develop a **better understanding of how the attributes of service providers relate to achieving outcomes** for service users and make these a core part of the selection process. These attributes could include a provider’s experience delivering a particular service, its local presence and established connections in communities, and its workforce capability and capacity.

Publishing **rolling schedules of upcoming tender opportunities** well in advance would create more certainty as to when contracts will come up for renewal, and when a decision on the outcome of the tender will be made. This would allow providers to better plan their activities or handover. Governments also generally only allow four to six weeks for service providers to respond to selection processes. This is not long enough to develop a high-quality proposal, or for providers to formalise collaborative arrangements to take advantage of synergies. Much longer periods should be allowed in tenders for potential providers to develop bids (three months should be the default).

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## The need for longer contract terms

Currently, contracts for the provision of family and community services generally default to a term of three years or less. Brotherhood of St Laurence described some of the effects of short-term contracts:

The practice of short term contracts means that providers operate in a climate of constant uncertainty. Precarious funding militates against collaboration by making providers disinclined to invest scarce time and resources in the effort required to build networks and learn new ways of working.

Short-term contracts can also be detrimental to service users because service providers spend too much time seeking short-term funding, which is a costly distraction from delivering and improving services. Short-term contracts can also be an impediment to service providers developing stable relationships with service users, hindering service provision and the achievement of outcomes for users.

It is difficult to identify an ideal contract length. What is clear, however, is that current contracting terms are too short. To address this, the Commission is recommending that governments move to a **seven-year default contract term**. Seven-year default contracts would allow for time for setup (making the investments that are necessary to deliver effective services, including workforce capacity and building relationships in the community) and time for a smooth transition to a new provider at the end of the contract. In between, service providers would have a much needed period of stability and, when combined with a stronger focus on user outcomes, would provide the basis for more effective service provision. At the end of this period, contracts should be retendered to find a balance between providing continuity and retaining the benefits of periodic contestability. As with any default, exceptions should be allowed where justified. For example, shorter contracts could be used to trial new programs.

Longer contracts would open the door for governments and service providers to adopt more ‘relational’ approaches to contract management. Relational contracting involves the parties to the contract seeking to maximise the effect of their joint efforts on improving user outcomes over time. This recognises that governments and service providers both have contributions to make to the effective delivery of services.

Increasing default contract lengths will emphasise the importance of strong selection processes and good contract management. A ‘set and forget’ approach by governments will not deliver outcomes for service users — provider performance must be monitored and poor performance remedied. This could include the removal of a provider in cases of failure. Incorporating formal reviews of service effectiveness into contracts should help to manage the risk of poor provider performance.

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## 7 Services in remote Indigenous communities

Human services should be making a greater contribution to improving the wellbeing of Indigenous people living in remote communities. Despite goodwill and significant resources, current approaches to commissioning human services in remote Indigenous communities are not delivering the benefits of contestability and are exacerbating its potential weaknesses.

About one in five Indigenous Australians live in a remote area. In 2011, there were over 1000 discrete Indigenous communities in remote areas of which more than three-quarters had a population of less than 50 people (figure 4). Indigenous Australians living in these communities have significantly worse quality of life than most other Australians. From 2003, the Steering Committee for the Review of Government Service Provision has published the *Overcoming Indigenous Disadvantage* report of indicators of Indigenous people's wellbeing. Over that time, there has been evidence of improvement in some areas, but outcomes have stagnated or declined in others. Improving the effectiveness of human services for Indigenous Australians living in remote communities should be a priority for governments.

The causes and consequences of disadvantage in remote Indigenous communities are complex and interrelated. Few remote communities have a mainstream economic base and the provision of government services is the dominant economic activity in many. The way services are designed and provided needs to reflect the circumstances of communities — the Commission's recommendations take account of this context.

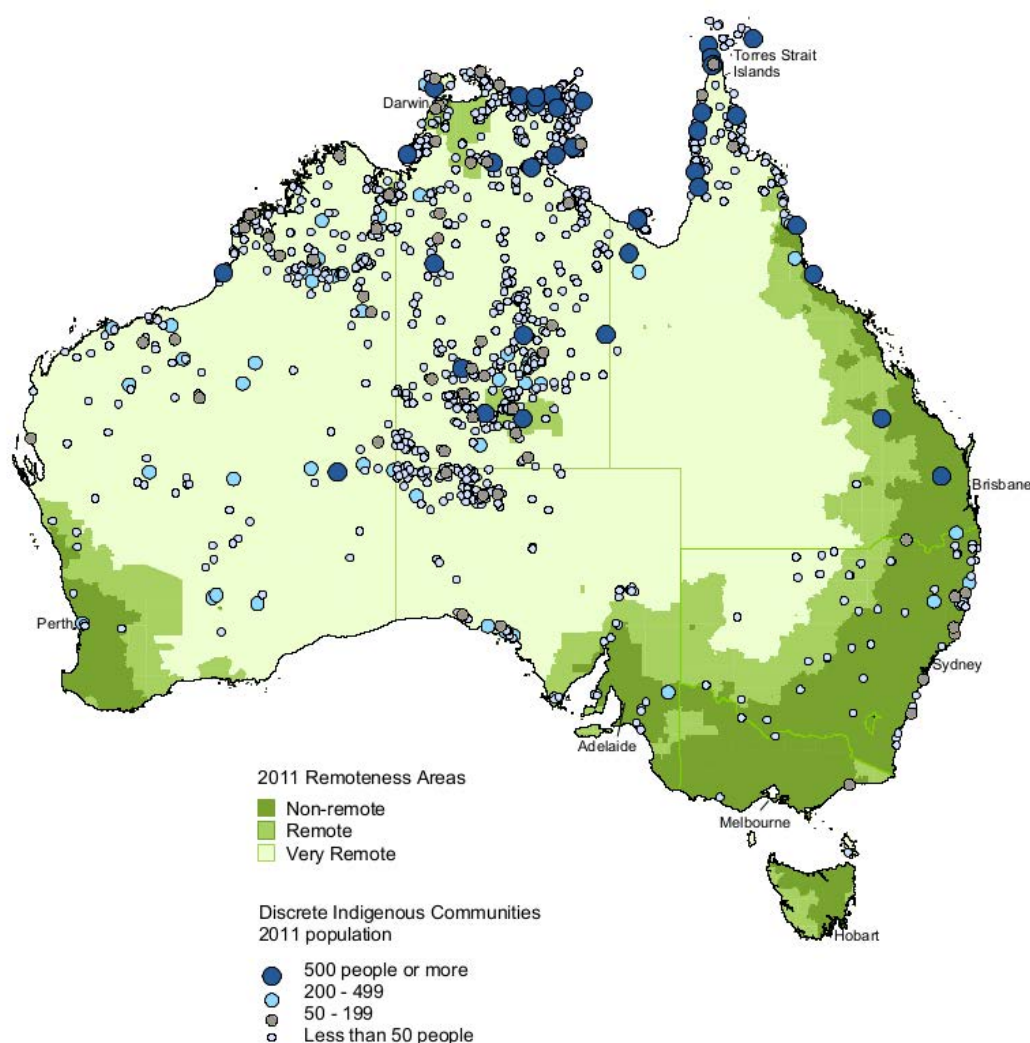
Competition between service providers is not commonplace in remote Indigenous communities, even where there are multiple providers, and user choice of service or provider is limited. The provision of human services in remote Indigenous communities, like family and community services, is largely designed around a model of commissioning where providers compete periodically through tender processes for funding to deliver services. For example, the Australian Government provides Indigenous-specific grants across a range of service areas through the Indigenous Advancement Strategy. State and Territory Governments also commission human services through tendering processes, such as housing for remote Indigenous communities.

Remoteness poses a number of challenges for service provision. It increases the costs of delivering services and prevents some services from being delivered at all. The size and remoteness of these communities means that they may not be able to support full-time services. Isolation also poses challenges, with some communities cut off from services for weeks or months each year. Even when they are accessible, travel can be difficult, costly, time-consuming and for some people, such as those who are frail or elderly, impossible. Access to online service alternatives can also be challenging due to a lack of IT infrastructure and, in some cases, a lack of the skills required to utilise those services.

Recruiting and retaining staff with skills in service provision and the necessary cultural competencies is an enormous challenge. Few small communities have local people with the

professional skills to deliver the suite of human services they need, and provider and staff turnover can be significant barriers to effective service provision.

Figure 4      **Discrete Indigenous communities by size and remoteness, 2011**



## The opportunity for reform

Initiatives to improve outcomes for Indigenous Australians through the provision of human services have often fallen short at both the design and implementation stages. Indigenous policy has been characterised by high levels of instability, with shifts between Indigenous-specific and mainstream programs, and by overlapping and shifting responsibilities within and across different levels of government. This was captured by Empowered Communities.

[Likewise,] Indigenous leaders and communities trying to take responsibility for improving the future of their peoples are too often stuck in a morass of red tape and policy churn associated

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with the political cycle and the all-too-temporary whims of successive governments and their ministers. While we have the knowledge about our lives and communities, government holds nearly all the power.

Greater policy stability would support providers to build trusting relationships with communities, underpin continuous improvement and innovation in service provision, and improve the ability of governments to attract providers and staff to remote communities. Constant changes by governments at all levels have created uncertainty and confusion for communities and service providers and have undermined the effectiveness of service provision. Most communities and services will struggle to succeed in this environment. Governments must exercise patience and consistency while maintaining the capacity to act to address high levels of dysfunction and harm when they arise.

Services in remote Indigenous communities are often poorly planned and uncoordinated. Decisions about service provision are made on the basis of jurisdictional, departmental and program boundaries, and this may come at the expense of a focus on achieving outcomes for users. The inefficiency created by poor planning and coordination is stark. The Aboriginal Medical Services Alliance Northern Territory gave an example of a remote community in Central Australia where about 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. The Alliance described what happens on the ground.

There was little in the way of communication or coordination with the local [Aboriginal Community Controlled Health Service], with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The resulting fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients is totally counter to the improved outcomes sought by this inquiry and yet this was the result of government policy to introduce greater competition and contestability into service delivery.

## **Toward a better model of service provision**

Much has been written about the successes and failures of initiatives to improve service provision in remote Indigenous communities. These lessons are often overlooked by governments and few formal evaluations have been undertaken — this needs to change. The Commission has identified a set of principles that would improve the effectiveness of service provision in remote Indigenous communities. These principles draw on lessons from previous initiatives to improve services in remote Indigenous communities, and on the ‘success factors’ that have been identified in the *Overcoming Indigenous Disadvantage* reports.

- *Greater community voice* — Giving communities opportunities to engage with governments to express their preferences and priorities could result in services that are better tailored to the community, are more likely to be used by the community and hence more effective. This is a way of enabling service users to have more say about the services they receive, and who provides them, in communities that are too small or

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remote to support competition between service providers. Increasing community voice is not a simple task and any expectation that Indigenous people should speak with one voice is unrealistic as well as unhelpful. Like other Australians, people living in remote communities often have strongly differing views about what is best, and not all communities have well-functioning representative bodies that are able to harness these views. This complicates engagement and service delivery.

- *Clearer outcomes* — Governments should work with communities to clearly identify and measure the outcomes that human services are intended to achieve. Policy makers need to take into account both the broad objective of improving Indigenous Australians' wellbeing, and also Indigenous Australians' preferences, priorities and conception of wellbeing.
- *Effective government structures and processes* — Governments should tailor the way they operate to the circumstances in remote communities. Putting people at the centre of service delivery in remote Indigenous communities would require more tailoring of service delivery to local circumstances. Achieving this requires a shift towards government structures and processes that support regional and local engagement, planning and decision making.
- *Building community capacity* — Building community capacity would support community involvement in service design, provision and evaluation. Too often, opportunities have been missed to connect the provision of services with the building of local capacity, including the capacity of Indigenous service delivery organisations and individuals.
- *Effective learning systems* — Building community and government capacity and service design and provision should be informed by effective learning systems that help to identify 'what works' (and for whom and in what context) in delivering human services in remote Indigenous communities.

## **Better commissioning arrangements would improve service effectiveness**

There is significant scope to improve the provision of human services to Indigenous people living in remote communities. The Commission is recommending changes to commissioning arrangements to promote longer-term stability for service users and providers, and to increase community involvement across the commissioning cycle. The proposed reforms address many of the same issues that arose in relation to family and community services, with adjustments to accommodate the different circumstances of remote communities, and take into account the principles for effective service provision outlined above.

Longer **default contract terms of ten years** for human services in remote Indigenous communities should be established to improve the continuity of service provision and contribute to better outcomes. In remote Indigenous communities there is a case for even longer contract terms than in family and community services, to allow extra time to establish

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community trust and invest in staff, capital and delivery models. Continuity has benefits for users for whom trusting relationships with providers are important. For providers, greater continuity would improve their ability to attract and retain staff and allow them to improve service quality by planning investments over a longer cycle. Longer contract terms might also make it easier for governments to attract more providers to remote areas.

Longer contract terms will need to be supported by a more relational approach to contract management. Communities, governments and providers should engage in collaborative reviews of contracts to assess progress and align effort with emerging priorities. This approach should complement mechanisms to ensure that providers are meeting performance standards.

**Improving the scheduling and timing of tender processes** would better facilitate coordination and the ability of providers to work together through, for example, forming consortiums or less formal forms of collaboration. Government should publish a schedule of upcoming tenders, align tenders for similar services in a particular community and provide more time for providers to develop their proposals. A benefit of this approach is its potential to encourage more partnerships between mainstream providers and local Indigenous organisations. Aligning tenders would also create opportunities for communities and governments to identify the mix of providers that is likely to achieve the best outcomes for the community.

Governments should **improve processes used to select service providers** to take into account all the relevant attributes of service providers that can contribute to outcomes for service users. In remote Indigenous communities, this should include attributes that are valued by the community such as on-the-ground connections and the ability to provide culturally appropriate services.

A **greater focus on skills transfer and capacity building** should be included in contracts. This would improve community development and resilience over time, could encourage providers to recruit and retain local staff, and lead to more service delivery by local people and organisations.

**Improvements to planning, evaluation and feedback systems** are essential underpinnings of better service provision. Governments should work with local communities to develop outcome measures for human services in remote Indigenous communities; conduct and publish community assessments to develop an understanding of community characteristics and needs; and gather and share information on ‘what works’ (including for whom and in what context).

## **Longer-term directions for service provision in remote Indigenous communities**

In its draft report, the Commission outlined a possible longer-term transition to a place-based model of service provision centred on community plans. These would be developed by

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communities and would inform governments' decisions about human services funding and delivery.

Following the release of the draft report, the Commission consulted with Indigenous community representatives, service providers and governments about this proposal. The consultations confirmed that there is merit to place-based approaches, but that a large-scale systemic rollout of place-based approaches across remote Indigenous communities is not feasible. Successful implementation of place-based approaches would depend on the capacity of both governments and communities. This capacity does not exist everywhere and would take time and effort to build. As discussed above, the Commission is mindful that persistent change has caused ongoing disruption to remote Indigenous communities. Expanding too far, too fast is a significant risk, and has been identified as a contributing factor to problems in previous reform processes.

The Commission considers that its recommendations on the provision of services to remote Indigenous communities would form a solid foundation on which to base a longer-term transition to place-based reforms, on a case-by-case basis, as government and community capacity is built.

While a large scale move to place-based approaches is not recommended, governments should not stand still. Governments should be willing to adopt more place-based approaches where communities can demonstrate that they are ready and government capacity exists (or can be readily built), taking into account the differing circumstances, needs and preferences of communities. A variety of models have merit and an approach that works in one community may not work in another. A number of Indigenous communities already have models in place (for example, Empowered Communities and the Murdi Paaki Regional Assembly). Where there are existing arrangements these should be built on, and learned from.

Governments will need to adjust their structures and processes and build the capabilities of their staff to implement more localised (including place-based) approaches. This will require governments to shift the balance away from centralised decision making toward greater regional capacity and authority. To do this governments should **give local staff more authority over local planning, engagement and service implementation**. Governments would need to support this transition by authorising, resourcing and building the capacity and capability of staff working on the ground. A more regional and localised approach would foster better understanding of communities and their needs, and would facilitate greater linkages between government decision makers and communities. It would also lay the foundation for more place-based approaches in the future.

## 8 Giving patients greater choice

A combination of rules and common practices limit patients' choice of healthcare provider when they receive a referral or a diagnostic request. These barriers to choice should be

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removed. Patients differ in their needs and preferences, and providers differ in their locations, performance, waiting times and out-of-pocket charges. All patients should be given the opportunity to choose the provider that best meets their needs, after receiving a referral and support from their GP (general practitioner). Better public information should facilitate this choice and drive provider self-improvement, such as adopting practices that have enabled a provider's peers to achieve superior clinical outcomes.

Each year, millions of Australians are referred by a GP to more specialised healthcare providers. In a year, GPs make about:

- 15 million referrals to specialists, most often to orthopaedic surgeons and dermatologists
- 9 million referrals to allied health professionals, chiefly to physiotherapists and psychologists
- 91 million requests for pathology tests and 15 million requests for radiology tests.

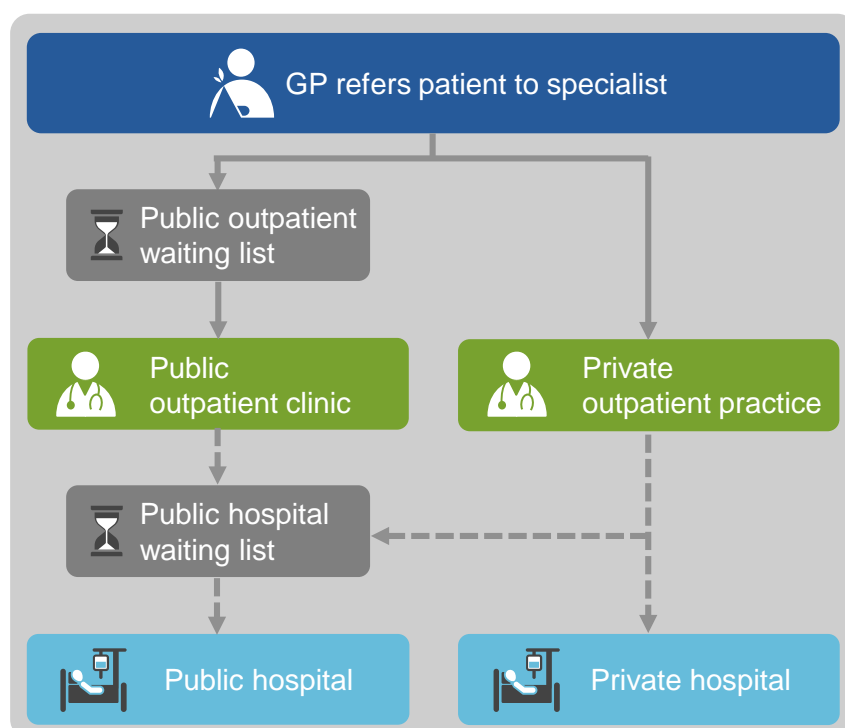
Patients referred to a specialist may go to a public outpatient clinic or a specialist working in private practice for their initial consultation. Which public clinic or private specialist they go to will also determine which hospital they are admitted to if they require inpatient care (figure 5).

Patients wishing to attend a public outpatient clinic are often given no choice but to attend the clinic nearest to their home. This can be due to custom and practice among local GPs, public outpatient clinics having a policy of refusing appointments for people who do not reside in the clinic's catchment area, or (in Perth) a requirement that referrals be processed through a central booking service that allocates patients to their nearest public clinic.

Patient choice is also limited by a common misperception among patients and providers that a named referral for a specialist or allied health professional, or a branded diagnostic request form, cannot be accepted by an alternative qualified provider. As a result, specialists sometimes refuse to see a patient because a different specialist is named in the referral, and the patient has to contact their GP's office to request that the name in the referral is changed.

These restrictions limit choice without delivering any significant benefit for either the patient or the community more generally. Patients who are given a specialist referral should have the opportunity to choose the public outpatient clinic they attend (with the specialist chosen by the clinic) or the individual specialist they see in private practice. Similarly, when patients are referred to an allied health professional, or pathology or radiology provider, they should have the opportunity to choose which one they go to.

Figure 5 Pathways to elective hospital admission



To give patients greater choice, the Australian, State and Territory Governments should:

- direct **public outpatient clinics to accept any patient with a referral** for a condition that the clinic covers, regardless of where the patient lives
- amend referral regulations to make it clearer that patients can **choose their private specialist**
- require a **clear patient advisory statement on all referrals and diagnostic requests** highlighting patients' right to go to an alternative provider to any named
- work with professional bodies to develop best-practice guidelines on how to **support patient choice**.

GPs would continue to be responsible for making referrals and requesting tests, and would play a vital role in supporting patient choice. Patients would still be able to rely on their GP to make decisions on their behalf, if they wish. Patients should also have the option, following support from a GP, to choose their provider independently after leaving the GP's practice. This would give patients the chance to do their own research, consider their options and perhaps consult others before making a decision.

Greater choice empowers patients to have more control over their lives. This in itself is likely to improve the wellbeing of patients. Choice also allows patients to make trade-offs between options to better match their preferences — such as choosing a public clinic that has a shorter waiting time but is further from home. Overseas studies have shown that greater patient

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choice, together with public information to support choice, can lead to better clinical outcomes — including fewer deaths — because it encourages some patients to seek out higher-performing hospitals and importantly prompts service providers to move closer to best practice among their peers.

## Information to support patient choice and provider self-improvement

The information available to patients to help them make choices on alternative hospitals, specialists and allied health professionals is limited. Information on the MyHospitals website, for example, largely relates to waiting times and other process measures, with almost no information on outcomes from specific treatments or measures of patients' experience with hospital services.

Experience in other countries has shown that publishing more information would further empower patients and help GPs to support them. There is also evidence that public reporting encourages healthcare providers to engage in self-improvement activity, particularly at the hospital level, possibly because of a peer pressure effect. To unlock these benefits, **more information should be publicly reported** to facilitate comparisons between alternative providers, including on clinical outcomes and the wide variation in out-of-pocket charges for private specialist outpatient consultations.

Governments in Australia already collect a large amount of information about individual hospitals but much of it is withheld from public view. The Commission's 2017 inquiry on data availability and use identified this as a common problem across the economy and recommended reforms to make data more accessible. This included a new Data Sharing and Release Act, National Data Custodian, and sectoral Accredited Release Authorities to streamline access to datasets. These would complement the healthcare-specific information reforms proposed in this report.

The current commitment to public reporting that the Australian, State and Territory Governments made in the National Health Reform Agreement should be strengthened and expanded. In particular, jurisdictions should, as **part of their health funding arrangements**:

- adopt a general policy of **publishing all data** they hold on individual hospitals, specialists and allied health professionals, unless it would clearly harm the interests of patients or breach privacy protections
- make the published data available in a **format that other organisations can readily incorporate** in advisory services they provide, such as in software used by GP clinics and in mobile applications used by consumers
- transform the MyHospitals website into a national **vehicle that better supports choice** by patients, and encourages self-improvement by individual hospitals, specialists and allied health professionals, including by reporting more outcome indicators such as patient-reported outcome measures

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- phase-in **public reporting on individual specialists and allied health professionals**, possibly beginning with their registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.

The Australian, State and Territory Governments should review progress in implementing these reforms three years after the new health funding arrangements come into force.

## 9 Public dental services

People who receive public dental services have little choice in who provides their care, when and where. Public dental services do not focus sufficiently on preventive care and early intervention. Left untreated, patients with preventable conditions often require complex — and costly — emergency and restorative treatments. Long-term reform of public dental services to shift the system’s focus from treating emergencies to targeted prevention and greater user choice has the potential to improve outcomes for people who are eligible for public dental services, and generate net benefits for the community as a whole.

Publicly funded dental services provide safety net access to basic dental care for people who face financial and other barriers to accessing care, such as some people with disability. Approximately 5.3 million adults and 3 million children are eligible for public dental services — about a third of Australia’s population. Public dental services operate alongside a substantial user-pays private sector.

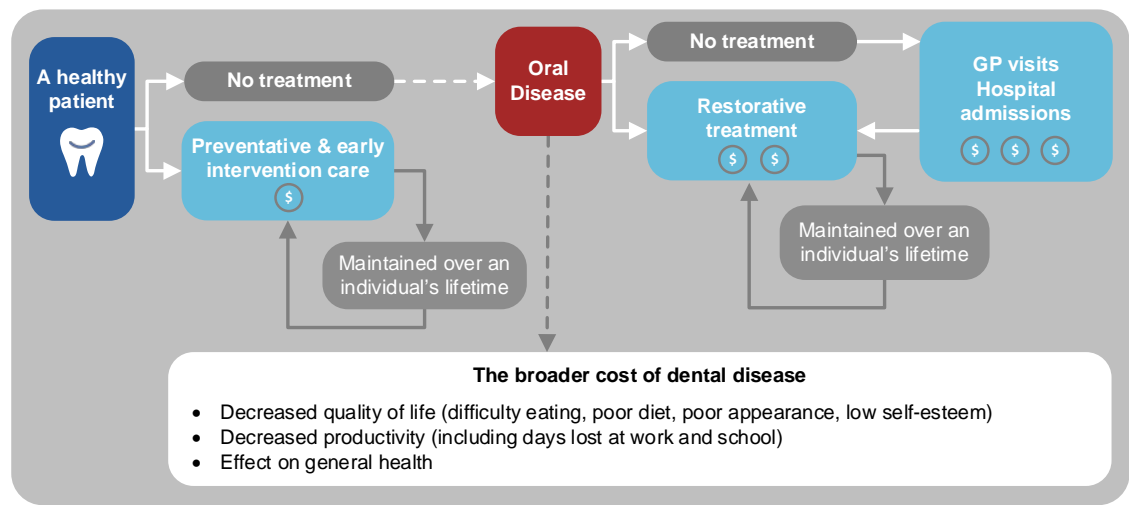
Introducing greater user choice and improving outcomes for users requires fundamental reform. To do so, governments should introduce a **consumer-directed care** approach that focuses on targeted preventive care. Under this approach, it is the user’s choice of dental clinic that determines where their funding is allocated. Improved choice would enable users to make decisions that suit them and generate incentives for providers to be more responsive to patients’ needs (providing the right treatment at the right time). Where user choice would not be feasible, governments should commission services that can best meet users’ needs. Changes to government stewardship arrangements, including improved public performance reporting and the development of oral health outcome measures, should be implemented to underpin these reforms.

### Measuring the effectiveness of public dental services

Most dental conditions are preventable. However, high levels of demand and government funding constraints mean that public dental services focus on treating emergency patients (seeing the most urgent cases first) and place other patients seeking general care on a largely ‘first come, first served’ waiting list. While waiting times for general public dental care vary across jurisdictions and over time (with variations in levels of funding from governments), patients can wait up to three years to receive care.

The time spent waiting to receive care means that the oral health of people at high risk of developing or worsening oral disease deteriorates — resulting in larger costs to them, to governments and the community for largely preventable conditions (figure 6). Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015-16. The time to treatment is therefore an important metric for improving the effectiveness of public dental services. **Public reporting of performance** in treating patients within clinically-acceptable waiting times (by risk category) would improve accountability and identify areas for performance improvement in the sector.

Figure 6 **A stylised pathway of dental health care and the costs**



Understanding how services contribute to improvements in oral health outcomes for users is essential to moving public dental services beyond the short-term focus on urgent care. **Developing an oral health outcomes framework** would improve accountability, and provide the basis for more comprehensive reforms to promote targeted preventive care. Outcome measures are not currently in use in Australia, but are being developed (in Victoria in the first instance). In England, outcomes have been measured by clinical indicators (such as rates of tooth decay) and patient-reported indicators (such as being able to speak and eat comfortably).

Performance benchmarks and outcome measures should be developed and implemented as soon as practicable. Governments could also use these new data sources to better understand the population's needs which, in itself, would improve the effectiveness of service provision. They are also a necessary first step in introducing consumer-directed care, and shifting the system's focus to targeted preventive care.

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## Improving choice and outcomes for users

Enabling people to have more choice over their dental provider is an important reform but further benefits could be achieved if this choice was coupled with a greater focus on preventive care. One way to achieve this is for dental clinics to be responsible for the care of a patient for a defined period. This requires balancing a user's ability to choose a different provider against the benefits derived from continuity of care by a single provider. The Commission's proposed consumer-directed care reforms strike this balance by giving users the choice over their provider (either public dental clinics or a participating private clinic) for a three year enrolment period.

Under the proposed model, users would present to public dental services (as is currently the case). Patients with urgent care needs should continue to be prioritised for treatment. People presenting for care would be enrolled in the Commission's consumer-directed care scheme once any urgent care needs have been met and subject to any waiting period. Once enrolled, patients would choose their preferred dental clinic for the enrolment period. Over time, this will increase the focus of public dental services on preventive care. The pace of transition will depend on levels of government funding.

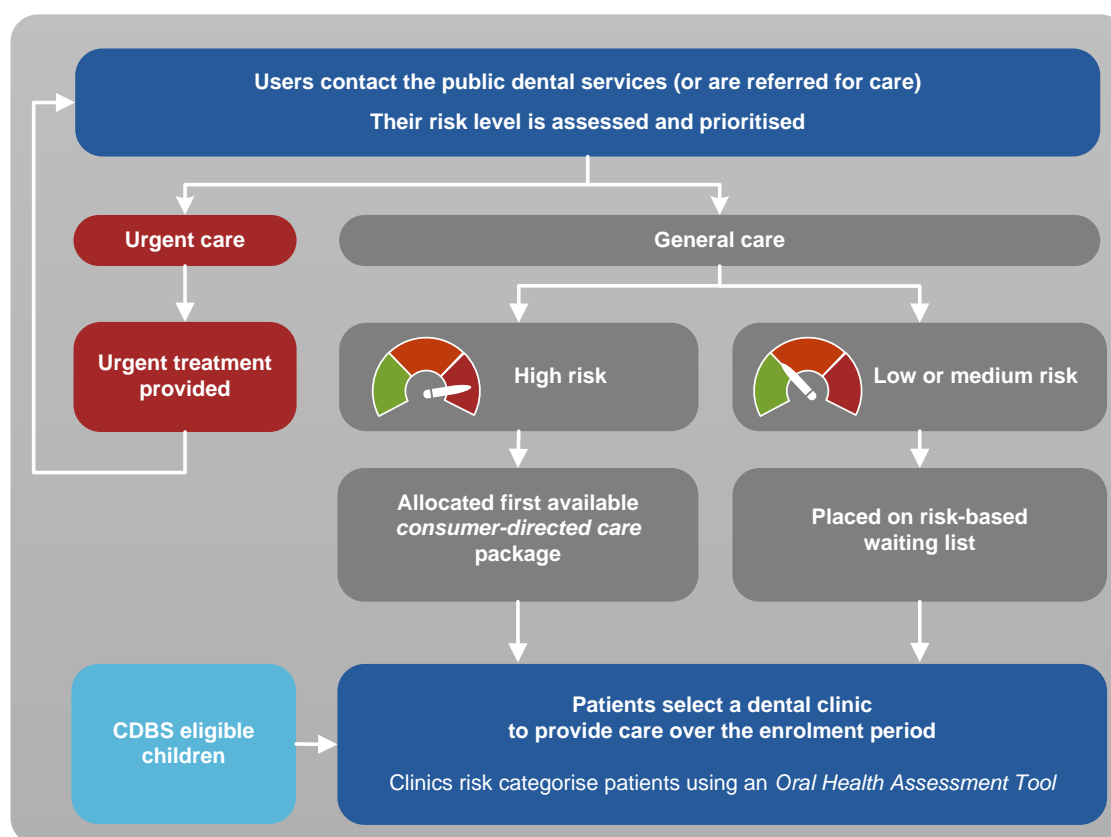
Implementing choice and obtaining the benefits of a targeted focus on prevention through consumer-directed care requires the development of a:

- **risk-based allocation model** that targets services to users at high risk of developing or worsening oral disease, providing access to services based on risk rather than the date that a user joined the waiting list (figure 7)
- **blended payment model** where governments pay providers a combination of payment types designed to reward preventive care and the overall quality of care, rather than the number of treatments provided (as occurs under fee-for-service arrangements) (figure 8).

Developing a risk-based allocation model will require governments to triage patients according to their risk of developing or worsening oral disease and would be used to target the oral health of those most at risk in the eligible population. Incorporating a **digital oral health record** into the My Health Record system could improve linkages with the broader health system (including GPs and hospitals), assist in the identification and triaging of patients at high risk of developing or worsening oral disease, and support user choice by ensuring a person's records are portable between providers.

Information from performance reporting, outcome measures, and digital oral health records would enable governments to more systematically identify those cohorts within the user population at high risk of oral disease. These stewardship changes would allow governments to make evidence-based decisions about how best to engage with people at high risk of oral disease, including the many users who only present to the public dental or health system when they require urgent care.

Figure 7 **How eligible users would access consumer-directed care**

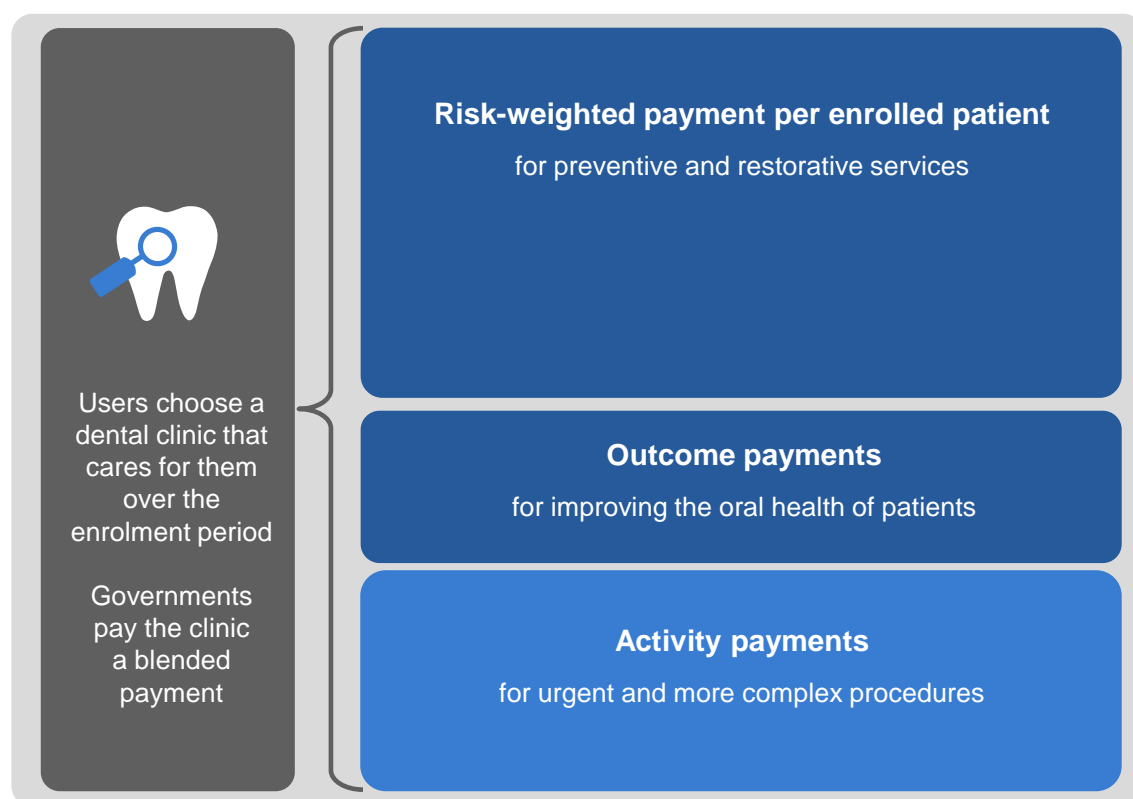


Development of a blended payment model will require governments to pay providers for each enrolled patient. This payment should be risk-weighted to reflect the treatment needs of different population groups. In addition, outcome payments should be introduced to reinforce incentives for providers to focus on prevention. Activity payments should be retained for urgent and complex treatments where the need for treatment is less predictable and, therefore, cannot be readily brought within the capitation payment (figure 8).

The Commission has drawn on overseas experience to develop the blended payment model. Evidence from clinical studies in Britain, Canada, Norway and Sweden indicate that an enrolment payment encourages providers to invest in preventive and early intervention care for their patients. ‘Blending’ the enrolment payment with outcome payments rewards clinics for the quality of care provided and, thereby, better aligns the interests of patients and providers.

Blended payment models are commonly used in health care across OECD countries to balance the incentives of different payment types. A similar blended payment model is being progressively trialled and rolled out for public dental contracts in England.

Figure 8      **How providers would be paid under consumer-directed care**



Poor oral health can track strongly from childhood to adulthood. Targeting of services for children therefore could have lifetime benefits for individuals and, potentially, for the health system. Adopting the proposed blended payment model for the Child Dental Benefit Schedule (CDBS), including the use of risk-weighted payments, would both encourage preventive care and provide children at high risk of oral disease with individual funding that reflects their care needs. Therefore, the CDBS should be amongst the first elements of the rollout of the Commission's proposed payment model.

Governments should also provide patients with improved consumer-oriented information. This information should focus on enabling choice of provider (such as the locations, waiting times, and published outcome measures of clinics) and highlighting the availability and benefits of dental care. The preventive care benefits of the proposed reforms would potentially be enhanced by outreach to people at high risk of oral disease who may not otherwise engage with dental services.

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## Providing services to users where choice is not feasible

There are some circumstances where introducing greater user choice is not feasible, such as in remote locations with small populations that may not be able to support multiple dental providers (or even a single provider all year round). Even in metropolitan areas there may be populations with complex and special needs that require services that can only be accommodated by a small number of providers. For example, in some jurisdictions services are provided in a person's residence if they are homebound due to disability or dementia. Improvements to governments' commissioning processes, including the need for a more **systematic approach to service planning, selecting providers and monitoring their performance**, would improve the provision of services for these users.

Governments should use the **oral health outcomes framework** to design contracts and select providers that focus on promoting the oral health of the people they treat. Outcomes-based commissioning of public dental services will focus governments and providers on understanding and addressing population needs and lowering barriers that may make some of the eligible population reluctant to seek out dental services.

## A staged implementation

Taken together, the Commission's recommendations represent a long-term and systemic reform pathway for public dental services.

The Commission's reforms should be implemented in a staged manner, starting with reforms to improve the stewardship of the system. Following the development of outcome measures, governments should improve their commissioning processes and examine opportunities for introducing greater contestability in public dental services. These reforms on their own would improve the effectiveness of public dental services in Australia.

Once the outcome measures are in use, the consumer-directed care scheme should be developed and trialled at a range of test sites. Results from the test sites should inform a staged rollout process.



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# Recommendations

## End-of-life care

### RECOMMENDATION 4.1

State and Territory Governments should increase the availability of community-based palliative care so that people with a preference to die at home can access support to do so. To achieve this, State and Territory Governments should:

- assess the need for additional community-based palliative care services
- design services to address identified gaps in service provision
- establish standards for community-based palliative care services and fund the provision of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care
- 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 against the specified standards
- ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.

### RECOMMENDATION 4.2

End-of-life care should be core business for aged care facilities, and the quality of end-of-life care in residential aged care should align with the quality of that available to other Australians. To achieve this the Australian Government should:

- remove current restrictions on the duration and availability of palliative care funding in residential aged care
- provide sufficient funding for this additional clinical care.

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#### RECOMMENDATION 4.3

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

- including the initiation of an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. At a minimum, this would require a general practitioner to introduce the concept of advance care planning and provide written information 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.

#### RECOMMENDATION 4.4

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

#### RECOMMENDATION 4.5

The Australian, State and Territory Governments should, through the Council of Australian Governments (COAG) Health Council, ensure that there is cross-jurisdiction co-operation to:

- plan, fund and deliver end-of-life care so that patients receive integrated services across different settings and jurisdictions
- set standards for end-of-life care in each of the settings in which it is provided (such as those that will apply to end-of-life care in hospitals in all jurisdictions from 2019)
- monitor and evaluate end-of-life care services.

The COAG Health Council should oversee the development and implementation of a data strategy for end-of-life care that:

- establishes a national minimum data set for end-of-life care (including collecting and publishing linked information on place of death, primary and secondary diagnoses and details of service provision at time of death)
- improves the accessibility of patient-level data (such as advance care plans or hospital discharge summaries) so that they are used to deliver high-quality care
- uses system-level data to enable governments to plan, monitor and evaluate how well end-of-life care services are meeting users' needs across all settings and jurisdictions, and to drive improvements in end-of-life care.

The COAG Health Council should, in 2025, commission an independent review of the effectiveness of end-of-life care across all settings in which it is, or should be, provided.

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## Social housing

### RECOMMENDATION 6.1

The Australian, State and Territory Governments should work together to introduce greater user choice, and improve the equity and responsiveness of the social housing system, by introducing a single system of financial assistance for eligible tenants. This system should be portable across rental markets for private and social housing.

- The Australian Government should extend Commonwealth Rent Assistance to tenants in public housing so that it is available to all eligible tenants in social housing properties.
- State and Territory Governments should each design and fund a housing supplement for eligible tenants in areas with acute rental affordability problems.

State and Territory Governments should abolish the current model of financial assistance in social housing by:

- charging market rents for tenants in social housing properties rather than rents set at a proportion of income
- providing existing social housing tenants the option of moving to the new system of financial assistance or continuing to pay rent set at a proportion of income for up to ten years after the single system of financial assistance is introduced.

The Australian Government should only extend Commonwealth Rent Assistance to public housing tenants in a jurisdiction if that State or Territory Government implements this recommendation in full.

### RECOMMENDATION 6.2

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

### RECOMMENDATION 7.1

State and Territory Governments should each publish a 10-year strategy for the supply of social housing properties in their jurisdiction. These strategies should include:

- an assessment of how many people will likely require social housing into the future, and analysis of their characteristics
- an analysis of types of properties tenants would likely require, such as number of bedrooms and disability supports, and where they should be located
- how governments plan to meet projected demand for social housing properties.

These strategies should be updated at least every five years.

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#### RECOMMENDATION 7.2

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

- tenant outcomes, including the outcomes of tenants renting in the private market that receive a housing supplement or tenancy support services
- the cost of managing social housing.

State and Territory Governments should clearly define the outcomes they are seeking to achieve through tenancy management and tenancy support services, and put in place frameworks to assess their success in meeting these outcomes over time. Outcome measures should, to the extent possible, be consistent and comparable to those developed for family and community services (recommendation 8.3).

#### RECOMMENDATION 7.3

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

#### RECOMMENDATION 7.4

State and Territory Governments should ensure that the entity responsible for managing social housing assets is separate from the entity responsible for social housing policy.

#### RECOMMENDATION 7.5

State and Territory Governments should amend the National Regulatory System for Community Housing to cover public housing so that all providers of social housing face consistent regulatory requirements, regardless of whether they are government or non-government providers.

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#### RECOMMENDATION 7.6

State and Territory Governments should:

- publish information on expected waiting times to access social housing, by region, in a format that is accessible to prospective tenants
- make publicly available the regulatory reports on the performance of providers that are undertaken as part of the National Regulatory System for Community Housing.

To facilitate choice-based letting, State and Territory Governments should publish information on available social housing properties, including the rent charged for the property, number of bedrooms and the location of the property. This information should be disseminated across a range of mediums, such as online and printed leaflets.

#### RECOMMENDATION 7.7

State and Territory Governments should ensure that applicants for social housing assistance receive a comprehensive up-front assessment of their eligibility for:

- a social housing placement
- the housing supplement (recommendation 6.1)
- tenancy or other service support, including support to enable the tenant to choose their home.

Applicants should also be made aware:

- that the housing supplement would be payable if they chose to live in either the private or social housing markets
- of the extent to which tenancy support services available in social housing would also be available to eligible tenants renting in the private market.

#### RECOMMENDATION 7.8

State and Territory Governments should improve the commissioning of tenancy support services by:

- ensuring that tenants renting in the private market have the same access to support services as tenants in social housing
- clearly separating the funding and contracting of tenancy support services from tenancy management services
- considering the application of recommendations contained in this inquiry to improve the commissioning of family and community services.

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## Family and community services

### RECOMMENDATION 8.1

The Australian, State and Territory Governments should build on existing initiatives and data to:

- analyse the characteristics and needs of the service user population to assist with system and program design and targeting
- develop and publish data-driven maps of existing family and community services
- identify outcomes for family and community services that articulate the improvements in service users' overall wellbeing that governments are seeking to contribute to through service provision
- develop plans to coordinate services for people who have complex needs
- develop and publish regional service plans to address the needs of people experiencing hardship.

These actions will require ongoing commitment from governments, working in consultation with service users and service providers.

### RECOMMENDATION 8.2

To improve processes used to tender family and community services, the Australian, State and Territory Governments should:

- publish a rolling schedule of upcoming tenders over (at least) the next twelve months
- allow sufficient time (a default of three months) 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
- 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).

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#### RECOMMENDATION 8.3

The Australian, State and Territory Governments should, within 24 months, agree on indicators of the wellbeing outcomes of people who use family and community services and apply them consistently across all such services.

Where it is not feasible to define or collect data on service user outcomes, governments should identify outputs from family and community services that can be used as proxies for outcomes.

Governments should broadly define outcome measures (and outputs) 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.

#### RECOMMENDATION 8.4

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

- monitor the performance of providers of family and community services in achieving outcomes for service users
- evaluate service providers, programs and systems in ways that are commensurate with their size and complexity, and publish the lessons of these evaluations
- 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.

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#### RECOMMENDATION 8.5

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

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

- increase default contract lengths for family and community services to seven years
- allow exceptions to be made, such as for program trials, which could have shorter contract lengths
- publish the justification for any contracts that differ from the default term
- initiate collaborative reviews (involving government and providers) to assess progress, adjust priorities as needed and identify opportunities for improvement
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of failure.

#### RECOMMENDATION 8.6

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

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## Services in remote Indigenous communities

### RECOMMENDATION 9.1

The Australian, State and NT Governments should set the length of human services contracts in remote Indigenous communities to allow adequate time for service providers to establish their operations; and have a period of continuity in service provision and 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 provision in remote communities.

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

- increase default contract lengths for human services in remote Indigenous communities to ten years
- allow exceptions to be made, such as for program trials, which could have shorter contract lengths
- publish the justification for any contracts that differ from the default term
- initiate collaborative reviews (involving communities, government and providers) to assess progress, adjust priorities as needed and identify opportunities for improvement
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of failure.

### RECOMMENDATION 9.2

To improve processes used to tender human services in remote Indigenous communities, the Australian, State and NT Governments should:

- publish a rolling schedule of upcoming tenders over (at least) the next twelve months
- allow sufficient time (a default of three months) 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.

The Australian, State and NT Governments should also gradually work to align tender processes for related services in communities, commencing with a small number of communities.

### RECOMMENDATION 9.3

The Australian, State and NT Governments should ensure that commissioning processes for human services in remote Indigenous communities incorporate skills transfer and capacity building for people and organisations in those communities.

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#### RECOMMENDATION 9.4

The Australian, State and NT Governments should take into account the attributes of providers that contribute to achieving outcomes for people living in remote Indigenous communities. These attributes may include:

- culturally appropriate service provision (specific to the region where the service is being provided)
- 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.

#### RECOMMENDATION 9.5

The Australian, State and NT Governments should invest in better planning, evaluation and feedback systems to underpin service provision by working together — and with local communities — to:

- develop outcome measures 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 and drawing on existing information where possible
- establish systems to identify and share information on 'what works' in human services in remote Indigenous communities.

These actions will require ongoing commitment from governments, working in consultation with communities, service users and service providers.

#### RECOMMENDATION 9.6

The Australian, State and NT Governments should adopt more regional and localised approaches to decision making and engagement with remote Indigenous communities, to underpin the greater use of place-based approaches to the design and provision of human services. To achieve this, the Governments should:

- give local staff more authority over local planning, engagement and service implementation
- provide capacity building support (such as cultural training) for staff working in remote Indigenous communities.

The Australian Government and State and NT Governments should work together to engage with communities on a coordinated basis.

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## Giving patients greater choice

### RECOMMENDATION 10.1

The Australian Government should amend the Health Insurance Regulations 1975 (Cwlth) to make it clearer that patients with a specialist referral can choose to have their initial consultation with any private specialist practising the relevant specialty. This includes clearly specifying that:

- referrals do not need to name a particular specialist
- any specialist practising the relevant specialty can accept a referral, irrespective of whether another person is named as the specialist in the referral.

### RECOMMENDATION 10.2

The Australian Government should amend the regulations for referrals and diagnostic requests to require:

- general practitioners and other referrers to advise patients that they can use an alternative to any provider mentioned in a referral or request
- all referrals to specialists and allied health professionals, and requests for pathology and radiology services, to include a prominent and easy to understand statement advising patients that they can use an alternative to any provider mentioned in the referral or request.

### RECOMMENDATION 10.3

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

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

### RECOMMENDATION 10.4

State and Territory Governments should change patient travel assistance schemes so that assistance is available to patients who must travel long distances to access specialist medical treatment, regardless of which provider they attend. The level of assistance should continue to be based on the cost of getting to the nearest provider.

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#### RECOMMENDATION 10.5

The Australian Government should develop best-practice guidelines on how general practitioners (GPs) and other referrers should support patient choice when making a referral or diagnostic request. These guidelines should be designed with the relevant professional bodies, and form part of a broader strategy to help GPs and other healthcare providers implement recommendations 10.1 to 10.4.

#### RECOMMENDATION 10.6

The Australian Government should undertake an evaluation of the choice reforms proposed in recommendations 10.1 to 10.5, five years after they commence operation.

### **Information to support patient choice and self-improvement by healthcare providers**

#### RECOMMENDATION 11.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the (soon to be negotiated) successor to the National Health Reform Agreement, with the aim of better supporting patients and their general practitioners to exercise patient choice, and encouraging performance improvement by service providers. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in recommendation 11.2
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals (including outpatient clinics), specialists and allied health professionals, unless it is clearly demonstrated that releasing the data would harm the interests of patients or breach requirements to protect privacy
- make the information that a jurisdiction publicly releases on hospitals, specialists and allied health professionals available in a format that other organisations can readily incorporate in advisory services they provide.

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

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that specialists are required to participate in public information provision in order to be eligible to provide any service that attracts a Medicare benefit
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision.

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#### RECOMMENDATION 11.2

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

- draw on lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England
- be based on market research on who would use an improved MyHospitals website, how their needs and health literacy vary, what indicators are useful to them, and how they could be informed by using best-practice approaches to presenting health information online
- put greater emphasis on reporting outcomes, such as by publishing patient-reported outcome measures and clinical outcomes such as readmission rates
- include reporting on waiting times at individual public outpatient clinics and ratings for the quality of end-of-life care and other services in hospitals (similar to ratings published by England's Care Quality Commission)
- phase-in reporting on individual specialists and allied health professionals as data become available, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.

#### RECOMMENDATION 11.3

The reforms detailed in recommendations 11.1 and 11.2 should be reviewed by the Australian, State and Territory Governments three years after the successor to the current National Health Reform Agreement comes into force.

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## Public dental services

### RECOMMENDATION 12.1

State and Territory Governments should report publicly against a set of benchmarks of clinically-acceptable waiting times for public dental services, split by risk-based priority levels. Reporting should commence as soon as possible. Governments should also make these benchmarks consistent across jurisdictions as soon as practicable.

To facilitate user choice, provider-level reporting should be published monthly. To facilitate performance monitoring, aggregate measures should be included in public dental services' annual reporting processes.

### RECOMMENDATION 12.2

The Australian, State and Territory Governments should establish outcome measures for public dental services that focus on patient outcomes and include both clinical outcomes and patient-reported measures.

Governments should build on the work done by Dental Health Services Victoria on outcome measures, with a view to developing and implementing a nationally consistent outcomes framework.

### RECOMMENDATION 12.3

State and Territory Governments should implement comprehensive digital oral health records for public dental services as soon as practicable. Once implemented, these systems should be incorporated within the My Health Record system.

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#### RECOMMENDATION 13.1

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

- risk-weighted capitation payments for preventive and restorative services for enrolled patients that incentivises the provision of clinically- and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)
- outcome payments, incorporating payments for clinical and patient-reported outcomes
- activity-based payments for urgent and more complex treatments (such as dentures). The dental treatments that would be eligible for activity-based payments should be limited to those that cannot be readily brought within the capitation payment.

State and Territory Governments should ensure that under the scheme:

- patients are offered choice of provider (public or private clinic) who will care for them for a defined enrolment period of three years
- users are able to change provider in certain circumstances, such as when moving city.

#### RECOMMENDATION 13.2

The Australian Government should direct the Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, to immediately commence development of:

- a costing standard for public dental services
- efficient prices for consumer-directed care payments.

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#### RECOMMENDATION 13.3

The Australian Government should introduce a new blended payment model for the Child Dental Benefit Schedule once the consumer-directed care scheme has been finalised. As described in recommendation 13.1, under the blended payment model participating providers should receive:

- risk-weighted capitation payments for preventive and restorative services for enrolled children
- outcome payments, incorporating payments for clinical and patient-reported outcomes
- activity-based payments for urgent and more complex treatments that cannot readily be brought within the capitation payment.

The Australian Government should replace the existing capped benefit with a capitation payment that is weighted to reflect the oral health care needs of eligible children.

#### RECOMMENDATION 13.4

State and Territory Governments should provide access to consumer-directed care through a risk-based allocation model.

Under the allocation model, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease.

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

- clinically- and cost-effective treatments that are necessary for the patient to attain basic oral health
- 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.

#### RECOMMENDATION 13.5

State and Territory Governments should establish effective commissioning processes for public dental services for those population groups who are not able to choose between alternative providers. This would include introducing:

- service planning aimed at addressing users' needs
- greater contestability where a consumer-directed care approach is not feasible
- an outcomes framework which focuses on users' oral health.

Reforms should commence as soon as practicable following the development of outcome measures (recommendation 12.2).

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#### RECOMMENDATION 13.6

The Australian, State and Territory Governments should transition to a consumer-directed care approach to providing public dental services by first establishing initial test sites before a staged rollout.

- Test sites should commence following the development of outcome measures (recommendation 12.2), and evaluate new blended payment and allocation models.
- Transfer of the Child Dental Benefit Schedule to the blended payment model should be an early priority of the rollout.



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# 1 The Commission's approach

## 1.1 What the inquiry is about

The Australian Government's *Competition Policy Review* recommended that governments should, wherever possible, put user choice at the heart of human services delivery (Competition Policy Review 2015). In its response to the Review, the Australian Government asked the Commission to undertake this inquiry to examine policy options that apply the principles of informed user choice, competition and contestability to the provision of human services. Desirable though they may be, applying these principles has proven to be neither simple nor without cost.

This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will access human services at some point in their lifetime, including children, the elderly, people facing hardship or harm, and people who require treatment for acute or chronic health conditions. People who use human services can lose their autonomy, and with it their dignity, if they have too little control over decisions that affect them. Reforms to the way human services are provided are needed to enable and support people and their families to have a stronger voice in shaping the services they receive, and who provides them.

The inquiry has been conducted in two stages. Completing the first stage of the inquiry, the Commission released a study report in December 2016 that found greater informed user choice, competition and contestability could offer the greatest improvements in outcomes for people who use:

- end-of-life care services
- social housing
- family and community services
- services in remote Indigenous communities
- public hospitals for elective care following a referral from their general practitioner
- public dental services.

The study report sets out the Commission's reasoning for identifying these services (PC 2016a).

The services identified in this inquiry reflect the Commission's views on the highest priorities for its task but are not the only services that would benefit from reform. For example, the Commission has previously found there is considerable scope to improve

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outcomes by promoting user choice, competition and contestability in the provision of residential aged care services (PC 2011a). Other services, such as disability supports through the National Disability Insurance Scheme (NDIS) and early childhood education and care, are also being reformed. All warrant continued scrutiny and evaluation to ensure the potential net benefits of those reforms are realised.

This is the final report for the second stage of the inquiry. It sets out the approach used by the Commission to identify and assess reform options to introduce greater user choice, competition or contestability into the priority services. It also presents the Commission's final recommendations for those services.

## **The conduct of the inquiry**

The Commission has consulted widely during the course of this inquiry. The process has included:

- publications inviting participant feedback, including an issues paper, preliminary findings report and study report as part of the first stage of the inquiry, and an issues paper and draft report for the second stage of the inquiry. In total, the Commission has received 598 submissions, including 112 following the release of the draft inquiry report in June 2017
- consultations with the Australian, State and Territory Governments, service providers and their peak bodies, employer representatives, community representatives, consumer advocates and academics
- a series of roundtables focusing on the priority services during the first and second stages of the inquiry
- public hearings in Sydney, Melbourne, Perth and Canberra following the release of the draft inquiry report.

Full details of the consultation process can be found in appendix A. The Commission thanks those who have participated in this inquiry.

## **1.2 The roles of government**

Human services are essential for the wellbeing of individuals and their families, and underpin economic and social participation. Ensuring that everyone, regardless of their means or circumstances, has access to a minimum level of high-quality human services promotes equity and social cohesion, which in turn contributes to the welfare of the community as a whole.

The number of services provided each year in Australia is considerable, for example, there were more than 10 million admissions to public and private hospitals in 2015 (AIHW 2016e). Other services, such as homelessness services and social housing, are

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each used by hundreds of thousands of people every year. Public and private expenditure on human services is significant — over \$300 billion in 2014-15 (SCRGSP 2017) — with demand for services projected to grow as more people live longer, incomes grow and technological advances increase the types of services that can improve a person's quality of life.

The circumstances and the settings in which people access human services will vary. Some people will be able to plan their use of services, others will face a short-term crisis or emergency. Some people will be well-informed, able to articulate their needs and make choices that improve their wellbeing, whereas some will rely on others to make choices on their behalf. The system for funding, providing and stewarding human services needs to cater for this diversity, now and into the future, as demand for high-quality services continues to grow.

## **Government involvement in human services**

The objective of government policies to provide human services is to improve the wellbeing of individuals and improve community welfare by promoting economic and social participation, and enhancing social cohesion. Meeting this objective requires that governments have a strong involvement in human services — through being a primary funder of most services, determining who has access to a service and who does not, stewarding markets for services and, in some circumstances, directly providing services.

There are sound efficiency and equity reasons for government involvement in human services. Governments may be involved in human services due to the presence of 'externalities' — some human services generate benefits beyond those that accrue to the recipient of the service. School education, for example, may benefit an entire society, not just the student, by assuring a more literate and numerate workforce, raising productivity and contributing to social capital. Without government intervention, markets for education would be unlikely to take these broader benefits into account and would fail to generate an efficient outcome from the perspective of the community — the service would be underprovided. In the case of school education, governments seek to address this externality by requiring children of a particular age to attend school, and providing funding to support their attendance.

Governments also may be involved in markets for human services because of information asymmetries. Human services are complex and it is often difficult for users to assess the quality of a service provider, or know what services they need, especially for one-off or emergency services (such as some health procedures). Unless governments can address these information asymmetries, such as by requiring that tailored information is provided to users, it can lead to providers under- or over-servicing some users, and users selecting services and providers that do not meet their needs.

From an equity perspective, markets for human services will not deliver an appropriate distribution of services across the community, leading to societal consequences that do not

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meet community expectations. Examples include people with limited incomes, or in particular locations, being excluded from certain services, such as hospital or dental care, without government support. Governments' approach to filling this gap can include funding universal access to a service, as is the case for emergency health care, and fully or partly covering the cost of a service to targeted groups in the community, as is the case for public dental services. Governments also choose whether to provide services directly (as is the case for the management of some public housing tenancies) or commission other providers to deliver services.

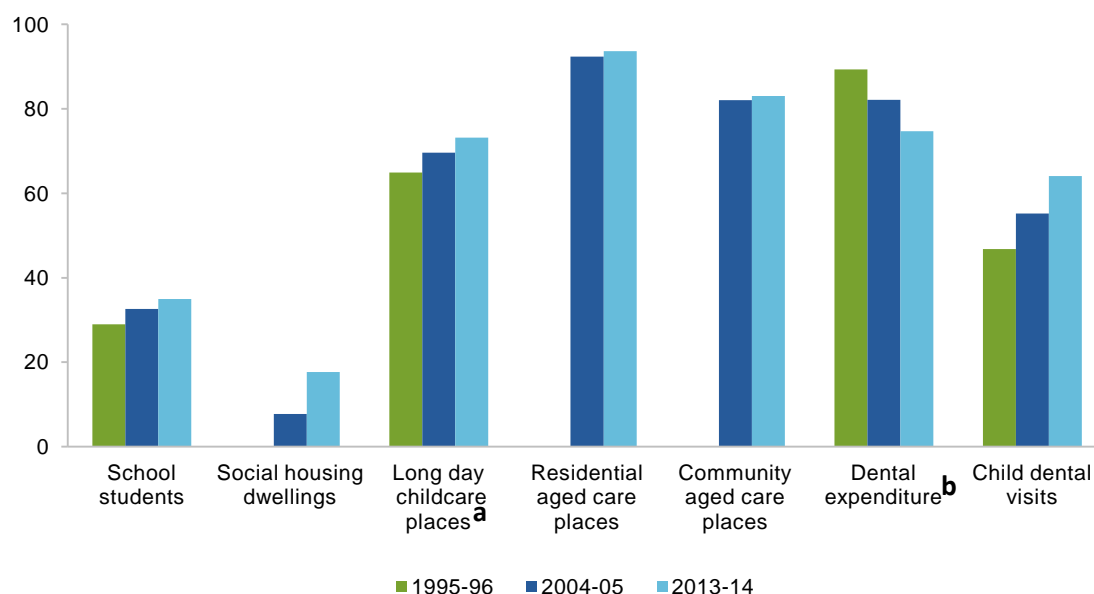
## **The funding and provision of human services**

The way human services are funded and provided has evolved over time. Traditionally, governments played little role in the funding and provision of human services, and people relied on social and family networks and, later, on not-for-profit bodies for support (Brown and Keast 2005). Disability support services, aged care, and many family and community services were originally provided by not-for-profit organisations through charitable donations and volunteerism (APSC 2013; Kendig and Duckett 2001; Phillips 2008). Over time the growing demands for support, and the need for *coordinated* support across different service areas, led to increased government involvement, by either partially or fully funding, or providing services in areas such as public housing, health and education.

In recent decades Australian governments have increasingly sought to decouple the funding of human services from the provision of those services. Governments were considered to be rigid in their model of service delivery, not responsive to community needs, or worse, ineffective and inefficient (Keast 2001; Keating 2000). From the mid-1990s, there has been a trend away from government provision of many services (figure 1.1). Most services are now provided by a mix of government and non-government providers, including not-for-profits, for-profits, sole traders, and mutuals or co-operatives. Non-government providers are more prevalent in some services, such as general medical practice, allied health, optometry, job, community and aged care services. The rollout of the NDIS requires further growth in the level of service provision by non-government providers.

The role governments take in markets for human services has not evolved in a systematic way. Changes partly reflect a difference of views on the benefits of a user focus in service delivery. Where previously providers were allocated fixed grants-based budgets and had discretion over who should receive services, some current models of provision, such as the NDIS, enable funding to 'follow the user'. This person-centred model of provision means that users, rather than providers or governments, allocate their budgets to the providers, supports and services that best meet their needs. This represents a departure from previous systems where, for some services, providers' considerations could take priority over users'.

**Figure 1.1 Non-government provision of human services**  
Per cent of total



<sup>a</sup> Data for long day childcare places relate to for-profit providers in 1994, 2003 and 2012. <sup>b</sup> Data relate to the share of non-government expenditure on dental services. While this has declined over the period considered, the share of private-sector dentists (as a proportion of all dentists) increased between 2000 and 2014 (from 84 per cent to 87 per cent).

Sources: ABS (2016e); AIHW (2005, 2015b, 2015c, 2016b); PC (2014); SCRGSP (2010, 2015).

## Governments' role as stewards of human services

Governments will (or should) always have the role of system stewards to help to ensure service provision is effective at meeting its objectives. The stewardship role is broader than overseeing the market and includes understanding the population and its service needs, policy design, regulation, oversight of service delivery, monitoring of provider performance, and developing ways for the system to learn and continuously improve. Stewardship also includes developing institutional and regulatory arrangements to underpin service provision that is responsive to users, accountable to those who fund the services, equitable, efficient and high quality. Stewardship is discussed in greater detail in chapter 2, but one further point is worth making here: governments retain ultimate responsibility for ensuring human services deliver their intended outcomes *regardless* of the arrangements under which those services are funded or provided.

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## 1.3 The objective of reform

The objective of reform is to improve the effectiveness of the provision of human services such that it improves outcomes for the users of those services and the welfare of the community as a whole. The Commission's task in this inquiry is to recommend reforms that improve outcomes for people who use end-of-life care services, social housing, family and community services, services in remote Indigenous communities, public hospitals and public dental services.

The Commission's focus is on reforms using the policy 'tools' set out in the inquiry terms of reference — the introduction of greater informed user choice, competition and contestability (box 1.1). Competition (as an adjunct to user choice) and contestability are a means to an end — improving the effectiveness of service provision. The Commission's approach recognises that greater informed user choice, competition or contestability will not always be beneficial, and not all areas of human services are amenable to these mechanisms. The costs and benefits of a reform option depend on the characteristics of the people accessing the service, the characteristics of the service itself and the market conditions where service providers and users interact.

For example, well-designed reform to introduce greater user choice in the provision of public dental services may generate net benefits for the service user and the broader community in areas with a vigorous private sector, where providers are able to differentiate their services on the basis of quality or price. The same reform option could impose net costs on the community if introduced in sparsely populated areas where the private sector is dominated by a single provider of dental services who is able to exert market power. Similarly, enabling choice of service provider can be empowering for a well-informed user who is able to act on their preferences, but will be of no direct benefit to those who do not have the capacity (or an agent) to make a decision in their best interest.

The potential costs and benefits of reforms that change the way human services are provided will fall unequally across the community. Recognising the trade-offs inherent in reforms to improve outcomes for users of human services, the Commission's overarching objective when assessing policy recommendations is to improve the welfare of the community as a whole.

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## **Box 1.1      Informed user choice, competition and contestability**

### **Informed user choice**

Someone, whether the user, the provider or a third party such as a regulator, must decide which services a particular user can receive. Informed user choice models empower users of human services to be actively involved in decisions about the services they use. There are many types of user choice. Users can directly make decisions about the services that they receive (for example, a person with a disability deciding which services best support their needs) and which organisation will provide services to them (for example, deciding between different residential aged care facilities). A user's choice may be assisted or facilitated through an agent or intermediary who is tasked with implementing the user's preferences. In other cases, organisations or governments take the needs and preferences of the user into account when making decisions on the user's behalf. A default option (with appropriate protections) may be used where users do not wish, or are unable, to make choices on their own behalf. To support informed user choice, governments may need to facilitate the flow of information about services to users or their agents and provide support to users to help them understand and act on that information.

There are circumstances when a user's agency is explicitly removed, such as being placed under a court order to attend rehabilitation for drug dependency.

### **Competition**

Competition involves government and/or non-government providers of a service (or substitute services) striving against one another to attract service users. If competition is effective, service providers will attempt to attract users by reducing the price they charge, improving the quality of their service, offering new and innovative services, or otherwise tailoring their services to better meet the needs of users. Providers will have more incentive to offer services that users want, including packages of services. Where competition is introduced in markets for human services, it is often done through individual entitlements (such as Medicare funding for general practitioner services or individual budgets under the National Disability Insurance Scheme) where users are able to choose from a range of providers, or coalitions of providers, based on their preferences.

### **Contestability**

Contestable markets are those where there are no substantial barriers preventing a provider that is not currently supplying services to users from doing so now or in the future. Contestable arrangements for provider selection are used widely in the context of commissioning — an increasingly common approach that governments use when engaging organisations (which could be government or non-government providers) to deliver human services. Contestability means that a provider of human services faces a credible threat of replacement if it underperforms. This could include the threat of replacing the management of a public provider with another public management team. Contestability does not necessarily require the outsourcing of publicly provided services to the non-government sector.

There are several criteria that must be satisfied for contestability to deliver the benefits of effective competition. These include: ongoing performance monitoring of providers; alternative providers or management teams that pose a credible threat of replacing an incumbent; and a mechanism to replace underperforming providers.

*Sources:* Baumol (1982); Competition Policy Review (2014, 2015); Davidson (2011); Sturgess (2015).

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## 1.4 Introducing greater informed user choice, competition and contestability

### Informed user choice

Informed choice can improve outcomes for users because it:

- empowers people to have greater control over their lives
- enables people to make decisions that best meet their needs and preferences
- generates incentives for providers to be more responsive to users' needs and drives innovation and efficiencies in service delivery.

There are different types of choice that users of human services could make — which provider; which service; and where, when and how that service is delivered. Some of these choices will be dependent (only certain types of providers can offer a specific service), and some will not be feasible for an individual user (a person with late-stage dementia, for example, may not be well placed to choose a medical specialist). The type of choice on offer is important because the benefits and costs of introducing greater choice differ according to which type of choice is being considered and for whom (Le Grand 2007).

The Commission's starting point is that users should have choice over the human services they access and who provides them, unless there are clear reasons otherwise. These reasons could include a lack of capacity to exercise informed choice and the inability of an agent to exercise choice on a user's behalf, or when decisions must be taken during a crisis, such as a medical emergency. Providing choice can also be expensive for governments, and the benefits of introducing greater choice need to be considered against its costs.

User choice has meaning to people *for its own sake*, independent of whether it drives changes in price or quantity, or drives innovation and efficiencies. People benefit from having increased control over their own lives. Baptist Care Australia and Churches Housing Incorporated (trans., p. 161) noted that it is important for people who use human services to 'have as much choice and control over what they do and how people address their problems as they can'. For example, greater choice in disability services in the United Kingdom and United States resulted in increased satisfaction with services and users feeling a greater sense of control over their lives (PC 2011b).

A common theme in submissions was a strong desire for people to have choice and the empowerment that comes with it. These are people that may not have had the opportunity to exercise a great deal of choice and control over their own lives (UnitingCare Australia, sub. 249). For example, Alzheimer's Australia (sub. 431, p. 7) stated:

Alzheimer's Australia is strongly supportive of the principle of user choice in human services. For people living with dementia, their families and carers, having a say in their everyday lives is a basic desire and underpins a sense of purpose and wellbeing. Many people living with dementia have expressed a desire to feel that they are participating in decision making regarding their care

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but also recognise that their ability to do so can be impacted by their diagnosis: capacity to make informed decisions may change from day to day or may decline rapidly.

Similarly, Queensland Advocacy Inc. (sub. 442, p. 4) noted that:

Choice is empowering and uncontroversial: it can facilitate greater independence and improve overall quality of life, particularly for people with disability who have long been denied dignity and full status as citizens and human beings, let alone choice and opportunities for self-determination.

Users benefit from choice when it better aligns the services they receive with the services they value. The introduction of choice-based letting for social housing in the United Kingdom resulted in increased tenant satisfaction with the home they received. Greater choice in UK hospitals resulted in consumers seeking out better performing hospitals. Yfoundations (sub. 438) noted that young people who are homeless have described a range of potential benefits from choice, such as the ability to find a place that best fits them, and to ‘feel more at home’ in their accommodation.

Providers respond to the user-centred incentives created by user choice. COTA Australia (sub. 456) highlighted some of the costs of not having decisions in the hands of users in aged care — higher-quality providers are unable to expand, poor providers receive a guaranteed supply of users, and people with greater needs have not had their needs met well.

A small number of participants in this inquiry considered that user choice should not be increased, pointing out that recipients of human services may not possess full knowledge of their preferences, have the capacity to act on their preferences, or have access to information that is necessary to make decisions (for example, the ACTU, sub. 100). Participants raised concerns that user choice can worsen outcomes for vulnerable users. The Salvation Army noted that its ‘... experience of choice and control in aged care is that the system does not provide well for disadvantaged people’, and that many of its clients ‘often do not have the services of an advocate, carer or family to support or assist them to navigate the processes’ (sub. DR523, p. 2). Similarly, Victorian Primary Care Partnerships (sub. DR546) noted that consumer directed care models can risk exacerbating inequalities for vulnerable populations.

Anglicare Australia went further, stating that choice in human services is, in its words, a ‘furphy’. Anglicare questioned whether people have a real choice over their general practitioner (GP), for example, because it is a choice based on convenience, location, availability (where there is a waiting list for new patients) and whether the visit is bulk billed, which for many people ‘is no choice at all’ (sub. 445, p. 17). Some participants also noted that price and quantity signals from service recipients to providers (and governments) that direct effort to service innovation, and resources to more highly valued uses, will be distorted when recipients do not face the full cost of providing the service, which is often the case.

The benefits of user choice should not be underestimated. However, limitations do exist and need to be carefully managed through government stewardship arrangements. Examples include arrangements to allow trusted friends or family to make decisions on a user’s behalf,

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default options where no explicit choice is taken, or co-payments to provide an incentive for users to consider the costs of service provision when deciding which services to consume.

For reasons discussed above — including a lack of alternative providers in sparsely populated regions, information asymmetries, or a user's lack of agency or willingness to make choices — the Commission recognises that there are circumstances where user choice is not desirable, but the onus should be on those seeking to remove choice to justify why.

If not the user, someone will be making a choice as to which services a person should receive and who should provide them. These could be decisions taken by governments (about who should be able to provide services or which services should be provided to a particular community, for example) or by providers (about which services should be offered to an individual). In these cases, it is critical that the best interests of users, rather than governments or providers, remain at the heart of service provision.

Yet even when user choice is not desirable, a focus on users can be achieved through other approaches (Alzheimer's Australia, sub. DR521, Little Company of Mary Health Care, sub. DR547). Examples include increasing 'user voice' and co-design so a person's (or community's) preferences are taken into account when others make decisions on their behalf. Mechanisms for communicating preferences between users, governments and providers that do not rely on user choice include co-design so users' preferences can be reflected in need identification, the articulation of service outcomes and service design (Mission Australia, sub. 277). Mechanisms to put users at the heart of service provision where informed user choice is not possible are discussed in chapters 2, 8 and 9.

## **Putting the focus on users though greater competition and contestability**

Used well, competition and contestability can be a powerful mechanism for improving the effectiveness of service provision. In the right circumstances, the potential benefits of competition as a driver include:

- strong incentives for providers to deliver more effective services and to be more focused on people who use services
- incentives for providers to reduce the price they charge
- a more efficient allocation of resources as providers are rewarded for delivering services that users want
- incentives for providers to innovate to improve efficiency and quality, or to tailor services to better meet the needs of people they serve.

Governments play a strong role in the funding and delivery of human services and users have different willingness and capacity to choose. Both of these affect whether competition in markets for human services would have the above benefits, and whether and how competition should be introduced. The capacity and willingness of users to choose also

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affects the potential net benefits of competition. For example, in most markets consumers decide how much they want to spend on a particular good or service and the size of the market will expand (or contract) depending on user preferences. Each provider's share of a market will vary as they try to attract more custom by lowering their prices or improving the quality of their offering. In contrast, decisions about whether a human service can be accessed by users are usually made by others — by governments based on the funding available or by providers where they are service 'gatekeepers' — with prices determined by governments.

There are several options for how greater competition could be introduced to markets for human services and the way in which it is done is an important determinant of the costs and benefits of reform (table 1.1). The expected net benefits of each reform option (including the accompanying changes to stewardship arrangements) would be driven by the characteristics of the service (figure 1.2). Broadly, the options include:

- opening a market to competition where users choose among alternative suppliers through, for example, a voucher scheme or consumer-directed budgets
- contestable processes can be used when competition between multiple service providers is not possible or desirable and can deliver many of the same benefits as competition. Contestable arrangements, where providers are selected by governments through competitive processes such as tenders, are widely used in human services. Examples include the selection of providers of family and community services, and some tenancy management services for social housing.

Where competition would not be effective, a third option could include contracts with incentives that are also designed to mimic competitive pressures, such as outcomes-focused budgets, performance-related funding or benchmarking.

Well-designed and managed systems of service provision could employ different combinations of informed user choice, competition and contestability depending on the characteristics of the service. Competition to provide the service may be used when there are sufficient suppliers, while contestability could be used for the same service to select a single provider where competition would be ineffective due, for example, to thin markets.

**Table 1.1 Filtering reform options**

<i>Model</i>	<i>Description</i>	<i>More likely to have net benefits when:</i>	<i>Supporting stewardship arrangements can include:</i>
User choice	<p>Users are able to choose the provider and/or service that best meets their preferences.</p> <p>Where users are unable to choose their provider (for example, because the market can only support one), they may have limited choice over other features, such as which service they receive, and when and where they receive the service.</p>	<p>Users (or their agents) have information, time and capability to make decisions that suit their preferences.</p> <p>Users (or their agents) are able to assess service quality.</p> <p>Users are motivated because the decision is important (for example, service differentiation is large).</p> <p>Services are used fairly often and users can learn from experience.</p> <p>Providers can respond to user preferences and users are able to switch providers at low cost.</p>	<p>Arrangements for user-oriented information on service offering, quality and/or price.</p> <p>Default options where choice is not explicitly made by a user (or their agent).</p> <p>Payments to providers that reflect the efficient cost of provision and can follow the user.</p> <p>Mechanisms for managing excess demand where the user does not face the full cost of provision.</p> <p>Safeguards to protect service users.</p>
Competition	<p>Users can choose to receive their service from multiple competing providers. Users may be able to choose their service and provider (for example, individual budgets), or choose a specified service from a range of providers (for example, vouchers).</p>	<p>Providers are able to respond to users by improving or differentiating their service offer or price.</p> <p>The market can support multiple providers and there are low barriers to market entry, expansion and exit.</p>	<p>Mechanisms to enter the market (for example, licence allocations).</p> <p>Payments to providers that reflect the efficient cost of provision.</p> <p>Safeguards to protect service users.</p>
Contestability	<p>Contestable approaches can be used when governments select service providers (could be a monopoly or multiple providers) to supply a market.</p>	<p>Alternative providers are willing to provide the service, even if they do not currently do so.</p> <p>Governments are able to assess service quality and contracts can be specified such that service provision will be effective.</p> <p>User preferences are taken into account when governments determine which services should be provided and by whom.</p>	<p>Needs-based assessment of services and clarity as to what is being commissioned.</p> <p>Credible threat of replacement of the provider (or its manager) if there is underperformance.</p> <p>Contracts specifying terms of provision, such as payment terms, quality obligations, mechanisms for addressing underperformance and incentivising good performance.</p> <p>Ongoing performance monitoring of providers, learning and evaluation.</p> <p>Safeguards to protect service users.</p>

As with user choice, a number of participants in this inquiry questioned whether competition should have a place in the provision of human services. Some were sweeping in their rejection. The St Vincent de Paul Society National Council (trans., p. 179), for example, stated that they ‘reject the starting point of this inquiry — namely, the premise that more

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competition and contestability is needed in human services'. Anglicare Australia (sub. 445) did not accept that competition is a driver of efficiency; that efficiency is an inherently good thing in human services; that the innovation that comes with competition between providers is of benefit to service users; or that it is appropriate to equate individual consumer choice with agency and wellbeing. The Illawarra Forum Inc. (sub. DR550) stated that introducing competition and contestability will result in vulnerable people being placed into hardship and reduce access to critical services. The Commission does not agree. Well established markets for schools, optometrists, GPs and allied health professionals, for example, demonstrate the value that choice and competition can bring to people who use those services, and the community as a whole.

Problems can emerge if competition and contestability are poorly implemented and Governments need to learn from the lessons of the past. Issues raised by participants included providers focusing on writing tender applications at the expense of their core business (ASU, sub. PFR326), funding uncertainty and competition damaging the collaboration between providers that is needed to drive positive outcomes for users with multiple and complex needs (CMHA, sub. 399; Merri Health, sub. 418; PHI, sub. 413; Shelter Tasmania, sub. 422; Tasmanian Government, sub. DR590; WACOSS, sub. DR583; YACSA, sub. 408).

The Commission agrees that markets for human services are not like other markets. COTA Australia (sub. 456, p. 7), for example, noted that 'human services are not simple exchange markets and the role of government should remain central in any delivery model'. Competition and contestability should only be pursued where they improve outcomes for service users and the community. The Commission has recognised in its recommendations that introducing greater competition and contestability in some areas is not appropriate. For example, the Commission has concluded that introducing further contestability into the delivery of public hospital services is unlikely to deliver additional net benefits at this time (chapter 11). Governments need to use their stewardship role to ensure that user choice and competition, where they are used, deliver ongoing net benefits to users and the community as a whole.

Policy settings and government stewardship should ensure that the incentives of providers and users are aligned and that government objectives are met. Chapter 2 highlights Australia's experience with the vocational education and training FEE-HELP scheme as a costly example of what can happen when policies are poorly designed. Counter-examples that demonstrate the value that user choice and competition can have in human services include well-established markets for childcare, dentists, schools, optometrists, GPs and allied health professionals, among others.

## **1.5 Assessing reform options**

In making its final recommendations to improve the effectiveness of the services considered in this inquiry, the Commission has assessed whether the reforms would lead to better outcomes for users and their families, and whether the likely benefits to the community of

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the proposed reforms would be expected to outweigh the costs. The Commission has conducted a qualitative, principles-based analysis of the potential costs and benefits of its proposed reforms. This analysis has taken into account:

- the incentives faced by service providers and users, such as whether providers would have incentives to improve the quality of services under the proposed reform, whether the incentives of providers and users would be aligned, and whether government objectives would be met
- evidence from case studies where user choice, competition and contestability have been introduced to human services, both in Australia and overseas
- quantitative evidence where available.

There are three key types of costs and benefits that the Commission has taken into account in its analysis.

- Reforms could change the effectiveness of service delivery captured by five attributes — the quality, equity, efficiency, accountability and responsiveness of service delivery (box 1.2).
- Reforms could have effects on the community beyond their direct effects on service effectiveness. For example, reforms to one human service could influence the demand for other human services. Treating more dental problems in a timely manner may reduce preventable hospitalisations. Similarly, improvements in social housing have been cited as being correlated with improvements in health outcomes for tenants (NSW FACS 2016d).
- Reforms could have implementation and compliance costs, including the costs of introducing and maintaining stewardship arrangements.

The Commission has taken into account the effects that reforms may have on costs and benefits over time. Reforms could have one-off or more enduring effects on providers' incentives to keep innovating and responding to users' preferences, and improve service quality, efficiency and equity. The effects of key trends and drivers, such as developments in technology and data availability could also influence the costs and benefits of reform.

A key factor is the risk of reform options — it is not just the quantum of costs and benefits that has been considered, but also how likely they are to be incurred or achieved. The Commission has considered the risk of reform options in policy design and implementation — this is particularly important given the potentially severe consequences of getting the provision of human services wrong. Reforms that are risky may be suited to a staged implementation so further information and evidence can be gathered before proceeding with a full roll out.

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## Box 1.2      The attributes of human services

### Quality

The concept of 'quality' in human services is open to interpretation and there is no single agreed measure of quality in any human service. One measure might be the effect that the service has on the user's quality of life, such as a medical treatment that successfully reduces chronic pain, or the improvement in literacy from school education. These effects can be difficult to measure and proxies might be used instead, including service outputs (such as the number of students completing a particular year at school). For many human services the way the service has been delivered might also be an important aspect of service quality. Intangibles, such as courtesy and cultural sensitivity, might influence users' views of service quality. Service providers, users and governments might regard measures of inputs (such as the number of staff or their qualifications) as indicators of service quality.

### Equity

The meaning of 'equity' can vary. Davidson (sub. PFR353, p. 4) noted that 'equity is about the fairness of the distribution of resources and services between different individuals and regions'. A key challenge when considering equity issues is balancing community expectations about service quality and how (and by whom) those services should be funded. Equity of access to services might be achieved by providing the same service to all members of the community on the same terms. For example, all Australian citizens are entitled to access emergency hospital care when they need it. Equity of access might not lead to equity of outcomes from human services. Some people have greater need than others, and achieving similar outcomes might require allocating more resources to serve people who face the biggest challenges.

### Efficiency

Economic efficiency is a measure of how well inputs are combined to produce outputs. It has several dimensions. Increasing *technical* efficiency can be achieved by producing more outputs without increasing inputs, or by producing the same outputs with fewer inputs. Increasing *allocative* efficiency can be achieved by determining the level of social resources that should be devoted to human services and then producing the combination of human services that the community values most, given those resources. Improving *dynamic* efficiency is achieved by continually improving technical efficiency (including through innovation in service delivery) and allocative efficiency (by adjusting the combination of human services that are delivered as preferences change).

### Responsiveness and accountability

Responsiveness refers to how well an individual or organisation reacts to things. Le Grand (2007) identified being responsive to the needs and wants of service users as an essential element of respecting people as deliberative and purposeful agents.

Although responsiveness is desirable, there are some qualifications to this attribute. Service users generally do not pay the full costs of human services so being solely responsive to their wishes could place an unreasonable burden on taxpayers and the broader community.

Accountability is acknowledging and reacting to the concerns of the people who fund human services (taxpayers and service users). Taxpayers are also users of human services, and their interests will often overlap. Beneficial human services require that these two attributes — responsiveness and accountability — are balanced.

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## The effectiveness of human service delivery

The potential costs and benefits from introducing greater user choice, competition and contestability may show up as improvements (or deteriorations) in the five service attributes presented in box 1.3. The Commission has assessed the effects of its reforms on these attributes.

- *Quality*: whether the reform options would lead to incentives for providers to offer high-quality services to users. The definition of ‘quality’ will vary depending on the type of service and on an individual users’ perspective of what constitutes quality (discussed below).
- *Equity*: who would be affected by the reform option and how they would be affected. The Commission has assessed the effect of its proposed reforms on various groups within the community.
- *Efficiency*: whether the reform option would lead to incentives for providers to reduce the costs of providing services while still maintaining quality, and for users to select the services that best meet their needs.
- *Responsiveness*: whether the reform option would result in service providers being more responsive to the needs of service users.
- *Accountability*: whether the reform option would result in service providers being more accountable to those who fund the services (taxpayers and users).

The proposed reforms would affect the attributes of effectiveness in different ways and, in some cases, negatively. Some reforms may lead to improvements in quality, with minimal effects on the other attributes. Some may lead to increases in the attributes across the board. Increasing the overall effectiveness of service provision may require trade-offs between the attributes. The potential costs and benefits of reform will also fall unequally across the community. Recognising these trade-offs, the Commission’s overarching objective in assessing policy recommendations is to improve the welfare of the community as a whole.

## Assessing how reforms would influence effectiveness

The incentives of service providers and users is a key driver of how reforms would change the effectiveness of service delivery. The analysis of reform options has considered whether the reform would result in the incentives of service providers and users being aligned with government objectives for service delivery, and whether users would receive services that best meet their needs.

The key aspect of the Commission’s framework is identifying the characteristics of service users, transactions and providers, how these characteristics affect the incentives of users and providers, and ultimately the potential costs and benefits of reform. The characteristics the Commission has taken into account are presented in figure 1.2. Each human service will have different characteristics. Some services have users who have the information and

capacity to choose, while others have users who may need high levels of support to exercise choice. For some services and locations there may be a large number of providers willing and able to offer the service, while other services may be best delivered as regional monopolies. For some services, governments may be able to easily define outcomes in contracts with providers and monitor those providers, while for other services this would be more difficult.

**Figure 1.2 Characteristics that influence the effectiveness of service provision**

Service users	Service transaction	Service providers
User-oriented information on price and quality needed to make choices	Whether the service is used on a one-off, emergency or ongoing basis	Scope for multiple providers or service options, including economies of scale and scope
Expertise needed to make choices	Search and switching costs	Whether the incentives of providers and governments are aligned
Nature and location of demand for services	Whether multiple services provided to users can be unbundled	The capacity for governments and users to observe and monitor providers
Willingness and capacity of users to exercise informed choice	Referral and allocation system	Whether there are alternative providers willing to provide the service
Complexity of needs	Relationship between the service provider and user	Barriers to contraction, expansion, entry and exit
The presence of an intermediary or agent whose interests align with those of the user		The market power of potential providers, and scope for providers to 'cherry pick' users
Support needed for users to understand and exercise choice		Workforce capability and capacity

These characteristics affect not only how the reform would influence the effectiveness of service delivery, but also what stewardship arrangements would need to be put in place to support the reform (which would have implications for the costs of reform options) (chapter 2).

Each of the services the Commission has proposed for reform is different — in the type and number of users, their capacity and willingness to make choices, the setting and circumstances under which services are accessed, and the share of the cost of service provision that is paid for by users and by governments. The starting point for reform also differs across the services. In some cases, improving service effectiveness through the application of competition principles would require major reform. In others, particularly those that currently operate well, service effectiveness can be improved with relatively minor reforms to introduce greater choice and competition. The Commission has tailored its proposed reforms to the unique circumstances of each service.

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## **Assessing changes in effectiveness is complex**

Different users place different weights on certain attributes over others, and they may even have different views on what an attribute, like quality, means. For example, for people with multiple and complex needs, quality may relate to how well services are integrated to meet their needs. For a person who makes occasional visits to a GP, their assessment of service quality will place less emphasis on integration and more on other factors, such as convenience and cost. Governments themselves may focus on indicators of quality such as mortality rates in public hospitals.

Users' experience and satisfaction with the way a service is provided is key to evaluating changes in effectiveness. However, sometimes users are unable to assess certain dimensions of service quality. They may not be well enough informed or have the necessary expertise. For example, a patient may rate his or her experience of choosing a particular specialist to perform a procedure highly because the specialist and support staff were well mannered, minimal pain was experienced and the facilities were comfortable. Data may show the specialist has higher avoidable complications and mortality rates than other specialists. If users had access to these data, they would be able to make a better informed choice taking account of the trade-offs between comfort and a higher risk of adverse medical events.

The Commission has taken care to not disproportionately rely on measurable indicators of the costs and benefits of reforms to users. Measurable and objective indicators of quality should not necessarily take precedence over more subjective or even intangible factors that matter to users. For reforms to truly put users at the heart of human service delivery, governments and providers need to take into account user-reported outcomes, and not look to substitute their own views of what is in users' best interests.

## **Reform would have stewardship, implementation and compliance costs**

Governments, users and providers would all face both upfront and ongoing costs of reform. The nature of these costs would vary depending on the reform — the Commission has not provided an exhaustive list of potential costs in this chapter, but has considered the range of costs relevant to each reform in its analysis.

Many of the costs of reforms would fall on governments as a result of implementing and maintaining stewardship arrangements (chapter 2). These could include the costs of establishing and maintaining institutions, monitoring providers, protecting consumers, enforcing regulations and being a 'provider of last resort'.

Reforms will involve implementation costs as both providers and users adjust to the new arrangements. Service providers may need to change the services they deliver, and some providers may exit the market. This is not a reason to not proceed with reform — indeed a benefit of reforms may be to replace poorer performing providers with better providers. However, for many users of human services continuity of service provision is important, and

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if their provider is replaced, this continuity can be disrupted. This transition needs to be managed from the user's perspective, so that transition costs are not unreasonably high (chapter 2).

Similarly, providers and users would face compliance costs. Users may need to be more active in searching for services, and deciding which services meet their needs. Providers would need to comply with regulatory and stewardship arrangements, including providing information and providing support to users.

## **Costs and implementation**

Governments have sound reasons to fully or partially fund many human services. To ensure that services flow to the intended beneficiaries and fiscal costs are outweighed by benefits to the community, access to these services needs to be carefully managed.

Eligibility arrangements for the human services covered by this inquiry vary considerably. In some cases, such as social housing and public dental, clear eligibility criteria govern access. In others, such as family and community services, eligibility is governed more flexibly. The Commission did not reconsider the existing eligibility arrangements for the services covered by this inquiry. In particular, it has not commented on whether changes to eligibility criteria should be considered as a means of constraining fiscal costs.

Introducing greater choice, competition and contestability will involve additional fiscal costs to governments, especially in the early years of implementation. The nature and extent of these costs vary considerably. For example, the costs of reform to remote Indigenous services largely relate to improving government stewardship and the engagement between government and remote communities. In social housing, enabling greater choice would involve converting an uncertain wait for a social housing property into a (potentially immediate) entitlement for portable financial support. In end-of-life care, allowing more people to die at home (in line with their preferences) would involve expanding the availability of services.

Over time, some of these additional fiscal costs borne by governments may be offset by reductions in other areas. The Commission's proposed reforms to social housing, for example, may reduce demand for public housing properties — requiring less future construction. Additional costs in the delivery of one service may also be offset by lower costs in other areas of service provision. More effective end-of-life care and public dental services could, for example, reduce demand for some hospital services.

The Commission considers that the benefits of the reforms proposed in this report are likely to outweigh the costs. It has not been able to provide a detailed quantitative cost-benefit analysis for all the reforms proposed, but has provided estimates of fiscal costs where feasible. Reasons for this include a lack of robust data on current levels of expenditure for some services, difficulties in 'valuing' the inherent benefits of greater user choice, and

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uncertainty as to how changes in services in one area would affect demand (and expenditure) in others.

The Commission has outlined a broad reform timetable for each service that could guide implementation. These timetables provide information on the sequencing of reforms and the timing of implementation. Consideration will need to be given to how these reforms sit against existing reform priorities and activities.

All of the services considered in this inquiry involve the Australian, State and Territory Governments. There is evidence that uncertainty about the roles and responsibilities across different levels of government has led to policy inertia and, in some cases, conflict over responsibilities and uncertainty over how stewardship is shared and service provision is coordinated across different settings. Neither fiscal costs, nor the unequal distribution of fiscal effects, should be an insurmountable barrier to implementing reforms that would generate significant net benefits to the community. For successful reform to occur, collaboration across jurisdictions will be critical.

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## 2 Government stewardship

### Key points

- Stewardship relates to the range of functions that both determine what human services should be made available and the effectiveness of those services. It involves three linked phases in a continuous cycle: service design; delivery; and improvement.
- Governments have not always given sufficient focus to stewardship, which has contributed to poor outcomes for users. Any reforms to human services need to be mindful of governments' ongoing stewardship role.
- Stewardship arrangements are difficult to get right and this inquiry has highlighted areas where governments need to improve. These include:
  - place greater focus on the user: the interaction between governments and providers can dominate design and delivery considerations. A better understanding of, and focus on, users would improve the design and delivery of services. This includes identifying and coordinating services for high-needs users who require multiple integrated services
  - greater coordination: coordination problems can arise within and across governments and providers. Policy developed in government silos can lead to competing objectives, and stewards losing sight of the users' overall wellbeing. Greater coordination, and engaging users and providers more during service design and delivery, can improve the effectiveness of service provision
  - more transparency: information can improve accountability and facilitate performance assessment, benefitting all parties. Equipped with improved information, users can assess providers, providers can plan their services and governments can evaluate how providers or systems are performing
  - smoother transitions: policy reforms can be large, costly and disruptive. Better planning and preparation for policy change can preserve continuity of outcomes and minimise negative effects on users. Overly ambitious reforms and rollout schedules can lead to issues in implementation, particularly of large and complex reforms. Transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Information and clarity about changes in advance can help.
- Other elements of stewardship that need improvement include:
  - systematic service planning which involves identifying community needs and government objectives, and planning service delivery. Proper service planning allows resources to be allocated more effectively to meet evolving needs
  - performance frameworks that use (ideally outcome) data to assess the performance of a provider or service. The frameworks can also be used for evaluating individual programs or the entire system. Such frameworks can improve accountability and efficiency
  - consumer protections such as licensing of providers, regulation, enforcement and complaints mechanisms. These promote quality and protect users, and are required regardless of the type of provider (government, not-for-profit or for-profit).

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## 2.1 Governments' role as stewards

Governments will (or should) always have the role of system stewards. Stewardship relates to the range of functions governments undertake to determine what human services should be made available and the effectiveness of those services. Importantly, governments retain ultimate responsibility for the effectiveness of human services, regardless of the arrangements under which those services are provided. The World Health Organisation (2000) outlined the importance of stewardship in the context of health services. It said:

[T]he ultimate responsibility for the overall performance of a country's health system must always lie with government. Stewardship not only influences the other functions, it makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution. The government must ensure that stewardship percolates through all levels of the health system in order to maximize that attainment. (p. 119)

Stewardship occupies a special place because it involves oversight of all the other functions [of the health system], and has direct or indirect effects on all the outcomes. (p. 24)

Stewardship arrangements are difficult to get right — the design and performance of these functions should be tailored to each service and to the settings in which it is provided. A particular consideration in human services is the role of governments as primary funders. Some users and providers do not bear costs themselves, and do not have the same incentives as participants in a typical market. This affects how they respond to regulations designed to meet government objectives, and adds complexity to stewardship decisions.

Governments have not always given stewardship sufficient focus — a point made by participants to this inquiry (for example, Brotherhood of St Laurence, sub. 286, Jesuit Social Services, sub. 284, Australian Council for Private Education and Training, sub. 279, Consumer Action Law Centre, sub. 260). This has led to some prominent policy failures involving both government and non-government providers, where users experience poor and sometimes harmful outcomes (box 2.1). This inquiry has highlighted particular areas where government stewardship should be improved.

Implementation and ongoing maintenance of sound stewardship arrangements needs to be a core part of the reform and delivery process, rather than an add on. Participants, including Baptist Care Australia and Churches Housing Inc (sub. DR532) and the Australian Association of Social Workers (sub. DR557), noted that improving stewardship would require a significant cultural change from both governments and stakeholders. Governments and providers will need to invest time and resources to build new capacities and change organisational cultures (chapter 8). If they do not adequately resource such capacity building, the benefits available from reform could be jeopardised (Public Service Research Group, University of New South Wales, Canberra, sub. DR572).

The stewardship framework outlined in this chapter involves three linked phases that exist in a continuous cycle of service design, delivery and improvement (figure 2.1). It

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incorporates policy design, regulation, oversight of service provision, monitoring of provider performance and means for the system to learn and continuously improve.

### **Box 2.1 Case study: stewardship failures**

Case studies of policy failures in parts of the health system and the vocational education and training (VET) system underscore the importance of good stewardship to encourage positive outcomes for users.

In 2015, the Victorian Department of Health and Human Services was notified of a cluster of perinatal deaths at Djerriwarrh Health Services. A clinical review identified that seven of the deaths were avoidable or potentially avoidable. A review by the Australian Commission on Safety and Quality in Health Care found that the department lacked processes to monitor and act on serious clinical incidents.

A further review of hospital safety and quality assurance (Duckett, Cuddihy and Newnham 2016) found that the department's oversight of hospitals was inadequate: the department did not have the information it needed to provide assurance on the quality of care; conducted no routine monitoring of patient outcomes or serious incidents; did not use the routine data at its disposal; and over-relied on accreditation processes.

The review recommended (among other things) changes to the stewardship of hospital safety and quality. These included legislative changes to clarify the system's objective, a stronger focus on users (patients), improvements in transparency by publishing safety and quality performance indicators, adoption of payment models to align incentives. The review also recommended several improvements to the performance monitoring framework for safety and quality in the system, including the use of a range of outcome measures. Chapter 11 of this inquiry examines reforms to information provision in hospitals.

In the VET system, reforms were not accompanied by adequate safeguards or oversight of providers. In 2012, the Australian Government expanded the VET FEE-HELP scheme. The reforms provided access to VET FEE-HELP loans for students undertaking some courses at VET providers that did not have credit transfer arrangements with a higher education institution.

As a result, there was a sharp increase in the number of (mainly full-fee) students. This led to students accumulating large debts that many are unlikely to ever repay. Some private providers aggressively marketed their courses, emphasising to students that they would not have to pay upfront, and in some cases offering inducements (such as 'free' laptops). Thousands of students signed up for courses that they had little prospect of completing. Better oversight of providers, combined with quality standards and improved information, could have avoided some of these issues.

Stewardship issues arising from a lack of user focus, transparency (including inadequate information collection and provision), coordination and consumer protections also occur in other human services. As this chapter highlights, these are areas that require improvement from governments in their stewardship role.

*Sources:* Australian Government (2016b); Birmingham (2016); DET (2015); Duckett, Cuddihy, and Newnham (2016); NCVET (2015); Senate Standing Committees on Education and Employment (2015).

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Figure 2.1    **Stewardship cycle**



## 2.2 Design

Once policy makers have determined a broad need, the stewardship process for a new service or program begins with its design. This involves the conceptual and planning elements that should be considered before a service can be provided. The first step in design is systematic service planning, which focuses on understanding the user population and their needs. Other elements of the design process include:

- managing access to services
- data needs
- consumer protections

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- payment models
  - models of provision.

## Systematic service planning

Systematic service planning (discussed further in chapter 8) guides the design of a service by developing an understanding of community and individual needs, the outcomes sought from the users' perspectives and the number and types of providers available to deliver services.

### Understanding the user population and their needs

The first step in systematic service planning involves governments developing an understanding of the relevant population and its service needs. In essence this requires consideration of what services are needed, where they are needed, how much should be provided, and to whom.

To do this, governments should identify the relevant service user population and understand the characteristics of that population. This guides the mix of services that will most effectively achieve outcomes for users. The variance of individuals' characteristics within a population will also inform service design.

Governments can build this understanding of users from both population-level data, and on-the-ground evidence from service users, providers and experts (chapter 8).

In addition to developing an overall understanding of users, systematic service planning involves governments:

- *identifying and articulating outcomes* that services and providers should achieve for users, and specify outcomes at the program and overall system level
- *planning for specialised services*, which may be needed to meet the needs of particular groups, such as culturally and linguistically diverse users
- *planning for users with complex needs*, which considers that the needs of individuals can lie across several government silos, and may require coordination between and within governments (below)
- *planning for regional needs*, which considers the needs of the population as a whole, taking into account that the needs of some users can differ from others. Regional planning also involves coordination between and within governments. The level at which planning occurs should be appropriate for the services being considered (including issues of scale, geography and jurisdictional responsibility for service provision). For example, each of the Primary Health Networks commission medical and healthcare services within their own region by undertaking needs assessments and identifying the region's priorities.

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In developing its reforms, the Commission has identified a need for governments to develop a better understanding of the user population and their needs in a number of areas, including:

- a detailed assessment of current and future needs for additional community-based palliative care (chapter 4)
- improved planning and assessment within social housing to understand the demand for and supply of social housing (chapter 7)
- data-driven maps of existing family and community services, and analysis of the characteristics and needs of their users (chapter 8)
- conducting and publishing ongoing assessments of the characteristics and needs of Indigenous Australians living in remote communities, including mapping the existing services provided in communities (chapter 9)
- planning to understand users' needs as a precursor to improved commissioning for public dental services (chapters 12 and 13).

### Setting specific objectives

Policy and program objectives will be influenced by the efficiency and equity considerations that underlie government involvement in markets for human services. Setting specific objectives is critical to providing clear direction for the design and delivery of a service, and setting a frame for the service to be evaluated against. The Community Council for Australia noted that the absence of clear policy goals is common in human services and detrimental to users:

A lack of clarity about policy goals and measures results [in] a failure to understand how best to deliver the desired outcomes. As a consequence, many areas across human services seem to be awash with ad hoc measures being developed by both government departments and the providers of services themselves. (sub. DR585, p. 3)

Setting a broad objective that is consistent across programs can facilitate a holistic approach to assessing the effect of a number of services.

Broad system-level objectives can provide little direction as to how specific services should be designed, funded and provided. Programs that meet the system-level objective will usually have more specific objectives. For example, the National Disability Insurance Scheme (NDIS):

... will provide about 460 000 Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. (NDIA 2017b)

Specific objectives facilitate decisions within the program to target the service and also sets benchmarks for monitoring and evaluation. The program objective often identifies the subset of the population that should be eligible for a service.

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## Incorporating provider and user voice

Many human services have been funded and delivered in a way that suits governments and providers, rather than with a focus on users (for example, chapters 8 and 9). This is in part due to traditionally close relationships between providers and governments, and the role that many providers play in enabling users to access services. Insufficient focus has been placed on users' needs, preferences and circumstances leading to ineffective services and poor outcomes (box 2.2). Improvements in users' wellbeing should be central to a service's objective and should not be lost in the design and delivery process.

### Box 2.2      **Area for improvement: focus on the user**

Focusing on the user in designing and delivering services can benefit users and improve the effectiveness of service provision. Chapter 1 notes the importance of choice in empowering people to have greater control over their lives, and enabling them to make decisions that best meet their needs and preferences. User choice also generates incentives for providers to be more responsive to users, which can lead to innovation and efficiencies in service delivery.

However, providers and governments have often decided what is best for service recipients. In the Commission's inquiries into *Caring for Older Australians* and *Disability Care and Support*, participants expressed their frustration at not being able to influence care decisions under the arrangements in place at the time, and having minimal choice over matters that affected their quality of life (PC 2011a, 2011b).

A comment reported by Aged Care Crisis (2010, p. 32) highlighted an instance where the provider's considerations took priority over users' preferences:

Eating is one of the few pleasures left to some elderly folk and where are the inspectors at the vital times. Why should the residents be fed at 4pm so staff can go home and not cost extra in wages? Ask anyone if they eat their dinner at 4pm.

In the context of reforms to disability support services, one participant noted the limited scope for service users to replace their provider:

There was no option, whatever this service provided, good and bad, and all in between, I had to wear it; I was in effect held hostage because I dare not depart for fear of losing funding support ... There were times I became despondent. I do not intend to illustrate specific instances of bad care or good care. The fact is, I was held virtual hostage to one service because of [the Australian Government's Home and Community Care program] being the nature it is, not supporting portability. (Dunstan 2010, p. 1)

The lack of a user-directed system was a main impetus for the Commission's recommendations for a consumer-directed model of care, in both aged care and disability support services, which governments are now implementing (PC 2011a, 2011b).

This inquiry has shown that interactions between governments and providers continue to dominate design and delivery. For example, governments tend to focus on the cost of service delivery and the 'quality' of tender applications rather than the ability of providers to deliver outcomes for users in family and community services (chapter 8). Similarly, service providers are required to deliver the (sometimes prescriptively defined) services in their contract, regardless of whether those services are the best way to produce outcomes for users. Further examples in other services are discussed in the following chapters, along with recommendations to improve the focus on the user.

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One way to improve the focus on the user is through engagement with users to understand their needs and preferences during the objective setting process.

Engagement can include *co-design* for some aspects. Co-design is a process whereby users become ‘active partners in designing, shaping and resourcing services, rather than being passive recipients of pre-determined services’ (Burkett nd, p. 7). Notably, co-design is more than seeking the views of users and providers through consultation, it also:

- seeks to understand the service from the users’ point of view (and to engage users to consider the providers’ point of view)
- starts with the end goal in mind, rather than focusing on problems with the existing services
- focuses on practical and implementable solutions to issues affecting users, including through testing ideas in practice and refining them as solutions are developed
- involves a range of communication methods to make possibilities and solutions tangible. This is particularly important when engaging with a range of participants who may interact with complex systems from different perspectives (Burkett nd).

As with other forms of engagement, the choice of participants for a co-design process matters. The users and providers directly involved in the service in question form a good starting point, but including those outside of the ‘usual suspects’ can be just as important for bringing in new ideas to solve longstanding issues.

Co-design processes are inclusive and draw on many perspectives, people, experts, disciplines and sectors. ... it is important to draw on many perspectives, to challenge orthodoxies, to question assumptions, and to draw in other possibilities. Co-design processes thrive when boundaries are flexible and silos are broken down, when real listening and dialogue can occur across unlikely alliances. (Burkett nd, p. 6)

## Coordination between and within governments

Poor (and siloed) planning, design and communication between and within governments leads to overlaps and gaps in service funding and provision. Coordination between governments (local, state and federal) is a broad area for improvement for stewards when designing human services (box 2.3).

At times there may be multiple stewards (from different levels, or parts, of government) involved in a given service, or for a group of users who require multiple services. Such instances of overlap create challenges for determining who should design and fund particular services, or elements of services. This inquiry has highlighted cases where a lack of coordination is reducing the effectiveness of the provision of some human services. For example, end-of-life care is provided in settings that are funded by the Australian, State and Territory Governments. A lack of clarity about the respective roles of each government within these funding arrangements has had adverse effects on the availability of high-quality

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end-of-life care (chapter 3). In such instances, coordination between stewards, and clear allocation of roles and responsibilities (including funding) is be important.

Another important element of coordination — between providers — is discussed in section 2.3. A coordinated approach from governments also assists providers. Aligning funding and objectives clarifies the specific role of each provider.

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**Box 2.3      Area for improvement: greater coordination**

At the service design stage, coordination between and within levels of government, and with providers and users is critical for effective service delivery. However, in many cases, providers and governments struggle to achieve proper coordination in human services.

Poor coordination is an issue for services in remote Indigenous communities. On the funding of these services, a Closing the Gap Clearing House report noted:

Many evaluations [of services in remote Indigenous communities] have reported on the fragmented and siloed funding arrangements that constrain the ability of Indigenous organisations, service providers and governments themselves to respond to community need. (Moran, Porter and Curth-Bibb 2014, p. 22)

The Council of Australian Governments' Trial in Wadeye explored ways to coordinate governments' work with the community. An evaluation of the Wadeye Trial noted that the burden of administering government funds increased rather than decreased, adding to the workload of the local government administering the services. A broader evaluation of all the trial sites (including seven other sites) noted that an additional challenge was achieving consistent decisionmaking across all levels of government.

The broader evaluation also highlighted the need to effectively engage with users and understand their perspectives. Some lessons included the need for mutual understanding between governments and Indigenous communities, training government staff on how to engage with Indigenous communities and developing governance mechanisms that reflect local communities views.

The need for greater coordination arises in many of the services examined in this inquiry, and can be addressed in different ways. For example, place-based approaches can be used to promote coordination of services in some remote Indigenous communities (chapter 9). In the context of family and community services (chapter 8), tender periods could be held open for longer to facilitate the formation of consortium bids by providers, and contracts could include funding to allow coordination between service providers.

Sources: Gray AM (2006); Morgan Disney & Associates (2006); Moran, Porter and Curth-Bibb (2014).

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Place-based approaches are 'designed and delivered with the intention of targeting a specific geographical location(s) and particular population group(s) in order to respond to complex social problems' (Wilks, Lahausse and Edwards 2015, p. viii). Place-based approaches can be a more effective way of tackling 'wicked problems' (complex problems with multiple interdependencies) than traditional, siloed approaches to service delivery. They involve giving greater priority to community-level planning, decision making and accountability, and require an understanding of each community's situation (chapter 9).

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A place-based approach is one way to overcome coordination issues, by shifting the emphasis of planning to what is needed within a community, rather than what can be provided by each arm or level of government. In doing so, it can also build a community's resilience and capacity to identify and develop responses to issues.

Focusing program interventions at the local level is a positive way to build community capability and social capital through community development activities. Location-based approaches may also address concentrated and entrenched problems found in the most disadvantaged locations. (Australian Social Inclusion Board 2011, p. 21)

Implementing place-based approaches requires significant resources, skills, patience and support from governments and communities. There have been many examples of poorly implemented approaches that have not delivered on the promise of the place-based approach. A strong focus on managing implementation risks is therefore important.

Poor coordination can also be overcome by focussing on outcomes for individuals. In particular, the presence of users with complex needs for a range of services may require 'people-based' approaches — that is, consideration of a set services from the perspective of the user, rather than a particular service silo, or geographic region. For example, in a health context, the Health Care Homes model is being trialled to provide coordinated care (including across hospital, allied health, pharmaceutical and specialist services) for patients with chronic and complex conditions.

## **Managing access to services**

Governments have sound reasons to fully or partially fund many human services, but they will need to manage access so that services flow to the intended beneficiaries and to manage fiscal costs.

Different funding models will have different implications for overall fiscal costs and users' access to services. For example, consumer-directed care models that allow greater user choice (such as the NDIS) allow users to determine how they access a service, but can be difficult to design in a way that allows governments to maintain control of expenditure. Conversely, direct government funding of service providers (as is the case for many family and community services (chapter 8)) gives governments more control over fiscal costs, but often gives providers discretion over which clients they serve and what services they provide.

The way governments can manage access depend on a number of factors including the objective of the service and who the intended service recipients are. Governments that are seeking to constrain costs (or target services) can use a range of mechanisms including co-payments, waiting lists (box 2.4), capped funding (for individual users or the service as a whole) and limits on access to services (such as, requiring a referral from a general practitioner to access specialist services or identifying a schedule of basic services that will be funded by government).

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## Box 2.4      **Mechanisms to manage access**

Access mechanisms are used widely in human services. Two of the primary mechanisms are waiting lists and co-payments.

*Waiting lists* effectively require users to ‘pay’ with their time to access services and can be an efficient means to manage limited funding (for example, those who can afford private services weigh up the relative financial and time costs of the options available to them).

However, they will not be efficient where users’ circumstances are allowed to worsen when they stay on a waiting list (for example, a health condition developing complications if left untreated), adding costs to the user and community. In this sense, rather than the number of people on a list, it is the time they spend on the list that is of greater concern. In a health context, waiting list times can be guided by clear, transparent clinical guidelines for benchmark periods beyond which the costs (particularly to the wellbeing of the user) worsen.

*Co-payments* are charges paid by users to cover part of the cost of accessing a service; governments (or other funders) cover the remainder. Co-payments can provide an incentive for users to consider the costs of service provision when deciding which services to access.

Co-payments can raise equity concerns if users from low-socioeconomic backgrounds cannot afford the co-payment; or users face particular barriers, such as having complex needs that require multiple visits. Some programs, such as the Safety Net Scheme under the Pharmaceutical Benefits Scheme account for such circumstances by placing a cap on the users’ total co-payment per year, with further access free at point of use (or at a greater concession).

## **Data needs**

The Commission’s inquiry report on *Data Availability and Use*, which had a broader scope than human services, put forward a framework that will improve general data infrastructure within human services (PC 2017a). Key elements relevant to human services included facilitating access to national interest datasets, creating a culture favouring data release, and a ‘comprehensive right’ to give individuals more control over data held on them.

In a human services context, data are particularly important for designing and targeting services. Data are also critical to facilitate transparency and provide a basis for performance assessment and improvement. Collecting data can, however, impose additional burdens on both providers and users which also needs to be considered.

## **Outcomes and performance frameworks**

An *outcomes framework* identifies the relevant data (outcome measures) which quantify how activities contribute to specific outcomes, and how the data are collected. Frameworks can encompass several categories of outcomes, including:

- *user outcomes* which are the effects of services on the wellbeing of individuals and families

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- *community or place-based outcomes* which assess the combined effect that services have on a particular community or location
  - *provider outcomes* which are the contributions that individual providers make to the wellbeing of the people they serve
  - *program outcomes* which are the outcomes achieved through an overall program or funding stream (often involving a group of service providers)
  - *system-level outcomes* which are the effects of the service system as a whole (including programs, and providers, across portfolios and governments) on users, providers and the broader community.

The Western Australian Council of Social Service (sub. DR583, p. 2) highlighted the importance of outcomes frameworks:

... the focus should be on community outcomes as the key criteria for defining service quality, efficiency and effectiveness. In the absence of shared outcomes frameworks and clear and comparable data on service outcomes to enable rigorous evaluation of services it is not possible to have meaningful ‘competition’ on services or a functioning ‘market’ for services.

Outcomes frameworks and the data to support them are discussed in the context of several human services in this inquiry, such as:

- measuring the outcomes of community-based palliative care in order to monitor and evaluate services’ performance (chapter 4)
- consistent outcome measures for family and community services (chapter 8) to be used in provider selection, performance management, and provider-, program- and system-level evaluations
- developing outcomes for human services in remote Indigenous communities (chapter 9) which take into account both the broad objective of improving Indigenous Australians’ wellbeing, and also Indigenous Australians’ preferences, priorities and conception of wellbeing
- an outcomes framework for public dental services based on clinical and patient-reported measures (chapter 12).

The sources of data affect the cost of collection, and the uses that the data can be put to. In the context of human services, relevant data sources include:

- *administrative data* collected primarily for the administration of services that relate to the transactions involved in accessing a service
- *provider data* relating to the providers’ own functions including the cost, quantity, quality of services provided, and data that they collect on users
- *user-generated data* coming directly from users, commonly obtained through surveys. These are directly relevant to the user’s outcomes and can also provide insights about changes in user behaviour.

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Outcomes frameworks feed into *performance frameworks*, which are used to assess the performance of a system, program or provider. In practice, outcome measures can be difficult to quantify and costly to collect. ‘Second-best’ metrics such as measures of outputs that proxy outcomes, combined with appropriate caveats and used in concert with other means, can be useful alternatives. The choice of performance measure is important, particularly when they are tied to providers’ remuneration as there is a risk that providers may focus on meeting specific measures rather than improving people’s wellbeing (box 2.5).

#### **Box 2.5 Case study: perverse incentives in the United Kingdom**

Harwich, Hitchcock and Fischer (2017, p. 40) stated in their report *Faulty by design — The state of public-service commissioning*:

The four-hour waiting-time target for Accident and Emergency (A&E) care ... was set in 2000 [in the United Kingdom] to improve care. Evidence supports the argument that longer emergency-department waiting times have been linked to mortality. Yet, the target put unnecessary pressure on clinicians to meet input targets, rather than address users’ health needs.

Hospitals who miss the target are investigated by NHS [National Health Service] regulators, and – despite NHS England allowing some hospitals to miss targets – A&E departments still receive negative media attention for breaching them. In the past, this has resulted in ambulances being parked outside A&E departments until staff believe they can treat [the patients] within four hours, and patients being admitted to hospital unnecessarily. One third of doctors surveyed by the [British Medical Association] had manipulated data to meet waiting targets. This distracts clinicians from focusing on treating the needs of patients in A&E.

Targets have led to negative behaviour elsewhere. At NHS Lothian, this targets-driven culture resulted in the manipulation of waiting-time data.

### **Data infrastructure**

While outcomes and performance frameworks guide much of the data needed, data infrastructure, which includes systems to manage, analyse, coordinate, share and present collected metrics, is critical to effectively collect and use data.

In addition to systems to manage risks associated with privacy concerns (PC 2017a), other considerations for data infrastructure in human services are:

- *who should pay for what?* Data collection and management are costly. Providers and stewards often collect data for their own purposes and can sometimes benefit from analysing and disseminating these data more broadly. Stewards should look to create incentives for data to be collected, analysed and shared when there would be an overall benefit to the community. In most human services, governments (as funders) will likely bear the cost relating to data. For example, they may increase their payment specified in contracts with providers in order to account for these costs (chapter 8) or pay ‘in kind’: the Department of Social Services’ (DSS) Data Exchange gives providers analysis of their own data in exchange for providers reporting performance data (DSS 2017b)

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- *can systems adapt to future requirements?* Data requirements for a service constantly change, particularly with continuing advances in technology. These changes can be difficult to predict. However, stewards can set up systems that better manage change, for example, by establishing data systems that can easily accommodate and adapt to new types of data and new uses for them (PC 2017a).

## Consumer protections

Consumer protections are needed to help protect users from poor quality providers (and outcomes) and help maintain continuity of service. Ensuring that appropriate consumer protection arrangements are in place can be particularly important in circumstances where governments fund a substantial expansion of services — as would be the case in expanding community-based palliative care services (chapter 4), or increasing the involvement of private providers in the delivery of public dental services (chapter 13).

Consumer protections can include measures to ensure that services are safe and fit for purpose, meet minimum quality standards and focus on managing (rather than eliminating) risks. There are broad safeguards in the Australian Consumer Law, but these may not offer the protection required to maintain the standard of care in human services expected by the community. As Alzheimer’s Australia (sub. 431, p. 2) submitted:

There must be a high level of government stewardship and a robust framework of consumer protections to ensure access and quality are maintained and improved, particularly for vulnerable users, including people living with dementia, their families and carers.

There is a range of other regulatory levers available to governments to protect users, including direct regulation, complaints and appeal processes and licensing of providers.

Licensing and accreditation set a minimum quality standard for entry into a given service by checking potential entrants against a set of criteria. For example, the Australian Health Practitioner Regulation Agency requires that applicants complete an approved program of study, as set by their relevant professional board (for example the Dental Board). Applicants must also meet a set of common registration standards, including: a criminal history check, recency of practice and continuing professional development requirements, possession of professional indemnity insurance and, in many cases, English language proficiency (AHPRA 2015). In addition to setting a bar for entry, registration boards can suspend or revoke licences or accredited status in cases of disciplinary action, providing an ongoing enforcement tool. The Australian Services Union highlighted that such accreditation processes can be beneficial for service users:

... the process of rigorous accreditation that most human services organisations have had to go through surely is one of the checks and balances that can be used during that seven-year [contract] process. As a front-line worker who was initially very sceptical of those processes in terms of benefits that may bump on towards clients, I certainly can say that I’ve been turned around because the degree of scrutiny and the high level of those standards and the cultural change that

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that scrutiny allows for the organisations to benefit the clients is very apparent in terms of service delivery. (trans., p. 368)

However, care should be taken in setting licence conditions to ensure that they are genuinely the minimum required for consumer protection and do not operate as a barrier to entry (protecting incumbent providers more than consumers). Potential barriers include excessive education requirements, cumbersome accreditation processes (to delay or limit transfer of registration from other jurisdictions) and unnecessarily narrow scopes of practice (that prevent qualified practitioners in one discipline from competing with others).

Last resort arrangements help to maintain continuity of service when a provider cannot deliver services to some or all users. Governments can coordinate other providers to take on users, bail out a failing provider, increase funding to the provider, or directly provide the service.

Whichever form of consumer protection is chosen, it is important that it does not exist in name only. Protections should be designed, implemented, resourced and enforced well to make a real difference for consumers.

## **Payment models**

Providers change their service offerings in response to the payments they receive. The incentives associated with payments are affected by three decisions that stewards should consider: who determines where governments payments should go; the type of payment model used; and the level of the payment.

### **Who determines where government payments should go?**

Broadly, three types of parties can determine which providers receive a payment for human services: users, third parties acting on users' behalf, or governments.

Under user-driven models, users choose a service provider and governments' payments follow their choice. For example, arrangements under the NDIS give users control of how to use their funds, creating incentives for providers to satisfy users' demand as providers are only funded when users choose them (NDIA 2017a).

However, user-driven models are not suited to every circumstance, such as for complex decisions that require expert opinion. In these cases, a third-party can choose a provider for a user and government payments would follow the third-party's choice. Governments can also use contestable processes to choose which providers to allocate funding to.

## The types of payment models

There are a number of ways that providers can be paid for delivering a service, each of which rewards different sorts of behaviour. The basic types of payment model include block funding, fee-for-service, capitation and pay-for-performance (figure 2.2).

Figure 2.2 Basic types of payment models

	Advantages	Disadvantages
<b>Block</b> Lump sum payments to provider covering all services for a set period of time	<ul style="list-style-type: none"><li>• Expenditure is predictable</li><li>• Simple to administer</li><li>• Adopting innovations does not impact providers' budgets</li></ul>	<ul style="list-style-type: none"><li>• Incentive to underprovide services to reduce workloads</li><li>• No explicit incentive to improve quality of service</li><li>• Limited accountability in how payments are spent</li><li>• Better providers attract more work but not necessarily resources</li></ul>
<b>Fee-for-service</b> Reimbursement for each unit of service provided	<ul style="list-style-type: none"><li>• Can support user choice</li><li>• Incentive to provide services to more people</li><li>• Incentive to provide services regardless of costs</li></ul>	<ul style="list-style-type: none"><li>• Incentive to increase activity and over service users</li><li>• Incentive to limit or reduce resources allocated to users</li><li>• Few incentives to work with other providers</li><li>• Funder bears financial risk of increased demand</li></ul>
<b>Capitation</b> Periodic lump-sum payments for each enrolled user	<ul style="list-style-type: none"><li>• Expenditure is predictable</li><li>• Incentive to reduce costs</li><li>• Incentive to provide preventive services</li><li>• Can encourage coordination between providers</li></ul>	<ul style="list-style-type: none"><li>• Difficult to monitor and enforce quality of service</li><li>• Incentives to shift service delivery to other providers</li><li>• Providers may not select users if the cost of providing to those users is not compensated by a risk adjustment</li><li>• Little incentive to increase quality/quantity of services</li></ul>
<b>Pay-for-performance</b> Rewards or penalties linked to performance measures	<ul style="list-style-type: none"><li>• Incentive to undertake beneficial services that would otherwise not be remunerated</li><li>• Can aid consistency in meeting quality standards</li></ul>	<ul style="list-style-type: none"><li>• Significant monitoring effort required</li><li>• Indicators hard to define; may not link well to outcomes or factors under provider's control</li><li>• Can be high compliance costs for providers</li><li>• Risk of unintended consequences such as 'cherry picking' users to meet targets</li><li>• May be little incentive for improvement beyond targets</li></ul>

Source: Adapted from PC (2015a).

Each model has advantages and disadvantages, some of which can be overcome by using a blend of models, or other levers, including regulation, to limit adverse outcomes. For example, capitation payment models, where providers receive a periodic payment for each

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enrolled user in the service, create incentives to deliver services to more users, but can lead to providers ‘cherry picking’ (only providing services to low-cost patients in order to maximise return). The risk of adverse outcomes can be managed by, for example, weighting payments to incentivise providers to meet government objectives. A blended payment model using capitation payments — as well as payments that reward providers for improving outcomes for users — is proposed by the Commission in its reforms to public dental services (chapter 13).

## Determining the level of payments

As stewards, governments are responsible for setting the level of payments to service providers. As the Commission identified in its report into the *Contribution of the Not-for-Profit Sector* (PC 2010), this includes determining whether the government is fully funding the activities of a service provider, and setting the level of payment at an adequate level. Getting the efficient level of payments for providers right is important to encourage the effective provision of human services, but setting and implementing this payment is difficult.

Simplified approaches to determining the level of payment to providers may be attractive to governments when designing a service or contract, but can have downsides. For example, a standard payment (which could be based on an average cost of delivering the service) may be paid for delivering a service to any user even though the cost of achieving outcomes can be higher for some people than others. In such cases, providers have an incentive to cherry pick users or focus on certain settings (where the government’s payment is above the actual cost of providing the service) and may deny or limit services to more costly users or settings (where the government’s payment is below the cost of provision). This can adversely affect equity outcomes as the cost of delivering services to a user, rather than their need for the service, may drive providers’ decisions about who can access services. Issues of effectiveness can also arise — the users who are more costly to serve may be the people who would have benefited the most from access to services.

Limiting downsides is not straightforward. Using alternative (possibly more complex) payment models or changing other design aspects (such as quality standards to guard against harmful cost-cutting) can help if they are carefully designed to limit gaming by providers.

Payment systems need to be considered in the context of broader mechanisms designed to encourage best practice from providers. Many human services are provided by professionals and organisations who have a strong interest in delivering quality outcomes for users. Promoting high standards through means such as performance monitoring and quality standards can provide an important complement to payment models.

## Models of provision

Governments have several options when determining which model of service provision would best meet the needs of users, and generate net benefits to the community as a whole.

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Broadly these options are: direct provision by government; opening a market to competition (the exact model of competition determines who is able to provide services); and using contestable processes to select service providers.

The preferred model of service provision depends on a range of factors including:

- the structure of the market (for example, the number of potential providers, or ease of market entry and exit)
- whether governments or service users are able to monitor service quality
- the ability for service providers to differentiate their services (and for users to make choices based on those differences)
- the costs of government stewardship arrangements.

Of particular relevance to this inquiry is the *commissioning* process, which is commonly associated with the contracting out service delivery model, but can involve provision by government or non-government service providers. Commissioning involves many of the elements of stewardship, but has a particular focus on relationships with providers, including careful consideration of provider selection processes (such as tenders) and governments' contract management practices. Commissioning is examined in social housing (chapter 7), family and community services (chapter 8), services in remote Indigenous communities (chapter 9) and public dental services (chapter 13).

## Choosing providers

Where the model of provision has moved away from sole service delivery by government, different types of providers can deliver services to users. Governments' stewardship role involves making sure that those providers that are best placed to achieve outcomes are in a position to do so. Good stewardship should ensure that the only regulatory barriers to entering (and exiting) a market are those necessary to achieve positive outcomes for users and effective of service provision.

There are a number of ways that governments can enable providers to enter a market. First, there are criteria that assess whether a provider is fit to enter a market, usually in the form of licences and accreditation. As noted above, licences provide consumer protection by setting minimum quality and education standards, and can be used as an enforcement tool. Second, beyond these entry criteria, governments can play a role in choosing providers, for example through competitive tendering. Finally, in circumstances of consumer-directed care (such as home-based aged care or the NDIS), the users themselves choose their providers. Depending on the model of delivery chosen, these choices may coexist in a given market.

There has been ongoing debate about whether one organisational form is intrinsically 'better' at providing (some) human services than any other (box 2.6). Participants in this inquiry, including the Centre for Social Impact (sub. 448) and Anglicare Australia (sub. 445), raised concerns about the relative performance of for-profit providers in human services delivery.

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Some, such as the Australian Services Union (sub. DR575), were opposed to any involvement of for-profit providers in human services. Others instead urged caution:

We are not arguing that for-profits should be excluded from the family and community services sector but rather that government consider carefully the impacts for-profit can have on monopsony markets and how that relates to the services sector and especially the most vulnerable in our society. (Catholic Social Services Australia, sub. DR533, p. 9)

The overall effectiveness of a provider is a factor of a number of attributes, and organisational form by itself is not a good guide to a provider's performance. Other attributes that can be relevant to the effectiveness of a provider (and thereby, users' outcomes) include its:

- on the ground experience (in a given service, location or with a particular user group)
- past performance (in the same or analogous services)
- size (in terms of the volume of services they can deliver)
- existing and potential workforce capability and capacity
- pre-existing relationships (with users or linkages with other relevant providers)
- local presence and established connections within communities.

The relevance of each of these factors will vary depending on the context of the specific service and the needs of the users in question. For example, in some instances a small provider with well-developed connections with the relevant community could be more effective than a large provider from outside the community.

In the Commission's view, stewards should focus on operational capabilities and their effect on users' outcomes when selecting providers, rather than apply blanket rules based solely on their organisational forms. Such blanket rules can result in unnecessary burdens on organisations, or otherwise suitable organisations not providing services. For example, although co-operatives could be suitable for providing services in remote areas, a Senate Committee heard that some funding was only available to organisations with a corporate form:

Mr Wy Kanak from Tranby College informed the committee that, under the Indigenous Advancement Strategy, Commonwealth Government grant funding above \$500 000 was only available to Indigenous organisations incorporated under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*. According to Mr Kanak this is causing deep distress in co-operatives such as Tranby College and may cause them to 'abandon their co-operative structure and reincorporate under the Aboriginal Councils Act'. (SERC 2016, p. 38)

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## Box 2.6      **Substance over form: providers' motivations**

While each of the main organisational forms involved in human services may have different primary motivations, careful program design by stewards can harness these in a manner that aligns providers' and governments' objectives. To do so, stewards should have an understanding of the primary motivations of each form, and how these motivations affect the choice of stewardship levers.

**For-profit providers** (FPs) are motivated to maximise their profits, which are distributed to owners. Typically, this manifests through a desire to meet specified outcomes (embodied in contracts, regulation or payment models) for the least cost. This creates an incentive to drive down costs and innovate, potentially resulting in savings to government that can be redeployed to more, or other, services. The focus on profits can also make them more responsive to changes in funding.

A focus on cost reduction brings with it a risk of quality reduction, potentially to detrimental levels. In a competitive market driven by informed user choice, users can signal their quality preferences by avoiding low-quality providers and seeking, even paying a premium for, high-quality providers. However, most human services markets do not meet these conditions, and where reforms are unable to introduce them, there is a need for stewards to maintain the quality of services (for example, by setting and enforcing minimum quality standards or service coverage requirements).

In contrast, **not-for-profit providers** (NFPs) must use any excess earnings for further production of their services. This shifts the primary motivation for NFPs to generally one of 'mission' or 'community purpose'. In a human services context, this purpose may result in an organisation focussing on ways to increase the availability and/or quality of its services to a greater range of users. The Centre for Social Impact (sub. 448) put forward views that this focus results in NFPs outperforming FPs in terms of quality of outputs, and engagement with, and trust from, users. However, if they are not aligned, there is a risk that an NFP's mission could take priority over users' and governments' objectives.

While varying across providers, another general focus of NFPs is on the process of delivering services. In a pure financial sense 'more participatory and inclusive processes can reduce the volume and/or quality of outputs absorbing resources and slowing down delivery' (PC 2010, p. 19). However, users and the community can benefit from being involved in service delivery. In addition, an inclusive process can help build trust and networks, improving service outcomes, and increasing social capital through volunteering, networking and community engagement activities to NFPs.

Another organisational form in human services is **co-operative and mutual enterprises** (CMEs) which are owned by, and run for the benefit of, members. The motivations of CMEs vary depending on the nature of members, which can be consumers, employees, businesses, or a combination of these.

Proponents (Business Council of Co-operatives and Mutuals, sub. 470) argue that CMEs' focus on members offer several benefits. Outside of the direct benefits to members, these include grass roots user involvement in service provision (potentially improving user choice at a group level) and adaptable and innovative services that focus on member needs.

Sources: Folland et al. (2013); PC (2010, 2011b); SERC (2016).

In the case of the Indigenous Advancement Strategy (IAS), incorporation is a proxy for performance, sound governance and risk management. However, other means can be used

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to more directly address such concerns. In the context of grants under the Indigenous Advancement Strategy, the Minister for Indigenous Affairs can provide an exemption from the incorporation requirement. Exemptions are considered on a case-by-case basis and ‘will take into account information demonstrating that the organisation is well-governed, high-performing and low risk’ (Australian Government 2014b, p. 9).

Governments, as stewards, need to ensure that all types of providers meet minimum standards and have incentives that align with users’ and governments’ objectives. Governments can use a range of levers (discussed elsewhere in this report, including contract terms, quality standards, payment models and performance monitoring) to align providers’ incentives with governments’ objectives, and promote effective service provision. In some cases, governments may provide services directly when effective stewardship of providers is too costly. When governments engage other organisations to deliver services they should provide incentives for innovation and efficiency. The differing motivations across organisational forms (box 2.6) may mean different contractual approaches could be required to provide these incentives.

Importantly, the attributes of any given provider do not absolve governments from their continued stewardship responsibilities. No one organisational type has a monopoly on good, or bad, service delivery. In particular, continued consumer protections are required regardless of the types of provider involved in delivering a service.

### Competitive neutrality

Government and non-government providers can compete in some human service markets. Maintaining competitive neutrality (a ‘level playing field’) between government and non-government providers is important to encourage competition and the efficient allocation of resources. Doing so ‘requires that government business activities not enjoy a net competitive advantage over competitors by virtue of their public ownership’ (Treasury and Department of Finance and Administration 2004, p. 1).

Australian, State and Territory governments agreed to competitive neutrality principles under the *Competition Principles Agreement* in 1995 and each jurisdiction has policies outlining how the principles apply (COAG 2007). Although there is some variation, each jurisdiction has its own competitive neutrality policy and complaint handling body (either independent bodies, or housed within other regulators or departments). The Australian Government had not released its review of its Competitive Neutrality Policy at the time of this inquiry, but the review’s consultation paper noted that it will not make recommendations specific to human services (Treasury 2017a).

Competitive neutrality will be important where reforms to human services expand user choice, competition, and contestability. The 2015 *Competition Policy Review* noted some challenges in securing competitive neutrality in human services including:

... structural separation; determining the operational form for government business activities, particularly when the activities sit within a broader range of government functions; and

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transparent costing and funding of [community service obligations]. (Competition Policy Review 2015, p. 265).

These challenges can be overcome, and should be considered as part of the reform and transition process (for example, by identifying the relevant government business unit for service delivery, and ensuring that appropriate costing is applied to government applicants in a tender process).

## **2.3 Delivery**

There are many aspects to delivery that should be considered by system stewards, including:

- coordination of providers and users
- information provision to the public
- managing transitions and implementation
- overseeing and engaging with providers.

### **Coordination of providers and users**

The delivery of services can be more effective when providers coordinate their efforts. Coordination can increase the effectiveness of service provision by allowing services to reduce duplication and specialise (Fine, Pancharatnam and Thomson 2005). For example, in relation to hospital services, the Royal Australasian College of Physicians stated that:

... rather than every hospital attempting to deliver every possible service in competition with its neighbours, each should develop its own strengths and niche, and should develop cross-referral and transfer procedures for access to specialised services that one or the other does not offer. (sub. 473, p. 5)

Similarly, in end-of-life care, there is a need for improved coordination between residential aged care, community-based palliative care, hospitals and primary care (chapter 3).

Some participants argued that for some types of services, such as areas of complex need, coordination and collaboration amongst service providers is more beneficial than the application of competition and contestability:

The provision of some areas of service provision — particularly services to vulnerable populations such as those with a mental illness, those living in regional areas, Indigenous Australians, as well as people with multiple and complex chronic conditions where continuity, collaboration and coordination between service providers are required may be less suited to the application of contestability and competition. (Catholic Health Australia, sub. 440, p. 4)

However, reforms to introduce greater competition and contestability can also include scope for coordination (the Commission has considered options to do so in the context of family and community services (chapter 8)).

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Coordination centred around particular users may also be required to ensure that their needs are met. This may require program design that brings services together in a manner that centres on users (for example, co-locating a range of health and social services that are likely to be needed by a particular group). Where this is not possible, an alternative is the use of service ‘navigators’ — third party agents who work on behalf of users to identify and bring together services for them.

## Information provision to the public

Public information can influence users’, providers’ and governments’ decisions, leading to effective service provision and better outcomes for users. For example, simply presented information that caters to users’ different needs and characteristics helps them find and choose a provider and make decisions about the particular services they need, promoting competition. In addition, publishing information on providers and using benchmarks can motivate providers to engage in greater self-improvement activity (chapter 11).

Many areas within this inquiry focus on improved information, including information on:

- waiting lists and provider performance to help tenants choose social housing properties (chapter 7)
- hospital performance to improve users’ choice of public hospitals (chapter 11)
- what to expect in public dental services, where to find a provider, waiting times and provider outcomes (chapters 12 and 13).

Stewards should carefully consider the nature of the information and the users they seek to inform. Some considerations include:

- *is the information valuable to users?* Information in a clear form can help users to understand the consequences of their choices. Public information on provider performance can also reduce users’ susceptibility to being exploited by unscrupulous providers
- *how much will the information cost to provide and who should pay?* Information provision to users, providers and governments comes at a cost, such as the additional effort required to tailor information to users (rather than providing aggregated medical data, for example). In most cases, it is likely that government should pay for this as they fund many services.

## Managing transitions and implementation

Reforms to human services can be large, costly and time-consuming. Transitioning to new arrangements following policy reform often disrupts service delivery and can affect many users and providers. Transitioning between providers can also be disruptive as users find and familiarise themselves with new providers. Stewards should plan for all transitions, with a

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focus on continuity of outcomes. This involves considering many of the aspects of all three phases of the stewardship framework. Experience suggests stewards have not always done this well (box 2.7).

## Transitioning to new policy settings

Stewards could utilise staged rollouts and policy trials to smooth the transition to new policy settings. Staged rollouts allow for continuity in service delivery while the groundwork for future reforms is put in place. Learnings from initial sites can lead to improvements when the reforms are fully implemented. An example of a staged rollout is the ongoing reforms to Australia's aged care system, which are planned to be implemented in three phases over 10 years (from 2012 to 2022) and are shifting the system as a whole toward consumer-directed care (Department of Health 2017a). Overly ambitious rollout schedules can lead to issues in implementation, particularly for large and complex reforms such as the NDIS (PC 2017c). Participants in this inquiry drew on the experience with the NDIS:

... further work around enabling smoother transitions is necessary. Lessons can be learned from the NDIS in supporting better outcomes for clients by informing and supporting the sector to prepare for transition to new ways of working and delivering services. Uniting Church service providers have had to restructure their workforce, introduce new IT and accounting systems and review organisational policies and procedures which has required significant resources and time. Additionally our service providers have played a key role in assisting clients to prepare for transition. (Uniting Care Australia, sub. DR514, p. 4)

While similar, in comparison to staged rollouts, policy trials allow the testing of ideas, including simultaneous testing of variations of a program, such as different contract structures or delivery models at different trial sites. Care should be taken to use representative trials to improve the usefulness of any information arising from them. Such information can improve specific aspects of services before wider delivery, as the DSS noted:

People will not always act in the way policy makers assume they will ... [T]he potential gap between policy makers' behavioural assumptions and actual behaviour should be tested and learnings incorporated into support mechanisms and information services. (sub. 476, p. 4)

In practice, trials have not always been designed and implemented in a way that delivers these potential benefits. Trials also offer less certainty for providers and users going forward, and may limit their willingness to participate.

Staged reform processes can incorporate trials of particular aspects of the reform within a broader rollout process. This allows a balance of testing and improved certainty for users and providers regarding the overall, long-term reform. The Commission's recommendations for reform of public dental services (chapter 13) have adopted this approach, with trials testing specific elements of the consumer-directed care model.

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## Box 2.7      **Area for improvement: smoother transitions**

### **Transitioning to new policy settings**

The *Western Australian Suicide Prevention Strategy 2009–13* highlighted problems from inadequate planning for implementation of programs (Western Australian Auditor General 2014).

The Strategy focused on improving the State's understanding of and capacity to prevent suicide. It aimed to promote a coordinated approach across all levels of government and the whole community, mainly through Community Action Plans (CAPs) involving community engagement, consultation, training and suicide prevention activities.

A report by the Western Australian Auditor General concluded that despite the Strategy engaging communities in planning, the 'benefits could have been greater' (2014, p. 4). The Auditor General found that unclear governance arrangements (including a lack of guidelines for communities to formulate CAPs) led to delays and shortened the timeframe available for the delivery of services.

In addition, the Strategy lacked proper planning and monitoring, which could have led to more effective services for users. In particular, an implementation plan was not in place for the life of the Strategy and limited quantifiable and objective measures of CAPs' performance made it difficult to assess the implementation of the program and evaluate 'what works'.

The Strategy highlights the need for systematic service planning, an area of particular importance in this inquiry.

### **Transitioning to new providers**

Transitioning between providers can be disruptive as users find and familiarise themselves with new organisations and staff. Participants in a 2015 Senate inquiry into the Department of Social Services' (DSS') tendering processes highlighted the importance of relationships of trust between providers and users, particularly for vulnerable people (SCARC 2015). The Western Australian Council of Social Service (2015, p. 3) said:

Vulnerable people who face significant life challenges ... require higher levels of certainty and trust, and there is significant evidence to indicate that the ongoing relationships with dedicated and caring support staff are critical to delivering outcomes that increase their resilience and improve their health and wellbeing ... These impacts [on vulnerable peoples' wellbeing from increased uncertainty due to DSS' tendering processes] have been exacerbated by the lack of communication and clarity about the timelines and processes for decision-making and notification, with service providers unable to discover who will be delivering new services within their areas so they can provide a supported referral.

In addition to greater information and clarity about processes, participants to this inquiry also highlighted the benefits of longer contracts to provide greater certainty for providers to foster relationship with users. For example, the Council to Homeless Persons said:

Many programs delivered by [Specialist Homelessness Services] require long-term contact, or significant investment in relationship building — both of which are common needs amongst those experiencing homelessness ... The homelessness sector may be severely exposed should funding renewal not occur. Alternatively, consumers could have their long-term supports, which have been built on trust, summarily withdrawn. This practice can be discouraged through long-term forward planning of contracts. (sub. 434, p. 12)

This inquiry has recommended measures for smoother transitions to maintain continuity of services, including through longer contract terms in family and community services (chapter 8).

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## Transitioning to new providers

Even within a given policy setting, users may face difficulties in transitioning between providers. Typically, this arises in a commissioning context where, after the end of a contract for one provider, a new provider is chosen to deliver the service. Such transitions can be particularly difficult for those with complex needs who may be reliant on the continuity of a service (Benevolent Society, sub. 457). From the users' perspective, building relationships of trust takes time with each new provider. Stewards can provide information and clarity about changes (in a tailored form for particular user groups) in advance to allow adjustment to occur more smoothly. During periods of transition, greater coordination and user navigation may be required (discussed above).

Some of the recommendations in chapter 8 are aimed at improving the transition between providers. For example, the use of handover periods (as part of longer default contract lengths) can support service continuity for users and allow for orderly transition of physical assets and data between providers.

## Overseeing and engaging with providers

In some instances governments will have responsibility for service delivery as direct providers. Even where governments are not directly involved, they have a role in the delivery phase in overseeing the provision of a service.

The exact form of government engagement with providers will depend on the model of provision and the risks involved in service delivery. In all of the models, governments will be involved in regulation of the services, typically for consumer protection purposes.

As noted above, the commissioning process is relevant to many of the services examined in this inquiry. Governments should play an active role in engaging with providers of commissioned services.

## Managing the contract and relationship with providers

Simply signing a contract with a provider does not absolve a government from responsibility for service provision. As discussed in chapter 8, governments need to perform a range of contract management functions, and several current practices could be improved.

In implementing outcomes and performance frameworks (above), the relationship of stewards and providers shifts from a focus on prescriptive contract terms to a focus on the users' wellbeing. Outcomes-based commissioning can facilitate — and be facilitated by — the use of 'relational' approaches to contract management. These approaches view a contract more as a long-term relationship rather than a legal document governing a one-off exchange. Relational approaches rely on trust between the parties, and flexibility towards achieving a common goal. The Commission has recommended reforms to the way governments

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commission family and community services (chapter 8) and services in remote Indigenous communities (chapter 9) that would facilitate increased use of relational approaches to contract management in those settings. These improvements include longer default contracts, consistent outcomes frameworks and choosing service providers based on their capacity to achieve outcomes for service users.

Maintaining an ongoing relationship with providers also allows stewards to identify and share problems, lessons and examples of what works. The incentive for providers to be honest with this feedback is improved if the relationship is one of mutual learning and improvement, rather than solely relying on punitive measure such as financial penalties. Ongoing discussions can act as informal benchmarks and as ‘early warning systems’ to identify challenges before they are picked up in data acquired through more formal monitoring processes.

### Ongoing monitoring

Ongoing monitoring of data and outcomes helps identify emerging trends which can lead to expansion, contraction or modification of services. In the context of outcomes frameworks, monitoring can reveal if performance is meeting, exceeding, or falling short of targets. For example, monitoring may reveal persistently increasing waiting times for a service, triggering design and delivery changes.

Monitoring measures may not be perfect, but instead act as ‘red flags’ that alert stewards to the need for further investigation. As Catholic Social Services Australia submitted, monitoring is a key component of a continual improvement process:

Even where there is good consultation at the design stage, implementation will often uncover variables which even good planning and design may not identify. Therefore, policy design requires persistent and appropriate monitoring and consumer safeguards ... (sub. DR533, p. 10)

Monitoring can increase transparency, a key area for improvement within human services (box 2.8).

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### Box 2.8      **Area for improvement: more transparency**

Transparency around all aspects of human services is critical to achieving the best outcomes for users. Transparency helps facilitate user choice, hold providers to account, foster effective service delivery, and promote accountability of governments and the system.

For example, Henke, Kelsey and Whately (2011, p. 66) highlighted the importance of publicly available data in ensuring transparency of hospitals' performance.

In 2009, Dr Foster (a private infomediary) analysed public data and found that a hospital in Stafford, England, had unusually high mortality rates. The NHS's Care Quality Commission then initiated an investigation, which revealed poor clinical practices. Two subsequent inquiries concluded that transparency was the key factor that led to the investigation — and that lives had been saved as a result.

Some of the factors that can limit transparency include:

- limited availability and use of data, for example in the health system where barriers (such as privacy concerns, fragmented data frameworks across jurisdictions, and diversity in IT platforms) have curtailed the benefits from data use to the community (PC 2017a)
- inadequate monitoring measures, such as where *output* measures are collected but *outcome* measures are not, meaning the effectiveness of services cannot be accurately assessed (NSW BHI 2015a)
- inadequate use of evaluations, such as across services for remote Indigenous communities, where evaluations are often not conducted and governments cannot learn about or implement 'what works' (SCRGSP 2016).

Ways to increase transparency include:

- separating governments' responsibilities for policy making and planning from their role in service provision, as has been put forward by this inquiry in relation to social housing (chapter 7). This limits conflicts of interest and, as a result, governments' incentives to conceal human service issues and failures.
- greater information collection and provision as proposed in relation to public hospitals (chapter 11), public dental services (chapters 12 and 13), and end-of-life care (chapter 4). For example, performance benchmarking facilitates user choice, and signals weak performance to governments and providers. Better data management and infrastructure will also help.

## 2.4 Improvement

A steward's role does not end once services are designed and delivered — they should look for ways to continually improve services and guard against poor outcomes. In addition to the ongoing monitoring conducted in the delivery phase, improvements to services can be guided by one-off and systemic reviews.

### One-off and systemic reviews

One-off and systemic reviews are useful for identifying larger service problems and reforms. Systemic reviews (such as every five years) are beneficial as they embed a framework for constant improvement, and can proactively identify issues. One-off reviews are often carried

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out when responding to a particular problem with a service, such as the *Targeting Zero* review (Duckett, Cuddihy and Newnham 2016) into hospital safety and quality assurance in Victoria (box 2.1).

In general, reviews should:

- be *transparent and engage users and providers*, such as through submissions, public hearings or using principles of co-design
- have *appropriate timeframes* that match the urgency, complexity and size of the issue being examined
- take into account the *broad effect of changes and ongoing developments* (such as demographic change). Recommended changes to one service can interact with other programs and affect different aspects of users' wellbeing (for example, changes to social housing programs can affect employment and health outcomes).

Regardless of whether they are identified through monitoring or reviews, potential improvements to services will only change user outcomes if they are implemented. Continual improvement to a service may be preferred as it often causes minimal disruption, allowing relationships (between consumers and providers, and providers and government) to develop. However, stewards should not shy away from larger reforms when they are needed, particularly where poor outcomes are damaging, systemic and persistent.

Reviews and improvements should identify problems and consider if the solutions lie in stewardship improvements or more direct service reforms. Importantly, systemic reviews should identify means of 'checking' (such as types of data or information to collect) that the reforms are progressing as intended towards their objective, and that unintended consequences are not emerging. Ultimately, stewardship is a continuous cycle, as the reforms identified in the improvement phase can trigger further changes to the design and delivery of a service.



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## 3 End-of-life care in Australia

### Key points

- End-of-life care is provided to people who have a medical condition that means they are likely to die within the next 12 months. Care services include physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff.
- Most of the 160 000 people who die in Australia each year would benefit from end-of-life care but many do not receive care that fully reflects their choices or meets their needs. Demand for care will grow rapidly in coming years as more people enter the older age groups in which most deaths occur.
- Where it is available, the quality of end-of-life care services in Australia is often excellent. But services are not available everywhere and to everyone who would benefit. Delivery of more effective end-of-life care will require investment and coordinated action across the Australian, State and Territory Governments.
- Hospitals play an important role in the delivery of end-of-life care. Hospital accreditation standards will, from 2019, prescribe a range of best-practice elements for end-of-life care. This should drive the changes that are needed to improve hospital care. However, dying in hospital is not the preferred outcome for most Australians. Too many people who, with appropriate support, could and would choose to die at home or in their aged care residence, die in hospital. Providing end-of-life care for these people where they live would better meet their clinical needs and reflect their choices.
- About 60 000 people die in residential aged care facilities each year. End-of-life care should be core business for residential aged care providers but the quality of end-of-life care in residential aged care is patchy at best. Too often, people are transferred back and forth between hospitals and aged care facilities, as aged care facilities lack palliative care expertise and qualified staff to administer pain relief.
- Many people are unable to communicate their wishes for end-of-life care at the time the care is provided. Yet few people talk about their end-of-life preferences with family and friends, and only about 15 per cent of Australians have prepared for the possibility of being unable to communicate by documenting their end-of-life care preferences in an advance care plan.
- While Governments have recognised community concern about end-of-life care, progress is being hindered by poor stewardship, including conflict over responsibilities and how service provision is coordinated across different settings. Reforms are needed to put users' needs and choices at the heart of end-of-life care services, and to ensure those services have the capacity to meet users' needs.

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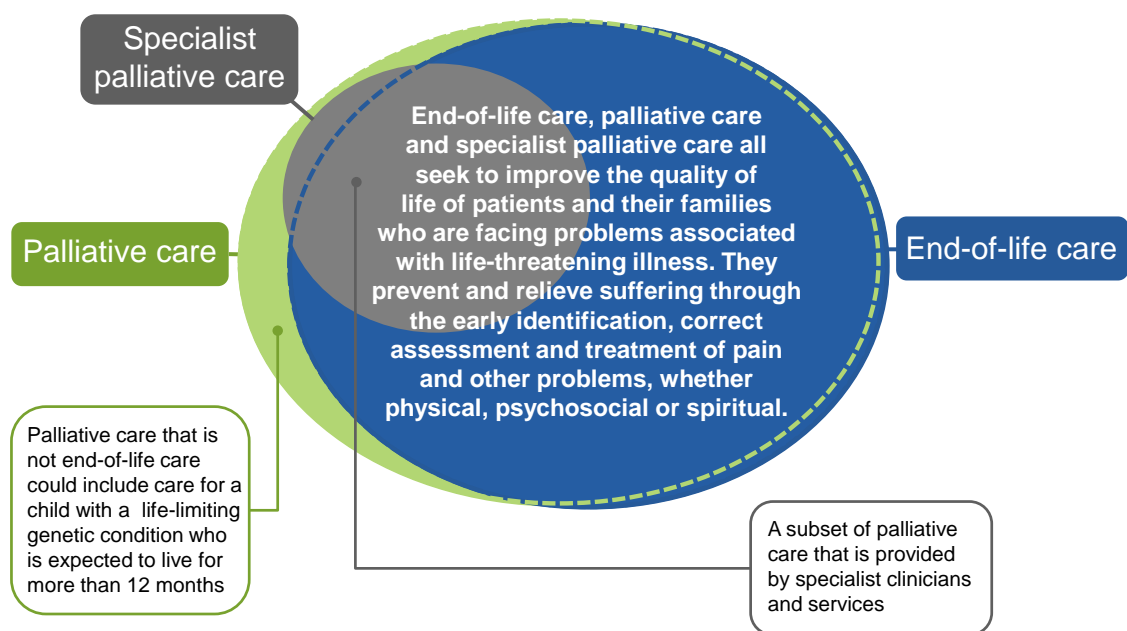
### 3.1 What is end-of-life care?

The Australian Commission on Safety and Quality in Health Care describes end-of-life care services as including ‘physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff’ provided to people who are ‘likely to die within the next 12 months’ (ACSQHC 2015a, p. 33).<sup>1</sup>

The terms ‘end-of-life care’ and ‘palliative care’ are used differently throughout Australia, although they largely entail the same approach to care provided to the same users (figure 3.1). Many scholarly articles refer to ‘end-of-life’ and ‘palliative’ care interchangeably (Bloomer, Moss and Cross 2011), and the Commission has taken the same approach in this report.

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Figure 3.1 **Stylised representation of end-of-life and palliative care**



Sources: Based on PCA (sub. PFR329), SA Health (2009) and WHO (2015).

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End-of-life care is not a single service provided by a particular profession and is provided in almost all settings where health care is provided, including in people’s homes (AIHW 2014a, p. 291; Department of Health 2017l). It typically encompasses a broad range of services, which can include advice and coordination of care, nursing and personal care, 24 hour hotlines, day hospice respite, emotional and practical support, and access to equipment (LSIC 2016). It can also include services for families and carers, such as bereavement support.

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<sup>1</sup> End-of-life care does not include euthanasia, assisted suicide or voluntary assisted dying.

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While some end-of-life care is provided by specialist inpatient or community-based palliative care services (including care in people's homes and in hospices), most is provided by generalist services (such as hospitals, community health services and residential aged care facilities). Most end-of-life care is provided by government-funded services, and these services are the sole focus of this report. However, people approaching the end of life can also purchase additional services if they wish.

Compared to many other healthcare disciplines, palliative care is relatively new, having started in the United Kingdom in the 1960s and been fully recognised as a medical speciality in the 1990s (Push for Palliative, sub. DR538).

### Shared stewardship between governments

Reflecting the range of services and settings covered by end-of-life care, stewardship responsibilities are shared between the Australian, State and Territory Governments. In broad terms:

- the Australian Government contributes to the funding of end-of-life care in hospitals (including via payments to State and Territory Governments for public hospitals), residential aged care (including palliative care via the Aged Care Funding Instrument), and community settings (for care provided by general practitioners via Medicare)
- State and Territory Governments are responsible for, and in many cases provide, end-of-life care in public hospitals and community health services, including community-based palliative care services.

The overlapping roles of the two levels of government has led to conflict over responsibilities, and uncertainty and buck passing over how stewardship is shared and service provision is coordinated across different settings. Overlapping responsibilities mean that, in some areas, each level of government has left it to another level to meet resourcing and other stewardship requirements. Weaknesses in current stewardship arrangements are discussed further in section 3.4.

### Mismatch between demand and supply of end-of-life care

There is scope for improvement in the choices available to people approaching the end of life about the setting in which they receive end-of-life care. Up to 70 per cent of Australians would prefer to die at home (PCA, sub. PFR329), but most end up dying in hospital instead (box 3.1). The mismatch between the most commonly preferred place of death (home) and the places where death most commonly occurs (hospital and residential aged care) arises even though preferences for place of care and place of death are not always the same and can change over time.

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### Box 3.1      **Many people who would prefer to die at home do not**

The Australian literature on end-of-life care (for example, Broad et al. 2013; Swerissen and Duckett 2014) and inquiry participants (including BUPA, sub. PFR380; HammondCare, sub. PFR330; Hobart District Nursing Service, sub. 419) referred to the discrepancy between the proportion of Australians who would prefer to die at home and the proportion who actually do so. Estimates of this discrepancy are uncertain, for two reasons.

First, as Dr Anthony Ireland noted, ‘there are no population-based data describing preferences of Australians for a “place of death”, especially for the relevant population’ (sub. DR527, p. 1). The Centre for Health Economics Research and Evaluation at the University of Technology Sydney pointed out that ‘an important limitation of the general population research to date is that it has focused on preferred place of death without reference to any specific context or to the place of care over the period of functional decline prior to death’ (sub. DR516, p. 3). Little Company of Mary Health Care noted that despite ‘many attempts through research, policy and survey we have no clear universally accepted understanding of what choice [of place of death] people would make or what might influence their choice’ (sub. DR547, p. 5).

Preferences about place of death can also change over time. While the direction of the change can vary, a review of 210 studies across 33 countries found preferences most commonly changed ‘from hospital to home, home to hospice and from home to hospital’ (Gomes et al. 2013, p. 10).

While conscious of these limitations, the same international review found that a majority of respondents preferred to die at home (Gomes et al. 2013). This is consistent with Australian evidence, where the best available estimate suggests that up to 70 per cent of Australians would prefer to die at home (PCA, sub. PFR329).

The second reason for uncertainty about the discrepancy between the proportion of Australians who would prefer to die at home and the proportion who actually do so relates to uncertainty about the proportion of Australians who die at home. This is typically said to be 14 per cent, but in the Commission’s view, that is likely to be an overestimate. The 14 per cent figure is often attributed to Broad et al. (2013), who used ABS and Australian Institute of Health and Welfare data from 2005 to infer the proportion of people over 65 who die in hospital, in residential aged care facilities or ‘other including private home’, with the latter category comprising 14 per cent.

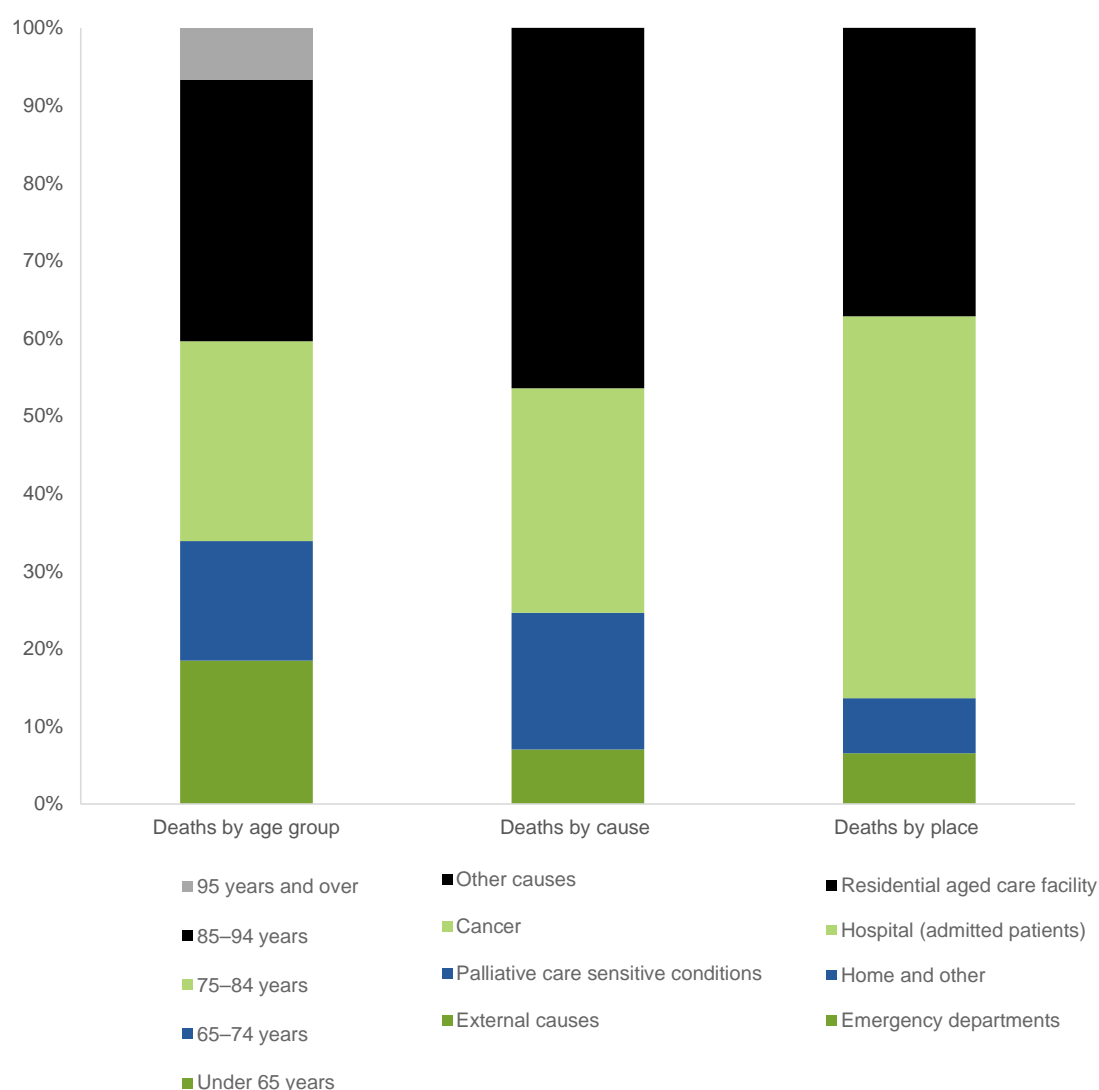
However, these figures do not include those who died in emergency departments. Once deaths in emergency departments are considered, the proportion of people who die at home is smaller than the commonly reported rate, and was likely to have been less than 10 per cent in 2014-15.

Estimates of the proportion of people who could potentially benefit from end-of-life care vary, typically from 50 to 90 per cent of those who die (for example, Murtagh et al. 2013; NHS England 2016; Rosenwax et al. 2005). Given that just under 160 000 people died in Australia in 2015 (ABS 2016a), this suggests that between 80 000 and 140 000 people would benefit from end-of-life care each year.

While there are data on the age, location and cause of deaths in Australia (figure 3.2), these data cannot be put together in such a way as to determine demand for end-of-life care, or the types of care provided in response to that demand. Participants highlighted the poor quality of the available data. For example, Dr Anthony Ireland said the place of death estimates may be inaccurate because the deaths of some residents of aged care facilities who die in hospitals are counted as occurring in both places (sub. DR527). This means that it is not currently

possible to provide an overall picture of the type, amount and quality of end-of-life care Australians receive (AIHW 2016d).

**Figure 3.2 Piecing together end-of-life care needs in Australia**  
Age, location and cause of death, 2015<sup>a</sup>



<sup>a</sup> Palliative care sensitive conditions comprise 11 conditions and diseases used by the Australian Institute of Health and Welfare to identify patients with diseases other than cancer who are likely to require palliative care (AIHW 2012a). Data for place of death are from 2014–15.

Sources: Productivity Commission estimates based on ABS (2016a) and AIHW (2015a, 2016a, 2016l).

What is clear is that demand for end-of-life care is growing, and will increase substantially in coming years. The annual number of deaths will double in Australia in the next 40 years, as a result of the ageing of the population and the progression of the large cohorts born during the post-World War II ‘baby boom’ into the older age groups (ABS 2013b). This will mean

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that end-of-life care providers will face a ‘tsunami of palliative care admissions ... as our baby boomers move through the system’ (Little Haven Palliative Care, sub. 458, p. 2).

End-of-life care needs are also changing, with a smaller proportion of people dying suddenly and dying from illnesses with a predictable trajectory (such as cancer), and more people experiencing a prolonged period of disability, frailty and illness and then dying ‘with unpredictable timing from a predictably fatal chronic disease’ (such as heart disease, lung disease, frailty and dementia) (ACSQHC 2013, p. 10).

### **3.2 Some end-of-life care is excellent**

Australia’s end-of-life care services, where they are available, are among the best in the world in terms of quality and affordability (EIU 2015). Services are not, however, available everywhere and to everyone who would benefit. This is not unusual internationally and ‘even top-ranked nations currently struggle to provide adequate palliative care services for every citizen’ (EIU 2015, p. 6).

The Australian Commission on Safety and Quality in Health Care provides clear guidance to acute hospitals on end-of-life care through its *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care* (ACSQHC 2015a). Developed in consultation with health consumers and carers, the consensus statement describes ten elements that are essential for delivering safe and high-quality end-of-life care. When hospitals deliver care that is in line with the consensus statement, that care is typically effective and in line with consumers’ preferences (although this is not always the case, as the actions described by the statement are currently ‘aspirational’ rather than required standards).

In some locations, hospices and community-based palliative care services largely succeed in supporting those who wish to die at home to die at home or in home-like environments. For example, Little Haven Palliative Care said that it supports 60 per cent of its patients to remain at home to die, and a further 24 per cent die with less than five days in hospital (sub. 458, p. 1). Hobart District Nursing Service said that in its hospice@Home service ‘after hours care is available 24/7 through the use of a contact centre, which includes advice, assessment, and possible rapid response deployment of local on-call nursing staff and medical care (via GP Assist) with the aim of avoiding unnecessary admissions to hospital’ (sub. 419, p. 4).

The Royal Australasian College of Physicians suggested that the Silver Chain group in Western Australia has been ‘successful in facilitating the integration of end-of-life care across hospital, hospice and home’ settings (sub. 473, p. 9). Another example of integrated end-of-life care is the authorised palliative care plan system implemented by the New South Wales Ambulance Service. When an authorised plan is in place for a palliative care patient, paramedics are permitted to act in accordance with a patient’s palliative wishes by, for example, administering additional pain medication or withholding resuscitation (NSW ACI 2015).

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Models of care are also emerging that integrate palliative care and residential aged care. For example, HammondCare operates a 9-bed specialist palliative care unit as part of a 124-place mixed low and high-care home. Known as the Lavender Palliative Care Suite, it:

... enables personalised and flexible care routines, and comprehensively provides for residents' individual physical, psychological, social and spiritual needs [and] demonstrates how specialised palliative care can be delivered within an existing residential aged care setting. (HammondCare, sub. 407, pp. 9–10)

Similarly, the Old Colonists' Association of Victoria said that 'few people leave [our] aged care facility to die, a fact that defies the national trend' (sub. DR501, p. 2). Through its Geriatric Rapid Acute Care Evaluation (GRACE) program, the Hornsby Ku-ring-gai Hospital Service in New South Wales helps residents of local aged care facilities to avoid the physical and emotional disruption of hospital admissions, including by providing advice on palliative care treatment options (NSW ACI 2013).

While there are examples of excellent end-of-life care, its supply is limited and only a small proportion of people who die each year receive it.

- In acute hospitals, the overall momentum of care delivery is toward life extension, and many clinicians regard patient death as their 'failure' or a result of their inadequacy (Bloomer, Moss and Cross 2011). This is appropriate. Nevertheless, patients often rely on clinicians to initiate conversations about end-of-life care, but many clinicians are inadequately trained about, and are intimidated by, holding such conversations (Bartel 2016).
- 'There is not enough palliative care' (Swerissen and Duckett 2014, p. 18) in some locations or for patients with illnesses other than cancer. Palliative Care Australia and the Palliative Care Outcomes Collaboration said that 'the greatest current barrier to patients receiving their preferred care is the availability and quality of palliative care services, including in the primary health sector' (sub. 417, p. 2).
- Not all of those who could benefit from end-of-life care know of its existence, or how to access it. For example, Breast Cancer Network Australia said that 'many people with metastatic breast cancer are not aware that palliative care is something that can support them soon after their diagnosis, assist in the management of pain and other aspects of their treatment and the disease, and enable them to plan ahead for end-of-life care' (sub. DR534, p. 3).

There is also a disconnect between the way in which the health system considers, or aims to consider, end-of-life care (the last 12 months of life) and definitions used in the aged care system (where intensive nursing and other end-of-life care services are only funded by the Australian Government in the last week or days of life). Taken together, these factors can severely limit the options that are available when people come to make choices about their end-of-life care.

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### **3.3 Too many Australians miss out on high-quality end-of-life care**

In light of the constraints on the supply of the types of care that users would prefer, particularly skilled palliative care at home, in hospices and in residential aged care, it is unsurprising that many people who would benefit from end-of-life care do not get the right care, in the right place, and at the right time. As a report published by the Australian Centre for Health Research put it:

... too many people are dying in a way they wouldn't choose, and too many of their loved ones are left feeling bereaved, guilty, and uncertain. The care most Australians receive at the end of life often does not reflect their values, goals, or informed choices. (Bartel 2016, p. 4)

There is scope for improvement in end-of-life care in all settings (including hospitals, community-based palliative care services and residential aged care facilities), and in the integration of care between settings.

#### **Treatment in acute hospitals is not always in line with the preferences of dying patients**

Acute hospitals are, by definition, designed to provide acute care, and the doctors who work in hospitals find it much easier to continue active treatment rather than make a decision to stop (ACSQHC 2013). This has led to hospitals being likened to a 'conveyor belt' (Hillman and Cardona-Morrell 2015, p. 1701) or an 'express train that only goes in one direction ... where a patient once admitted receives a "chain reaction" of interventions' (Willmott et al. 2016, p. 500).

Once they are in hospital, patients approaching the end of life, and their families and carers, can find it hard to understand whether or not hospital is the best place for them and, if they would prefer to forgo certain medical interventions, can find it hard to express those preferences. This inhibits user choice and can lead to poorer care. As Aged & Community Services Australia put it:

With their focus on curative treatment, acute hospitals are often not ideal places for providing appropriate end-of-life care that promotes comfort and quality of life. (sub. 411, p. 4)

Systemic issues in acute care at the end of life include uncertainty of prognosis, delayed recognition of dying by clinicians (especially junior clinicians), poor communication with patients, families and community care providers, and the focus of specialist clinicians on the organ or disease group of their specialty (which can come at the cost of holistic assessment and management of end-of-life care needs) (ACSQHC 2013, pp. 24–25). In addition, the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney expressed concern about 'the high number of hospital staff who are not aware of, or properly respect, patients' wishes as expressed in [advance care] directives' (sub. DR516, p. 4).

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Admission to hospital can be particularly difficult and risky for people with dementia as they ‘face numerous hazards during their stay in hospital and often experience adverse outcomes, including physical and cognitive functional decline, under-nutrition, skin tears and fall-related injuries’ (AIHW 2013a, p. 1). In addition:

People with dementia are frequently not recognised to be dying, and are admitted to acute hospitals in the final few days or weeks of life for the treatment of conditions such as pneumonia or urinary tract infection. This is despite evidence to suggest that acute hospital admission can be detrimental to people with dementia and stressful for their carers (Hennings, Froggatt and Keady 2010, p. 114).

Not all hospitals have formal systems in place to help identify people approaching the end of life. For example, in New South Wales, only 61 per cent of clinical units in local health districts said that they routinely identify patients who are likely to die in the next 6 to 12 months so that end-of-life planning can begin (CEC 2013, p. 7). This leads to a situation where ‘almost two-thirds of terminally ill people for whom home or hospice palliative care would be appropriate die in hospital, often receiving heroic interventions’ (Scott 2014, p. 127). A recent study of Department of Veterans’ Affairs clients aged over 70 years confirms this — only one-third of those who died in hospital received palliative care during the admission in which they died (Ireland 2017).

Even for those who receive palliative care in hospital, such care often comes too late. For example in Victoria, close to two thirds of patients with metastatic lung cancer were engaged with palliative care services at the time of death, but about a quarter of those were referred to those services in the hospital admission during which they died (Philip et al. 2015).

There is also evidence that many of the people who are approaching the end of life in acute hospitals receive non-beneficial treatments (Cardona-Morrell et al. 2016) or undergo tests and scans that do not have a clear effect on care (Clark et al. 2014). While some of these tests and treatments may be sought by patients, this may reflect unrealistic expectations about the likelihood of success of medical interventions such as cardiopulmonary resuscitation (ACSQHC 2013, pp. 12–13).

Indeed, a high degree of medical intervention may have an adverse effect on the quality of care at the end of life. Intensive care physicians are often among those who express concern about the quality of some deaths in hospital. For example, an intensive care consultant told the Australian Commission on Safety and Quality in Health Care that:

To answer your question very directly, you asked ‘Do people die well in this hospital?’ They absolutely do not. People are allowed to linger for far too long, in far too much pain, and causing far too much distress to themselves and their family and the people who care for them ... The current situation, to speak frankly, is completely unacceptable. (ACSQHC 2013, p. 8)

Non-beneficial or unwanted treatments performed near the end of life are often conceptualised as something that occurs in intensive care units (ICUs). Yet only a minority of people are admitted to an ICU at the end of life. In New South Wales, 12 per cent of those who died spent time in an ICU in their last year of life (Goldsbury et al. 2015, p. 7). Similar

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results were found in South Australia, where the Health Performance Council of South Australia found that 13 per cent of people who died were admitted to an ICU at some stage in the twelve months prior to their deaths, and that a minority (17 per cent of ICU patients, or 2 per cent of total patients) were identified as palliative in the twelve months prior to their death yet spent time in an ICU (HPC 2013).

Many patients would benefit from, and would choose, conservative disease management and support (such as outpatient programs to manage chronic heart or kidney failure) instead of, or in conjunction with, acute care as they approach the end of life. However, those who would benefit are not assured of access to such care. For example, only half of chronic heart failure disease management programs have secured long-term funding (Scott and Jackson 2013). Indeed, the very success of supportive care and disease management approaches in helping people with progressive illnesses to manage their conditions and avoid hospitalisation can be a barrier to obtaining ongoing funding. If such programs are successful in keeping people in relatively good health in the community for longer, they can no longer claim to be treating people who would otherwise be in hospital, and so may lose funding (PC 2017d).

## **End-of-life care is not always available**

Often, people who would benefit from certain types of end-of-life care — such as specialist palliative care or support to die at home — miss out. Many, perhaps tens of thousands of, people cannot access desired support to die in their own home and die in hospital instead. For example, the Victorian Auditor-General found that:

Demand for home-based care is increasing and some metropolitan community palliative care services have struggled to meet this demand, resulting in waiting lists to access services. This can place additional stress on patients and carers, and can mean that some people who have chosen to die at home cannot spend their last days there. (VAGO 2015, p. vii)

Others would prefer to be cared for at home, but are unable to die there, even with support. Dr Anthony Ireland said that:

... mounting needs for symptom control, increasing physical dependency, resultant carer distress or unexpected acute medical events not uncommonly occur in patients who are approaching death. These often overwhelm the capacity of families and community-based care providers. Hospital (or preferably hospice) is often a welcome haven for patient and carers in such situations. (sub. DR527, p. 2)

Yet too often, hospice care is not an option, either because there is no hospice in the area or because there are no available places. For example, Sandra Coburn said, in relation to her father's death, that the support offered by the hospice was 'largely illusory', as the relevant hospice 'had very limited beds (15 at that stage) and could only keep people for a limited period. My father was not yet close enough to death to qualify, despite only having a predicted 4–6 weeks to live' (sub. DR558, p. 2).

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At the national level, the Institute for Healthcare Transformation at Deakin University said ‘access to care is largely determined by age, diagnosis and geography rather than individual need’ (sub. DR587, p. 4). The Australian Health and Hospitals Association considered that:

Palliative care services have not been broadly embedded into the health system and are fragmented, with varying access and capacity across the country, depending on diagnosis, age, cultural background, geographical location, available resources and clinician knowledge. (AHHA, sub. 427, p. 10)

One indicator of this variation is that family members of those who died under the care of an in-home palliative care service consider themselves among the lucky few (McMillen 2017), while another is concern about poor end-of-life care services in rural areas (box 3.2).

### **Box 3.2      End-of-life care in rural areas**

There is limited evidence about the quality and accessibility of end-of-life care in rural areas, and the way in which this care compares to that available in urban areas. It is clear there is a strongly increased chance of dying in hospital in remote and very remote regions. This could, in part, be due to aged care facilities being located in hospitals in some country areas (HPC 2013).

Several participants told the Commission that Australians living in rural areas have limited access to, and choice about, the end-of-life care services they receive. For example, HammondCare said:

... services are inadequate in many rural and remote areas of Australia and the provision of around-the-clock services is also limited. Rural areas also have poorer access to specialist palliative care services which results in a greater reliance on general practitioners and community nurses, especially after hours, many of whom are not appropriately trained in the provision of palliative care. (sub. 407, p. 3)

Further, ‘those living in rural and remote areas are likely to find it much more difficult to access specialised palliative care services’ (CHA, sub. 440, p. 5), with 85 per cent of specialist palliative medicine physicians working in major cities (AIHW 2016k).

There can also be some advantages to receiving palliative care in a small rural hospital, as it can become an extension of the sense of community fostered in rural areas (Urbis 2016a).

It is also less than ideal that the number of community-based palliative care providers across Australia is not known with certainty. The best measure is the number of community-based palliative care services that contribute data to the Palliative Care Outcomes Collaboration — there are 36 of these throughout Australia (Connolly et al. 2016) (though Palliative Care Australia has a directory that currently lists about 200 community-based palliative care providers (PCA 2017b)).

Another indicator of the room to improve end-of-life care is that many Australians who would prefer to die at home do not have their preference fulfilled (box 3.1). COTA said:

It is really a very poor thing for a country like ours that so many people are unable to die in the place and in the kind of context that they would want to. (trans., p. 325)

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Australia is not alone in apparently having rates of dying at home that are much lower than people say they want. In 2011, 65 per cent of deaths in Canada occurred in acute care hospitals, even though many Canadians (63 per cent according to an Ontario survey) express a preference to die at home (Costa et al. 2016, p. 2).

Some community-based palliative care providers report that government funding covers a relatively small proportion of their costs. For example, Little Haven Palliative Care said that 35 per cent of its annual budget (\$256 000) is covered by Queensland Government funding (sub. 458, p. 1). (The remainder is covered by fundraising, bequests and donations (Little Haven Palliative Care, sub. 458, att. 2, p. 8)).

Access to both inpatient and outpatient palliative care services is lower among certain groups, including Indigenous Australians (box 3.3), people from culturally and linguistically diverse backgrounds, and people with disabilities (HCSC 2013; LSIC 2016; NSW ACI 2014; SCARC 2012; Urbis 2016a). While people with illnesses other than cancer have many of the same end-of-life care needs as those with cancer (Moens et al. 2014), they are commonly under-represented among those receiving specialist palliative care (Currow et al. 2008; LSIC 2016).

### **Box 3.3      End-of-life care for Indigenous Australians**

Inquiry participants told the Commission that enabling Indigenous Australians to ‘spend their twilight years in their ancestral lands’ (National Congress of Australia’s First People, sub. DR565, p. 7) is a vital, but too often overlooked, element of high-quality end-of-life care. Elaborating on this, the National Congress of Australia’s First People said:

... many of our peoples unfortunately have to pass away in environments alien to them, often associated with the engrained historical trauma, and not sensitive to cultural dignity otherwise received in the lands of their respective peoples ... this perpetuates a vicious cycle of separation from one’s ancestral land, and rootlessness that afflicts a sizable proportion of our peoples. (sub. DR565, p. 8)

Similarly, the Cancer Council NSW (sub. DR537) expressed concern about poor access to end-of-life care for Australians living in remote Indigenous communities. Palliative Care Australia (sub. DR500) noted that place of death is culturally and spiritually significant for many Aboriginal and Torres Strait Islander peoples, and that many feel a need to ‘return to country’ at the end of their lives.

## **Residential aged care services often struggle to meet end-of-life care needs**

### **Residential aged care is transforming into an end-of-life care service**

The aged care system includes a range of different services, many of which are designed to help older Australians live independently in their own home. As people approach the end of

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life, their care needs increase and many move to a residential aged care facility (RACF).<sup>2</sup> This is usually a permanent move — just over 80 per cent of permanent RACF residents die there (about 60 000 people per year) (AIHW 2017g).

Residential aged care is increasingly provided to people who are older and who have higher care needs. Between 2012 and 2015, the proportion of RACF residents who were assessed as having high care needs across all three care domains (activities of daily living, behaviour and complex health care) rose from 18 per cent to 27 per cent (an increase of just over 15 000 people) (AIHW 2012b, 2015d). Based on current trends, residential aged care is transforming into an end-of-life care service (PC 2015c). BaptistCare Australia and Churches Housing remarked on this, noting that:

The trend for residents to arrive closer to the end of life, with much more complex health and behavioural needs, has been so rapid and marked that there is now discussion about whether residential aged care facilities more closely resemble a ‘hospice’ than a ‘home’. (sub. DR532, p. 4)

### End-of-life care in residential aged care facilities is often inadequate

While the care provided in some RACFs is excellent (section 3.2), participants told the Commission that palliative and end-of-life care are poorly provided in many facilities. This situation is not helped by current policy settings which do not provide the incentives needed to ensure quality care is available to all of those who would benefit from it.

Both Alzheimer’s Australia (2017, p. 11) and Palliative Care Australia (PCA 2016a, p. 3) expressed concern about unmanaged severe pain in RACFs. BaptistCare Australia and Churches Housing (sub. DR532) said that in a rural BaptistCare facility without 24-hour nurse cover, residents who require certain medications after hours must wait while the on-call nurse drives for 30 minutes on country roads to attend to them.

Christy Pirone, Margaret Brown, Dr Chris Moy and Dr Christine Drummond said that:

The number of transfers [from residential aged care] to the acute hospitals because of inadequate staffing and access to appropriate care can be considered to be a failure in our system of care at the end of life. Those who die when old, have equal rights to be cared for with dignity and respect. (sub. DR559, p. 3)

Palliative Care Australia members reported ‘an inability for some [aged care] services to provide palliative care at the end of life, particularly if the person dying has complex symptoms’ (PCA 2016a, p. 6). This can lead to RACFs being ‘reluctant to accept clients who are dying, despite the fact that there is no clinical need for them to remain in an acute setting’ (NSW Ministry of Health 2016a, p. 7).

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<sup>2</sup> In this inquiry, the Commission has focused its consideration of aged care on residential aged care. While aged care home care services may occasionally be sole providers of end-of-life care, the Commission was unable to obtain data to suggest that this occurs in anything but a handful of cases.

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The evaluation of the National Palliative Care Strategy quoted a service manager who said that end-of-life care in aged care is:

... dire with few [registered nurses] being employed in aged care facilities, high turnover of staff, lack of skilled staff and lack of awareness of dying and palliative care needs. People enter aged care facilities now with little time left to live (3–6 months in many cases) and yet the staff are not skilled in palliative care and round the clock pain medication cannot be given as there are no [registered nurses] available. (Urbis 2016a, p. 31)

Alzheimer's Australia (sub. DR521) said that staff working in RACFs need additional training in palliative care, while the Royal Australasian College of Physicians (sub. DR580) considered that palliative care in RACFs may lack input from medical practitioners.

Palliative Care Australia said that in RACFs, the 'structure and staff mix is heavily weighted in the lower paid unregulated staff (PCAs) [personal care assistants] with inadequate levels of qualified healthcare staff especially outside standard business hours' (PCA 2016b, p. 6). People who are approaching the end of life are transferred to acute hospitals for pain management because these staff do not have the skills to lead and coordinate end-of-life care for residents. In 2008-09 about 9600 permanent residents of RACFs died in hospital (AIHW 2013b). More recent data are not available.

Recognition of the particular end-of-life care needs of people with dementia, who comprise about two-thirds of those in residential aged care, was an area of particular concern (Alzheimer's Australia, sub. 431; Davis et al. 2009; SCARC 2012). Likewise, Allied Health Professions Australia expressed concern that the exclusion of residents of aged care facilities from eligibility for Medicare-funded mental health and chronic disease management programs can severely limit residents' access to allied and mental health care (sub. DR496).

Participants also told the Commission that some community members can find it hard to access end-of-life care in aged care, with the Federation of Ethnic Communities' Councils of Australia saying:

... culturally appropriate care under the current home and residential care for older people from CALD [culturally and linguistically diverse] backgrounds is scarce or inadequate ... Many people from CALD communities are not aware of the palliative care supports available to them and do not plan the end of life needs. (FECCA, sub. 433, p. 3)

The Combined Pensioners and Superannuants Association said that 'the information available to clients through the audit reports of the Australian Aged Care Quality Agency does not provide much insight into the way palliative care is actually delivered and what clients can expect' (sub. DR542, p. 3).

Another constraint on access to aged care is the current system of accreditation and approvals of aged care providers and the allocation of bed licences. In some cases, restrictions on the number of aged care places and their locations limit consumers' ability to choose RACFs that best suit their end-of-life care needs. Aged care reforms are moving toward providing users with greater choice over the services they receive, and a move toward a fully demand-driven system of residential aged care has been signalled by the relevant Australian

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Government committee, but the timeline remains uncertain (Aged Care Sector Committee 2016).

### Assessment and funding systems do not take proper account of palliative care needs

The Australian Government is primarily responsible for regulating, and providing public funding for, aged care services. This includes end-of-life care provided to the approximately 60 000 people who die in RACFs each year.

Many participants told the Commission that the funding arrangements have adverse effects on end-of-life care in RACFs (box 3.4). For example, Leading Age Services Australia said that the current funding system ‘certainly does not encourage nor support end-of-life care and services to the resident, let alone the family and others’ and that there is ‘a disconnect between the funding provided for care and the actual care people receive in residential aged care’ (sub. 463, p. 7). Indeed, only one in six people who died in residential aged care received funding for palliative care (AIHW 2016j).

In light of these concerns, reforms are needed to ensure that people residing in residential aged care receive end-of-life care that aligns with the quality of care available to other Australians.

### Few Australians make plans for their end-of-life care in advance

Many people will be unable to communicate their wishes for end-of-life care at the time the care is provided. Consequently, to have a real choice in the care they receive, people must communicate their wishes in advance, ideally by preparing and maintaining a high-quality advance care plan (ACP) (box 3.5).

Governments, hospitals and non-government organisations have made efforts to promote advance care planning, as it has many demonstrated individual and societal benefits, including increased likelihood that patients will receive medical treatment in accordance with their wishes and die in their place of choice, reduced burden on substitute decision makers, and a reduction in the practise of defensive medicine (where doctors engage in costly, active treatment that patients may not want) (Detering et al. 2010; Respecting Patient Choices Program 2012).

Despite these efforts, relatively few people have an ACP. A national telephone survey conducted in 2012 found that only 14 per cent of Australians had an ACP (White et al. 2014). In a separate study of people aged over 65 years presenting to emergency departments, 13 per cent had ACPs (Street et al. 2015).

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### **Box 3.4      Limits on Australian Government funding for end-of-life care in residential aged care**

The Australian Government's Aged Care Funding Instrument (ACFI) is used to assess the care needs of those living in residential aged care. ACFI assessment involves determining whether the resident has low, medium or high care needs across three care domains (activities of daily living, behaviour and complex health care). Funding in each of these domains is categorised as either high, medium, low or nil.

#### **Time limits on palliative care**

The ACFI specifies that funding specifically for palliative care is only allowable 'in the last week or days' of a resident's life. This limit is strictly adhered to in Australian Government decisions, which has pursued Administrative Appeals Tribunal cases against aged care facilities that sought funding to provide palliative care for too long (for example, *Southern Cross Care* [2014] AATA 623).

In addition, the ACFI specifies that funding specifically for palliative care requires a directive from a medical practitioner or specialist nurse, as well as completion of a pain assessment. LASA said that 'the required directive is difficult to obtain for providers. As ACFI funding for palliation is provided for a short period only the effort to obtain the directive required exceeds the benefit gained for the resident' (sub. DR512, p. 6).

#### **The 'high' funding ceiling**

Not only does the ACFI severely restrict the duration of palliative care, ACFI funding for palliative care is not available to all residents — if a resident is already receiving 'high' funding for an ACFI domain, no additional funding is made available if their care needs in that domain increase further. The AIHW reported that in 2014-15 more than 50 per cent of residents of RACFs received 'high' level funding for their health care (AIHW 2016b). This means that no additional funding is available for palliative care (or any other additional health-care needs) for more than half the residents of aged care facilities as they approach the end of life.

The Commission considers that there are several reasons for the continued low uptake of ACPs.

- People are often reluctant to contemplate their own frailty or mortality. Others may simply prefer to live 'one day at a time' and, provided the person has sufficient information and understanding about what an ACP entails, this wish should be respected (Rietjens, Korfage and Heide 2016, p. 421).
- To the extent that people are aware that there is not enough community-based palliative care, this may reduce their motivation to prepare an ACP. As Little Haven Palliative Care said 'in the absence of access to quality end-of-life care in many communities, advanced care wishes, if they include remaining at home to die, may be irrelevant' (sub. DR579, p. 2).
- Advance care planning conversations, particularly those that are necessary to develop high-quality ACPs, take time. Clinicians and patients (and their families) usually require several sessions to discuss all the relevant issues, often over a period of weeks

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(HammondCare, sub. 407; Scott et al. 2013). Clinicians can struggle to find the time to have these conversations in busy hospital or general practice environments.

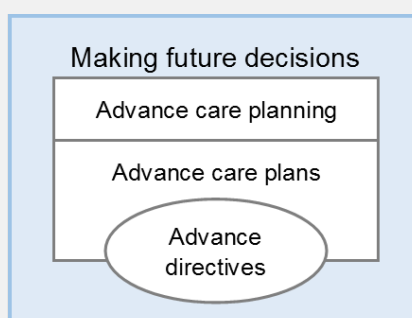
- Many clinicians also feel unprepared to talk about dying, and few have the training or confidence to initiate conversations with their patients about end-of-life care. Even among health professionals working in palliative care services, who would be expected to be best placed to comfortably discuss end-of-life care, about 30 per cent feel unconfident or only somewhat confident in initiating ACP discussions and answering patient and family questions about an ACP (Sellars et al. 2015).

Taken together, these factors suggest that it will never be possible or desirable for everyone to have an ACP. As it stands, however, many people approach the end of life unable to speak for themselves and without a plan in place to guide their care.

### Box 3.5      **Advance care planning: some definitions**

#### **What is an advance care plan?**

An advance care plan (ACP) outlines a person's preferences regarding medical treatment or goals of care in the event they are unable to communicate this themselves at the time that care is provided. ACPs are one component of a wider planning process, as illustrated below.



An ACP often (though not always) includes an advance directive (see below). Other possible components include a letter to the person who will be responsible for this decision making, an entry in the patient medical record, a spoken instruction or other communication which clearly enunciates a patient's view, or any combination of these (Department of Health 2012).

#### **What makes an ACP 'high quality'?**

To be 'high quality', an ACP must fully reflect the patient's wishes and also be useful to clinicians in guiding care decisions. Rather than a stand-alone document, a high-quality ACP reflects a high-quality planning process, including an ongoing conversation between the patient, family or carers and a trained clinician, and regular reviews and updates (Scott et al. 2013). Well-maintained, high-quality ACPs have been shown to increase compliance with patients' end-of-life wishes and to improve family members' perceptions of the quality of their loved one's death (Detering et al. 2010).

#### **What is an advance directive?**

An advance directive (sometimes advance care directive) is an ACP that has been formally recorded, according to its legal status under common law or state legislation (PCA 2012).

*Sources:* ACPA (2017); Brinkman-Stoppelenburg et al. (2014); Street and Ottmann (2006).

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## Not enough is known about end-of-life care

Several inquiry participants (including COTA Australia, sub. 456; Queensland Nurses' Union, sub. 405) pointed out a need for more rigorous transparency and accountability for both service providers and commissioning bodies working in end-of-life care. CHERE said that:

Data is urgently needed, not only to allow for the appropriate measurement of place of care at the end-of-life and place of death, but also to allow for the accurate measurement of health care costs. (sub. 516, p. 4)

Little Company of Mary Health Care considered that:

The current absence of comprehensive population based data biases policy and funding decisions towards those problems which are visible through the acute hospital lens. (sub. DR547, p. 9)

The Health Performance Council of SA said that:

... more performance information about quality, access, equity and health outcomes of ... end-of-life care services, aged care services and primary care should be transparent and in the public domain. (sub. 437, p. 6)

Such performance data are a fundamental starting point for improving the delivery of those activities to the community (PC 2017a). As Aged Care Crisis said:

Data is essential for managing facilities, for government, local community and provider policy, for consumer and community information, for public discourse, for the market to work, and to anchor regulatory effort to what is happening in the facilities and the sector. (sub. DR525, app. 2, p. 33)

Yet current data and information relating to end-of-life care in Australia are 'fragmented and incomplete' (AIHW, sub. DR508, p. 4), and there are significant gaps in even the most basic administrative data about end-of-life care. In some cases, this is because the information is simply not recorded — for example, the number of days that residents of RACFs spend in hospital (each year, or in their last year of life) is not counted.

Other data are collected but are not linked or made available in an affordable, accessible format. For example, information on the age, location and cause of deaths in Australia is available but the linking of these datasets is not routinely carried out, and the process for obtaining linked datasets is complex, lengthy and expensive (PC 2017a, p. 509). Consequently, these details cannot be put together in such a way as to provide an overall picture of the type, amount and quality of end-of-life care Australians receive (AIHW 2016d).

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### **3.4 Poor stewardship is hindering better end-of-life care**

While the quality of end-of-life care services in Australia is often excellent, they perform less well on equity considerations, as too many people approaching the end of life end up with little real choice about the care they receive. Similarly, while some services are effective, offering only hospital services to many people who would prefer to be, and could be, well cared for at home, reduces the overall effectiveness of end-of-life care in Australia. It also means that end-of-life care services are not as responsive as they should be to users' needs and choices.

Poor stewardship by governments is a major barrier to the delivery of better end-of-life care in Australia. Inadequate planning, overlapping and uncertain funding and other responsibilities between different levels of government, and limited use of data to monitor and improve services, are all impediments to change.

The significant shortfall in the availability of end-of-life care in settings where people would prefer to receive it — in the community and in RACFs — is the result of poor planning and allocation of resources by governments. This has led to a high proportion of people receiving care (and dying) in hospital, which is often the setting that they least prefer and is the most costly for taxpayers. Investing in end-of-life care in the community and in aged care facilities would avoid this.

To achieve better planning and resource allocation, there will need to be greater collaboration between the Australian, State and Territory Governments. As noted in section 3.1, there is currently overlap in the roles of the different levels of government, which has led to uncertainty and buck passing over how stewardship is shared and service provision is coordinated across different settings.

The problems resulting from the lack of cross-jurisdiction co-operation have been particularly evident for residents of aged care facilities. They may miss out on specialist palliative care because it is unclear whether it is the Australian Government's responsibility as steward of the aged care system, or the role of State and Territory Governments as providers of specialist palliative care.

- The Australian Government rarely acknowledges that providing end-of-life care is (or should be) core business for residential aged care and has, for many years, failed to ensure that residential aged care providers receive sufficient funding for delivering palliative care (box 3.4).
- State and Territory Governments can be reluctant to fund palliative care for people aged over 65 years who, by virtue of their age, could also be eligible for aged care funded by the Australian Government. Some State and Territory Governments have end-of-life and palliative care policies that omit the needs of those in aged care, or focus only on specialist palliative care (ignoring the end-of-life care needs of frail elderly people who do not require specialist care).

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More generally, there needs to be better coordination of end-of-life care between residential aged care, community-based palliative care, hospitals and primary care. This will require stronger collaboration between governments on identifying and delivering coordinated end-of-life care across all settings.

While there has been some useful cross-jurisdiction co-operation on very specific issues — such as developing guidelines on end-of-life care for adults in acute hospitals (ACSQHC 2015a) — broader attempts at collaboration have lacked substance and been ineffective. For example, since 2000, there has been a National Palliative Care Strategy endorsed by all jurisdictions but a recent evaluation found that its goals were unclear and it has not delivered any improvements in care (box 3.6).

### **Box 3.6      The National Palliative Care Strategy**

Australia has had a National Palliative Care Strategy since 2000, with the current version published in 2010. The strategy is endorsed by the Australian Health Ministers' Advisory Council (the secretaries of the Australian, State and Territory Departments of Health). Its overarching objective is that all Australians with a life-limiting illness live well until the end of life.

A recent evaluation of the 2010 strategy found that it is not clear what it is seeking to achieve and how achievements can be demonstrated, and so it 'has not been effective in aligning state, territory and Commonwealth planning and policies' (Urbis 2016a, p. 43). As Palliative Care Australia put it, 'it was a strategy that sat on a shelf since 2010 with no KPIs, no monitoring, no evaluation' (trans., pp. 118–9).

The evaluation also highlighted the value placed on national governance structures to improve collaboration and accountability, and recommended that 'an action or implementation plan should be developed to guide implementation of the Strategy going forward, with identified objectives, actions, responsibilities, and indicators' (Urbis 2016a, p. 44).

An updated National Palliative Care Strategy is being prepared, a draft of which was released for public consultation in August 2017. Plans for implementing, monitoring and evaluating the updated strategy are still being developed.

*Sources:* Australian Government (2010); Urbis (2016a, 2017).

Poor stewardship is also evident in the failure of governments to address major gaps in the collection and publication of information on end-of-life care. Without such information, the stewardship functions of governments to plan, monitor and improve service provision are significantly constrained. State and Territory Government end-of-life and palliative care policies and plans often contain few tangible measures or goals for ensuring that all of the people who would benefit from palliative care receive it. Among other things, this weakens consumer protection and limits accountability.

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## 4 Reforms to end-of-life care

### Key points

- The Australian, State and Territory Governments should work together so that Australians can access end-of-life care that better matches their preferences. This will require governments to put greater focus on providing end-of-life care in the place where a person lives.
- A significant increase in the availability of community-based palliative care is required. To achieve this, State and Territory Governments should:
  - assess the need for additional services, select providers (typically using competitive processes) and adequately fund those providers
  - establish standards for community-based palliative care services and fund the delivery of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care
  - ensure that monitoring frameworks and consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.
- Available evidence indicates that the savings from avoiding a single hospital admission for palliative care (costing about \$11 000) would more than cover the cost of providing community-based care over a period of months (costing between \$6000 to \$10 000).
- People living in residential aged care facilities should receive end-of-life care that aligns with the quality of that available to other Australians. Delivering this will require the Australian Government to:
  - remove current restrictions on the duration and availability of palliative care funding in residential aged care, so that clinical care is available to all residents at the end of life
  - fund this additional care
  - ensure that clinically trained staff hold timely conversations with aged care residents about their future care needs and preferences, and support residents to prepare an advance care plan if they wish to do so.
- General practitioners and practice nurses could play a much larger role in helping people to articulate their preferences for end-of-life care through advance care planning. Changes to Medicare item numbers are needed to enable this.
- The effectiveness of the above reforms will depend on governments implementing broader improvements to their stewardship of end-of-life care. This should involve the Australian, State and Territory Governments, through the COAG Health Council:
  - co-operating to plan, fund, and set standards for end-of-life care so that patients receive high-quality care in each setting and in each jurisdiction
  - developing and implementing an end-of-life care data strategy that establishes a national minimum data set for end-of-life care, and improves the accessibility and use of data
  - commissioning an independent review in 2025 of the effectiveness of end-of-life care across all settings in which it is, or should be, provided.

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A comprehensive approach to end-of-life care recognises that the patient and clinicians are both essential participants in discussions and decision making about care needs at the end of life. End-of-life care is provided in the community, residential aged care facilities (RACFs) and hospitals. Stewardship is spread between different levels of government. A stronger focus is needed on care that responds to each patient's choices, values and preferences, given the realities of the patient's clinical condition and treatment options. This requires greater coordination of care between settings. It will also require a coordinated response and ongoing stewardship from health authorities at all levels of government.

The Commission is recommending a number of reforms to put users' needs and choices at the heart of end-of-life care services (table 4.1).

The reforms have been designed to be implemented as a package to increase their effectiveness and to ease the transition. In particular, improving end-of-life care in the community and residential aged care facilities could reduce demand for some hospital services because more people nearing the end of their lives would have an alternative to visiting hospital. Ultimately, though, potential longer-term savings should not be the primary driver of reforms to increase access to high-quality end-of-life care.

As noted in chapter 3, most end-of-life care is provided by government-funded services, and these services are the sole focus of this report. However, people approaching the end of life can also purchase additional services if they wish.

## **4.1 Improving acute care at the end of life**

Most Australians currently die in hospital, and many receive end-of-life diagnoses or referrals to community-based palliative care services while in hospitals or outpatient clinics. Hospitals therefore play a critical role in the delivery of quality end-of-life care. Reform is needed to address the many systemic issues that can make it difficult for hospital staff to deliver good end-of-life care (chapter 3).

### **New standards to improve end-of-life care in acute hospitals**

Efforts to improve the way in which patients approaching the end of life are supported in acute hospitals are already underway as part of ongoing revision of the National Safety and Quality Health Service (NSQHS) Standards. Hospitals must meet the NSQHS Standards in order to obtain and retain accreditation. Version 2 of the NSQHS Standards, which will be implemented in 2019, will require hospitals to meet the elements of the *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care* (ACSQHC 2017). As noted in chapter 3, the consensus statement describes ten elements that are essential for delivering safe and high-quality end-of-life care, with a focus on patient-centred communication and shared decision making, and the organisational prerequisites necessary for delivering patient-centred care.

**Table 4.1 Overview of proposed reforms to end-of-life care**

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Community-based palliative care</b>		
<b>Recommendation 4.1</b> State and Territory Governments to increase the availability of community-based palliative care so that people with a preference to die at home can access support to do so.	Assess needs as soon as practicable. Implementation timeframe depends on assessed needs.	Community-based palliative care could cost less than its hospital equivalent. Patients would be able to access community-based palliative care that supports them to die at home if they choose.
<b>End-of-life care in residential aged care</b>		
<b>Recommendation 4.2</b> The Australian Government to remove current restrictions on the availability and duration of funding for palliative care in residential aged care, and provide sufficient additional funding so that people living in residential aged care receive end-of-life care that aligns with the quality of that available to other Australians.	As soon as practicable.	Costs would depend on the extent of unmet need, which is currently unknown. Residents of residential aged care facilities would receive end-of-life care that aligns with the quality of that available to other Australians.
<b>Advance care planning</b>		
<b>Recommendation 4.3</b> The Australian Government to: <ul style="list-style-type: none"> <li>include initiating an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers</li> <li>introduce a new Medicare item number to enable practice nurses to facilitate advance care planning.</li> </ul>	As soon as practicable.	There would be extra demand on general practitioners' time, but enabling practice nurses to assist would reduce this. More people would prepare advance care plans and receive care that matches their end-of-life care preferences even if they were unable to communicate those preferences.
<b>Recommendation 4.4</b> The Australian Government to include the facilitation of ongoing conversations about advance care planning in the aged care Quality of Care Principles.	As soon as practicable.	Residential aged care facilities would spend time ensuring that the choices of residents and their families guide their end-of-life care.
<b>Improving stewardship of end-of-life care</b>		
<b>Recommendation 4.5</b> The Australian, State and Territory Governments to co-operate to: <ul style="list-style-type: none"> <li>plan, fund, deliver and set standards for end-of-life care across different settings and jurisdictions</li> <li>develop and implement a strategy for end-of-life care data, including developing a national minimum data set for end-of-life care</li> <li>review the effectiveness of end-of-life care across all settings.</li> </ul>	Enhance cross-jurisdiction co-operation and develop data strategy as soon as practicable. Review in 2025.	Cost of negotiating and implementing cross-jurisdiction arrangements, such as consistent data collection. Improvements to efficiency resulting from better co-operation and better data would contribute to a reduction in costs.

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## **Implementation of the new end-of-life care standards in hospitals**

One notable element of the consensus statement is a requirement to use triggers to recognise patients approaching the end of life (people who are likely to die within the next 12 months — chapter 3). Many hospitals across Australia are already using triggers to identify these patients, but others are yet to do so.

### **Training clinicians to talk about end-of-life care with patients**

Triggers will only be effective if they prompt clinicians to initiate conversations about the end of life, and thereby enable patients to have timely and ongoing discussions about their end-of-life care with their clinicians, families and carers. Individual clinicians may have to overcome barriers to these discussions. For example, clinicians often fear causing distress or damaging hope. There is, however, evidence that this reluctance can be reduced through targeted training (box 4.1).

### **Focusing on the needs and preferences of individual patients**

It is important that efforts to systematically identify patients who are approaching the end of life, and to equip clinicians to hold conversations about end-of-life care with them, do not become ‘tick and flick’ exercises. The experience in the United Kingdom with the Liverpool Care Pathway (box 4.2) highlights the risk that the approaches used to implement triggers and care pathways may not give sufficient regard to each individual patient and their preferences.

The UK experience also highlights the importance of ensuring that institutional arrangements at the hospital level (including training and clinical governance systems) are designed to support the implementation of standards for high-quality end-of-life care, and that triggers are used to prompt discussions, not to force decisions or transitions in care.

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## Box 4.1      **Training clinicians to talk about end-of-life care with patients**

### *Clinicians feel unprepared to talk about dying*

For clinical staff, patient deaths are often expected. Yet the heavy, emotive nature of death, dying and future care needs make them difficult subjects for clinicians to address (Scott et al. 2013).

Triggers may prompt clinicians to have conversations with patients about their future care needs and preferences, and assist clinicians to determine the best timing for those conversations. But clinicians do not always have the skills or understanding necessary to know when and how to hold these difficult conversations (Nedjat-Haiem et al. 2016) or the technical knowledge to facilitate planning (Seal 2007; Street et al. 2015).

### *Training can help*

Several inquiry participants, including HammondCare (sub. 407, DR515), MIGA (sub. 432), Leading Age Services Australia (sub. 463) and the Royal Australasian College of Physicians (sub. 473), suggested that training is needed to give clinicians the confidence necessary to start conversations about end-of-life care. Christy Pirone, Margaret Brown, Dr Chris Moy and Dr Christine Drummond (sub. DR559, p. 4) said the use of triggers to prompt discussion on goals of care was a key step, but this would require 'building capacity of the workforce ... to enable identification of a person at the end-of-life and the skills to partner with consumers to discuss and plan care in respect to a person's wishes'.

There are a number of training programs that have demonstrated their effectiveness in teaching clinicians to engage patients and their families in shared decision making about end-of-life care. For example, the Respecting Patient Choices program is designed to help hospitals establish systems that cater for improved care planning, including staff training programs with a 'person centred' 'complex' advance care planning approach (Brinkman-Stoppelenburg, Rietjens and Heide 2014). Based on a US model and first implemented in Australia at the Austin Hospital, Respecting Patient Choices includes additional practical training (role plays and scenarios) that are specific to the Australian context.

Prior to the introduction of Respecting Patient Choices at the Austin, about 9 per cent of patients had advance directives and only about half of those were active (Lee et al. 2003). After implementing the Respecting Patient Choices training program, 47 per cent of patients were offered advance care planning, of which 70 per cent went on to prepare a written plan. Of the patients who died, about three quarters had some expression of their treatment wishes recorded in their medical record, and one quarter had completed a formal advance care plan document (Lee et al. 2003). The Respecting Patient Choices program has now been adopted by health services and communities across Australia and implemented in at least one lead hospital in every state (CareSearch 2017b).

HammondCare pointed to a range of other educational resources designed to increase clinicians' skills and knowledge about end-of-life conversations and palliative care, including:

- the Palliative Care Curriculum for Undergraduates (PCC4U) program, which targets undergraduate health students
- the online training modules, practical workshops and screening and assessment tools developed as part of the Advance Project, which currently targets practice nurses but could be extended to general practitioners, nurses working in other settings, including aged care, as well as allied health professionals
- the Program of Experience in the Palliative Approach (PEPA), which provides free palliative care workshops and placements in palliative care services. (sub. DR515, pp. 3–4)

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#### **Box 4.2      The rise and demise of the Liverpool Care Pathway**

A new End of Life Care Strategy was adopted in England in 2008. It was developed with the aim of giving people approaching the end of life more choice about where they would like to live and die (UK Department of Health 2008).

The strategy encouraged hospitals to adopt a care pathway originally developed for the care of cancer patients in acute hospital settings — the Liverpool Care Pathway (LCP). In 2008, the LCP had been implemented in hospices and aged care homes, and had been modified to be used for people with other conditions, for example renal disease and heart failure. The LCP was actively promoted by the National Health Service and was adopted as standard practice by more than 1800 health care institutions (Chan et al. 2014).

By 2012, allegations emerged that patients had been placed on the pathway prematurely, or had been poorly managed once they were on the pathway. The UK Government commissioned an independent review of the LCP, which found that although the LCP had clear benefits when used correctly, it had been treated as a ‘tick box exercise’. The review recommended that the LCP name be abandoned, the term ‘pathway’ avoided and that the LCP be replaced by an ‘end of life care plan’ (Neuberger 2013).

Responses to the review pointed out it is ‘as illogical to discredit guidance because of errant clinicians as it is to ban the Highway Code because of bad drivers’ (Regnard 2014, p. 172). After significant media attention, however, the damage was done and the LCP was abandoned.

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#### **Responsibility for end-of-life care in acute hospitals**

In hospitals, where many health professionals can be involved in a patient’s care, training clinicians to talk about end-of-life care is only part of the story. It is also important to clarify responsibilities for initiating and conducting end-of-life conversations. Even with appropriate triggers and training for clinicians, this will require concerted effort by hospital leadership. The common refrain that ‘end-of-life care is everyone’s responsibility’, while true, needs to be reinforced by the actions of hospital leadership.

Under the NSQHS Standards, the hospital board, chief executive or senior executive are already required to demonstrate that they monitor the safety and quality of care. This will be extended in version 2 of the NSQHS Standards to include a requirement for a formal governance process to ‘oversee the development, implementation and ongoing review of systems for end-of-life care’ (ACSQHC 2015a, p. 23).

In England, the importance of senior oversight of end-of-life care has been reinforced through public reporting on hospital quality. Hospitals that do not have clear senior oversight of end-of-life care receive poorer ratings for it (box 4.3). Similar measures should be incorporated into Australia’s public reporting on hospital performance (chapter 11).

### Box 4.3 Transparency about end-of-life care quality in the United Kingdom

In England, a large amount of consumer-oriented information about healthcare providers has been made available online. Patients can see an overall rating that England's healthcare regulator — the Care Quality Commission (CQC) — has given to individual hospitals.

The CQC's assessment of each hospital provides easily accessible information about the quality of each service area, including end-of-life care, using a traffic light system (see example at right). These service ratings can be disaggregated into ratings for five objectives (safety, effectiveness, caring, responsiveness or well-led).

The hospital whose ratings are shown below was rated as inadequate for 'well-led' in end-of-life care because:

- there was insufficient time for senior staff to provide leadership and governance
- it was slow to develop end-of-life care services in line with national guidelines
- quality, performance and risks were not effectively managed.

#### CQC inspections & ratings of specific services

Medical care (including older people's care)	Good ●
Urgent and emergency services (A&E)	Requires improvement ●
Surgery	Good ●
Intensive/critical care	Good ●
Maternity and gynaecology	Requires improvement ●
Services for children & young people	Good ●
End of life care	Requires improvement ●

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Source: CQC (2016).

## 4.2 Enabling more people to be supported to die at home if they wish

Under current arrangements, the supply of quality end-of-life care services to help people to die at home or in a home-like environment is not sufficient to meet demand, with tens of thousands of people missing out on the home-based care they would prefer (chapter 3). As the Grattan Institute pointed out:

... in principle, dying people should be able to choose a community-based palliative care package that supports them to die in place, particularly if they want to die at home. (Swerissen and Duckett 2014, pp. 27–28)

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In practice, only a small proportion of people who would prefer this type of care have access to it in a way that meets their needs. The Commission considers that addressing the current shortfall in community-based palliative care should start with State and Territory Governments commissioning additional community-based palliative care services. Many inquiry participants agreed (for example, ACSA, sub. DR541; Alzheimer's Australia, sub. DR521; Benetas, sub. DR543; Breast Cancer Network Australia, sub. DR534; Catholic Health Australia, sub. DR567; City of Whittlesea, sub. DR519; Sandra Coburn, sub. DR558; Community Council for Australia, sub. DR585; MND Australia, sub. DR513; Northern Territory Government, sub. DR593; Palliative Care Australia, sub. DR500; RACP, sub. DR580; Silver Chain, sub. DR509).

Governments should take a systematic approach to commissioning and service delivery by being clearer about what outcomes they are seeking to achieve, for whom and where (chapter 1). This includes ensuring that respective roles of (State- and Territory-Government funded) community-based palliative care services and (Australian Government funded) aged care services are agreed and well-understood by governments, providers and service users (section 4.5).

Enabling people approaching the end of life who wish to die at home to choose between community-based palliative care providers is the long-term objective (recognising that increasing the availability of community-based palliative care is the more immediate priority).

This section considers the issues that will be particularly important to address in order to effectively commission community-based palliative care services. The recommendations relating to commissioning family and community services (chapter 8) and stewardship of human services (chapter 2) are also likely to have broader lessons for commissioning and ongoing oversight of palliative care services.

## **Assessing demand for community-based palliative care services**

Understanding the population's characteristics, needs and preferences and the role played by existing service providers is critical to good stewardship (chapter 2). In the draft report, the Commission said that the starting point for providing additional community-based palliative care should be a detailed assessment of the current and future demand for such care, and current gaps in service provision.

Little Haven Palliative Care (sub. DR579) suggested that the gaps in community-based palliative care service provision are well documented, and instead of further needs assessment, resources would be better directed towards providing care. However, other participants were supportive of needs assessment (Cancer Council NSW, sub. DR537; Leading Age Services Australia, sub. DR512; Christy Pirone, Margaret Brown, Dr Chris Moy and Dr Christine Drummond, sub. DR559; Victorian Healthcare Association, sub. DR531).

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HammondCare said that it:

... reaffirms that a substantial increase in the availability of community-based palliative care is required, drawing on the experience and expertise of service providers, service users and representative organisations to assess that need. (sub. DR515, p. 1)

Palliative Care Australia (sub. DR500) noted that it is currently reviewing its guidance documents on palliative care service planning and provision, which could help to inform assessments of current and future palliative care needs.

While there is clear need for a major increase in the availability of community-based palliative care, it is highly likely those needs and gaps will differ between regions, as ‘there is huge variability in the delivery of palliative care services across the country’ (Catholic Health Australia, sub. 440, p. 5). Carefully assessing needs and specifying the highest priorities for additional community-based palliative care services would enable governments to target funding to areas where it would have the greatest effect on end-of-life care outcomes.

In addition to assessing the need for more community-based palliative care services in particular locations, State and Territory Governments should consider the diverse needs of different members of the community.

- Leading Age Services Australia (sub. DR512, p. 4) pointed out that ‘any identification of gaps should pay attention to the diversity of Australia’s community to determine whether groups exist in the community whose cultural, religious or way-of-life needs are unlikely to be met by mainstream services’.
- Alzheimer’s Australia (sub. 431, p. 14) noted that ‘all providers of palliative care should be required and supported to ensure that their services are dementia-friendly’. A large proportion of people approaching the end of life have dementia or other cognitive impairments.
- Some participants emphasised the particular needs of Indigenous Australians, many of whom place cultural and spiritual significance on ‘returning to country’ at the end of their lives (Cancer Council NSW, sub. DR537; National Congress of Australia’s First People, sub. DR565; Palliative Care Australia, sub. DR500). The Northern Territory Government anticipates that palliative care ‘on country’ will be an area of service growth as the Aboriginal population in the Northern Territory ages (sub. DR593).
- Christy Pirone, Margaret Brown, Dr Chris Moy and Dr Christine Drummond (sub. DR559, p. 3) drew attention to the needs of people approaching the end of life who have a disability. For example, people with intellectual disability living in community group homes can struggle to obtain end-of-life care in those homes, as staff typically lack the knowledge and skills necessary to care for the dying (Wiese et al. 2012).
- Paediatric palliative care patients have different needs to those of adults, and their parents also need support in their roles as care-givers and proxy decision makers (RACP, sub. 473).

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Drawing on the experience and expertise of service providers, service users and the organisations that represent them will be an essential component of a comprehensive needs analysis. Bringing this experience and expertise into the process of service design gives stakeholders opportunities to influence program design and the development of outcome measures that will be used to determine success, and to assist governments in assessing the costs of providing effective services. The involvement of local service users and providers is consistent with the experience of commissioning in England, which has shown that ‘fundamental to any commissioning plan for end-of-life care is a local strategy, jointly developed with local people and key partners, clearly setting out your vision for end-of-life care’ (NHS England 2016, p. 12). In this regard, user-focused information on the needs assessment process, such as the *10 Questions to ensure good end of life care in your area* publication available in the United Kingdom (NCPC 2013), could prove useful.

## Designing services to meet demand

The objective of the design stage of the commissioning process is to develop and implement systems of service provision that will contribute to meeting the needs identified during the needs assessment. The substantial increase in services likely to be needed across Australia will require careful stewardship, planning and implementation. Workforce and provider availability may limit the speed at which services could be expanded. However, experience suggests that change is possible within a reasonable time frame. For example, a large increase in service availability was recently achieved in Tasmania — the hospice@HOME program cared for over 2000 people between its establishment in December 2014 and June 2016, servicing people for whom community-based end-of-life care was previously unavailable (The District Nurses 2017, p. 9).

Participants highlighted the need to ensure that service delivery models are designed for different geographic areas. In metropolitan areas, this could involve commissioning multiple providers of community-based palliative care services. Were this to be the case, State and Territory Governments would need to determine if people should have choice between providers, and if so, how to enable that choice. The Commission considers that, where feasible, offering service users choice of provider should be the long-term goal of government and increases in service availability should be designed with this in mind. However, initial priority needs to be given to ensuring the wider availability of high-quality end-of-life care services which place users’ interests at the centre of delivery.

The Commission also recognises that choice will not be possible in all areas. For example, in regional areas, options may be more limited if there is not the population base to support more than one service provider. Remote service provision may be possible for some users and for some (but not all) services. For example, the National Rural Health Alliance said:

The need for access to good telehealth and ongoing access to appropriate specialist care is also important to ensure people approaching the end of life are able to remain in their community with the appropriate care and support for themselves and their carers. (sub. 428, p. 12)

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Remote service delivery models such as telehealth have been demonstrated to help patients ‘to feel supported and remain in their place of residence, hence reducing the pressure for avoidable hospital admissions and use of other services’ (Middleton-Green et al. 2016, p. 1).

### Building on existing person-centred services

People approach the end of their lives with different illnesses, different preferences and different levels of family and community support, which leads to a wide degree of variation in end-of-life care needs. Further, as noted in chapter 3, end-of-life care can encompass a broad range of services delivered by public and private providers, including advice and coordination of care, nursing and personal care, 24 hour hotlines, day hospice respite, emotional and practical support, and access to equipment (LSIC 2016). It also includes services for families and carers, such as bereavement support.

While community-based palliative care providers can, and should, respond to the urgent and diverse needs of their patients in a flexible way, it is also important to ensure that government-funded providers limit their service offerings to those that are clinically necessary or that are essential for peace and wellbeing at the end of life. This would include nursing and medical care and the provision of equipment.

State and Territory Governments should establish standards for community-based palliative care services and fund the provision of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care.

Other important service specifications for community-based palliative care could include:

- providing access to necessary equipment
- working with patients to smooth transitions between different settings of care (both before their discharge from hospital to community-based care and, should their care needs or preferences change, prior to their admission to hospital or hospice)
- helping patients (and their families and carers) to plan their care needs and preferences, including by providing education about the circumstances a dying person will face and services that they are likely to require
- integrating with other health care services, including specialist palliative care and allied health providers
- services for families and carers, such as bereavement support
- maintaining records and collecting data on the cost, quantity and quality of services provided.

Users should continue to be able to purchase additional services if they wish to do so.

Within these broad parameters, and subject to appropriate consumer safeguards, providers should then be responsible for delivering care that meets the needs of individual clients. This

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could look very different for different people. Some will require regular assistance to cope with increasing pain and nausea, while others will be in less physical pain but greater distress about their relationships with loved ones. The palliative care provider would be expected to provide more nursing care to the former, and counselling to the latter.

Dozens of community-based palliative care providers across Australia already deliver services that meet this description using a range of different models. At the same time, governments need to ensure that all providers are delivering the specified standard of care as defined by those governments. The details of service agreements between State and Territory Governments and providers are not published, so the Commission has not been able to assess the extent to which those arrangements would provide a good starting point for the expansion of community-based palliative care.

### Determining eligibility for services

Several criteria are already used to determine eligibility for existing community-based palliative care services. Most rely on the judgments made by treating doctors, typically involving an assessment that the person is likely to die within the next 12 months. In 2016, hospitals were the source of about two-thirds of referrals to community-based palliative care, with most of the remaining referrals coming from GPs (PCOC 2016). This reliance on clinical assessment is appropriate as end-of-life trajectories are inherently uncertain, and determining when a person would benefit from end-of-life care requires medical skill and judgment. Doctors also need support and guidance in making those judgments, as well as training in initiating conversations about end-of-life care (box 4.1).

As it currently stands, people who have been judged as needing end-of-life care are sometimes turned away by community-based palliative care providers who lack funding (or, in the case of hospices, beds) to care for everyone who is eligible. These people are then left to seek care elsewhere, typically in a hospital or residential aged care facility. This situation will continue until there are enough community-based palliative care services available to meet demand.

Although rates of death from cancer and from chronic illnesses other than cancer are fairly consistent across jurisdictions, the share of palliative care patients with a non-cancer diagnosis varies a lot between jurisdictions. There appears to be limited rationale for this variation, and so it will be important to ensure that eligibility criteria to access community-based palliative care services are not biased against those who currently miss out on palliative care.

It will also be important to ensure that palliative care services remain focused on meeting the needs of those approaching the end of life. If the duration of care extends beyond the last 12 months of life, it will necessarily cost more to provide. There is therefore a need to monitor that palliative care service providers deliver their services to those with a diagnosis that clearly indicates their need for end-of-life care. Tracking the mean and median duration of care provision, as well as variance around those measures, may be useful in this regard.

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The Commission considers that community-based palliative care services should be open to any individual with an end-of-life diagnosis where it is both consistent with the individual's preferences and their clinical condition. While governments should plan to meet demand for care, it is unrealistic to expect services to be offered everywhere in the short term. Governments therefore need to plan so that, where services are constrained, provision of community-based palliative care is appropriately managed.

### Designing palliative care services that are well integrated with other services

While good end-of-life care will be different for each individual, a consistently important factor is that it is provided in an integrated manner. From a user's perspective, 'an individual receiving palliative care should experience that care as a single service regardless of how it is administered' (PCA and PCOC, sub. 417, p. 1), or whether it is provided in hospital, aged care or the community. A range of different models could be used to deliver integrated care (box 4.4).

### Selecting and funding providers of community-based palliative care

Once palliative care needs have been assessed and service models designed to meet those needs, State and Territory Governments should consider the most suitable approach to selecting service providers.

In general, the preferred approach should be to run competitive processes, such as tenders, to select providers for the additional community-based palliative care services. In some regional and remote areas, a lack of suitable potential bidders will require governments to provide services directly or nominate an existing supplier. The Mallee Track Health & Community Service (sub. DR499, p. 4) noted that existing multipurpose services (which deliver integrated health and aged care services for some small regional and remote communities) could provide 'a ready platform to achieve a holistic, wrap around, [end-of-life care] service in rural and remote areas'.

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#### Box 4.4      **Toward better integrated care**

Integrated care coordinates the actions of the multiple actors that affect a person's health and care needs. This type of care is particularly important for people at the end of life because:

... regardless of previously expressed choices or preferences people approaching or reaching the end of life will continue to require access to a range of home-based, community and hospital services. (Little Company of Mary Health Care, sub. DR547, p. 6)

Christy Pirone, Margaret Brown, Dr Chris Moy and Dr Christine Drummond said that:

Even where there is access to highly skilled palliative care providers, the plan of care to support a person who wishes to die at home can fail due to a lack of coordination in person-centred planning and resources across health sectors. (sub. DR559, p. 1)

There are many potential ways to improve the integration of end-of-life care across settings.

- Palliative Care Australia suggested that Primary Health Networks could play in role in facilitating integrated care, 'particularly referral between general practice and specialist services' (sub. DR500, p. 1).
- The Royal Australasian College of Physicians considered that 'a designated Navigator to advise and guide the integration of services for particular patients' (sub. 473, p. 9) would be beneficial.
- Hobart District Nursing Service said that it achieved integrated care by commencing the package of care before the recipient leaves an acute care facility (sub. 419, p. 3).
- Case conferences that promote integrated care among medical specialists and GPs have been shown to reduce the cost of hospitalisations for patients receiving end-of-life care (Hollingworth et al. 2016). Case conferencing can also reduce hospitalisations and slow functional decline in patients receiving specialist palliative care (Abernethy et al. 2013).
- The Bushland Health Group employs a nurse practitioner to integrate palliative care into the its residential aged care facilities. This model of care recently won a National Innovation and Excellence in Aged Care award from the Australian Aged Care Quality Agency (AACQA 2017).

Each of these methods could contribute to ensuring that people approaching the end of life can access the services they need as those needs change. The relative merits of different methods of delivering integrated care will depend on the models of care delivered by community-based palliative care providers in different regions.

Improving the integration of care is important not just for those approaching the end-of-life, but also for the health system more broadly. Designing and implementing integrated patient-centred care throughout the health care system will require several changes to structures and funding arrangements to improve coordination of care (PC 2017d).

#### Selecting the service provider

Contestability can have a range of potential benefits in human services (chapter 1), and could also have benefits for community-based palliative care services. Indeed, community-based palliative care is ideally suited to this type of contestable approach, as there are no substantial barriers preventing a provider that is not currently supplying services to users from doing so now or in the future. This was recently demonstrated in Tasmania where, until recently, substantial increases in the availability of community-based palliative care had been

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achieved. Similarly, HammondCare pointed to the Palliative Care Home Support Program in New South Wales, which demonstrates that:

... competitive processes to select providers with expertise in [end-of-life care] — either individually or through consortium arrangements — can produce significantly improved outcomes for patients and their families. (sub. DR515, p. 1)

Approaching the market to provide additional community-based palliative care services would not require State and Territory Governments to make changes to existing service arrangements — Governments could choose to leave current services in place while adding to the service offering. This approach was supported by the Victorian Healthcare Association (sub. DR531) and Cancer Council NSW (sub. DR537, p. 3), which suggested that ‘the focus should be on strengthening what is already on offer, including specialist palliative care services, to meet community needs’.

Existing service providers could:

- tender to increase the availability of services so more people could access care
- tender to provide services in additional locations
- act as a ‘prime provider’ and subcontract to others.

Providers of other related services, such as aged care and community health, could also seek to enter the palliative care market.

The process used to choose providers (or to assess the capacity of a lone applicant to provide the desired services) should focus on whether providers will be able to meet the expected needs of their clients. Several inquiry participants suggested that competitive tendering arrangements do not always lead to the selection of providers who can best meet clients’ needs, instead tending to disadvantage small providers. For example, Little Haven Palliative Care said:

... competitive tender processes advantage larger scale providers with capacity to deliver services on a national basis. Having the administrative support and a greater understanding of the tender process they may present very well on paper. Smaller organisations can be disadvantaged in the process. This happened in Metro North Hospital and Health Service District. Karuna Hospice (a very highly regarded and compassionate service) which had served Queensland Health and the Windsor community so well, was unsuccessful, with the tender awarded to a national provider, who at the time had no presence in Queensland ... (sub. DR579, p. 1)

The Audit Office of New South Wales suggested that the expression of interest process used to allocate funding for palliative care in that State does not result in funding being directed to the areas where needs are greatest, but rather to the health services that have the greatest skill writing expressions of interest (AONSW 2017). This concern is similar to those described by participants in family and community services (chapter 8) and services in remote Indigenous communities (chapter 9).

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To address this, governments need to design selection criteria that focus on the ability of service providers to improve outcomes for service users and not discriminate on the basis of organisational type or service model, nor should it disadvantage providers who are seeking to enter the market. Governments also need to allow sufficient time for providers to prepare considered responses to tenders, and enter into contracts that reflect the length of the period required to achieve the agreed outcomes (which will mean longer contracts in many cases). Further details on designing tendering arrangements that are less prescriptive and that incorporate more flexibility are provided in chapters 2 and 8.

## Funding

The funding required to provide additional community-based palliative care will depend on the extent of unmet demand, which should be assessed, as noted above.

The available evidence suggests that the cost to governments of providing community-based palliative care can be in the order of \$6000 to \$10 000 per person (box 4.5). This implies that providing additional places for, say, 10 per cent of the people who die each year (16 000 places) would cost governments about \$160 million per year.

Community-based palliative care is currently provided at no cost to the user. The Commission's view is that this should continue for basic services, at least into the medium term, but that this arrangement should be reviewed as part of the 2025 review of end-of-life care services (recommendation 4.5). Complementary services such as 'massage, aromatherapy, relaxation, meditation, acupuncture, or art and music therapy' (CareSearch 2017a) should continue to be funded by the user.

Expanding the availability of services will impose a direct cost on government. These direct costs need to be considered against the potential for avoided hospital costs. The Commission's view is that funding an increase in community-based palliative care is likely to be cost effective for government, as home-based care can cost less (sometimes much less) than its hospital-based alternative. The available evidence suggests that average admission for palliative care in a sub-acute hospital can cost almost \$11 000 (box 4.5). Thus, avoiding one hospital admission could cover the cost of an individual's community-based palliative care over a period of months (assuming it costs about \$10 000), as well as better meeting the preferences of people approaching the end of life. However, the net cost to State and Territory Governments of increasing the availability of community-based palliative care will ultimately depend (among other things) on the extent of unmet demand, which is currently unknown.

While there are potential savings for governments from having fewer hospital admissions, providing more people with access to high-quality community-based palliative care should be the primary driver of reform.

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**Box 4.5      Community-based palliative care would better meet users' needs and could cost less than its hospital equivalent*****Community-based palliative care***

The Commission examined the financial and annual reports of 12 not-for-profit providers of community-based palliative care (which were required by the Australian Charities and Not-for-profits Commission to publish information about their finances and activities). Across these organisations, the average total cost of providing community-based palliative care ranged between \$6000 and \$10 000 per person, with a mean of just under \$8000. This provided an average of between 40 and 100 hours of care, delivered over a period of days up to several months. These cost estimates do not include the contribution of volunteers, whose assistance in non-clinical roles is critical to the successful operation of many, if not most, community-based palliative care providers.

***Palliative care in hospitals***

The Independent Hospital Pricing Authority (IHPA) reported that the average cost per palliative care separation in sub-acute care was \$10 750 in 2014-15, with some patients visiting hospital multiple times in the weeks and months leading up to death (IHPA 2017). Similar costs were found in a recent database study, using data from the Department of Veterans' Affairs, of 20 000 hospital episodes ending in death. The study found the mean total cost per separation was \$10 800 if the patient was in a designated palliative care bed (about one-third of patients in the study) or \$16 200 for those with no recorded palliative care access (Ireland 2017, p. 549).

***Care at home could cost less***

Participants agreed that community-based palliative care services cost less than their hospital equivalents. For example, Little Haven Palliative Care said that it:

... is caring for 78 palliative patients in the community at an approximate cost to [Queensland Health] of \$700/day (Total – not per patient). Should just one of these patients not have access to community-based palliative support and end up in hospital the cost would be upwards of \$1600/day. (sub. 458, p. 1)

The District Nurses said that the average cost of one of their hospice@HOME packages is \$39-\$78 per day, compared to an acute care admission of \$1500-\$1600 per day (trans., p. 303). Analysis by the Silver Chain Group (sub. 176) found that each dollar invested in extending home-based palliative care services in New South Wales would free up \$1.44 of expenditure on inpatient bed capacity at metropolitan hospitals.

Taken together, all of these sources of information suggest that reducing the proportion of people who die in hospital, and supporting more people to die at home or to stay at home for longer, would not lead to an increase in costs, and may be less expensive. It would also help people to avoid the stress and disruption of hospital admissions, which can be substantial.

This was the view of the Grattan Institute, which found that the costs of supporting individuals to die at home are lower than hospital and residential care, and that overall savings could be achieved if hospital and residential care were replaced by community-based services (Swerissen and Duckett 2014, p. 21).

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## Monitoring and evaluation of community-based palliative care services

### Consumer safeguards

When governments engage community-based palliative care providers to deliver end-of-life care, they must also put safeguards in place to ensure that those providers deliver high-quality care. Safeguards are particularly important in end-of-life care, given the vulnerability of users, the time-critical nature of their care needs and the stress that an end-of-life diagnosis entails for users, their families and carers. As LASA said:

Peoples' vulnerability and the medications required to be kept in the household make strong safeguards and oversight essential for all community palliative care services ... (sub. DR512, p. 5)

The design of appropriate safeguards depends on the risks that are being guarded against. In community-based palliative care, a critical risk is that the service provider may not respond to urgent care needs in the correct manner (for example, by failing to provide necessary medications, to answer an after-hours phone line or to respond to patient concerns in a timely manner). There is a need to ensure that quality care continues to be provided, and that oversight is maintained, as the volume of services provided increases.

To address risks to the safety and quality of care, many health services are required to meet the NSQHS Standards. Independent accreditation agencies monitor these health services to ensure that they deliver safe and high-quality care in accordance with the NSQHS Standards. The accreditation agencies provide data on the outcomes of their assessments to State and Territory Governments so that Governments can support health service improvement and respond to emerging issues. Community-based palliative care services in several jurisdictions are already accredited under this system. This approach should be considered by other State and Territory Governments. Governments will also be in a better position to directly monitor the quality of care provided by community-based palliative care services as more data on those services become available (section 4.5).

In addition to the safeguards provided through accreditation, there is a health care complaints commissioner or health ombudsman in each State and Territory who is able to respond to concerns about the quality of health care, including complaints about community-based palliative care. To the extent that health care complaints commissioners and ombudsmen are fulfilling this role, there is limited rationale for setting up a dedicated complaints system for community-based palliative care.

More critically, if people who are receiving community-based palliative care have urgent unaddressed care needs, the rest of the health system remains available. People in community care settings can access the broader health system through their general practitioner (GP) (or after hours GP), the ambulance service or through a hospital admission. These alternatives provide an important backstop and an assurance that people who need care will receive it.

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## How should the outcomes of the new services be assessed?

Governments should develop and apply performance frameworks for the provision of community-based palliative care that are focused on service users and outcomes. A key objective for these services is to allow people who want to die at home to do so. Possible metrics include the number and proportion of deaths that occur at home with the support of community-based palliative care (as opposed to unplanned deaths at home). But these should not be the only measures of success. For example, helping people to stay at home for longer should also be counted as a measure of success for the service. This is true regardless of whether people spend the last few days of life, when pain and care needs can be greatest, being cared for in a setting that better meets those care needs, such as a hospital or hospice. Measuring the number and proportion of people who receive most of their care at home (over, say, the last 100 days of life (AONSW 2017)) would therefore be useful. This was emphasised by the Centre for Health Economics Research and Evaluation at the University of Technology Sydney, which said:

... we have concerns about death at home being perceived as necessarily the most desirable outcome, embedding incentives in program designs for service providers to encourage informal carers to continue providing care at home when this may not be in the interest of either the carer or the patient. (sub. DR516, p. 4)

MND Australia said that:

... for some people the preference is to remain in their residence of choice for as long as possible but to die in hospital. This could be for a variety of reasons such as the needs and preferences of their carer or the availability of specialist support to address complex symptoms. (sub. DR513, p. 3)

Quality of services also matters. Information which provides insights into users' experiences of the service would also be desirable, and better data are needed in order to track progress against outcome measures. Many of these measures will require data to be collected where it currently is not, and would need to be done in a way that does not unreasonably impose on the person being cared for or their loved ones. Strategies for enhancing data on end-of-life care are considered in section 4.5.

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#### RECOMMENDATION 4.1

State and Territory Governments should increase the availability of community-based palliative care so that people with a preference to die at home can access support to do so. To achieve this, State and Territory Governments should:

- assess the need for additional community-based palliative care services
- design services to address identified gaps in service provision
- establish standards for community-based palliative care services and fund the provision of those services for people who wish to and are able to die at home. The standards should include integrated and coordinated nursing, medical and personal care
- 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 against the specified standards
- ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.

### 4.3 Supporting end-of-life care in residential aged care

About half the people who need end-of-life care each year receive that care, and die, in a RACF. Despite this, governments and aged care service providers rarely acknowledge that end-of-life care is core business for aged care, and many residential aged care services struggle to meet the end-of-life care needs of their residents (chapter 3).

A review of the aged care system was completed on 1 August 2017. Access to palliative or end-of-life care was ‘raised numerous times by consumers, carers and providers’ during the review, but it was not considered by the reviewers as it ‘does not align specifically with the terms of reference’ (Department of Health 2017h). This narrow focus misses the core role residential aged care plays at the end of life for its clients.

Improving the effectiveness of end-of-life care service provision for residents of aged care facilities, irrespective of any other changes that may occur in the broader aged care system, should be a key focus for further reform. In order for older Australians, particularly those residing in RACFs, to receive end-of-life care that aligns with the quality of care available to other Australians, two main reforms are needed. They are:

- providing residents with greater access to services delivered by clinically qualified staff
- helping consumers to select RACFs that deliver high-quality end-of-life care.

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## Improving end-of-life care in residential aged care

Residents of aged care facilities need to be provided with greater access to services delivered by clinically qualified staff. Achieving this will involve the Australian Government:

- removing funding restrictions that unnecessarily limit the duration of palliative care in RACFs and its availability to residents who have pre-existing high health care needs
- providing sufficient funding for this additional clinical care
- ensuring that residential aged care providers are accountable for the increased funding and that is used to meet or exceed the standard of end-of-life care specified by government.

Many inquiry participants supported this reform direction (AASW, sub. DR557; ACSA, sub. DR541; AHHA, sub. DR561; AHPA, sub. DR496; Benetas, sub. DR543; CHA, sub. DR567; City of Whittlesea, sub. DR519; LASA, sub. DR512; Little Company of Mary Health Care, sub. DR547; OCAV, sub. DR501; Palliative Care Australia, sub. DR500; Queensland Government, sub. DR592; RACP, sub. DR580; Silver Chain, sub. DR509; UnitingCare Australia, sub. DR514; VHA, sub. DR531).

## Delivering adequate resourcing for palliative care in residential aged care

Several participants suggested that the aged care funding instrument (ACFI) (chapter 3) needs to be changed to address the longstanding and widespread concerns about poor quality end-of-life care in RACFs.

The funding arrangements for home care and residential aged care should recognise palliative care as an intensive service provision activity that requires an appropriate level of funding to ensure the provision of quality palliative care services. (ACSA, sub. 411, p. 5)

LASA suggested that a separate payment for palliative care ‘would enable residential care facilities to purchase more and better end-of-life services and expertise for [their] residents’ (sub. DR512, p. 6).

Making intensive nursing and other palliative care services available only in the last week or days of life does not align with users’ needs nor with the way in which the health system considers, or aims to consider, end-of-life care (the last 12 months of life). Nor does it accord with what is known about the trajectories of decline for those with dementia, who comprise more than two thirds of aged care residents.

To address this unwarranted discrepancy, the Commission considers that the Australian Government should properly resource RACFs to provide palliative care to all residents for a longer period of time, including to residents who already have pre-existing high health care needs. Restrictions in the ACFI that unreasonably limit the duration of palliative care in RACFs and its availability to residents who have pre-existing high health care needs should be removed.

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The Commission reached a very similar conclusion in its 2011 report on *Caring for Older Australians*, finding that palliative care should be funded such that equivalent levels of care can be provided across settings of care, and that the Australian Government should ‘ensure that residential and community care providers receive appropriate payments for delivering palliative and end-of-life care’ (PC 2011a, p. 234). These types of funding are still not available.

While there is a need to remove barriers to accessing specialist palliative care services (box 4.6), the large majority of those who die each year, including those who die in residential aged care, do not require ongoing support from a specialist palliative care service. They simply require skilled care delivered in the RACF that is their home. As such, end-of-life care is core business for the aged care system, and the Australian Government, as steward of the aged care system, is responsible for ensuring that people in the aged care system receive end-of-life care that aligns with the quality of care available to other Australians.

**Box 4.6      Removing barriers to accessing specialist palliative care services**

Participants (including Good Shepherd Australia New Zealand, sub. DR517; HammondCare, sub. 409) suggested that people living in residential aged care facilities may not, in practice, be able to access specialist palliative care services if and when they need to do so. For example, LASA said:

The delivery of specialist palliative care services varies across jurisdictions, where often, especially in residential services, access to specialist palliative care professionals can be very limited. There is often a misunderstanding that people residing in residential services are not eligible to receive state based services such as specialist care. This misconception needs to change. (sub. 463, p. 6)

The limited focus on residents of aged care facilities in most states’ and territories’ end-of-life or palliative care plans reinforces this misconception. Palliative Care Australia said:

Older Australians residing in Residential Aged Care Facilities should be provided equity of access to specialist palliative care if needed, in the same way that those services are available to other Australians. (PCA 2016a, p. 7)

The Commission agrees that people living in a residential aged care facility who require specialist palliative care should have the same access to it as those in the broader community. Where there are misconceptions about eligibility for services, the Australian, State and Territory Governments should work together to address them with hospitals, specialist palliative care services and residential aged care facilities.

Improvements to end-of-life care for close to 60 000 people who die in residential aged care each year (or who would have preferred to die there but are transferred to hospital due to lack of skilled care) can and should occur regardless of any issues that may exist in access to specialist palliative care. In doing this, the Australian Government Department of Health and the AACQA should consult with the Independent Hospital Pricing Authority about appropriate funding benchmarks. These could include, for example, the cost of providing palliative care in sub-acute care services. This will help to ensure that aged care funding is

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sufficient for people in the residential aged care system to receive end-of-life care that aligns with the quality of care available to other Australians.

### Ensuring that additional funding results in better end-of-life care

Removing the unnecessary limitations on the duration and availability of palliative care in RACFs will only be effective at improving end-of-life care if it is accompanied by sufficient additional funding. The magnitude of funding required will depend on the extent of unmet need, which is currently unknown.

There is a range of ways in which residential aged care providers could use the additional funding to provide end-of-life care for their residents that meets the standard set by government and aligns with the quality of care available to other Australians. Potential strategies could include, for example, purchasing the services of skilled staff from community-based palliative care providers, or employing additional skilled staff themselves. Subject to standards being met, this should be a decision for the individual provider.

#### *Expert service providers or additional skilled staff*

Hospital- and community-based palliative care providers deliver end-of-life care in many parts of Australia. In those places, residential aged care providers could choose to engage their expertise in improving end-of-life care for residents. Many of the considerations discussed in section 4.2 would then be relevant for the aged care provider in engaging such services.

Alternatively, residential aged care providers could employ nurses or nurse practitioners whose role would be to lead and coordinate end-of-life care in the RACF. This could be similar to the system suggested by the RACP, which recommended that the Commission consider ‘the Scandinavian model which assigns on-site practitioners or senior nurses to attend to simple cases to avoid unnecessary hospitalisation’ (sub. 473, p. 9). The nurses or nurse practitioners could coordinate care for residents approaching the end-of-life and facilitate advance care planning (including conducting advance care planning discussions with residents, families and carers). Nurse practitioners could also prescribe certain medications (within the nurse practitioner scope of practice).

Nurses or nurse practitioners could also train and support other staff in the RACF to deliver higher quality end-of-life care. Many RACF staff are untrained in aged care or end-of-life care, and many of those who are trained received training of poor quality (ASQA 2013). There is therefore a role for nurses or nurse practitioners in providing training to their colleagues, with a focus on the immediate needs of particular residents.

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Inquiry participants agreed that nurses are well placed to lead and coordinate end-of-life care in RACFs. For example, Baptist Care Australia and Churches Housing said:

Ideally, one or two senior nurses in each facility would have responsibility for local expertise in palliative care. At the same time, the other care staff need training to support palliative care, and staffing models need to address the changing needs of larger cohorts entering the end of life stage. (sub. DR532, p. 5)

Push for Palliative described an ‘excellent approach to providing expert care in RACFs’ that ‘reduced transfers to hospital by two thirds in its first year of operation’ (sub. DR538, p. 3). In this model:

... RACFs are visited by a palliative specialist nurse at least once a week. The specialist palliative care nurse spends up to eight hours in each facility, seeing patients, meeting relatives, having discussions, making clinical recommendations, up-skilling staff in capacity and confidence, liaising with GPs and ensuring that the necessary medications are on hand. Advice is available 24/7. (sub. DR538, p. 3)

Transition toward a more widespread presence of nurses and nurse practitioners in RACFs would take time. Several participants — including Aged Care Crisis (sub. DR525), the Combined Pensioners and Superannuants Association (sub. DR542), Little Company of Mary Health Care (sub. DR547), Graham McPherson (sub. DR492) and Push for Palliative (sub. DR538) — considered that increased presence of nurses in RACFs should be hastened through regulation, such as the introduction of nurse–resident ratios or requirement for a registered nurse to be present in a RACF at all times.

However, the Commission’s support for a more widespread presence of nurses and nurse practitioners in RACFs to lead and coordinate end-of-life care is not an endorsement of broader arguments to increase the stringency of requirements for nursing care in RACFs. The Commission remains of the view that mandatory staffing ratios are unlikely to be an efficient way to improve the quality of care in aged care (PC 2011a). The absence of ratios and nurse presence requirements within RACFs allows them to staff flexibly in response to residents’ changing needs, and gives them an incentive to invest in innovative models of care or adopt new technologies that could assist care recipients. Imposing ratios or nurse presence requirements would also be at odds with principles of good stewardship (chapter 2), which require governments to focus on outcomes for users, rather than to prescribe processes or inputs.

### *Coordination with primary care*

While many GPs provide care to residents of RACFs and some RACFs even have onsite GPs, accessing GP care remains a problem for many. After hours care, in particular, can be lacking. This is why the Commission is not recommending relying solely on GPs to deliver improvements in end-of-life care for residents of aged care facilities.

The need to improve primary care in aged care is well known, and aged care is one of the six key priority areas for the Primary Health Networks (PHNs). PHNs are already delivering

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a range of initiatives in this domain. For example, Sydney North PHN is testing a range of approaches to supporting end-of-life care in RACFs, with a view to reducing unplanned hospitalisations of older people in residential aged care (Sydney North PHN 2016). Broader efforts to improve the integration of care (box 4.4) will also assist in improving primary care for residents of aged care facilities.

### *Consumer safeguards*

The aged care system already has a range of consumer safeguards in place.

- The AACQA accredits Australian Government-subsidised aged care homes and provides compliance monitoring, information and training to providers.
- Since 1 January 2016, the Aged Care Complaints Commissioner has operated as an independent statutory office holder. The office of the Aged Care Complaints Commissioner provides an avenue for anyone to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government.
- The Older Persons Advocacy Network supports consumers and their families to raise concerns about aged care services and systems (OPAN 2017).

It is important that governments ensure that these consumer protections are effective. While the standards required of aged care providers are broadly worded (chapter 3), the AACQA conducts both scheduled and unannounced visits to RACFs to ensure that they are complying with them. It can and does issue sanctions and reduce accreditation periods in order to improve the quality of care at facilities that are found to be delivering substandard care. The effectiveness of these quality assurance arrangements was recently examined as part of an independent review of national aged care quality regulatory processes which has not yet been published (Department of Health 2017n).

A range of other measures are underway to provide more detail about the quality of end-of-life care that RACFs are expected to deliver. In particular, the palliAGED website was launched in May 2017, and is a source of online evidence-based guidance and knowledge for palliative care in aged care. Six peak bodies have also endorsed guiding principles on the delivery of palliative and end-of-life care services in residential aged care (PCA 2017a). Together with any related recommendations from the independent review of national aged care quality regulatory processes, and the Commission's recommendation to make palliative care available to all residents who require it, these are likely to drive improvements in end-of-life care in aged care.

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#### RECOMMENDATION 4.2

End-of-life care should be core business for aged care facilities, and the quality of end-of-life care in residential aged care should align with the quality of that available to other Australians. To achieve this the Australian Government should:

- remove current restrictions on the duration and availability of palliative care funding in residential aged care
- provide sufficient funding for this additional clinical care.

### **Helping consumers to select residential aged care facilities that deliver high-quality end-of-life care**

Information on the quality of aged care remains hard for consumers to access

There are significant challenges in providing effective information for aged care clients. People turn to aged care services when they are experiencing an increase in their frailty and, for many, a reduction in their cognitive capacity. Information about aged care options typically needs to be obtained and understood in stressful circumstances, such as during recovery from an acute health episode or following the loss of support from a spouse or family carer. Decisions can be prompted by crises, and made when the person is vulnerable (PC 2015c). This makes it a particularly difficult time for aged care consumers and their families to consider their end-of-life care needs.

Unless consumers have easy access to information about the quality of care that they can expect to receive in the RACFs they are considering, they cannot select the RACF that best aligns with their care needs and preferences, including those for end-of-life care. This gives aged care providers little incentive to deliver the types of care that consumers value, and to make improvements in that care. In this respect, end-of-life care differs from many of the other services that users receive, and in some cases pay extra for, in residential aged care.




Two main changes are needed to address this gap in information. First, the Australian Government should specify and clearly communicate the standard of end-of-life care that aged care providers are expected to deliver. This standard of care needs to be clear and understandable, not just to aged care providers but also to residents.

Second, consumers need more information about the ways in which RACFs meet or exceed the standard set by the Australian Government for end-of-life care in residential aged care. Despite the recent and ongoing aged care reforms, there has been only limited progress in providing aged care recipients with information on variations in the quality of care, including the quality of end-of-life care.

- The Australian Government provides information on the system, and data for consumers through the MyAgedCare website, including a searchable list of RACFs around Australia.

- The Australian Aged Care Quality Agency (AACQA) publishes detailed accreditation reports that outline the agency’s assessment of the quality of care in each RACF. These include consideration of palliative care, but this information is not nearly as easy to find as it could be and is sometimes presented in a misleading fashion. For example, myagedcare.gov.au does not link to AACQA reports and uses the same ‘big tick’ symbol to denote facilities that are accredited and those that are currently being sanctioned for failing to meet the standards (figure 4.1).

Figure 4.1 **Information shown on *My Aged Care* about a residential aged care facility that does not provide appropriate clinical care or behavioural management**

 Accredited	✓
Accreditation period	1 Year
Certified	✓
Commonwealth Government subsidised	✓
 Current Sanctions	✓
 Current Notice of non compliance	✓
Availability	✓

Source: Australian Government (2017c).

This contrasts with the system operating in the United States, which has a ‘Nursing home compare’ website that includes a user-friendly star rating system — based on health, staffing and quality benchmarks — of registered nursing homes. Research in the Netherlands found that ‘an internet report card can be a useful tool for current and future consumers to assess the quality of nursing home care, and thus support their decision-making process regarding the choice of a nursing home’ (Van Nie, Hollands and Hamers 2010, p. 342). While the extent to which nursing home report cards and other similar rating systems are actually used by consumers to make decisions about care has yet to be definitively established, it is nevertheless in the interests of consumers to publish such information because of its potential to encourage provider self-improvement.

... and people can be reluctant to consider end-of-life care needs

The negative effects of the absence of information about expected standard of care in, and the quality of, residential aged care are compounded by a general reluctance to consider that

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a move to residential aged care will be the last stage of life. As Palliative Care Australia put it:

... there is an unwillingness in the community to openly acknowledge that most people in residential care will be there until the end of their life. Legislation and policy are also silent on this matter. Consequently, when choosing a service the potential palliative care needs of the resident may not be given sufficient attention. (PCA 2016a, p. 4)

Increased efforts to promote and normalise advance care planning (section 4.4) may help to reduce this reluctance.

When selecting a RACF, consumers are also effectively making a choice about the type and quality of end-of-life care they will receive, although they (and their families) may be reluctant to recognise this. Some resources are available to support choice, such as a guide titled *10 Questions to Ask About Palliative Care in Residential Aged Care* (Combined Pensioners and Superannuants Association, sub. DR542). However, it is notable that government publications designed to guide consumer choice of a RACF do not mention end-of-life care. For example, *Five Steps to Entry into an Aged Care Home* (Department of Health 2016a) suggests eleven questions for consumers to consider when choosing an aged care home, but makes no mention of end-of-life and palliative care (or even that people's care needs will change and increase over time). Similarly, the *Aged Care Roadmap* (Aged Care Sector Committee 2016) is notable for its focus on making dementia care core business throughout the aged care system, without any mention of end-of-life care or palliative care.

A good first step would be for the Australian Government to ensure that all of its aged care publications — both for consumers and policy makers — explicitly acknowledge that one of the roles of residential aged care is to provide end-of-life care.

## 4.4 Advance care planning

Increasing the uptake of high-quality advance care plans (ACPs) — that is, a plan that is developed after conversations with family members, generally with the support of a trained clinician (box 3.5) — is a vital component of putting users' needs and choices at the heart of end-of-life care services.

Having conversations about end-of-life care and preparing an ACP should be routine for people with life-limiting illness. This is true despite ongoing interjurisdictional variation in legal frameworks for advance care planning, particularly those surrounding advance directives (AHMAC 2011). Uncertainty or lack of knowledge about the applicable laws is not sufficient justification to hold back on efforts to promote, and thus to forgo the benefits of, advance care planning.

There was broad agreement among inquiry participants (including Cabrini Palliative Care, sub. PFR343; HammondCare, sub. 407; LASA, sub. 463) and in the research literature (for example, Carter et al. 2016; Detering et al. 2010; Rhee, Zwar and Kemp 2012; Scott et

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al. 2013) that a high-quality ACP is a key component of effective end-of-life care for people who would otherwise be unable to make their wishes known. Several studies and reports echoed these sentiments, while noting that competent and conversant patients can always speak for themselves, and should be supported to do so wherever possible.

While inquiry participants agreed on the importance of advance care planning, they expressed differing views about when and how to encourage it. Many advocated public awareness campaigns to encourage people to talk about death and dying, despite limited evidence that such campaigns lead to widespread behaviour change (box 4.7).

#### **Box 4.7      Encouraging people to talk about death and dying**

Many inquiry participants supported increased efforts to raise public awareness about death and dying and to encourage people to plan for their end-of-life care needs (for example, AHHA, sub. DR561; HammondCare, sub. 407; Institute for Healthcare Transformation at Deakin University, sub. DR587; LASA, subs. 463 and DR512). Some highlighted current initiatives to encourage talk about death and dying.

- The GroundSwell Project said that its 'Dying to Know Day' initiative is 'a national call to bring to life conversations about dying, death, loss and grief' (sub. DR566, p. 1).
- The Institute for Healthcare Transformation at Deakin University said that its DeathOverDinner campaign 'encourages people to have end-of-life conversations at the dinner table with family and friends rather than the ICU when it's too late' (sub. DR587, p. 18).
- The Palliative Care Outcomes Collaboration and Palliative Care Australia (sub. 417) cited Dying to Talk, Death Cafés and Compassionate Communities as examples of programs that help people to have conversations about their preferences for care at the end of life.

However, HammondCare (sub. 407, p. 4) noted that even advocates of public awareness campaigns acknowledged that 'available [ACP] resources go widely unused and campaigns to normalise its practice have only resulted in minimal uptake'.

While this may in part be due to what LASA (sub. 463, p. 9) described as a 'stigma' against discussing death and dying, it is also due to the complexity of the messages related to advance care planning. In some areas of public communications, such as road safety, people can be motivated to change their behaviour by inducing fear of an adverse outcome (an accident or a fine), and convincing them that behaviour change will reduce the likelihood of that outcome (Delaney et al. 2004). These motivations do not apply to advance care planning. Completing an advance care plan does not reduce the likelihood of death, or of being unable to communicate one's end-of-life care preferences. It merely reduces the consequences of this latter situation. There is also little evidence that passive education alone, without direct counselling, inspires and equips patients or clinicians to have difficult conversations and write plans for a future they are reluctant to imagine (Ramsaroop, Reid and Adelman 2007).

While public awareness campaigns can only ever be a small part of the solution in this space, measures to increase the availability of community-based palliative care (recommendation 4.1) will help to increase the 'death literacy' of family and friends (GroundSwell Project, trans., p. 65). Research also suggests that 'end-of-life caregiving provides a deeply personal connection to death and dying and is a catalyst to developing death literacy' (Noonan et al. 2016, p. 32).

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Some participants, including Sarah Marlow (sub. DR490) and Palliative Care Western Australia (trans, p. 452) advocated strengthening incentives for completion of ACPs. Other participants considered that promoting the completion of ACPs should be secondary to promoting conversations. For instance, the Institute for Healthcare Transformation at Deakin University said that ‘the output of an advance care plan, directive or document *per se* is not the critical element. What is important is the process of having the opportunity to have numerous discussions with loved ones and suitably skilled professionals’ (sub. DR587, pp. 9–10).

For another group of participants, the timing of conversations about end-of-life care was the most important factor. For example, MND Australia said:

Discussions around end-of-life care need to be instigated as soon as the person with MND is ready, preferably before speech is affected, to ensure optimal interaction and communication to address their more profound concerns. (sub. DR513, p. 4)

On this latter point, the introduction of new standards for end-of-life care in acute hospitals (section 4.1) will be an important step, as the standards will require hospital clinicians to ‘identify opportunities for proactive and pre-emptive end-of-life care discussions’ (ACSQHC 2015a, p. 11). Given those changes, the Commission’s focus is on supporting advance care planning in primary care and residential aged care.

## **Supporting advance care planning in primary care**

When ACPs are prepared in a sensitive, professional way with appropriately trained doctors, nurses or allied health professionals (such as social workers), they are more likely to contain information that is both general enough to be applicable in most situations and specific enough to provide real guidance to the clinicians charged with the patient’s end-of-life care (HammondCare, sub. 407; Scott et al. 2013). Research also suggests there are clear benefits to advance care planning occurring in the primary care setting, before hospitalisation (ANZICS 2014; Scott et al. 2013).

HammondCare (subs. 407, DR515), LASA (sub. DR512) and PCOC and PCA (sub. 417) suggested that GPs and other primary care providers are well placed to facilitate advance care planning. Many other inquiry participants also supported this approach (including AASW, sub. DR557; ACSA, sub. DR541; AHHA, sub. DR561; CHA, sub. DR567; City of Whittlesea, sub. DR519; CHERE, sub. DR516; Silver Chain, sub. DR509; Tasmanian Government, sub. DR590).

## **Encouraging advance care planning in the GP’s office**

The Australian and New Zealand Intensive Care Society recommends incorporating advance care planning into the ‘75 plus’ health check (ANZICS 2014, p. 52). This fits well with the idea of high-quality advance care planning as an ongoing conversation — once someone has

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an ACP, the annual health check provides a recurring opportunity to continue the conversation and revisit the plan if their circumstances or preferences have changed.

GPs are already required to complete a range of actions in order to claim the item numbers associated with the ‘75 plus’ health check (items 701, 703, 705, 707) (for example taking a detailed medical history, conducting a comprehensive physical examination and providing a preventive healthcare management plan). In addition to the mandatory items, the Australian Government has endorsed the use of the ‘75 plus’ health check for advance care planning (Decision Assist 2015). Currently this is optional and is not explicitly mentioned in the Medicare Benefits Schedule guidance notes for GPs.

The Commission considers that initiating an advance care planning conversation should be an additional requirement for GPs to claim item numbers associated with the ‘75 plus’ health check, where the patient has the cognitive capacity to meaningfully engage in such a conversation. The fact that ‘a patient’s health trajectory is often unknown and will continue to change’ (RACGP, sub. DR524, p. 1) should not preclude GPs from starting a conversation with patients about their future care needs. On the contrary, it is the inherent uncertainty of future care needs that makes early and high-quality advance care planning so important.

Initiating advance care planning may be as simple as providing written information (such as brochures or planning templates) and introducing the purpose and content of ACPs to the patient. This written information could address questions such as the benefits of ACPs, the legalities of advance care planning, the role of the substitute decision maker, and where people can get further advice. An increasing volume of advance care planning information is already available, much of it online, and some of which is targeted to specific users (for example, people with dementia) (HammondCare, sub. 407). Research indicates that written material is most effective if clinicians actively discuss the information provided with patients (Ramsaroop, Reid and Adelman 2007). As noted earlier, training is likely to be required to increase doctors’ confidence and skills in this area (box 4.1).

If a follow-up appointment is required, which will often be the case so that a family member or other substitute decision maker can be present, general Medicare item numbers could be used as they are currently.

### Practice nurses also have a role to play in advance care planning

Trained practice nurses or other allied health professionals are well placed to have advance care planning conversations. Advance care planning by trained nurses and health professionals has been shown to improve patient outcomes and also reduce stress, anxiety and depression in surviving relatives (Detering et al. 2010). A dedicated training package for practice nurses — called ‘Advance’ — is already operational. Supported by the Department of Health, Advance includes screening toolkits and assessment tools designed for use by nurses working in GP clinics (Advance 2017).

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Despite this, the Australian Nursing and Midwifery Federation considered that nurses are underutilised in advance care planning (ANMF, sub. 474). The Commission agrees, and considers that trained practice nurses could facilitate more advance care planning conversations in primary care settings. As with other activities undertaken by practice nurses, the patient's GP would continue to play a role in overseeing the care provided, including 'the preparation, development and sign-off of plans or directives for their patients' (RACGP, sub. DR524, p. 2).

The involvement of practice nurses in advance care planning will be an important means of increasing the availability of advance care planning to those aged under 75 years who may be approaching the end of life. To enable this, a practice nurse item number for advance care planning should be created, enabling GP clinics to allocate their practice nurses' time to advance care planning facilitation.

#### RECOMMENDATION 4.3

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

- including the initiation of an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. At a minimum, this would require a general practitioner to introduce the concept of advance care planning and provide written information 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.

### **Making advance care planning a normal activity in aged care facilities**

Residential aged care providers should have ongoing conversations with residents about their goals of care or future care needs. Yet few residents of aged care facilities have ACPs, and not all RACFs have trained staff who can facilitate advance care planning in a professional, sensitive way. LASA identified this as a serious concern, noting that 'if a person has not been provided with information about advance care planning or a conversation has not been initiated prior to their admission into residential services then the system has failed them' (sub. 463, p. 6).

More could be done to ensure that people approaching the end of life in residential aged care are given the opportunity to record their preferences for future care (Alzheimer's Australia 2013). The AHHA (sub. DR561, p. 7) said that advance care planning needs to be 'normalised' as part of standard healthcare maintenance and planning. Research supports this view. Abbey said that aged care providers should be required to discuss advance care plans with any new clients entering the community or residential aged care system, describing it as a 'basic requirement for good care' (2013, p. 3).

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The Draft Aged Care Quality Standards proposed as part of the development of a Single Aged Care Quality Framework include a requirement that assessment and planning ‘includes advance care planning and end-of-life planning if the consumer wishes’ (Department of Health 2017o, p. 19). While the mention of advance care planning in aged care regulations is a welcome development, the proposed standard still places the onus on the resident and the timing of such discussions is ‘guided by working with the older person and taking the lead from them’ (ACSA, sub. DR541, p. 3). Yet people typically wait for doctors or other care providers to broach the subject, while clinicians wait for patients or family members to do so (Scott et al. 2013). An external trigger is needed to break this cycle.

To this end, the Commission considers that the Australian Government should include requirements for ACPs in the aged care Quality of Care Principles, which are the standard against which RACFs are accredited. Many inquiry participants supported this approach (including AHHA, sub. DR561; Alzheimer’s Australia, sub. DR521; Benetas, sub. DR543; CHA, sub. DR567; CHERE, sub. DR516; PCA, sub. DR500; Silver Chain, sub. DR509 and UnitingCare Australia, sub. DR514). However, there were also some participants who expressed reservations.

Aged care providers should be required to ensure that clinically trained staff hold ongoing conversations with aged care residents about their future care needs. This would ideally be part of the role of nurses or nurse practitioners employed in the RACF, but could also be undertaken by GPs or as part of an arrangement with an external palliative care service. The requirement should include helping each resident (or their family or carers) to understand the purpose of ACPs, and to develop or update one. Aged care providers should demonstrate that they have met this requirement by having a current ACP for each resident, or by documenting that the resident does not wish to complete one, within two months of admission to the facility.

The requirement should be designed in a flexible and person-centred manner, so that it encourages conversations rather than ‘being “enforced” through regulatory standards in a manner that encourages “tick-a-box” compliance’ (HammondCare, sub. DR515, p. 3).

... the ongoing communication around goals of care, their clarification and/or amendment should be the focus of any recommendation and mandated requirement — rather than the completion of a document at any single point of time. (Little Company of Mary Health Care, sub. DR547, p. 8)

It should also be inclusive of the role that non-clinically trained staff, such as direct care workers and pastoral care staff, can play in good end-of-life care, as LASA (sub. DR512) and HammondCare (sub. DR515) pointed out.

While non-clinically trained staff should not be excluded from advance care planning conversations, as noted above, people are more likely to prepare ACPs and the advance care planning conversations are more effective, when they are guided by trained clinicians. Introducing a requirement for clinically trained staff to hold ongoing conversations with residents about their future care needs would substantially increase the extent to which a resident’s choices guide their end-of-life care.

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#### RECOMMENDATION 4.4

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

## 4.5 Effective stewardship of end-of-life care

The Commission's recommendations outlined above would go some way toward addressing weaknesses in government stewardship identified in chapter 3. This section considers how to address two other weaknesses in stewardship that were identified in chapter 3. They are:

- buck passing between the Australian, State and Territory Governments, which has hindered access to services and the coordination of care across different settings
- major gaps in the collection and publication of information about end-of-life care, which has constrained the capacity of governments to plan, monitor and improve the provision of end-of-life care services.

The section also considers how improved stewardship could be facilitated in the longer term through an overarching review of end-of-life care.

### Cross-jurisdiction co-operation in end-of-life care

The Commission's recommendations to strengthen the role of State and Territory Governments in community-based palliative care (recommendation 4.1), and the Australian Government in residential aged care (recommendation 4.2), will help to clarify stewardship responsibilities and deliver improvements in care in those settings. However, without improved collaboration between levels of government, there will continue to be gaps, overlap and uncertainty which will hinder access to services and the coordination of care between residential aged care, community-based palliative care, hospitals and primary care.

The Council of Australian Governments (COAG) Health Council should be the lead forum for cross-jurisdiction collaboration on end-of-life care. It is comprised of Government Ministers with responsibility for health matters from the Australian, State, Territory and New Zealand Governments, and was established to enable cross-jurisdiction co-operation on health issues, especially primary and secondary care, and to consider increasing cost pressures. The COAG Health Council has an advisory and support body, the Australian Health Ministers' Advisory Council (AHMAC), which operates as a national forum for planning, information sharing and innovation. Given their clear responsibility for health care and frequent consideration of aged care matters, the COAG Health Council and AHMAC

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provide a forum for jurisdictions to co-operate in planning, funding and delivering end-of-life care, so that patients receive integrated services across different settings and jurisdictions.

A recent example of collaboration between the Australian, State and Territory Governments to improve end-of-life care is the current discussions to update the National Palliative Care Strategy (chapter 3). It is expected that the revised strategy will be endorsed by AHMAC, as has occurred previously. While past versions of the strategy have lacked substance and had limited effectiveness, there are signs that the next iteration may be more useful. At the time of writing this report, a draft of the strategy had been published which included a national governance structure for end-of-life care which would operate under AHMAC to:

- provide oversight of implementation and monitoring of the National Palliative Care Strategy
- strengthen mechanisms for collaboration and knowledge transfer (Urbis 2017, p. 12).

The creation of an end-of-life care governance structure that reports to AHMAC (and through it to the COAG Health Council) is an essential component of cross-jurisdiction collaboration for end-of-life care.

Governments also need to collaborate in establishing standards for high-quality end-of-life care in each of the settings in which it is provided. They have done so in some areas, such as the updated version of the National Safety and Quality Health Service Standards, which will apply to hospitals in all jurisdictions from 2019 (section 4.1). Cross-jurisdiction co-operation in setting standards for end-of-life care should continue.

## **Data on end-of-life care**

Too often, data on end-of-life care are not collected or are not widely available, making it difficult or impossible to examine usage patterns, costs or outcomes. Several inquiry participants, including the Health Performance Council of SA (sub. 437), PCA and PCOC (sub. 417), the RACP (sub. 473), and the Tasmanian Government (sub. 485) called for a coordinated approach to improving data on end-of-life care.

The Commission agrees that collecting and using better data on end-of-life care is essential for the Australian Government to fulfil its role as steward of end-of-life care in residential aged care, and State and Territory Governments to fulfil their roles as stewards of end-of-life care in hospitals and community-based palliative care.

### **National data strategy for end-of-life care**

Each government could work independently to deliver some of the necessary data improvements. For example, the Australian Government Department of Health recently contracted the AIHW to undertake palliative care data development activities, including

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improving access to existing data and developing new and improved data sources (AIHW, sub. DR508). But these data development activities cannot be successfully achieved in isolation. A comprehensive and coordinated approach will require the development of a national data strategy for end-of-life care, overseen by the COAG Health Council, that:

- establishes a national minimum data set for end-of-life care
- improves the accessibility of patient-level data so that they are used to deliver high-quality care
- uses system-level data to enable governments to plan, monitor and evaluate how well end-of-life care services are meeting users' needs and to drive improvements in end-of-life care.

Accountability for the national data strategy for end-of-life care should be established via AHMAC, reporting to the COAG Health Council. One potential way forward would be to form a new subcommittee for end-of-life care data, under existing AHMAC information management committees and the proposed new national governance structure for end-of-life care (which also reports through AHMAC to the COAG Health Council). The end-of-life care data subcommittee could perform an equivalent function in end-of-life care to that performed by the National Mental Health Performance Subcommittee in mental health.

Inquiry participants supported the development of a national data strategy for end-of-life care (including AHHA, sub. DR561; Benetas, sub. DR543; Breast Cancer Network Australia, sub. DR534; Cancer Council NSW, sub. DR537; Catholic Health Australia, sub. DR567; CHERE, sub. DR516; City of Whittlesea, sub. DR519; Sandra Coburn, sub. DR558; Little Company of Mary Health Care, sub. DR547; Palliative Care Australia, sub. DR500; RACP, sub. DR580; Silver Chain, sub. DR509).

### Developing a national minimum data set for end-of-life care

One aim of the data strategy should be to establish a national minimum data set for end-of-life care. This would require gathering more data (for example, information about the number of hospital patients who usually reside in a RACF; the availability of community-based palliative care in different regions; or the prevalence of ACPs) or drawing on existing data collections (notably the data on care delivery and outcomes collected by the Palliative Care Outcomes Collaboration).

Collection processes for additional data should be streamlined and rely on existing systems where possible. For example, the AIHW said that existing State and Territory health information systems could be used to address some of the recognised data gaps, including palliative care-related expenditure (sub. DR508).

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The national minimum data set for end-of-life care should include, in the first instance, linked basic information about a person's end-of-life care, such as:

- place of death. Sufficiently detailed information about location to enable comparison between different locations and settings should be available, along with the name of the institution for hospital, hospice and RACF deaths
- primary and secondary diagnoses. For example, a patient with advanced dementia who died from pneumonia should have both conditions documented
- details of service provision at time of death. This should include details of what, if any, health care or residential care funding they received at the time of death, at what level and for how long, so that the mean and median duration of care provision in both specialist and generalist settings, as well as variance around those measures, can be tracked
- patients' end-of-life care preferences (starting with whether the deceased had an ACP).

Other relevant information might include the number and duration of hospital visits in the last year of life, whether the deceased was receiving active treatment or palliative care at the time of death, whether the ACP (if one existed) was followed and if not, why not, and details of any additional support received. This might include support from a family member, carer or volunteer.

Resulting data should be published, shared between governments and made available to researchers in accordance with the framework for data sharing and release outlined in the Commission's report on *Data Availability and Use* (PC 2017a).

The costs of collecting additional data will depend on the nature and extent of gaps in existing data collections. These may vary between jurisdictions, providers and settings of care, with details determined during development of the end-of-life care data strategy. Improvements to efficiency resulting from better data would contribute to a reduction in costs.

### Using data to improve patient care

In addition to collecting and linking more data, the national end-of-life care data strategy should seek to address problems with data at the patient level. One area of focus should be the accessibility of data within and between care settings.

Effective coordination of documentation for end-of-life care patients transferring between settings is 'critical' especially when patients are near death (Manias et al. 2017, p. 25). This is not always achieved, however, and poor transfer of information at transitions of care has been identified as a key safety and quality issue for patients with complex healthcare needs, such as people approaching the end of life. For example, even when someone has prepared an ACP, it is not uncommon for it to be overlooked or ignored. HammondCare said that ACPs were often not used because they were not available when they were needed,

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particularly ‘when care moves across settings, or occurs out of hours, or when locums may be used’ (sub. 407, att. 1, p. 26).

One way to improve the transfer of patient information across settings would be through greater use of the My Health Record (MHR) system. The MHR is a secure, online summary of a person’s health information. Inquiry participants, including AHHA (sub. 427), MIGA (sub. 432), HammondCare (sub. 407), and Christy Pirone, Margaret Brown, Dr Chris Moy and Dr Christine Drummond (sub. DR559), supported making greater use of the MHR system, particularly as an access point for ACPs.

Participation in the MHR system is currently voluntary for patients and providers, but an opt-out approach is being adopted over 2017-18 and 2018-19. The Department of Health estimates that 98 per cent of the Australian population will have an MHR by 1 December 2018 (Australian Government 2017b; Department of Health 2017m). There is still work to be done on the clinical usability of the MHR system, however. For example, it is not fully interoperable with existing software used by many health practitioners and does not contain a patient’s full health record, with much information (including hospital data) retained on local systems (PC 2017a). In developing the national end-of-life care data strategy, governments should consider the role of the MHR system, including whether additional incentives are needed to encourage its use in end-of-life care.

### Driving system-level improvements in end-of-life care

Data that allow performance monitoring and evaluation of government activities are a fundamental starting point for improving the delivery of those activities to the community (PC 2017a). Data on end-of-life care are no exception.

As Casarett, Teno and Higginson (2006) pointed out, the stakes are particularly high in end-of-life care, since the ageing population, in which an increasing number (and proportion) of people have a prolonged period of decline and substantial needs for care, magnifies the problems arising from insufficient data, and therefore the benefits associated with improved data availability and use.

In the short run, improvements to service delivery would follow from performance monitoring and comparison of usage patterns, costs and outcomes. This would inform government policy by identifying areas that should be priorities for improvement and describing the effectiveness of existing programs, as well as their cost effectiveness. It would also allow health care providers (and patients) to compare their own performance with that of the sector, and support providers to engage in greater self-improvement activity. For example, Benetas said:

This information could not only inform government policy, it would also provide the sector with invaluable information to help improve service delivery. (sub. DR543, p. 4)

In the long run, better data on end-of-life care would enable governments to accurately plan for future end-of-life care needs at the population level. This is particularly important, given

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the substantial increase in demand for end-of-life care that is expected over the coming years (chapter 3). Better data would help guide capacity building and funding decisions, such as decisions about training of healthcare professionals in end-of-life care. It would also help policy-makers to anticipate how demographic trends will affect future needs and priorities for care delivery (Casarett, Teno and Higginson 2006; OECD 2017b).

Better data would also help to ensure that government policies reflect public priorities and assist governments to better understand the quality of care provision, including patients' psychosocial experiences and other details about their care. This could be achieved by recording the experiences of family and carers, as is done in the United Kingdom (box 4.8).

#### **Box 4.8      The VOICES survey of bereaved people**

In England, the Office for National Statistics runs an annual National Survey of Bereaved People (known as the VOICES survey), which collects information on people's views on the quality of care provided to a friend or relative in the last 3 months of life.

The survey includes questions about the physical and practical experiences of dying, including perceived pain relief and coordination of care, but also about some of the psychosocial aspects, including the perceived level of deprivation, dignity and respect, and the level of support for relatives, friends or carers at the end of life. The results of the survey are used to inform policy decisions and to enable evaluation of the quality of end-of-life care in different settings, across different ages and different causes of death.

*Source:* Office for National Statistics (2016).

## **Reviewing the end-of-life care system**

The recommendations proposed by the Commission are designed to put users' needs and choices at the heart of end-of-life care services in Australia, and to improve the availability and quality of end-of-life care in each of the settings in which it is currently provided. Several participants called on the Commission to go further, and to recommend the creation of a separate end-of-life care system. For example:

- Hobart District Nursing Service said that 'the time has come for palliative and end-of-life care to be separately funded to reach across age and funding barriers' (sub. DR581, p. 1)
- Sarah Marlow considered that 'funding needs to be available through Medicare to access palliative and [end-of-life] care services at home with no assets testing to ensure that all Australians, irrespective of age and financial circumstances have equal and unbiased access to high-quality health care at home' (sub. DR490, p. 2)
- Benetas suggested that there could be scope for palliative care services to achieve 'synergies and amalgamation with the Commonwealth [aged care] home care program over time' (sub. DR543, p. 2).

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One-off reviews can be useful in identifying issues and finding solutions for larger systemic issues of this nature (chapter 2).

By 2025, many aspects of end-of-life care in Australia will have changed. First, the demand for end-of-life care will increase significantly — by 2025, the annual number of deaths in Australia is projected to reach 180 000, representing a 15 per cent increase from 2015 (Productivity Commission estimates based on ABS 2013b, 2016c). Not only will there be more people in need of end-of-life care, but each person's care needs are likely to be greater, as a growing proportion of people will die from frailty, dementia and other chronic diseases whose trajectory is uncertain (chapter 3).

In 2025, the services available to people approaching the end of life will also need to be substantially different to those currently available, as current services are not meeting the needs of people approaching the end of life. Ideally, there will be substantially more end-of-life care provided in people's homes. There will also be significant changes in aged care, where ongoing reforms are in progress (Department of Health 2017a) and many reviews have recently been completed or are underway (for example, Department of Health 2017e, 2017h, 2017o; McNamee et al. 2017).

Stewardship arrangements will also be different in 2025, following the planned establishment of a national governance structure for palliative and end-of-life care with a formal link to AHMAC, and through it to the COAG Health Council.

The Australian, State and Territory Governments should undertake a comprehensive review in 2025 to assess whether end-of-life care services are meeting the needs of people approaching the end of life and the costs and benefits of doing so. The review should be conducted by an independent body, so that it can objectively examine the roles and responsibilities of each Government and the mechanisms used for cross-jurisdiction collaboration. It should examine the effectiveness of end-of-life care across all settings in which it is, or should be, provided. It should also consider the extent to which funding and other stewardship arrangements are contributing to the quality, equity, efficiency, accountability and responsiveness of end-of-life care throughout Australia. The review would also provide opportunity to consider the effectiveness of, and possible reforms to, the proposed national governance structure for palliative and end-of-life care.

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#### RECOMMENDATION 4.5

The Australian, State and Territory Governments should, through the Council of Australian Governments (COAG) Health Council, ensure that there is cross-jurisdiction co-operation to:

- plan, fund and deliver end-of-life care so that patients receive integrated services across different settings and jurisdictions
- set standards for end-of-life care in each of the settings in which it is provided (such as those that will apply to end-of-life care in hospitals in all jurisdictions from 2019)
- monitor and evaluate end-of-life care services.

The COAG Health Council should oversee the development and implementation of a data strategy for end-of-life care that:

- establishes a national minimum data set for end-of-life care (including collecting and publishing linked information on place of death, primary and secondary diagnoses and details of service provision at time of death)
- improves the accessibility of patient-level data (such as advance care plans or hospital discharge summaries) so that they are used to deliver high-quality care
- uses system-level data to enable governments to plan, monitor and evaluate how well end-of-life care services are meeting users' needs across all settings and jurisdictions, and to drive improvements in end-of-life care.

The COAG Health Council should, in 2025, commission an independent review of the effectiveness of end-of-life care across all settings in which it is, or should be, provided.



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## 5 Social housing in Australia

### Key points

- Australia's social housing system is broken. People in similar circumstances can receive vastly different rates of financial assistance depending on whether they rent in the private or social housing market. Even within social housing, levels of implicit assistance vary significantly.
- More than 400 000 households are eligible for, but cannot access, social housing. Over 150 000 are on waiting lists. Depending on their location, non-priority applicants can wait up to ten years for a social housing property. Many people eligible for social housing properties have chosen not to apply and rent in the private market.
- Current approaches to managing social housing provide people with little choice over where they live. This denies people the benefits of choice and a lack of competitive pressure can mean that providers have less incentive to improve tenant outcomes, such as through improving the quality of properties. Income-based rents provide social housing tenants with little incentive to adjust their living arrangements when their circumstances change.
- Some parts of Australia have become particularly expensive to live in, which affects all people on low incomes, not just those eligible for social housing. Discussions on social housing are often dominated by questions of supply and affordability. Insecure tenancies and a shortfall of affordable rental housing in the private market have increased pressure on social housing.
- Relying only on supply-side responses will not deliver more choice or ensure those eligible for social housing receive timely support.
- Provision of social housing is slowly shifting from a model of public supply (owned and managed by governments) to a mixed model. Community housing providers are playing a greater role, partly because tenants in community housing are eligible to receive Commonwealth Rent Assistance.
- The role of tenancy support services should not be overlooked. They can help to stabilise tenancies, and assist people who find it difficult to find and maintain a tenancy in the private market. These services are particularly important for those at risk of homelessness. About 2000 tenants (about 7 per cent of all tenancy exits) were evicted from social housing in 2012-13.
- Australia's social housing system needs to be reset. Changes are needed to: deliver financial support that empowers tenants to have more choice over where they live; improve government stewardship; create an even and contestable playing field for those managing social housing; and provide portable tenancy support across social and private housing for people who require additional support to access and maintain a tenancy.
- The merits of the Commission's proposed reforms do not rely on an increase in the supply of properties that are affordable to households on low income, nor on greater rental security of tenure in the private market, desirable though these may be.

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Social housing is part of the broader housing assistance system in Australia (figure 5.1). Housing assistance often involves financial assistance, such as the assistance received by tenants in social housing properties who have their rent set at a proportion of their income, and the provision of Commonwealth Rent Assistance (CRA) to tenants currently renting in the private market (box 5.1). Housing assistance can also include other forms of support, such as support services to maintain a tenancy (for example, assisting tenants to understand their tenancy obligations) and support for people to transition from social housing into private housing. The type of housing assistance a person is eligible for depends on their circumstances, and in some cases they may be eligible for more than one type.

The social housing system covers the allocation of tenants to properties, the ownership and management of properties, and the provision of financial assistance to tenants. Social housing includes both:

- public housing — properties managed by State and Territory Government housing authorities, such as Housing SA or Housing NSW
- community housing — properties managed and, in some cases owned, by a non-government provider.

Governments also manage culturally appropriate housing that is only allocated to Indigenous Australians, referred to as state-owned and managed Indigenous housing<sup>1</sup>. State and Territory Governments dominate the ownership of social housing properties, although most jurisdictions also accommodate social housing tenants in privately owned properties. The Australian Government contributes about \$1.3 billion each year to the funding of social and affordable housing through the National Affordable Housing Agreement, which has a broader remit including homelessness (SCRGSP 2017).

There is no benchmark for the ‘right’ level of social housing properties in an economy. The level of social housing needed, and the level of housing assistance more broadly, will depend on interactions with other government policies, including the level of income support provided (box 5.1).

Eligible people who need the support (both financial and non-financial) offered in social housing are often unable to access it. Over 150 000 households are on waiting lists to enter social housing properties and some households can wait 10 years or more.

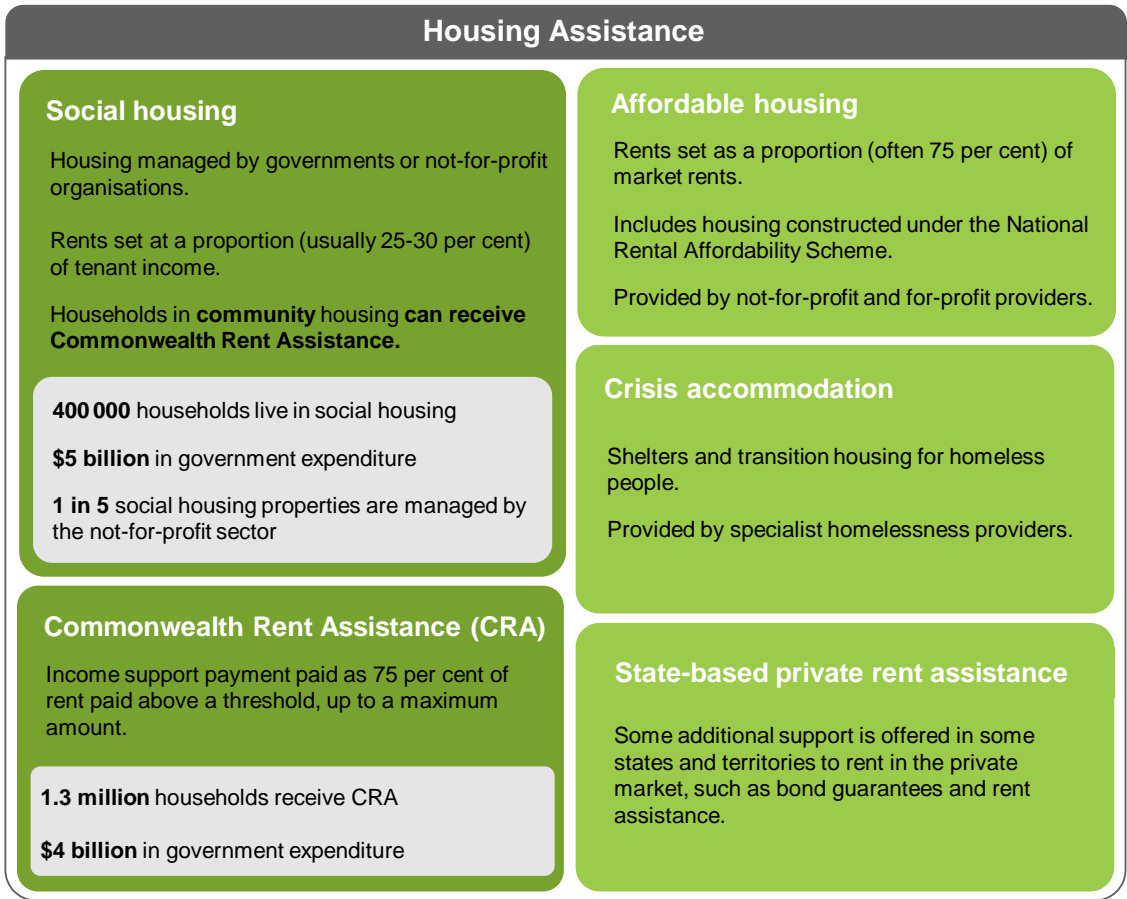
Many people eligible for social housing have chosen not to apply and rent in the private market. About 850 000 households in the private rental market satisfy the income eligibility criteria for social housing (Productivity Commission estimates based on the Australian Government Housing Dataset). The NSW Federation of Housing Associations et al. (sub. 406) estimated that there are roughly twice as many low-income people renting privately as there are renting social housing. Long waiting times could have deterred some people from applying. The Little Company of Mary (sub. DR547) also stated that many

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<sup>1</sup> Throughout this report the term ‘public housing’ includes both mainstream public housing and state-owned and managed Indigenous housing, unless explicitly stated otherwise.

people they care for do not wish to live in government housing, and the Victorian Royal Commission into Family Violence (2016) noted that social housing often does not offer the flexibility to provide support for people at risk of family violence.

Figure 5.1     **Housing assistance in Australia**



Sources: DSS (2017a); SCRGSP (2017).

Many households on income support in the private rental market are considered to be in ‘rental stress’. In 2016 over 40 per cent of CRA recipients paid more than 30 per cent of their income in rent — a benchmark that is commonly used as an indicator of rental affordability (although this benchmark has its limitations — chapter 6) (SCRGSP 2017). Queensland Advocacy Incorporated (sub. 442) and Jesuit Social Services (sub. 420) highlighted some of the hardships faced by people who miss out on social housing but lack the financial means to find a home in the private rental market. This included homelessness, people living in sub-standard sharing arrangements and, in a small number of cases, young people remaining incarcerated given their lack of access to a home.

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## Box 5.1      **Financial assistance for rental housing**

### **Social housing**

Tenants in social housing properties pay rent that is set at a proportion of tenant income (typically 25 per cent) or at the estimated market rent, whichever is lower. The implicit assistance that tenants receive is equal to the difference between the market rent for the property they live in, and the rent they actually pay. Tenants living in community housing can also receive Commonwealth Rent Assistance (CRA) but this assistance is passed straight through to the housing provider. Public housing tenants are not eligible for CRA.

### **Commonwealth Rent Assistance**

A household renting in the private rental market or in community housing is eligible for CRA if they pay more than a minimum rent threshold, and are receiving a qualifying social security payment (such as Newstart Allowance, Youth Allowance or the Age Pension). CRA is not rationed, and all households who are eligible for the payment receive it. Many people in the private rental market who receive CRA would also be eligible to apply for social housing.

CRA is payable at the rate of 75 cents for every dollar of rent above the rent threshold, up to a maximum amount. The rent thresholds and maximum amount (and, hence, the level of assistance) vary depending on household characteristics, such as the number of children in the household, and increase with the consumer price index. For example, a single person with two children will receive assistance if they pay more than \$77 per week in rent, and they can receive a maximum payment of \$78 per week. A household's CRA payment may be reduced if their income is higher than a threshold amount, which varies depending on the welfare payment they receive.

### **The difference between CRA and assistance received in social housing**

The two types of financial assistance lead to a two-tiered system. Tenants in social and private housing can receive vastly different levels of financial assistance, even though their circumstances are similar, except for the tenure of their housing. For example, a couple with an income of \$500 per week (before CRA) and paying the median rent for a one-bedroom apartment in Melbourne (\$340 per week) to a private landlord would receive about \$60 per week in financial assistance. The same couple in social housing would implicitly receive about \$215 per week in assistance. If the couple paid the median rent for a one-bedroom apartment in regional Victoria (\$180 per week) to a private landlord they would still receive about \$60 per week in assistance, but the implicit assistance they would receive in social housing decreases to about \$55 per week.

### **Overseas models**

Countries structure financial support differently, placing more or less emphasis on direct support for housing. CRA is designed as a supplementary payment to other income support (for example, the age pension). Compared with countries such as the United Kingdom, Germany and Ireland, it generally comprises a small proportion of the total income support Australian households receive. For example, the 'Housing Benefit' program in the United Kingdom can pay up to 100 per cent of an eligible tenant's rent in both private and social housing. Housing assistance is the second largest government welfare expense in the United Kingdom, after the age pension, and typically constitutes a large proportion of the income support received by people on low incomes.

*Sources:* ABS (2015); DSS (2017a); NSW FACS (2016e); OECD (2016b, 2017a); UK Government (2017); UK OBR (2017); Victorian DHHS (2017b, 2017c).

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The type and amount of financial assistance a household receives depends on the sector from which they rent their home, rather than their circumstances. Households that rent in the private market can receive a vastly different (often much lower) level of financial assistance compared with the implicit assistance provided to households that rent social housing, even when their circumstances are otherwise similar (box 5.1). Even within social housing, rates of implicit assistance vary widely depending on the location and characteristics of the property. These arrangements are inequitable and result in many of the 400 000 or so households in social housing having a considerable financial disincentive to exit.

## 5.1 The role of social housing

Social housing provides a safety net for people on low incomes (mostly those receiving income support) who face barriers to sustaining a tenancy in the private rental market. Access to a social housing property can play an important role in increasing tenants' quality of life. While income is a primary eligibility factor, the circumstances of people seeking social housing vary significantly. Consequently, the reason for seeking social housing can reflect a combination of factors.

- *Financial assistance.* Some households facing rental stress in the private market seek access to social housing properties to reduce the cost of housing to a more affordable level.
- *Access to housing.* Some people seek access to social housing properties because they face difficulties accessing the private rental market. Landlords can, for example, be reluctant to rent to some people, including those with poor rental history and those with complex needs. Discrimination and racism on the part of the landlord can also prevent people from finding a home (AHV, sub. PFR316; Bleasdale 2007).
- *Stability of tenure.* Some people seek the substantially greater tenure security provided in social housing properties compared with the private market. This stability is highly valued by some eligible households and can provide a foundation for tenants to improve their economic participation, settle into and engage with the community, and support their health (TUNSW 2016). For people in a precarious employment situation, the knowledge that they have somewhere to live should they be unable to keep their job provides some peace of mind (Wiesel et al. 2014). National Seniors Australia (sub. PFR360) stated that undesirable and unplanned relocations can have a negative effect on an older person's health and wellbeing.
- *Support services.* Access to support services can play a valuable role in assisting people to access and maintain a tenancy, although access to these services may not be a key driver for tenants seeking social housing properties.

Australia's 'build and own' model of social housing — where governments build (or subsidise community housing providers to build) properties to use as social housing — has remained relatively stable since its introduction, but its focus has shifted significantly over time. Originally constructed as affordable rental housing for low-income working families,

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many of these families now receive financial support through CRA to rent in the private market. Increasingly, the social housing system has focused on people who have difficulty finding and maintaining a tenancy for reasons other than affordability. These people often draw on support services, such as treatment for mental health conditions, to help them maintain their tenancy.

## **Financial assistance**

Financial assistance in social housing is designed to ensure tenants pay an ‘affordable’ level of their income in rent, an approach known as ‘income-based rent setting’. Income-based rents are commonly set at 25 per cent of income. This compares to the 30 per cent benchmark that is often used to gauge rental affordability in private markets (Burke, Stone and Ralston 2011). Jurisdictions generally charge market rents only if they are lower than the 25 per cent benchmark.

Unlike market rents, income-based rents do not vary depending on the characteristics and location of the property. In practice, this means that the level of implicit assistance provided is specific to both the tenant and the property. The advantage of this approach is that it provides tenants with the certainty and security of knowing that their rent will adjust if their circumstances change. Against this, it makes tenants less responsive to the trade-offs faced by people renting in the private market, such as deciding on whether to meet the extra cost of living in a higher-priced suburb.

The implicit assistance received by households in social housing properties varies considerably both across and within jurisdictions. This is a function of many factors. In particular, the level of implicit assistance is heavily dependent on local housing market conditions. Implicit assistance is, for example, generally much higher in New South Wales (a jurisdiction with high-cost housing) than in Tasmania (where housing costs are lower). Within New South Wales, tenants living in inner city areas of Sydney receive much higher levels of implicit assistance than those living in regional areas. In Victoria, some households can receive more than \$300 a week in implicit assistance while other households with similar incomes receive less than \$50 (figure 5.2). The circumstances of the tenant can affect the level of assistance they receive. People on higher incomes will pay a higher rent, and will receive lower levels of implicit assistance, all else being equal. Households are also allocated properties of varying quality, and therefore varying market rents.

Households on the same income and with the same characteristics, such as size of the household, can also receive a significantly different level of assistance depending on whether they rent social housing or in the private market. The Commission estimates that households in public housing in Victoria receive on average about \$50 per week more in financial assistance than if they received CRA (box 5.2).

Some of the difference in assistance may be justifiable, for example due to differences in income, household composition or rental costs. Nonetheless, the widely varying subsidies created by income-based rents make it difficult to maintain equity in the system. People with

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very similar circumstances can receive widely different levels of government support in social housing. It can also result in people with higher incomes receiving more support than those on lower incomes.

### **Box 5.2      The difference between CRA and income-based rents**

The Commission has undertaken analysis of the difference between the implicit assistance received through rents set at a proportion of a tenant's income and what tenants would receive under the current Commonwealth Rent Assistance (CRA). The analysis was undertaken for tenants currently in public housing in Victoria, South Australia, and the Australian Capital Territory (data are not available to include tenants in community housing in the analysis).

- The implicit assistance received through rents set at a proportion of income was estimated by subtracting the amount of rent paid by a household from the market rent of the property they live in. The Commission used market rents that were estimated by the relevant housing authority.
- The level of CRA that a household would receive was estimated based on the market rent for the property they are currently in, as well as the characteristics of the household, such as the number of people. Where multiple households were sharing a home it was assumed that they split the rent evenly.

The Commission estimates that, as a whole, people living in public housing in Victoria receive \$200 million more in financial assistance annually (or about \$2500 per household) than they would if financial assistance was provided through the current CRA. In South Australia households receive about \$80 million more (or about \$1750 per household) and in the Australian Capital Territory households receive about \$100 million more (or about \$8500 per household).

The difference between assistance levels under rents set at a proportion of household income and under CRA varies substantially between households. Assuming that tenants remain in their current home:

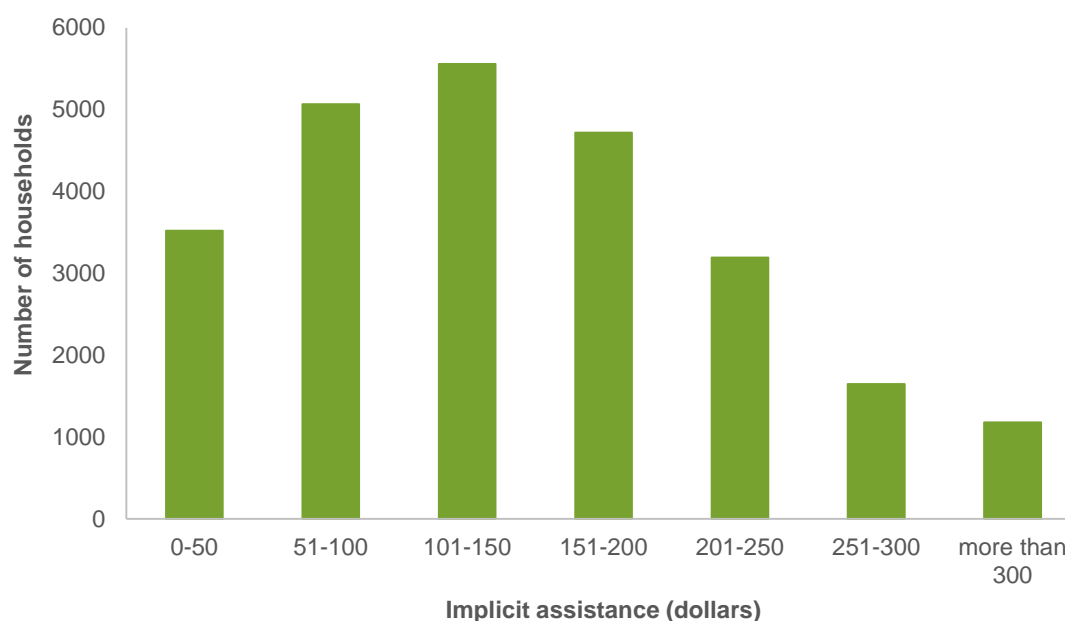
- just over a quarter of households in Victoria and South Australia would be better off if they were receiving the current level of CRA rather than paying rent set at a proportion of their income, as they are currently paying close to market rents. In the Australian Capital Territory just over 6 per cent would be better off
- just over half of households in Victoria and South Australia would be at least \$500 worse off annually if they received the current level of CRA rather than paying rent set at a proportion of their income. In the Australian Capital Territory about 90 per cent would be at least \$500 worse off annually
- about 6 per cent of households in Victoria would be at least \$10 000 worse off annually if they received the current level of CRA rather than paying rent set at a proportion of their income. In South Australia, about 1 per cent would be at least \$10 000 worse off annually, and in the Australian Capital Territory about 43 per cent would be at least \$10 000 worse off annually.

These are upper-bounds estimates, and the proportion of people worse off would be lower if tenants were given a choice of home. Some tenants may be in properties that cost more than they are willing to pay at market rates, for example, a single person may currently be in a two-bedroom home and have no need for the extra bedroom. If they were given a choice, some of these tenants might choose to move into less expensive properties.

*Sources:* Productivity Commission estimates based on DHHS (Vic), DCSI (SA) and HCS (ACT) unpublished data.

**Figure 5.2 Implicit housing assistance received by single people with incomes between \$400 and \$500 a week**

Public housing in Victoria, gross income from all sources, as at June 2016<sup>a</sup>



<sup>a</sup> Does not include people in shared housing or single parents.

Source: Productivity Commission estimates based on DHHS (Vic) unpublished data.

Accounting for income-based rents can be difficult for governments. While rental payments appear in government accounts as a revenue stream, the level of implicit financial assistance provided to households (the amount of revenue forgone compared to a market rent) does not. This lessens transparency and obscures signals for ensuring public funding is targeted where it achieves the best outcomes.

Decisions by governments about how to target housing assistance are difficult and often emotive but tough decisions are needed to improve the effectiveness of the social housing system. Some governments have taken steps to change the location and composition of their social housing stock (box 5.3).

Income-based rents operate differently from the ‘contribution’ model used to support tenants in the private market via CRA (box 5.1). Under the contribution model tenants receive a level of support based on their rent and household’s characteristics (such as household income and size), that is portable across properties. This allows tenants more choice, and encourages them to make trade-offs between the features and price of different properties (for example, whether the cost of an extra bedroom is worthwhile). Unlike income-based rents, the level of assistance is capped — providing tenants with less ‘protection’ from changes in the market rent. Capping also limits the range of properties a tenant can affordably rent.

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**Box 5.3      High-value social housing properties at Millers Point**

In 2014 the NSW Government announced that high-value social housing properties on the Sydney Harbour foreshore, including in the suburbs of Millers Point and The Rocks, would be sold, with the proceeds used to build additional social housing in other parts of New South Wales. Tenants in these properties received a very high level of implicit assistance — up to \$850 per week in some cases. The NSW Government noted that for every tenant assisted in Millers Point, it could assist five tenants in the suburbs of Wollongong, or three and a half tenants in Newcastle. As of August 2017 about \$450 million had been raised from the sale of 233 properties, which has been used to fund construction of nearly 1100 new social housing properties.

*Sources:* Goward (2014); NSW FACS (2017b).

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## **Access to housing**

Providing access to housing for those unable to rent in the private market is a core function of the social housing system. Access to the limited amount of social housing properties is managed via waiting lists. These are generally divided into at least two categories — one for general applicants and one for priority applicants in greatest need.

A household's eligibility for the general waiting list mostly depends on household composition, income and the value of the assets they hold. The specific income and asset limits vary between each state and territory. For example, a single person is eligible for the general waiting list in Victoria if their gross income is less than about \$50 000 each year, compared to about \$31 000 each year in New South Wales (for comparison, the Australian median income for a single person is about \$31 000 each year). A single person receiving the maximum age pension amount (about \$23 100 each year) would satisfy the income eligibility criteria in all states and territories.

Eligibility for the priority waiting list is often based on additional criteria relating to personal safety, extreme hardship and homelessness. Supply constraints mean that in all jurisdictions most entries into social housing come from the priority list (SCRGSP 2017). For the country as a whole, three out of four new allocations of social housing in any year are for priority tenants.

Waiting times vary across the country. Jurisdictions do not generally identify a benchmark for waiting times against which performance is measured. Different waiting times reflect both demand and supply factors. In New South Wales, a non-priority applicant can wait 10 years or more, depending on the area in which they wish to live (NSW FACS 2016a). In some states, such as Tasmania, the waiting times are shorter, although most tenants can still expect to wait between six months and five years (TAO 2016). Waiting times for priority applicants are shorter, but can still be lengthy (SCRGSP 2017).

People seeking access to social housing properties are usually given an opportunity to express some preference for the location and features of the home they wish to live in.

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Jurisdictions seek to ensure tenants are offered properties based loosely on their needs and preferences. In reality, though, choice is limited. Those that reject two offers — and in some cases, one offer — of a home are moved to the back of the waiting list. Essentially this is a take it or leave it allocation process.

Access to social housing properties for tenants who need the support and stability they provide is currently determined by the amount, location and composition of public and community housing properties. Housing is an expensive, long lived asset, and the inflexible ‘build and own’ model makes it difficult for governments to respond quickly to changes in demand. Many properties are in locations or have characteristics (such as high-density high-rise apartments) that would no longer be considered best practice or be appropriate for the changing demographics of people entering social housing.

Over time a mismatch has emerged between the type of properties held by social housing providers (particularly government providers) and the needs of those entering the system. For example, about a half of applicants on the Victorian public housing waiting list are single people, but only a quarter of Victorian public housing properties are one-bedroom properties (VAGO 2010). More recently several governments, including those in New South Wales and Victoria, have been moving towards the use of head leasing, which offers some potential to be more flexible over time (chapter 6).

The number of social housing properties are determined by each State and Territory Government. Across Australia, social housing properties make up a small percentage (about 4 per cent) of total housing stock. Levels of social housing vary significantly from a low of about 3 per cent in Victoria to a high of 9 per cent in the Northern Territory (ABS 2017c; SCRGSP 2017).

The number of social housing properties across Australia has been relatively stable since 2007. This is in the context of a significant one-off investment in supply via the Australian Government’s Social Housing Initiative, which funded the construction of about 20 000 new properties (see below). Jurisdictions do not generally publish information on expected demand for social housing into the future (beyond the current waiting list) or their plans for meeting that demand.

There are also concerns that governments have not invested enough in maintaining social housing properties. Income from rents and charges is generally insufficient to cover ongoing expenditure, including property maintenance. Most public housing authorities are in deficit and some have responded by deferring maintenance, leading to a deterioration in the quality of properties (SCRGSP 2017; VAGO 2012).

Traditionally, governments have built and managed social housing properties. In recent times, there has been a move towards a mixed model of provision through a significant increase in the number of properties managed by community housing providers. This has been driven by a number of factors, not least of which is that tenants of community housing providers can be eligible for CRA (Pawson et al. 2013).

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## Stability of tenure

Social housing provides much greater tenure security than offered in the private rental market. Historically, social housing provided life-long tenancy. While providing security for tenants, life-long tenancies reduce governments' ability to respond to changing circumstances. Some governments have responded by moving away from life-long tenancies — for example, in New South Wales tenants are now offered 5–10 year fixed term leases.

Social housing providers focus strongly on supporting stable tenancies. Both public and community housing providers manage tenancies to avoid evictions or unnecessary movement of tenants where possible. Despite this, in 2012-13 over 2000 tenants were evicted from social housing due to a tenancy breach (about 7 per cent of all tenancy exits) (Wiesel et al. 2014).

## Tenancy support services

The role played in social housing by tenancy support services should not be overlooked. People eligible for social housing vary widely in their need for tenancy support services. About 4 per cent of people in public housing in 2016 also used drug and alcohol counselling services, about 20 per cent accessed mental health services, and about 11 per cent required support services for day-to-day living (AIHW 2017e). One estimate by Pawson et al. (2015) suggested that about 19 per cent of expenditure on housing management by community housing providers is on tenancy support, including case management and managing tenancies at risk and community services such as social outings and community events.

Tenancy support services are targeted at three key areas.

- *Helping a tenant to sustain a tenancy.* Access to long-term support can help to stabilise tenancies and prevent evictions. Some tenancy support programs have cited 80–90 per cent success rates in supporting people with experiences of homelessness to sustain tenancies (box 5.4). For example, the Tenancy Plus program in Victoria provides case management support to enable social housing tenants to establish and maintain a tenancy. Support to maintain a tenancy can range from help with budgeting through to referrals to other services and intensive support and supervision (Costello, Thomson and Jones 2013).
- *Assisting tenants to improve their economic participation and providing skills to help tenants to exit the social housing system.* For example, the NSW Future Directions Social Housing strategy emphasises support to give tenants the choice to exit social housing (NSW FACS 2016b).
- *Linking social housing with broader support services.* For example, the Housing and Accommodation Support Initiative in New South Wales links accommodation supports with clinical care for people with mental health problems (box 5.4). Similar programs exist in most other states and territories — in 2014 almost one in five social housing tenants accessed mental health services (AIHW 2014d).

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## **Box 5.4      Tenancy support can help tenants maintain their tenancy**

### **Tenancy Plus**

The Victorian Tenancy Plus program (called the Social Housing Advocacy and Support Program (SHASP) until 2017) provides tailored case management services and support for social housing tenants to maintain their tenancy. Services are provided by several non-government organisations and are funded by the Victorian Government. Tenants in the private rental market are not covered under Tenancy Plus.

The type of support offered under Tenancy Plus varies depending on the needs of the tenant. It can include support and advice, help with legal issues, financial counselling, skills training, or referrals to other services. There are two key focuses of Tenancy Plus — helping people to transition from homelessness to being in public housing, and helping people whose tenancies are at risk. For about a third of people who were referred to the (then) SHASP in 2014, their main issue was financial difficulty and rental arrears. Other reasons for being referred to the SHASP include mental health issues, anti-social behaviour, drug use and hoarding and squalor.

Most people who engaged with the SHASP in 2014 either maintained their tenancy or were still working with their SHASP provider. About 2 per cent of SHASP clients were evicted from their property.

The Victorian Government announced changes to Tenancy Plus in June 2017, increasing its budget to \$7.2 million, expanding the scheme to cover tenants in community housing and shifting the emphasis of the program from crisis support to an early intervention approach. The program aims to support more than 3800 tenants who may be at risk of eviction.

### **The Housing and Accommodation Support Initiative**

The Housing and Accommodation Support Initiative (HASI) in New South Wales is a partnership between NSW Health, Housing NSW and providers of tenancy support. The scheme aims to provide people who have mental health problems with stable housing integrated with clinical and psychosocial rehabilitation services. Under the HASI, tenants receive, tenancy support services and rehabilitation services from non-government organisations, clinical care services from specialist mental health services, and housing from social housing providers. Services under the HASI are also available for tenants in the private market.

In 2009, about 1000 people received support through the HASI. The (non-accommodation) costs of the HASI were about \$11 000–\$58 000 per person annually, depending on the level of support needed.

An evaluation of the HASI in 2012 found positive outcomes for service users. The average number of days spent in a mental health inpatient hospital each year decreased by 59 per cent, and 90 per cent of users successfully maintained their tenancy. There was also an improvement in life skills, an increase in community participation and a reduction in behavioural issues among program participants.

*Sources:* Bruce et al. (2012); Foley (2017); SHASP Managers Network (2014).

Limited support services are also sometimes available for people in the private rental market, including services that offer support to some tenants to locate, establish and maintain a tenancy. (These services are often referred to as private rental brokerage services.) Support services can also have flow-on benefits to other aspects of a tenant's life, such as improvements in health, and increases in community participation (box 5.4).

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Inquiry participants emphasised the need for access to support services in the social housing system. For example, Homelessness NSW (trans., pp. 32–33) stated:

To put somebody in [social housing] and then go, ‘Okay, well, we’ve got a roof over your head, see you later,’ actually compounds the problem and then can cause problems around the area because then people don’t know what they’re doing. They get distressed, it increases their stress levels, they may have some sort of response that wouldn’t necessarily be helpful in the community.

Similarly, Jesuit Social Services (sub. 420) noted that long-term support is needed for people with complex needs, and that this support can have benefits in terms of reducing the burden on other human services.

Many people do not get access to these services, and many people evicted from social housing properties have not been provided with any support (Homelessness NSW, sub. DR520). In 2012–13, over 2000 tenants were evicted from social housing due to a tenancy breach (about 7 per cent of all tenancy exits) (Wiesel et al. 2014). Social housing is often the last viable source of stable accommodation and termination of their tenancy can result in homelessness and increased risk of involvement in child protection and criminal justice (QMHC 2015). Community Housing Limited (trans., p. 265) stated that about one-sixth of its tenants are evicted. The Queensland Mental Health Commission (2015) noted that tenants with a mental health condition often do not understand their tenancy obligations, and what may constitute a breach of their tenancy.

Many support schemes targeted at social housing tenants are not made available to those renting in the private market and private rental support schemes are often ad hoc with gaps in their provision. Private rental support services generally require a tenant to be ‘rental ready’ before they will provide support to establish and maintain a tenancy. This reflects a view that it is nearly impossible to find stable accommodation for more complex tenants, and the high cost of assisting these tenants (Tually et al. 2016).

The Royal Commission into Family Violence in Victoria (2016) highlighted several shortcomings of private rental support services. It noted that support often ceases once a person finds a home and that little support is offered over the long term. A similar point was noted by Melbourne City Mission (sub. DR510), which stated that service users often have their supports cut off, and cannot access support unless they re-enter the ‘crisis service loop’. The Royal Commission into Family Violence in Victoria (2016, p. 85) stated that ‘scant attention is paid to improving victims’ ability to be resilient in the private housing market by helping them improve their status in the labour market and, as a consequence, their level of earned income’. Funding packages for private rental support are often exhausted quickly — one example was given of a regional provider that had used all of its allocated funding by halfway through the financial year.

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## 5.2 The broader housing market

Demand for social housing depends on a range of factors, with the cost of renting in the private market and security of tenure being significant. Higher rental prices increase demand for social housing properties by increasing the (implicit) financial assistance in social housing, making social housing a more attractive sector from which to rent a home. As noted earlier, the security of tenure in social housing properties, relative to the private market, can also be of benefit to some people in social housing, where the rights and protections of tenants are often stronger (Wiesel et al. 2014). Consideration of social housing reform needs to be set in a context of broader efforts to improve the operation of the housing markets and the wide variations in the affordability and nature of housing across, and within, states and territories.

### Rental affordability

Rental prices vary considerably across the country, reflecting local housing market conditions. In the capital cities median rents are highest in Sydney (about \$520 per week for a two bedroom apartment) and lowest in Adelaide and Hobart (about \$280 per week for a two bedroom apartment) (SCRGSP 2017). Regional areas often have much lower rental prices than in cities. Like housing prices, rents have grown rapidly over the past decade, with particularly strong growth between 2007 and 2012 (ABS 2017a). The largest increases were in Sydney, Darwin and Perth, although rental prices in Perth and Darwin have fallen from their recent peaks.

Rent increases have been outstripping income growth for both wage earners and some households receiving income support. This is placing additional pressure on tenants renting privately who often pay an amount in rent that leaves little income left over to purchase essential goods and services (SGS Economics & Planning 2015). For example, Hulse et al. (2015) noted that 25 per cent of households in the bottom income quintile paid more than 50 per cent of their income on rent.

There is little doubt that a shortfall exists of homes affordable to people on low incomes. In response, many participants advocated for building more affordable private and social housing (AHURI, sub. DR495; Anglicare sub. DR574; CFRC, sub. DR506; CHP sub. DR522; CSSA, sub. DR533; JSS, sub. DR530; National Shelter, DR582; NSW FHA sub. DR539; TUV, sub. DR563). Hulse et al. (2015) put the shortfall of affordable homes for households in the bottom income quintile at about 270 000 homes in 2011, mostly in Sydney, Melbourne and Brisbane. Yates (2017) noted that an additional 20 000 affordable dwellings need to be built each year just to maintain supply shortages at their current levels.

The shortfall of affordable homes is despite property developers constructing a record number of new homes in recent years. This additional supply has not (at least as yet) had a major impact on rents at the lower end of the market, partly because the new dwellings have been ‘overwhelmingly priced in the higher price deciles’ (AHURI 2017, p. 1). According to

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AHURI, about 80 per cent of new apartment approvals between 2005-06 and 2013-14 were priced in the top three price deciles.

To address a lack of affordable housing, the Australian Government has previously offered subsidies for the construction of affordable housing. Between 2008-09 and 2011-12, the Australian Government allocated just over \$5 billion for the construction of about 20 000 social housing properties (DSS 2013). The National Rental Affordability Scheme commenced in 2008, and had subsidised about 32 000 dwellings as at June 2016, at an expected cost of about \$3.3 billion (ANAO 2016). This scheme was closed to new entrants in the 2014-15 budget.

Governments have policy initiatives underway to improve rental affordability in the private market.

- The Victorian Government's Homes for Victorians strategy includes changes to speed up planning approval processes, increasing access to surplus government land for developments, providing greater support for people renting in the private market and a tax on vacant properties (Victorian Government 2017b).
- The Australian Government (2017b) announced in its 2017-18 Budget that it will:
  - establish a bond aggregator to facilitate access to lower-cost finance for the community housing sector, which could assist them to construct additional social and affordable housing
  - negotiate a new funding agreement for affordable housing with the State and Territory Governments, which will include housing supply targets and prioritise planning and zoning reforms and the renewal of public housing stock.
- The New South Wales and Victorian Governments have established funds for the purpose of investing in additional social and affordable housing.

Despite these initiatives, several participants stated that current policy settings and market conditions are discouraging investors from building homes that are affordable to low income households (CFRC, sub. DR506; CHL, sub. DR551). More generally, there is an active debate about housing policy settings. The Commission has not assessed or made recommendations on other actions governments could take to improve rental affordability. Governments need to continue implementing reforms so that homes in the private rental market can be affordable and accessible for people on low incomes. The merits of the Commission's proposed reforms do not rely on an increase in the supply of properties that are affordable to households on low incomes, desirable though this may be.

## **Tenure security**

In Australia's private rental market, tenancies are usually short term (often 6 to 12 months), and tenants can be evicted on short notice. A strong and consistent theme of the Commission's consultations was a need to strengthen tenure security, in particular to protect

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tenants against ‘no-fault’ termination provisions (Anglicare, sub. DR574; Homelessness NSW, trans., p. 32; National Shelter, sub. DR582; TUV, sub. DR563). Anglicare (trans., p. 222) gave an example from New South Wales where ‘children have had to go into foster care because their parents cannot find accommodation sufficiently quickly after being summarily evicted with no reason given’. Such outcomes are unacceptable.

Getting the right balance between tenure security and flexibility for tenants and landlords is difficult. Some tenants prefer short-term leases to maintain flexibility, and longer leases limit the ability for landlords to regain possession of their property. Nonetheless, the negative effects of short-term leases often fall disproportionately on households with low incomes that may desire longer-term leases, but lack the bargaining power to negotiate them (Victorian Government 2017a).

Some governments have flagged reform options to improve tenure security. The Australian Government announced in its 2017-18 Budget that it will work with State and Territory Governments to standardise the use of long-term leases (Australian Government 2017a). The Victorian Government has already announced that it will introduce a standard long-term tenancy agreement, and a review of the NSW tenancy law recommended changes to incentivise their use. The Victorian Government is also in the process of reviewing its tenancy law (Victorian Government 2017c).

The Commission has not assessed the costs and benefits of reforms to improve tenure security, and has not made recommendations in this area. National Shelter (sub. DR582) and the Tenant’s Union of Victoria (sub. DR563) noted that longer-term leases and greater security of tenure, would enhance tenant choice between social and private housing. Improving the security of tenancies in the private market would also reduce the burden on social housing.

## **5.3 Towards a better social housing system**

Australia’s social housing system is broken. Eligible tenants have little choice over the home they live in and can face a lengthy wait to access housing, and the type and amount of financial assistance available to households is inequitable. There is little transparency around the outcomes governments are seeking to achieve from the social housing system. The introduction of greater choice and competition could substantially improve the effectiveness of social housing but the cost would be significant.

Increases in the level of stock of housing affordable to lower income earners would clearly assist. Relying only on supply-side responses will not deliver more choice or ensure those eligible for social housing receive timely support. Past experience also suggests that meeting the needs of tenants who are eligible for social housing assistance via increased supply would be very costly and take considerable time. For example, under the National Rental Affordability Scheme annual subsidies for each new dwelling amounted to \$10 000 of which

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around \$4000 was, or is likely to be, passed on to tenants as lower rent. The remainder provides a subsidy to landlords (DSS 2012; Rowley et al. 2016).

Four major areas of reform are needed to address the underlying problems in the social housing system and unlock choice for users (figure 5.3). Reforms are needed to:

- create a single system of financial assistance that is portable across the private and social housing rental markets. A single system of assistance would improve choice, reduce existing inequities and provide governments with a more flexible way of improving outcomes for people whose primary housing need is increased rental affordability. This new system needs to address the wide gap between financial support provided for tenants in the private sector and those in social housing (chapter 6).
- improve government stewardship of social housing. These reforms need to ensure that planning and delivery of social housing is transparent and focused on achieving clear outcomes for users (chapter 7).
- ensure that a level playing field exists between government and other providers of social housing. These reforms need to increase contestability for the supply of social housing, and to ensure that government does not hold an unfair advantage over other providers (chapter 7).
- making tenancy support services portable across private or social housing so, to the greatest extent possible, services follow the user. Reforms to tenancy support services need to strengthen the role of intake and assessment systems to identify people who need them and connect them to service providers (chapter 7).

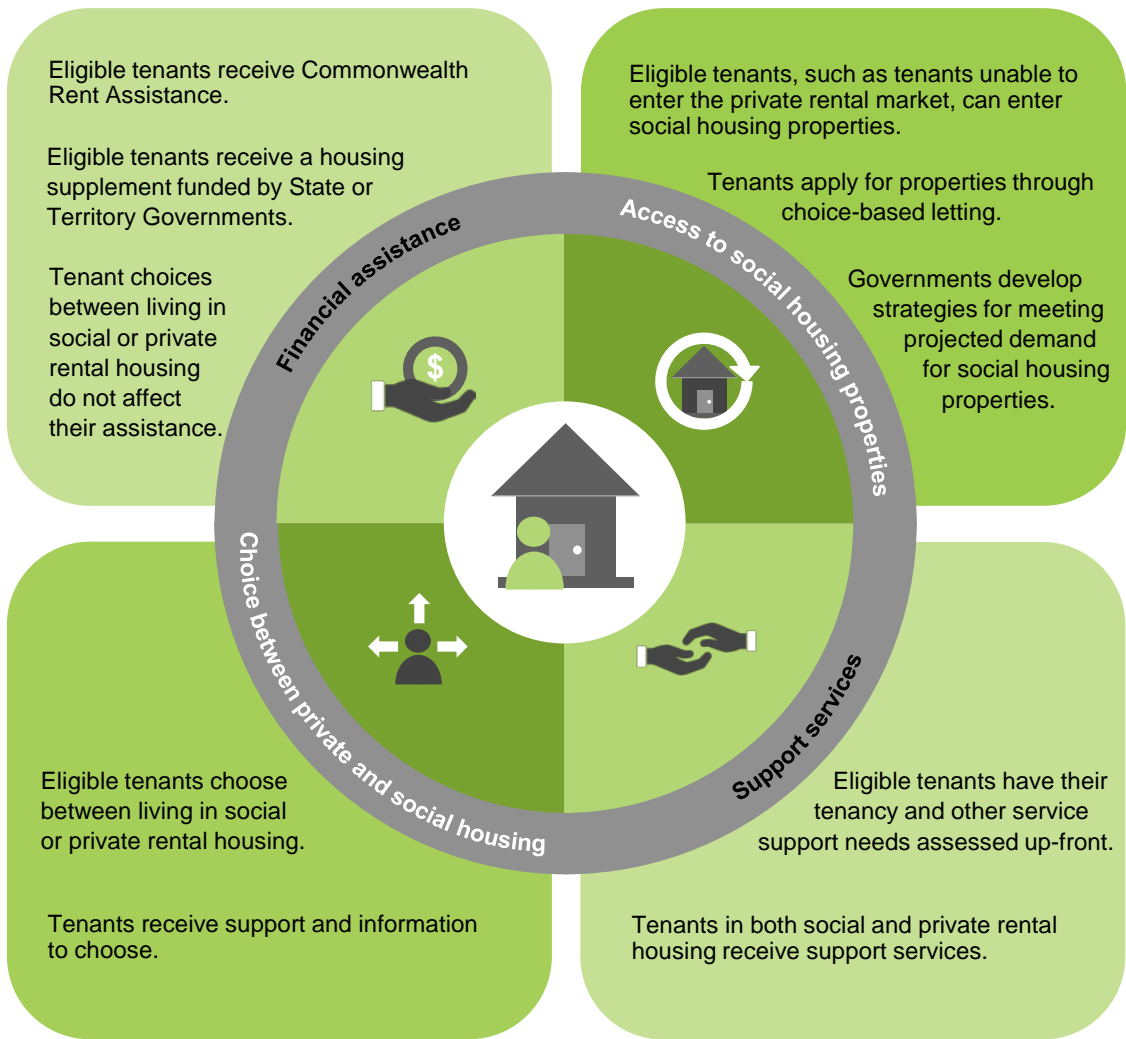
Unlocking user choice requires governments to rethink the way they meet the needs of tenants who are eligible for housing assistance — to shift the focus of social housing away from providing financial assistance and tenancy support services according to whether a person lives in public, community or private housing toward a single system of financial assistance that can be accessed regardless of the type of housing a person chooses to live in.

The proposed reforms summarised in figure 5.3 present the Commission’s approach to a single system of financial assistance — an approach that would place the user at the centre of the social housing system. The reforms also recognise the significant variation in local housing market conditions in each state and territory, including the variation in the affordability and nature of housing across and within jurisdictions. Importantly, the design of the reforms is flexible enough to enable each State and Territory Government to tailor implementation to meet the outcomes it seeks from the social housing system, given these variations.

Implementing the reforms proposed in chapters 6 and 7 will require a new agreement between, and increased effort from, the Australia Government and the States and Territory Governments (chapter 6). The financial reforms, in particular, will involve additional fiscal costs, with these varying across jurisdictions. States and Territories with higher priced-housing will inevitably face higher costs in delivering support to those in housing need. Reform will also inevitably involve some trade-off between financial certainty and

choice for future social housing tenants. As with other areas of social policy, measuring these effects in dollar terms is difficult. Taken together, the Commission’s view is that the benefits of the reform in improving the effectiveness of social housing more than outweigh the costs.

Figure 5.3     **Putting the user at the centre of social housing — the Commission’s recommendations**



## Evaluating reforms

The Commission’s reforms should be evaluated five years after they are implemented based on whether they have been successful in putting users at the centre, and at improving outcomes for users and the broader community. Each State and Territory Government has different objectives for its social housing system, and the indicators that they use to assess the effects of reforms will vary. Regardless, the Commission considers that there are several

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metrics that should be considered in the evaluation of reforms, based on the five attributes of human service delivery (chapter 1).

- The quality of housing assistance, including both assistance received to rent in social and private housing, should be based on whether tenants are receiving stable housing that meets their needs, and is affordable. Quality can be measured by tenant satisfaction measures — whether tenants are happy with the home they live in — as well as affordability measures based around self-reported financial stress. The quality of tenancy support services could be assessed based on measures of economic participation and the stability of tenure, as well as broader measures of a tenant’s wellbeing (chapter 7).
- Equity is a key driver of the reform path, and the effect of reforms across the groups of people eligible for social housing should be assessed.
- Assessing the efficiency of the social housing system can include use of both financial metrics, based around the costs of providing tenancy management and tenancy support, as well as utilisation metrics — whether social housing properties are underutilised or overcrowded.
- Responsiveness should be assessed based on whether tenants are able to exercise genuine choice of home, as well as whether the social housing system is able to identify tenant needs, and deliver appropriate services to them.
- Reforms should be evaluated based on whether they provide incentives for accountable and transparent decision making, including separating the key functions of housing authorities to ensure that there are no conflicts of interest.

Evaluation across these metrics should be used to inform continuous improvement in the delivery of social housing. Where some jurisdictions implement reforms before others, the evaluation can also be used to inform whether and how to proceed with reform in other jurisdictions.



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## 6 Choice and equity in social housing: a single system of financial support

### Key points

- A single system of financial assistance that is portable across rental markets for private and social housing should be established. A single system of financial assistance would:
  - enable a person to choose where they live based on their preferences — their access to financial assistance (and tenancy support services) would ‘follow them’
  - address current inequities by targeting the type and amount of financial assistance a person receives to their circumstances, rather than the type of housing they live in.
- The establishment of a single system of financial assistance hinges on reforms being undertaken at both the national and state and territory level so assistance can be provided as a package.
  - The Australian Government should extend Commonwealth Rent Assistance (CRA) to tenants in public housing so that it is available to all eligible tenants in social housing properties. People who live in private and community housing already receive CRA, people in public housing do not. This change would provide a consistent baseline level of support.
  - State and Territory Governments should provide and fund an additional housing supplement. The supplement should target eligible tenants in areas with acute rental affordability problems for whom CRA is insufficient.
- State and Territory Governments should charge new social housing tenants market rents. Existing tenants should continue to pay rents set as a proportion of their income for up to 10 years, unless they elect to move to the new system of financial assistance earlier.
- Many households could benefit from reform.
  - Over 50 000 social housing tenants have expressed dissatisfaction with the property they are in. They currently face a stark choice — remain in social housing in an unsuitable property or move to the private rental market and potentially receive less financial assistance.
  - Increasing choice would lead to some tenants moving into private housing, which would result in more social housing properties becoming available for tenants who need them.
  - There are about 850 000 households eligible for, but not in, social housing. The proposed State- and Territory-funded housing supplement could benefit these households where they are in areas with acute rental affordability problems.
- Even with greater choice between social and private housing, there would remain a strong role for social housing properties to provide a home for people who have limited opportunity to rent in the private market.
  - A choice-based letting model would provide these tenants with more choice of home.

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The current two-tiered system of financial assistance must be replaced for choice and competition to address the problems in the social housing system. The system is fundamentally inequitable — the financial assistance a household receives depends on the sector from which they rent their home, rather than their circumstances. The way financial assistance is provided discourages user choice because tenants often have a strong incentive to enter, or remain in, social housing properties, rather than seeking potentially more suitable housing in the private rental market. Tenants in social housing properties are less responsive to the trade-offs faced by people renting in the private market, such as deciding on whether to meet the extra cost of living in a higher priced suburb (chapter 5). The system is further complicated by the fact that some social housing tenants receive Commonwealth Rent Assistance (CRA), while others do not.

People who live in social housing have little say over the home they are allocated. They are often unable to satisfy their preferences for aspects of a home such as its layout, location and size. The suitability of the allocated property can often be a question of luck.

This chapter sets out recommendations to increase choice for tenants, both between entering social housing and private housing (sections 6.2, 6.3 and 6.4), and within social housing (section 6.5). The Commission's recommendations to increase user choice and equity in the social housing system are summarised in table 6.1. Chapter 7 outlines reforms that support the recommendations in this chapter, and other reforms to improve the contestability, stewardship and planning, and user focus of the social housing system.

## **6.1 The importance of choice**

Enabling tenants to have greater choice between private and social housing would increase the opportunity for tenants to find a home that meets their requirements. Many social housing tenants could benefit.

- About 13 per cent of public housing tenants surveyed in 2013 — equivalent to over 50 000 households in social housing — expressed a desire to leave public housing in the short term (Wiesel et al. 2014). Concerns raised by tenants included rowdy and unsafe neighbours, poorly maintained or undersized properties, or properties that were unsuitable for a person with disability. Many of these tenants are deterred from leaving social housing because, under current policies, they would receive less financial assistance in the private rental market. A similar number of social housing tenants have expressed dissatisfaction with the property they are in (AIHW 2017e; SCRGSP 2017).
- There is a mismatch between the housing requirements of some tenants, and the size of the homes they live in. About 16 per cent of households in public housing are in homes that have more bedrooms than the household requires (SCRGSP 2017).
- There are some tenant cohorts, such as single parents, who have expressed a particularly strong desire to move from public housing and into private rentals, but are no more likely than other tenants to do so (Seelig et al. 2008; Whelan 2009; Wiesel et al. 2014).

People living in an unsuitable social housing property currently face a stark choice. They can remain in an unsuitable property, or move into a home in the private market where tenancies can be insecure and the amount of financial assistance they receive can potentially be (sometimes substantially) lower (chapter 5). Many who do move face significant financial hardship and can find it difficult to maintain their tenancy. About 17 per cent of households that exited public housing in 2002 lived in public housing again by 2010 (Wiesel et al. 2014).

**Table 6.1 The Commission's recommendations**  
Introducing user choice and contestability into social housing

<i>Proposed reform</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Improving choice between social and private housing</b>		
<p><b>Recommendation 6.1</b> Australian, State and Territory Governments to introduce a single system of financial assistance that is portable across rental markets for private and social housing.</p> <ul style="list-style-type: none"> <li>The Australian Government should extend Commonwealth Rent Assistance to tenants in public housing so that is available to all eligible social housing tenants.</li> <li>State and Territory Governments should each design and fund a housing supplement to eligible tenants in areas with acute rental affordability problems.</li> </ul> <p>State and Territory Governments should charge market rents for tenants in social housing, with arrangements for existing social housing tenants grandfathered for up to 10 years.</p>	Medium to long-term	<p>Extending CRA to public housing tenants would cost the Australian Government about \$1.2 billion each year. Fiscal costs to State and Territory Governments are dependent on the design of the housing supplement.</p> <p>Running two systems of assistance nationally over the transition period would have an administrative burden.</p> <p>Addresses inequities between private and social housing and grants tenants greater choice and access to the private market.</p> <p>Housing supplement would help deliver affordability to eligible tenants in areas with acute rental affordability problems.</p> <p>Social housing providers would receive additional revenue, which could be used to construct additional properties, or improve existing properties.</p> <p>Making the financial assistance received by tenants more explicit would improve government decision making by increasing transparency.</p> <p>Choice between private and social housing would increase competitive pressures on housing providers.</p>
<b>Choice within social housing</b>		
<p><b>Recommendation 6.2</b> State and Territory Governments to introduce choice-based letting for tenants entering into, and transferring between, social housing properties.</p>	As soon as practicable	<p>Choice-based letting involves setup costs. Support needs to be given to tenants who may struggle to exercise choice.</p> <p>Grants tenants in social housing a greater choice of home.</p> <p>Can provide information to governments about the type of housing that tenants prefer.</p>

People who need to quickly change their housing situation could benefit from greater choice between social and private housing. The Victorian Royal Commission into Family Violence (2016, p. 85) found that while social housing properties may be a suitable long-term option

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for some people at risk of or experiencing family violence, they rarely offer the flexibility to deliver a rapid response or a property in the right location to suit their needs.

Compared with social housing, the private rental market can offer greater locational choice and flexibility in meeting the needs of family violence victims. Social housing is generally offered in areas where there is a vacancy, rather than where a woman needs to live.

The benefits of exercising choice go beyond tenants' increased satisfaction with their home. Tenants empowered with greater choice are more likely to engage with their local community (section 6.5), and can locate closer to any services they need, including schools and hospitals (BSL, sub. 289). Better housing outcomes have been linked to improved health outcomes, which could have flow-on benefits to government expenditure for other human services (NSW FACS 2016c). Choice between social and private housing could be of particular value to long-term recipients of housing support (Henry et al. 2009).

Greater choice between social housing and private rental housing could take some pressure off the social housing system. It could increase the availability of social housing properties by making it easier for tenants to move into, or remain in, private housing — in particular for those who are in, or looking to enter, social housing to reduce their housing costs. Some of the more than 150 000 households on waiting lists to enter social housing could benefit as they would be able to access social housing sooner. It could also lead to more social housing properties to choose from (section 6.5).

Most people entering social housing properties are able to make choices over the home they live in, if given the opportunity. Some people, such as those with mental health conditions, may require support to exercise choice (CMHA, sub. 399; QAI, sub. 442). This is discussed in chapter 7.

Some social housing tenants wish to remain there. Social housing is an important safety net for people who value the stability and support offered within social housing (Wiesel et al. 2014). Others may face substantial barriers to entering the private rental market. Some social housing tenants are discriminated against, landlords can be reluctant to rent to tenants without a strong financial history, and some real-estate agents consider some tenants, such as those with a severe disability or a history of mental illness, as not suited to renting in the private market (AHV, sub. PFR316; JSS, sub. 420; TUV, sub. DR563). While some barriers to entering the private market can and should be overcome (for example, governments can improve tenancy support in the private market (chapter 7) or enter into alternative leasing arrangements (such as headleasing — chapter 7)), the safety net provided by social housing needs to be maintained and its effectiveness improved.

## **6.2 Unlocking choice: A single system of financial assistance**

Unlocking user choice requires governments to rethink the way they meet the needs of tenants who are eligible for housing assistance — to shift the focus of social housing away

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from providing financial assistance and tenancy support services according to whether a person lives in private, public or community housing toward a single system of financial assistance that can be accessed regardless of the type of home a person chooses to live in. Reforms to enable people to have a genuine choice over where they live would improve the responsiveness of the social housing system to the requirements of tenants by increasing competition between housing providers.

The Commission has considered two ways that a single system of financial assistance could be implemented.

- Governments could *extend rent assistance based on a proportion of income* to those receiving housing assistance in the private sector. This model is used to provide assistance to some tenants renting in the private market in the United States.
- Governments could *contribute an amount toward the rental cost* of eligible tenants, with the contribution based on a proportion of the tenant's rent. The contribution could be provided regardless of whether the tenant rents in the social or private sector, and rents in social housing would be set at the market rate. CRA is an example of a payment that contributes to rental costs.

The Commission favours a contribution to rent model, due to the balance of benefits and incentives it would deliver. This model would create a price incentive for tenants to choose the property that best suits their needs, whether that is in the private market, or in a choice-based letting system in social housing (section 6.5). This price incentive is not a feature of income-based rents. As rents for all properties (up to a rent cap) are set at the same level, tenants face an incentive to rent the most expensive property that government would subsidise, and have little incentive to resist rent increases by private landlords (Gibbons and Manning 2006).

The key benefit of income-based rents is that they prioritise affordability and financial stability for tenants. Some tenants place significant value on the certainty that income-based rents provide (Wiesel et al. 2014). While affordability of housing is a strength of setting rents at a proportion of tenant incomes, it does not necessarily guarantee that tenants will avoid 'rental stress'. There is evidence of some households who exceed the 25–30 per cent income rental threshold facing little financial difficulty (Burke, Stone and Ralston 2011). Similarly, some households that pay less than 25 per cent of their income in rent can face significant rental stress (box 6.1).

Many participants stated that a contribution to rent model would lead to significant affordability issues for tenants. Sydney and Melbourne were cited as examples of locations that would be unaffordable for households on low incomes. Not all those who are eligible for social housing live in Sydney, Melbourne or other high cost locations but, for those who do, affordability under a contribution to rent model can be preserved through the design of the scheme (discussed further below). This should be based on an important principle — tenants who have a *requirement* to rent a more expensive property should be provided with additional assistance. At the same time, tenants who have a *preference* to rent a more

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expensive property should be able to rent one, but should face at least some of the additional cost of that decision.

### **Box 6.1      What is ‘affordable’ rent?**

An often-used indicator of rental housing affordability is the ‘proportion of income rule’ — a household is considered to be in rental stress if it spends more than a certain proportion of its income on rent. For the private rental market, this proportion is sometimes considered to be 30 per cent.

The proportion of income rule is at best a crude measure of affordability. It does not take into account important differences between households that affect their ability to meet housing costs, including the characteristics of the household (such as the age of family members), and their non-housing costs (such as food, transport and medical costs). Another indicator of housing affordability, known as the ‘residual income’ approach, considers whether households can afford to purchase essential non-housing goods and services once they have paid their rent, although it requires subjective judgments about essential expenditure and suffers from a lack of data.

The point-in-time snapshot provided by indicators of housing stress must also be set against how housing experiences can change over time. As the circumstances of a household change — for example, once any children grow up and leave home — their capacity to meet rental costs will also change. By one estimate, nearly three in four households in housing stress will no longer experience it within one year, and only a small minority will be experiencing housing stress within five years. Some types of households are particularly susceptible to long, or recurring, periods of housing stress. These include low-income households with dependent children, migrants from non-English speaking backgrounds, and the self-employed.

*Sources:* AHWG (2016); Burke, Stone and Ralston (2011); IPART (2016); Wood, Ong and Cigdem (2014).

Some studies cite disincentives to work as a key disadvantage of setting rents at a proportion of tenant incomes, and advocate for changes in the financial assistance model for social housing as a result (Dockery et al. 2008; Henry et al. 2009). This is not a strong reason for reform. Several studies, including previous empirical work undertaken by the Commission, found that changing rent setting arrangements is unlikely to boost employment among public housing tenants (Cigdem-Bayram, Ong and Wood 2017; IPART 2017; PC 2015b). CRA, which is an example of a contribution to rent payment, also has a minimal effect on employment among its recipients (Cigdem-Bayram, Ong and Wood 2017). Simply put, it is the characteristics of individuals, and not the housing assistance they receive, that most explains their likelihood of being in employment.

## **6.3      Designing a single system of financial assistance**

A single system of financial assistance that is portable across rental markets for private and social housing would serve two purposes. One, it would enable a person to choose where they live based on their preferences rather than the type of financial assistance they would receive — their access to financial assistance (and tenancy support services) would ‘follow them’. Two, it would address current inequities by targeting the type and amount of financial

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assistance a person receives to their circumstances, rather than the type of housing they live in. Getting the design of this system right, including eligibility criteria and how assistance levels are calculated, is necessary to achieve these outcomes.

### **Financial assistance should be provided as a package**

Income-based rents should be replaced with a system of financial assistance that is portable across rental markets for private and social housing (box 6.2). The establishment of a single system of financial assistance hinges on reforms being undertaken at both the national and state and territory level so assistance can be provided as a package.

- The Australian Government should extend CRA to tenants in public housing so that it is available to all eligible tenants in social housing properties. People who live in private and community housing already receive CRA, but people in public housing do not. This change would provide a consistent baseline level of support.
- State and Territory Governments should provide and fund an additional housing supplement. The supplement should target eligible tenants in areas with acute rental affordability problems for whom CRA is insufficient (discussed below).

This package of financial assistance creates a payment that responds to demographic and housing market differences between, and within, jurisdictions. Rental prices vary significantly across the country and the financial assistance provided in jurisdictions where rental prices are high (such as New South Wales) may not be suitable in jurisdictions where rents are lower (such as Tasmania). The package of financial assistance also creates clear responsibilities for governments. The Australian Government would be responsible for providing a consistent baseline of financial assistance, and the State and Territory Governments would be responsible for responding to local housing market conditions in their jurisdiction. This would increase transparency and improve government accountability.

### **State and Territory Governments should provide and fund a housing supplement**

In contrast to the views put to the Commission in several submissions (for example, CHP, sub. DR522; National Shelter, sub. DR582; TUV, sub. DR563), CRA would provide an adequate contribution to rental costs for many tenants in private and social housing. For example, about one quarter of households in public housing in Victoria and South Australia would be better off if they received CRA rather than their assistance through income-based rents (chapter 5). About 60 per cent of people who currently receive CRA pay less than 30 per cent of their income in rent — an often used (but imperfect) indicator of ‘rental stress’ (SCRGSP 2017).

Some tenants need to rent in higher-cost areas or in higher-cost properties, and CRA does not account for differences in rental prices between regions or properties above the maximum rent cap. Some of these households would be able to access additional programs that contribute toward their rental costs. For example, the National Disability Insurance

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Scheme contributes toward the cost of accommodation in situations where the participant has a need for specialised housing due to a disability (NDIA 2014). Where these programs, and CRA, are not sufficient to meet a household's requirements, State and Territory Governments could pay a housing supplement to that household.

Eligibility for, and the level of, the housing supplement would be a matter for State and Territory Governments, but should be calibrated to the demographics and housing market characteristics of their jurisdictions. The supplement should:

- be provided to eligible tenants in areas with acute rental affordability problems
- be set at a level (or levels) where eligible tenants can afford housing that meets their requirements, but provides incentives for them to choose the housing they most value given their needs and financial circumstances
- be portable — tenants eligible for the supplement should be able to use it in either private or social housing
- recognise that a tenant's need (and eligibility) for financial support can change over time. For example if a person's employment situation changes and they are earning a higher (or lower) level of income, then the amount of assistance that they receive should adjust. These adjustments should be calibrated with those applying to income support payments to avoid financial disincentives to employment, and introducing new inequities between recipients of income support payments. This could be achieved, for example, by designing the housing supplement as an add-on to the existing CRA and using the same adjustment (taper) arrangements.

In addition to giving people in social housing a genuine choice over where they live (section 6.1), many people currently living in the private market could benefit from the housing supplement. Of the about 850 000 households eligible for, but not in, social housing:

- more than 150 000 households are on waiting lists to enter social housing (SCRGSP 2017)
- around 450 000 households are currently paying more than 30 per cent of their income in rent (Productivity Commission estimates based on the Australian Government Housing Dataset).

The proposed State- and Territory-funded housing supplement could benefit these households where they are in areas with acute rental affordability problems. Once assessed these people could potentially use their supplement in the private market immediately. This could take pressure off waiting lists and ensure that people who need social housing receive it more quickly (box 6.2).

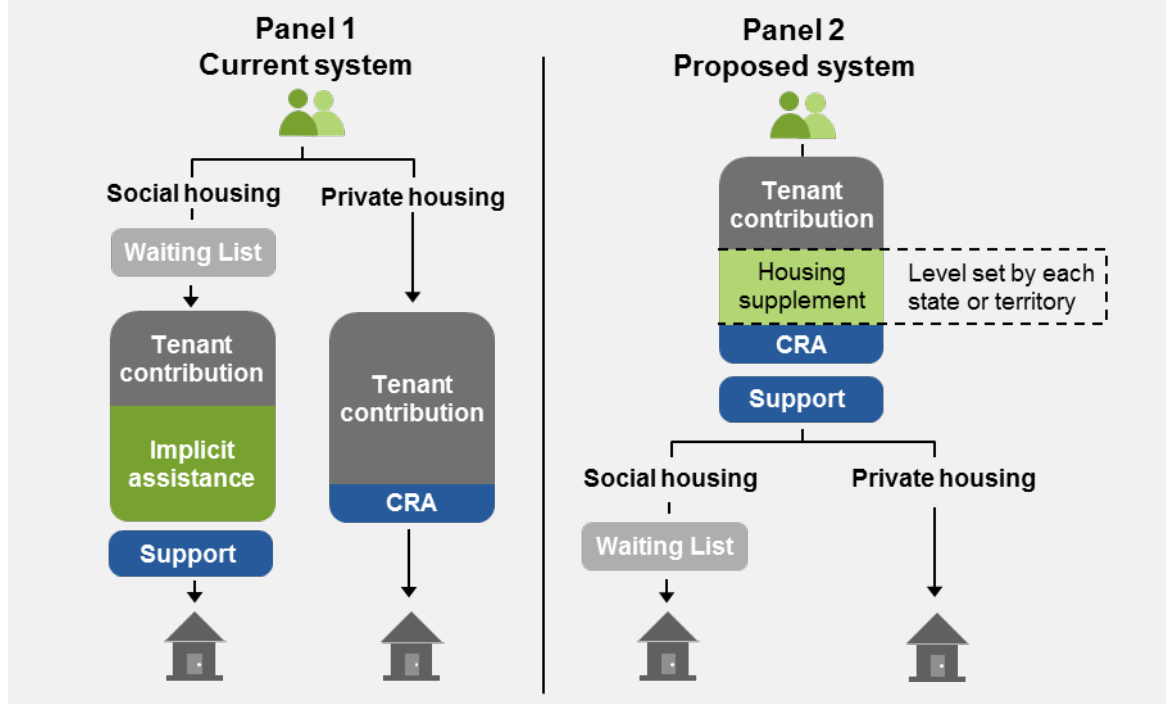
## Box 6.2 A single system of financial assistance

The figure below illustrates the financial assistance and tenancy support received by a household under the current and proposed systems of assistance. In the example, the household is assumed to be a couple with no children that lives in an area with acute rental affordability problems.

Panel 1 of the figure shows the level of financial assistance and tenancy support the couple receive under the current system. The couple receive a different level of assistance and support depending on whether they live in private or social housing.

- In private housing they receive Commonwealth Rent Assistance (CRA) and pay market rents.
- In social housing they generally face a wait to be allocated a property. Once allocated a property, they pay a rent set at a proportion of their income (usually 25 per cent) and receive implicit assistance equal to the difference between the rent they pay and the market rent. They also have access to tenancy support services. If the couple lives in community housing some of their implicit assistance is funded through CRA.

Panel 2 shows the financial assistance the couple would receive under the Commission's proposed single system of assistance. The couple would receive a package of assistance that is portable between rental markets for private and social housing. This would include CRA and, because they live in an area with acute rental affordability problems, a housing supplement. Eligibility for, and the level of, the housing supplement would be a matter for State and Territory Governments. The couple would have access to tenancy support services regardless of whether they live in private or social housing. If they choose social housing they may continue to face a wait to be allocated a property, but would receive their assistance package during this waiting period. Social housing properties would be allocated through choice-based letting, giving the household more choice of home. Social housing properties would continue to offer more secure tenancies than generally available in the private rental market.



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Each level of government controls policy levers that influence drivers of housing demand, supply and affordability. For example, the Australian Government sets national taxation policy and macro-prudential regulations, and State, Territory and Local Governments set planning and zoning rules. However, the financial costs of unaffordable housing — and the incentive to take action — are not shared equally by all governments. Whereas the Australian Government is exposed to rising rental prices through the CRA, the fiscal cost to State and Territory Governments of rising rental prices is relatively limited. Vesting responsibility for the housing supplement in the State and Territory Governments would increase their financial exposure to rising rental prices and could provide a stronger incentive for them to undertake reforms that improve housing affordability (chapter 5).

There would be administrative costs involved in managing the housing supplement. Regular reporting of household incomes would be required to determine the level of assistance households are eligible to receive, and ongoing assessment of eligibility. State and Territory Governments already have payment systems in place, but it is likely that further investment in these systems would be needed to deliver the housing supplement.

An alternative may be for the Australian, State and Territory Governments to collaborate on delivery of the payment by using the Australian Government's existing income support payment system. This could reduce administrative costs by reducing the need for each State and Territory Government to develop separate payment systems. This would be a matter for negotiation between governments when designing reforms.

## **New social housing tenants should be charged market rents**

Underlying the Commission's reforms is the principle that people in similar circumstances should receive similar levels of financial assistance. Tenants in social housing often receive higher levels of support through the implicit assistance embedded in income-based rents. A move to market rents for new social housing tenants would, over time, address this inequity.

A move to market rents makes the financial assistance received by tenants more explicit. This could improve government decision making by providing a transparent signal to policy makers and the public about how government funds are spent. Charging market rents in social housing also provides a common base from which the level of financial assistance provided to a household can be calculated. Some State and Territory Governments, such as New South Wales and Victoria, currently determine the market rent of a social housing property by benchmarking it to private properties with similar characteristics in the local area (NSW FACS 2017a; Victorian DHS 2013).

Charging new social housing tenants market rents would reduce some of the inequities between tenants living in social housing properties (chapter 5). When paired with providing financial assistance through the single system, market rents mean that households who are living in a more expensive property contribute more toward the cost. Market rents would also move social housing providers onto a more sustainable financial footing. This revenue could help to address the large maintenance backlog in social housing (chapter 5).

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Charging market rents in social housing could reduce some of the administrative costs associated with income-based rents. For example, the Tenants' Union of New South Wales (2016, p. 13) noted that 'income-based and residual income-based rents create high levels of complex administration' and that errors in income disclosure and rent calculation can 'lead to complex — and often unnecessary — investigations of fraud'.

### **Income-based rents should be grandfathered for existing tenants**

Some existing social housing tenants would be financially worse off if they stayed in their current property and were moved onto the new system of financial assistance. Adjusting to this change would be difficult, requiring households to either pay a higher rent or move to a more affordable property. Some tenants would find the change more difficult, in particular when they are settled in their home and community, or if they are currently receiving a large rent discount.

The Commission is cognisant of these difficulties and is of the view that people who are currently living in social housing properties should continue to pay rents set as a proportion of their income for up to 10 years before being required to pay market rents, unless they elect to move to the new system of financial assistance earlier. This grandfathering of existing rent-setting arrangements recognises that some long-term decisions, such as where to enrol children in school, are often made with a particular housing situation in mind. Existing social housing tenants who continue to pay their grandfathered income-based rents would not be eligible for the additional housing supplement or, if they are in public housing, CRA. Tenants with grandfathered rent-setting arrangements would not gain any 'special' rights to their home that other social housing tenants do not have. Tenants who move out of their current property would be moved onto the new arrangements.

### **A new agreement between governments is required**

The reforms proposed by the Commission would require a new agreement between the Australian, State and Territory Governments. The Australian Government should only extend CRA to public housing tenants in a jurisdiction if that State or Territory Government agrees to implement reforms to introduce a well-focused housing supplement to address affordability concerns for people on low incomes and charge market rents for all tenants in social housing.

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#### RECOMMENDATION 6.1

The Australian, State and Territory Governments should work together to introduce greater user choice, and improve the equity and responsiveness of the social housing system, by introducing a single system of financial assistance for eligible tenants. This system should be portable across rental markets for private and social housing.

- The Australian Government should extend Commonwealth Rent Assistance to tenants in public housing so that it is available to all eligible tenants in social housing properties.
- State and Territory Governments should each design and fund a housing supplement for eligible tenants in areas with acute rental affordability problems.

State and Territory Governments should abolish the current model of financial assistance in social housing by:

- charging market rents for tenants in social housing properties rather than rents set at a proportion of income
- providing existing social housing tenants the option of moving to the new system of financial assistance or continuing to pay rent set at a proportion of income for up to ten years after the single system of financial assistance is introduced.

The Australian Government should only extend Commonwealth Rent Assistance to public housing tenants in a jurisdiction if that State or Territory Government implements this recommendation in full.

### **The fiscal effects of choice-based reform**

Delivering choice in social housing will involve costs. These costs primarily result from the creation of the single system of financial assistance, although there would be other costs, such as the costs involved in improving the stewardship of social housing and improving tenancy support services (chapter 7).

The Commission has conducted a static analysis of the fiscal effects of extending CRA to public housing tenants. The analysis provides a point-in-time (July 2016) cost estimate. As the population grows and prices in the rental market change, the number of people eligible for CRA would also change, and this would affect the level of expenditure required. The analysis does not take into account factors such as households relocating or new households forming.

Based on this analysis, the Commission estimates that the Australian Government would be required to increase its expenditure on CRA by about \$1.2 billion each year to extend CRA to public housing (Commission analysis; SCRGSP 2017). This is similar in magnitude to existing Australian Government payments under the National Affordable Housing Agreement, which has a broader remit including homelessness.

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State and Territory Governments would receive additional rental revenue over the long term from social housing properties. They would also be required to fund the housing supplement for eligible tenants in areas with acute rental affordability problems. Actual costs to State and Territory Governments of the supplement would depend on its design and, in particular, how tightly each government targets the supplement, making any estimates of cost hypothetical. Given this, the Commission has not provided estimates of the potential cost of the supplement to State and Territory Governments — it has no basis to make a selection from the range of the possible combinations of eligibility and supplement design that are available to those governments.

## **The level of Commonwealth Rent Assistance**

The objective of CRA is to provide tenants in the rental market on a low income with additional financial assistance in recognition of the housing costs they face. Several participants noted that the contribution of CRA toward rental costs has decreased in recent years and that it no longer provides an adequate level of support for many tenants (CHL, DR551; CHP, sub. DR552, CSSA, sub. DR533; HHS, sub. DR568; JSS, sub. DR530; National Shelter, sub. DR582; TUV, sub. DR563).

The Commission notes that the relative value of CRA compared with rental prices has declined over time. Increases in the maximum CRA payment are currently tied to the consumer price index (CPI), which has been outstripped by growth in rental prices over the past decade (figure 6.1). Between June 2003 and June 2017, the CPI increased by about 41 per cent, compared with an increase of about 64 per cent in average rental prices nationally over the same period (ABS 2017a). Between 2003 and 2016 (the last year that data are available), the average rent paid by households on low incomes<sup>1</sup> and renting from a private landlord increased by 100 per cent (ABS 2004, 2017b).

A consequence is that the maximum CRA payment no longer provides an adequate contribution toward rental costs for many households. The minimum amount of rental expenditure needed to receive the maximum CRA payment is now reached at a relatively low level of rent. About 80 per cent of households receiving CRA receive the maximum amount of CRA, up from about 67 per cent in 2007 (SCRGSP 2008, 2017). A couple with no children receives the maximum CRA payment if they are renting a property with market rent of about \$180 per week or more (DSS 2017). In Melbourne, only 10 per cent of one-bedroom apartments rent for \$235 per week or less (Victorian DHHS, pers. comm., 11 April 2017).

The maximum CRA payment would need to be increased by about 15 per cent to address the decline in the value of CRA relative to rental prices since 2007. A larger increase would be needed to restore the relative value of the maximum CRA payment to its previous levels for households on low incomes. Maintaining the relative value of CRA into the future would

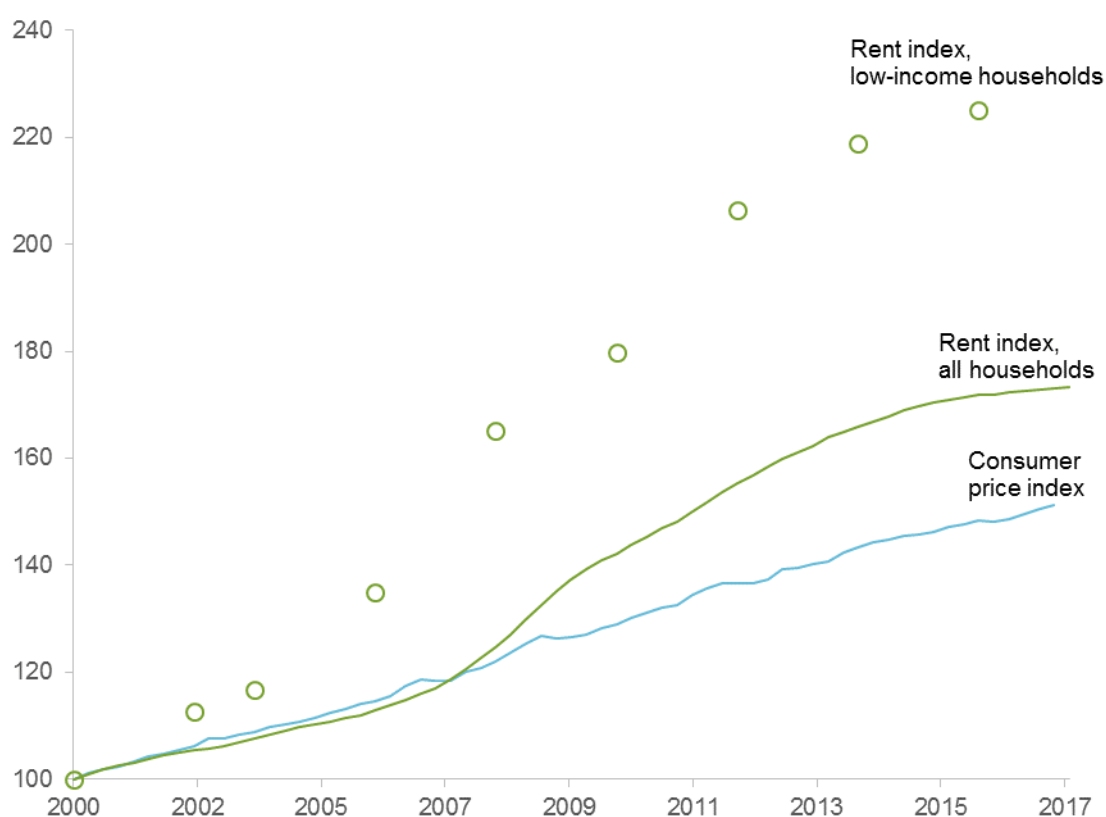
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<sup>1</sup> Households with an equivalised income that puts them at or below the 40<sup>th</sup> income percentile.

require the Australian Government to change the way it indexes the payment, for example, by indexing the maximum CRA payment to the average rent paid by recipients of the CRA.

While desirable, addressing the decline in the relative value of CRA compared with rental prices is not essential to the design of greater choice and competition in the social housing system.

**Figure 6.1 Rental prices have increased faster than CPI<sup>a</sup>**  
December quarter 2000 to June quarter 2017



<sup>a</sup> Rent index for all households is constructed by the ABS using a weighted average of the eight capital cities. Rent index for low-income households includes rents paid to private landlords only.

Sources: ABS (Consumer Price Index, Australia, Mar 2017, Cat no. 6401.0; Housing Occupancy and Costs, Australia, various years, Cat no. 4130.0 and 4130.0.55.001).

## Rental costs for non-subsidised tenants

Some participants noted that an increase in housing assistance could raise rental costs for non-subsidised tenants (CHP, sub. DR522; CSSA, sub. DR533; JSS sub. DR530, National Shelter, sub. DR582). The effect of providing eligible households with a housing supplement on housing demand would depend on how the supplement is designed.

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Nonetheless, an increase in housing assistance would increase the demand for private rental housing and, in turn, affect the price of rental properties. The Commission is unaware of any research that has quantified the effect private rental assistance has on the Australian housing market, but one factor affecting how rental prices change are local housing market conditions. In areas where property developers can more easily build additional properties in response to changes in rental demand — such as on the metropolitan fringe — price changes are likely to be small. In areas where the supply of rental properties is constrained the change in rental prices could be greater.

## **Residualisation and neighbourhood segregation**

National Shelter (sub. DR582) considered that the Commission's reforms would increase income segregation between suburbs, as market rents in social housing pressure people on low incomes to move into cheaper suburbs on the metropolitan fringe. This would not necessarily be the case. The system of financial assistance proposed by the Commission would increase the amount of housing assistance available for some people, and open up more opportunities for people renting privately to access housing in less disadvantaged neighbourhoods. At the same time, social housing would continue to be occupied by those who need it.

A related concern is the concentration of disadvantage within social housing estates. Approximately 40 per cent of social housing properties in New South Wales are co-located in large-scale housing estates (NSW FACS 2016b). As social housing provides a safety net for people with high needs, this can create neighbourhoods where a high proportion of residents are disadvantaged. A social environment can develop that compounds the effects of disadvantage, and increases the chance that disadvantage is passed on from one generation to the next (Vinson 2009). Australian research has found that a child who resides in a lower-income neighbourhood has a higher chance of being unemployed in early adulthood as a result (Andrews, Green and Mangan 2002). Some social housing tenants are also negatively affected by the neighbourhood stigmatisation that comes with concentrations of disadvantage (Jacobs and Flanagan 2013; Pawson, Hulse and Cheshire 2015).

State and Territory Governments agreed to reduce the concentration of disadvantage in social housing estates as part of the National Affordable Housing Agreement. The Commission agrees this is an important objective. One approach to reduce the concentration of disadvantage in social housing estates is to redevelop estates into 'mixed use' communities. Existing social housing is cleared, and in its place a mix of social, affordable and private housing is built. Due to higher property density the original number of social housing properties can be maintained, but within a neighbourhood that comprises a wider variety of households. This is an approach that several State and Territory Governments have adopted to reduce concentrations of disadvantage in their social housing communities. Planning interventions such as incentives for property developers to include a number of affordable housing properties in new residential developments can also help to achieve a mix of tenants in a community (Davison et al. 2012).

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## **6.4 Transitioning to a single system of financial assistance**

Introducing greater user choice into the social housing system would require changes to the way that financial assistance for housing is currently provided (recommendation 6.1). Implementing significant reforms requires careful management from governments to avoid problems for users. In some states and territories the fiscal costs of reform could be high during the period where existing social housing tenants continue to pay rents set at a proportion of income. A net increase in expenditure may be required in the short term to provide a housing supplement to households renting in the private market. However, the increase in revenue from market rents is only realised after households currently in public housing move onto the single system of financial assistance, or leave their current home.

If necessary, State and Territory Governments could choose to implement reforms to financial assistance on a staged basis, increasing the number of supplements over time and managing demand via waiting lists. This would allow them to increase expenditure in line with the increase in revenue as public housing tenants move to market rents. A staged implementation would allow governments to gather further information and evidence before proceeding with a full roll out, and provide time to implement other reforms to increase the net benefits of implementing a new model of assistance (chapters 5 and 7).

Initially limiting the number of housing supplements available would maintain some of the inequities of the current system of financial assistance, as some households would receive the supplement while others facing similar circumstances would not. State and Territory Governments that opt to transition to a single system of financial assistance (recommendation 6.1) should do so in as short a time as possible so that the period that these inequities persist is minimised. During any transition, priority should be granted to households with the highest needs.

## **6.5 Enabling greater choice within social housing**

Even with greater choice between social and private housing, there would remain a strong role for social housing properties to provide a home for people who have limited opportunity to rent in the private market. For example, eligible people can enter social housing because landlords in the private market are reluctant to rent to them, or because they value the stability offered by greater security of tenure.

The reforms to the system of financial assistance proposed in section 6.3 would, over time, lead to more social housing properties being available. Some tenants who are currently in social housing would find it easier to move into private housing, and some applicants who would have entered social housing solely for affordability reasons could elect to remain in the private rental market. This would provide State and Territory Governments with an opportunity to focus the allocation of social housing properties on those who are not well

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placed to enter the private rental market, or need the unique stability offered by social housing.

## **Social housing tenants should have more choice over where they live**

Participants to several studies and inquiries have cited the need for, and benefits of, social housing tenants having more choice over the homes they are allocated. The NSW Federation of Housing Associations et al. (sub. 235) and National Shelter (sub. 232) supported moves to increase choice of home for social housing tenants, as well as steps to increase their involvement in routine decision making. Youngcare (sub. PFR323) argued the need for tenants with disabilities to have choice of home and to be able to move to different homes as their needs change. The Council of Single Mothers and their Children (sub. 435) stated that the current placement model in social housing means that people receive housing that bears little or no relevance to their needs, and places further strain on households.

Tenants entering social housing properties should also have a choice of home. This would complement the move to market rents in social housing — the rent that a tenant would be willing to pay would be another aspect of the property that the tenant could have choice over.

## **International experience shows the benefits of choice-based letting**

An option to increase a person's choice over the home they are allocated is choice-based letting, which has been implemented in several countries overseas, including the United Kingdom and the Netherlands. Choice-based letting allows households to apply for properties they are interested in, changing the allocation process from one driven by the housing provider to one driven by the preferences of households (box 6.3). Participants were generally supportive of using a choice-based allocation scheme in Australia to improve user choice and system efficiency (AHV, sub. PFR316; CHL sub. DR551; HHS sub. DR568; NSW FHA et al., sub. DR539; QShelter, sub PFR352).

Evaluations of choice-based letting schemes in the United Kingdom found a range of benefits (Marsh, Cowan and Cameron 2004; Pawson and Watkins 2007).

- Tenants reported feeling increased agency over their housing situation, and thought it was a more open and transparent allocation process.
- People were more likely to stay in the same area, invest in the local community, and have stable accommodation.
- There was evidence that choice-based letting can improve the efficiency and quality of the social housing system. For example, data collected through choice-based allocation schemes was used to identify the housing characteristics that tenants prefer, and to target areas of high demand and need.

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Overall, about 80 per cent of registered users preferred the choice-based system compared with allocation models where the choice of home was made by a government agency (Brown and Yates 2005).

### **Box 6.3      Choice-based letting in the United Kingdom**

Choice-based letting schemes in the United Kingdom generally follow the same broad approach wherever they are used, although the exact details of the schemes vary between local government areas. Available social housing properties are advertised in newspapers and online, along with eligibility requirements such as income level and household size. All households that are eligible for social housing and meet the listed property requirements can apply. Applicants who may have difficulties using choice-based letting are identified, and direct assistance to navigate the system offered to these households.

Applicants are ranked against published selection criteria, such as waiting time, applicant age and the needs of the household. The applicant with the highest ranking is offered the property, and the qualifications of the successful tenant are published so that unsuccessful applicants can understand why they were not offered the property. Applicants are able to refuse the offer of a property, although in some cases there are penalties for refusal, such as not being able to apply for another property for a specified time period. A small number of people are directly allocated properties for social reasons, including health problems arising from their housing situation, homelessness, catastrophic circumstances or clearance due to urban renewal.

*Sources:* Brown and Yates (2005); Marsh, Cowan and Cameron (2004); Pawson et al. (2006).

Several participants questioned whether all the benefits of choice-based allocation schemes enjoyed internationally can be replicated here, due to our substantially smaller stock of social housing relative to countries that have introduced choice-based letting (AHV, sub. PFR316; CFRC sub. DR506; CHL sub. DR551; National Shelter, sub. 232; NSW FHA et al., sub DR539, SA Government sub. DR571). The United Kingdom has a larger and more diversified stock of social housing than Australia, meaning that tenants have a wider range of property types, in a wider range of locations, to choose from. Moreover, there is a better chance that the tenant's preferred property will become available in a suitable timeframe.

Despite these differences, there would still be benefits to implementing choice-based letting in Australia. About 10 per cent of all social housing properties — or approximately 40 000 properties — are vacated each year Australia-wide (AIHW 2016g; Wiesel et al. 2014). The number and variety of properties that become available will vary between each region, but most tenants could be presented with more choice than is currently offered. Those tenants who are flexible with the location and type of home in which they live, or those that are able to wait longer for a more suitable property to become available, would likely benefit the most. Even for tenants who have limited flexibility, choice between four or five properties is an improvement over a choice of one or two that the current system provides. Importantly, choice-based letting would enable social housing tenants to choose a property with a suitable rent.

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The Council to Homeless Persons (sub. DR522) raised concerns that people with complex needs, such as homeless people, could be at a disadvantage when applying for properties. Similar concerns were raised by some providers of homelessness services in the United Kingdom, although there was no indication that formerly homeless households were disadvantaged by choice-based letting once they received the right support (Brown and Yates 2005). The information and upfront support that all tenants should receive so that they can fully participate in a choice-based letting scheme is discussed in chapter 7.

### Choice-based letting has costs

The cost of implementing choice-based letting would vary depending on the requirements of each state and territory, including the number of properties that are covered by the scheme. As a guide, if the cost per property of establishing a choice-based allocation scheme in Australia was the same as that of a medium-sized housing association in the United Kingdom, then the up-front costs would range from \$10 to \$25 per property (Pawson et al. 2006). If set up costs are re-incurred every 5 years (due to depreciation), a benefit to tenants of \$2 to \$5 per property each year would be enough to justify this cost. The NSW Independent Pricing and Regulatory Tribunal (2017) noted that choice-based letting schemes implemented internationally have generated significant benefits that cover these costs.

Ongoing operation costs of choice-based letting schemes in the United Kingdom were found to be similar to those for non-choice-based schemes (Pawson et al. 2006; UK Audit Commission 2006). Given the focus of social housing in Australia on providing shelter to households with high needs, a greater proportion of applicants are likely to need support to prepare and submit applications (CFRC, sub. DR506). Ongoing costs would therefore likely be higher than in the United Kingdom. Under choice-based letting, applicants are required to actively and continually apply for homes. This increases costs, both in terms of tenant time and effort, and the cost of providing information and support to those who are vulnerable.

### Choice-based letting should be implemented with the single system of financial assistance

The Commission considers that State and Territory Governments should introduce choice-based letting for tenants in social housing. State and Territory Governments should also improve upfront support services to facilitate equitable participation in the scheme and publish the information needed to make an informed choice of home (recommendations 7.6 and 7.7). The NSW Independent Pricing and Regulatory Tribunal (2017) recommended that the NSW Government adopt a choice-based letting system with the existing social housing rent model kept in place, and other jurisdictions, including Victoria, are investigating choice-based letting using trials (Victorian DHHS 2016b).

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The Commission's proposed system of financial assistance (recommendation 6.1) would be likely to enhance the benefits of choice-based letting. Some people who are currently in social housing would elect to move into a home in the private market, which could increase the number of homes available for social housing tenants to choose from. The proposed system of financial assistance, in conjunction with choice-based letting, would also generate information about tenant preferences which governments can use to inform their planning processes and better allocate tenants to properties.

**RECOMMENDATION 6.2**

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

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## 7 A better social housing system: improving user focus

### Key points

- Reforming the social housing system would require strong government stewardship.
  - Clear government plans for how they would meet the future demand for social housing properties are essential, given the long-lived nature of housing assets and the inherent inflexibility of the social housing system.
  - Assessment of the outcomes for tenants receiving housing assistance, particularly tenants renting in the private market, would need to be improved.
- Continuing to make the management of social housing properties contestable would provide incentives for managers of social housing properties to improve the effectiveness of service provision, and increase the pressure on them to provide well-maintained properties that meet the requirements of tenants.
  - Contestable approaches should be open to all types of providers, and be backed by a full evaluation of property management transfers.
  - The management of public housing properties should be separate from social housing policy to improve the accountability of public housing providers. Public housing providers and non-government providers of social housing should face consistent regulatory requirements.
- Enabling users to have greater choice over their home requires that tenants are provided with adequate information on properties and support to help them make choices. Longer-term support is needed for some tenants to help them to sustain their tenancy.
  - High-quality intake and assessment services are key to matching tenants with both financial and non-financial housing support. Current intake and assessment services are fragmented and it can be difficult for tenants to identify the support they are eligible to receive. In some cases, tenants may not receive additional support services because providers are unable to identify what support the tenant requires.
  - Many support services targeted at social housing tenants are not made available to tenants renting in the private market. Making access to support services portable between social and private rental housing is an important part of enabling choice.

The Commission's recommendations to introduce greater user choice into the social housing system seek to:

- improve equity and increase user choice by providing a single system of financial assistance that is portable between the private and social housing markets, coupled with a move to market rents for social housing

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- enable tenants in social housing properties to have more choice over the home they will live in.

This chapter outlines reforms that both support those proposed by the Commission in chapter 6, and would increase the focus on users and improve the social housing system in their own right. The reforms in chapter 6 would require an increased focus on government stewardship, and support for users to exercise choice and maintain their tenancy. The effectiveness of social housing could also be improved by continuing to introduce contestability into the management of social housing, and implementing reforms to create a more level playing field for government and non-government managers of social housing. The Commission's recommendations to put users at the centre of the social housing system are summarised in table 7.1.

## **7.1 Improving government stewardship**

Sound stewardship arrangements should be a core part of the reform process for human services (chapter 2). The Commission's reforms for the social housing system would require strong government leadership, planning and monitoring of the system, to help to ensure that the social housing system improves outcomes for users.

### **Planning to meet future demand for social housing**

The first step in providing any human service is to understand the relevant population, and their service needs and preferences (chapter 2). Given the long-lived nature of housing assets and the inherent inflexibility of the system, up-front planning is essential to ensure that the social housing stock meets the requirements of people who need it.

Demand for social housing currently exceeds supply in all states and territories and there is a clear mismatch between the social housing stock and the requirements of social housing tenants (chapter 5). The Commission's reforms would reduce the burden on the social housing system by increasing the opportunities for eligible tenants to choose to live in private rental housing (chapter 6). Nonetheless, governments should assess the extent of unmet demand for social housing properties, and outline a strategy for how they would meet this demand, including through constructing new social housing properties, providing further support services for tenants to enter the private rental market, or headleasing properties.

**Table 7.1 The Commission's recommendations for social housing**  
Improving the user focus

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Improving government stewardship</b>		
<b>Recommendation 7.1</b> State and Territory Governments to publish regularly updated strategies for social housing, containing assessed demand for social housing properties and how they plan to meet it.	As soon as practicable	Administrative costs for governments. Provides greater transparency on approaches that governments are taking to address unmet demand for social housing properties.
<b>Recommendation 7.2</b> State and Territory Governments to improve data on tenant outcomes (including tenants receiving assistance to rent in the private market) and the efficiency of housing providers.	As soon as practicable	Compliance costs for housing providers. Allow governments to make better decisions about who should provide tenancy management and tenancy support services. Allows for a full evaluation of the social housing system.
<b>Increasing contestability of tenancy management</b>		
<b>Recommendation 7.3</b> State and Territory Governments to make the management of social housing properties more contestable through open commissioning processes.	Ongoing — management transfers to be staged over time	Commissioning processes can impose administrative costs for governments and providers. Contestability increases incentives for providers to improve outcomes for tenants.
<b>Creating a more even playing field for providers</b>		
<b>Recommendation 7.4</b> State and Territory Governments to separate the regulation and management of social housing properties.	As soon as practicable	Improve the transparency and accountability of government decision making, particularly when selecting social housing providers.
<b>Recommendation 7.5</b> The Australian, State and Territory Governments to amend the National Regulatory System for Social Housing to cover providers of public housing.	As soon as practicable	Transition costs as public housing providers switch to the regulatory scheme. Create a more level playing field between public and community housing providers.
<b>Improving services for users</b>		
<b>Recommendation 7.6</b> State and Territory Governments to publish information on waiting times, provider performance, and information to facilitate choice-based letting.	As soon as practicable	As these data are already collected, the costs would be low. Provides information for tenants to make better choices over the home they would like to live in. Improves accountability.
<b>Recommendation 7.7</b> State and Territory Governments to ensure that applicants for social housing receive an assessment of their eligibility for financial assistance and tenancy support, and are made aware of all of their options for assistance.	As soon as practicable	Providers of intake and assessment services would need to spend more time with some tenants. Provides tenants with support to make informed choices over the home they need, and matches them with the tenancy support service they need.
<b>Recommendation 7.8</b> State and Territory Governments to: <ul style="list-style-type: none"> <li>• separate the contracting of tenancy support services from tenancy management</li> <li>• ensure that tenants renting in the private market have the same access to tenancy support services as those in social housing properties.</li> </ul>	As soon as practicable	Budgetary costs due to increased funding for private rental tenancy support services. Improve clarity about the role of tenancy support, and funding dedicated to it. Improve access to support for tenants in the private rental market, to facilitate choice and improve the capacity of tenants to sustain a tenancy. Improve equity between tenants renting in the social and private housing markets.

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Some State and Territory Governments have strategies for social housing in place, or are in the process of putting in place strategies. For example, Infrastructure Victoria (2016) included social housing in its 30-year Infrastructure Strategy. The NSW Government accepted an Independent Pricing and Regulatory Tribunal (IPART) recommendation that the Government should publish a social housing strategy, updated annually (NSW Government 2017a).

Most governments have an affordable housing strategy in place that sets out long-term policy goals for the social housing system. However, not all governments have a clear and transparent strategy that provides details on how they will meet demand for social housing properties.

State and Territory Governments should do more to assess the future demand for social housing properties and develop strategies for meeting that demand into the future. The Commission considers that all State and Territory Governments, in consultation with other providers of social housing, should publish a clear and regularly updated social housing strategy. There should be three essential components to a social housing strategy.

- How many people need social housing properties, both now and into the future? This should take into account both tenants who have expressed demand for social housing properties through putting themselves on a waiting list, and also eligible households who seek to enter social housing properties, but are not on a waiting list.
- What types of properties do tenants require and where should they be located? For example, some tenants may have strong reasons for living in a particular area, such as its proximity to employment or services. Some tenants may require housing with particular features, such as accommodation suitable for people with a disability. Governments should work with providers to build a picture of the requirements of tenants entering social housing. This should take into account information gathered by governments on tenant preferences through choice-based letting and through tenant choices in the private rental market (chapter 6).
- How do governments plan to meet the demand for social housing properties, both now and into the future?

#### RECOMMENDATION 7.1

State and Territory Governments should each publish a 10-year strategy for the supply of social housing properties in their jurisdiction. These strategies should include:

- an assessment of how many people will likely require social housing into the future, and analysis of their characteristics
- an analysis of types of properties tenants would likely require, such as number of bedrooms and disability supports, and where they should be located
- how governments plan to meet projected demand for social housing properties.

These strategies should be updated at least every five years.

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## Headleasing could give social housing tenants more choice of home

Headleasing is a tool that governments can use to give potential social housing tenants access to a wider choice of home (box 7.1). Rather than building a new government-owned housing asset to provide stable accommodation to tenants, headleasing properties can replicate this benefit while providing flexibility over property type and location. This avoids one of the pitfalls of the current social housing system, namely, that the long-lived nature of housing assets combined with shifting demographics can result in a mismatch between the characteristics of the social housing stock and those receiving assistance. Headleasing properties outside of existing social housing estates can also help to reduce concerns about neighbourhood segregation (chapter 6).

### Box 7.1      **What is headleasing?**

A headleased property is one that is owned by private individuals or corporations, and leased to a social housing provider. The social housing provider then selects a tenant and enters into a separate lease with them. With a headlease, the private landlord is generally responsible for routine property maintenance, and the social housing provider is responsible for tenancy management (such as collecting the rent and passing on any maintenance requests). The social housing provider is usually liable (up to a cap) for any property damage after the application of the tenant bond and any insurance proceeds.

Both government and community housing providers headlease properties from the private market, although it is more common in the community housing sector. About 20 per cent (12 500 properties) of all community housing properties are headleased from the private market. Some assistance is available to community providers to help them to headlease properties, such as the \$76 million Community Housing Leasing Program in New South Wales. About 2 per cent (3000 properties) of NSW public housing properties are headleased.

*Sources:* AIHW (2016i); NSW FACS (2014a); NSW FHA (2014).

Providers of social housing already enter into headleasing arrangements, generally in cases where a suitable public housing property cannot be found (CHL, sub. DR551; NSW FACS 2014b; Victorian DHS 2012). As noted in chapter 5, headleasing is used in some states and territories to assist women escaping domestic violence, and as part of initiatives to find accommodation for the homeless (CHP 2016; NSW FHA et al., sub. 406).

Headleasing has costs. Governments may need to pay additional rents to private landlords to encourage them to lease their property for an extended period of time. Headleasing is also not an endless source of stable housing — there needs to be adequate supply of homes in the private market to allow for headleasing opportunities, and headleasing reduces the number of homes available to tenants in the private market. A detailed assessment of current and future demand for social housing (chapters 2 and 7) would help governments to assess the need for headleasing arrangements, and enable them to weigh up the costs and benefits of entering into these arrangements.

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## Setting outcomes

Clear outcomes are needed for the social housing system. This has several dimensions, including the performance of service providers, individual programs and the system as a whole. Ultimately though, the performance of the system should be assessed against the outcomes achieved for tenants receiving housing assistance, including those in the private rental market. These outcomes could include measures such as the number of tenants transitioning between social housing and the private rental market, employment outcomes for tenants receiving housing assistance, whether tenants sustain a stable tenancy, as well as improvements in tenant satisfaction with the quality of the properties they rent. It could also include assessing whether service provision is equitable and responsive to the needs of tenants.

Several participants highlighted the importance of consulting with the community sector to define and develop outcome measures (GSANZ, sub. DR517; Illawarra Forum, sub. DR550; Yfoundations, sub. DR497). The Commission agrees that, as with other areas of policy, consultation with key stakeholders is important to ensure that outcomes frameworks include the right measures. Consultations need to focus not only on the community housing sector, but also on tenants' groups, to identify the requirements of service users, including what outcomes the tenants themselves want from the social housing system.

The Australian Association of Social Workers (sub. DR557) noted that outcomes frameworks in social housing should be linked to outcomes for other services to enable a holistic response to service users. For example, providing stable housing to tenants can have effects on other aspects of a tenant's life, such as their mental health. Tenants receiving housing assistance can also access many other human services that are critical for their economic and social participation. The Commission has recommended that governments should develop indicators of wellbeing of people that are applied consistently across all family and community services (recommendation 8.3). These indicators could also form the basis of defining outcomes for tenants receiving housing assistance.

## Measuring performance

Data can be used to underpin contestable approaches to selecting providers, allow providers to benchmark and improve their own performance and allow governments to evaluate the effectiveness of the housing system as a whole. Data can be collected on user outcomes, provider performance, the performance of programs and the performance of the system as a whole (chapters 2 and 7). There are several sources of data on the effectiveness of service provision in the social housing system.

- The main data available on tenant outcomes are tenant satisfaction measures collected through the National Social Housing Survey undertaken by the Australian Institute of Health and Welfare (AIHW). The survey includes measures of overall tenant satisfaction, and tenant satisfaction with the amenity of the property they live in (such as its size and modification for special needs) with the location of the property they live in and with

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their housing provider. Some housing providers are also undertaking their own assessments of tenant outcomes, such as through the House Keys survey undertaken by the NSW Federation of Housing Associations (NSW FHA 2015).

- Data on the performance of individual providers are obtained through requirements under the National Regulatory System for Community Housing (NRSCH) (these data are not publicly available — section 7.3). Under the system, providers must provide evidence to prove that they meet several performance criteria, including demonstrating that the provider manages its housing assets in a manner that ensures suitable properties are available now and in the future; and that the provider is fair, transparent and responsive in delivering housing assistance.
- Data on the overall performance of the social housing system are available through the Report on Government Services, compiled annually by the Productivity Commission using data collected from State and Territory Governments. The report includes data on maintenance, (implicit) financial assistance provided to tenants, utilisation of properties and size of waiting lists.

There are gaps in social housing data. The AIHW (sub. DR508) stated that government housing officials have agreed that more work is required to assess the current evidence base to ensure that governments can make effective decisions about housing and homelessness policy. Pawson et al. (2015, p. 1) noted that ‘Australia’s existing suite of official social housing performance measures is seriously inadequate in this respect and lags well behind other service realms’. Importantly, the available data focus on social housing — there is little information available on outcomes for tenants receiving assistance to rent in the private market, aside from broad indicators of rental stress. There are little data available to assess the effectiveness of tenancy support services across both the social and private sectors.

In 2015, the Australian Housing and Urban Research Institute (AHURI) released a report examining ways to improve data collection for the social housing system across Australia (box 7.2). The NSW FHA et al. (sub. 406) noted that they supported the direction of these recommendations.

## Measuring outcomes for tenants

Data collected on tenant outcomes can allow governments to monitor the performance of individual providers based on whether they are delivering a high-quality service and are achieving positive outcomes for their tenants. This can align the incentives of governments and providers and allow governments to replace underperforming providers. Data on outcomes can also be used to evaluate individual programs and the social housing system as a whole, and help determine ‘what works’ (and what does not work) to improve outcomes for tenants receiving housing assistance.

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### Box 7.2      **AHURI study on the effectiveness and efficiency of social housing**

In 2015, AHURI released a report on measuring the effectiveness and efficiency of social housing. The report noted that there were several gaps in the reporting on social housing across the public and community sectors, and made several recommendations to governments.

- Transparency on the costs of social housing provision and tenant outcomes should be a top priority for governments.
- The methodology for estimating the costs of providing social housing differs by jurisdiction. A new and consistent metric for estimating social housing costs is needed, which breaks down social housing management costs into different categories, such as cost incurred in tenancy management and costs incurred in tenancy support.
- Alignment is needed between the national social housing survey and tenant satisfaction surveys undertaken by community housing organisations.
- Public housing authorities report on tenancy sustainment metrics, but community housing providers do not. This metric should be expanded to larger community housing providers.
- There is a need for additional tenant outcome measures, such as data on the effectiveness of a social housing landlord in aiding work-capable tenants to find employment.
- Under the National Regulatory Scheme for Community Housing, provider-level data on cost of provision, operational performance and outcome metrics should be published.

*Source:* Pawson et al. (2015).

Data on outcomes for tenants receiving housing assistance are largely limited to tenant satisfaction measures for tenants in social housing properties. These metrics can be powerful — improving the satisfaction of tenants is one way of determining whether services are improving outcomes — but they do not tell the whole story. Data on tenant outcomes, such as the sustainment of tenancies or a tenant’s success in finding employment, are not consistently collected across public and community housing providers (Pawson et al. 2015). As noted earlier, there are little data available on outcomes for tenants receiving assistance to rent in the private market.

Data to enable rigorous evaluation of social housing policies are often not collected. Community Housing Limited (sub. DR551, p. 11) noted that ‘the lack of outcome evaluation for various long-standing programs has been evident’. The Audit Office of New South Wales (2015) stated that transfers of the management of social housing properties have not been supported with data collection to measure outcomes (section 7.2). Similarly, there is a lack of evidence and evaluation of tenant outcomes from tenancy support programs, particularly those for tenants in private rental properties. Tually et al. (2016, p. 96) noted that:

Long-term evaluation of the work of PRBPs [Private Rental Brokerage Programs] has not been undertaken externally, although we understand that a number of evaluations have been prepared by individual agencies for internal use. Determining the value of, and outcomes from, PRBP initiatives is therefore difficult.

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Costello, Thompson and Jones (2013) also noted that data are needed to inform the development of remedial solutions, and evaluations of existing innovative programs need to be undertaken.

Measuring outcomes for tenants receiving housing assistance is complex, and there is no agreed approach that can be used to assess outcomes. Some State and Territory Governments are beginning to put in place frameworks to assess outcomes. For example, the Tasmanian Government (2015) requires providers to estimate their ‘social return on investment’ as part of the Better Housing Futures management transfers. The NSW Government is developing an outcomes framework for the social housing system focusing on health, social and community, empowerment, economic, safety and education outcomes (NSW FACS 2016c). These approaches are still in their infancy and their success is unclear. It is important that the approaches are evaluated, and rolled out more broadly if they prove to be successful.

Outcome measures should cover tenants receiving assistance to rent in the private market where feasible. This would enable an assessment of outcomes across private and social housing, and also enable a full evaluation of the Commission’s reforms (chapter 5).

The City Futures Research Centre (sub. DR506) noted that the National Housing and Homelessness Agreement, announced in the 2017-18 budget, could be used to drive improved data. The AIHW (sub. DR508) noted that it plans to work with State and Territory Governments to develop better data on outcomes to support this national agreement. This process could be used as a basis to improve outcomes frameworks in each state and territory.

### The costs of managing social housing properties

Data on the costs of managing social housing properties across providers are needed for governments to make decisions about who should manage social housing properties (Tasmanian Government, sub. 485). During the course of this inquiry, the Commission found insufficient evidence to determine whether social housing properties are more cost-effectively managed by the public sector or the community sector, let alone determine the differences *between* individual government or community housing providers.

The AIHW produces a metric on the net recurrent cost of managing social housing properties. Pawson et al. (2015) outlined several reasons why this measure is inadequate. In particular, it is highly aggregated and includes tenancy management and support, as well as property maintenance. Differences in costs can be strongly driven by the extent to which providers have older stock and need to undertake additional maintenance or offer additional support for tenants. There are also differences in how jurisdictions estimate costs, which limits the comparability of the data across jurisdictions. Participants during consultations agreed that current metrics to estimate the costs of managing social housing properties are inadequate.

Improving metrics on the costs of managing social housing properties would improve the ability of governments to assess the performance of individual providers of tenancy

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management and to select managers of social housing properties if using contestable approaches and also to improve the transparency of the system. The methodology should be broken down into the costs of the various functions that social housing tenancy management providers deliver.

#### RECOMMENDATION 7.2

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

- tenant outcomes, including the outcomes of tenants renting in the private market that receive a housing supplement or tenancy support services
- the cost of managing social housing.

State and Territory Governments should clearly define the outcomes they are seeking to achieve through tenancy management and tenancy support services, and put in place frameworks to assess their success in meeting these outcomes over time. Outcome measures should, to the extent possible, be consistent and comparable to those developed for family and community services (recommendation 8.3).

## 7.2 Increasing contestability of tenancy management

Four out of five social housing properties in Australia are managed by government housing authorities, and service provision for these properties has generally not been subject to contestable arrangements. Governments have transferred the management of some social housing properties to not-for-profit providers (in some cases, for-profit organisations may have been part of a consortium of not-for-profit bidders (NSW FHA et al., sub. 406)). There are a large number of providers that could provide social housing services, whether they are not-for-profit, co-operatives and mutuals, or for-profit providers.

Some governments have a policy position of further transfers of the management of public housing to non-government providers (NSW FACS 2016b; SA Government 2012). Commonly, management transfers seek to maximise the revenue available for social housing — tenants in community housing are eligible for Commonwealth Rent Assistance, while those in public housing are not. Transfers of management, along with transfers of stock, have also sought to allow providers to leverage additional private finance to increase the stock of social housing. It is unclear whether this objective has been achieved (Pawson et al. 2013).

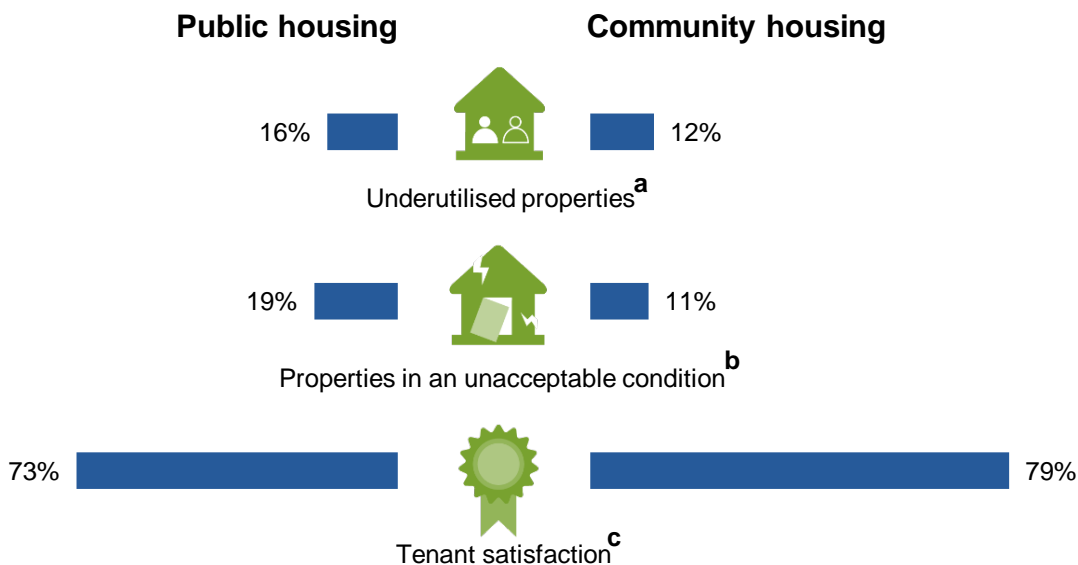
### The benefits of contestable tenancy management

Continuing to make the management of social housing properties contestable should lead to several benefits for tenants. Well-managed contestability in the management of social housing properties would provide incentives for managers of social housing to improve the

effectiveness of service provision, and increase the pressure on them to provide well-maintained properties that meet the requirements of tenants.

There is some evidence that tenancy management transfers in Australia have led to better outcomes for social housing tenants. Community housing providers have a lower underutilisation rate and higher tenant satisfaction than public providers (figure 7.1). Participants noted that community housing providers have a more customer-focused approach to service delivery (Mission Australia, sub. 277; NSW FHA et al., sub. 235; NT DTF, sub. 261) and play a community development role (Anglicare Australia, sub. PFR391). QShelter (sub. PFR352) stated that responsiveness to local needs can be improved by having a diverse range of community housing providers — a particular benefit for states with large regional differences.

Figure 7.1 Indicators of public and community housing, 2016



<sup>a</sup> Underutilisation refers to the percentage of properties that have at least two more bedrooms than the number of tenants living in them. <sup>b</sup> A property is considered to be in an unacceptable condition if it does not have working facilities for washing people, washing clothes, preparing food, and sewerage, or has more than two major structural issues. <sup>c</sup> Tenant satisfaction is the percentage of people who reported being satisfied or very satisfied with their housing.

Source: SCRGSP (2017).

This evidence should be treated with caution, as public and community providers are currently not placed on an equal footing. The extra income obtained through Commonwealth Rent Assistance provides an advantage to community providers and could be used to improve the quality of their service. Similarly, in some cases the stock transferred to community providers has been newer and of better quality than most homes in public housing, which may account for some of the improved outcomes.

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## **Management should be made more contestable, but there is a need for proper evaluation**

The Commission considers that the management of social housing properties should be made more contestable. This position is broadly supported by participants, particularly community housing providers (CHL, sub. DR551; CHP, sub. DR522; City of Whittlesea, sub. DR519; National Shelter, sub. DR582; NSW FHA, sub. DR539; SA Government, sub. DR571). To support a move to greater contestability, governments need to establish clear outcome and performance frameworks, consumer protections and monitoring frameworks. Periodic evaluations would allow for an assessment of the benefits and costs of transfers, and to inform future transfers. This has been a shortcoming of previous transfers. For example, the Audit Office of NSW (2015, p. 15) has noted that, in relation to management transfers:

It is unclear whether the Department [of Family and Community Services] has achieved its desired outcomes for tenants. For example, the Department wanted more flexible, tailored services for tenants and more resilient communities but it did not determine how it would measure these outcomes.

Gaps exist in current data collection. The Commission's recommendation on improving data on the social housing system would assist evaluations of greater contestability (recommendation 7.2).

Some inquiry participants highlighted limitations and drawbacks of commissioning processes to select managers of social housing properties, including the cost and complexity of responding to tenders, a disruption of services to users when transitioning between providers, an erosion of coordination between providers and challenges when commissioning Indigenous services (National Shelter, sub. PFR369, sub. DR582; Shelter WA, sub. PFR341). Steps can be taken to address these concerns. In part, the complexity of commissioning processes is a result of unclear boundaries between tenancy management and tenancy support (section 7.4). Clear separation of these roles may help simplify commissioning processes. Other concerns can be addressed by careful contract design, governments monitoring the performance of providers, and through culturally appropriate processes suitable for selecting providers of Indigenous services (chapters 2, 8 and 9).

## **Commissioning processes should be open to all types of provider**

Previous approaches to transfer the management of social housing properties have only been open to not-for-profit providers. Improving the effectiveness of contestability requires that commissioning processes are open to all types of providers. The Commission does not consider that one provider type is inherently better placed than other provider types to manage social housing properties (chapter 2). The NSW Federation of Housing Associations et al. (sub. 235) agreed, noting that there was no reason why for-profit providers could not manage social housing properties. A not-for-profit provider that is better placed to manage social housing properties should win a tender, but this outcome should not be pre-determined at the outset.

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Importantly, the Commission does not consider that non-government providers will always be better at managing social housing properties than government providers. The option of the management of social housing properties remaining with the government should not be excluded from the commissioning processes. Even where the management of properties ultimately remains with the government, contestability can have benefits by increasing the pressure on the government provider to maintain and improve its performance.

**RECOMMENDATION 7.3**

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

## **Title transfers**

Some participants (mainly community housing providers) argued that the ownership of social housing properties (that is, the property title) should be transferred from government to community housing providers, claiming several benefits (CFRC, sub. DR506; CIS, sub. DR544; National Shelter, sub. DR582; NSW FHA et al., sub. DR539; Shelter WA, sub. PFR341). Most prominently, these participants considered that having title of a property would facilitate lower-cost finance for community housing providers to construct additional social housing properties. Participants also stated that title transfers would provide a stronger incentive for providers to maintain the value of the property, and that providers would be better able to make long-term investment decisions as the risk that governments would opt to change providers is lower (CFRC, sub. DR506; NSW FHA et. al., sub. 406).

Uncompensated transfer of titles would, in effect, involve a gift of public assets to non-government organisations. Once title has been transferred it would become much harder for governments to replace an underperforming provider. It also reduces the incentives that providers face to improve their service delivery and limits the ability of governments to hold providers accountable for poor service. Once title has been transferred, it can also be difficult for governments to ensure that the properties are used for social housing over the long term (Tasmanian Government, sub. 485).

Transferring the title of some public housing properties to community housing providers could assist them to borrow more funds and build more stock, although the Commission is sceptical that transfers of title are the best way to achieve this outcome. The amount providers can borrow depends primarily on the amount and stability of income they have to make loan repayments, not the value of their assets (Pawson et al. 2013; VAGO 2010). Assessing a previous transfer of title to community housing providers, the Victorian Auditor-General's Office (2010, p. 15) found that 'the transfer of assets did not increase their rental income and hence does not provide any greater capacity to service interest and capital repayments for borrowings'. Moreover, there are other ways to achieve a stable income

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stream that providers could borrow against, for example, by entering into long-term management contracts. The Commission does not support transferring the title of social housing properties to non-government providers for the purpose of reducing a provider's cost of finance.

## **7.3 Creating a more even playing field for providers**

### **Clarifying roles within government**

In most states and territories, the housing authority responsible for managing social housing properties is contained within the department responsible for housing policy. There is a case for a separation of social housing policy and service provision to improve accountability and remove potential conflicts of interest (Haven, Home, Safe, sub. DR568; UnitingCare Australia, sub. DR514). There may be conflicts of interest if the department setting criteria for tenders to manage social housing properties is also competing for the tender itself (section 7.2). Contestability requires that the government social housing provider faces a credible threat of replacement if it underperforms, which would not be the case if that provider is responsible for monitoring its own performance.

IPART (2017) recommended that the NSW Government move to a purchaser-provider model. Under the model proposed by IPART, the NSW Department of Family and Community Services (FACS) would be responsible for social housing policy and planning, as well as managing contracting arrangements with providers. Managers of social housing properties, including the public Land and Housing Corporation, would receive funding from FACS and operate on a commercial basis. The Commission agrees that, to avoid conflicts of interest, policy and planning should be separate from provision. Jurisdictions that have not done so should seek to separate these roles, such as by having these responsibilities sit in different departments or by establishing a new entity.

Government providers should not be advantaged (or disadvantaged) relative to other providers due to government ownership when competing in commissioning processes. (Commissioning is a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement (chapter 8).) State and Territory Governments have policies in place to ensure that applicants do not receive a price advantage due to being a government body because they, for example, do not pay the same taxes as non-government businesses (for example, NT Government 2010). The management of social housing properties should be subject to these policies.

Separating housing policy and service provision could lead to potential tension between commercial and social objectives placed on the public housing provider. This was a concern with similar reforms implemented in New Zealand in the 1990s. Housing New Zealand was required to act in a commercial way, but also had social objectives placed on it, such as focusing on housing for people with low incomes. Tensions between its social and

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commercial objectives led to conflict between the Government and Housing New Zealand and resulted in several resignations from the Housing New Zealand board (Thorns 2000). Housing New Zealand also embarked on a series of asset sales to maximise its commercial returns, including selling properties in less profitable locations (Murphy 2004).

There are clear differences between the reforms in New Zealand and the reforms proposed by the Commission. The Commission sees a strong and continuing role for the social housing system to provide homes, including for people who face barriers to entering the private market. This is distinct from the early 1990s social housing reforms in New Zealand, where an overarching commercial objective was placed on the public housing provider. The Commission considers that, while public providers need to be efficient, they should not be subject to a requirement to deliver a *commercial* dividend to governments.

#### RECOMMENDATION 7.4

State and Territory Governments should ensure that the entity responsible for managing social housing assets is separate from the entity responsible for social housing policy.

## Regulation of providers

Community housing providers are regulated under the NRSCH (box 7.3). All states and territories — with the exception of Western Australia and Victoria — have joined the NRSCH. Registration under the NRSCH is voluntary, but State and Territory Governments often require that a provider be registered as a precondition to receiving funding for housing services.

A key concern with the NRSCH is that it does not cover public housing providers. The Commission has seen no compelling justification for this. In principle, regulation should be consistent across providers with different organisational structures — whether they are government, not-for-profit, mutual and co-operative, or for-profit. This approach is taken in England, where the Homes and Communities Agency regulates all social housing providers, including government, not-for-profit and for-profit providers.

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### **Box 7.3      National Regulatory System for Community Housing**

The National Regulatory System for Community Housing (NRSCH) is the national system of registration, monitoring and regulation of community housing providers that came into effect on 1 January 2014. The NRSCH seeks a clear separation between regulatory activities, and state and territory policy and funding activities. There is no obligation for a community housing provider to be registered under the national system, although governments can make registration a precondition for receiving funding for housing services.

Registration under the NRSCH is divided into three tiers, with different levels of regulatory scrutiny and monitoring applying to providers based on the scale and scope of their activities. Housing providers that engage in activities that involve a higher level of risk, such as property development or managing a large number of tenancies, are subject to higher levels of oversight. Registered housing providers must demonstrate a capacity to meet and achieve ongoing compliance with the National Regulatory Code, and have in place arrangements to manage their assets in the event of a business wind-up or deregistration.

#### **National Regulatory Code**

The code sets out the performance and outcome requirements that must be met by each tier of registered housing provider. It is outcomes focused, and does not prescribe how the provider should achieve each requirement. The code covers tenant services (including that the provider must be fair, transparent and responsive in delivering housing assistance to tenants), housing assets, community engagement, governance, probity, business management and financial viability. If a tenant considers that their provider is not meeting the requirements of the code, they are able to make a complaint to their registrar, which can result in the deregistration of the provider.

*Sources:* NRSCH (2014b, 2014c); Victorian Housing Registrar (2014).

Several participants agreed that regulation should be consistent across providers, and that the NRSCH could be expanded to cover public housing providers (Anglicare Australia, sub. DR574; Baptist Care Australia and Churches Housing, sub. DR532; CFRC, sub. DR506; NSW FHA et al., sub. DR539). Consistent regulation of providers would extend a set of rights and protections to all tenants, regardless of which organisation is managing their tenancy. Consistent regulation would also help balance any competitive advantage or disadvantage experienced by providers in different sectors, and assist governments to select the provider best placed to deliver services. It would also create a more level playing field between public and community housing providers (recommendation 7.3) and improve the data available on public provider performance (recommendation 7.1). There would be some costs as public providers transition to the NRSCH, but the Tasmanian Government (sub. DR590) stated that these costs are unlikely to be significant, as public housing providers already have adequate policies and information systems in place.

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#### RECOMMENDATION 7.5

State and Territory Governments should amend the National Regulatory System for Community Housing to cover public housing so that all providers of social housing face consistent regulatory requirements, regardless of whether they are government or non-government providers.

## 7.4 Improving services for users

The recommendations outlined in chapter 6 would provide people receiving housing assistance with additional options when choosing a home to live in. Greater user choice should be further supported by the provision of information to make choices, guidance when making choices, and to assist them to remain in their preferred home.

### Information to help households to choose their home

Like all users of human services, social housing tenants require information to enable them to decide both the home and the provider of tenancy management services (if renting social housing properties) that they expect would best meet their needs. Much of this information (such as the quality of a home) can be observed by potential tenants — the social housing system does not have the same information asymmetries that are prevalent in many other human services. There are three key areas where information could be improved, including providing information on the social housing properties available to support choice-based letting (recommendation 6.2), information on potential waiting times to enter social housing properties, and information on provider performance.

Information on social housing properties, similar to that available in the private rental market, would be needed to support choice-based letting. Governments could be guided by the experience of the United Kingdom when deciding what information is to be provided to tenants. Importantly, information needs to be disseminated across a range of mediums so that tenants who, for example, do not have access to the internet can receive information. In the United Kingdom, information on available properties, such as the number of bedrooms and location, is shared online and through bulletin boards and printed leaflets (Marsh, Cowan and Cameron 2004). In some cases, high-priority applicants receive information on available properties through targeted mail outs.

Tenants should receive information on the expected waiting times to enter social housing properties. Some jurisdictions, such as New South Wales, publish information on expected waiting times for social housing properties across regions, but most do not. Other jurisdictions publish the information in a format that is difficult for tenants to understand (NSW FHA et al., sub. 235). Better information on waiting times for particular locations would allow tenants to make informed trade-offs. A tenant can choose to wait for an

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extended period of time for a social housing property in their preferred location, or seek to receive a property quicker in a different location.

There is little publicly available information on individual providers, and making this information available would enable tenants to make more informed choices over the home they would like to live in. Pawson et al. (2014) and the NSW FHA et al. (sub. 406) noted that information provided as part of the NRSCH on cost of provision, operational performance and service outcomes could be made publicly available. Such an approach is used internationally. For example, in Scotland the housing regulator publishes information on each individual provider's performance, including tenant satisfaction and adherence to maintenance standards (Scottish Housing Regulator 2017). Under the NRSCH, housing registrars monitor compliance with the National Regulatory Code, and conduct annual or biannual compliance assessments of registered providers. Information and evidence collected can include information on:

- tenant satisfaction — providers are required to demonstrate that they have maintained a satisfactory level of tenant satisfaction, and it is recommended that larger providers undertake a tenant survey of satisfaction at least every two years
- managing complaints — providers are required to demonstrate that complaints and appeals are reviewed to ensure they have been handled fairly, and that there are no ongoing or repeated failures
- support services — providers are required to demonstrate that they have in place arrangements to ensure tenants receive appropriate support to maintain tenancies where relevant
- property conditions — providers are required to demonstrate that properties are well maintained and that they meet property condition standards (NRSCH 2014a).

Participants noted that publication of this information would be likely to 'give more power to consumers' (Council to Homeless People Victoria, sub. DR522, p. 16), be important for 'decreasing asymmetry of information' (UnitingCare, sub. DR514, p. 10) and enable more informed choices. As this information is already collected, there appears to be few additional costs involved in making it available to tenants — any information that is legitimately commercial-in-confidence could be removed from the reports before publishing.

Providing information on waiting times and the performance of individual providers would have benefits beyond improving information to users. The benefits would be greater if the information was provided in combination with greater choice as proposed in chapter 6. Both sets of information would improve the accountability of decision makers and providers to the broader community. Underperforming providers would be more easily identified, and have strong incentives to improve their performance and their responsiveness to tenant needs. NSW FHA et al. (sub. DR539) stated that publishing performance information could improve confidence in the social housing sector, and increase its ability to raise private finance.

#### RECOMMENDATION 7.6

State and Territory Governments should:

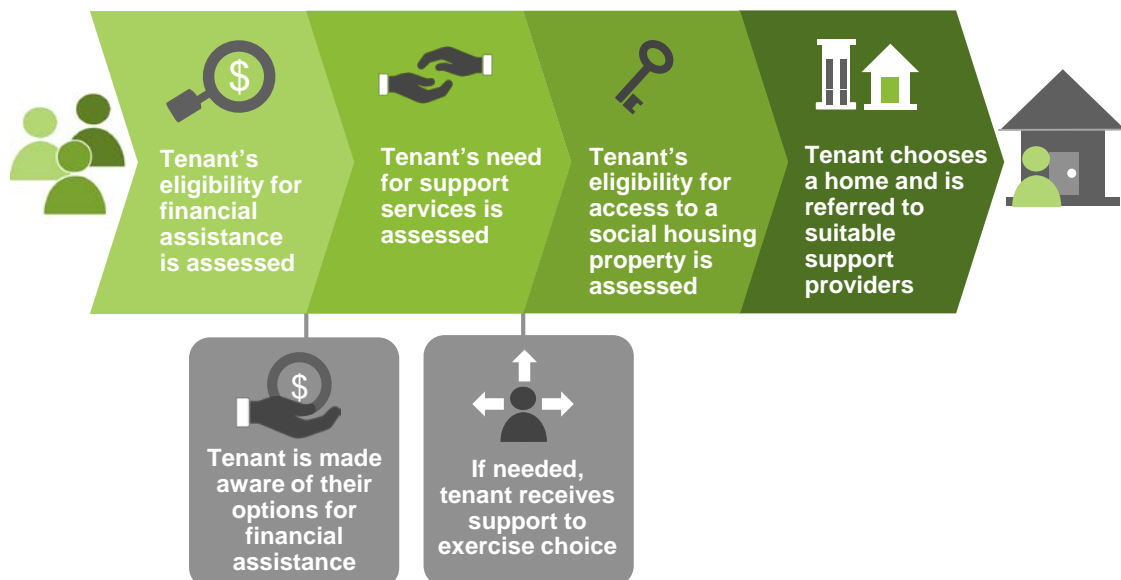
- publish information on expected waiting times to access social housing, by region, in a format that is accessible to prospective tenants
- make publicly available the regulatory reports on the performance of providers that are undertaken as part of the National Regulatory System for Community Housing.

To facilitate choice-based letting, State and Territory Governments should publish information on available social housing properties, including the rent charged for the property, number of bedrooms and the location of the property. This information should be disseminated across a range of mediums, such as online and printed leaflets.

### Intake and assessment services

People that require access to social housing properties go through initial intake and assessment services, which determine a person's eligibility for social housing properties (figure 7.2). These services often also determine a person's need for tenancy support services, including in some (limited) cases through triage services to match people to the services they need.

Figure 7.2 **Role of intake and assessment services**



Intake and assessment services vary across jurisdictions. Some jurisdictions have a centralised intake service, such as Tasmania, where most tenants will receive an initial assessment through the centralised service, while in other jurisdictions intake and assessment

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processes are more decentralised. For example, in Victoria tenants can access social housing properties through a local housing office or through individual community housing providers.

There is evidence that existing intake and assessment services need improvement. In some jurisdictions, the system is fragmented, which makes it difficult for users to identify the support they are eligible to receive. Jesuit Social Services (sub. 420) considered that reform is needed to improve access and enable easier navigation of the system. Wiesel et al. (2014) noted that some people were confused about the types of assistance available to them. The assessment of tenants' needs also appears deficient in some jurisdictions, which means that tenants may not receive the support they need. The Queensland Mental Health Commission (QMHC 2015, p. 18) noted that the Queensland Department of Housing and Public Works is 'unable to identify which of their social housing tenants, including those on the State Housing Register, are living with a mental illness, mental health difficulties or substance use problems'. Similarly, the Royal Commission on Family Violence in Victoria (2016) noted that data from the Victorian Department of Health and Human Services appeared to dramatically underestimate the number of people waiting for social housing that were experiencing domestic violence.

A common theme in the Commission's consultations for this inquiry was that people's need for tenancy support services and support to exercise choice varies widely. Some social housing tenants need little to no support to maintain a tenancy, whereas others need intensive support. In some cases, providers may need to offer outreach services to ensure that a person receives the support they need, while in other cases tenants will approach the social housing system themselves.

High-quality intake and assessment services are key to ensuring that levels of non-financial housing support matches need. State and Territory Governments should ensure that social housing applicants receive a comprehensive assessment of their eligibility for assistance and tenancy support, and are made aware of all of their options for assistance. Importantly, tenants should receive the support needed to enable them to choose their home if required.

- Tenants need to be able to navigate the system, and be made aware of the assistance they could receive, including whether they are eligible for a 'housing supplement' (recommendation 6.1), and the support they would receive to rent in social or private housing.
- While many people are able to make choices over the home they wish to live in themselves (or have someone to do so on their behalf), others will require support to make choices. The Penrith Homeless Institute (sub. 413, p. 1) stated that 'vulnerable people including youth will require support in exercising their choice both in social housing and [the] private rental market'. There are several forms that support to exercise choice could take. Tenants could be referred to a tenancy support provider to offer support (this role is already played by some services in the private market (Tually et al. 2016)). Where no other support is available, the provider of intake and assessment

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services may need to apply for properties on the applicant's behalf. Support could also be provided to enable applicants to view available properties (Lomax and Pawson 2011).

- Providers of intake and assessment services conduct upfront assessments that could be used to refer tenants to support services that meet their needs. This assessment will be straightforward for many people, as they are able to manage their tenancy on their own and have little need for support. A more detailed assessment will be required for people with greater needs. Alternatively, for people who access other services, their need for tenancy support could be apparent through assessments from other service providers, such as mental health providers.

#### RECOMMENDATION 7.7

State and Territory Governments should ensure that applicants for social housing assistance receive a comprehensive up-front assessment of their eligibility for:

- a social housing placement
- the housing supplement (recommendation 6.1)
- tenancy or other service support, including support to enable the tenant to choose their home.

Applicants should also be made aware:

- that the housing supplement would be payable if they chose to live in either the private or social housing markets
- of the extent to which tenancy support services available in social housing would also be available to eligible tenants renting in the private market.

## Improving the provision of support services

Tenancy support services can help to stabilise at-risk tenancies, which is vital given the limited accommodation options that some tenants have if evicted from social housing (chapter 5). Programs such as Tenancy Plus in Victoria (chapter 5) have had a high rate of success in stabilising the at-risk tenancies of their users. Homelessness NSW (sub. DR520) highlighted several programs that have had 80–90 per cent success rates in supporting people with experiences of homelessness to sustain tenancies.

Governments should do more to ensure that these services are available to the people who need them, whether they are in social housing properties or the private rental market. The Commission's recommendations on the commissioning of family and community services are also relevant for tenancy support services (chapter 8).

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## Support for tenants in the private rental market

Many support schemes targeted at social housing tenants are not made available to tenants renting in the private market (chapter 5). Evaluations of some support services available overseas, such as the Private Rental Sector Access Development Program in the United Kingdom, found that tenancy support can help tenants with complex needs to sustain a private tenancy (box 7.4).

### **Box 7.4      The UK Private Rental Sector Access Development Program**

The Private Rental Sector Access Development Program aimed to assist single homeless people in the United Kingdom, who were not well served by existing services, into private rental accommodation. The program provided funding for about 150 organisations to deliver support services. The funded organisations varied in size and scope, but included:

- a day centre that offered support for ‘rough sleepers’ and people with addiction problems, and was seeking to offer housing support for its clients
- an organisation focused on youth homelessness that provided help to sustain a tenancy and ongoing support
- an organisation that provided services to ex-offenders and was undertaking intensive resettlement work with its clients.

About 8000 tenancies were created over the lifetime of the program, and 90 per cent of tenancies were sustained. The cost to governments was about \$1600 per sustained tenancy.

*Source:* Rugg (2014).

Access to support services for tenants who choose to rent private housing is an important part of enabling choice, both to ensure that tenants in private housing are able to establish and sustain their tenancy and to improve their economic and social participation. It is important that access to support services does not end if a tenant makes the choice to rent in the private market. NSW FHA et al. noted that:

... tenant choice about housing tenure should not be distorted by rationed access to ancillary services. People should not need to be in social housing to access services such as tenant support, financial counselling or community mental health care. (sub. 406, p. 7)

Similarly, Melbourne City Mission (sub. DR510) noted that some people require support regardless of the sector they rent in. The Illawarra Forum (sub. DR550) supported extending access to support services for eligible tenants who rent in the private market.

Financial assistance that is portable across rental markets for private and social housing should be complemented with portable tenancy support. Improved access to tenancy support services could help to further enhance the benefits of user choice of home, and lead to improved housing outcomes for tenants renting in the private market. There may also be offsetting reductions in fiscal costs in other areas of policy. Both Homelessness NSW (sub. DR510) and the Council to Homeless People Victoria (sub. DR522) highlighted that stabilising tenancies is substantially cheaper than providing support once a person is in crisis.

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The Victorian Government noted that tenants evicted from housing often enter crisis and transitional housing, which it estimated cost about \$34 000 per year (CHP, sub. DR522).

Additional funding would be needed to offer support to tenants currently renting privately. For example, the UK Private Rental Sector Access Development Program cost about \$1600 per sustained tenancy (box 7.4). The Council to Homeless People Victoria (sub. DR522) stated that the cost of the Victorian Tenancy Plus program was about \$2000 per tenant in 2014.

### Improving the contracting of tenancy management and tenancy support services

Inquiry participants stated that the line between tenancy management and tenancy support is sometimes blurred, and the role of community housing providers in delivering services is unclear. Two concerns were raised.

- During consultations, participants noted that community housing providers are being asked to do too much with too few resources, and that the system is stretched to capacity. Launch Housing (2016) noted that, in Victoria, community housing providers are not able to deliver tenancy and additional support on current levels of funding. Similarly, Pawson et al. (2015) noted that it was unclear how additional support services would be funded by providers in a resource-constrained environment.
- Governments often do not make clear the role they want tenancy management providers to play in tenancy support. The NSW FHA et al. (sub. 406, p. 5) noted that tenancy support services ‘along with community development and other non-housing outcomes, are different functions and need to be better specified in procurement arrangements’. Pawson et al. (2015) also noted that many of the objectives that governments want community providers to pursue are yet to be explicitly stated.

Delivery of support services for tenants eligible for social housing is, and should remain, a responsibility of the State and Territory Governments. These Governments should improve their contracting of tenancy support services to clarify the support available for tenants and who should provide it. The Governments should explicitly state what support services they want provided to social housing tenants in funding agreements, and allocate funding where needed. This would make clear what objectives the Governments have for the delivery of support services and ensure that providers have the resourcing available to deliver services to meet these objectives. Some State and Territory Governments are working toward developing outcomes frameworks for social housing (NSW FACS 2016c; chapter 8) which, if designed and implemented well, could help to clarify the role of tenancy management providers and the outcomes that governments want them to achieve.

The Commission also supports State and Territory Governments making a clear distinction between tenancy management services and tenancy support services in commissioning processes and funding agreements. Importantly, it should not be assumed that community housing providers will be best placed to provide tenancy support to the tenants in properties that they manage.

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Participants generally agreed with the Commission's proposal to separate tenancy management services from tenancy support services in contracting processes (for example, Council to Homeless People Victoria, sub. DR522; UnitingCare Australia, sub. DR514; Yfoundations, sub. DR497). There was some disagreement between participants as to whether the delivery of tenancy management and support services should always be through separate providers. Jesuit Social Services (sub. 420) and Queensland Advocacy Inc. (sub. 442) supported a clear separation between these roles. Jesuit Social Services (sub. 420, p. 12) noted that this would help 'ensure that support is driven by a therapeutic and not tenancy management approach'.

Other participants emphasised that, while the funding streams could be different, the same provider should remain able to deliver both support and management services if they are awarded both funding streams (Baptist Care and Churches Australia, sub. DR532; Yfoundations, sub. DR497). The Commission agrees that there should be no barrier to the same organisation providing both sets of services. Having one provider offering tenancy support and management services may have some benefits, such as better integration of services. As noted by Yfoundations (sub. DR497), in some locations, there may only be one provider capable of delivering both tenancy management and tenancy support services.

Having different providers delivering tenancy management and tenancy support can also have benefits — it can make it easier to replace a provider of tenancy support or tenancy management that is underperforming, and it can make it easier for tenants to move home while retaining their relationship with their provider of tenancy support. Ultimately, State and Territory Governments should commission the organisation best able to deliver the user outcomes being sought. Once again, the Commission's recommendations for family and community services would be relevant (chapter 8).

#### RECOMMENDATION 7.8

State and Territory Governments should improve the commissioning of tenancy support services by:

- ensuring that tenants renting in the private market have the same access to support services as tenants in social housing
- clearly separating the funding and contracting of tenancy support services from tenancy management services
- considering the application of recommendations contained in this inquiry to improve the commissioning of family and community services.

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## 8 Commissioning family and community services

### Key points

- Family and community services are not delivering the best possible outcomes for the people who use them. Problems include service gaps, duplication, poor coordination between service providers, excessively prescriptive contracts and short-term funding.
- Family and community services are not well-suited to the widespread introduction of greater user choice at this time. Instead, governments should focus on practical reforms to improve their stewardship of family and community services — the way they plan the system of services, select providers on behalf of users, and contract services so that users are at the centre of service provision.
- The recommendations include that governments should:
  - analyse the characteristics and needs of the service user population
  - identify the outcomes that governments are seeking to achieve through family and community services
  - develop service plans for each region and for services for people who have complex needs
  - publish a rolling schedule of upcoming tenders and allow enough time for service providers to develop responses to tenders
  - develop frameworks to measure service providers' contributions to service user outcomes and use this information in service planning, provider selection, contract management, evaluation and ongoing improvement
  - evaluate service providers, programs and systems, publish the lessons of these evaluations, and release de-identified data on family and community services
  - increase default contract terms to seven years, with enhanced safeguards, to achieve a better balance between funding continuity for service providers and periodic contestability
  - provide payments to service providers that reflect the efficient cost of service provision.

Family and community services are not delivering the best possible outcomes for the people who use them, their families, or for governments that fund them. Governments could improve outcomes for service users by making practical reforms to the way they plan the system of services, select providers and manage contracts with service providers (table 8.1).

**Table 8.1 Overview of proposed reforms to family and community services**

All reforms are directed at the Australian, State and Territory Governments

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Systematic service planning</b>		
<b>Recommendation 8.1</b> Build on existing initiatives and data on the characteristics of the service user population and the service provider base. Develop service plans to coordinate services and address community needs. Identify outcomes for family and community services.	Ongoing	Costs of data collection, stakeholder consultation and analysis. Services that better address user needs, better service coordination for people with complex needs.
<b>Processes for selecting service providers</b>		
<b>Recommendation 8.2</b> Design criteria for selecting service providers that focus on their ability to improve outcomes for service users and not discriminate on the basis of organisational type. Publish rolling schedules of upcoming tenders. Allow sufficient time for providers to prepare considered responses, including the development of integrated bids across related services.	As soon as practicable As soon as practicable	Costs of data collection and analysis. Better outcomes for people using services; more efficient resource allocation. Potential to increase collaboration between providers.
<b>Performance frameworks</b>		
<b>Recommendation 8.3</b> Develop indicators of wellbeing outcomes for family and community services, for use in provider selection, performance management and provider, program and system-level evaluations.	24 months	Governments and service providers would need to expand their capabilities in data management and analysis.
<b>Recommendation 8.4</b> Monitor the performance of providers in achieving outcomes for service users, and 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, and the release of de-identified data to service providers and researchers.	As soon as practicable As soon as practicable	More information about the effects of services on people's wellbeing would support system planning, provider selection and the effectiveness of services.
<b>Contract management practices</b>		
<b>Recommendation 8.5</b> Increase default contract lengths to seven years. (Exceptions could be made, such as for program trials but justification should be published.) Ensure contracts contain adequate safeguards in any cases of failure by providers.	As existing contracts expire and new contracts commence.	Less flexibility for governments to change funding priorities. Greater continuity facilitates investment by providers in service quality and gives users more continuity of service.
<b>Recommendation 8.6</b> Provide payments to providers for family and community services that reflect the efficient cost of service provision.	As existing contracts expire and new contracts commence.	Costs of data collection, analysis and contract design. More equitable access and increased capacity for providers to invest in service improvement.

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## 8.1 Context and scope

### What are family and community services?

Family and community services address a range of circumstances, including crisis support, transitional support, building capability, early intervention and prevention. Examples include services for family support, homelessness, family and domestic violence, alcohol and other drugs and settlement support. Governments fund family and community services to improve the wellbeing of people at risk of hardship or harm. The goal of these services is to achieve outcomes for service users — changes in knowledge, skills attitudes, values, behaviour, condition or status — that increase their wellbeing (PC 2010).

Service provision is dominated by the not-for-profit (NFP) sector, although government remains a direct service provider in some areas. For-profit entities are sometimes specifically excluded from government funding. Governments provide the majority of funding for NFP service providers, largely through contestable processes where providers ‘compete’ periodically for funding to deliver services.

The focus of this inquiry is family and community services where governments select providers, user choice is limited and funding is often not linked to outcomes. Consistent with the terms of reference, recommendations focus on services commissioned by the Australian Government and State and Territory Governments. Local governments also commission family and community services and recommendations may also be applicable to them.

### Funding for services

Annual funding of family and community services by the Australian, State and Territory Governments totals several billion dollars. The large number of programs and funding lines across jurisdictions and government agencies makes estimating a total difficult. As at the end of April 2017, two significant components of Australian Government expenditure — the Department of Social Services (DSS) Families and Communities Programme and the Department of Health’s grants for mental health programs — had active grants worth about \$2.9 billion and \$2.2 billion respectively (Department of Health 2017f; DSS 2017d). At the State and Territory Government level, two service areas — expenditure on family support services and homelessness (funded under the National Affordable Housing Specific Purpose Payment and the National Partnership Agreement on Homelessness) was \$789 million and \$764 million respectively in 2015-16 (SCRGSP 2017).

Government funding to NFP organisations whose main activities were in social services totalled \$7.2 billion across over 5000 organisations in the 2015 reporting year (ACNC 2016). (This figure includes some activities, such as disability services, which are outside the scope of family and community services.) Larger providers receive funding through many agreements with several governments. For example, Mission Australia (sub. 277) stated that it delivers 589 programs and services, and receives funds from 41 government agencies as well as foundations and trusts.

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## Changes over time: from charity to commissioning

Prior to the 1970s many of the family and community services that are now funded by governments were provided by charities, funded via donations (PC 2010). Governments have substantially increased their funding for family and community services since the 1970s — funding that, for the most part, was allocated to NFP bodies as general support. Since the 1980s, governments have adopted more competitive funding models, including ‘purchase of service contracting’, which involves ‘government agencies contracting with a provider to deliver a service to an eligible group of clients in exchange for money’ (PC 2010, p. 323).

These changes to funding models and the relationships between governments and service providers recognise that governments are ultimately responsible for the outcomes of services delivery. Funding models that reflect the objective-driven design of government spending programs have, however, created some tension between government objectives for service provision and the mission-driven purpose of NFP organisations (box 8.1).

### Box 8.1      **Tensions in service delivery**

The evolution of family and community services from a charity-driven model to one funded and driven by governments has created tension between governments and the not-for-profit (NFP) sector over the objectives of family and community services. This was identified in the Commission’s 2010 study of *The Contribution of the Not-For-Profit Sector*. Participants in that study identified ‘inherent tensions between a market-based approach to the procurement and funding of human services and the characteristics and motivations of community organisations’ (PC 2010, p. 297). These included that ‘purchase of service contracting’ was:

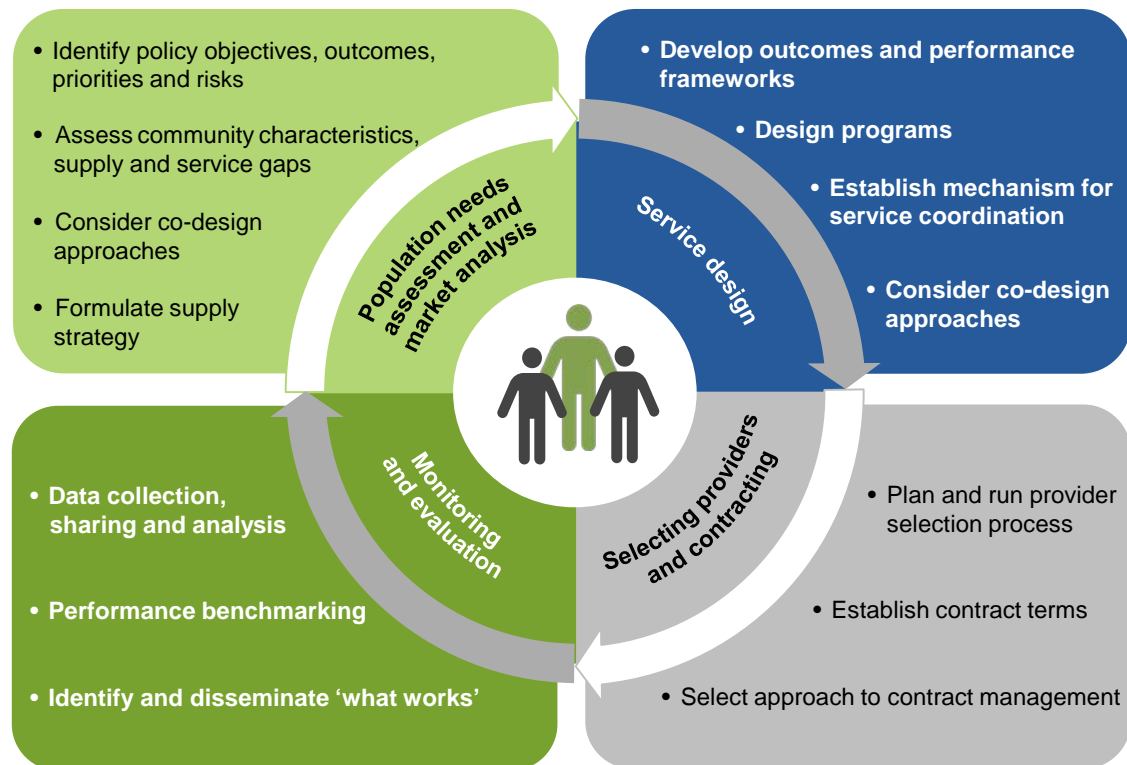
- creating incentives for community organisations to take on the practices and behaviours of the government agencies they deal with (or so called ‘isomorphism’)
- distracting NFPs from their purpose thereby contributing to ‘mission drift’
- creating a perception in the community that NFPs are simply a delivery arm of government
- eroding the independence of NFPs in ways that make it difficult for them to remain responsive and flexible to community needs
- being inherently biased in favour of large organisations and thereby contributing to a loss of diversity in the sector. (PC 2010, pp. 309–310)

As the Commission noted in the study report, several submissions to this inquiry also identified a tension between the value of supporting not-for-profit organisations to pursue a positive (but often broad and unmeasurable) social mission, and funding models that are primarily focused on providing services to improve the wellbeing of individuals and their families (GSANZ, sub. 282; St Vincent de Paul Society National Council, sub. 285). In considering these issues, it is important to recognise that governments are responsible for, and set the objectives of, family and community services. Providers can choose to tender for funding that aligns with their mission, but governments have a responsibility to put the interests of service users at the centre.

In recent years many governments have endorsed ‘commissioning’ as their preferred approach to stewardship of family and community services. Commissioning is a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and

improvement (figure 8.1). Governments often use contestable approaches in the provider selection stage to allocate funding, although in some cases governments use closed or restricted tender processes.

Figure 8.1 **The commissioning cycle**



Sources: Based on Department of Health (2015); Dickinson (2015); NHS (2016); Routledge (2016).

Governments have not always successfully translated the principles of commissioning into effective practice. For example, the Brotherhood of St Laurence stated that ineffective commissioning was a barrier to service integration at one of its service hubs. It identified the problem as:

Lack of integration at the level of commissioning as a consequence of policy silos, both between departments and between local, State and Commonwealth Governments. An incoherent patchwork of different funding priorities and commissioning arrangements creates barriers for providers, even those in the same service area, to develop closer working relationships, let alone integrate their service offers. (sub. 479, p. 19)

There has been some innovation in commissioning, including the development of social impact investment (box 8.2). This approach has demonstrated the benefits of clearly articulating the intended outcomes of family and community services, and having a clear focus on, and understanding of, the service user. Experience to date has also demonstrated the limitations of social impact investment models (discussed further in section 8.3).

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## Box 8.2      **Social impact investment**

The Australian Treasury defined social impact investment as ‘investments made with the intention of generating measurable social and/or environmental outcomes in addition to a financial return’ (2017b, p. 8). It includes: social enterprises, social impact investment funds and social impact bonds. A social impact bond is a form of outcomes-based funding with a:

... financing mechanism in which governments or commissioners enter into agreements with social service providers, such as social enterprises or non-profit organisations, and investors to pay for the delivery of pre-defined social outcomes. (Galitopoulou and Noya 2016, p. 4)

This approach has required governments and providers to identify and articulate the outcomes funding is designed to achieve for individual service users and to consider the extent to which outcomes truly reflect provider effort. Social impact investment models emphasise the importance of governments having a clear focus on, and understanding of, the service user.

Use of social impact bonds for family and community services is growing in Australia. The NSW Government funds two social impact bonds for family support services (NSW Government 2017b). Other bonds are being developed to reduce homelessness, over-representation of Indigenous children in out-of-home care and harmful use of alcohol and other drugs in Victoria, Queensland and South Australia (Donaldson 2017; Pallas 2016; 2017).

As an example of how social impact bonds can operate, under the NSW Government’s Resilient Families social benefit bond, payment is calculated based on the number of children involved in the program that enter out-of-home care or have a risk assessment or a helpline report, relative to a control group of similar children that did not enter the program. Funding for the service is \$10 million and returns to investors will be paid at the end of the five-year program in 2018 (Benevolent Society 2015).

Interim evaluation reports for the two NSW bonds have found that the Newpin bond is ‘achieving a higher [family] restoration rate than other interventions’ (Urbis 2016b, p. ii) and that the Resilient Families bond has had mixed success to date (ARTD Consultants 2016).

Social impact investment is only feasible when all parties are able to agree on outcomes that are directly linked to provider actions, and that can be achieved and measured in a timely manner. These conditions apply in only a limited range of services. Moreover, social impact bonds are complex, and the design and implementation of bonds is costly.

The upfront transaction costs for establishing a bond are high — not just in terms of the range of experts a not-for-profit organisation is required to contract in [order] to set up such a complex financial instrument (which in itself is considerable) — but also the level of meaningful engagement required between the parties to the transaction to fully understand all aspects of the arrangement. (Benevolent Society, sub. 457, p. 4)

The prerequisites of measurable outcomes that are linked to services as well as the cost and complexity of designing the bonds will limit the applicability of social impact investment to a niche of family and community services. However, the approach can provide lessons for the broader commissioning system, including the benefits of defining outcomes and evaluating service provider performance.

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## Who uses family and community services?

Hundreds of thousands of people access family and community services each year. The number of programs and services makes it difficult to estimate the total number of people who use these services but public information is available for some services, including that:

- about 279 000 people received homelessness services in 2015-16, of which:
  - 106 000 were experiencing family and domestic violence
  - 72 000 had a mental health issue (AIHW 2017b, 2017h)
- about 284 000 people participated in Australian Government funded Community Mental Health activities in 2014-15<sup>1</sup> (DSS 2016b)
- about 115 000 people received alcohol and other drug treatment in 2014-15 (AIHW 2016c)
- about 27 000 children commenced intensive family support services in 2015-16 (SCRGSP 2017).

People who use family and community services have a range of needs, and the costs of providing services vary significantly depending on their characteristics. Some people need assistance to address a temporary crisis or transition, others have complex needs and require multiple services over a long period. Often, a small proportion of service users has very high service requirements and accounts for a large share of the total cost of some services. For example, in its position paper on the costs of the National Disability Insurance Scheme, the Commission noted that ‘while only 18 per cent of packages approved from 1 July 2016 are more than \$100 000, they account for 56 per cent of scheme costs’ (PC 2017c, p. 16).

## User choice

The characteristics of the users and, in some cases of the service itself, mean that user choice of service or provider will not be appropriate for all people (such as people with severe cognitive impairment) and in all circumstances (such as responding to emergencies). However, many people can exercise some degree of choice over the services they receive. Governments have developed phone and web-based service directories to help these people navigate the service system, such as the Australian Government DSS Carer Gateway and the Queensland Government’s oneplace (DSS 2016d; Queensland Government 2017).

There can be other barriers to overcome for service users able to exercise choice. One is that there is no entitlement to a level of service, let alone any entitlement to choose a provider — providers often have discretion over which clients they serve and what services they provide. Another barrier is the availability of services. Services are provided at no charge to service users and demand exceeds supply by a wide margin in many services. For example, in

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<sup>1</sup> Some of the programs that make up these activities are transitioning to the National Disability Insurance Scheme (DSS 2016c).

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2015-16 approximately 100 000 requests for specialist homelessness services were unable to be met (AIHW 2017i).

In some areas of family and community services (such as some carer support services) governments have taken steps to increase user choice. This is a positive step for the users of those services. However, family and community services are not well suited to the widespread introduction of greater user choice at this time. Instead, governments should focus on practical reforms to improve their stewardship of family and community services — the way they plan the system of services, select providers on behalf of users, and contract services so that users are at the centre of service provision.

## 8.2 Problems with the current arrangements

There is considerable scope to improve family and community services across the five attributes of effective service provision identified in chapter 1. The Commission identified many problems with the sector in its 2010 report on the *Contribution of the Not-for-Profit Sector* (PC 2010), including:

- [that] governments are not making the most of the knowledge and expertise of NFPs when formulating policies and designing programs
- excessively short-term contracts
- tendering, contractual and reporting requirements that are disproportionate to the level of government funding and risk involved
- the sheer volume of contracts that community-based organisations have to manage.

The Community Services Industry Alliance (sub. 410, p. 8) stated that problems identified in that study have persisted, including: ‘extensive reporting’, ‘short term heavy-handed contracts’ and ‘micro-management’. The following sections set out the main problems that the Commission identified in the sector. The Commission’s recommendations to help address these problems are presented in section 8.3.

### Better understanding the needs of the service user population

Understanding the population and the services it needs is essential to making sound decisions about what services should be provided, where and to whom. This includes understanding the number of people that are facing hardships that could be addressed through family and community services, their characteristics, and the distribution of needs within the service user population — from straightforward, one-off assistance through to ongoing coordinated assistance.

Governments currently do not have the information they need to adequately understand the needs of the service user population. This lack of knowledge undermines governments’ ability to plan services effectively and to prioritise between users. It contributes to

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duplication and uncoordinated service delivery that lead to inefficiencies and inequitable access, and are barriers to achieving the best outcomes for the largest number of people. Children's Ground (sub. DR562, p. 2) observed that the lack of systematic planning can have adverse effects on service users.

Complex economic and social disadvantage requires engaging with multiple government and non-government services to have needs met. People are required to 'share their story' with every new service and undertake additional assessments to meet strict criteria.

The effects of the lack of planning are magnified by Australia's federal system. Several different agencies across different levels of government are responsible for commissioning family and community services, but there is no process for coordination between them. For example, the Brotherhood of St Laurence (sub. 479, pp. 19–20) stated:

An incoherent patchwork of different funding priorities and commissioning arrangements creates barriers for providers, even those in the same service area, to develop closer working relationships, let alone integrate their service offers. A recent request for EOIs [expressions of interest] to deliver a new state government employment program nominated several sites, apparently unaware that the same locations were already served by another, almost identical, state-funded program.

## **Processes to select providers**

Contestable selection processes can be an effective way to identify the providers that are best placed to achieve outcomes for service users. However, participants identified some shortcomings in selection processes.

### **Scheduling and length of tender rounds**

Governments generally only allow four to six weeks for service providers to respond to selection processes. This is not long enough to develop a high-quality proposal, or for providers to formalise collaborative arrangements to take advantage of synergies. Several inquiry participants stated that the time available to submit tender applications can be a barrier to providers forming consortiums to jointly tender for contracts, and can undermine informal collaboration between service providers.

A key problem with the processes of the Going Home Staying Home (GHSH) reform of the NSW homelessness services sector, was the short period for tender proposals combined with an expectation of collaboration because the number of contracts being awarded was reduced. What occurred in some districts is that services located close together that had previously cooperated, put in competing tenders that led to a break-down in the relationships between the services. Arguably more time would have allowed these services to negotiate cooperative arrangements. Also, in cases where such arrangements were made, many of these were unstable because the short time-frames had not allowed organisation to form a sound basis for cooperation and resolution of differences. (Yfoundations, sub. DR497, p. 14)

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Short application periods can also reduce the extent of contestability in family and community services commissioning processes. For example, Southern Youth and Family Services (sub. 234, p. 6) stated that smaller providers are ‘more compromised by tight timeframes’ than larger providers. Tender processes that inadvertently lock out smaller providers could undermine the benefits of contestability.

Problems with short tender application periods are compounded by a lack of accurate forward schedules of commissioning processes and tenders. Robert Kerr (sub. 2, attachment 1, p. 8) stated:

... time allowed for tendering is typically two to four weeks, which inhibits proposed program development. And the forward schedule of tenders is often incomplete or out of date.

### Selection processes focus on the wrong things

Many participants argued that governments tend to focus on the cost of service delivery and the ‘quality’ of tender applications rather than the ability of providers to deliver outcomes for users. This creates incentives for service providers to direct their energies to a relevant but narrow issue (cost) and a more or less irrelevant issue (tender preparation), rather than focusing on achieving outcomes for service users (and demonstrating that they are able to achieve outcomes).

Over recent years, the need for more professional tender writing has led to increased investment in submission preparation. Greater competition runs the real risk of this being taken to an even higher and more costly level. And that doesn’t necessarily lead to more effective outcomes, just fancier, more detailed and more expensive tender submissions. (CEWA, sub. 403, p. 3)

When the government is the customer, a well presented and well thought through funding application or tender counts for much more than years of success in delivering real outcomes within communities. This kind of market encourages more investment in consultancy firms to write funding applications. It does not encourage increased investment in services improvement to achieve better outcomes. (CCA, sub. 193, p. 4)

Some inquiry participants suggested that smaller providers are disadvantaged by current commissioning practices, and that processes that favour larger organisations can threaten the survival of smaller providers and reduce diversity.

The aim of government should be to maintain the diversity of expertise that exists in the sector. Unfortunately there is a tendency of large government departments to prefer working with large not-for-profits. (Yfoundations, sub. 438, p. 5)

The [WA Department for Child Protection and Family Support] has observed that competitive tender processes can have smaller organisations experience difficulties competing for funding, leading to mergers with larger organisations. This has reduced options for service provision. (WA CPFS, sub. PFR386, p. 4)

The Commission notes these concerns and agrees that commissioning practices should not unreasonably disadvantage smaller (or larger) providers. It is important, however, that governments’ primary focus is on ensuring the effectiveness of the services that are

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delivered. Diversity should be supported where it contributes to improved outcomes but not for its own sake.

## **Performance frameworks**

Government systems for collecting and harnessing information on ‘what works’ (and does not work) to achieve outcomes for service users remain underdeveloped. The lack of evidence is an impediment to planning the service system to achieve efficient resource allocation and selecting the best service providers to deliver quality services to people experiencing hardship. Where governments have collected evidence for performance monitoring and accountability, they have tended to focus on inputs and (in some cases) outputs, rather than outcomes for service users.

## **Contract management practices**

### **Contract lengths**

Contract end dates create certainty for governments and service providers. They also give governments opportunities to ‘test’ the market at regular intervals to ensure that they are getting the best possible services. However, current contract lengths (which typically default to three years or less) are too short. Three-year contracts do not give service providers adequate funding stability. Short-term contracts can also be detrimental to service users because service providers spend too much time seeking short-term funding, which is a costly distraction from delivering and improving services. Short contracts can be an impediment to service providers developing stable relationships with service users, hindering service provision and the achievement of outcomes for users. The lack of certainty inhibits planning, collaboration between service providers, innovation and staff retention (box 8.3).

#### **Box 8.3      Participants’ views on contract lengths**

The practice of short-term contracts means that providers operate in a climate of constant uncertainty. Precarious funding militates against collaboration by making providers disinclined to invest scarce time and resources in the effort required to build networks and learn new ways of working. (BSL, sub. 479, p. 19)

... organisations delivering human services need longer-term secure funding, as the current short-term funding model has deleterious effects on service providers’ capacity to plan for and provide community services. (St Vincent de Paul Society National Council, sub. 285, p. 25)

Presently, organisations have little incentive to invest in training and skill development or create career opportunities for their staff as they have little certainty about future funding. This model hampers innovation, and the trial of new strategies and approaches. (ASU, sub. 480, p. 3)

Our main concern here is around funding levels, limited contract terms and their inflexibility. Ultimately, these factors create uncertainty for not-for-profit providers, stifle innovation within the sector, and hinder service provision and outcomes. (JSS, sub. PFR336, p. 13)

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A related problem is that governments often renew contracts at very late notice. Uncertainty about whether funding will be renewed affects providers' ability to attract and retain staff, which in turn can negatively affect service users.

Without knowledge of future funding streams, or even whether they will be delivering the same services in the next year services cannot plan for the future, reposition their organisations within the sector, or make large financial commitments. This restricts innovation. It further leads to difficulties in attracting and retaining the best employees, who may be drawn to the employment security of contracts of greater duration than 12 months, or who may seek new employment opportunities due to the fact that their existing contract is due for expiry and funding renewal has yet to be announced. (Council to Homeless Persons, sub. 434, p. 12)

### Inflexible contract management

Excessively prescriptive contracts constrain the capacity for providers to respond to the needs of users and are a barrier to achieving the benefits of contestability. For example, the St Vincent de Paul Society National Council (sub. 285, p. 24) stated:

Prescriptive and inflexible contracts are often administratively onerous, resulting in staff spending a disproportionate amount of their time managing reporting systems rather than delivering services. For smaller organisations, these effects can be particularly acute, diverting resources that would otherwise be used in responding to community needs.

### Funding is not aligned to the efficient costs of service provision

The costs of achieving outcomes for service users vary across different service needs, user populations, and according to location and the scale of provision. Participants identified service areas where government funding does not always align to the costs of service delivery.

Current funding models for SHS [specialist homelessness services] are based on metropolitan assumptions, and fail to account for the significant time and travel costs associated with providing support services to regional and rural areas. (CHP, sub. 434 p. 6)

A significant and central problem for the community-managed mental health sector with the application of a market-based approach through the NDIS [National Disability Insurance Scheme], has been fitting complex psychosocial support into a price structure that provides a 'general' or efficient price, which has seen the sector not able to provide complex supports within this structure. The costs of service delivery are going to be different dependent on the individual and this will raise the same issues being experienced with the NDIS. (CMHA, sub. DR498, p. 4)

Funding arrangements can constrain a provider's ability to invest and undertake other activities associated with service improvement.

The delivery of quality outcomes for service users is dependent on providers being able to invest in quality management mechanisms. Pricing for disability services have failed to incorporate activities such as performance monitoring, quality assurance, continuous improvement and workforce training, development and planning. (CSIA, sub. 410, p. 8)

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Funding levels can also influence service providers' behaviour in ways that reduce service effectiveness. Service providers have incentives to 'cherry pick' clients who are relatively low cost if funding does not cover the efficient costs of providing services to high-needs clients.

## **Governments' approach to risk management**

Currently, governments' approach to risk management in family and community services involves using prescriptive contract terms to manage the risks to government (such as the risk of cost overruns and the risk of governments being blamed for catastrophic failures in services). Managing risks through prescriptive contracts can achieve security for governments, but it can come at a cost — service provision that does not focus on the need to achieve outcomes for service users.

Sturges (2017) stated that there is a culture of risk aversion among public servants that is driven by governments' audit-focused approach to accountability. Although the Sturges paper was based on research into government procurement practices in the United Kingdom, inquiry participants agreed that risk aversion in government is an issue in Australia. For example, the Community Council for Australia stated that 'governments and their officials see control as protection against risk' (sub. DR585, p. 11). Children's Ground (sub. DR562, p. 2) stated:

Political cycles means that governments are reluctant to create change, even when they recognise things are not improving, due to the risk of media attention.

Governments' risk aversion feeds into selection processes and contract management, and constrains innovation that would improve service quality and efficiency. For example, the Bridge Youth Service et al. (sub. DR576, p. 4) stated:

The increase in quality standards covering similar issues, particularly in relation to governance, management and appropriate financial supervision, has generated an increase in separate, independent review cycles. The result for agencies like ours is multiple often duplicative reviews, which do little to improve the quality of the service our clients receive.

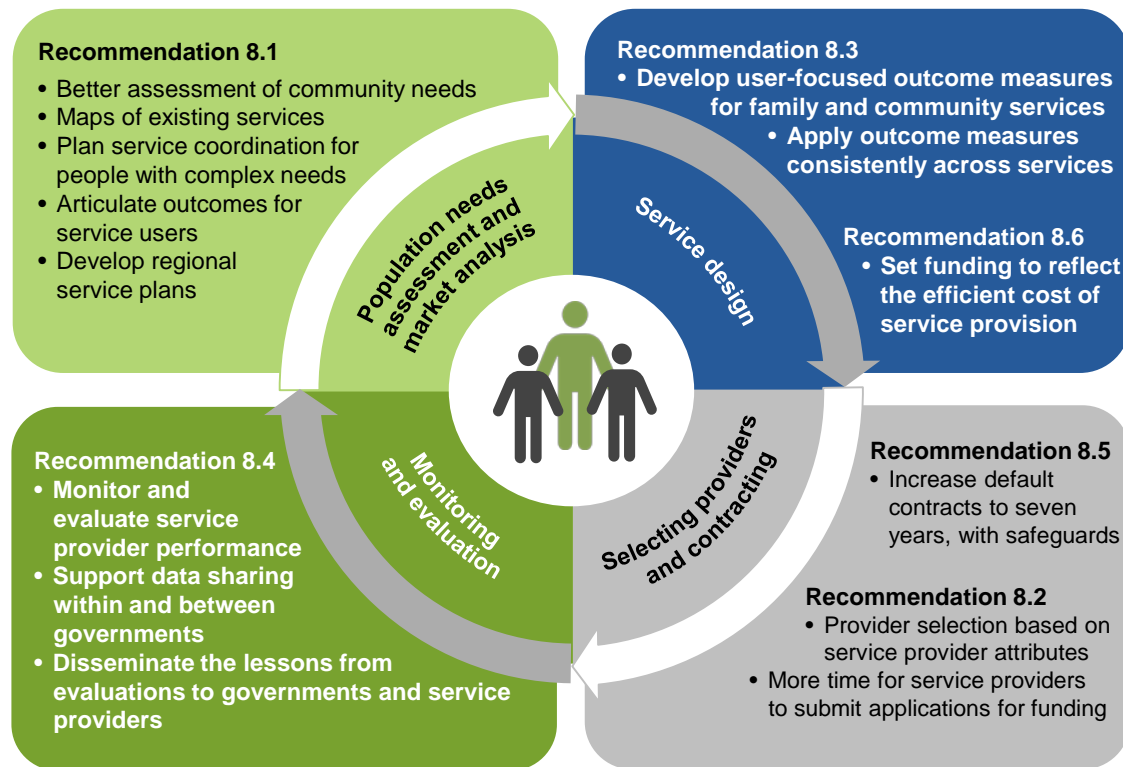
Ultimately, risk averse attitudes that are expressed through prescriptive contract terms have the effect of passing on risks to service providers and service users, who are usually less well placed to manage them.

## **8.3 Reform directions**

Although service providers have achieved positive outcomes for many Australians facing hardship, the family and community services system as a whole has developed in an ad-hoc way. This inquiry presents an opportunity to re-set the system with an overarching plan to achieve better outcomes for service users. Turning the system around to put the focus on the people who use the services will require cultural change across all levels of government.

Governments can begin the journey with some practical changes across all stages of the commissioning cycle (figure 8.2).

**Figure 8.2 Reforms to commissioning family and community services**



## Better understanding the needs of the service user population

To put service users at the centre of commissioning family and community services, governments need to build on existing initiatives and data to understand the service user population and the existing service providers, set clear objectives and plan to coordinate services.

### Identifying the service user population and its needs

Governments need to understand the population and its service needs in order to make decisions about what services should be provided, where, and to whom. This includes understanding the number of people that need a service, their characteristics and service needs and the distribution of needs within the service user population (from straightforward, one-off assistance through to ongoing coordinated assistance).

New data and analytical techniques are opening up possibilities for better population analysis. The analysis underpinning the Australian Government's Priority Investment

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Approach to Welfare provides one example where a more detailed understanding of the level and intensity of need across the community as whole, and in particular regions and cohorts, can provide a basis for targeting investment in family and community services. The actuarial analysis that was undertaken for the Approach identified the characteristics of people who are likely to have a high reliance on welfare payments across their lives (DSS 2016a). Some participants agreed that better population analysis has promise for family and community services.

Better information on population or cohort coverage and service outcomes is equally important to both improve service access and to enable services to best meet the needs of cohorts and communities. (WACOSS, sub. DR583, p. 6)

There is significant evidence that many identifiable cohorts amongst those experiencing homelessness are both currently underserved compared to their needs, and at a greatly increased risk of experiencing homelessness in the future (and into the long-term). Appropriately designed 'investment approaches' developed in line with consumers' expressed needs, could improve outcomes for service users as well as deliver cost savings into the future, and are worth exploring. (CHP, sub. 434, p. 9)

The NSW Government is using an investment approach to improve the out-of-home care system in its Their Futures Matter reforms. It stated:

The investment approach ensures that effort and funding is focused on providing services which have the greatest social return as well as promoting a cost-effective system. (NSW FACS, sub. 484, p. 12)

Other participants stressed that service providers and other community stakeholders have insights that are not evident from population-level data. The Australian Association of Social Workers stated that ground-level experience is crucial to identifying emerging needs.

Our members' experience is that the exact nature of the community service needed in a location cannot be deduced from demographic data in the same way that need for physical infrastructure can. In the case of services such as schools, there is a clear relationship between the age of a population and the number of schools it will require. By contrast, there is not the same clear relationship with the type of community support services that those children, young people and their families will require. For example, in the instance of housing stress among older single women, the social workers identified this need only through empathic and detailed discussion with women presenting with other needs, such as anxiety and stress, and only after a trusting relationship had been established. The underlying pattern emerged during staff meetings and was confirmed by detailed interrogation of data collected by local government. (sub. DR557, pp. 5–6)

Population analysis, coupled with on-the-ground evidence drawn from service providers and others with local experience or an understanding of particular cohorts, could be used to build a detailed picture of the needs of people experiencing hardship. It could also be used to underpin stronger service design and planning, particularly for people with complex needs who require multiple services on an ongoing basis.

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In addition to improving their population-level evidence base, the Commission is recommending that governments work more closely with service providers to build a more detailed picture of the needs of people experiencing hardship. Effective commissioning and stewardship would also involve consultation with other stakeholders, such as local governments, as suggested by the City of Whittlesea (sub. DR519) and Haven Home Safe (sub. DR598).

### Identifying service providers and service gaps

Governments need to understand the service provider population to identify gaps and duplication in service provision, and to inform planning for service coordination. Currently governments collect information on existing services, but in an uncoordinated, duplicative and irregular fashion (Southern Youth and Family Services, sub. DR555; The Bridge Youth Service et al., sub. DR576; WACOSS, sub. DR583).

NFP organisations currently collate information about family and community services. For example, Infoxchange manages the Service Seeker directory, which is a searchable directory of social services across Australia, including maps of services in a specified area (Infoxchange nd). WACOSS pointed to an example of using online technology to facilitate timely and comprehensive information collection.

WACOSS has developed a simple, intuitive and accessible interactive directory for emergency relief services that enables service providers to take control of updating their own data. Building on this system it is possible to provide a comprehensive, self-sustaining accessible and up-to-date online directory of the social services to support professional referrers, individuals and families to navigate our complex service system. (sub. DR583, p. 5)

Governments should improve their coordination of data collection and collate and publish maps of existing services.

### Articulating user-focused outcomes

The way governments define the outcomes they are trying to achieve sets the parameters for the relationship between service providers and governments.

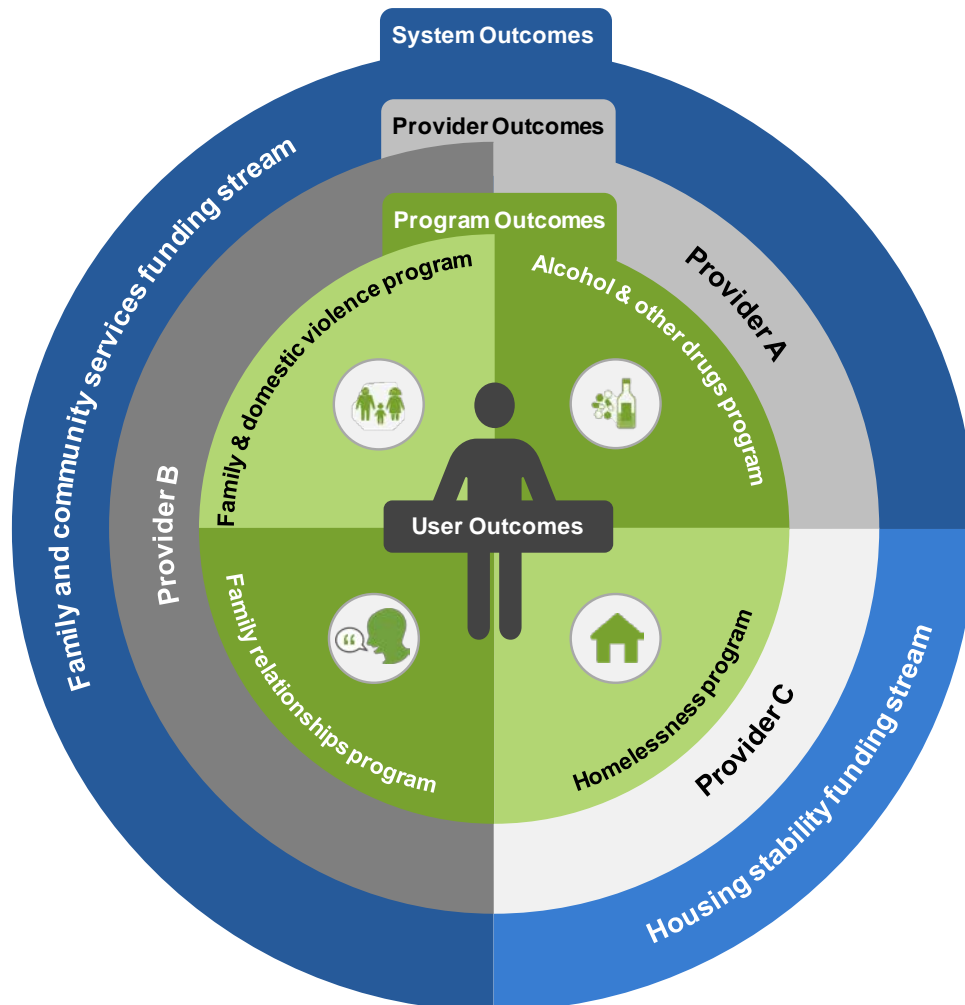
Governments that commission family and community services typically define outcomes for specific funding programs. This program-oriented approach is not consistent with a focus on service users. The system would be more effective in achieving outcomes for service users if governments developed cross-program outcomes frameworks that articulate outcomes at all levels — service user, service provider and program (figure 8.3) — and can be used to track changes in wellbeing at an individual level consistently across services. Family Life (sub. 57, p. 2) captured this in its submission:

Outcomes must be clearly articulated in meaningful terms of improvements and changes for the intended beneficiaries of public policy, whether these beneficiaries are individuals, a particular

group of citizens, or communities and the broader society. We need to be clear about our goals, set outcome targets and measures for tracking our performance towards those outcomes.

**Figure 8.3 How outcomes fit together**

A stylised example of a person who uses services across four programs that are delivered by three providers and funded through two funding streams.



### Planning for coordinated services

More effective service coordination could contribute to better outcomes for people with complex needs who can otherwise be at risk of 'falling through the cracks' of a service system that is not set up to provide comprehensive, coordinated and ongoing support. Coordination can also reduce the waste associated with duplication. Governments need to ensure that the right mix of services are provided to meet the needs of the community and must also establish mechanisms for service coordination. This will require action on two fronts. First, governments should invest more in planning for services to meet the needs of

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people who need multiple, ongoing coordinated services. Upfront investment in service planning could significantly improve outcomes for people with complex needs, and could also lead to medium-term savings for governments through greater efficiency in service provision.

Second, the Australian, State and Territory Governments should work together to establish mechanisms for service coordination. One option would be to allocate responsibility for service coordination to dedicated regional bodies. This already occurs to a limited extent in some family and community services.

- Primary Health Networks have a role in commissioning ‘services within the community mental health sector (which is part of the family and community services sector)’ (MIFA, sub. DR549, p. 3).
- Mallee Track Health and Community Service (sub. DR499) described the ‘multipurpose service model’ in aged care services, which involves pooling funds for services and building on the skills of existing workers to overcome skills shortages.
- WACOSS (sub. DR583, p. 3) stated that regional planning, coordination and service integration might be assisted by ‘the development of Strategic Regional Advisory Councils in Kimberley and Pilbara, and engagement of local community services with regional human service managers in District Leadership Groups to facilitate a collaborative approach to regional services’.
- The Communities for Children program coordinates targeted interventions for children up to five years old in 45 regions. In each region, a non-government organisation is funded as a ‘facilitating partner’ to establish committees and ‘oversee the development of community strategic plans and annual service delivery plans’ (Muir et al. 2010, p. 35). Service providers are funded to undertake the activities specified in the community plans. The Benevolent Society (sub. 457, p. 8) stated that the Communities for Children program ‘provides a good model for effective service coordination’.

These place-based approaches to service planning, commissioning and delivery hold significant promise. However, there is no single model or approach that is clearly suitable to be rolled out across all family and community services throughout the country (the Commission has reached a similar conclusion for service delivery in remote Indigenous communities, discussed in chapter 9). An alternative is for existing State and Territory Government departments to take responsibility for developing regional service plans, with the Australian Government using these plans to inform its own funding decisions. This approach could be lower cost than establishing new bodies, and may impose less of a burden on service providers.

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#### RECOMMENDATION 8.1

The Australian, State and Territory Governments should build on existing initiatives and data to:

- analyse the characteristics and needs of the service user population to assist with system and program design and targeting
- develop and publish data-driven maps of existing family and community services
- identify outcomes for family and community services that articulate the improvements in service users' overall wellbeing that governments are seeking to contribute to through service provision
- develop plans to coordinate services for people who have complex needs
- develop and publish regional service plans to address the needs of people experiencing hardship.

These actions will require ongoing commitment from governments, working in consultation with service users and service providers.

### Processes for selecting service providers

Governments need to adjust selection processes to ensure that service providers have enough time to develop and submit their proposals, including developing joint ventures where appropriate. Governments should also develop a better understanding of how the attributes of service providers are related to achieving outcomes for service users, in order to select the mix of providers best suited to delivering the user outcomes they seek.

#### Scheduling and length of tender rounds

Governments should provide greater certainty about when tenders will be sought by publishing a rolling schedule of upcoming tenders over (at least) the next twelve months. This should be relatively straightforward for existing contracts that have a defined end date. For new programs, governments might occasionally need to slow down the roll-out in order to provide opportunities for providers to develop applications. In the Commission's view, this is a worthwhile trade-off overall, although there could be limited circumstances when urgency means that contracts are awarded at shorter notice.

Once tenders are open, the appropriate length of time to allow for tender applications would depend on the characteristics of each contract. Some inquiry participants commented on past tender processes that they considered too short.

- The 2014 DSS tender round was open for five weeks. Southern Youth and Family Services stated that the tender round 'provided for a stressful, short time-framed and

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confusing application process’ (sub. 234, p. 7). Anglicare Australia stated that the tender process was rushed and extremely costly for service providers (sub. 445).

- The NSW Government’s ‘Going Home Staying Home’ tender process opened on 27 November 2013 and closed on 7 February 2014 — a period of about ten weeks, including the Christmas period (KPMG 2015). As noted above, Yfoundations (and other inquiry participants) were critical of the tender approach for the reforms.

Tender periods for complex family and community services should be longer than the current normal practice. The Commonwealth Procurement Rules specify a minimum period of 25 days for potential suppliers to lodge submissions (Department of Finance 2017). This period may be adequate for tendering simple services in well-developed markets, but will not elicit the type of well-considered (and often collaborative) proposals needed to improve service effectiveness in family and community services. For these services, a default minimum period of three months would be more appropriate. Governments should also notify providers of the outcome in a timely manner ahead of the commencement of the contract and allow enough time for transition when new providers are selected.

A further positive step would be to coordinate the timing of tenders so that contracts for related services were open simultaneously. For example, governments could agree to open all tenders for family support services in a region at the same time and hold them open for long enough to facilitate consortium bids by local providers.

### Selecting providers based on their attributes

The ability of a service provider to deliver outcomes is related to its attributes, including the provider’s past performance, size, connection to the local community and governance arrangements. As noted in chapter 2, organisation type — such as whether a provider is for-profit, NFP or a mutual enterprise — is not in itself a good guide to a provider’s capacity to achieve outcomes for service users. Many inquiry participants disagreed and argued against any involvement of for-profit organisations in family and community services. Some participants objected to service providers making profits from delivering services to people experiencing hardship (for example, Australian Services Union, sub. DR575; Illawarra Forum Inc., sub. DR550; SYFS, sub. DR555). Others argued that for-profit providers are not able to achieve the wider community benefits associated with volunteerism and pursuit of a broader ‘mission’ (for example, FRSA, sub. DR554).

The Commission agrees that different organisational forms have different capabilities and underlying motivations and this can influence their alignment with governments’ objectives and their operational capabilities. In some situations, one organisational form may be better able to deliver outcomes than another. However, this does not mean that one organisational form should always be preferred. Different organisations should be evaluated on a case-by-case basis and there is no justification for a blanket ban on any type of service provider.

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#### RECOMMENDATION 8.2

To improve processes used to tender family and community services, the Australian, State and Territory Governments should:

- publish a rolling schedule of upcoming tenders over (at least) the next twelve months
- allow sufficient time (a default of three months) 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
- 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).

## Performance frameworks

Governments should develop and apply performance frameworks that are focused on service users and outcomes. They should also strengthen program evaluation and build a learning system for family and community services.

### Outcomes measures and outcomes frameworks

Measuring service users' outcomes is the foundation of any performance framework in a user-focused system (CSIA, sub. PFR395; UnitingCare Australia, sub. PFR313). Outcome measures are data that quantify how activities contribute to user outcomes (chapter 2). An outcomes framework identifies the outcome measures that are chosen for each outcome and how the data are to be collected.

One example is the DSS Data Exchange Framework (DEX). DSS collects data on outcome measures that are reported by providers, through user surveys and are collected from research and government datasets. Data on individuals are linked (using a 'statistical linkage key') within the DEX across services, providers and over time. DEX data can also be linked with other government datasets (DSS 2014).

The DEX outcomes framework is based on measuring changes to user wellbeing over time. For example, consider the case of a person seeking assistance with homelessness. Suppose at the beginning of the period, the service provider reports that a user's circumstances align with score 1 for the housing domain, 'significant negative impact of poor housing on independence, participation and wellbeing', and score 2 for the behaviours goal domain. At the end of the case, the provider may report that the user's wellbeing aligns with score 3, 'progress towards housing stability', and score 4, 'moderate progress to date in achieving behaviour goals' (DSS 2014, pp. 25–27). These scores can be used to assess the effectiveness of services for individual service users, cohorts, locations or entire programs.

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The Australian, State and Territory Governments have outcomes frameworks either in place or under development (box 8.4). This is a positive step but there is a considerable way to go before user outcomes are identified and measured across all areas of family and community services.

Whilst a transition to an outcomes-based approach is desirable and aligns with the Productivity Commission's discussion to date, there has been little work done to redesign systems, define community service outcomes and enable effective measurement. (CSIA, sub. 410, p. 1)

### The challenges of using outcomes frameworks

Several inquiry participants pointed out that collecting data on service user outcomes is challenging.

While service outputs are generally easy to measure in terms of: hours, service events, and time on waiting lists; services outcomes are less tangible though not necessarily outside the scope of measurement. (Baptist Care (SA) Inc., sub. 123, p. 1)

Inquiry participants also identified the challenge of attributing outcomes to service providers, particularly for services that address complex social problems. Outcomes can take many years to achieve and factors other than service provision contribute to changes in a person's wellbeing.

We note, however, that in practice, outcomes-based approaches can be challenging to implement. Program logics tend to oversimplify the antecedents to change, and limit interconnections between a range of outputs from a system of providers. (MIFA, sub. DR549, p. 6)

That the SHS [specialist homelessness sector] Program is one component within a much broader service system and does not have control of the levers to prevent and address homelessness (eg housing, domestic violence, other government reforms) and that any outcomes-based contracting approach needs to be carefully considered in this context. (Homelessness NSW, sub. DR520, p. 4)

Some participants suggested that service providers can game outcomes frameworks, such as by cherry picking clients.

Even though the [Productivity Commission's Draft Report] recommendations consider the process of outcomes-based commissioning in detail, our members have observed how easy it is for organisations to manipulate their intake criteria, their recording practices and their client feedback. (AASW, sub. DR557, p. 6)

Critically, those with multiple and complex needs are less likely to sustain a tenancy, and therefore less likely to achieve a positive outcome in a competitive model that rewarded successful sustainment of tenancies. Competitive contracts based on outcomes would create a situation whereby organisations would be more likely to be awarded future contracts or renewals by turning away those most in need. (Council to Homeless Persons, sub. 434, p. 8)

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#### **Box 8.4 Outcomes frameworks in use or development**

The NSW Government has at least four outcomes frameworks in use or under development, including:

- the NSW Human Services Outcomes Framework, which will first be applied to social housing before being adopted more broadly (NSW FACS 2016d)
- the Quality Assurance Framework, which has been designed to measure and improve outcomes for children and young people in out-of-home care (NSW FACS 2017c)
- an outcomes framework for homelessness services (NSW FACS 2015)
- one for family support services and other initiatives that aim to reduce demand for out-of-home care (NSW FACS 2016f).

The Queensland Government uses the Social Investment Reform Performance Framework for monitoring the performance of family and community service providers and introduced outcome measures to the framework in 2014 (Queensland DCCSDS 2016).

The Victorian Government is testing an outcomes framework under its integrated services trial, Services Connect (Victorian DHS 2015).

The WA Partnership Forum is developing an 'across sector joint outcomes framework to measure the impact of earlier intervention programs, services and policies' (WA CPFS, sub. PFR386, p. 4).

In 2014 the Tasmanian Department of Health and Human Services introduced an Outcomes Purchasing Framework to apply to all the community services it funds. The Framework is intended to define and measure the changes that services achieve for service users. The Framework 'was designed to align with the Australian Department of Social Services new approach to program performance reporting, Data Exchange' (Tasmanian Government, sub. 485, p. 28).

The SA Department for Communities and Social Inclusion uses Results-Based Accountability, an outcomes-based framework for quality improvement, in its programs (SA DCSI 2017a). The Department's Thriving Communities initiatives are based on a collective impact approach, and progress towards 'outcomes that reflect the community's priorities and needs' are measured to support ongoing learning and improvement (SA DCSI 2017b).

As part of its Better Services reforms, the ACT Government stated that an 'outcomes framework will be developed as a key accountability measure to support improved outcomes and ongoing improvement' (ACT Government 2014, p. 20).

The NT Government is 'working with the cross-jurisdiction Children and Families Secretaries group to agree on national outcome statements and measures. This includes working with Aboriginal organisations to define outcome measures for the safety and wellbeing of Aboriginal children' (sub. DR593, p. 16).

Where the challenges of collecting and interpreting outcomes data can be overcome, outcomes measurement is the 'gold standard' for performance management. However, if this is not possible or not cost-effective, governments can evaluate service providers' contribution to achieving long-term outcomes by including 'interim and proxy measures of progress' (DSS, sub. 476, p. 13) in outcomes frameworks. Outputs can be useful proxies for outcomes where there is evidence of a strong causal link (such as the link between providing crisis accommodation and achieving immediate safety for people fleeing domestic violence).

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#### RECOMMENDATION 8.3

The Australian, State and Territory Governments should, within 24 months, agree on indicators of the wellbeing outcomes of people who use family and community services and apply them consistently across all such services.

Where it is not feasible to define or collect data on service user outcomes, governments should identify outputs from family and community services that can be used as proxies for outcomes.

Governments should broadly define outcome measures (and outputs) 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.

### Program evaluation and a learning system

Program evaluations are currently not done frequently (or at all for smaller programs) and those that are completed do not systematically lead to increased service effectiveness. A lack of system-level evaluation is a barrier to understanding how service systems work for users who participate in multiple programs, and to effective system planning. Inquiry participants recognised the importance of increasing the frequency and quality of evaluations. Jesuit Social Services (sub. 420, p. 4) called on governments to ‘evaluate and disseminate practice learnings amongst stakeholders in order to enable innovation and better outcomes’. CCA (sub. 193, p. 7) stated that ‘knowing what has been tried and what works is critical to improving service delivery’.

Evaluating providers, programs and systems has costs as well as benefits, and the scope of an evaluation should be commensurate with the size and complexity of the program. However, the current level of evaluation is inadequate and governments should take steps to increase the number of programs that are evaluated (and published) and the quality of the evaluations.

An effective system of family and community services would incorporate a learning system — findings from evaluations should inform changes to system planning and program design. Governments would also identify and disseminate the lessons from evaluations to increase the application of effective service models. The Commission recommended wider sharing of information in its 2010 report on the *Contribution of the Not-for-Profit Sector* (PC 2010).

Increasing the sharing of information could run up against some challenges. In its inquiry report *Data Availability and Use*, the Commission identified some cultural barriers within government that limit the usefulness of data.

Despite recent statements in favour of greater openness, many areas of Australia’s public sector continue to exhibit a reluctance to share or release data.

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The entrenched culture of risk aversion, reinforced by a range of policy requirements and approval processes, and often perverse incentives, greatly inhibits data discovery, analysis and use.

The lack of public release and data sharing between government entities has contributed to fragmentation and duplication of data collection activities. This not only wastes public and private sector resources but also places a larger than necessary reporting burden on individuals and organisations. (PC 2017a, p. 153)

Addressing these issues and sharing more data on the outcomes of family and community services could contribute to significant ongoing improvement to service effectiveness.

#### RECOMMENDATION 8.4

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

- monitor the performance of providers of family and community services in achieving outcomes for service users
- evaluate service providers, programs and systems in ways that are commensurate with their size and complexity, and publish the lessons of these evaluations
- 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.

## Contract management practices

Service providers could deliver more effective services if their contracts emphasised achieving outcomes for service users, were longer, less prescriptive and incorporated more flexibility. Some simple changes to contract terms could facilitate smarter approaches to contracting.

### Outcomes-based commissioning

Outcomes-based commissioning is a general term that encompasses several approaches to focusing on outcomes in commissioning and service delivery (box 8.5). The Brotherhood of St Laurence (sub. 479, p. 37) described how identifying outcomes and having them well understood by all involved in commissioning and delivering services has benefits in itself.

As the commissioning process unfolded, as the stakes increased, as relationships were tested and nerves frayed, it was this shared belief in the goal of the endeavour that provided the incentive for all parties to develop workable compromises and 'work-arounds' to keep the project afloat.

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Outcomes-based funding involves some or all funding being linked to the achievement of outcomes. Designing outcomes-based funding arrangements is costly and poses significant challenges including attribution of outcomes to services and creating incentives for service providers to take a narrow focus, or to ‘park’ or cherry-pick clients (Tomkinson 2016).

#### Box 8.5      **Outcomes-based commissioning**

Outcomes-based commissioning encompasses a variety of approaches to commissioning, including outcomes-based:

- **funding** — the government collects data on outcomes and links a provider's funding with their performance against outcomes targets (also referred to as outcomes-based contracting)
- **provider performance management** — the government collects data on outcomes that it uses to monitor and compare provider performance
- **service evaluation** — the government collects data on outcomes that it uses to evaluate the effectiveness of programs and the service system
- **program design** — the government designs program guidelines, service agreements and provider selection processes to maximise intended outcomes by carefully specifying outcomes and minimising the specification of activities, outputs and processes, where appropriate
- **service delivery** — providers use data on outcomes to support case-management and to provide a tailored service response to their clients.

The benefits, costs and risks of having an outcomes focus to commissioning family and community services depend on which of these elements are applied.

In some cases governments have addressed these challenges through sophisticated contract design, such as social impact investment. However, this approach can only be used when service user outcomes can be measured and when there are robust and timely causal relationships between services and outcomes. Experience with social impact bonds demonstrates that it is not always possible (or cost-effective) to define and measure outcomes to the degree necessary. The successes — and failures — of social impact techniques highlight a number of areas where and how governments should improve the practice of commissioning family and community services.

Although social impact investment models are only applicable in a limited range of circumstances, there would be benefits in bringing into the broader commissioning system the focus that social impact investing has on defining and achieving outcomes for service users. There could be scope to expand outcomes-based funding beyond current levels in cases where services can achieve measurable and tightly defined outcomes in a reasonable time frame, but it is likely to remain a relatively minor part of the overall service system.

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## Longer contract terms

Governments should increase the length of contracts for family and community services. In its report on the *Contribution of the Not-for-Profit Sector*, the Commission recommended:

The length of service agreements and contracts should reflect the length of the period required to achieve agreed outcomes rather than having arbitrary or standard contract periods. (PC 2010, p. 347)

Although in theory contract lengths should reflect the circumstances of each contract, this may not be practical for governments operating thousands of contracts across a range of services. Instead a ‘default’ contract term that balances the advantages of longer contracts and the advantages of regular contestability can be desirable.

In the draft report for this inquiry, the Commission recommended that default terms for family and community services contracts be set to seven years, with scope for exceptions where shorter contracts would be appropriate, such as program trials. Where governments choose to use shorter contracts, they should explain their reasoning to potential service providers.

Seven-year default contracts would allow for time for setup (making the investments that are necessary to deliver effective services, including workforce capacity and building relationships in the community) and time for a smooth transition to a new provider at the end of the contract. In between, service providers would have a much needed period of stability and, when combined with a stronger focus on user outcomes, would provide the basis for more effective service provision. In consultations, service providers suggested that, as a rule of thumb, the set-up and handover periods could take about a year each, meaning that service providers would have five years of their contract to focus solely on service delivery. At the end of this period, contracts should be retendered to find a balance between providing continuity and retaining the benefits of periodic contestability.

Several inquiry participants supported the draft recommendation for seven-year default terms (including Anglicare Australian, sub. DR574; ASU, sub. DR575; CHP, sub. DR522; City of Whittlesea, sub. DR519; CSIA, sub. DR507; Illawarra Forum Inc., sub. DR550; NDS, sub. 518; Public Service Research Group, University of New South Wales, sub. DR572).

Melbourne City Mission (sub. DR510) and Yfoundations (sub. DR497) suggested that the default contract length should be ten years. Some participants suggested five years (COTA Australia, trans.; The Bridge Youth Service et al., sub. DR576). Several governments offered qualified support for contracts longer than three years.

- The Queensland Government stated that the Department of Communities, Child Safety and Disability Services ‘has five-year service agreements in place with funded service providers, where appropriate’ (sub. DR592, p. 9)
- The NT Government stated that it ‘is not considering seven-year contracts as a default option, but there may be scope for five-year contracts with an option for extension of two years’ (sub DR593, p. 17).

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- The Tasmanian Government stated that extended contracts ‘could be expected to deliver a range of benefits’, but that the four-year election cycle would mean ‘that there is limited funding and political certainty beyond that period of time’ (sub. DR590, p. 18).
  - The WA Government stated that since the implementation of the Delivering Community Services in Partnership policy ‘the standard length of community service contracts in Western Australia is five years (commonly with three-plus-one-plus-one contract terms)’ (WA Government, sub. DR596, p. 5)

### *Managing the risks of longer contracts*

The flipside of providing greater funding certainty for service providers would be a reduction in flexibility for governments including, for example, when funding priorities change. Participants raised the concern that longer contracts could increase the risk that ineffective providers would be locked in for extended periods if governments took a ‘set and forget’ approach to contract management. This is a risk that could be managed through some sensible adjustments to contract management practices. Inquiry participants agreed that an essential element of longer contracts would be the introduction of safeguards to manage underperformance. For example, the Tasmanian Government stated that if longer contracts were introduced:

Tasmania would need to develop a more robust performance management framework that offers options for recourse, other than de-funding, where a service provider is failing to perform under a contract. (sub. DR590, p. 18)

A performance framework for service providers with extended-term contracts would need to incorporate regular assessments of service effectiveness. Governments should work with service providers and service users to regularly review progress toward user-focused outcomes to ensure that priorities are being met and identify opportunities to improve performance. This might involve a regular review, as part of a more ‘relational’ approach to contract management (as discussed below). To manage the most serious risks, governments, as the stewards of the family and community services system should set and maintain clear bottom-line standards for provider performance which, if breached, result in contract termination.

### **Relational approaches to contract management**

Longer contracts would open the door for governments and service providers to adopt new ways of working together to achieve better outcomes for service users. Currently, governments tend to use simplistic approaches to contract management. Sturges (2017, p. 11) put it succinctly:

... the procurement and contract management tools that are appropriate for buying ‘paperclips’ — highly commoditised, easily specified goods and services — are not appropriate for commissioning complex support services and front-line human services.

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In a world of longer contracts, governments and service providers could increase their focus on achieving outcomes for service users by adopting more relational approaches to contract management. Relational contracting involves the parties to the contract seeking to maximise the effect of their joint efforts on improving user outcomes over time. This recognises that governments and service providers both have contributions to make to the effective delivery of services. The Commission recognised the potential benefits of this approach in its report *Contribution of the Not-for-Profit Sector*. (In that report the Commission described this approach as ‘joint ventures’ between governments and service providers.)

Under the joint venture approach relatively more weight is given to achieving outcomes through relational rather than contractual governance. To be successful, these types of arrangements need a high degree of flexibility and trust based on each party having a good understanding of the other, an alignment of purpose in relation to the service being provided, and effective communication. (PC 2010, p. 326)

The relational contracting methodology has been applied in human services, including by the NSW Department of Family and Community Services in some homelessness services (Yfoundations, sub. DR497). The District Health Board for the Canterbury region of New Zealand has introduced ‘alliance contracting’ for its contracts with district nurses, allied health and laboratory services. The collective responsibility for the contract has been found to foster co-operation and the incentive to direct resources to areas of underperformance (Timmins and Ham 2013).

Taking a relational approach to contract management would pose some risks, including a reduction (real or perceived) in accountability if performance management was not based on objective measures (such as cost per service episode). Governments and service providers would need to invest in developing new capabilities to implement the relational approach, including developing outcomes frameworks and collecting and analysing outcomes data.

#### RECOMMENDATION 8.5

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

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

- increase default contract lengths for family and community services to seven years
- allow exceptions to be made, such as for program trials, which could have shorter contract lengths
- publish the justification for any contracts that differ from the default term
- initiate collaborative reviews (involving government and providers) to assess progress, adjust priorities as needed and identify opportunities for improvement
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of failure.

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## Aligning payment with the efficient cost of provision

Governments should align the level of payment to service providers with the efficient costs of achieving outcomes for people and account for factors that cause costs to vary. As noted in chapter 2, setting and implementing this payment level is difficult. Inquiry participants identified several factors that should be considered, including:

- location (CHP, sub. DR522; SYFS, sub. DR555; UnitingCare, sub. DR514)
- administration (ASU, sub. DR575; MIFA, sub. DR549)
- capital and maintenance (SYFS, sub. DR555)
- professional development and continuous quality improvement (AASW, sub. DR557; ASU, sub. DR575; MIFA, sub. DR549; SYFS, sub. DR555)
- compliance with government quality requirements (SYFS, sub. DR555; UnitingCare, sub. DR514)
- the costs of coordinating with other service providers, when this is a contract requirement (FRSA, sub. DR554)
- indexation of payments to account for cost increases (such as increasing wages) (CEWA, sub. DR564)
- program evaluation (MIFA, sub. DR549).

This list is not exhaustive, but gives an indication of what governments should consider when setting funding for family and community services. The analysis required to estimate the efficient costs of provision is likely to be complicated and costly. Governments should initially focus on making use of the data they already collect and identifying the information required to improve their estimates and contract design over time.

### RECOMMENDATION 8.6

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

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## 9 Human services in remote Indigenous communities

### Key points

- Human services should be making a greater contribution to improving the wellbeing of Indigenous people living in remote communities.
  - Despite goodwill and significant resources, current approaches to commissioning human services in remote Indigenous communities are not delivering the benefits of contestability and are exacerbating its potential weaknesses.
  - Policy instability has created uncertainty and confusion for communities and service providers, and has undermined the effectiveness of service provision.
- Service provision in remote Indigenous communities faces challenges including isolation, time-consuming (and often costly) travel, and difficulty recruiting and retaining staff with the necessary skills and capabilities. There are often limited economic opportunities and, in some communities, the provision of government services is the main economic activity.
- The following changes to commissioning arrangements would promote longer-term stability for service users and providers, and increase community involvement:
  - improvements to commissioning processes (contract lengths, tender timing and alignment and provider selection processes)
  - a greater focus on skills transfer and capacity building
  - improvements to planning, evaluation and feedback systems.
- The Commission has also considered a longer-term transition to a ‘place-based’ model of service provision. Consultations with inquiry participants confirmed that there is merit to place-based approaches, but that a large-scale systematic rollout of place-based approaches across remote Indigenous communities is not feasible.
  - Government and community capacity for place-based reforms does not exist everywhere and would take time and effort to build. Expanding too far, too fast is a significant risk.
- Governments should be willing to adopt more place-based approaches on a case-by-case basis where communities can demonstrate they are ready and government capacity exists (or can be readily built).
- Governments should shift the balance away from centralised decision making in government toward greater regional capacity and authority to improve responsiveness to local needs.

There is considerable scope to improve the effectiveness of human service provision in remote Indigenous communities through practical reforms. The Commission is recommending commissioning improvements that can be made in the shorter term as well as longer-term changes to improve the responsiveness of services to local needs (table 9.1).

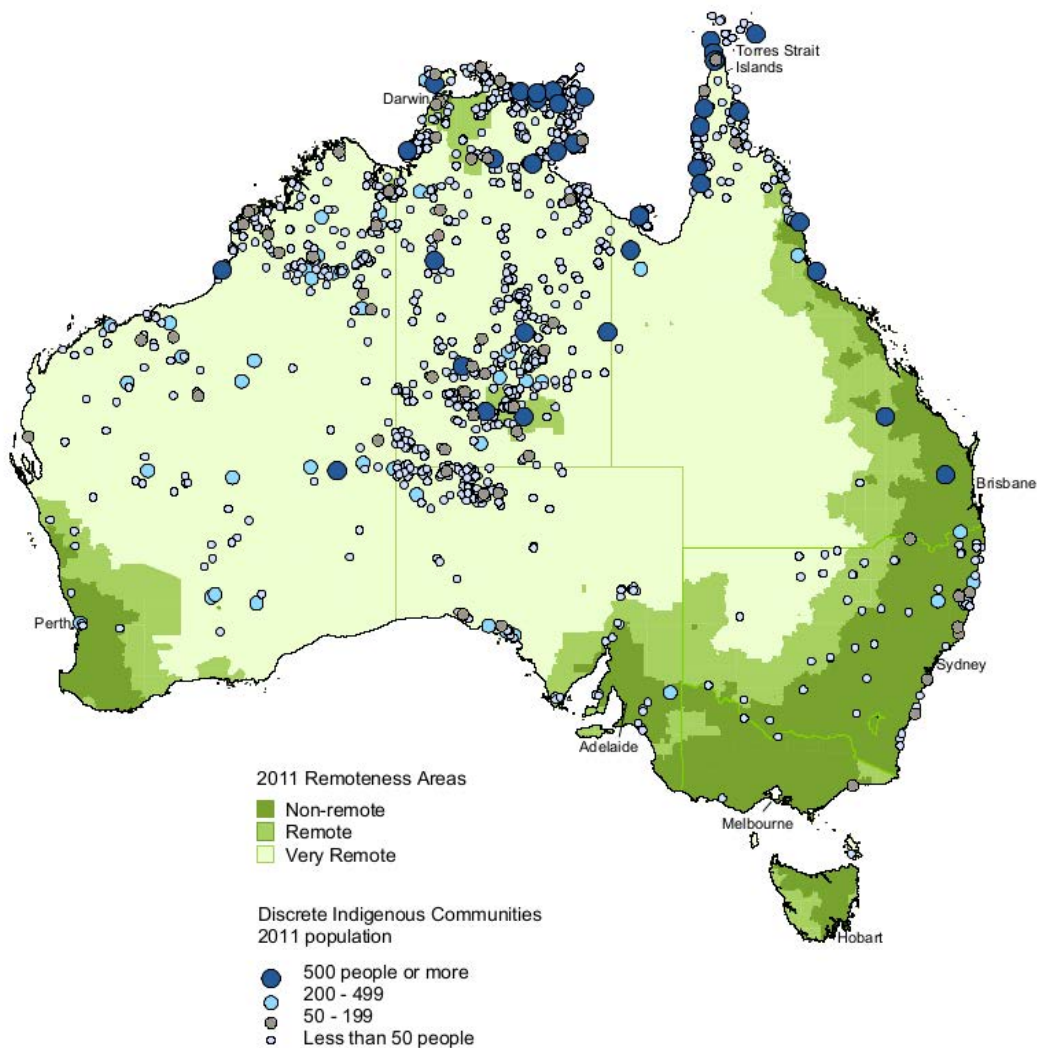
**Table 9.1 Overview of proposed reforms to human services in remote Indigenous communities**

All reforms are directed at the Australian, State and Northern Territory Governments

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Improved commissioning arrangements</b>		
<b>Recommendation 9.1</b> Increase default contract lengths to ten years. (Exceptions could be made, such as for program trials but justification should be published.) Ensure contracts contain adequate safeguards in any cases of failure by providers.	As existing contracts expire and new contracts commence.	Could increase consequences of selecting the wrong providers; less flexibility for government to change funding priorities. Facilitate greater investment by providers in service quality, increased time to invest in relationships and build trust. Lower administrative costs.
<b>Recommendation 9.2</b> Publish rolling schedules of upcoming tenders. Allow sufficient time for providers to prepare considered responses, including the development of integrated bids across related services. Align tender processes for related services.	Aligning tender processes should be rolled out gradually, commencing with a small number of communities. The remaining reforms should be implemented as soon as practicable.	Create opportunities for communities and governments to identify a mix of providers that is likely to achieve the best outcomes for the community.
<b>Recommendation 9.3</b> Ensure commissioning processes incorporate skills transfer and capacity building for people and organisations in communities.	As soon as practicable.	Potentially higher cost of service provision in the short term. Community development; reduced travel costs.
<b>Recommendation 9.4</b> Take into account the attributes of providers that contribute to achieving outcomes for people living in remote Indigenous communities (including, for example, culturally appropriate service provision).	As soon as practicable.	Increase in administrative costs for governments. May lead to selection of higher cost providers, potentially offset by increased effectiveness. Improve service quality through selection of providers that can better achieve outcomes. Improve responsiveness through including attributes valued by the community.
<b>Recommendation 9.5</b> Invest in better systems to underpin service provision by developing outcome measures, conducting community assessments and establishing evaluation and feedback systems.	Ongoing	Governments and service providers would face costs of data and information gathering, analysis and sharing. Improved efficiency and quality of services (better targeted to community need).
<b>Responsiveness to local needs</b>		
<b>Recommendation 9.6</b> Adopt more regional and localised approaches to decision making and engagement with communities. Give local staff more authority over local planning, engagement and service implementation.	Commence as soon as practicable, expanding over time as capacity is built.	Resourcing and capacity-building for regional staff. Better understanding of communities and their needs, greater linkages between government decision makers and communities.

About one in five Indigenous Australians live in a remote area (ABS 2013a). In 2011, there were over 1000 discrete Indigenous communities in remote areas (figure 9.1), of which more than three-quarters had a population of less than 50 people (ABS unpublished data). Remote communities are unique and challenging environments for service provision.

Figure 9.1 **Discrete Indigenous communities by size and remoteness, 2011**



Source: ABS (Census of Population and Housing, unpublished).

Some participants suggested that the Commission should also develop recommendations to improve human services delivered to Indigenous Australians in non-remote areas (Department of Health, sub. DR569; NCAFP, sub. DR565; VACCHO, sub. 455). The Commission recognises this view and notes that some of the discussion in this chapter is relevant to providing services to Indigenous people living in non-remote parts of Australia.

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Indigenous Australians as a group are among those most likely to experience deep and persistent disadvantage (McLachlan, Gilfillan and Gordon 2013). Indigenous Australians living in remote communities have significantly worse quality of life than most other Australians. Where data are available, they also suggest that Indigenous people living in remote communities have worse life outcomes than other Indigenous people. From 2003, the Steering Committee for the Review of Government Service Provision has published the *Overcoming Indigenous Disadvantage* report of indicators of Indigenous people's wellbeing. Over that time, there has been evidence of improvement in some areas, but outcomes have stagnated or declined in others (SCRGSP 2016).

The causes and consequences of disadvantage in remote Indigenous communities are complex and interrelated. Remoteness and scale play a role — they are often correlated with limited economic development, fewer opportunities for employment and diminished potential for positive life outcomes, relative to metropolitan and regional centres. Few remote communities have a mainstream economic base and the provision of government services is the dominant economic activity in many. The way services are designed and provided needs to reflect the circumstances of communities — the Commission's recommendations take account of this context.

Remoteness poses a number of challenges for service provision. It increases the costs of delivering services and prevents some services from being delivered at all. The size and remoteness of these communities means that they may not be able to support full-time services. Isolation also poses challenges, with some communities cut off from services for weeks or months each year. Even when they are accessible, travel can be difficult, costly, time-consuming and for some people, such as those who are frail or elderly, impossible. Access to online service alternatives can also be challenging due to a lack of IT infrastructure and, in some cases, a lack of the skills required to utilise those services.

The cultural and social context for delivering services is also complex. Remote Indigenous communities are diverse, with different characteristics, capacity, resources, representative arrangements and culture. Communities are dynamic — their circumstances and characteristics change over time. Discussions within communities can involve a complex interplay of cultural, inter-family relationships and other factors. Recruiting and retaining staff with skills in service provision and the necessary cultural competencies is an enormous challenge (NT Government, sub. DR593, Tasmanian Government, sub. 485). Few small communities have local people with the professional skills to deliver the suite of human services they need. Building the relationships needed to deliver services effectively takes considerable time, and provider and staff turnover can be a significant barrier to effective service provision.

## **9.1 The opportunity for reform**

Indigenous policy has been characterised by high levels of instability, with shifts between Indigenous-specific and mainstream programs, and by overlapping and shifting

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responsibilities within and across different levels of government. Constant policy changes by governments at all levels have created uncertainty and confusion for communities and service providers and have undermined the effectiveness of service provision. This was captured by Empowered Communities (2015, p. 8).

[Likewise,] Indigenous leaders and communities trying to take responsibility for improving the future of their peoples are too often stuck in a morass of red tape and policy churn associated with the political cycle and the all-too-temporary whims of successive governments and their ministers. While we have the knowledge about our lives and communities, government holds nearly all the power.

Children's Ground (sub. DR562, pp. 1–2) outlined the effects that policy instability and shifting responsibilities and priorities have on service providers and service provision.

Funding is influenced by political cycles, constant changes in senior government ministers and staff and policy platforms. Coupled with competitive and short-term funding allocations, services are forced to focus on survival — being reduced to competing for funding for siloed programs that allow them to deliver only specific and discrete outputs, rather than a focus on prevention, long or even short-term outcomes. Too often this environment means that organisations are adjusting to fit into Government priorities for financial survival rather than community priorities. This is an entrenched pattern across service sectors and systems.

Most communities and services will struggle to succeed in this environment. Governments must exercise patience and consistency while maintaining the capacity to act to address high levels of dysfunction and harm when they arise. Greater policy stability would support providers to build trusting relationships with communities, underpin continuous improvement and innovation in service provision, and improve the ability of governments to attract providers and staff to remote communities.

The Commission's current inquiry into Australia's system of horizontal fiscal equalisation has, in its draft report, recognised the unclear delineation of responsibilities for service provision across governments more generally, and has identified Indigenous programs as a priority area for reform (PC 2017b).

While governments have articulated high-level objectives for improving Indigenous outcomes, they do not have a clear vision of what they are trying to achieve at a community level. They have not invested enough in developing an understanding of the needs and existing service levels in communities, or a common set of outcomes that governments and providers can work toward in service provision.

## **A better model of service provision is needed**

The models of human service provision that can be effective in larger population centres are not working in remote Indigenous communities. The reality of remote Australia is that not all services can be delivered everywhere. There is nonetheless considerable scope for improvement.

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Competition between service providers is not commonplace in remote Indigenous communities, even where there are multiple providers, and user choice of service or provider is limited. The provision of human services in remote Indigenous communities, like family and community services (chapter 8), is largely designed around a model of contestability where providers compete periodically through tender processes for funding to deliver services. For example, the Australian Government provides Indigenous-specific grants across a range of service areas through the Indigenous Advancement Strategy. State and Territory Governments also commission human services through tendering processes, such as housing for remote Indigenous communities. This can be a sound model if implemented well.

Despite goodwill and significant resources, current approaches are not delivering the benefits of contestability (including better outcomes for service users, more innovation and greater efficiency) and are exacerbating its potential weaknesses (poor collaboration and a lack of service continuity). A number of participants argued that competition and contestability have contributed to fragmentation in human services in remote communities, and that moves to increase competition and contestability would worsen the situation (APO NT, sub. 478; CAAC, sub. 430; CMHA, sub. 399). For example, the Aboriginal Medical Services Alliance Northern Territory (sub. 477, p. 6) stated:

The principal driver of the high levels of fragmentation seen recently in remote Aboriginal service delivery in the Northern Territory is the move to greater competition and contestability and the undermining of comprehensive needs based planning processes such as those established under the [Northern Territory Aboriginal Health Forum], which could assess needs at a jurisdictional level and strategically allocate resources on that basis.

Services in remote Indigenous communities are often poorly planned and uncoordinated, both between and within governments, and between service providers. Decisions about service provision are made on the basis of jurisdictional, departmental and program boundaries, and this may come at the expense of a focus on outcomes for users. The inefficiency created by poor planning and coordination is stark. For example, the remote community of Jigalong in Western Australia received 90 different social and community services in 2013-14 for a population of less than 400 (WA DPC 2014). The Aboriginal Medical Services Alliance Northern Territory gave another example of a remote community in Central Australia where about 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. The Alliance (sub. 274, p. 5) described what happens on the ground.

There was little in the way of communication or coordination with the local [Aboriginal Community Controlled Health Service], with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The resulting fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients is totally counter to the improved outcomes sought by this inquiry and yet this was the result of government policy to introduce greater competition and contestability into service delivery.

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Consultation with Indigenous people who live in remote communities is inconsistent and disjointed. Participants lamented the frequency of white Landcruisers full of people rolling into town for meetings, often to discuss the same things as the car-load of people from another department who came for a meeting the week before. The frustrations are exacerbated when the people who come to the communities do not have the authority over local planning, engagement or service implementation to act on the issues that community representatives raise with them.

Uncoordinated consultation imposes a burden on communities where resources are already stretched and leads to fatigue and disengagement. More broadly, the uncoordinated approach to decision making is an inefficient way to allocate resources and effort, and leads to duplication of services and a lack of coordination between providers ‘on the ground’. The lack of coordination is a barrier to service providers addressing the complex and entrenched problems faced by some Indigenous Australians in remote communities.

Governments have also largely failed to evaluate approaches to service provision in remote Indigenous communities. The 2016 *Overcoming Indigenous Disadvantage* report noted the lack of rigorously evaluated programs in the Indigenous policy area (SCRGSP 2016).

## **9.2 Lessons from previous reforms**

Initiatives to improve outcomes for Indigenous Australians through the provision of human services have often fallen short at both the design and implementation stages. Governments have trialled many approaches to achieving better outcomes in remote Indigenous communities, with little sustainable success.

Australian governments have been testing ‘new approaches’ to addressing Indigenous disadvantage for more than ten years, particularly since the abolition of the Aboriginal and Torres Strait Islander Commission (ATSIC). Indigenous affairs is largely characterised by a litany of reports and strategies, but implementation failure. (Phillips-Brown, Reddel and Gleeson 2013, p. 255)

### **The Council of Australian Governments trials**

The Council of Australian Governments (COAG) trials, announced in 2002, aimed to introduce a whole-of-government, co-operative approach in eight (remote and non-remote) communities. Over time the concept of place-based approaches (service provision models based on achieving outcomes for a place) was also incorporated in the trials. The trials aimed to tailor government action to identified community needs and aspirations, coordinate programs and services, work in partnership with communities, and build the capacity of governments and communities (Morgan Disney & Associates 2006). Each trial was led by one Australian Government agency and one State or Territory Government agency. The trials were intended to use a flexible approach, with different arrangements implemented in each community. For example, the trials included joint planning through ‘planning days,

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community forums, “100 day plans” and the adoption of Action Plans in a number of sites’ (Morgan Disney & Associates 2006, p. 19). Over the period of the trials there were a number of changes in the broader Indigenous policy environment, including the abolition of the Aboriginal and Torres Strait Islander Commission, the establishment of the Office of Indigenous Policy Coordination and Indigenous Coordination Centres.

Evaluations of the COAG trials yielded several lessons, including:

- consistency of community committee membership and lead agency staff was associated with higher trust, and strong government partnerships (across all three levels of government) were associated with stronger relationships with communities
- place-based approaches appeared to work most effectively where there were clearly identifiable Indigenous communities with strong, representative leadership and where government agencies played a facilitative leadership role, engaging across government and with community leaders
- governments and communities need to be willing to understand and work respectfully with each other
- solutions need to be responsive to local circumstances through flexible (not one-size-fits-all) approaches
- whole-of-government, place-based initiatives require systemic changes at the local, community, state and national level (Morgan Disney & Associates 2006).

## **The National Partnership Agreement on Remote Service Delivery**

The National Partnership Agreement on Remote Service Delivery (NPA RSD) (agreed by the Australian, NSW, Queensland, SA, WA and NT Governments) commenced in 2009 and introduced a new remote service delivery model in 29 priority locations. The new model adopted a place-based approach, established a single government interface in each community to coordinate services, developed local implementation plans and collected baseline evidence to assist in monitoring progress (Australian Government 2013b). Bilateral plans were also developed between the Australian Government and the participating State and Territory Governments, setting out milestones, performance benchmarks and indicators for services, and identifying priority communities for the rollout of the new approach (ANAO 2012).

Also in 2009, the statutory office of the Coordinator General for Remote Indigenous Services was created to oversee the implementation of the NPA RSD, report twice-yearly on progress and work across agencies to cut through bureaucratic blockages and ensure services were delivered effectively (CGRIS 2009).

The evaluation of the NPA RSD noted a number of lessons from the reforms.

- In the NPA RSD there was pressure to finalise plans quickly (to address service issues) that may have affected community engagement.

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- The focus on concrete changes (such as new government infrastructure and coordination and engagement mechanisms) may have come at the expense of less concrete aspirations such as enhancing governance and leadership capacity within communities.
  - Some government stakeholders considered the NPA RSD involved a heavy reporting burden, which may have related to the local implementation plans containing a large number of actions.
  - Many stakeholders considered that responsiveness to community needs could be improved by greater devolution of decision making to regional and local levels (Australian Government 2013b).

The role of the Coordinator General for Remote Indigenous Services was abolished in 2014. In his final report the Coordinator General outlined a number of lessons, including:

- joint planning and engagement between communities and all levels of government is required with greater responsibility for communities built into decision-making processes
- effective community empowerment requires investment in strengthening community governance mechanisms
- the need for agreed performance measures and standards for improved monitoring, evaluation and accountability at the local, jurisdictional and national level
- the skills of individuals and the collective capacity of both government and community need to be strengthened and supported (CGRIS 2014).

## **The Indigenous Advancement Strategy**

The Indigenous Advancement Strategy (IAS) commenced on 1 July 2014 and replaced more than 150 Australian Government Indigenous-specific programs and activities. The strategy is administered by the Department of the Prime Minister and Cabinet. The IAS includes five broad programs: jobs, land and economy; children and schooling; safety and wellbeing; culture and capability; and remote Australia strategies. The IAS was designed to ‘reduce red tape and duplication for grant funding recipients, increase flexibility, and more efficiently provide evidence-based grant funding to make sure that resources hit the ground and deliver results for Indigenous people’ (Australian Government 2014b, p. 4).

The Australian Government also established a regional network, with staff located on the ground in communities. It was intended that ‘staff in the [Prime Minister and Cabinet] Network will engage with communities to negotiate and implement tailored local solutions designed to achieve results against government priorities’ (Australian Government 2014b, p. 4). The Australian Government intended for Indigenous communities to have the key role in designing and delivering local solutions to local problems — to date this has not been the case in practice.

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Many inquiry participants raised the IAS as an example of failure (AMSANT, sub. 477; AHCWA, sub. 468; CAAC, sub. 430; NHLF, sub. 475; VACCHO, sub. 455). A common criticism was that the tender process disadvantaged Indigenous organisations. Another issue raised by inquiry participants was that the IAS was extremely centralised. The 2014 IAS grant funding round was the subject of both a Senate inquiry (SFPARC 2016) and an Australian National Audit Office (ANAO) performance audit (2017a). Issues identified in those assessments included that:

- the timeframe for implementation was too short and key implementation stages and timeframes were not met
- the tender process resulted in gaps in service delivery that had to be filled through new contracts and adjustments to existing contracts
- Indigenous organisations were disadvantaged in the tender process
- grants were not assessed in a way consistent with the program guidelines, some obligations under the *Commonwealth Grants Rules and Guidelines* were not met and records of key decisions were not kept
- the program design of the IAS lacked a clear evidence base
- performance targets were not established for all funded projects
- the consultation strategy was not fully implemented, and community involvement was limited
- regional investment strategies (which were intended to map each region's profile against priority indicators, identify key policy and geographic areas that would have the greatest impact on improving outcomes, and reflect community-identified priorities) were not developed
- the extent to which the regional network could adopt the intended partnership approach (partnering with communities to design and deliver local solutions to local problems) during the grant round was limited due to the short timeframes involved.

The Department of the Prime Minister and Cabinet accepted the recommendations in the ANAO audit, and noted that actions had already been taken or were underway to implement them (ANAO 2017a).

### **9.3 Toward a better model of service provision**

Much has been written about the successes and failures of initiatives to improve service provision in remote Indigenous communities. These lessons are often overlooked by governments and few formal evaluations have been undertaken — this needs to change. The Commission has identified a set of principles that would improve the effectiveness of service provision in remote Indigenous communities. The principles draw on the lessons from previous initiatives to improve services in remote Indigenous communities, and build on the principles for effective stewardship of human services (chapter 2) and effective

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commissioning of family and community services (chapter 8). The Commission has also taken into account the following set of ‘success factors’ identified in the *Overcoming Indigenous Disadvantage* reports:

- co-operative approaches between Aboriginal and Torres Strait Islander Australians and government — often with the non-profit and private sectors as well
- community involvement in program design and decision-making — a ‘bottom-up’ rather than ‘top-down’ approach
- good governance — at organisation, community and government levels
- ongoing government support — including human, financial and physical resources. (SCRGSP 2016, p. 3.18)

## **Greater community voice**

The characteristics of Indigenous communities (including their size and remoteness) mean that user choice through competition between providers will rarely be appropriate. Nonetheless, governments are making choices about who will provide which services, and along with providers are deciding how services will be delivered.

An alternative to user choice is ‘community voice’ — giving communities opportunities to engage with governments to express their preferences and priorities. Community voice can take a variety of forms, from engagement with communities to take their views into account in decision making, through to communities making decisions about the services they receive, or communities allocating funding.

Commissioning is often conceptualised as a cycle that involves planning the service system, designing services, selecting providers, managing contracts and ongoing monitoring, evaluation and improvement (chapter 8), and community voice can be exercised across the entire commissioning cycle. Several participants supported the idea of community voice, in remote Indigenous communities or more broadly (for example, Children’s Ground, sub. DR562; Opportunity Child, sub. DR535; Queensland Government, sub. DR592).

Increasing community voice in human services in remote Indigenous communities could result in services that are better tailored to the community, are more likely to be used by the community and hence be more effective.

The Smith Family’s experience of working in remote communities demonstrates that services that do not consider the unique cultural context of the specific community will not be utilised by community members. Community involvement in determining and designing appropriate services is paramount to service utilisation. (The Smith Family, sub. 469, p. 5)

The potential benefits of community involvement in program design and decision making have been recognised in previous initiatives (section 9.2). More recently, the Prime Minister’s Indigenous Advisory Council (tasked with advising the Australian Government

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on practical changes which can be made to improve the lives of Indigenous Australians) also noted the importance of collaborative approaches.

The Council reiterated to Government genuine partnership and collaboration with Aboriginal and Torres Strait Islander peoples will be critical to ensure policies coming forward to Government are driven and supported by aspirations and needs of local communities. (DPMC 2017b)

The draft report of the current Queensland Productivity Commission (2017) inquiry into service delivery in remote and discrete Aboriginal and Torres Strait Islander communities also noted the potential benefits from enabling community voice.

Community voice will only result in improved services if it is taken into account in program design and decision making and leads to changes in practice on the ground. Indigenous communities will only develop greater trust in governments if they see that there is genuine commitment to taking their views into account when decisions are made. For example, in relation to culturally appropriate service provision, the National Congress of Australia's First Peoples (sub. DR565, pp. 4–5) noted that:

The suggestion that the Government account for the cultural competency of service providers is particularly welcome. However, Aboriginal and Torres Strait Islander organisations cannot be faulted for remaining somewhat sceptical of the ability of the Australian Government to fund “culturally appropriate service provision”, given the extraordinary number of similar promises which have been made and broken in the past.

Increasing community voice is not a simple task and any expectation that Indigenous people should speak with one voice is unrealistic as well as unhelpful. Like other Australians, people living in remote communities often have strongly differing views about what is best, and this complicates engagement and service delivery. However, the impossibility of achieving consensus need not diminish the value of community voice.

The challenge for governments is to find ways to provide for communities to voice their preferences and priorities. One barrier to increasing community voice can be determining which bodies (or individuals) have the authority to represent their communities. Some communities have representative organisations that have the support and trust of community members and can speak on behalf of the community. However, this is not universal and the challenge for governments is even greater when a community does not have a well-functioning representative body.

## **Clearer outcomes**

Governments should work with communities to identify and measure the outcomes that human services are intended to achieve. To facilitate this, governments should establish better opportunities for Indigenous Australians living in remote communities to articulate the outcomes they want to achieve.

Outcomes can be defined and evaluated at several levels — service user, service provider, program and system (chapter 8). For human services in remote Indigenous communities,

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outcomes should be developed for both users and the community as a whole. Policy makers need to take into account both the broad objective of improving Indigenous Australians' wellbeing, and also Indigenous Australians' preferences, priorities and conception of wellbeing. Many inquiry participants drew attention to the holistic Indigenous Australian concept of health or wellbeing that encompasses:

... not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being. (National Aboriginal Community Controlled Health Organisation, quoted in NHLF, sub. 475, p. 2)

Similarly, Aboriginal Peak Organisations Northern Territory (sub. 478, p. 3) raised concerns that the definition of service quality adopted by this inquiry may not be broad enough to apply to the Indigenous context.

Of concern, firstly, is the way in which some of the objectives of human services have been framed (second Issues Paper, p 3). 'Quality' in an Aboriginal context must include broader measures of wellbeing, such as cultural or spiritual wellbeing, and not restricted to narrower conceptions of health outcomes. In this light, empowerment becomes a critical aspect of ensuring that Aboriginal services are 'quality' services, because of the impact that empowerment has on Aboriginal people's sense of self-worth.

Mainstream service models and outcomes frameworks that focus only on individuals (rather than communities or families) might not reflect the outcomes that are important to Indigenous people in remote communities. The report of the Yawuru Wellbeing Project (a research project that investigated the meaning of wellbeing to Yawuru people) noted that:

Connections to family and community, to the land, to culture and traditions, are all fundamental to how Yawuru feel about themselves, and their sense of a good life. Yet all too often, the sorts of indicators of social and economic development used to inform policy-making, or to evaluate policy or community initiatives, fail to represent such values in any meaningful way.

The problem here is not just the lack of consensus on how wellbeing for Indigenous communities should be conceptualised, but — more critically — that many of the indicators most commonly used to capture Indigenous peoples' wellbeing are drawn from western concepts that fail to reflect the essential elements of a good life that resonate with Yawuru people. (Yap and Yu 2016, p. 8)

Many inquiry participants noted the importance of culturally appropriate service provision. End-of-life care, in particular, was raised by a number of inquiry participants as a service area where culturally appropriate service provision is particularly important.

Quality care at the end-of-life is realised when it is culturally appropriate to the particular needs of individuals and groups that includes families, kindships and tribes. The place of dying and death is culturally and spiritually significant for many Aboriginal and Torres Strait Islander peoples and the need to 'return to country' is very important for many at the end of their lives. (PCA, sub. DR500, p. 2)

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## Effective government structures and processes

A Department of the Prime Minister and Cabinet (Patterson 2017, p. 5) discussion paper on machinery of government in Indigenous affairs highlighted the influence that government has on the success or failure of policies.

How well the [Australian Public Service] transitions from one administration to the next; how well it carries over the lessons of past practice and how well it exercises leadership in its own domain are serious practical and ethical questions. It is curious then, that contemporary focus on ‘failure’ in Aboriginal and Torres Strait Islander policy and practice is often framed as a failure in the efforts of Aboriginal and Torres Strait Islander communities rather than as a failure of public service efforts. We need a better understanding about the role and effectiveness of the [Australian Public Service] in Australian Indigenous affairs.

Government structures and processes, and the capabilities of staff, need to be suitable for the policy being implemented. Governments should tailor the way they operate to the circumstances in remote communities. Changing the approach to human services in remote Indigenous communities to put users at the centre of service provision, and promote community empowerment, would require changes in the way governments work — with communities, across departments, and with other governments. Achieving this requires a shift towards government structures and processes that support regional and local engagement, planning and decision making.

Government staff working in remote Indigenous communities need the skills to work with communities, to support meaningful engagement and to design programs and commission services that meet the diverse needs of these communities. Cultural training (training related to cultural differences to prepare people for living and working in another culture) has long been used as a means of preparing people for international assignments (Bhawuk and Brislin 2000). Inquiry participants noted that cultural training for staff is common practice in international development and argued that this should also be the case for non-local staff working in remote Indigenous communities. The SA Government (sub. DR571, p. 4) suggested that ‘mandatory cultural training specific to the region be considered for all staff working in a remote community, preferably prior to commencement of work in that community’.

## Building community capacity

Governments should support remote Indigenous communities to build their capacity. This would support community involvement in service design, provision and evaluation, through:

- increasing the number of community members involved in service provision (including human services) and in representative roles
- Indigenous service delivery organisations having the capacity (including governance, skills and staff) to deliver services in communities

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- Indigenous representative organisations having the governance, skills and support to make decisions about resource allocation and to exercise community voice.

Too often, opportunities have been missed to connect the provision of services with the building of local capacity, including the capacity of Indigenous service delivery organisations and individuals. Governments should also continue to build on and engage with regional representative organisations to support a move to greater community engagement and empowerment.

Capacity-building activities should be informed by an understanding of communities' existing strengths and preferences. As Tsey et al. (2012, p. 9) observed:

Measures to improve governance by imposing a one-size-fits-all approach to addressing Indigenous governance are unlikely to be workable or sustainable.

Some capacity-building arrangements currently exist, and could be built on. The Office of the Registrar of Indigenous Corporations provides resources and training programs to increase corporate governance knowledge, skills, efficiency and accountability within organisations. An ANAO (2017b) audit of the Office of the Registrar of Indigenous Corporations found that it supports good governance in Indigenous corporations. Jawun, a not-for-profit organisation, places people from the private sector, government and philanthropic organisations into Indigenous organisations to build the capacity of Indigenous people. These bodies, and others, have experience and skills that governments and communities could learn from.

## **Effective learning systems**

Governments, service providers and communities need to learn 'what works' (and for whom and in what context) in human services in remote Indigenous communities. Effective learning systems should inform community and government capacity building, and service design and provision. Governments should identify and disseminate lessons from evaluations to increase the application of effective service models (chapter 8).

Governments have tried many approaches to service provision in remote Indigenous communities and many of them have been reviewed. However, governments seem to cherry-pick the lessons from history, as they did with the NPA RSD, for example.

The road that the Council of Australian Governments travelled to get to the National Partnership Agreement on Remote Service Delivery had many clear sign posts from previous interventions and experiences of what works in place-based and community strengthening approaches for remote communities. As often seems to be the case, some lessons were firmly embraced in both the policy and implementation of the new approach, whereas others have been left to languish by the road side. (Phillips-Brown, Reddel and Gleeson 2013, p. 245)

Program failures in remote Indigenous communities have sometimes been met with overreaction from governments when a more measured approach could have achieved better results and maintained community trust. Governments have a role as stewards of the system

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to manage underperformance, including by removing providers in cases of failure (chapter 8). However, this needs to occur within a system where governments and communities work early to identify and address problems and learn from the past.

An effective service system would incorporate ongoing service monitoring, evaluation and continuous improvement. Explicitly requiring that programs are monitored and evaluated with input from communities can enhance community voice and improve service implementation and ongoing provision. Evaluations that are carried out after programs have concluded are not adequate — evaluation needs to be an ongoing process embedded in program design. Evaluation should lead to ongoing discussions between governments, service providers and communities about the effectiveness of services, and be integrated with mechanisms to adjust contracts to improve outcomes.

## **9.4 Improvements to commissioning practices**

The failures in service provision for Indigenous people living in remote communities are not due to a lack of intent, effort or resourcing. Improving service provision in remote Indigenous communities is hard and change will come slowly. Governments and the community need to be patient. This requires a 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.

The Commission is conscious that a major issue for remote Indigenous communities has been the rapid shifts in policy over time. It is recommending changes to commissioning arrangements that can be implemented as existing arrangements lapse and that would promote longer-term stability for service users and providers, and increase community involvement across the commissioning cycle. The recommendations address participants' concerns about the effect of current commissioning arrangements on users and providers. The proposed reforms address many of the same issues that arose in relation to family and community services (chapter 8), with adjustments to accommodate the different circumstances of remote communities, and take into account the principles for effective service provision (section 9.3).

These reforms, if well-implemented, have the potential to significantly improve the effectiveness of service provision over time, and consequently, to improve the wellbeing of Indigenous Australians living in remote communities. In addition, the reforms provide a foundation for moving toward greater community involvement and empowerment in decisions affecting the wellbeing of Indigenous people living in remote communities.

### **Longer contract terms**

Many inquiry participants argued that uncertainty around funding arrangements is an impediment to effective service provision and that contract terms are too short (for example,

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AHCWA, sub. 468; Anglicare Australia, sub. 445; CAAC, sub. 430; DSS, sub. 476; SA Government, sub. 460). This was also raised in relation to family and community services (chapter 8). The Senate inquiry into the IAS recommended that ‘where possible and appropriate, longer contracts be awarded to ensure stability so that organisations can plan and deliver sustainable services to their communities’ (SFPARC 2016, p. 64). The Queensland Productivity Commission (2017), in the draft report of its current inquiry into service delivery in remote and discrete Aboriginal and Torres Strait Islander communities, made a draft recommendation that contract terms should be longer.

Increasing certainty by increasing default contract lengths could improve outcomes by improving the continuity of service provision for users (for whom trusting relationships with providers are important). It would also provide scope for service providers to improve service quality by planning investments, such as staff development and new approaches to service provision, over a longer cycle. Short contracts, contracts with uncertain end dates, and uncertainty around contracts due to policy changes make it difficult to attract providers in remote areas (where, if the contract ends they may have no other work), and make it difficult for providers to attract and retain staff.

For governments, this approach would encourage a greater focus on upfront planning and community engagement as well as more active stewardship. Fewer contracting rounds will free resources to focus on creating stronger learning systems, community engagement and capacity development. For service providers, it provides more opportunity to invest in strong relationships both with the community and with other providers and government.

Longer contracts would also pose risks. Inquiry participants raised concerns that longer contracts could reduce the flexibility of governments to change their funding priorities (chapter 8). Some participants suggested that governments prefer to allow contracts to run their course, rather than intervene to address concerns about poor services, or replace ineffective providers. Longer contracts could increase the risk of communities being stuck with ineffective providers for many years.

Governments should actively manage contracts with input from communities. They should also develop and use safeguards for withdrawing contracts and ensuring continuity of service provision (through provider of last resort arrangements) in the event of a provider failure (chapter 2). A number of submissions highlighted the importance of appropriate safeguards and stewardship arrangements, if longer contract terms were adopted (AHHA, sub. DR561; CHA, sub. DR567; RACP, sub. DR580; UnitingCare Australia, sub. 514). Further, Chaney and Gray (sub. DR489) argued that if longer contract terms are implemented it is vital that the Commission’s recommendations on support for community skills and capabilities (recommendation 9.3) and improvements to provider selection processes (recommendation 9.4) be explicitly reflected in contracts.

The Commission has built on its discussion of contract terms in family and community services (chapter 8) when considering the benefits and potential risks of longer contracts in remote Indigenous communities. In those services the Commission’s recommendation is for default contract terms of seven years. In remote Indigenous communities there is a case for

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even longer contract terms, to allow extra time to establish community trust and invest in staff, capital and delivery models. The Commission's view is that ten-year default contract terms, incorporating contract reviews (discussed below) and the potential for contract termination for poor provider performance, is the right balance for services in remote Indigenous communities. As with family and community services, there should be some flexibility around the default contract length. For example, a shorter contract term could be warranted for the trial of a new service type. Governments should publish the justification for any contracts that differ from the default term.

In family and community services (chapter 8) the Commission has recommended that contracts include regular reviews as a safeguard to balance the risk of longer contract terms, as part of a more relational approach to contract management. Relational methods involve government and providers regularly working together to review progress, ensure priorities are being met and identify opportunities to improve performance. Governments should shift to a more relational approach to contracting in remote Indigenous communities, and community involvement should also be incorporated in these processes. Communities, governments, and providers should engage in collaborative reviews of contracts to assess progress and align effort with emerging priorities. In the remote context, these reviews should be conducted frequently (say every two years), consistent with a more collaborative approach.

#### RECOMMENDATION 9.1

The Australian, State and NT Governments should set the length of human services contracts in remote Indigenous communities to allow adequate time for service providers to establish their operations; and have a period of continuity in service provision and 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 provision in remote communities.

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

- increase default contract lengths for human services in remote Indigenous communities to ten years
- allow exceptions to be made, such as for program trials, which could have shorter contract lengths
- publish the justification for any contracts that differ from the default term
- initiate collaborative reviews (involving communities, government and providers) to assess progress, adjust priorities as needed and identify opportunities for improvement
- ensure contracts contain adequate safeguards to allow governments to remove providers in any cases of failure.

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## Tender scheduling and timing

Currently there is little coordination of the start and end dates of contracts within remote Indigenous communities. Aligning the start and end dates of contracts for related services could create opportunities for communities and governments to identify the mix of providers that is likely to achieve the best outcomes. For example, service providers and communities might consider joint-venture arrangements if several contracts became available simultaneously. A more coordinated approach to contract timing could also focus communities and governments on future opportunities to change service provision in a community. This process would need to be managed well to ensure service continuity as the timing of contracts are aligned and decisions on providers are taken.

Governments should provide greater certainty about when tenders will be sought by publishing a rolling schedule of upcoming tenders over (at least) the next twelve months. They should also allow sufficient time (a default of three months) for providers to prepare a considered response (chapter 8). This would better facilitate coordination and the ability of providers to work together through, for example, forming consortiums to jointly tender for contracts or less formal forms of collaboration (chapter 8). A benefit of this approach is its potential to encourage more partnerships between mainstream providers and local Indigenous organisations.

Governments should also notify providers of the outcome in a timely manner ahead of the commencement of the contract and allow enough time for transition when new providers are selected. Uncertainty about whether funding will be renewed affects providers' ability to attract and retain staff, which in turn can negatively affect service users (chapter 8).

### RECOMMENDATION 9.2

To improve processes used to tender human services in remote Indigenous communities, the Australian, State and NT Governments should:

- publish a rolling schedule of upcoming tenders over (at least) the next twelve months
- allow sufficient time (a default of three months) 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.

The Australian, State and NT Governments should also gradually work to align tender processes for related services in communities, commencing with a small number of communities.

## Supporting community skills and capacity

The provision of government-funded human services is often a large part of the economy in remote Indigenous communities and is an opportunity for governments to invest in building

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local capacity. In designing services and selecting providers, governments should include a focus on skills transfer and building the capacity of people and organisations in the community. The NT Government (sub. DR593, p. 18) released an Economic Development Framework in June 2017, that includes actions to ‘change the way governments deliver human services in non-urban areas to create economic development opportunities’. This includes exploring ways to increase local service delivery and employment and building the capacity of local people.

Difficulty recruiting and retaining staff has been identified as an issue in remote Indigenous communities, and building a local skills base could encourage providers to recruit and retain local staff. For example, a service agreement for housing services could include specific funding to provide training for local people to learn how to maintain properties.

Over time, building the skills and capacity of people and organisations in the community could lead to more local service delivery. Any capacity building, or transfer of skills or responsibility should occur at a pace and in a way that suits the circumstances of the community.

Building and utilising a local skills base could have additional costs initially. However, over time, it would improve community development and resilience and could lower the cost of service provision (such as through lower transport costs).

#### RECOMMENDATION 9.3

The Australian, State and NT Governments should ensure that commissioning processes for human services in remote Indigenous communities incorporate skills transfer and capacity building for people and organisations in those communities.

## Provider selection processes

Many inquiry participants argued that competitive tendering arrangements tend to disadvantage Indigenous organisations. (The IAS was commonly raised as an example.) One reason given for this was that large mainstream organisations have greater resourcing for and experience in responding to calls for tender.

Competitive tender processes also tend to favour large-scale NGOs which have the skills and capabilities to develop effective grant applications. Though some larger organisations offer brokerage or subcontracting to local communities, as discussed above, others implement a ‘one size fits all’ approach that doesn’t reflect the diversity and complexity of local communities. The Department [of Social Services] tries to counter this when assessing funding applications and requires applicants to demonstrate how they will service the local community. (DSS, sub. 476, p. 8)

Another issue raised by inquiry participants was that tender processes do not always take into account the attributes of Indigenous organisations that mean that they can be more

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effective than mainstream service providers. Some inquiry participants argued that the status of an organisation as community controlled should be taken into account when selecting providers, or that community controlled providers should be preferred providers (CHA, sub. DR567; RACP, sub. DR580).

Aboriginal Medical Services Alliance Northern Territory (sub. 477) argued that, compared with mainstream primary care, Aboriginal Community Controlled Health Organisations provide greater health benefits, improve access for Indigenous people, deliver culturally appropriate services, are more likely to be committed to processes of clinical governance and evidence-based medicine and employ more Indigenous people (and develop their skills and career path). They also argued that Aboriginal Community Controlled Health Organisations are instrumental in developing and supporting innovative models of care (including through partnering with mainstream providers).

This is consistent with the situation described by participants in family and community services: that governments focus disproportionately on the financial cost of service provision and the quality of tender applications when selecting service providers (chapter 8). The cost of service provision is important to effective provision of services, as is the administrative competence of service providers, but other factors should also be considered. A shift in focus is needed to take into account all the relevant attributes of service providers that can contribute to outcomes for service users. In remote Indigenous communities, this should include attributes that are valued by the community such as on-the-ground connections and the ability to provide culturally appropriate services. Ultimately, service providers should be selected based on their ability to achieve outcomes for users, with the cost of the service considered in the context of the expected benefits.

A more thorough assessment of tender applications might be more resource intensive and could result in an increase in administrative costs for governments, although these might be offset from having fewer tenders. Additionally, a greater focus on the non-cost aspects of tender applications, such as a providers commitment to coordinating with other service providers, could result in higher-cost providers being selected, resulting in higher costs of service. However, the significant potential for better outcomes in remote Indigenous communities means that the benefits are likely to exceed the costs.

While inquiry participants were broadly supportive of the Commission's draft recommendation on improvements to provider selection processes, some questioned whether it would achieve change in practice. The National Congress of Australia's First Peoples (sub. DR565) argued that it was unclear whether the draft recommendation would significantly alter the disadvantages faced by smaller Indigenous organisations. Community Mental Health Australia (sub. DR498) expressed concern that the draft recommendation could be interpreted very broadly and was potentially little different to what already occurs.

The Commission is making recommendation 9.4 because there is a clear need for change. Governments should implement material changes in their provider selection processes to take into account all the relevant attributes of service providers that can contribute to their ability to achieve outcomes for service users.

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#### RECOMMENDATION 9.4

The Australian, State and NT Governments should take into account the attributes of providers that contribute to achieving outcomes for people living in remote Indigenous communities. These attributes may include:

- culturally appropriate service provision (specific to the region where the service is being provided)
- 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.

### **Planning, evaluation and feedback systems**

Improvements to planning, evaluation and feedback systems are essential underpinnings of better service provision. As a starting point for better service provision, governments should work together to develop outcome measures for human services in remote Indigenous communities, informed by the preferences and priorities of communities (section 9.3).

As noted in the Commission's consideration of family and community services (chapter 8), governments need to understand the needs of the full range of service users in order to deliver the mix of services that communities need. Without this knowledge, governments are not able to plan services effectively or to prioritise between users. This contributes to duplication, uncoordinated service provision, inefficiency and inequitable access. At the same time, it is important to supplement this information with on-the-ground evidence.

In remote Indigenous communities, a fundamental requirement for effective service provision is an understanding of the current situation, to inform service planning. Governments should conduct ongoing assessments of the characteristics of communities to provide information about communities' needs and capacities. This information should be published so that it can be used by communities and providers. The assessments would cover:

- community characteristics (including demographics and service user characteristics)
- community organisations and forums (including representative organisations and service providers)
- community strengths and capacity (including successful organisations and programs)
- the services that are delivered in the community, who provides them, who they are provided to and who funds them
- infrastructure available in the community (including IT infrastructure that can support technological innovations such as telehealth)

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- trends and drivers influencing the above characteristics (recognising that community circumstances are not static) — for example, trends in the expected future demand for services due to demographic change.

The assessments could identify gaps and overlaps in service provision that could be taken into account in commissioning and could increase the quality and efficiency of services through better targeting community needs. The information gathered could also assist in determining what capacity building support could assist communities and could contribute to service coordination and accountability.

Governments would need to draw on the knowledge of communities and service providers in the community assessments. Communities should be involved in the assessment process, and their views on community characteristics should be taken into account. For example, communities may have a different view to government on their strengths, or on the drivers influencing community needs. Sharing the information gathered with communities can also support community buy-in, understanding and decision making. *Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC)*, provides an example of both community involvement in gathering information and of sharing this information with the community. LSIC began with two years of consultation with communities and service providers to shape the study design. A strong theme emerging from those consultations was the need to work collaboratively with communities and ensure that Indigenous people were involved in the research. LSIC employs Indigenous research administration officers to conduct the survey. LSIC also feeds the information gathered back to communities by providing community booklets and factsheets that share the findings of the study with communities (Bennetts Kneebone et al. 2012).

The Commission recognises that collecting this kind of information can be resource intensive. Governments should draw on existing information where possible — there is much to be gained from the coordination and sharing of existing data. For example, there would be great merit in the Australian Government utilising information on services gathered as part of the Western Australian Regional Services Reform process. Assessments should also be undertaken with a clear understanding of what the information will be used for, and this should inform the types of information collected. Government decision makers need to use these assessments in the design and provision of future services.

Evaluation and an understanding of ‘what works’ (including for whom and in what context) also underpins better service provision. Explicitly requiring that programs are evaluated with input from communities can enhance community voice and improve service implementation. Evaluations that are carried out after programs have concluded are not adequate — evaluation needs to be an ongoing process embedded in program design. There are different ways to conduct evaluations, and evaluations can be tailored to the program and knowledge, skills and resources of the local community. Evaluating providers, programs and systems has costs as well as benefits, and the scope of an evaluation should be commensurate with the size and complexity of the program (chapter 8).

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Governments should also gather information on ‘what works’ and share it across communities, governments and providers. This would then feed back into service commissioning and provision. This should be done with the understanding that approaches that work in one community may not work in another.

#### RECOMMENDATION 9.5

The Australian, State and NT Governments should invest in better planning, evaluation and feedback systems to underpin service provision by working together — and with local communities — to:

- develop outcome measures 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 and drawing on existing information where possible
- establish systems to identify and share information on ‘what works’ in human services in remote Indigenous communities.

These actions will require ongoing commitment from governments, working in consultation with communities, service users and service providers.

## 9.5 Longer-term directions for service provision in remote Indigenous communities

In its draft report, the Commission outlined a possible longer-term transition to a place-based model of service provision centred on community plans. These would be developed by communities and would inform governments’ decisions about human services funding and delivery.

Following the release of the draft report, the Commission consulted with Indigenous community representatives, service providers and governments about this proposal. The consultations confirmed that there is merit to place-based approaches, but that a large-scale systemic rollout of place-based approaches across remote Indigenous communities is not feasible. This suggests that a more cautious approach than initially outlined by the Commission is warranted.

Governments should work to lay the foundation for place-based approaches by strengthening government and community capacity, and be willing to adopt more place-based approaches where communities can demonstrate that they are ready and government capacity exists (or can be readily built).

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## Place-based approaches

Australia's federal system of government poses challenges to coordinating the planning and provision of human services. Many stakeholders pointed to the potential of place-based approaches — programs designed and delivered with the intention of targeting a specific geographical location(s) and particular population group(s) in order to respond to complex social problems (Wilks, Lahausse and Edwards 2015). Place-based approaches cut across the government 'silos' that are a barrier to coordination. The potential benefits of place-based approaches to human services are widely recognised, and place-based approaches have been used in a number of previous initiatives (section 9.2). Phillips-Brown, Reddel and Gleeson (2013, p. 247) noted that:

Within Australia, the shift towards whole-of-government service delivery to meet the needs of a geographically defined local community has been occurring since the 1970s.

Within the broad objective of taking a place-based approach to service provision, a spectrum of models have been proposed. Some features are common across models. Wilks, Lahausse and Edwards (2015) found that a common element of place-based approaches is the involvement of the local community (through consultation and active involvement in decisions). Other models go further in delegating authority to local decision makers. For example, some favour implementing place-based approaches by giving Indigenous people more control over the funding and design of local services. Others promote a regional governance approach. No single model has universal support.

There are signs that place-based approaches are gaining traction in policy making for Indigenous communities, with a range of models in operation around Australia, including the Empowered Communities proposal, Local Decision Making in New South Wales, and Regional Services Reform in Western Australia (box 9.1). The Indigenous Affairs Group of the Department of the Prime Minister and Cabinet (sub. 265, p. 2) cited the principle in its submission to this inquiry.

Importantly, place-based approaches build community capacity to identify and develop solutions to issues. These approaches are also more likely to lead to sustainable improvements over the longer term.

The Queensland Government (sub. DR592, p. 3) noted that it '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'.

Initiatives like these hold promise, but will need time and patience from all stakeholders to achieve results. For example, the Murdi Paaki Regional Authority, often raised by inquiry participants as an example of good practice, has evolved and built its current arrangements and capacity over many years (box 9.2). Place-based approaches are also highly resource intensive and would not be appropriate everywhere.

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### Box 9.1      **Some current examples of place-based and community voice reforms**

**Empowered Communities (EC)** is a proposal for long-term reform of Indigenous policy, based on empowerment and development. The proposal is a place-based approach involving regional and community planning and priority setting. There are currently eight EC regions around Australia (in remote and non-remote areas). The Australian Government is supporting the EC model by sharing data and providing funding for ‘backbone’ organisations in seven of the EC regions. Work is currently underway in each region to identify first priorities and establish longer-term regional development agendas. Empowered Communities leaders and the Department of the Prime Minister and Cabinet are co-designing a joint decision-making approach for joint planning and increasingly sharing decision-making authority with local leaders.

**Local Decision Making** in New South Wales aims to place Indigenous Australians at the centre of service design, planning and delivery, thereby enabling a staged devolution of decision making and accountability to the local level. This is done through the negotiation of accords between regional alliances and the NSW Government, which outline agreed priorities and projects, and decision-making processes. The NSW Government signed the first Local Decision Making accord with the Murdi Paaki Regional Assembly in 2015, and in early 2017 entered into accord negotiations with the Three Rivers Regional Assembly and the Illawarra Wingecarribee Alliance Aboriginal Corporation.

**Regional Services Reform** in Western Australia aims to bring about long-term systemic change to improve the lives of Indigenous Australians in regional and remote Western Australia. The reforms had an initial focus on the Pilbara and Kimberley and in 2017 expanded into the Goldfields. Strategic Regional Advisory councils bring together governments, communities, service providers and industry, while District Leadership Groups are implementing change at a local level.

*Sources:* Aboriginal Affairs NSW (2015, nd); DPMC (2017a); Empowered Communities (2017); WA RSRU (2017).

### Box 9.2      **The evolution of the Murdi Paaki Regional Assembly**

The Murdi Paaki Regional Assembly (MPRA) is a self-formed regional governance body that represents Indigenous people in 16 communities across Western New South Wales. The Assembly has evolved in the Murdi Paaki region over 20 years, since its inception as the Wangukumara Regional Council Far West Aboriginal and Torres Strait Islander Commission Regional Council and has steadily built up its capacity to plan, advocate, lobby, attract resources for communities and manage or guide developments throughout the region.

The MPRA has been conducting regional planning for many years, with the current regional plan noting that it ‘continues the tradition of setting a framework for strategic development first documented twenty years ago in July 1995’ (MPRA 2016, p. 2). Another key element of the MPRA is the Community Working Parties (CWPs). CWPs provide a direct link between communities and the MPRA. The CWPs are ‘the foundation stones of the [MPRA] and are the community’s Aboriginal voice, not only on their needs and aspirations, but also the issues faced by their community’ (MPRA nd).

(continued next page)

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### Box 9.2 (continued)

MPRA is considered as an example of success. The evaluation of the Murdi Paaki Council of Australian Governments trial in 2006 noted that:

Among stakeholders familiar with the COAG Trials elsewhere in Australia, Murdi Paaki is regarded as the most advanced Trial site in terms of community capacity and governance. (Urbis Keys Young 2006, p. ii)

More recently the MPRA was awarded the 2016 Indigenous Governance Award in the non-incorporated category.

Not only has the MPRA maintained and built its capacity over a long period of time, but it has done so in an environment of frequent change to Indigenous policy. The Murdi Paaki region was one of the eight Council of Australian Governments trial sites, and two communities in the region were priority locations for the new remote service delivery model under the National Partnership Agreement on Remote Service Delivery (section 9.2). In 2015, the Murdi Paaki region was the first to enter into an accord with the NSW Government under Local Decision Making (box 9.1).

*Sources:* Australian Government (2013b); DPMC (nd); MPRA (2016, nd); MPRC (2002); Scullion (2016); Urbis Keys Young (2006).

## Laying the foundation for place-based approaches

The Commission is mindful that constant changes to policy have caused ongoing disruption to remote Indigenous communities (section 9.1). Any significant changes to services in remote Indigenous communities would take time. Expanding too far, too fast is a significant risk, and has been identified as a contributing factor to problems in previous reform processes. The lessons of the past caution against over-reach and over-promising — governments and communities must have realistic expectations about what changes can be implemented and how quickly change can occur.

Successful implementation of place-based approaches (including community planning) would depend on the capacity of both governments and communities. This capacity does not exist everywhere and would take time and effort to build.

Communities are diverse and have different levels of capacity to engage with place-based approaches. In New South Wales, as part of Local Decision Making, the NSW Government established good governance principles that must be met before communities progress through each phase of the initiative (Aboriginal Affairs NSW 2016). Evaluations of the COAG trials found that place-based approaches appeared to work most effectively where there were identifiable Indigenous communities with strong, representative leadership (section 9.2).

The capacity of governments (section 9.3) is another constraint to the broad application of place-based approaches. Chaney and Gray (sub. DR489, p. 2) argued that:

The existence of a siloed environment within the [Australian Public Service] remains an inhibitor to the effective adoption and implementation of place-based policies and structures. From our

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perspective, it is apparent that there is no clear locus of responsibility within the Government to drive the required transition within the [Australian Public Service] and across service providers.

Given these constraints, the Commission considers that a large-scale move to place-based approaches across remote Indigenous communities is not feasible. The Commission considers that its recommendations on the provision of services to remote Indigenous communities would form a solid foundation on which to base a longer-term transition to place-based reforms, on a case-by-case basis, as government and community capacity is built.

While a large scale move to place-based approaches is not recommended, governments should not stand still. Governments should be willing to adopt more place-based approaches where communities can demonstrate that they are ready and government capacity exists (or can be readily built), taking into account the differing circumstances, needs and preferences of communities. A variety of models have merit and an approach that works in one community may not work in another. Where there are existing arrangements these should be built on, and learned from.

At the same time, governments should work to lay the groundwork for further use of place-based approaches. There should be an ongoing focus on building capacity in communities and governments (section 9.3), with the aim that over time place-based approaches could be developed with more communities.

Governments will need to adjust their structures and processes and build the capabilities of their staff to implement more localised (including place-based) approaches. Historically, the risk appetites of governments have been a barrier to moving from rhetoric of community engagement and empowerment to routine practice that reflects these principles on the ground in communities. Governments have often sought to manage the risks of program failure through centralised, prescriptive approaches that inhibit the development of productive relationships with communities.

To move beyond rhetoric on community engagement and involvement, governments should shift the balance away from centralised decision making toward greater regional capacity and authority. To do this governments should give local staff more authority over local planning, engagement and service implementation. Governments would need to support this transition by authorising, resourcing and building the capacity and capability of staff working on the ground. A more regional and localised approach would foster better understanding of communities and their needs, and would facilitate greater linkages between government decision makers and communities. The evaluation of the NPA RSD noted that many stakeholders considered that greater devolution of decision making would improve responsiveness to community needs (section 9.2).

Changing the way governments make decisions would be a gradual process that must evolve from governments' current approaches to service provision. The Australian Government should lead the process of moving to a more regional and localised approach. Where possible, the Australian Government should work together with the State and NT

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Governments in engaging with regions. The Australian Government, through the Department of the Prime Minister and Cabinet regional network, already has staff present on the ground in communities across Australia and could use this as a basis for shifting the balance to more local engagement with communities, with more authority and responsibility vested with regional network staff.

RECOMMENDATION 9.6

The Australian, State and NT Governments should adopt more regional and localised approaches to decision making and engagement with remote Indigenous communities, to underpin the greater use of place-based approaches to the design and provision of human services. To achieve this, the Governments should:

- give local staff more authority over local planning, engagement and service implementation
- provide capacity building support (such as cultural training) for staff working in remote Indigenous communities.

The Australian Government and State and NT Governments should work together to engage with communities on a coordinated basis.



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## 10 Patient choice

### Key points

- Each year, millions of Australians are referred by a general practitioner (GP) to a specialist, allied health professional, or pathology or radiology provider.
  - Where patients referred to a specialist go for their initial consultation also determines which hospital they will be admitted to if they require inpatient care.
- Patients' ability to choose which healthcare provider they go to when they receive a referral is limited by:
  - outpatient clinics refusing to see a patient when there is another public clinic closer to the patient's home
  - a common misperception that a named referral for a specialist or allied health professional, or a branded diagnostic request form, cannot be accepted by an alternative provider.
- All patients should be given the opportunity to choose the provider that best meets their needs, after receiving a referral and support from a GP.
  - Giving patients this opportunity would mainly involve removing barriers to patients exercising existing rights to choice, rather than giving them major new entitlements.
- The reforms would lead to more patient-centred care and improve patient wellbeing by:
  - empowering patients to have more control over their care and choose options that better match their preferences, such as a public clinic further from home with shorter waiting times
  - encouraging providers to improve service quality, efficiency, accountability and responsiveness
  - increasing equity of access for patients who are able to choose to access providers other than the one nearest them.
- Patients would have greater choice if the Australian, State and Territory Governments:
  - amended referral regulations to clarify that patients can choose their private specialist
  - required that referrals and diagnostic requests included a clear statement that advises patients of their right to choose their provider
  - directed public outpatient clinics to accept any patient with a referral for a condition that the clinic covers, regardless of where the patient lives
  - continued to give travel assistance to patients in more remote areas based on the cost of travelling to the nearest provider, but allowed this to be used for travel to an alternative provider.
- The Australian Government should also work with professional bodies to develop best practice guidelines on how to support patient choice.
- Under the proposed reforms, GPs would continue to be responsible for making referrals, requesting diagnostic tests, and supporting their patients.

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## 10.1 Introduction

The Commission is proposing reforms to give patients greater ‘referral choice’ over which provider they go to when referred by a GP for more specialised health care (table 10.1). GPs refer patients to specialists, allied health professionals,<sup>1</sup> and pathology or radiology providers (by requesting diagnostic tests). GPs would continue to be responsible for making referrals, requesting tests and supporting their patients, under the reforms.

Increasing patient choice would empower patients and improve service quality by encouraging healthcare providers — including GPs, specialists, allied health professionals, pathology and radiology providers, public outpatient clinics and hospitals — to be more responsive to patient preferences (discussed further in section 10.4).

The Commission developed the proposed reforms with consideration to what effective service provision would look like from the perspective of patients, providers, and governments.

- Patient choice would be supported by GPs and other healthcare providers, and by ongoing improvements in user-oriented information. This support would let patients with differing levels of health literacy exercise choice.
- Providers would be able to attract patients by improving service quality and being more responsive to patient preferences. To facilitate this, providers would be able to benchmark their service quality and efficiency against their peers.
- Governments would help healthcare providers to understand and support patient choice, and would publish comparative information for both patients and providers. Governments would monitor the operation of patient choice to facilitate ongoing improvement and to increase the accountability of providers.

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<sup>1</sup> The term ‘specialist’ is used in this report to refer to medical specialists, not including GPs. The term ‘allied health professional’ is used to refer to health professionals other than doctors and nurses, such as dentists, audiologists and optometrists.

**Table 10.1 Overview of proposed reforms to patient choice**

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Increasing choice for referred patients</b>		
<b>Recommendation 10.1</b> Australian Government to amend referral regulations to make it clear that patients can choose which private specialist they go to when they are referred.	As soon as practicable.	Additional cost of GP time where supporting choice requires longer consultations. Empower patients and support them to make choices that better satisfy their needs and preferences.
<b>Recommendation 10.2</b> Patients to be informed by GPs and by a clear statement on all referrals that patients can use an alternative to any provider mentioned in a referral.	As soon as practicable.	Cost of changing referral systems and forms to include statement. Inform patients of their existing rights and options.
<b>Recommendation 10.3</b> Public outpatient clinics to accept any patient with a referral for a condition the clinic covers, regardless of where the patient lives.	As soon as practicable.	Increase choice for public patients. Improve equity of access for patients that can choose an alternative clinic.
<b>Recommendation 10.5</b> Australian Government to develop, with professional bodies, best-practice guidelines on how to support patient choice, as part of a strategy to help GPs and other providers to implement the proposed choice reforms.	As soon as practicable.	Cost of implementing strategy. Empower patients and support them to make choices that better satisfy their needs and preferences. Make choice work better for patients, GPs, specialists and other providers. Help GPs and other referrers to support patient choice.
<b>More flexible travel assistance</b>		
<b>Recommendation 10.4</b> Patients who must travel long distances to access specialist medical treatment should be able to access patient travel assistance schemes regardless of which provider they choose to attend.	As soon as practicable.	May be an increase in number of patients accessing the scheme. Increase choice for patients who must travel long distances to access specialist care. Improve equity of access for patients that can choose an alternative provider.
<b>Evaluation of reforms</b>		
<b>Recommendation 10.6</b> Australian Government to evaluate patient choice reforms.	5 years after implementing reforms.	Cost of evaluation. Identify further beneficial improvements.

## 10.2 Referral pathways

Patients typically need to visit a GP and obtain a referral before they can access government-funded services from a specialist, or pathology or radiology provider (except in emergency cases). This reflects the central role of GPs in coordinating patient care and referring patients to other providers when more specialised medical or diagnostic services are appropriate. GPs also make referrals to allied health professionals, such as optometrists, although patients may attend an allied health professional without a referral.

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In a year, GPs make about:

- 15 million referrals to specialists (at an average rate of almost one specialist referral in every ten GP consultations), most often to orthopaedic surgeons and dermatologists
- 9 million referrals to allied health professionals, chiefly to physiotherapists and psychologists
- 91 million requests for pathology tests and 15 million requests for radiology tests (GPs often request multiple diagnostic tests in a single consultation).<sup>2</sup>

While this report mainly discusses referrals made by GPs, the same approach also applies to referrals made in outpatient settings by others, such as specialists and allied health professionals.

Patients referred to a specialist can have their initial outpatient consultation with either a specialist working in private practice or one employed in a public outpatient clinic.

There is no charge to see a specialist in the public sector but patients may be placed on a long waiting list for an appointment (box 10.1). Services are largely funded by State and Territory Governments, with a contribution from the Australian Government.

Waiting times are usually shorter for specialist outpatient appointments in private practice. Patients may bear an ‘out-of-pocket’ cost if the price of the consultation is higher than the fixed benefit paid by Medicare. Out-of-pocket costs vary significantly between specialists providing the same service (box 10.2). There can also be out-of-pocket costs for services supplied by allied health professionals, and pathology and radiology providers.

## **Specialist consultations leading to an elective hospital admission**

An initial specialist outpatient consultation may be followed by others, usually at the same public clinic or with the same specialist working in private practice. For many patients the entire course of their treatment occurs in an outpatient setting. However, following one or more outpatient consultations, some patients need to be admitted to hospital for elective care.

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<sup>2</sup> Specialist and allied health referral numbers are for 2016-17; they are Productivity Commission estimates based on data published by the (Australian Government) Department of Health (2017b) and Britt et al. (2016). Pathology and radiology request numbers are for 2015-16, published by the (Australian Government) Department of Health (2016b, 2016c).

## Box 10.1 Waiting times for elective care

### Public outpatient waiting times

Waiting times for initial public outpatient appointments vary a lot depending on clinic resources and the urgency of the patient's condition. Patients with urgent conditions may be able to make an appointment immediately. Other patients (with less urgent conditions) are placed on a waiting list, and may face very long waiting times (up to several years). For example, of patients attending a public 'general surgery' clinic in the first quarter of 2017 in Queensland, 10 per cent of patients with the *most* urgent conditions had waited longer than 35 days, while 10 per cent of patients with the *least* urgent conditions had waited longer than 438 days (Queensland Health 2017d). The Commission has proposed that all State and Territory Governments publish more useful data on public outpatient clinic waiting times (chapter 11).

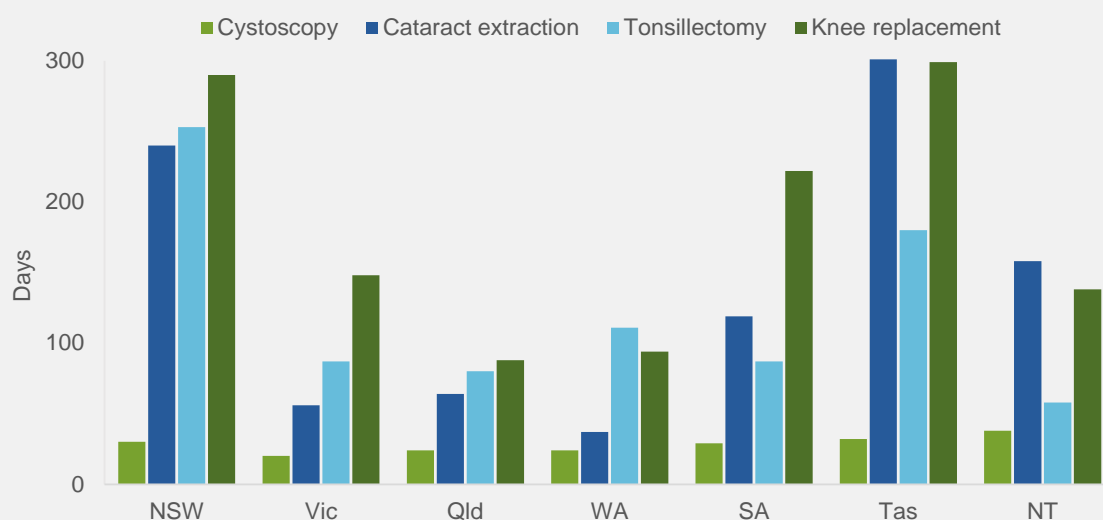
### Private outpatient waiting times

Patients may not be able to see a particular private specialist for an outpatient consultation immediately, but waiting times are usually shorter than for public outpatient consultations (especially for less urgent conditions). Private outpatients are more likely to be asked to make an appointment a few weeks or months in the future, rather than being added to a waiting list. There are limited data on waiting times for private outpatient consultations. One study found that patients in Melbourne waited an average of 33 days for a private paediatric outpatient appointment (Kunin et al. 2017).

### Elective surgery waiting time for public hospitals

Waiting times for elective surgery at a public hospital also depend on clinical urgency. In 2015-16 the median waiting time was 37 days. However, many patients faced much longer waiting times — 10 per cent waited longer than 260 days (AIHW 2016f). Waiting times varied by procedure and across States and Territories (figure below). The median waiting time for elective surgery in public hospitals is longer for patients residing in more disadvantaged areas (AIHW 2016a). There are limited data on waiting times for elective inpatient care other than surgery.

### Median waiting times for common elective surgeries in public hospitals, 2015-16



Source: AIHW (2016f).

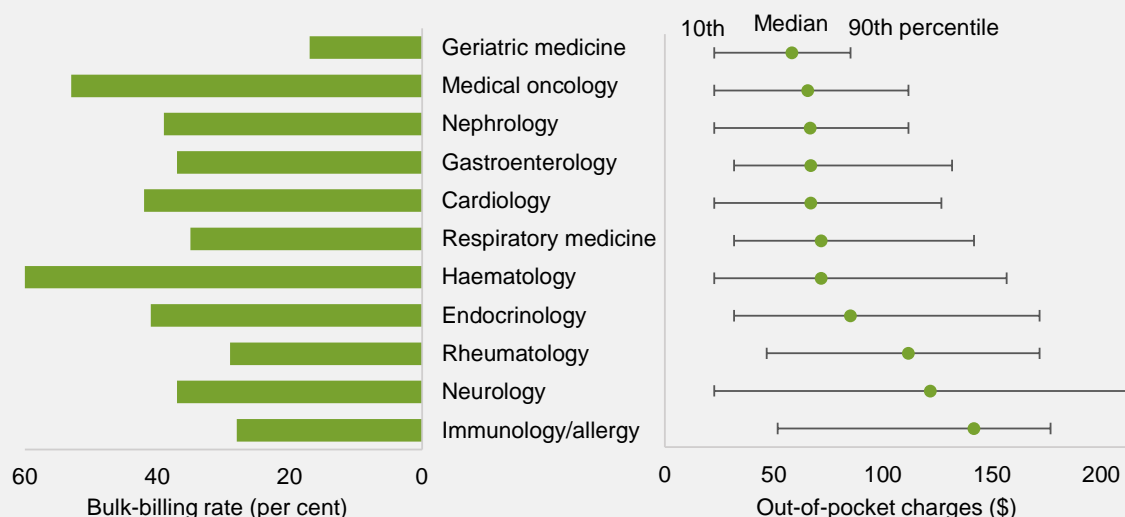
## Box 10.2 How much do private outpatients pay for consultations?

Specialists set their own prices for private outpatient consultations, but the Australian Government contributes a fixed Medicare benefit. The benefit is equal to 85 per cent of the ‘schedule fee’ for private outpatients (and 75 per cent for private inpatients). As at October 2017, schedule fees were \$150.90 for an initial consultation with a consultant physician (a non-surgical specialist – item 110) and \$85.55 for an initial consultation with other specialists (item 104) (Department of Health 2017j). Other schedule fees apply to different types of specialist consultations or treatments.

Specialists can set their price equal to the Medicare benefit, so that the patient does not pay a fee (‘bulk-billing’). Alternatively, they can set their price higher than the benefit, in which case the patient must pay the difference (‘out-of-pocket’ charges). Private health insurance cannot be used to pay out-of-pocket charges for *outpatient* services. In 2016-17, about 40 per cent of private specialist outpatient consultations were bulk-billed. Of those that were not bulk-billed, the average patient contribution was about \$75 (Department of Health 2017b).

Bulk-billing rates and out-of-pocket charges vary a lot — between and within specialties (figure below) and between jurisdictions. In 2016-17, the Northern Territory had the highest bulk-billing rate for private specialist outpatient consultations (53 per cent) and Western Australia the lowest (27 per cent). Other jurisdictions had rates between 36 and 46 per cent (Department of Health 2017b). Many specialists charge more to high-income patients than to low-income patients (Johar et al. 2016). The Commission considers that private specialists’ out-of-pocket charges should be published as part of a shift to systematic public reporting on individual specialists (chapter 11).

### Bulk billing rates and out-of-pocket charges for initial consultations, 2015<sup>a</sup>



<sup>a</sup> Private consultations with a consultant physician. The distribution of out-of-pocket charges excludes (bulk-billed) consultations with no out-of-pocket charge.

Source: Freed and Allen (2017).

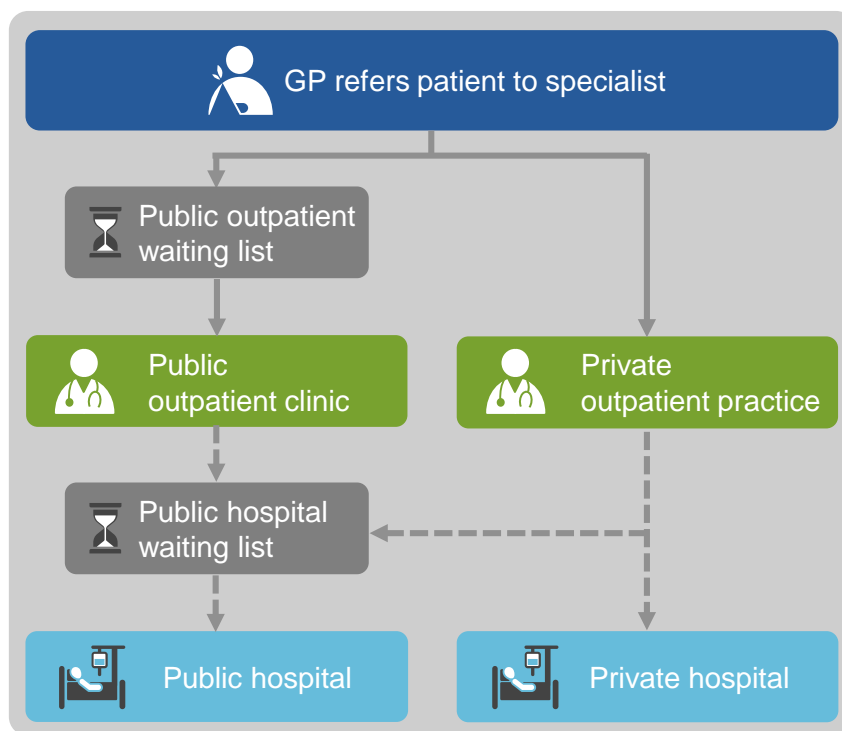
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There are essentially three pathways from a specialist outpatient consultation to an elective hospital admission (indicated by the dotted lines in figure 10.1):

- public outpatient to public inpatient — public outpatients who need to be admitted are wait-listed at the hospital attached to the public outpatient clinic they attended, unless the hospital is unable to treat the patient
- private outpatient to public inpatient — an outpatient who sees a specialist in private practice can sometimes be admitted as a public inpatient, if their specialist has admitting rights at a public hospital<sup>3</sup>
- private outpatient to private inpatient — an outpatient who sees a specialist in private practice is usually booked in for admission at a private hospital and treated by the specialist they saw as an outpatient.

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Figure 10.1 **Alternative pathways to an elective hospital admission**



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The private outpatient to public inpatient pathway raises equity issues. Patients following this pathway are able to access public inpatient services without first queuing on a public outpatient waiting list, although they must usually still join a public *hospital* waiting list. Moreover, access to this pathway can depend on where the patient lives, which GP refers

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<sup>3</sup> This is restricted in Queensland because patients can only be placed on a public hospital surgery waiting list after they have had a public outpatient consultation (Queensland Government 2015). It is possible in other cases because almost half of all specialists work in both the public and private sectors (about one third work only in the public sector and one fifth only in private practice) (Freed, Turbitt and Allen 2016).

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them and whether they are willing to pay any out-of-pocket charges for a private outpatient consultation. The number of people following this pathway varies a lot between jurisdictions but precise numbers are not known. Increasing patient knowledge about this pathway, and supporting patients to make informed choices about which route they wish to follow, would reduce this inequity.

In 2015-16 there were more than 2.4 million admissions to public hospitals for elective care, and more than 3.5 million elective admissions to private hospitals. In the same year, about 700 000 patients were admitted to public hospitals for elective surgery, and about 1.5 million were admitted to private hospitals. The most common elective surgeries were cataract surgery and removal of skin cancers (AIHW 2017a). On average, Australian hospitals perform well against those in comparable countries in terms of quality, equity, efficiency, accountability and responsiveness (AIHW 2016a; Schneider et al. 2017; St Vincent's Health Australia, sub. 207).

### **10.3 Giving patients greater choice**

The Commission proposes that, when a GP refers a patient for an initial specialist consultation, the patient should always be given the opportunity (following support from their GP) to choose either the:

- public outpatient clinic they attend (with the specialist chosen by the clinic)
- individual specialist they see in private practice.

Similarly, when patients are referred to an allied health professional, or pathology or radiology provider, they should always be given the opportunity to choose which one they go to, with support from their GP.

The Commission's proposed reforms (detailed below) would largely remove barriers to patients exercising existing rights to choice (box 10.3) and help GPs to support patient choice, rather than giving patients major new entitlements. The reforms aim to increase patient choice where the benefits are likely to outweigh the costs.

- The Commission is proposing that public patients be given the opportunity to choose the outpatient clinic they attend, although the public clinic (or public hospital, if the patient is admitted) would continue to decide which specialist treats each patient. Specialists and other doctors work in teams in public clinics and hospitals, and allowing them to allocate work within these teams is important for efficiency and the education of trainee doctors.
- Well-established clinical norms dictate that (where possible) public outpatients are admitted to the hospital attached to the public outpatient clinic they attend, and private outpatients are admitted to a (private or public) hospital where the specialist they saw for their outpatient consultation has admitting rights. The Commission does not propose changing these norms, as doing so could impede efficiency and interfere with continuity of care.

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- Patients admitted to (public or private) hospital may subsequently be referred to other specialists within the hospital, have tests ordered or be transferred to another hospital. The benefits of increasing choice for patients after they have been admitted are unlikely to outweigh the costs. Such costs could include a patient occupying a hospital bed while waiting for a bed to become available at their ‘chosen’ hospital.

## Helping GPs to support patient choice

GPs are uniquely well placed to advise patients on referral choices. GPs know the circumstances of the patient when they make a referral or request a test, have knowledge of healthcare providers, and they hold a position of trust.

The proposed reforms would strengthen the capacity of GPs to support their patients to get the care they want and need. GPs would continue to be responsible for making referrals and requesting tests; recommending providers to patients (which could include naming a particular provider in a referral or using a branded request form); and directing patients to useful sources of information. The proposed reforms would give GPs additional guidance and information to help them support patient choice.

### Box 10.3      **Current barriers to patient choice**

#### *Patients’ right to choose between private healthcare providers is not well known*

Choice of private provider is hindered by a common misperception among patients and providers that a named referral for a specialist or allied health professional, or a branded diagnostic request form, cannot be accepted by an alternative provider. Patients receiving a referral that specifies a provider may not be informed of their right to choose an alternative.

#### *Choice of public outpatient clinic is restricted*

Patients wishing to use a referral at a public outpatient clinic are often given no choice but to attend the clinic nearest to their home. This can be due to custom and practice among local GPs, public outpatient clinics having a policy of refusing appointments for people who do not reside in the clinic’s catchment area, or (in Perth) a requirement that referrals be processed through a central booking service which allocates patients to their nearest public clinic.

#### *Travel assistance schemes are inflexible*

All State and Territory Governments run patient travel assistance schemes which give financial assistance to patients who must travel long distances to access specialist medical treatment. However in most jurisdictions, patients cannot claim any assistance if they choose to go to a provider other than the nearest one.

Some participants suggested ‘system navigators’ could support patient choice (AHHA, sub. 427; Diana Voss, sub. 450; Tasmanian Government, sub. 485). Such navigators already play a role supporting some patients with cancer or diabetes to make more complex treatment

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decisions. However, in the case of referrals and diagnostic requests, they would duplicate a function that GPs are usually better placed to provide.

The level of involvement that patients want in making choices with their GP will vary, but the available evidence indicates that most want at least some involvement. In a recent survey of 1000 Australians aged 50–75 run by the Macquarie University Centre for the Health Economy (MUCHE), 85 per cent of respondents said that if they needed admitted care they would want their GP to discuss which hospitals they could choose from. Only 5 per cent wanted their GP to choose a hospital without any input from the patient (Cutler, Gu and Olin 2017).

It is unclear to what extent GPs currently support patients to make referral choices. The Commission heard that many GPs consistently support their patients to choose (when the patient wants this) but also that some GPs usually make choices on behalf of their patients. Evidence on where most GPs are along the spectrum is scarce. The Royal Australian College of General Practitioners (RACGP) submitted that:

GPs already support patient choice when referring. When a GP refers a patient to another medical specialist, the patient is usually presented with a choice at the time of the referral and consents to the referral once a shared decision has been reached. (sub. DR524, p. 2)

All patients should be given the opportunity to choose their provider with GP support. This includes patients with low health literacy, who may require more support. Patients could still rely on their GP to make referral decisions on their behalf, if they wish.

Patients should also have the option, following support from a GP, to choose their provider independently after leaving the GP's practice. This would enable them to take time to consider their options and to draw on additional sources of information, such as the views of others. The Commission is *not* proposing that patients make referral choices without any GP input.

The RACGP (sub. DR524, p. 4) was concerned that 'if a patient chooses their own medical specialist for a referral and does not inform their GP, the GP may have no way of following up with the specialist for any required action'. However, good patient care requires the provider receiving the referral to inform the GP of the outcome of the consultation or test. The Medical Board of Australia's code of conduct for doctors states:

Good patient care requires coordination between all treating doctors. Good medical practice involves: 1. Communicating all the relevant information in a timely way. 2. Facilitating the central coordinating role of the general practitioner ... (2014, pp. 13–14)

The GP could follow up with the patient if they are not informed by the provider. GPs and other providers should ensure that patients receive good care no matter which providers they choose to use.

To help GPs and other referrers support patient choice, the Australian Government should develop best-practice guidelines, as part of a broader strategy to inform and assist healthcare providers to implement the reforms. This should be developed in collaboration with

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professional bodies. The RACGP (sub. DR524) and the Royal Australasian College of Physicians (sub. DR580) expressed interest in providing such input.

In chapter 11, the Commission has proposed reforms to improve the information available to GPs and their patients. The progress of these reforms should not be used as a reason for postponing reforms aimed at increasing patient choice, although better information would amplify the benefits of greater patient choice (section 10.4). GPs are well placed to support patients' referral choices by supplementing the information already available to patients, such as surgery waiting times, with other relevant information such as provider quality.

In England, reforms to patient choice included a national online booking system for patients to arrange their outpatient appointment online, either while in the GP's office or by themselves after receiving a referral. The Commission considered such a system but found the potential costs were not justified at this time. It would likely be expensive and complex to implement across states and territories. The National Health System in England spent £280 million on its 'Choose and Book' system between 2002 and 2012 (Dusheiko and Gravelle 2015). The Queensland Government (2016c) has announced a more modest plan to provide online booking for public outpatient appointments by 2020.

## **Clarifying existing rights to choose between private providers**

Patient choice is limited by a common misperception among patients and healthcare providers that a named referral for a specialist or allied health professional working in private practice, or a branded diagnostic request form, cannot be accepted by an alternative provider. As a result, specialists sometimes refuse to see a patient because a different specialist is named in the referral. The patient must then contact their GP's office to ask them to change the name in the referral.

The Australian Government Department of Health advised the Commission that current regulations for private sector providers give them scope to supply services irrespective of whether they are named in the referral.<sup>4</sup> This is unclear in the regulations for specialists working in private practice, and so should be amended to clarify the right of patients to exercise choice over specialists in private practice.

A clear patient advisory statement should be included on all referrals to specialists, allied health professionals, and pathology and radiology providers to highlight the right of patients to take the referral to an alternative provider to any that is named. This will involve the amendment of existing regulations, which require such a statement on branded request forms for pathology and radiology tests, but leave scope for the statement to be displayed in a way that limits its effectiveness (box 10.4). The regulations should ensure that the patient

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<sup>4</sup> The requirements are specified in the Health Insurance Regulations 1975 (Cwlth), Health Insurance (Allied Health Services) Determination 2014 (Cwlth) and Health Insurance (Pathology Services) Regulations 1989 (Cwlth).

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advisory statement is prominent and easy to understand, to maximise its effectiveness in informing patients about their right to choose a provider.

#### **Box 10.4 Patient advisory statements on branded request forms**

GPs requesting pathology or radiology services for patients may print or write the request on a branded form, which carries provider details such as clinic addresses. The Health Insurance Regulations 1975 (Cwlth) require branded request forms to include a patient advisory statement. For radiology, the regulations state that the form must contain:

... a statement that informs the patient that the request may be taken to a diagnostic imaging [radiology] provider of the patient's choice ... (r. 19(1)(d))

To satisfy this, branded radiology request forms typically include a statement like:

Your doctor has recommended you use [name of radiology provider]. You may choose another provider but please discuss this with your doctor first.

For pathology, the regulations require the following statement:

Your doctor has recommended that you use [name of pathology provider]. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor. (r. 18A(1)(a))

The wording of these statements means they do little to support patient choice.

- They tell the patient not to choose a different provider without discussing this with the doctor requesting the test, which may require an additional visit to the GP.
- The pathology statement threatens non-payment if the patient chooses inappropriately. The Australian Government Department of Health advised that it is 'unlikely to ever be necessary' for a GP to insist on a particular pathology provider on clinical grounds because 'accreditation requirements ensure there is consistency in quality between providers' (pers. comm. 14 July 2017).

Moreover the statement is often included on the form in a small font and is usually positioned where the patient could easily miss it.

Requiring patient advisory statements on branded request forms is well intentioned, but as these statements currently appear they are likely to do little to help patients understand their options and exercise choice. This should inform the implementation of the Commission's proposed patient advisory statements.

These reforms would, in addition to support from a GP, help patients understand their options. They would also be consistent with the Australian Charter of Healthcare Rights adopted by all jurisdictions in 2008, which states that patients have a right to be informed about services, treatment, options and costs in a clear and open way (ACSQHC 2008).

The Commission's proposal to clarify patients' rights to choose between private specialists was generally supported by participants, including the Australian Healthcare and Hospitals Association (sub. DR561), Breast Cancer Network Australia (sub. DR534), and the Royal Australasian College of Physicians (sub. DR580). An exception was the RACGP (sub. DR524), which instead proposed that GPs be given discretion to decide whether a patient can take a named referral to an alternative specialist. The Commission does not agree.

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This approach would run counter to the current regulations and represents a backwards step for patient choice. There is no compelling reason to remove some patients' rights to choose their provider, given the benefits associated with choice (section 10.4). Rather, existing rights should be clarified to facilitate patient choice.

**RECOMMENDATION 10.1**

The Australian Government should amend the Health Insurance Regulations 1975 (Cwlth) to make it clearer that patients with a specialist referral can choose to have their initial consultation with any private specialist practising the relevant specialty. This includes clearly specifying that:

- referrals do not need to name a particular specialist
- any specialist practising the relevant specialty can accept a referral, irrespective of whether another person is named as the specialist in the referral.

**RECOMMENDATION 10.2**

The Australian Government should amend the regulations for referrals and diagnostic requests to require:

- general practitioners and other referrers to advise patients that they can use an alternative to any provider mentioned in a referral or request
- all referrals to specialists and allied health professionals, and requests for pathology and radiology services, to include a prominent and easy to understand statement advising patients that they can use an alternative to any provider mentioned in the referral or request.

## **Removing restrictions on choice of public outpatient clinic**

GPs almost always refer patients to the public outpatient clinic nearest the patient's home (when referring to a public clinic). While most State and Territory Governments do not explicitly require this, public clinics may refuse to see a patient if there is another public clinic nearer their home (Cutler, Gu and Olin 2017). Victorian public clinics, for example, can refuse to see a patient under guidelines that state:

If a referral is received for a service that could be provided at a facility closer to the patient's home, specialist clinic staff may contact the referrer and ask them to redirect the referral. However, ... [p]rovided there are valid reasons why the patient should be seen at the original hospital, the referral should not be refused on the basis of the patient's location. (Victorian Department of Health 2013, p. 13)

Such arrangements create uncertainty about whether a referral will be accepted at any public clinic other than the nearest.

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A further barrier to choice in some regions is that GPs send referrals to a local hospital network, rather than a specific clinic in that network. The local hospital network then forwards the referral on to the clinic that it decides to be the most appropriate to see the patient (typically the one nearest to the patient's home). In metropolitan Perth, referrals are centrally administered across more than one local hospital network by the WA Central Referral Service. GPs are required to send referrals to the Central Referral Service, which identifies the catchment area in which the patient lives, and sends the referral on to the clinic for that catchment area.

The scope for patients to choose is also limited by a common practice among GPs of lodging referrals directly with a public clinic (or centrally-administered booking service) to request a consultation (rather than giving the referral to the patient to lodge). Some jurisdictions require this, such as Western Australia for the Central Referral Service. The convenience and certainty of this approach may have value to patients, but this needs to be balanced against the barrier to choice it can create.

The Commission recommends that public outpatient clinics no longer be allowed to refuse consultations based on where a patient lives, or to require referrals to be lodged directly by the patient's GP. Patients should have the option of lodging referrals, allowing them to independently choose which public clinic they go to after discussion with their GP.

## Redistribution of demand

Participants raised two broad concerns about how a redistribution of demand among public clinics could reduce access for some patients.

- Greater demand at more popular clinics could lead to longer waiting times (Little Company of Mary Health Care, sub. DR547; Queensland Government, sub. DR592; RACP, sub. DR580; SA Government, sub. DR571; VHA, sub. DR531)
- Lower demand at other clinics, particularly if they are smaller ones in regional or remote areas, could threaten their viability and lead to closure — thereby reducing access for patients in these areas (AHHA, sub. DR561; Queensland Government, sub. DR592; VHA, sub. DR531).

The proposed reforms would likely lead to modest changes in demand and waiting times — with longer waiting times for some services at some public clinics (and hospitals), and shorter waiting times for others. Evidence from other countries suggests that when given choice, many patients will still choose to go to the nearest provider (section 10.4). Additionally, changes in waiting times will discourage a large redistribution of demand — as waiting times increase at more popular clinics they will become less attractive relative to those where waiting times are falling.

The reforms should improve equity of access for patients who are able (with GP support) to choose to access providers other than the one nearest them. Patients whose nearest provider has a relatively long waiting time would no longer be prevented from going elsewhere.

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Importantly, across all services, patients with more urgent conditions will continue to receive priority access (box 10.2).

Greater patient choice may lead to falling demand in some locations, including in regional or remote areas. Changing demand provides valuable signals about patients' needs and preferences, and how these match with the services offered. Where demand for a service falls, providers may need to make the service more attractive to patients, such as by improving quality.

State and Territory Governments and local hospital networks should actively monitor changes in demand, and investigate and respond to significant changes in demand. Where demand falls they may need to consider remedial action to improve service quality or reconsider the allocation of resources within the jurisdiction.

In summary, removing restrictions on patients' choice of public clinic would lead to some redistribution of demand. The benefits associated with changes in demand sending a signal to providers and governments, in addition to the broader benefits of allowing patients to choose between public clinics (section 10.4), are likely to outweigh the cost of any resulting reduction in patient access.

## Care coordination

Patients should be able to consider care coordination among other provider characteristics when choosing which public clinic to attend. Poor coordination may lead to worse patient outcomes. The Victorian Healthcare Association (sub. DR531) suggested that decoupling surgical care from local post-operative and rehabilitation services could increase the risk of poor health outcomes for patients.

The Victorian Healthcare Association also argued that greater patient choice would increase the costs that hospitals bear to ensure that their services are coordinated with those provided outside the hospital.

... hospitals have a strong understanding of services that are offered in their local area but less so in other regions. If more people from outside a hospital's geographical area seek out-patient and in-patient care, they will require extra resources to keep updated databases of services that are not in their catchment, and in situations where this information is not available, clinicians will need to devote significant time and resources to discharge planning (already a complex process), increasing the cost of service provision and further adding to a significant administrative burden. (sub. DR531, p. 5)

However, several participants told the Commission that its recommendations would not require major changes in how hospitals coordinate care. Hospitals already coordinate care for patients not residing nearby, particularly hospitals serving a geographically dispersed population such as those providing highly specialised services (such as transplants) to patients across a whole State.

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The treating specialist is usually responsible for providing post-operative care, although a GP may provide it if the patient lives far from the specialist. In August 2017 the Australian Government proposed changes that would fund GPs to provide post-operative care to patients (Department of Health 2017d).

The Commission recognises that local relationships between hospitals and post-operative and rehabilitation services can enhance care. However, providers should respond to patient choice and work to connect patients with services that are appropriate to their needs. Providers should inform patients of any risks associated with receiving care far from their place of residence. However, patients should not be restricted from going to any clinic that covers their health condition.

Public clinics would still have the discretion to reject a referral if they are not able to provide the relevant service. Not all public clinics offer all services. The Royal Australasian College of Physicians (sub. DR580, p. 4) pointed out that some endocrine disorders ‘require management by a multidisciplinary team, and these patients should be directed to those hospitals where such teams are located’.

#### RECOMMENDATION 10.3

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

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

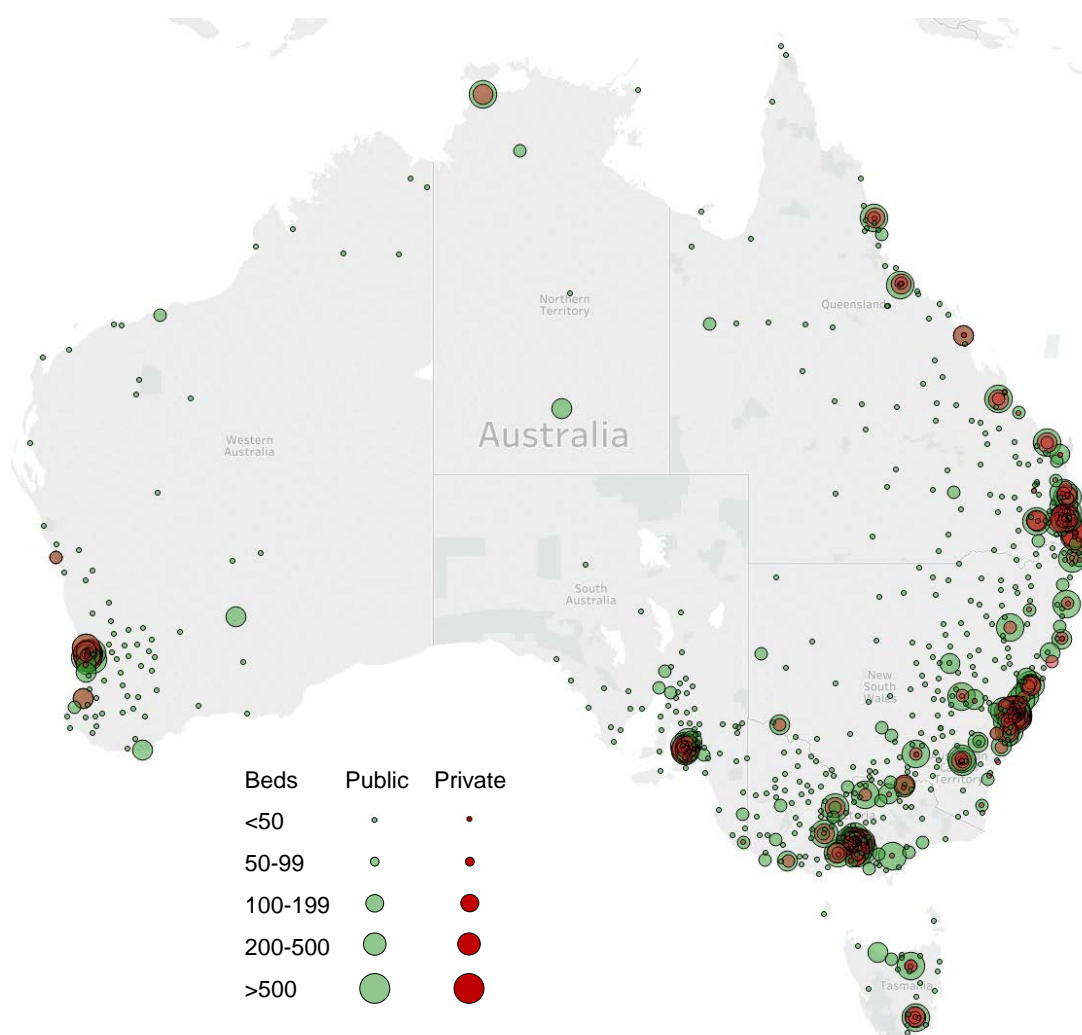
## Making patient travel assistance schemes more flexible

Patients living outside major cities tend to have less access to elective care. Over 85 per cent of specialists locate their practice in major cities and only 3 per cent provide services in outer regional, remote and very remote areas (Scott, Yong and Mendez, sub. 87). Hospitals are clustered around major cities (figure 10.2) — particularly larger public and private hospitals, where most elective surgery is performed.

It may be more difficult for patients in regional and remote areas to exercise referral choices, as getting to alternative providers may involve significant travel (with its associated time and financial costs). The Australian Healthcare and Hospitals Association noted that:

For many consumers there is no practical alternative public hospital that can be selected (e.g. if the nearest geographic alternative involves an unreasonable travel burden) ... (sub. 427, p. 5)

Figure 10.2 Location and size of hospitals, 2017<sup>a</sup>



<sup>a</sup> Data are for September 2017. Bed counts include chairs for same-day admissions.

Sources: AIHW (2017d) and Productivity Commission estimates of bed numbers where AIHW data are not available.

Nonetheless there is evidence that those living in regional and remote areas may be more willing to consider, and travel further to, alternative providers. The MUCHE survey found that respondents living outside major cities were more willing to travel longer distances (up to 60 kilometres) to attend a better quality hospital (Cutler, Gu and Olin 2017). Similarly a survey of more than 2000 English patients found that those living outside of urban centres were more likely to choose to attend a non-local hospital (up to two hours away) (Dixon et al. 2010).

All State and Territory Governments run patient travel assistance schemes which give financial assistance to patients who must travel long distances to access specialist medical treatment (National Rural Health Alliance 2014). The level of assistance is based on the cost

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of getting to the nearest provider and in most jurisdictions is only available to patients who go to the nearest provider. As is the case now, only patients who cannot access specialist medical treatment nearby should be able to claim assistance. However, allowing these patients to claim assistance regardless of which healthcare provider they choose to attend, while still basing the level of assistance on the cost of getting to the nearest provider, would increase patients' referral choices without costing governments significantly more.

This reform should improve equity of access for patients in regional and remote areas who would be able to choose to access providers other than the one nearest them. These patients would no longer be penalised for going to an alternative provider when their nearest provider has a relatively long waiting time, or when the alternative provider better meets their preferences.

This reform was supported by participants including the Australian Healthcare and Hospitals Association (sub. DR561), Breast Cancer Network Australia (sub. DR534), the Royal Australasian College of Physicians (sub. DR580) and the Victorian Healthcare Association (sub. DR531). It was not supported by the Queensland Government (sub. DR592) or SA Government (sub. DR571) as they were concerned that it would cause a geographic redistribution of demand that would make it harder to access services in some locations. However, only a fraction of patients access travel assistance, and many of these are still likely choose to go to the nearest service (section 10.4). The aggregate effects on demand for particular services are therefore likely to be slight, and the benefits of more flexible travel assistance are likely to outweigh the costs.

#### RECOMMENDATION 10.4

State and Territory Governments should change patient travel assistance schemes so that assistance is available to patients who must travel long distances to access specialist medical treatment, regardless of which provider they attend. The level of assistance should continue to be based on the cost of getting to the nearest provider.

#### RECOMMENDATION 10.5

The Australian Government should develop best-practice guidelines on how general practitioners (GPs) and other referrers should support patient choice when making a referral or diagnostic request. These guidelines should be designed with the relevant professional bodies, and form part of a broader strategy to help GPs and other healthcare providers implement recommendations 10.1 to 10.4.

## Monitoring the effects of reforms

Governments should monitor the effects of these reforms to identify where fine tuning is warranted. This could include surveying patients to establish to what extent, and in what

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way, GPs are supporting patients' referral choices, and whether patients require other support. The Australian Government could also survey GPs or other providers to establish that they understand the referral guidelines, and whether (and how) the Government should further assist GPs to support patients' referral choices. Wherever possible, monitoring should take advantage of existing data collection to maximise the net benefits to the Australian community.

Five years after introducing the reforms, the Australian Government should undertake a comprehensive evaluation to assess the costs and benefits, and whether further changes are needed. The evaluation should be undertaken in consultation with State and Territory Governments.

**RECOMMENDATION 10.6**

The Australian Government should undertake an evaluation of the choice reforms proposed in recommendations 10.1 to 10.5, five years after they commence operation.

## **10.4 Key benefits and costs of the reforms**

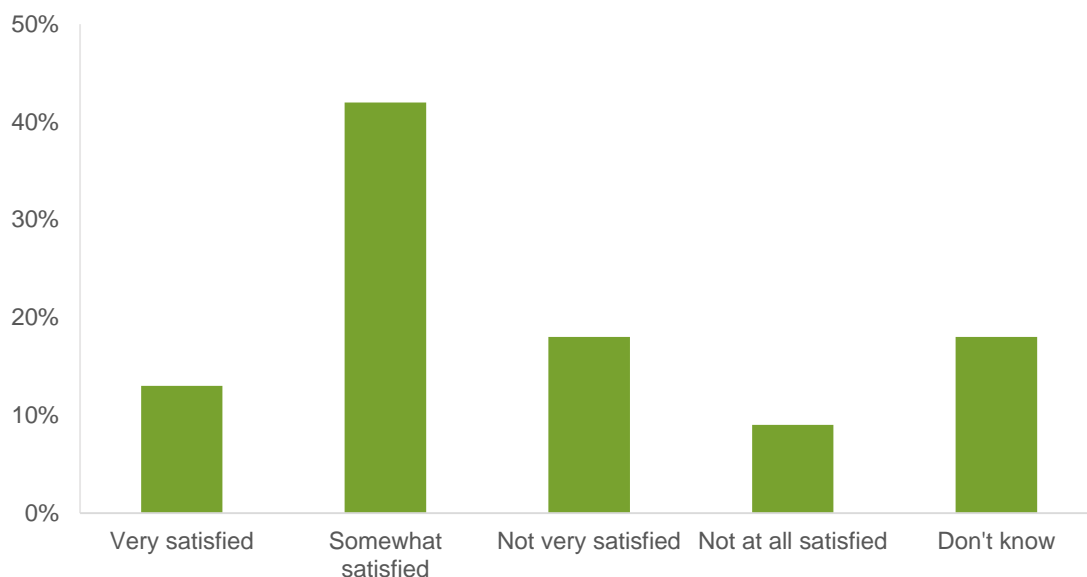
### **Intrinsic value of choice**

Choice has intrinsic value by empowering people to have greater control over their lives (chapter 1). Reviewing choice in the English public health system, Dixon et al. (2010, p. 13) argued that choice of hospital is justified by its intrinsic value, citing a link between providing a choice and 'positive psychological indicators such as perceived control, intrinsic motivation, task performance and life satisfaction'.

Australian evidence suggests that many patients would like more choice. A user survey on the Healthshare website — which has information on healthcare providers, including a directory of private specialists — found that almost 95 per cent of (more than 1500) respondents said they would like to have the option to choose their own specialist when referred by a GP (Healthshare, sub. DR591). The MUCHE survey found that about 70 per cent of respondents were either somewhat satisfied, not very satisfied or not at all satisfied with the amount of choice available in the public hospital system (and a further 18 per cent responded 'don't know') (figure 10.3). These results are comparable to survey results from other countries (Coulter 2004; Dixon et al. 2010). Patients' desire for choice may reflect its intrinsic value or other benefits (discussed below).

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**Figure 10.3 Satisfaction with choice in the public hospital system<sup>a</sup>**



<sup>a</sup> Based on a survey of one thousand 50- to 75-year-old Australians in December 2016.

Source: Cutler, Gu and Olin (2017).

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## Choice lets patients satisfy their individual preferences

Patients differ in many ways, including where they live, their ability (or willingness) to pay out-of-pocket charges, and preference over the timing of their care. Providers differ in their locations, performance, waiting times and out-of-pocket charges. Increasing patients' referral choices would allow them to choose providers that better match their individual preferences (box 10.5). The Royal Australasian College of Physicians (sub. DR580, p. 3) suggested that, for example, 'some patients may find it more appropriate to have access to care close to their workplace rather than close to home to reduce travel time to appointments that are within working hours'.

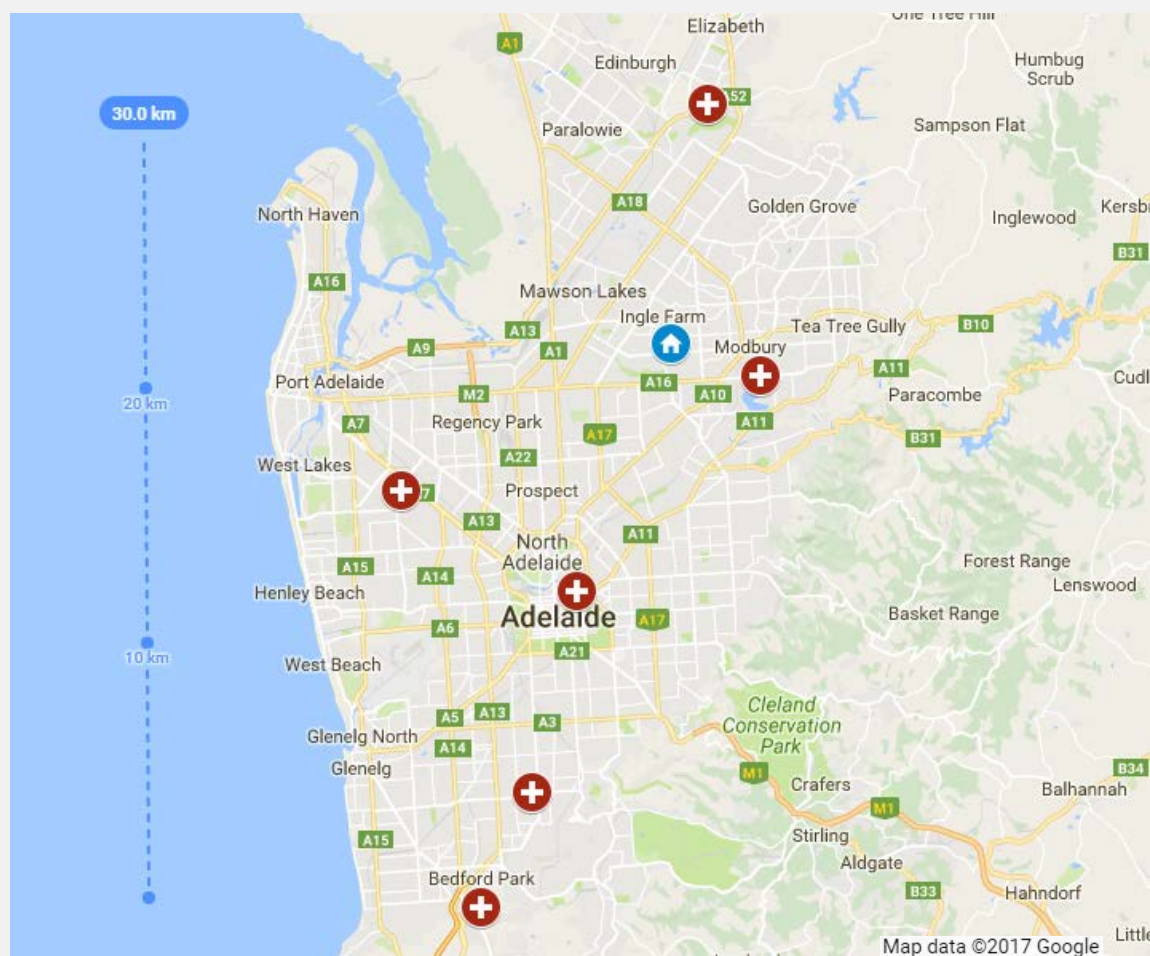
Evidence from other countries suggests that patients tend to choose the nearest hospital, although they may choose an alternative depending on other characteristics such as quality of care and waiting times (Kolstad and Chernew 2009). When patients in England were given more choice in the mid-2000s, the share of patients attending their nearest hospital fell from three-quarters (in 2002-03) to one-half (in 2012-13) (Moscelli et al. 2016). Patients who have had a bad experience at the nearest hospital are more likely to choose one further afield, while patients with poor mobility, such as older or chronically ill patients, are less likely (Dixon et al. 2010).

### Box 10.5 Case studies: potential benefits of proposed reforms

**Jess lives in Ingle Farm, a suburb of Adelaide** (the blue house on the map below). Her GP decides to refer her to a neurologist. Jess tells the GP she does not have private health insurance and does not want to pay any out-of-pocket charges. The GP tells her there are six public neurology clinics around Adelaide (red crosses on the map — at Modbury Hospital and Lyell McEwin, each about 15 minutes' drive from her home), Royal Adelaide Hospital and Queen Elizabeth Hospital (each about 30 minutes' drive), and Repatriation General Hospital and Flinders Medical Centre (each about 45 minutes' drive).

The GP gives Jess a brief rundown of what he knows about each of the clinics. He explains to Jess that she can take the referral and do some more research before choosing which clinic she would like to go to, which Jess agrees to. Jess speaks to her brother, who is a nurse, and looks up some information on infection rates on the MyHospitals website. She decides to send her referral to the clinic at Royal Adelaide Hospital in central Adelaide, which is not the closest clinic to her home, but is very close to her work in Adelaide's city centre.

Jess has benefited from being able to make an informed choice in line with her preferences, and being able to attend a public clinic other than the one closest to her house. She also felt empowered in gathering her own information on the six options and choosing between them.



(Continued next page)

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### Box 10.5 (continued)

**Adam lives in Thirroul, about 20 minutes' drive north of Wollongong.** His GP decides to refer him to a dermatologist. The GP asks Adam whether he has private hospital insurance and discusses Adam's choice to be treated as a public or private outpatient. Adam decides he would like to be treated as a private outpatient as he wants to be seen straight away, although his condition is not urgent. The GP tells Adam there are numerous private dermatologists in Wollongong and offers to discuss a few with Adam, but Adam says he is happy to go to any local dermatologist the GP recommends. The GP gives Adam a referral, and the details of three dermatologists — thinking that at least one will be able to see Adam immediately — for Adam to call to make an appointment.

Through discussion with his GP, Adam has satisfied his preference for an immediate appointment, without being overwhelmed with choice. Without the referral regulations being clarified, Adam may have had to contact the GP's office to get the name of the specialist on the referral changed. Both he and the GP's office have avoided this complication.

**John lives in Emerald, in Queensland.** His GP decides to refer him to an orthopaedic surgeon for a problem with his elbow. When asked, John tells his GP he does not have private health insurance and prefers to not to go to a specialist who has out-of-pocket charges. John also says that he prefers not to travel more than necessary. The GP explains to John there is no orthopaedic clinic at Emerald Hospital and that, as the nearest orthopaedic surgeon is more than 50 km from Emerald, John qualifies for assistance under Queensland's Patient Travel Subsidy Scheme.

The GP tells John that there are orthopaedic clinics attached to both Rockhampton Hospital (about 3 hours' drive) and Gladstone Hospital (about 4 hours' drive) where John can go and not pay any out-of-pocket charges. The GP gives John her opinion on the two options and explains to John that he can take the referral and go away and think further about the choice before sending the referral to the clinic of his choice — John likes this idea. Over the next few days, John looks up information on each hospital on the MyHospitals website, and speaks to a friend who has recently been to Gladstone Hospital, before choosing to send his referral to the Gladstone clinic.

John has benefited from being able to make an informed choice that meets his needs and receiving travel assistance towards the cost of this attendance. Additionally, he felt empowered in taking control of the decision between the two public clinics.

**Holly lives in the Melbourne suburb of Prahran.** Her GP suggests she get a precautionary magnetic resonance imaging (MRI) brain scan, although she is not eligible to receive the scan at a public clinic and it will not attract a Medicare benefit. Holly is happy to pay to get the scan. The GP provides her with a branded request form for the scan, which includes a clear statement saying that the request can be taken to an alternative provider. The GP tells Holly that she can take the request form to any MRI provider, gives her the names of three large provider groups and suggests that she look at their websites to choose among the dozens of clinics. After the consultation, Holly uses the websites to find two MRI clinics close to her home, at Cabrini Hospital in Malvern and at The Avenue Hospital in Windsor. She calls each to ask their prices and decides to book an appointment with the less expensive one.

Holly has benefited from being informed of her options and directed to relevant information. She is able to choose the provider that is best for her, based on location and price. If her choice had not been supported, she may have attended a more expensive clinic, further from her home.

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Precisely how Australian patients would respond to greater choice is uncertain, given that there is limited information on the service characteristics they value when choosing a provider. In the MUCHE survey, respondents choosing between (hypothetical) hospitals cared most about quality of care — as indicated by average health gains, rates of readmission and adverse events. Respondents' choices indicated they would be willing to travel further and wait longer to access better quality hospitals (Cutler, Gu and Olin 2017).

## **Patients' choices can drive service improvements**

Greater patient choice over which providers they use can drive providers to compete for patients by increasing service quality and becoming more responsive to patients' needs and preferences (such as by improving hospital amenities). This holds for allied health professionals, pathology and radiology providers, specialists, outpatient clinics, and hospitals. Competition for patients can also drive providers to improve efficiency, in order to free up resources that can be used to attract or service more patients. Private providers may reduce out-of-pocket charges to attract patients.

There is limited Australian evidence on the effects of competition between healthcare providers. Two studies of public and private hospitals in Victoria produced mixed findings. Palangkaraya and Yong (2013) found that greater competition was associated with fewer unplanned readmissions for cardiac patients but also a slight increase in mortality. Chua, Palangkaraya and Yong (2011) found an ambiguous relationship between competition and hospital efficiency. A recent study of Australian GPs — who, like other private providers, set their own prices — found that more competition leads to more bulk-billing and lower out-of-pocket charges, without affecting consultation length (which is associated with quality of care) (Gravelle et al. 2016).

There is extensive evidence from other countries (mostly from England and the United States) on the effects of competition between hospitals. Where hospitals are not able to set prices — as with public clinics and public hospitals in Australia — greater competition among hospitals is generally associated with higher quality (box 10.6; Gaynor 2006). There is limited evidence on the effects of competition between specialists, allied health professionals, or pathology or radiology providers.

Considering the available evidence, and the structure of Australia's health system, the Commission considers it unlikely that the proposed choice reforms would alone drive dramatic service improvements. However, these reforms are likely to sharpen the incentives to providers to establish or maintain a good reputation, to be responsive and provide high-quality care to patients, and (for those setting prices) to keep their prices competitive.

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### Box 10.6 Patient choice in England

A range of reforms were introduced in England from 2006 to increase patient choice. Prior to 2006, GPs referred public patients needing elective care to a clinic at the nearest hospital. In 2006, patients were given some choice over which hospital they attended, and from 2008 they have been able to choose any public or private hospital covered by the English National Health Service. Patients also have access to a useful website to compare alternatives (chapter 11) and an online booking service (Choose and Book).

Quantitative studies have found that following these reforms:

- patients sought out better performing providers — hospitals with lower pre-reform mortality rates and waiting times had a greater increase in elective patients post reform than those with higher mortality rates and waiting times (Gaynor, Moreno-Serra and Propper 2013). Among people seeking a coronary artery bypass graft, choices made by sicker patients were more sensitive to reported mortality rates (Gaynor, Propper and Seiler 2012)
- hospitals in more competitive locations generally improved service quality the most — death rates for patients admitted after a heart attack fell the most in hospitals that had more nearby competitors (Cooper et al. 2011). Hospitals located in more competitive areas also had larger declines in mortality from other causes and lower lengths of stay for elective surgery (Gaynor, Moreno-Serra and Propper 2013). However, one study found that the reforms increased emergency readmissions for patients who had hip or knee replacements, and had no effect on hospital quality for coronary bypass patients (Moscelli, Gravelle and Siciliani 2016).

### The cost of GPs' time to support patient choice

The Australian Government, through Medicare, broadly funds GP consultations according to the time they take — including time supporting patient choice. Both the RACGP (sub. PFR337) and the Australian Medical Association (sub. 481) stated that giving patients more choice would increase the length of some GP consultations and hence their cost. The Commission agrees. GPs who take more time to support choice would receive additional funding under the existing Medicare Benefits Schedule, as some consultations that go longer would be eligible for a higher benefit (table 10.2).

Patients paid out-of-pocket charges for about 15 per cent of GP consultations in 2016-17 (Department of Health 2017b). Some GPs have higher out-of-pocket charges for longer consultations. They would need to advise their patients about the possibility of additional out-of-pocket charges before taking time to support choice.

The Commission has estimated that, under the proposed reforms, the additional costs of longer GP consultations would be relatively small for both the Australian Government and patients as a group (box 10.7). These costs are likely to be outweighed by the benefits discussed above.

**Table 10.2 Medicare Benefits Schedule for GP consultations**

<i>Consultation type</i>	<i>Current benefit<sup>a</sup></i>	<i>Per cent of consultations<sup>b</sup></i>	<i>Definition<sup>c</sup></i>
Level A	\$16.95	2.9	Consultation for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
Level B	\$37.05	80.4	Consultation <b>lasting less than 20 minutes</b> , including any of the following that are clinically relevant: <b>taking a patient history</b> ; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to one or more health-related issues, with appropriate documentation.
Level C	\$71.70	15.3	Consultation <b>lasting at least 20 minutes</b> , including any of the following that are clinically relevant: <b>taking a detailed patient history</b> ; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to one or more health-related issues, with appropriate documentation.
Level D	\$105.55	1.5	Consultation <b>lasting at least 40 minutes</b> , including any of the following that are clinically relevant: <b>taking an extensive patient history</b> ; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to one or more health-related issues, with appropriate documentation.

<sup>a</sup> As at October 2017. Benefits shown are for consultations at consulting rooms. Other benefits apply for consultations in nursing homes or elsewhere. <sup>b</sup> In 2016-17. <sup>c</sup> Bold added to highlight differences between definitions for Level B, C and D type consultations.

Sources: Department of Health (2017i); DHS (2017).

### **Box 10.7 The cost of funding additional GP time to support choice**

The Commission estimated the cost of funding additional GP time to support patient choice, relative to a base case that represents the status quo. The base case was constructed using survey data from the Bettering the Evaluation and Care of Health (BEACH) program on the time distribution of GP consultations and the proportion involving a referral or diagnostic request. Data from Medicare and the Department of Veterans' Affairs were used to generate population estimates from these survey results.

No data are available on the extent to which GPs already support choice. The share of base case consultations that would increase in length, and by how much, under the reforms is also uncertain. Reflecting this uncertainty, the Commission estimated the cost of additional GP time under a range of alternative assumptions. It was assumed that between 10 and 40 per cent of consultations with a referral, and between 5 and 20 per cent of consultations with a diagnostic request, would go longer due to the reforms.

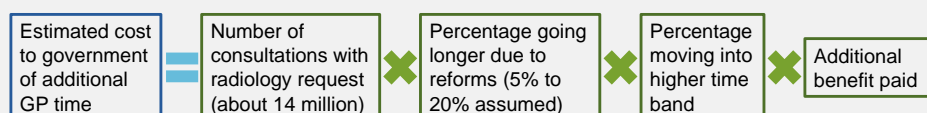
How much extra time would be taken in such cases (and hence the likelihood of attracting a higher Medicare benefit) was also varied in the cost estimates. A higher upper bound was set on the

(continued next page)

## Box 10.7 (continued)

assumed additional time needed for referrals compared with diagnostic requests. As per the Medicare Benefits Schedule (table 10.2), a consultation would only attract a higher benefit when its duration increased enough to move it into a higher time band.

### Approximation of government cost equation for radiology requests



The resulting estimates suggest that the additional cost to the Australian Government would be in the range of \$6 million to \$24 million per year (equivalent to 0.08 per cent to 0.32 per cent of Medicare spending on GP services).

This comprised:

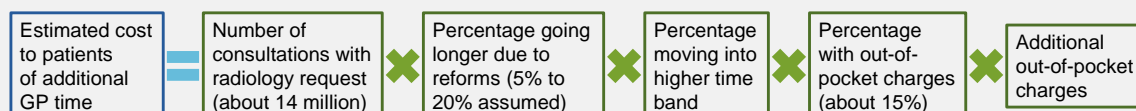
- for **specialist referrals**, \$2.5 million (if 10 per cent of consultations take more time) to \$10.0 million (if 40 per cent of consultations take more time)
- for **referrals to allied health professionals**, \$1.1 million (if 10 per cent) to \$4.5 million (if 40 per cent)
- for **pathology requests**, \$1.4 million (if 5 per cent) to \$5.7 million (if 20 per cent)
- for **radiology requests**, \$800 000 (if 5 per cent) to \$3.4 million (if 20 per cent).

These cost ranges are in direct proportion to the percentage of consultations that go longer due to the reforms. If GPs spend time supporting many more patients to make referral choices, then the costs of funding additional GP time could be toward the upper bound estimates, but the benefits will be proportionately higher. The estimates equate to an average cost to the Australian Government of about \$1.50 for each consultation that goes longer due to the reforms.

In previous years, roughly 40 per cent of consultations were charged at a lower rate than they could be, given their length (those that go longer than 20 minutes but are charged as Level B, or longer than 40 minutes but are charged as Level C). This is not accounted for in the cost estimates. To the extent that this continues, it would reduce the cost estimates commensurately.

Incorporating data on GPs' out-of-pocket charges, and assumptions about how these charges vary with consultation length, the Commission estimated the increase in aggregate out-of-pocket charges due to the reforms.

### Approximation of patient cost equation for radiology requests



Counting GP time to support all types of referrals and requests, additional out-of-pocket charges were estimated to be between \$260 000 and \$1 million per year (equivalent to 0.3 per cent to 1.2 per cent of total patient spending on GP out-of-pocket charges). Again this range is in direct proportion to the percentage of consultations that were assumed to go longer due to the reform.

*Sources:* Productivity Commission estimates based on Britt et al. (2004, 2016), Britt, Valenti and Miller (2014), Department of Health (2017b, 2017i), and Department of Veterans' Affairs (pers. comm. 17 October 2017).

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## **Would the private health system be affected?**

Some participants argued that increasing choices for public patients could reduce demand for private health insurance, and increase the burden on the public health system (for example, AMA, sub. 481; NRHA, sub. 428). Catholic Health Australia noted that:

... offering choice of provider may risk undermining one of the key benefits of private health insurance – which could ultimately lead to adding further demand on the public hospital system. (sub. 440, p. 5)

The effect of the proposed reforms on the private health system depends on their effect on both the decision to take out private hospital insurance (on which there are some data), and the decision to access private outpatient or hospital services (on which data are limited).

Just under half of all Australians held private hospital insurance in June 2017 (APRA 2017). A 2014-15 ABS survey found that, on average, people had private hospital insurance for three or four reasons. The most commonly cited reasons were security or protection or peace of mind; to allow treatment as private patient in hospital; and shorter waiting times. About one-third of those with private hospital cover gave ‘choice of doctor’ as one of their reasons (ABS 2016d).

The proposed reforms are unlikely to have a significant effect on the take up of private hospital insurance, or on the private–public balance of hospital services in Australia. People have private hospital insurance for many (and multiple different) reasons, and choice is far from the most common. The proposed reforms would not affect the advantages of attending a private specialist or private hospital (instead of a public outpatient clinic or public hospital), such as being able to choose the treating specialist and avoid a waiting list.



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# 11 Information to support patient choice and provider self-improvement

## Key points

- Better public information about hospital and clinician performance would support patient choice and encourage self-improvement by health providers.
- Patients can already draw on some information. However, more information should be publicly reported to facilitate comparisons between providers, including on clinical outcomes and the wide variation in out-of-pocket charges between specialists working in private practice.
- Other countries have shown that it is possible to publish more information on individual providers to help empower patients and assist general practitioners to support patient choice. There is also evidence that publishing more information would prompt providers to engage in greater self-improvement activity.
- To better inform patients and their GPs, and encourage more self-improvement by providers, the Australian, State and Territory Governments should, as part of their health funding arrangements, commit to:
  - releasing all data they hold on individual hospitals (including outpatient clinics), specialists and allied health professionals unless it would clearly harm the interests of patients or breach privacy protections
  - disseminating the information nationally through an improved MyHospitals website
  - allowing non-government organisations to use the data in advisory services they provide
  - phasing-in public reporting on individual specialists and allied health professionals, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.
- Progress in implementing these reforms should be reviewed by the Australian, State and Territory Governments three years after the new health funding arrangements come into force.
- The Commission's 2017 inquiry on data availability and use recommended a package of broader reforms to make data already gathered by governments and others more accessible. These would complement the healthcare-specific information reforms proposed in this report.
- This report does not propose changes to make health care provided to public patients in hospitals more contestable than currently. Governments are already able to commission non-government providers when they are satisfied that it is possible to sufficiently codify and enforce the performance required by an external contractor.

The Commission proposes a number of reforms to improve published information on individual hospitals (including outpatient clinics), specialists and allied health professionals (table 11.1).<sup>1</sup>

**Table 11.1 Overview of proposed health information reforms**

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Strengthened government commitment to public reporting</b>		
<b>Recommendation 11.1</b>		
Australian, State and Territory Governments to adopt a general policy of publicly releasing any data they hold on individual hospitals (including outpatient clinics), specialists and allied health professionals, unless clearly demonstrated that it would harm the interests of patients or breach privacy protections.	12 months <sup>a</sup>	Cost of renegotiating relevant parts of health funding agreement between governments, but publishing more information would support choice and improve patient outcomes by encouraging self-improvement by healthcare providers.
Australian, State and Territory Governments to make data on individual hospitals, specialists and allied health professionals available in a format that other organisations can readily include in advisory services they provide.	As soon as practicable	Wider dissemination of information that supports choice and facilitates provider self-improvement.
Australian Government to require specialists to participate in public information provision in return for being eligible to provide any service that attracts a Medicare benefit.	12 months <sup>a</sup>	Cost of amending legislation. Extra compliance costs for specialists but will facilitate self-improvement and support choice.
State and Territory Governments to require all specialists serving public patients to participate in public information provision.	12 months <sup>a</sup>	Extra compliance costs for specialists and data processing costs for governments, but would facilitate patient choice and provider self-improvement.
<b>Improve the MyHospitals website</b>		
<b>Recommendation 11.2</b>		
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 individual hospitals, specialists and allied health professionals. Australian, State and Territory Governments to provide relevant data and other assistance.	Phase-in as soon as practicable	Cost of data development and website redesign. Better informed patients and will encourage provider self-improvement.
<b>Review progress of reforms</b>		
<b>Recommendation 11.3</b>		
Australian, State and Territory Governments to review above reforms after three years.	Three years	Cost of review but may lead to reporting that is more effective in supporting choice and self-improvement.
<sup>a</sup> Adoption of the recommended policy or requirement would be followed by the phasing-in of public reporting over more than 12 months, where needed to develop and collect comparable data in collaboration with jurisdictions, service providers, consumer groups and other interested parties.		

<sup>1</sup> The term ‘specialist’ is used in this report to refer to medical specialists, not including general practitioners. ‘Allied health professional’ refers to health professionals other than doctors and nurses (such as dentists, audiologists and optometrists).

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The proposed changes have merit in their own right and would increase the benefits of recommendations made in chapter 10 to give patients greater choice over where they receive health services accessed through a referral. The information reforms would also encourage self-improvement by providers of referred health services. Central to the reforms is strengthening and expanding the commitment to public reporting that the Australian, State and Territory Governments made in the 2011 National Health Reform Agreement (NHRA).

The reforms proposed in this chapter would complement broader recommendations made in the Commission's recent inquiry on data availability and use, which called for a number of changes to improve access to, and utilisation of, data across the economy (PC 2017a). This included a new Data Sharing and Release Act, National Data Custodian, and sectoral Accredited Release Authorities to streamline access to datasets.

## 11.1 Introduction

This chapter considers how reforming published information on individual hospitals, specialists and allied health professionals could support greater patient choice, provider self-improvement, and contestability. There is a case for information provision in health care because suppliers typically have a significant information asymmetry over the patients they serve and governments that regulate and fund them (Arrow 1963).

Information provision is particularly important for contestability because governments should only contemplate a contestable model for publicly-funded services in cases where they are able to codify and measure required performance. It is also necessary to publish the collected information to make service commissioners and individual providers more accountable.

Publishing information on individual providers could prompt improved outcomes through two additional channels:

- patient choice (informed patients seeking out better performing providers)
- self-improvement by providers (through benchmarking against their peers).

Much of the research on the effects of publishing information on individual healthcare providers has focused on performance indicators — such as mortality rates — which are often not presented in a consumer-oriented format, cover only a small subset of service characteristics that patients value, and may not be sufficiently specific to a particular illness or treatment to be seen as relevant by individual patients.

This could explain why studies typically find that published performance indicators have rarely influenced choices made by patients (Devlin and Appleby 2010; Dixon et al. 2010; Faber et al. 2009; Fung et al. 2008; Marshall and McLoughlin 2010; NZHQSC 2016a; Totten et al. 2012; Werner and Asch 2005). Other information sources have tended to be more widely used by patients, such as the views of their general practitioner (GP), friends and family (Day and South 2016; Victoor et al. 2012). Further research is required on

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whether there are more consumer-oriented approaches to public reporting which would encourage patients to make greater use of performance indicators (Boyce et al. 2010; Hibbard 2003). There could also be scope to make indicators more specific to the circumstances of individual patients and provide better support to interpret the information.

There is evidence that public reporting encourages health care providers to engage in self-improvement activity, particularly at the hospital level, possibly because of a peer-pressure effect (Bevan 2013; Cacace et al. 2011; Campanella et al. 2016; Chen 2010; Fung et al. 2008; Lamb et al. 2013; Smith et al. 2009; Totten et al. 2012). This suggests that, even if patients do not use performance indicators, it is in the interests of patients to publish the data to encourage providers to deliver more effective services in terms of quality and efficiency, as well as to make them more responsive and accountable.

## **11.2 What information would support choice, provider self-improvement and contestability?**

To support greater patient choice, provider self-improvement and contestability, public information has to describe service characteristics that are valued by patients (as consumers) and governments (as system stewards). Its usefulness will also depend on whether the amount of information, and its presentation, is tailored to the varying capacity and willingness of patients, their supporting GPs, health care providers and governments to use it.

This section gives a broad overview of the types of information that would support greater choice, provider self-improvement and contestability. It is not intended to be a detailed guide or to nominate specific indicators for a particular service characteristic.

### **Supporting patient choice**

GPs would continue to play an important role in supporting patients under the choice model recommended in chapter 10, and so information needs to be accessible and useful to both groups. In some cases, patients may wish to rely solely on their GP to access and interpret the information but patients should, after an initial discussion with their GP, have the option of using available information to make choices independently.

The Commission's proposed choice model would, for referrals to a specialist or allied health professional, facilitate patient choice over either a public outpatient clinic (which in most cases also determines the public hospital a patient is admitted to, if needed) or a health professional working in private practice. To support this model, information would therefore be needed on both individual hospitals and health professionals.

There are many service characteristics that patients can value, including:

- convenience (such as opening hours and distance from a patient's home)

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- waiting time to receive the service
  - out-of-pocket charges (for health professionals working in private practice)
  - courtesy of staff, specialists and allied health professionals
  - amenity of facilities
  - clinical outcomes.

Studies of hospital choice have found that distance from home is a major determinant of which provider is chosen, with patients tending to select the nearest hospital by default (Boyce and Browne 2013; Dixon et al. 2010; Kolstad and Chernew 2009). However, there is also evidence that patients will bypass the nearest hospital when its clinical or other outcomes are significantly worse than other providers (Beckert, Christensen and Collyer 2012; Gaynor, Propper and Seiler 2012; Moscelli et al. 2016).

Patients have bypassed hospitals with worse outcomes despite (as noted above) rarely making choices based on published performance indicators. Studies have found that patients instead tend to rely on their own experience (particularly a bad experience with the nearest hospital), that of friends and family, and the advice of their GP (Day and South 2016; Dixon et al. 2010). In Australia, these sources can provide information that is more relevant to a given patient's illness or treatment options than the (limited) performance indicators that governments currently publish (detailed below). A recent survey showed that Australians have less trust in the information published by governments compared to their own experiences, those of family and friends, and a GP's opinion (Cutler, Gu and Olin 2017).

Patients may wish to trade off different characteristics, such as choosing a closer facility with lower amenity, which suggests that they should be given information on as many traits as possible. However, there is a risk that the amount of information could far exceed what patients are able or willing to process, possibly facilitating indecision rather than choice. A balance therefore has to be struck that provides information with sufficient breadth and detail to assist patients but does not overwhelm them.

A further challenge is to accommodate the possibility of marked differences between patients in their ability and willingness to use information, including because of differences in health literacy (ACSQHC 2014b; Barber et al. 2009; RACGP, sub. DR524; Tasmanian Government, sub. 485; Victorian Healthcare Association, sub. DR531). As noted above, making the information accessible and useful to GPs will help them to support patients to choose.

One way of accommodating the varying ability and willingness among patients to use information is to have an interactive website (or mobile application) that has a limited number of headline indicators, possibly with visual aids such as infographics, but with the ability to drill deeper into the data as desired by an individual patient or their supporting GP. As detailed below, there are already websites in Australia that provide some information on individual hospitals, specialists and allied health professionals but they have significant limitations in their current form.

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## **Supporting provider self-improvement**

The service characteristics reported for the purpose of encouraging provider self-improvement should be largely the same as those for supporting choice, to ensure provider alignment with patient preferences. The key difference is in how the information should be presented, with providers requiring detailed data to benchmark effectively, rather than more consumer-oriented summary measures. As noted above, consumer-oriented measures and the underlying data could be built into a single website (or mobile application), but this is not essential. What is critical is that the data intended for benchmarking are publicly available, rather than being restricted to service providers, and that they name individual providers so as to maximise the incentive to undertake self-improvement.

## **Supporting contestability**

Compared to information that supports user choice, contestability will tend to require greater emphasis on performance indicators that measure clinical and other outcomes, so that governments can monitor whether policy objectives are being met. The indicators are likely to need to be more detailed and technical than those designed for consumers. Timely reporting is also more important so that governments can intervene promptly when underperformance occurs.

A further difference is that governments are more interested than patients in accountability measures, such as levels of expenditure, to understand how well resources are being used to deliver health outcomes. As noted above, patients are largely influenced by convenience (particularly distance from home) but clinical and other outcomes are also influential when the nearest provider is considered to be significantly worse than more distant options.

The next section of this chapter identifies weaknesses in how State and Territory Governments currently monitor a range of performance indicators in their role as system stewards, and give providers access to the data to encourage self-improvement.

## **11.3 How well does current reporting support choice, provider self-improvement and contestability?**

The Commission's inquiry on data availability and use detailed how a large amount of information is collected on the health system for a variety of purposes, including to track activity and expenditure, process insurance claims and maintain electronic patient records (PC 2017a). The Commission has also previously found that the collected data often have limited usefulness due to deficiencies in collection methods, restrictions on who can access the data, and because useful types of information are missing (PC 2015a). As a result, many potential benefits from health data are being forgone (table 11.2).

This section focuses on health data that are relevant to patient choice, provider self-improvement and contestability. Recent reviews of such data in Australia (discussed

below) have found that the large amount of information gathered from hospitals does not always give patients the information they need to be fully informed about choices, service providers to engage in self-improvement, and governments to undertake timely monitoring. An international comparison of health care transparency by KPMG International (2017) suggests that this problem is not unique to Australia.

**Table 11.2 Types of health data, users, benefits and gaps**

<i>Type of information</i>	<i>Potential users and benefits</i>	<i>Key gaps</i>
Performance of individual health care organisations and health professionals (quality, safety, outcomes, costs).	<p>Helps consumers to choose where to obtain treatment.</p> <p>Enables governments, taxpayers and insurers to assess value for money and hold providers to account.</p> <p>Encourages providers to compete to improve performance.</p> <p>Helps organisations to identify good practices and ways to improve quality or reduce costs.</p>	<p>Cost data and quality measures are not reported for all hospitals.</p> <p>Measures of patient experience in hospitals vary across jurisdictions, and are not always timely or comprehensive</p> <p>No performance data currently reported for health professionals.</p> <p>Information on the characteristics of patients treated is not always complete.</p>
Patient health records.	<p>Improves the coordination of care by allowing health professionals to access and share data on individual patients.</p> <p>Reduces risk of medical errors or duplicated testing.</p> <p>Facilitates clinical and epidemiological research (using de-identified data).</p>	Take up of national electronic health records has been modest, in part due to concerns over quality of included information.
Other administrative data.	<p>Facilitates clinical and epidemiological research (using de-identified data).</p> <p>Enables research into policy effects.</p> <p>Supports development of an evidence base for improving medical practice, developing clinical guidelines or evaluating health treatments and technologies.</p>	Many data are collected, but it has been difficult for researchers to access or link datasets.

Source: PC (2015a).

## National reporting by governments

At a national level, patients can access information on individual specialists and allied health professionals on a website maintained by the Australian Health Practitioner Regulation Agency (AHPRA). However, the website is essentially confined to providing registration details so that patients can check that they are dealing with a licensed professional.

There is a significant amount of national reporting on public hospitals, typically under the auspices of the Council of Australian Governments (COAG), but it is not well suited to supporting patient choice, provider self-improvement or contestability. Few of the reported indicators measure patient outcomes, and what is reported is often not disaggregated below state or territory level.

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A further problem is that it is difficult to navigate the data because they are built on a complex system of frameworks and reports. There are currently three main reporting frameworks:

- National Health Performance Framework (NHPF)
- Performance and Accountability Framework (PAF)
- Report on Government Services (ROGS).

A recent review undertaken for the Australian Health Ministers' Advisory Council called for reporting arrangements to be rationalised because the purposes of current frameworks are unclear and overlap (Nous Group 2017). The review recommended a single overarching framework based on the NHPF, with elements of the PAF incorporated as appropriate. Other existing frameworks would be linked and subordinate to the overarching framework.

The review also recommended a shift in emphasis to reporting outcomes because:

Many of the current indicators focus on throughput or output rather than measuring the change or improvement of patient's experience or clinical outcome. This does not provide insight to the effectiveness of the health system at either a patient or population level. (Nous Group 2017, p. 11)

The current specification for the PAF already includes a large number of outcome indicators but many of these are not actually reported due to ongoing data and methodological problems. The PAF is also unusual in being designed to allow reporting at the level of individual hospitals (but not specialists or allied health professionals). For this reason, it was the framework adopted for the MyHospitals website, which is supposed to be a national vehicle for informing patients (box 11.1). In reality, the limited number of indicators currently reported under the PAF has meant that MyHospitals is largely confined to reporting waiting times and other process measures for public hospitals (table 11.3). MyHospitals is even more limited in the information it provides on private hospitals due to their participation being voluntary and, for those that do participate, fewer indicators tend to be reported than by public hospitals.

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#### **Box 11.1      The MyHospitals website**

MyHospitals was established in late 2010 by the Australian Institute of Health and Welfare (AIHW) to provide greater public access to information on hospital performance. The Australian, State and Territory Governments had committed to set up the website as part of the National Health and Hospitals Network Agreement. Their commitment to this initiative was reiterated in the succeeding National Health Reform Agreement in 2011, which described the website as a vehicle for patients to compare available services and performance at different hospitals. It could also be used by GPs to help patients choose a hospital.

The AIHW (sub. DR508, p. 11) noted that 'the website is not solely focused on patient choice and can attract a broad audience, including consumers, clinicians, hospital administrators, researchers/academics, policy makers and journalists'.

(continued next page)

### Box 11.1 (continued)

The website currently has information on more than 1000 public and private hospitals. Users can search for a hospital by state or postcode, view the hospital's profile and the services it offers, see data for some performance indicators, and compare to other hospitals. All public hospitals are listed on the website but only around half of all private hospitals are covered (about 300 establishments) because their participation is voluntary.

In late 2011, COAG endorsed the Performance and Accountability Framework as the basis for performance reporting on individual hospitals. The framework has 17 performance indicators for hospitals but only seven of these are currently reported on MyHospitals (table 11.3). The indicators that are reported largely concern waiting times and other process measures. There is almost no information on the outcomes from specific treatments, apart from average length of stay in hospital for a few conditions. Private hospitals listed on the website tend to report even fewer indicators than public hospitals.

In February 2016, a progress report on two of the indicators not yet reported by public hospitals — the hospital standardised mortality ratio and in-hospital mortality rate for specific conditions — stated that it would not be meaningful or helpful to report them until there was greater national consistency in the data. The report identified inconsistent coding practices between hospitals, differences in admission policies between jurisdictions, and an inability to track patients who are transferred between hospitals. It noted that resolving the problems would require a concerted effort by agencies such as the Australian Commission on Safety and Quality in Health Care, and the AIHW, working with national committees responsible for coding standards, and also with state and territory system managers to align coding practices with national standards.

Sources: AIHW (2016h; sub. DR508); NHPA (2012, 2016).

Table 11.3 **MyHospitals does not report every indicator it is meant to**

Indicator	Reported on MyHospitals? <sup>a</sup>
<b>Safety and quality</b>	
1. Hospital Standardised Mortality Ratio	✗
2. Deaths in low-mortality Diagnostic Related Groups	✗
3. In-hospital mortality rate for selected conditions <sup>b</sup>	✗
4. Unplanned readmission rate for selected conditions <sup>c</sup>	✗
5. Healthcare-associated <i>Staphylococcus aureus</i> infections	✓
6. Healthcare-associated <i>Clostridium difficile</i> infections	✗
7. Rate of community follow-up within 7 days of discharge from psychiatric admission	✗
<b>Patient experience</b>	
8. Measures of patient experience with hospital services	✗

(continued next page)

Table 11.3 (continued)

<i>Indicator</i>	<i>Reported on MyHospitals?<sup>a</sup></i>
<b>Access</b>	
9. Access to services by type of service compared to need	✗
10. Emergency Department waiting times by urgency category	✓
11. Percentage of Emergency Department patients transferred to a ward or discharged within 4 hours, by triage category	✓
12. Elective surgery patient waiting times by urgency category	✓
13. Waiting times for cancer care	✓
<b>Efficiency and financial performance</b>	
14. Relative Stay Index for multi-day stay patients	✓
15. Day of surgery admission rates for non-emergency multi-day stay patients	✗
16. Cost per weighted separation and total case weighted separations	✓
17. Financial performance against activity-funded budget	✗

<sup>a</sup> Indicators reported by public hospitals. Private hospitals listed on the website tend to report fewer indicators than public hospitals. <sup>b</sup> Acute myocardial infarction, stroke, fractured neck or femur, and pneumonia. <sup>c</sup> Acute myocardial infarction, knee and hip replacements, depression, schizophrenia, and paediatric tonsillectomy and adenoidectomy.

## Reporting at a state and territory level

The hospital indicators published at a national level are typically derived from detailed information that State and Territory Governments gather to fulfil their responsibility to oversee the provision of public hospital services.<sup>2</sup>

Among other things, public hospitals are required to report on a large number of performance indicators embedded in service agreements and associated performance frameworks. Targets are set for many of the indicators, which if not met can lead to a graduated system of intervention by the relevant health department (for example, NSW Ministry of Health 2013, 2016b).

State and Territory Governments sometimes give public hospitals access to data gathered from their peers to encourage self-improvement. An example of this is an activity-based management ‘portal’ developed by NSW Health (Damato 2015). In Queensland, public hospitals have access to a graphical tool — termed variable life adjustment displays — which plots differences in actual and predicted outcomes for various clinical indicators and

<sup>2</sup> The data that State and Territory Governments supply for national reporting are specified in a series of national minimum datasets, with the data provided to the Australian Institute of Health and Welfare. This is done in accordance with the National Health Information Agreement, which also specifies a nationally agreed set of performance indicators to be reported. The agreement also commits State and Territory Governments to providing various datasets to the Independent Hospital Pricing Authority to assist its calculation of the Australian Government’s funding contribution for public hospitals.

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compares to the statewide average (adjusted for patient characteristics) to flag when internal review is required (Duckett, Coory and Sketcher-Baker 2007; Queensland Health 2016d). Moreover, some public hospitals have access to international benchmarking data from the health care analysis company Dr Foster.

Governments contribute to the funding of some clinical quality registries, which gather outcomes data on a specific illness or treatment to facilitate improved practice (box 11.2). The Australian Government Department of Health (sub. DR569, p. 4) noted that clinical quality registries are ‘playing a significant role in changing the culture and fear [among specialists] around public reporting’.

### **Box 11.2 Clinical quality registries**

Clinical quality registries are organisations that systematically monitor the quality of health care within specific clinical domains by routinely collecting and analysing health-related information. They use the data to identify benchmarks and variation in clinical outcomes and feed this information back to specialists for self-improvement. Reports may also be provided to hospital management, health care funders, clinical colleges and researchers.

There is significant heterogeneity across registries. Some monitor the quality of care for a specific service, such as blood transfusions or cardiac surgery, while others focus on a particular disease, such as lung or prostate cancer, and some target a range of conditions and services, such as those associated with major trauma. Reporting arrangements vary, with participation sometimes voluntary and coverage limited to a single state or subset of hospitals, while others cover both Australia and New Zealand. Some registries are partly funded by governments but most are managed by a non-government organisation.

There is evidence that clinical registries can facilitate improved quality and safety by both providing feedback to service providers and by publishing performance data on individual providers. Publication is likely to create additional impetus for providers to engage in self-improvement, rather than prompting consumers to seek out higher-performing providers, given that the information generated by registries can be difficult for patients to interpret.

Publishing performance data can encourage self-improvement by not only hospitals and specialists but also providers of prosthetic devices. Catholic Health Australia (sub. PFR350) noted that outcomes published by the National Joint Replacement Registry have often prompted suppliers to withdraw poorer performing devices from the market, even though consumers do not base their choices on the performance data.

Registry data could also be a useful resource for State and Territory Government monitoring of service quality and safety. However, the data are not routinely included in datasets assembled by governments as part of their stewardship role. For example, a 2016 review of hospital safety and quality assurance in Victoria found that many registries did not provide their data to the state health department, even in cases where the registry was partly funded by the Victorian Government. The review recommended that the Victorian Government make its funding of registries conditional on all performance metrics being provided to the state health department and relevant hospital management at the same time as they are fed back to clinical units.

*Sources:* ACSQHC (2014a, 2016); AIHW (2016m); Duckett, Cuddihy and Newnham (2016); Larsson (2012).

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Data collection on individual specialists also occurs as part of self-improvement initiatives in particular specialities. For example, the Royal Australasian College of Surgeons (2017; sub. PFR374) facilitates ongoing improvement through audits of surgical mortality in each jurisdiction in collaboration with the relevant State or Territory Government. Medibank Private and the Royal Australasian College of Surgeons (2016a, 2016b, 2016c, 2016d, 2016e, 2017) have used data on services provided to private patients to inform surgeons about variation in surgical practice and out-of-pocket charges.

Some jurisdictions have been developing patient-reported outcome measures (PROMs), which are emerging as a useful addition to indicators traditionally used to monitor the performance of health care providers (box 11.3).

### **Box 11.3 Patient-reported experience and outcome measures**

Public hospital patients have been surveyed about their experiences for many years, with varying approaches and transparency across jurisdictions. For example, the NSW Bureau of Health Information regularly publishes results for emergency departments, admitted services, outpatient clinics, small hospitals and maternity units. In Victoria, public hospitals are given survey results each quarter. Providers in Queensland have in recent years been given survey results for emergency departments, small hospitals, maternity units and orthopaedic outpatient clinics.

A drawback of patient experience surveys is that they focus on processes rather than health outcomes. There is an emerging trend to address this by using patient-reported outcome measures (PROMs), which ask patients about their health and health-related quality of life. They are the only way to measure some symptoms (such as pain and nausea) and a patient's judgment of their functioning. They can therefore be a useful complement to clinical outcome measures reported by service providers, such as readmission and mortality rates.

The countries most advanced in implementing PROMs at a systemwide level are England, the Netherlands, Sweden and United States. England was a leader in 2009 when it began to require routine collection and publication of PROMs for patients before and after varicose vein, groin hernia, and hip and knee replacement surgery. In the United States, the focus has been on a number of chronic conditions. In the Netherlands and Sweden, PROMs collection is undertaken as part of clinical registries for specific diseases or conditions.

In Australia, the NSW Agency for Clinical Innovation and the Cancer Institute NSW have been leaders in PROMs. Several NSW local health districts have implemented demonstration projects that include small-scale PROMs collections. In Victoria, some providers already collect PROMs and the Agency for Health Information is developing a pilot for a statewide collection. There is also a trend for clinical registries to use PROMs as part of their measurement of outcomes.

To date, evidence on the benefits of PROMs is mixed. Studies have found strong evidence that PROMs have improved patient-provider communication and patient satisfaction but have yet to be widely used by providers as a tool to improve clinical outcomes.

*Sources:* ACSQHC (2012); Boyce and Browne (2013); Chen (2015); Chen, Ou and Hollis (2013); Devlin and Appleby (2010); Duckett, Cuddihy and Newnham (2016); Kyte et al. (2016); NSW BHI (2016); Queensland Health (2016b); Thompson et al. (2016); Victorian DHHS (2016a, 2017d); Williams et al. (2016).

State and Territory Governments do not publish much of the data they gather, particularly on clinical outcomes at the level of individual hospitals, specialists or allied health

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professionals. However, some jurisdictions do release more information than available nationally. For example, the NSW Government regularly publishes hospital-level data online for elective surgery, emergency departments and patient experience (NSW BHI 2017; box 11.3). Similarly, the Queensland Government maintains a website that provides more information on its public hospitals (Queensland Health 2017b). The Victorian, SA and WA Governments also make some hospital-level information available online (SA Health 2017; Victorian DHHS 2017a; WA Department of Health 2017).

The data that State Governments do publish have similar limitations to information on the MyHospitals website, particularly an almost exclusive focus on process measures such as throughput and waiting times for emergency departments and elective surgery. For public outpatient clinics, even the reporting of process measures is very limited, giving patients little information on differences in waiting times between clinics.

The Queensland Government recently released a discussion paper inviting feedback on how it could expand public reporting of quality and safety to drive ongoing improvements in health care (Queensland Health 2017a). A specific policy proposal will be developed after the feedback period ends in October 2017, followed by targeted consultations on the proposal with affected stakeholders.

## **Non-government initiatives to inform choice**

Patients have always been able to draw on the experiences of family and friends when considering alternative providers of health care. As a trusted source of advice, this can have a significant influence on choice. The advent of the internet has created an opportunity for individuals to broaden this to drawing on the experiences of a wider group, although consumers should not rely solely on this source due to the possibility of being misled by fake reviews and websites that give a biased impression by deleting unfavourable posts.<sup>3</sup>

Patient Opinion Australia (POA) operates a website where individuals can search reviews that others have posted on the care they have received at a local health service.<sup>4</sup> The relevant health service can post a response, and this may be followed by a published dialogue between the patient and provider. The website is moderated by POA to ensure published material is not defamatory. If patient feedback is very critical, POA may contact the individual to check that it is sent in good faith.

The POA website was established in 2012 and is modelled on a similar UK website that has operated since 2005. POA is run on a not-for-profit basis. It earns revenue by offering a

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<sup>3</sup> Section 29(1) of the *Competition and Consumer Act 2010* (Cwlth) prohibits false or misleading representations through testimonials but this depends on timely detection of the behaviour. The ACCC (2013) has published a guide on how businesses and review platforms can comply with the law.

<sup>4</sup> It is illegal for user ratings and reviews to be used to advertise regulated health services. However, testimonials are generally allowed on consumer information sharing websites which invite public reviews because they are intended to help consumers make more informed decisions and are not considered advertising (AHPRA 2014).

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subscription service to service providers, which gives them access to tools and support to help staff make the most of patient feedback. Subscribers can also compare how they are doing and generate reports. Over 150 organisations subscribe to POA.

In 2013, health insurer NIB established a website, called Whitecoat, where people can compare local specialists and allied health professionals based on user ratings and reviews. A number of other insurers now also contribute to the website and an online booking service has been introduced. Reviews are sourced from Whitecoat users and clients of affiliated health insurers. Before reviews are published they are moderated, including to ensure that they do not assess a provider's expertise or quality of clinical care. Unlike the POA website, Whitecoat does not include responses from service providers.

Health insurers have also partnered with Healthshare, which facilitates choice through:

- a website where patients can search by location for specialists and allied health professionals working in private practice. The resulting information can include a health professional's special interests, practice locations, hospital affiliations and whether there are out-of-pocket charges for clients of a particular health insurer
- an add-on to the software used by many GP practices which, in addition to a search function similar to the Healthshare website, enables GPs to automatically populate referral letters with patient and specialist details
- a free online service called Specialist Now, which assists patients to find earlier appointments with specialists working in private practice.

## **Weaknesses in reporting limit the case for greater contestability**

In the study report for this inquiry, the Commission observed that there may be scope for State and Territory Governments to use more contestable approaches to commissioning health care that hospitals provide to public patients (PC 2016a). This could be for an individual health service, subset of services, or an entire public hospital.

State and Territory Governments are already able to utilise private sector providers when they wish to. For example, governments sometimes commission private hospitals to reduce elective surgery waiting lists for public patients (Tasmanian Government, sub. 485). Government-operated public hospitals use private providers for pathology and radiology testing.

Governments also have a long history of funding not-for-profit organisations to provide entire public hospitals.<sup>5</sup> The commissioning of for-profit operators to provide public hospitals is rarer, following a series of failed attempts to do so in the 1990s (Australian Council of Trade Unions, sub. 100; Duckett 2013; Illawarra Forum, sub. 444; NSW Nurses

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<sup>5</sup> This includes major public hospitals such as St Vincent's Hospital (Sydney); Mercy Hospital for Women (Melbourne); Mater Adult, Children's and Mothers' Hospitals (Brisbane); St John of God Midland Public Hospital (Perth); and Calvary Public Hospital (Canberra).

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and Midwives' Association, sub. 247; Queensland Nurses' Union, sub. 405).<sup>6</sup> Governments found it difficult to sufficiently codify required performance across the many services provided by an entire hospital, leading to conflicts with operators over contract requirements.

Since the 1990s, governments have developed more robust systems for monitoring levels of hospital activity and expenditure, particularly for acute in-patient services. However, safety and quality remains challenging to codify and enforce in a timely way as part of a service agreement. While there are methodologies to measure some aspects of safety and quality, they require an investment of time and resources to develop and maintain. Examples include efforts to measure mortality rates (box 11.1) and survey patients using PROMs (box 11.3).

The findings of a 2016 review of hospital safety and quality assurance in Victoria suggest that State and Territory Governments have a lot more work to do before they can be confident that performance monitoring in their own hospitals, let alone that of external contractors, is as effective as possible.

... most states monitor only a narrow range of safety indicators, and over-rely on individual incident reports rather than analysing trends. As a result, many health departments in Australia do not know the true rate of complications in their hospitals, how safety varies across the different hospitals they oversee, or whether safety is improving over time. They mostly lack the information required to identify concentrated risks to patient safety, and even the knowledge of whether their existing safety policies are working. (Duckett, Cuddihy and Newnham 2016, p. 8)

Compared to public hospitals, there are currently less extensive reporting requirements for private hospitals, and so State and Territory Governments can be even less well informed about their safety and quality (Australian Healthcare and Hospitals Association, sub. 427; Duckett, Cuddihy and Newnham 2016; Tasmanian Government, sub. 485).

While there is scope for more effective performance reporting by both public and private hospitals, it is unrealistic to expect that it will ever be possible to fully codify and measure every aspect of hospital safety and quality that is valued by the community. Governments will therefore continue to face the prospect that, when commissioning services from an external provider, they will be entering into an incomplete contract in the sense that required performance cannot be fully specified.

Governments are already able to commission non-government providers when they are satisfied that it is possible to sufficiently codify and enforce the performance required by an external contractor. Given this, and in light of the above, the Commission is not proposing changes to make public hospital services more contestable than currently.

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<sup>6</sup> Apart from Joondalup Health Campus in Perth, the few public hospitals currently run by for-profit operators tend to be relatively small facilities located outside capital cities. This includes Mildura Base Hospital, Peel Health Campus, Noosa Hospital and Albury Border Cancer Hospital (Australian Private Hospitals Association, sub. PFR381).

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## 11.4 Proposed reforms

Improving public reporting on individual hospitals, specialists and allied health professionals would support patient choice and encourage self-improvement by service providers. Current gaps in available data can leave consumers (and their GPs) in the dark about what they are choosing. Health care providers and governments can be unaware of prolonged safety breaches — such as occurred at Djerriwarrh Health Services in Bacchus Marsh, Victoria — due to gaps in performance data needed to undertake timely monitoring and give feedback to hospital managers, specialists and allied health professionals (ACSQHC 2015c; Duckett, Cuddihy and Newnham 2016).

The Commission considers that the case for better public information provision is strong. More user-oriented reporting (including, on out-of-pocket charges, courtesy of staff and health professionals, amenity of facilities, experiences of other patients, and clinical outcomes) would further empower consumers and bring additional benefits from the patient choice recommendations in chapter 10. Development of better information should occur concurrently, and not delay, patient choice reforms. More broadly, information provision would be in the interests of patients, facilitate more self-improvement by service providers, and help to strengthen State and Territory Government oversight of service provision.

Many inquiry participants supported publishing more information.

CHA [Catholic Health Australia] supports greater provision and transparency of appropriately risk-adjusted performance information. In doing so, we note that the publication of such information often prompts providers to compare their performance with their peers which results in performance improvement — even where consumers themselves do not change provider in response to the provision of performance information. (Catholic Health Australia, sub. 440, p. 4)

AHHA [the Australian Healthcare and Hospitals Association] in general supports reform recommendations that improve transparency in the health care system to support patient choice and enhance system accountability and efficiency ... AHHA strongly supports the reporting of clinical outcomes data ... (AHHA, sub. DR561, p. 3)

... most health consumer choices are made in a vacuum of relevant and important data. Consumers are just not appropriately supported to make data-driven health choices ... Transparent data drives culture change, and culture change is at the heart of all the intransigence in the health sector to delivering patient-centred care. (Health Consumers' Council (WA), sub. 447, p. 2)

To make informed choices about clinician and/or hospitals services, consumers need access to all levels of information i.e., individual clinician performance, clinician led-team outcomes, and hospital outputs compared with peers. (Jeanette Sheridan, sub. 451, p. 6)

CHERE [the Centre for Health Economics Research and Evaluation] agrees with the Commission's recommendations for the increased availability of currently collected data and the extension of data collections to include more information on clinical and patient-reported outcomes. (CHERE, sub. DR516, p. 5)

The Tasmanian Government supports the proposal to make more information on hospital services available to the public. To gain most advantage from this expanded reporting effort, this initiative

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should be facilitated through the Australian Health Ministers Advisory Council (AHMAC) and devolved to the Australian Institute of Health and Welfare (AIHW) and its policy and data development committee structure. (Tasmanian Government, sub. DR590, p. 23)

... [Alzheimer's Australia is] supportive of the proposed information reforms in strengthening and expanding the commitment to public reporting. A jurisdictional move to a general policy of publishing all data on individual hospitals and specialists, unless it would clearly harm the interests of patients, will be a big step towards transparency and informed decision making for all consumers. (Alzheimer's Australia, sub. DR521, p. 3)

Better information provision would also be consistent with the Australian Charter of Healthcare Rights, which all jurisdictions adopted in 2008 to explicitly acknowledge that patients 'have a right to be informed about services, treatment, options and costs in a clear and open way' (ACSQHC 2008, p. 1).

Some stakeholders raised concerns about specific issues that would arise in shifting to greater public reporting, including privacy constraints and the potential for reported data to provide a misleading impression of relative performance. These issues are discussed further below.

## **Strengthen cross-jurisdiction commitment to public reporting**

The system of national reporting for individual hospitals outlined above is based on commitments made by the Australian, State and Territory Governments in the NHRA. Specifically, as part of their funding agreement for health care, the governments committed to a national system of public performance reporting on every individual public hospital, to use the MyHospitals website as the online vehicle for such reporting, and for the website to allow performance to be compared between hospitals.

The hospital-level data are provided by State and Territory Governments to the Australian Institute of Health and Welfare (AIHW) to process and publicly report an agreed set of indicators. A number of other agreements and technical documents, and cross-jurisdiction committees, support the reporting arrangements. This includes the previously mentioned Performance and Accountability Framework, which details the indicators that jurisdictions have agreed will be reported (listed in table 11.3 above).

The NHRA provides the broad architecture through which the Australian, State and Territory Governments could agree to improve information provision to support greater patient choice and provider self-improvement. There is an opportunity for this to occur as part of broader negotiations for a successor to the NHRA, which the Australian Government Department of Health (sub. DR569) expected to begin before the end of 2017 and lead to a new agreement being finalised in 2018.

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## **Make data available to other information providers**

In addition to publishing information through existing channels, including the MyHospitals website, the Australian, State and Territory Governments should commit to making published data available in a format that enables other organisations to readily incorporate it into advisory services they provide.

For example, to help GPs support patient choice during a consultation, the information could be incorporated into software used by GP clinics, similar to the above-mentioned searchable directory of specialists provided by Healthshare. There may also be scope to include the information in regional Health Pathways services, which are web-based portals being developed to help GPs and other health professionals identify the best pathway for a particular patient, including guidance on referring patients to local specialists. Mobile applications are another potential channel for disseminating information to GPs, as well as directly to patients.

## **Publicly release as much data as possible**

As a general principle, the Australian, State and Territory Governments should commit to publishing the data they hold on individual hospitals, specialists and allied health professionals, unless it is clearly demonstrated that releasing the data would harm the interests of patients. This would also be subject to satisfying protections on privacy, which require the consent of individual people and organisations to release information that identifies them (box 11.4).

As noted above, some states already publish a large number of process measures online for individual hospitals, such as waiting times and number of services provided for elective surgery. In New South Wales, this is done centrally by the Bureau for Health Information, with the data presented in a user-oriented format online with a search facility. The central website could be expanded to publish all hospital-specific performance data gathered by the NSW Government.

It may be less straightforward to do this in other jurisdictions because they do not have as well-developed arrangements for publishing information on individual health care providers. The SA Government noted that:

Many of the existing consumer information dashboards [in South Australia] were initially designed to assist hospital management, clinicians and staff to monitor and manage the flow of patients in emergency departments and inpatient units. It would take a targeted engagement, design and build strategy to re-engineer them to be truly customer focused. (sub. DR571, p. 5)

The MyHospitals website is likely to be a more cost-effective vehicle for disseminating the information across all jurisdictions and so should be used for this purpose.

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## Box 11.4 Privacy protections for health information

### Commonwealth legislation

The *Privacy Act 1988* (Cwlth) specifies how and when personal information can be collected and disclosed by Australian Government agencies and private sector organisations (including private sector providers of health care). Personal information is defined as information or an opinion about an identified, or reasonably identifiable, individual. Such information can generally only be collected if it is reasonably necessary for, or directly related to, one or more of the collecting entity's functions or activities. The information cannot be used or disclosed for a secondary purpose unless a certain condition is met, such as consent from the relevant individual, to comply with a court order, or it is allowed under a public interest determination made by the Australian Information Commissioner.

More stringent privacy protections apply to information held by the AIHW. It is subject to both the Privacy Act and additional requirements in its own legislation — the *Australian Institute of Health and Welfare Act 1987* (Cwlth) — which prohibit the AIHW from releasing information concerning a person — which is defined more broadly than the Privacy Act to include deceased persons and bodies corporate — unless one of the following exceptions applies.

- The data provider has given written permission to release the information to a specific party.
- The AIHW Ethics Committee has approved release of the information and it would be consistent with the terms set by the data provider.
- Release is in the form of publications containing de-identified statistics, information and conclusions.

The AIHW cannot be forced to divulge information protected by its legislation, even by a court of law. Such information is also exempt from the *Freedom of Information Act 1982* (Cwlth).

Audits of surgical mortality have been declared a quality assurance activity under Part VC of the *Health Insurance Act 1973* (Cwlth). This provides a form of qualified privilege which protects audit data on individual surgeons from being disclosed for purposes other than the audit, even to a court, without the surgeon's consent. There is an exception for the Commonwealth Minister of Health to authorise disclosure if it relates to conduct that is a serious offence against a state or territory law. Audit data are also protected by state-based declarations in some jurisdictions.

### State and territory requirements

The Commonwealth Privacy Act does not apply to State and Territory Government agencies, such as public hospitals. Instead, most states and all territories have enacted their own legislation specifically to protect the privacy of health information they hold. An exception is South Australia, which has incorporated some privacy requirements into broader health legislation and issued administrative directions and codes for its agencies to follow. Similarly, Western Australia does not have a legislated privacy regime but government agencies are subject to various confidentiality requirements, and privacy principles are provided for in freedom of information legislation.

*Sources:* ANZASM (2016); (Australian Government) Department of Health (2014); AIHW (2011, 2014b, 2014c; sub. DR508); OAIC (2014, 2017); Royal Australasian College of Surgeons (sub. DR595).

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## Improve the MyHospitals website

The Commission supports the concept of a national website to inform patients and their GPs about individual providers of health care.<sup>7</sup> It could also be a source of information for hospitals, specialists and allied health professionals to benchmark themselves for self-improvement.

A national website should not exclude the development of alternative information services, such as those targeted at GPs (for example, Healthshare's add-on to software used by GP practices) or patients (including through mobile applications), given the Commission's above proposal that governments make their data available in a format that other organisations can readily incorporate in advisory services they provide.

The current national website, MyHospitals, should be seen as a work-in-progress with significant potential for improvement. The breadth of information available to patients in England through the National Health Service (NHS) website, and its consumer-oriented presentation, provides an example of what to aim for (box 11.5).

MyHospitals has been active for more than six years, so now is an opportune time for the AIHW to consider how to improve it. This should include market research on who uses the website currently, who might in the future, their varying needs and health literacy, what indicators are useful to them, and best-practice approaches to presenting health information online.

There may be potential to redesign the website so that it is more user-friendly and intuitive, providing a small number of headline indicators in a format such as infographics but with scope for patients, their GPs and others to drill much deeper into the data as they wish. The AIHW could draw on lessons learned with the NHS website and other overseas examples of information provision (for example, Boyce et al. 2010; Dixon et al. 2010; Gigerenzer et al. 2008; Hibbard and Peters 2003; Kumpunen, Trigg and Rodrigues 2014).

As noted in chapter 4, the Commission has concluded that Australian public reporting on individual hospitals should include ratings for the quality of end-of-life care, similar to those published by England's Care Quality Commission. Quality ratings for other hospital services should also be reported, as occurs in England.

Another characteristic that should be reported is waiting times at individual public outpatient clinics, which governments have rarely published to date. The Queensland Government (sub. DR592, p. 13) was concerned that a significant investment would be required to report waiting times in 'real-time'. However, this is not essential. A similar approach to that already used to report elective surgery waiting times would be a major improvement. For example, governments could use historical data over a recent period to report median, 10th and 90th percentile waiting times by specialty and urgency.

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<sup>7</sup> For patients who are blind or vision impaired, information would also have to be accessible in a format such as audio, large print or braille (Australian Blindness Forum, sub. 412; Vision Australia, sub. 421).

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### Box 11.5      **Information provision in England**

In England, a large amount of consumer-oriented information about health care providers has been made available online. Patients are able to search the National Health Service website for hospitals and health professionals in their area, and compare performance indicators for individual:

- hospitals, divided into various reporting categories (including key facts, efficiency, safety, food, friends and family test, patient-reported outcome measures, reporting culture, cleanliness and infection control, complaints and parking facilities)
- consultants in 14 specialities, with the number of indicators varying between speciality (they can include mortality rates, readmissions, average number of days that patients stay in hospital, and number of procedures performed in the past year).

Indicators are often presented in an easy-to-understand format, such as a tick or star rating, but with scope to drill down into the data to see quantitative results, definitions and data sources.

To give a broader perspective on performance, the hospital indicators include information reported by staff (such as whether they would recommend the facility) and patients (including their perceived health improvement, user ratings and written reviews, and whether they would recommend the hospital to friends and family).

Patients can also see an overall rating that England's health care regulator — the Care Quality Commission (CQC) — has given to individual hospitals. On the CQC website, this can be disaggregated into ratings for individual objectives (safety, effectiveness, caring, responsiveness or well-led) and specific service areas (such as surgery or end-of-life care). By law, hospitals must display their ratings where patients can easily see them (such as the main entrance) and on their website (if they have one).

There are also other websites that patients can turn to for information, including one hosted by the Society for Cardiothoracic Surgery in Great Britain and Ireland, which provides additional detail on the performance of individual surgeons and surgical units.

The AIHW (sub. DR508) and other inquiry participants agreed that it would be worthwhile to consider how to improve the MyHospitals website (Australian Healthcare and Hospitals Association, sub. DR561; Royal Australasian College of Physicians, sub. DR580). The AIHW stated that:

Further research and analysis would be useful in understanding how the website is used by different sections of the public, and how its usefulness may be improved ... The AIHW supports investigating the approaches taken and the measured results achieved by overseas websites, such as the UK's National Health Service (NHS) website, to improve and enhance the MyHospitals website, to further encourage performance improvement. (sub. DR508, p. 11)

The AIHW should, in consultation with governments and other stakeholders, identify gaps in the indicators currently available on MyHospitals and how to address them. Future information provision could include PROMs and results from staff surveys. The lack of progress in reporting clinical outcome measures, such as mortality rates, would also have to be addressed.

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## Phase-in public reporting on individual specialists and allied health professionals

The choice model proposed in chapter 10 would give patients the option of choosing a specialist or allied health professional who works in private practice. Governments and private health insurers already collect some data on health professionals but patients are denied access to all but the most basic information. This is in contrast to England, where patients can access a single government website to search for a specialist or allied health professional working in a particular discipline near the patient's home and, for some professions, view various performance indicators (box 11.5).

In Australia, the MyHospitals website should be expanded to include reporting on individual specialists and allied health professionals, similar to what already occurs in England. The data could also be made available to non-government bodies to incorporate in information services they provide.

The AIHW should consult with governments, health professionals, consumers and other interested parties on what information to report on the MyHospitals website for individual professionals. The arrangements should be underpinned by a joint Australian, State and Territory Government commitment in the (soon to be negotiated) successor to NHRA that there will be public reporting on individual professionals. Reporting would have to be phased-in as specific indicators are developed and associated data assembled and processed by the AIHW. Box 11.6 outlines a potential sequence for doing this.

### **Box 11.6      How reporting on individual health professionals might be phased-in on the MyHospitals website**

Reporting on individual specialists and allied health professionals on the MyHospitals website could be phased-in as follows.

- Provide registration details using information currently published by the Australian Health Practitioner Regulation Agency — including where and when they trained, and any conditions, undertakings or reprimands attached to their registration — but with a search function that makes it easy for patients to search in their region by speciality.
- Add process data on each specialist and allied health professional, such as:
  - location, contact details, opening hours and available parking where they practice
  - out-of-pocket charges (for health professionals working in private practice)
  - number of relevant procedures performed
  - hospitals where they have admission rights.
- In the longer term, report clinical outcomes achieved by individual specialists, such as whether patient-reported outcome measures, mortality, revision and unplanned readmission rates are within an acceptable range. Priority should be given to reporting on procedural specialists where variation in clinical performance can have a large effect on a patient's quality of life.

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A longer-term goal should be to release risk-adjusted information on the clinical outcomes achieved by individual specialists, such as their mortality, revision and unplanned readmission rates. This future work should include development and reporting on PROMs. Priority should be given to reporting on procedural specialists where variation in clinical performance can have a large effect on a patient's quality of life. Governments and professional bodies are best placed to facilitate the collection of comparable data on clinical outcomes. This is not a straightforward task and, if poorly implemented, could mislead consumers and efforts by specialists to improve (discussed further below).

The choice model proposed by the Commission would not enable patients who use the public health system to choose which specialist or allied health professional provides their health care. However, it could still be worthwhile for governments to report on professionals working in the public health system to encourage their self-improvement. Moreover, there is overlap in the workforce for the public and private health sectors, with some specialists treating both public and private patients.

### User ratings and reviews for specialists and allied health professionals

In the draft report for this inquiry, the Commission proposed that the MyHospitals website include user ratings and reviews for individual health professionals. The AIHW (sub. DR508, p. 11) cautioned that this would 'not necessarily align with data quality and other standards' which, as a statistical agency, it is required to adhere to for its traditional performance reporting.

While there are some advantages in well-managed user ratings being linked to clinical information, it is not essential for the AIHW or any other government body to take on this role. Unlike clinical outcome measures (including patient-reported ones) and administrative data (such as waiting times), there is not a strong case for governments to be involved in setting a methodology for user ratings and reviews, or gathering and publishing the information.<sup>8</sup> Non-government bodies such as POA and Whitecoat have already shown capacity to publish user ratings and reviews. Furthermore, these bodies are affiliated with health insurers, which have shown a strong interest in supporting further improvements to better inform consumers.

A small number of participants had more general concerns about user ratings and reviews.

The AMA [Australian Medical Association] is ... opposed to user ratings because they ... risk unwarranted damage to a specialist's reputation [and] ... it is not clear how [the] AIHW could access the patient's clinical records to ensure specialists are not criticised for aspects of treatment they are not responsible for. It is noteworthy the Supreme Court of NSW awarded a medical practitioner close to half a million dollars after being defamed by a discontented former patient in a targeted social media campaign. (AMA, sub. DR589, p. 2)

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<sup>8</sup> User ratings and reviews should not include an assessment of clinical outcomes. That is the role of patient-reported outcome measures (PROMs), where there is a strong case for government involvement.

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User ratings and reviews have the potential to be highly unreliable as performance indicators, insofar as they create opportunities for the reporting of vexatious or vindictive feedback. (Royal Australasian College of Physicians, sub. DR580, p. 7)

... there are significant risks in publishing subjective data such as user ratings as there may be a tendency for such data to be biased, either for or against a service ... In the United States, the use of patient satisfaction ratings contributed to loss of job satisfaction among physicians when they perceive that these ratings could result in adverse professional consequences.<sup>9</sup> Satisfaction may also be more reliant on perceptions that their expectations have been met rather than the healthcare outcomes achieved and may even be harmful if used as a quality of care measure. There are also concerns that performance measurement criteria for clinicians that incentivise high patient satisfaction scores may lead to provision of healthcare driven by patient satisfaction rather than evidence-based practice, although there is little demonstrable evidence for this at present. (Victorian Healthcare Association, sub. DR531, pp. 6–7)

The Commission recognises that a poorly managed system of user ratings and reviews could be abused in ways that are not in the interests of patients or health professionals. The evidence suggests, however, that these risks can be managed. For example, POA and Whitecoat have shown that it is possible to moderate comments and give providers a right of reply, which can help to ensure that user ratings and reviews provide useful information to patients and feedback to professionals that is not captured by other forms of reporting.

## **Address concerns about reporting clinical outcomes for specialists**

As noted above, the Commission proposes that the AIHW phase-in public reporting of clinical outcomes for specialists in collaboration with the relevant professions. Submissions from professional bodies (Australian Medical Association, sub. DR589; Royal Australasian College of Physicians, sub. 473, DR580; Royal Australasian College of Surgeons, sub. PFR374) indicated that their support would be conditional on:

- public reporting being effective in facilitating better outcomes
- data being risk-adjusted to control for casemix differences between specialists
- reported differences in performance being statistically significant
- recognition that teamwork can influence clinical outcomes.

The Commission considers that these concerns can be addressed, as outlined below. The concerns should not be used to deny Australians access to clinical outcomes data that have been available to patients in other comparable countries for many years. Several US states have publicly reported the performance of individual cardiac surgeons since the early 1990s.

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<sup>9</sup> This comment by the VHA (sub. DR531) was based on results from a US survey by Zgierska, Rabago and Miller (2014), which may have been distorted by sample-selection bias, given that there was a low response rate (4 per cent of targeted doctors in a state-level medical society) and emergency-department clinicians were over-represented in responses (57 per cent of respondents). Moreover, the authors noted that they were unable to control for other factors that may influence doctors' perceptions and decision making, such as malpractice concerns.

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In England, the mortality rates of individual cardiac surgeons have been publicly reported since 2005. Reporting has since expanded on the NHS website to include a range of indicators for individual consultants in 14 specialities.

### Effectiveness of public reporting in facilitating better outcomes

Like hospital-level reporting, available evidence indicates that public reporting on individual specialists would encourage them to engage in greater self-improvement activity.

Most studies on the effects of public reporting focus on the US experience with reporting on cardiac surgeons, particularly a significant decline in risk-adjusted mortality following the introduction of the New York State Cardiac Surgery Reporting System (NYSCSRS). The extent to which this decline can be attributed to public reporting, rather than a general trend of improving outcomes from cardiac surgery, has been the subject of much debate. However, there is evidence that the overall decline in mortality rates in New York was partly due to the NYSCSRS (Jha and Epstein 2006; Oakley 2011; Peterson et al. 1998; Smith et al. 2009). Moreover, exposing the mortality data to public scrutiny prompted efforts to address major deficiencies in collection and reporting methods, which would have facilitated more effective stewardship (Harlan 2001).

There has also been a downward trend in risk-adjusted mortality for cardiac patients in England since the introduction of public reporting on individual surgeons (Bridgewater et al. 2007; Shaw, Taylor and Dix 2015). Like the US experience, publishing the data highlighted deficiencies in collection and reporting methods, thereby adding impetus to strengthen information also relevant to stewardship (Bridgewater et al. 2013; Radford et al. 2015; Williams 2013a).

The benefits from specialist-level reporting need to be weighed against the cost associated with collecting and publishing the data. However, much of the data are already collected in Australia, or should be, for stewardship purposes, and so the additional cost of public reporting could be relatively small. For example, audits of surgical mortality already gather data on surgeons in each state and territory of Australia (RACS 2017; sub. PFR374). Publishing the data could, like in other countries, also generate a benefit by giving added impetus to address data deficiencies which hamper the stewardship role of governments.

### Data are risk-adjusted to control for casemix differences between specialists

A common concern about specialist-level reporting is that it could encourage specialists to cherry pick low-risk patients and avoid more complex cases, thereby resulting in inequitable access to care (Australian Medical Association, sub. DR589; Chen 2010; Chou et al. 2015; Hannan et al. 1997; Pearse and Mazevska 2010; Radford et al. 2015; Royal Australasian College of Physicians, sub. DR580; Royal Australasian College of Surgeons, sub. PFR374; Werner and Asch 2005). Most research on this topic is based on surveys of specialists, who sometimes stated that they were more reluctant to treat high-risk cases following the

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introduction of public reporting (Bridgewater et al. 2007; Narins et al. 2005; Schneider and Epstein 1996; Smith et al. 2009; Walker et al. 2013). However, there is little evidence of reporting actually resulting in avoidance of high-risk patients.

It is now common for clinical outcomes to be reported in risk-adjusted terms, which controls for differences in the mix of treated patients and largely removes the incentive for cherry picking. Risk adjustment also addresses the concerns that some inquiry participants had about consumers being misled by clinical outcomes data (for example, Royal Australasian College of Physicians, sub. DR580). The risk-adjustment approach is now well established in England and implemented in collaboration with the professions (box 11.7). The NYSCSRS also publishes risk-adjusted data for individual specialists (NY DOH 2016).

### **Box 11.7      The journey to risk-adjusted reporting in England**

England began a shift to publicly reporting risk-adjusted clinical outcomes for individual specialists in the mid-2000s. Specialists had previously opposed public reporting, partly due to concerns that like-for-like comparisons were not possible. Professor Andrew Street (Centre for Health Economics, University of York) observed that this argument became outdated with the development of risk-adjustment techniques, which in England are now being implemented in collaboration with specialists, but the argument is still used to resist public reporting in Australia.

The excuse no longer holds: like-for-like comparisons are now perfectly possible, as recent experience in England testifies ... The Society for Cardiothoracic Surgery in Great Britain and Ireland led this initiative, collecting data about individual surgeons and devising its own approach to adjusting risk between surgeons ... The Society also evaluated what happened next. Doctors weren't forgoing more risky operations to protect their outcome data, because they were confident the risk-adjustment was correct. And survival rates following surgery improved across the board because doctors compared and questioned their performance relative to their peers. They've published the data annually for hospitals and individuals ever since ... Following this experience, publication of performance data has since been rolled out across the NHS, starting in 2013 with the publication of activity and death rates for hospital doctors in ten specialities ... (Street 2016)

The Royal College of Surgeons of England shifted its position to supporting the release of surgeon-level data from 2013 and stated that:

The objective of publishing the data is to drive forward improvements in care and enable patients to understand far more about the nature of a surgeon's work and their recovery after an operation ... It is believed that, by revealing what others have achieved in their clinical area, surgeons are more likely to reflect on their practice and be inspired to improve while providing patients with accurate information on their surgeon's outcomes. (RCS 2017)

The President of the Royal College of Surgeons from 2011 to 2014, Professor Norman Williams (2013b, p. 1), backed the change because patients 'have a right to know of doctors who are not meeting the standards expected of them' and observed that almost all surgeons in England had consented to releasing their surgical audit data.

This occurred despite many misgivings concerning the accuracy of the risk adjustment, team versus individual performance, risk-averse behaviour ... Despite the drawbacks and the criticisms I have no doubt that the exercise has been a success ... this was a watershed moment for the profession and I am sure that in years to come we will all look back with great pride that we ... adopt[ed] this transparency agenda as a means to drive up standards and inform the public ... Transparency is a potent means of driving up standards for both delivery of care and training ... (Williams 2013a, pp. 250–1)

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As detailed in box 11.8 for mortality rates, risk-adjustment methodologies are already used in Australia to monitor clinical outcomes but the resulting performance indicators are almost never published. The box also illustrates how funnel plots can be used to present risk-adjusted data in a way that facilitates accurate interpretation. The NHS website in England uses an alternative, more consumer-oriented, approach to address concerns about how the data could be misinterpreted. Mortality, revision and unplanned readmission rates are simply presented as being ‘OK’ if they are within an acceptable range, rather than publishing precise rates which may differ between specialists but not by so much as to be statistically significant. The underlying data are available for those who are interested.<sup>10</sup>

### Box 11.8      **Measuring risk-adjusted mortality rates**

Mortality rates are often used as a measure of clinical performance because there is a clear outcome (death) to measure. However, without risk adjustment, much of the variation in this indicator over time and between providers could be due to differences in patient characteristics, rather than the performance of service providers.

Risk-adjusted mortality rates are now regularly calculated in several jurisdictions using routinely collected data, including Queensland, Canada, England, the Netherlands, and Scotland. Moreover, the Australian Commission on Safety and Quality in Health Care has developed national coefficients to assist jurisdictions within Australia to risk-adjust two measures of mortality (the hospital standardised mortality ratio and condition-specific mortality for four conditions). However, mortality rates are rarely published at a service provider level in Australia.

A key step in risk adjustment is to use a logistic regression model to estimate coefficients for various risk factors — such as patient age, gender, comorbidities and type of admission — that quantify how the probability of mortality has varied with each factor across a population of service providers. The results are then used to estimate an *expected mortality rate* for each provider, based on the characteristics of its patients.

The risk-adjusted mortality rate for each provider is often presented as the ratio of its actual to expected deaths. In essence, this ratio compares actual outcomes for the provider's set of patients with the outcomes expected if its patients had been treated by the average provider. Hence, each provider is compared with a hypothetical average provider treating the same patients, not another actual provider that treated different patients. For this reason, it can be misleading to compare risk-adjusted rates between providers.

An Australian example is the 30-day risk-standardised mortality ratio published by the NSW Bureau of Health Information for hospitals treating five clinical conditions (acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip-fracture surgery). If this ratio is less than one, it indicates that a hospital has lower than expected mortality compared to the hypothetical average NSW hospital that treated the same group of patients. However, small deviations from one are not considered to be meaningful.

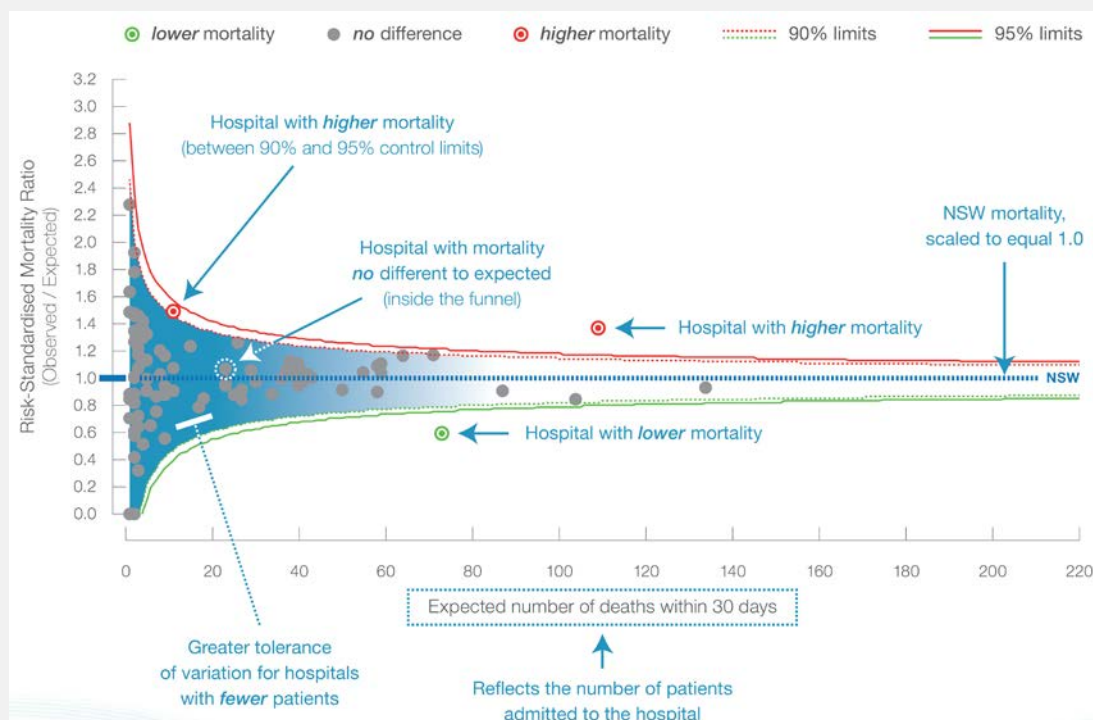
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<sup>10</sup> In contrast, the US Hospital Compare website only publishes a qualitative rating for (hospital-level) mortality (possible ratings are worse than, no different than, or better than the national average). Joynt et al. (2016) noted that this limits the peer-pressure effect of public reporting (especially because few hospitals are rated as different from the national average) and so could explain why a downward trend in mortality rates did not accelerate after public reporting began in 2008.

## Box 11.8 (continued)

Funnel plots (illustrated below) are used to show when there is a high level of confidence that a hospital's mortality ratio is greater than expected.



Hospitals with fewer patients (appearing towards the left-hand side of the figure) tend to have greater variability in deaths simply by chance and so the funnel's 90 and 95 per cent confidence limits are wider. A mortality ratio above the 90 per cent limit of the funnel is interpreted as the hospital having higher than expected mortality, based on the patients it treated. If a hospital is outside the 95 per cent limits, there is greater confidence about its outlier status.

Sources: ACSQHC (2014c, 2015b); AHRQ (2014); Ben-Tovim et al. (2009); Brand et al. (2013); CMS (2017a, 2017b); Dr Foster (2014); Flowers et al. (2010); NHPA (2012, 2016); NHS Digital (2016); NHS Scotland (2011, 2016a, 2016b); NSW BHI (2013, 2015b); NY DOH (2016); Taylor and Aylin (2014); YNHSC and CORE (2017).

No risk-adjustment methodology is perfect because it can only control for risk factors that are measured and depends on the quality of data and modelling (AHRQ 2014). However, as the support of specialists and their associations in England demonstrates, public reporting of risk-adjusted indicators has gained acceptance over time as publication has driven improvements in methodologies and associated data.

Another essential element in gaining the support of specialists, and ensuring that reporting is not misleading, is to give specialists an opportunity to review and comment on their performance data prior to release. The Royal Australasian College of Physicians (sub. DR580) noted that data currently gathered by Australian jurisdictions are not generally made available to the relevant specialist and there is no opportunity for them to provide a rationale for any disparity, variation or poor outcome.

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## Reported differences in performance are statistically significant

In some cases, a specialist's reported performance may differ from the average for his or her peers, but not by a sufficiently large amount to be statistically significant in the sense that there is a high probability that the difference is due to more than chance. To identify performance differences that are statistically significant, it is common to publish a confidence interval around the peer average, beyond which there is a high probability (usually 90 or 95 per cent) that a provider's performance is truly above or below the peer average. An example is illustrated in box 11.8 for hospital-level reporting of mortality rates.

For specialists, the confidence interval will tend to narrow as the frequency of the relevant procedure (such as cardiac surgery) and measured outcome (such as mortality) rises, thereby increasing the indicator's statistical power to identify genuine differences in performance.

The Royal Australasian College of Surgeons (sub. PFR374) noted that a 2016 NZ Government review had decided not to support specialist-level reporting partly because overseas experience had shown that the typical caseload of specialists is unlikely to be sufficiently large to provide the statistical power needed to identify real differences in performance (NZHQSC 2016b).

This conclusion was largely based on a study by Walker et al. (2013), which analysed the statistical power of mortality rates for four types of surgery in England.<sup>11</sup> However, in the case of cardiac surgery, the authors concluded that the number of procedures undertaken by individual surgeons was 'sufficient to allow the process of detection [of poor performance] to operate with reasonable statistical power' (Walker et al. 2013, p. 3), although this was based on a relatively low bar for defining poor performance and an acceptable rate of detection.<sup>12</sup> A similar result was found for hip-fracture surgery but the likelihood of identifying poor mortality rates in the other two types of surgery was much lower. To achieve an acceptable level of statistical power, the authors recommended:

- using data for a longer period (such as three years) to increase the number of procedures for a given specialist, although this reduces the timeliness of reporting
- measuring only outcomes that occur frequently for the relevant procedure
- only reporting at a team or hospital level when the detection rate for individual surgeons with poor performance would be less than 60 per cent.

The mortality rates reported for cardiac surgeons in England and New York are based on data over three years. Moreover, Walker et al. (2013) concluded that mortality is sufficiently common to be a useful indicator for cardiac surgery. This is not always the case for other

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<sup>11</sup> The four types of surgery were adult cardiac surgery; oesophagectomy or gastrectomy for oesophagogastric cancer; bowel cancer resection; and hip-fracture surgery. The Victorian Healthcare Association (sub. DR531) also cited Walker et al. (2013) as evidence that small caseloads hinder meaningful reporting.

<sup>12</sup> Poor performance was defined as a 95 per cent probability that the surgeon's mortality rate was twice the national level. It was estimated that 69 per cent of cardiac surgeons did enough procedures over a three-year period to be detected in seven out of ten cases when they truly met this definition of poor performance.

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specialities and so consideration would have to be given to measuring other outcomes. Indeed, the specialist-level performance indicators published in England vary between the 14 specialities where reporting occurs. Whether reporting would have insufficient statistical power even after pooling data over a longer period and measuring more frequent outcomes is a matter that can be judged on a case-by-case basis for individual specialities.

### **Recognition that teamwork can influence clinical outcomes**

The Royal Australasian College of Surgeons (sub. PFR374) said that it supported the release of performance data at the team level, but not individual specialists, because medical interventions in public hospitals are provided by teams and serious failures in health care are often related to systemic issues rather than individual competence. The NZ Government review that the Royal Australasian College of Surgeons referred to went further by arguing that publishing the results of individual surgeons seems likely to promote individualistic behaviour and that, if it is team-based medicine that is to be encouraged, it does not seem sensible to publish data based on one team member (NZHQSC 2016b). Similarly, the Royal Australasian College of Physicians (sub. DR580, p. 7) argued that reporting outcomes for individual specialists would ‘disrupt the team work environment by incentivising people to act in a ‘tick the box’ fashion to satisfy indicators even if this is at the expense of collaboration’.

The Commission agrees that clinical outcomes in hospitals are often the result of teamwork which can include, among others, surgeons, anaesthetists and nurses. Moreover, there may be value in reporting performance at a team or unit level, particularly when the caseload of individual specialists in a particular speciality is too low to provide much statistical power. However, claims that specialist-level reporting conveys no useful information and undermines teamwork are overstated.

The Commission has not seen any evidence that specialist-level reporting in England, the United States or other countries has led to a systemic problem with individualistic behaviour undermining teamwork. The fact that such reporting is supported by the Royal College of Surgeons of England and the Society for Cardiothoracic Surgery in Great Britain and Ireland (box 11.7) suggests that the benefits far outweigh the negative effects, if any, on teamwork. In Australia, the audits of surgical mortality that the Royal Australasian College of Surgeons oversees in each jurisdiction in collaboration with State or Territory Governments gather information on the outcomes of surgeons and provide feedback to them on their performance.

### **Facilitate progress in improving reporting**

Progress in improving reporting, especially on clinical outcomes, has often been slow, as illustrated by the prolonged development and indefinite timeframe to publish the safety and quality indicators that are supposed to be on the MyHospitals website (box 11.1 and table 11.3). Too often it has taken the exposure of a major safety incident to provide the impetus to reform reporting. A recent example was an announcement by the Victorian

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Government (2016) that, following safety breaches at Djerriwarrh Health Services in Bacchus Marsh, it would implement a significant package of improvements to the collection, use and publication of data on health service delivery.

While slow progress in improving reporting can sometimes be explained by the complexities of measuring outcomes, another barrier has been a reluctance among governments, hospitals and health professionals to be exposed to greater public scrutiny. This is despite clear evidence showing that it is in patients' interests for performance data to be published because of its positive effect on provider self-improvement. Paternalism can also be a barrier to improved reporting, with patients seen as being incapable of interpreting information if they were allowed to see it (Mead 2017). A further barrier can be data perfectionism, where the default position is that any information which is less than perfect must be withheld from the public because they would be easily misled.

The Commission's above proposal to strengthen the cross-jurisdiction commitment to public reporting in the successor to the NHRA, including to release as much data as possible, should convey a clear expectation to all stakeholders that reporting must be improved. However, the Commission recognises that this will not guarantee progress, given past resistance to change. It is therefore also recommended that there be a review of progress in improving reporting three years after the successor to the NHRA comes into force.

In the case of specialists, it should, as noted above, be possible to address their concerns about how clinical outcomes are measured and reported. Nevertheless, overseas experience suggests that they may still be reluctant to be exposed to greater transparency. In England, resistance to releasing data on individual surgeons was eventually overcome by the combination of a 2001 public inquiry, which highlighted a lack of transparency regarding a notorious case of malpractice in cardiac surgery, and the subsequent introduction of freedom-of-information legislation enabling *The Guardian* to force the release of mortality data for individual heart surgeons in 2005 (Bridgewater et al. 2007; Guardian 2005; Kennedy et al. 2001; NZHQSC 2016a, 2016b; Street 2016; UK Department of Health 2002). Similarly, the longest-running US reporting program — the NYSCSRS — was forced to begin releasing data on individual surgeons in 1991 when it lost a freedom-of-information lawsuit initiated by the publication *Newsday* (Barua and Esmail 2011; Harlan 2001; NZHQSC 2016a, 2016b).

In Australia, public reporting on the performance of individual specialists would, as proposed above, have to be developed and implemented in collaboration with the relevant professions to ensure the data are useful and that privacy protections are respected. However, this should be accompanied by a clear expectation from governments that there would be widespread participation by specialists in information provision. In particular:

- the Australian Government should require specialists in private practice to participate in public information provision in order to be eligible to provide any service that attracts a Medicare benefit<sup>13</sup>

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<sup>13</sup> It would be impractical to limit this eligibility test to only private outpatient services that lead to an elective hospital admission as a public patient. As the Australian Medical Association (sub. DR589) noted, that would be difficult for Medicare to administer, increase billing complexity for specialists, and create uncertainty for patients.

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- State and Territory Governments should require specialists treating public patients to participate in public information provision.

#### RECOMMENDATION 11.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the (soon to be negotiated) successor to the National Health Reform Agreement, with the aim of better supporting patients and their general practitioners to exercise patient choice, and encouraging performance improvement by service providers. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in recommendation 11.2
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals (including outpatient clinics), specialists and allied health professionals, unless it is clearly demonstrated that releasing the data would harm the interests of patients or breach requirements to protect privacy
- make the information that a jurisdiction publicly releases on hospitals, specialists and allied health professionals available in a format that other organisations can readily incorporate in advisory services they provide.

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

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that specialists are required to participate in public information provision in order to be eligible to provide any service that attracts a Medicare benefit
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision.

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#### RECOMMENDATION 11.2

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

- draw on lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England
- be based on market research on who would use an improved MyHospitals website, how their needs and health literacy vary, what indicators are useful to them, and how they could be informed by using best-practice approaches to presenting health information online
- put greater emphasis on reporting outcomes, such as by publishing patient-reported outcome measures and clinical outcomes such as readmission rates
- include reporting on waiting times at individual public outpatient clinics and ratings for the quality of end-of-life care and other services in hospitals (similar to ratings published by England's Care Quality Commission)
- phase-in reporting on individual specialists and allied health professionals as data become available, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.

#### RECOMMENDATION 11.3

The reforms detailed in recommendations 11.1 and 11.2 should be reviewed by the Australian, State and Territory Governments three years after the successor to the current National Health Reform Agreement comes into force.



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## 12 Reforms to underpin more effective provision of public dental services

### Key points

- People who receive public dental services in government operated clinics have little choice over who provides their care, when and where.
- Ad hoc use of fee-for-service vouchers has not resulted in a systemic improvements in user choice or the effectiveness of public dental services.
- Dental conditions are largely preventable, but public dental services do not focus on the preventive care needed to improve patients' oral health.
  - Patients too often require complex — and costly — emergency and restorative treatments. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015-16.
- Without timely access to care, oral disease can give rise to significant costs:
  - for individuals these include pain, discomfort, infection, and detrimental effects on their broader health and wellbeing
  - for governments, complications can lead to higher costs through more expensive treatments and increased demand for services in other parts of the health system
  - for the community more broadly, costs include productivity lost through reductions in a person's capacity for economic and social participation.
- Time to treatment is therefore an important metric for service effectiveness. Public performance reporting of patients treated within clinically-acceptable waiting times (benchmarked by risk category) would improve accountability and identify areas for performance improvement.
- Governments should develop oral health outcome measures to improve their understanding of the effects of public dental services on users' oral health. Outcome measures also improve the focus on the user and have a range of uses in analysing, planning, commissioning and paying for public dental services.
- Public dental services largely exist in a silo with little integration with the broader health system, or between the public and private dental sectors.
  - Governments should adopt digital oral health records to assist in tracking patients over time and across services, improve triaging processes and facilitate user choice with portability of a person's dental records.
- These reforms would enable governments to improve their stewardship of public dental services and provide the information for governments to better identify people at high risk of oral disease within the user population, including those who do not currently present to public dental services. They also underpin broader reforms to shift the focus of public dental services to targeted preventive care.

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Access to high quality, timely dental care can alleviate oral health problems, reduce pain and improve a person's quality of life. The most common barriers to accessing dental care are cost, including dental fees, and the location of a dental practice, particularly for people living in remote areas. Limited access to dental care can result in dental problems going untreated, giving rise to a range of other costs, including increasing pain and difficulty eating, and potentially avoidable hospital admissions. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2015-16 (AIHW 2017a).

State and Territory Governments are primarily responsible for delivering public dental services, with funding support from the Australian Government through the Child Dental Benefits Schedule (CDBS) and National Partnership Agreements. In 2015-16, State and Territory Government expenditure on dental services was \$761 million and Australian Government expenditure was \$792 million (AIHW 2017c). Australian, State and Territory Governments have developed a National Oral Health Plan that is intended to provide strategic direction and a framework for collaborative action (COAG Health Council 2015). While the National Oral Health Plan outlines guiding principles for improvements to the oral health system, it does not contain mechanisms to translate the plan into practice.

Unlike hospital care, public dental services are not open to all through universal access arrangements. Public dental services provide safety net access to basic dental care for eligible users who face financial and other barriers to accessing care, such as some people with disability. People with low-incomes are able to access public dental services with eligibility leveraging off criteria for other government services.<sup>1</sup> In March 2014,<sup>2</sup> there were approximately 5.3 million adults holding relevant concession cards (unpublished data from the Department of Social Services), representing about 23 per cent of the Australian population. Eligibility is somewhat wider for children.<sup>3</sup> As at 1 January 2014, there were approximately 3.1 million children eligible for the CDBS (Australian Government 2016c), representing an additional 13 per cent of the population. Hence, in the most recent comparable year, 2014, approximately 36 per cent of the population was eligible for publicly funded dental services.

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<sup>1</sup> Eligibility for adults is determined through holding a concession card (a Commonwealth Health Care Card or Pensioner Concession Card, and in New South Wales and Queensland a Commonwealth Seniors Health Card which has a broader eligibility criteria). These concession cards are typically issued to those receiving Commonwealth social security income support payments such as the Age pension, Disability Support Pension or Newstart allowance. In the Northern Territory eligibility also includes all remote residents living 100 kilometres or more from a private dental practice, and identified special needs groups (such as rheumatic heart disease and cancer patients).

<sup>2</sup> More recent data are available for adult concession card holders. In March 2017 there were 5.5 million card holders, representing a similar proportion (23 per cent of the population) to that observed in March 2014 (DSS 2017c). More recent public data on the number of children eligible for the Child Dental Benefits Schedule are not publicly available.

<sup>3</sup> All children are eligible for public dental services in New South Wales, South Australia, Tasmania and the Northern Territory. Various age limits apply in the other states and the ACT. The Australian Government's CDBS is a means-tested program for children.

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The remaining two thirds or so of the Australian population are ineligible to receive publicly funded dental services. They access dental care through the 13 100 private dental providers who operate throughout Australia (ABS 2016b). These providers usually practise in small, sometimes single dentist, clinics, although this is changing with the emergence of larger practices that are often associated with health insurance companies. Patients pay for the dental care they receive, sometimes with contributions from their private health insurance covering all or part of the cost.

Public dental services are provided predominately through public dental clinics. State and Territory Governments own and operate these clinics and staff them with salaried dental professionals. The current emphasis on government provision of public dental services can limit the ability of patients to choose their dental professionals and the time and location of treatment.

Many participants to the inquiry, including the Australian Dental and Oral Health Therapists' Association (ADOHTA sub. DR526), Australian Healthcare and Hospitals Association (AHHA sub. DR561) and cohealth (sub. DR584), argued for more funding for public dental services. High levels of demand and government funding constraints mean that public dental services focus on seeing the most urgent cases first and place patients seeking general care on a largely 'first come, first served' waiting list. At the end of June 2017, there were some 100 000 adults in New South Wales alone waiting for general dental care in the public system — of which, about one quarter were not seen within the clinically-accepted benchmark time (Centre for Oral Health Strategy 2017a). While waiting times for non-urgent public dental care vary across jurisdictions and over time (with variations in funding), public patients can wait up to three years to receive care (SCRGSP 2017).

Moreover, not everyone eligible for public dental care seeks it. Between 2014-15 and 2015-16, only 31 per cent of the eligible population in Victoria accessed public dental services or joined the waiting list (VAGO 2016). Uptake of the CDBS has also been low — only 30 per cent of eligible children accessed services in 2014 (ANAO 2015; Australian Government 2016c).

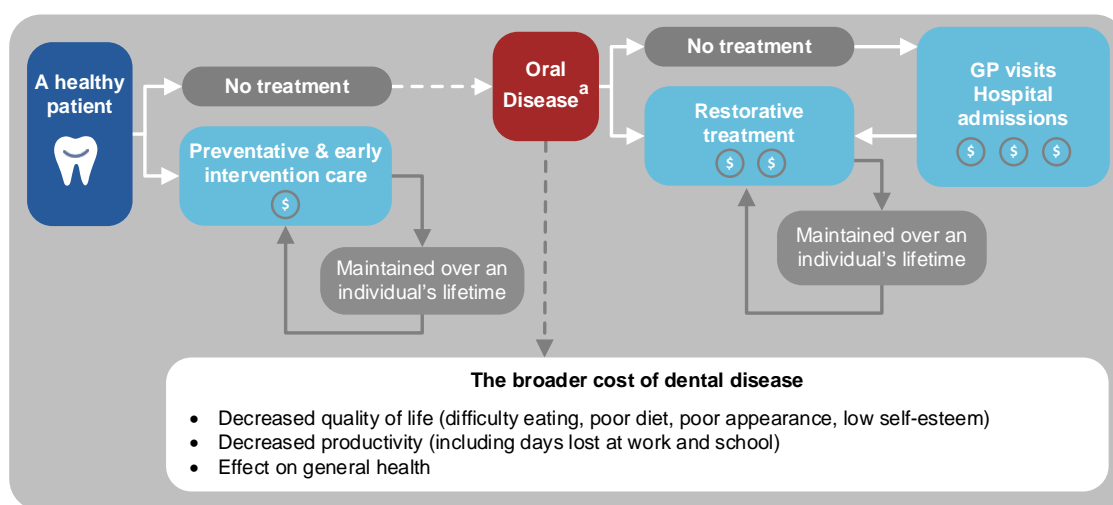
Compared with some other parts of the health system, public dental services have not been a major focus for governments. Public dental services face difficulties in tracking patients over time, and exist in a silo, with little integration with the broader health system. Performance reporting is limited, not comparable between jurisdictions, and does not include patient outcomes. There is therefore considerable scope to improve accountability to those who fund public dental services (governments and users).

This chapter sets out some initial priorities for reform that would underpin a set of broader reforms outlined in chapter 13.

## 12.1 The potential avoidable costs of oral disease

Oral disease costs individuals through pain, discomfort and infection, and has a detrimental effect on their broader health and wellbeing. Oral disease reduces a person's capacity for economic and social participation, and imposes costs on the broader community through increased demand in other parts of the health system and decreased productivity (figure 12.1).

Figure 12.1 A stylised pathway of dental health care and the costs



<sup>a</sup> Oral disease covers a range of disorders, from mouth ulcers and oral cancer to teeth and mouth trauma. The two main forms of oral disease are dental caries (tooth decay) and periodontal (gum) disease, which are largely preventable and reversible if treated early. The Australian Institute of Health and Welfare (AIHW 2002) noted that about 90 per cent of all tooth loss can be attributed to untreated dental caries and periodontal disease.

Many dental conditions are preventable (VAGO 2016). Ensuring timely access to preventive dental care can address conditions at an early stage and avoid the onset of oral disease. Prevention aims to eliminate or reduce the prevalence of oral health problems. Prevention can occur at several stages, both before and after oral disease has arisen. Broadly, there are three types of prevention (AIHW 2014a):

- primary prevention reduces the likelihood of developing oral health problems
- secondary prevention interrupts or minimises the progress of a problem at an early stage
- in cases where oral disease has already occurred, tertiary prevention halts the progression of further damage to teeth and gums.

Restorative treatment (like fillings) can be viewed as a form of tertiary prevention. However, this type of treatment does not address the root cause of oral disease (ADOHTA sub. DR526, North Richmond Community Health, sub. PFR 320). For instance, tooth decay can be prevented, reversed or arrested at several stages (Featherstone 2008). As such, oral health

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conditions are well-suited to primary and secondary prevention. Tooth decay is an infectious disease that can be prevented by: eliminating established bacteria from the mouth (by personal and professional cleaning); increasing the resistance of teeth to decay (through fluoride application or fissure sealants); and control of the sugar composition within an individual's diet (Balakrishnan, Simmonds and Tagg 2000). Preventive approaches to care like the Caries Management System aim to shift the focus toward primary and secondary prevention:

The treatment goal of the CMS [Caries Management System] is to stop the progression of existing lesions, prevent new lesions, and reduce future needs for restorative care. (Warren, Curtis and Evans 2016, p. 107)

Preventive care can have benefits for all users, but these benefits vary between individuals according to their risk factors (box 12.1). The cost of preventive treatments do not vary to the same degree. As such, while the provision of preventive services to all patients may not be cost-effective, a *targeted* preventive approach to dental care (that focusses on individuals at high risk of worsening oral health) can be both clinically and cost effective. Several studies have shown the cost-effectiveness of such targeted preventive approaches to dental care (box 12.3).

However, the way governments currently manage their waiting lists for general care (on a largely 'first come, first served' basis) means that, for those at high risk of oral disease, their oral health deteriorates while waiting to receive care, resulting in potentially large avoidable costs to public dental users, governments and the community (discussed below).

The avoidable cost of oral disease has three important implications for the effective delivery of public dental services. First, the time to treatment is an important metric for service effectiveness (section 12.2). Second, governments need to identify people who are at high risk of oral disease (section 12.2) and commission services to lower barriers for, and engage with people reluctant to seek dental care (chapter 13).

Third, reforms to public dental services that shift the focus from treating existing conditions to delivering targeted preventive care and early intervention would improve the oral health of the eligible population. Reforms to give public dental users greater choice over their dental provider can generate incentives for providers to be more responsive to patients' needs — to provide the right treatment at the right time. (Long-term reforms to introduce consumer-directed care and encourage the delivery of preventive care to public dental patients are discussed in chapter 13.)

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## Box 12.1      **Who is at high risk of oral disease?**

Oral health is influenced by:

- behavioural factors, such as smoking and alcohol consumption, diet, stress, and hygiene
- biological factors, such as the shape and vulnerability of teeth to external influences, and other genetic conditions such as cleft lip and palate
- medical conditions, including taking medications that can alter the flow of saliva and increase the risk of dental caries (tooth decay)
- environmental factors, such as policies to support access to services and water fluoridation
- cultural factors
- socioeconomic factors, which affect an individual's ability to access dental treatment and preventive care, and have been linked to behavioural factors like sugar, tobacco and alcohol consumption.

The interaction of these factors determine an individual's risk of developing particular conditions and their oral health needs. The risk of developing common forms of periodontal (gum) diseases, for example, has been associated with: age, smoking, infrequent dental visits, low education and income levels, and some medical conditions (including diabetes and osteoporosis).

Sub-population groups may face multiple risk factors and, as a result, experience a high burden of oral disease. Based on survey and administrative data, de Silva et al. (2016) identified a range of risk indicators to identify communities at high risk of oral disease including, for example, personal behaviours of the population, use of services and disease outcomes. The authors suggested that these population level indicators could be used to develop a framework for assessing community level risk to use as a basis for allocating public dental services.

Targeting and individual risk assessment can play an important role in improving the oral health of the population. To help address oral health inequalities, the National Oral Health Plan identified four priority populations that experience the greatest burden of oral disease and most significant barriers to accessing care. The identified populations were:

- people who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander people
- people living in regional and remote areas
- people with additional and/or specialised health care needs (including people living with mental illness, people with physical, intellectual and developmental disabilities, people with complex medical needs, and frail older people).

The plan also suggested that the frequency of check-ups and oral health care should be determined through individual risk assessments.

*Sources:* AIHW (2002); COAG Health Council (2015); DHSV (2011); de Silva et al. (2016).

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## The costs to quality of life and general health

Poor oral health can lead to difficulties with eating, sleeping, socialising and working without pain or embarrassment. Dental conditions with cosmetic, but not necessarily painful, symptoms can also affect a person's wellbeing.

Dental disease can affect the way a person looks and sounds, with a significant impact on wellbeing – a person whose appearance and speech are impaired by dental disease can experience anxiety, depression, poor self-esteem and social stigma which in turn may inhibit opportunities for education, employment and social relationships. (NACDH 2012, p. 15)

Poor oral health can affect an individual's overall nutrition and has been associated with a number of other diseases, such as heart and lung infections and stroke. Poor oral health can also cause complications when interacting with other conditions. For example, gum disease can affect a person's blood sugar intake and increase the risk of diabetic complications (CHC 2015).

These costs to individuals' wellbeing are difficult to quantify, but very real.

In 2013, about one quarter of surveyed adults reported feeling uncomfortable about their dental appearance (AIHW 2015c). In the same year, one fifth of surveyed adults reported avoiding eating certain foods because of problems with their teeth (AIHW 2015c). These issues were more prevalent among adults eligible for public dental care, with one third reporting feeling uncomfortable with their dental appearance and 29 per cent avoiding eating certain foods.

## The costs to the economy from reduced productivity

Oral disease can have a negative effect on productivity through time lost due to dental problems and related treatments, that would otherwise be spent working or studying.

Using self-reported survey information on days missed from work or study and days of reduced activity because of dental problems in 2010, the Australian Research Centre for Population Oral Health (ARCPOH 2012) estimated that:

- there were approximately 2.4 million occasions per year of people taking half a day or more from work or study. Assuming that individuals were away on average for three quarters of a day, the average cost to the economy in lost productivity was estimated to be approximately \$453 million annually
- in addition, there were approximately 1.6 million occasions per year of people cutting down on their usual activity. Assuming that lost time for these individuals accounted for on average one quarter of their day, the average cost to the economy in lost productivity was estimated to be approximately \$103 million annually
- the combined cost to the economy from lost productivity was estimated to be in the order of \$556 million annually.

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Getting a handle on the true productivity lost from a lack of publicly-funded preventive care is difficult. On the one hand, not all of the estimated self-reported productivity costs will be for dental problems that were avoidable, and not all will be attributable to those eligible for public dental services. On the other hand, as noted by the Australian Research Centre for Population Oral Health (ARCPOH 2012), the analysis does not include the value of missed time and reduced activity for people not in paid employment or study.

## **The costs to the health system**

People who have untreated dental conditions may seek treatment for pain and infection from other health services, including GPs and hospitals. GPs and emergency departments are, however, generally unable to provide comprehensive urgent dental treatment, requiring patients to seek further care from a dental provider (Cohen 2013).

With little integration with the broader health system, public dental services face difficulties in tracking the health outcomes of their patients over time. The true cost to the health system from treating public patients for preventable oral disease is, therefore, not well understood. The limited information that is available tends not to distinguish the population eligible for public dental services from the wider population. For this reason, care is needed not to overstate the potential cost savings to the health system from publicly-funded preventive care.

### **Potentially preventable GP visits**

In 2011, over 750 000 GP visits were estimated to be for dental problems and complaints. In these visits, GPs usually provided prescriptions for painkillers and antibiotics, referred patients to dentists, or provided advice on dental hygiene (NACDH 2012). Under the 2017 Medicare Benefit Schedule, the cost to the Australian Government of 750 000 visits to the GP for dental problems could be close to \$28 million annually.<sup>4</sup> The demand for prescribed antibiotics also has cost implications for the Pharmaceutical Benefits Scheme, the size of which is unknown (NACDH 2012).

### **Potentially preventable hospitalisations**

People who have untreated dental conditions also seek treatment for pain and infection in hospitals. As noted above, dental conditions were the second-highest cause of acute potentially preventable hospitalisations — accounting for about 67 000 admissions in 2015-16 (up from approximately 64 000 admissions in 2013-14) (AIHW 2017a). These are hospitalisations for conditions that potentially could have been avoided if timely and

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<sup>4</sup> This highly indicative estimate of the cost to the Medicare Benefit Schedule assumes that each visit to the GP would take place at the GP's consulting rooms for less than 20 minutes and, therefore, would be eligible for benefit of a \$37.05 per appointment in 2017 (Department of Health 2017j).

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adequate non-hospital care had been provided. These conditions include dental caries, periodontal disease, cysts and other disorders of teeth and supporting structures (Rogers 2016).<sup>5</sup>

Using data from the Victorian Admitted Episode Dataset, Rogers (2016) found that in 2013-14 hospitalisation rates for potentially preventable dental conditions were highest among young children (particularly children aged 5 to 9 years), for whom the main cause was dental caries (tooth decay). The potential benefits from avoiding more costly interventions are not limited to children — the same data show that people aged over 65 accounted for almost 15 per cent of avoidable hospitalisations.

Rogers (2016) estimated that expenditure in public and private hospitals for approximately 15 000 potentially preventable dental hospitalisations was close to \$56 million in Victoria in 2013-14 — that is, an average cost of \$3733 per patient. Assuming this average cost, the estimated cost of the roughly 64 000 admissions nationwide that year would have been about \$240 million.<sup>6</sup>

Public patients accounted for one third of all potentially preventable hospitalisations in Victoria (Rogers 2016). Extrapolating Rogers' (2016) results further, if patients eligible for public dental services accounted for one third of all acute potentially preventable dental hospitalisations nationwide, the cost of treating public patients in hospital for potentially preventable dental conditions would have been in the order of \$80 million in 2013-14.

### The costs of oral disease occur over a lifetime

After the onset of oral disease, the cost of treating it continues over a lifetime. Oral disease (even when treated by fillings or periodontal treatments) will have irreversible lifetime effects and results in a cycle of treatment need.

Furthermore, the initial treatment will often result in a cycle of retreatment and repair with further irreversible damage and so carry a lifetime financial cost. The practice of dentistry is largely constructed around this cycle of repair and replacement. The major benefits from managing risk and preventing disease are not immediate but accrue over a lifetime. (Steele 2014, p. 33)

Poor oral health can track strongly from childhood to adulthood (de Silva-Sanigorski et al. 2012). Early detection and prevention may have lifetime benefits for individuals and, potentially, for the health system. While preventive care is often delivered by a dental professional, it can be particularly effective when combined with educational and outreach programs targeted at influencing the behaviour of selected cohorts, such as young people (box 12.2).

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<sup>5</sup> Hospitalisation for dental conditions that are not considered to be preventable — such as, for impacted teeth, cleft lip and palate conditions, and disorders of tooth development — are excluded (Rogers 2016).

<sup>6</sup> Based on 2008-09 data on the average cost per admission, Richardson and Richardson (2011) estimated that the direct cost of 50 000 potentially preventable dental conditions admissions was approximately \$233 million annually.

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## Box 12.2      Behavioural influences on oral health

Personal behaviour can have a significant influence on oral health – both positive and negative. For example, regularly consuming sugary drinks could negatively affect oral health. However, this could be counteracted to some degree by an otherwise healthy diet, combined with regular tooth brushing and dental check-ups.

The National Advisory Council on Dental Health (2012, p. 64) observed that ‘for children in particular, behavioural influences can establish long-term patterns which can affect their oral health into adulthood’.

Commenting on the results from the 2012–14 national child oral health survey, Armfield et. al. (2016) noted that there was generally poor compliance with recommendations regarding oral health behaviours. For example, only about 40 per cent of parents reported that they started brushing their children’s teeth with toothpaste at or around the recommended age of 2 years old. Visiting patterns were more positive; about 80 per cent of children had accessed dental care within the previous 12 months, and a similar proportion reported that the reason for their visit was for a check-up.

Governments acknowledged in the National Oral Health Plan (CHC 2015) that further efforts are required to enhance the oral health literacy of Australians. All governments run oral health promotion programs that are designed to improve oral health literacy and increase access to public dental services by those at high risk of oral disease. Oral health promotion can also be effective if used in concert with broader health promotion strategies. As the NT Government (sub. 593 p. 23) observed:

The risk factors for oral disease are shared by Australia’s most prevalent chronic diseases (cardiovascular disease, obesity and tobacco-related illnesses), and there are likely to be significant efficiency gains from shared approaches which target Australia’s most prevalent non-communicable diseases, such as nationally consistent preventive health policy.

Dental Health Services Victoria indicated that it is currently investigating using behavioural interventions (such as oral health education) for patients while they are on the waiting list for dental care (trans., pp. 247–9).

## Targeted preventive care can avoid the larger costs of oral disease

Preventive care has been generally accepted as a cost-effective way to deliver services as it can ‘avoid’ the onset of some oral diseases and the subsequent costs for individuals, governments, and the community (figure 12.1).

However, driven by high levels of oral disease and high demand for services, the public dental sector is focused on delivering urgent care (particularly for adults).

The current public dental system struggles to address the lifestyle and broader health issues affecting oral health and although an immediate dental problem can usually be alleviated, it can often be through the unnecessary removal of tooth structure, which invariably leads to other health and quality of life problems. (Calache, Hopcraft and Martin 2013, p. 17)

This can result in public dental services taking a surgical or ‘drill and fill’ approach to the management of symptoms of dental caries which may not lead to the best management of

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the disease itself. In turn, this approach can increase the demand on public dental programs, leading to longer waiting times, and the ineffective use of public resources (Calache, Hopcraft and Martin 2013).

There is evidence that targeted preventive dental care that is based on an individual's risk profile can be a cost-effective approach to delivering dental services (box 12.3). Minimal intervention dentistry, for example, departs from the traditional surgical approach to focus on the risk assessment of individual patients and the early detection and prevention of oral disease. By focusing on early care, Calache, Hopcraft and Martin (2013) argued that adopting minimum intervention dentistry in Australia's public dental system could help to reduce the need for complex restorations and improve the oral health of public dental patients.

The National Health Service (NHS) in England is progressively introducing a risk-based preventive dental care pathway. The pathway focuses on managing risk, creating a healthy oral environment through providing preventive care, encouraging healthy behaviours, and engaging in continuing care. An initial oral health assessment informs a 'traffic-light' system indicating whether patients are at high (red), medium (amber) or low (green) risk of oral disease, and to tailor the care provided (including recall intervals). Evidence from the initial pilot suggested that the pathway was effective in reducing risk and improving patients' oral health (Steele 2014), but further research is needed to determine the cost-effectiveness of the approach (Hulme et al. 2016).

Targeted investment in preventive dental care is likely to have long-term benefits to individuals, governments and the wider community from preventing the onset of oral disease. The Victorian Auditor-General's Office (VAGO 2016) suggested that shifting the focus of services from treatment to prevention would represent a more cost-effective way to deliver public dental services.

However, the Victorian Auditor-General's Office also noted that there is a backlog of people with oral disease who require treatment, and getting the balance right between prevention and treatment is a longer-term objective. Previous injections of funding have done little more than clear pre-existing waiting lists, and in some cases have seen waiting lists increase as more patients sought treatment (VAGO 2016).

While patients with urgent care needs should continue to be prioritised for treatment, long-term reform is needed to shift the focus of the system towards providing preventive dental care for patients at high risk of oral disease.

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### **Box 12.3      The cost-effectiveness of preventive dental care**

The costs and benefits of preventing and treating oral disease occur over a lifetime. Similarly, the benefits to an individual's oral health of interventions to prevent oral disease may occur with a long lag time. Estimates of the long-term costs and benefits of prevention interventions are therefore challenging, and relatively few evaluations consider both the benefits and costs of an intervention (Morgan et al. 2012). To date, results have come from small-scale trials which cannot necessarily be extrapolated to apply to the broader population.

However, some clinical studies (outlined below) provide evidence that a targeted preventive approach to dental care can be clinically- and cost-effective. These studies tend to find that the benefits of preventive dental care are greatest for patients at high risk of oral disease, and are potentially *not* cost-effective for those at low risk.

#### **The cost-effectiveness of the Caries Management System**

Warren et al. (2010) evaluated the long-term cost-effectiveness of a three year randomised clinical trial of the preventive approach underpinning the Caries Management System (CMS) in private dental practices in New South Wales and the ACT. The CMS is a non-invasive program designed to prevent cavities arising from dental caries, to stop the progression of existing lesions, and reduce future needs for restorative care.

After adjusting for the baseline incidence of dental caries, the authors found the CMS significantly reduced the incremental number of decayed, missing and filled teeth (DMFT). Extrapolating the cost and outcomes beyond the study period, the incremental cost per DMFT avoided was estimated to be \$1795 over a patient's lifetime.

In the four years following the trial, patients at dental practices that maintained the CMS continued to have reduced caries risk and lower restorative needs (Evans, Clark and Jia 2016).

The CMS was found to be most cost-effective for high-risk patients, but not for low-risk patients:

When compared with standard dental practice in Australia, the CMS is most cost-effective in patients who have a high underlying incidence of developing dental caries. The CMS is unlikely to be cost-effective in patients with a low risk of developing dental caries unless the costs associated with the program can be constrained (for example, by assuming that the monitoring of caries activity is performed by a dental hygienist rather than a dentist). (Warren et al. 2010, p. 759)

#### **Cost-effectiveness of a telephone program in disadvantaged communities**

Pukallus et al. (2013) examined the oral health outcomes for children living in low socioeconomic areas in Queensland who received a telephone delivered education program to prevent early childhood caries. Early childhood caries are a significant problem in low socioeconomic populations, and can be costly to treat as young children may need to be treated under general anaesthesia or sedation. The costs of early childhood caries are compounded by higher caries rates in later childhood and adulthood.

The program provided oral health instruction to parents when their children were aged around 6, 12 and 18 months. Outcomes were compared to a usual care group of children from the same district who received care in the public dental system. By age 6 years, the telephone intervention program was estimated to have prevented 43 carious teeth and saved approximately \$113 000 in healthcare costs per 100 children.

Pukallus et al. (2013) concluded that a preventive intervention by telephone is likely to generate considerable and immediate patient benefits and cost savings to the public dental services in low socioeconomic areas.

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## 12.2 Establishing the basis for improvement

As the Commission's study report (PC 2016b) found, public dental services do not support users to seek timely treatment for oral health problems. The reforms to introduce consumer-directed care and to improve commissioning systems proposed in chapter 13 are intended to achieve this goal. However, before these proposed reforms can proceed, governments should improve the operation of the existing public dental services in three ways.

First, public dental services need to put in place ways to provide more timely care for people that have a high risk of developing or worsening oral health problems. Public dental services should benchmark waiting times for different types of users to ensure dental care can be accessed in an appropriate timeframe.

Second, public dental services should start measuring the outcomes of their services in terms of the oral health of their users.

Third, public dental services should adopt digital oral health records to improve linkages with the broader health system, and enable greater continuity of care.

In addition to underpinning long-term reform, these improvements would be beneficial and should be pursued in their own right. They would improve the accountability of existing public dental services to those who pay for them (governments and users through co-payments), and assist targeting of those at high risk of oral disease.

### Benchmarking waiting times

In addition to the patient's pain, there are a number of costs if oral health conditions go untreated that could potentially be avoided with more timely access to dental care (section 12.1). With that in mind, it is the *time* on the waiting list that is of most interest and not the number of people on the waiting list. As demand and the availability of resources can fluctuate over time, 'waitlists may not be inherently bad as long as the eligible patients are able to access the required care within desirable time frames' (Dudko, Kruger and Tennant 2016, p. 278).

The risk of escalating harm while awaiting treatment, and therefore the clinically-acceptable timeframe, will vary by patient. Therefore, public performance reporting should include benchmarked waiting times based on the maximum clinically-acceptable timeframe for treatment by risk (or triage) group. Dental Health Services Victoria (DHSV) outlined how such an approach could work and its role in monitoring the system:

An alternative approach to comparative waiting time performance metrics would be to further develop response time targets for patients of different triage categories. Triage is already done for emergency public dental services with targets to treat within defined times. However, risk is not currently categorised when people go onto the waiting list – so their condition may deteriorate over time, rather than preventing the worsening of the most serious conditions.

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As is done in other parts of the health system (notably, for elective surgery patients) dental patients — both hospitalised and in the community — should be prioritised in accordance with risk triage categories and with guidelines for such prioritisation and triaging. This would enable assessment and monitoring of waiting time targets, together with relative funding levels between jurisdictions, per risk-weighted patient. (sub. PFR366, p. 21)

The triaging systems used in Queensland and New South Wales go some way toward that proposed by DHSV. In New South Wales, access to dental assessment and treatment is based on dental treatment needs as well as socio-economic factors – an approach that cohealth (sub. DR584) emphasised. Adults can be classified as ‘high treatment need’ based on two clinical criteria: having three or more decayed (or ‘cariious’) teeth or scoring poorly on an index of gum disease (Centre for Oral Health Strategy 2017b). The recommended treatment time for adults with high oral health need is 12 months from their initial assessment. The triaging guidelines also give priority to (among others):

- children with tooth decay or gum disease (recommended to be treated within 6 months)
- pregnant women with poor oral health (recommended to be seen within 3 months)
- people referred from a medical practitioner who require treatment for a medical condition, such as transplant surgery (recommended to be seen within 2 weeks).

The Australian Dental Association (ADA sub. DR545) argued that there was little value in splitting waiting lists by priority groups because it could create burdensome administrative costs and mean that minor dental issues are delayed until they need more complex and costly treatment. This concern highlights the need for the public dental services to include the potential deterioration in patient oral health as a factor in the prioritisation process. Prioritisation of urgent and general waiting lists, combined with appropriate benchmarks for maximum waiting times, should improve oral health overall. Waiting times that are benchmarked to the likelihood of deterioration are already used in Queensland (table 12.1).

All public dental services triage and prioritise access for patients in need of urgent care (box 12.4), but not all publicly report whether they meet their triage goals. For example, in Tasmania there are five triage categories with recommended appointment timeframes, but the only public reporting is on the urgent triage category (Tasmanian Health Service 2016). In contrast, Queensland publishes monthly reports for every clinic on the number of adults waiting or seen within clinically-acceptable benchmark times for all its priority categories (table 12.1). For example, in January 2017, 85 per cent of ‘priority 2’ category urgent patients seen in the Toowoomba dental clinic had been waiting less than the clinical benchmark time of 3 months (Queensland Health 2017c).

**Table 12.1 Clinical benchmarks for waiting times in Queensland public dental services**

<i>Clinical category</i>	<i>Benchmark waiting time</i>
<b>Seeking clinical assessment:</b> a brief examination to prioritise patients clinical needs and allocate patient to an appropriate waiting list	1 month
<b>Priority 1:</b> condition may deteriorate to become emergency, or dental care is delaying other urgent treatment	1 month
<b>Priority 2:</b> condition causes some pain or dysfunction but is not likely to deteriorate quickly or become an emergency	3 months
<b>Priority 3:</b> condition causes minimal or no pain or dysfunction, is unlikely to deteriorate quickly or become an emergency	12 months
<b>General:</b> non-urgent dental care, e.g. a check-up	24 months

*Sources:* Queensland Health (2015, 2017c).

Regular publication of data allows thorough analysis to be conducted (such as comparisons across the State or over time), improving the usefulness of the data in assessing system performance, and is an essential element of good government stewardship (chapter 2). For users, improvements in accountability can encourage governments and service providers to better allocate resources, thereby improving the responsiveness and effectiveness, of service provision.

The frequency of publication, as well as the level (clinic, region or jurisdiction) should match the purpose for which the data are intended. For example, publication should be monthly and at the lowest level available, preferably for individual public dental clinics, to support increased user choice. As the Victorian Auditor-General's Office observed, while 'wait time data is accurate only at a point in time, making this data publicly available could assist patients in making decisions about accessing public dental services, as they could compare wait times at different [community dental agencies] in their region' (VAGO 2016, p. 28).

For performance monitoring it would be more appropriate to report on longer timeframes and at a higher level. This should be at least annually at the jurisdiction level, similar to the reporting in the *Report on Government Services*. Publishing these data would also be consistent with the Commission's *Data Availability and Use* report (PC 2017a), which recommended that governments release all non-sensitive publicly funded datasets. In particular, the Commission recommended that, subject to risk assessment and mitigation efforts, low risk data that could be used for program or agency performance management purposes should be released.

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## **Box 12.4      How patients are triaged by public dental services**

Public dental services in all jurisdictions triage patients with urgent dental problems. While each jurisdiction is different, all use an initial telephone assessment. Some jurisdictions make efforts to prioritise access to general care. Victoria, for example, prioritises specific population groups with greater treatment needs than the general population, including children, homeless people, and Aboriginal and Torres Strait Islander people.

### **Telephone triaging**

In Tasmania triaging is conducted by trained receptionists over the telephone using triage software. Patients are asked questions about their symptoms, such as whether they have pain that wakes them during the night, or whether they have any swelling of the mouth or face. The triage software determines the severity of the complaint and determines the patient's priority for accessing care. There are a number of possible priorities, including: see today; see in 2 days; see in 3 weeks; see in 6 weeks; and add to the waiting list for general care (which, in Tasmania, could be up to three years) (SCRGSP 2017).

### **A Relative Needs Index**

South Australia and New South Wales have developed a telephone triage questionnaire, the Relative Needs Index (RNI). Luzzi et al. (2009) found evidence that some patient-reported symptoms in the RNI were a good predictor of a dentist's clinical judgment around the urgency of treatment. For example, patients that had pain in their jaw when opening their mouth wide were 2.4 times more likely to be clinically assessed as requiring treatment within 48 hours compared to those who did not have pain. The largest statistically significant effect was for patients that reported frequent difficulty sleeping because of pain or discomfort. The study found it was also possible to determine levels of priority for general dental care using the RNI. Victoria began using the RNI to triage urgent care in 2016, but no jurisdiction uses the RNI to triage access to general care.

Jones (2012) reported that a trial of the RNI at four clinics in South Australia found it was successful in shifting efforts away from urgent care toward more preventive, general care. Using the RNI resulted in the proportion of staff hours spent on urgent care falling from 60 per cent pre-implementation to 40 per cent post-implementation, with a proportionate increase in the time spent on general, preventive care.

### **A tiered approach**

In Queensland, patients are given an initial assessment over the phone, with three possible outcomes: being provided an appointment for urgent care; being placed on the general waiting list; or being referred for a clinical assessment. A clinical assessment is a brief examination that is used to prioritise patients based on their clinical needs. All patients seeking treatment for a problem (that are not immediately given an appointment for urgent care) will undergo a clinical assessment. Additionally, patients that meet certain criteria will be given a clinical assessment, including Aboriginal and Torres Strait Islanders, those with denture related concerns, those with disability, children aged 0 to 3 years and refugees and asylum seekers. A clinical assessment can result in a patient being given access to urgent care, being placed on the general or priority waiting lists, or being advised that they do not require dental care.

*Sources:* DHSV (2016); Luzzi et al. (2009); Ponnusamy et al. (2013); Queensland Health (2015); VAGO (2016).

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While the publication of waiting time performance brings transparency itself, benchmarking also has other benefits. Public dental services can use waiting time measures to monitor trends in demand and identify areas for performance improvement, including whether the service can meet population needs, whether eligibility criteria are capturing the intended users. In particular, public dental services could use more detailed data on a clinic-by-clinic basis (in combination with other data such as demographic trends) for service planning and resource allocation within a jurisdiction, as well as providing information on areas that have managed their waiting list well or poorly.

There is, at present, no way to compare the timeliness of access to public dental services between jurisdictions, because they are not measured on a consistent basis. Average waiting times are included in the annual *Report on Government Services* (SCRGSP 2017), but are not comparable between jurisdictions (and the New South Wales government does not participate). This impedes accountability. If public dental services were able to compare their performance with different jurisdictions they could look to the better performers for ways to improve their system. For example, jurisdictions could have compared the effects of the different ways they used the funding provided under the 2013 National Partnership Agreement. While there may be some initial difficulty in coordinating a consistent set of benchmarks across jurisdictions, as well as potential short-run transition costs for clinics to change their reporting practices, the Commission considers the ongoing benefits outlined above to be significant enough to warrant these efforts. Nonetheless, while it would be preferable for benchmarks to be consistent across jurisdictions, initial implementation should not be delayed in pursuit of complete consistency.

#### RECOMMENDATION 12.1

State and Territory Governments should report publicly against a set of benchmarks of clinically-acceptable waiting times for public dental services, split by risk-based priority levels. Reporting should commence as soon as possible. Governments should also make these benchmarks consistent across jurisdictions as soon as practicable.

To facilitate user choice, provider-level reporting should be published monthly. To facilitate performance monitoring, aggregate measures should be included in public dental services' annual reporting processes.

## A need to develop outcome measures

A fundamental requirement for an effective public dental system is the ability to assess the performance of service provision on the basis of outcomes, rather than outputs or inputs alone. Outcome measures, including clinical outcomes and patient-reported outcomes, would show how public dental services are improving the oral health of users.

Outcome measures are not routinely collected and published for public dental services. Some jurisdictions report some performance indicators (such as waiting times), but on the whole,

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performance measures for public dental services are not well developed. As the SA Government observed, ‘there is at present no nationally consistent framework for reporting and accountability for public providers of dental services’ (sub. 460, p. 4).

System-level outcomes show the effect the public dental service as a whole has on users, providers and the broader community (chapter 2). Governments laid out a set of outcome indicators in the National Oral Health Plan to allow ongoing monitoring of their progress in improving oral health (CHC 2015). Indicators included measures of tooth decay, gum disease, tooth loss and disease impact (such as the proportion of people experiencing toothache). As system-level indicators, these would reflect the effectiveness of broader policies, such as water fluoridation and oral health promotion, in addition to the provision of dental care.

More broadly, governments and public dental providers could use outcome measures in a variety of ways to improve the effectiveness of public dental services.

- Governments could use outcome measures to:
  - monitor providers’ performance over time
  - commission services from public dental providers that can improve oral health in a cost effective way (box 8.7 in chapter 8 outlines the forms of outcomes-based commissioning, including outcomes-based program design, monitoring, evaluation and funding)
  - give providers an incentive to prioritise activities that are proven to be clinically- and cost-effective, such as targeted preventive care
  - benchmark the performance of different providers, to highlight best practices which can be shared.
- Providers could use outcome measures to:
  - compare themselves, to see if there are service improvements from other providers they could adopt
  - improve their responsiveness to users’ needs.

Outcome measures could also improve accountability within the system. Publication of program outcomes would help to keep governments accountable for provider performance, reinforcing their stewardship role. Governments could also use program outcomes to evaluate the effectiveness of public dental services in meeting population needs over time.

All governments have acknowledged the need for continuous improvement in the safety and quality of oral health services and endorsed benchmarking programs incorporating clinical outcomes and other quality indicators (CHC 2015). Dental Health Services Victoria has observed that there is a need for public dental services to apply a ‘value based health care model’ that aims to achieve the best outcomes for users in a cost-effective way. It is working with the International Consortium for Health Outcomes Measurement, and partners from the Harvard School of Dental Medicine and private health insurer HCF Australia to develop a

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consistent and well-accepted set of standards for measuring oral health outcomes (DHSV, sub. 465). Dental Health Services Victoria aims to use the outcome measures, which are due to be completed around mid-2018, to analyse the effectiveness of its services and prioritise high-value care (that contributes to patient oral health) while eliminating low-value care.

The Queensland Government is also working to improve its collection of clinical outcomes, specifically levels of tooth decay (sub. 592). The Queensland Government envisages that over the next one to two years it will be able to use electronic health records to produce regular records on levels of dental decay for all child and adult public dental patients using routinely collected data.

### What types of outcome measures should be used?

There is a range of performance measures in use around the world that could be adopted for public dental services in Australia. Gonzales et. al. (2006) conducted an exploratory study of the international literature and found 57 possible measures. Some measures are already collected and reported by Australian public dental services, including measures of inputs (such as funding levels and numbers of dental professionals) and outputs (including activity and mix of services). The biggest gaps in performance reporting for public dental services in Australia fall into two groups: oral health (or clinical) outcomes and patient-reported outcomes.

Oral health outcomes can be used as indicators for the quality of dental care when there are reliable measurements available both before and after care. Patient-reported outcome measures (discussed below) can give important insights into not only the level of oral disease experienced but also whether that disease had been treated in a timely fashion (AIHW 2015c). The NHS in England has developed a dental outcomes framework that incorporates both oral health outcomes and patient-reported outcomes (box 12.5).

#### *Patient-reported outcome measures*

Patient-reported outcome measures (PROMs) are increasingly being used in the broader health sector. For example, in England, the NHS has collected PROMs on four types of elective surgery since 2009 (PROMs are discussed in a public hospital context in chapter 11). These data are used by the NHS to evaluate potential improvements to hospital services and recently have been linked to payment incentives in pay-for-performance schemes (Gomes et al. 2016). In Australia, the Victorian Department of Health and Human Services began collecting PROMs data from Victorian health services (including hospitals) in July 2017.

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### Box 12.5      **Dental Quality Indicators in England**

The National Health Service in England is trialling a system that rewards dental providers for high quality outcomes. The outcome measures used in the trials include clinical measures and patient function and experience measures.

The clinical outcome measures are aimed at assessing providers' performance in maintaining or improving a patient's condition over time. Patient condition is measured by three outcomes: one related to tooth decay; and two related to gum disease.

- Tooth decay is measured by the percentage of patients whose number of decayed teeth is maintained or reduced over time.
- The first gum disease measure is the percentage of patients whose gum condition (measured on a five point scale) is maintained or improved over time. The second gum disease measure relates to the percentage of patients whose gums bleed upon examination.

At the beginning of the trial, dental providers were trained in using a standardised assessment tool. The training included clear definitions of the terms used in the outcomes framework.

The patient experience measures are based on the results of patient surveys issued to a random sample of patients following their completion of a course of treatment. There are seven survey questions. One question asks about the patients' function: are you able to speak and eat comfortably? The other questions ask about patient satisfaction, for example 'would you recommend this practice to a friend?'

*Sources:* UK Department of Health (2011, 2016).

Questionnaires have been used to measure patient-reported outcomes for oral health. For example, the Oral Health Impact Profile is a questionnaire that measures people's perception of the social impact of oral disorders on their wellbeing (Slade 1997). The questionnaire is used to gather information on whether oral health problems are causing people to have trouble pronouncing words or are making life in general less satisfying. It has been used in a variety of contexts, including to compare the impact of oral disorders on the wellbeing of populations across countries and to test the effectiveness of treatment on quality of life (Slade et al. 2005; Yeh et al. 2016).

Patient-reported measures (covering outcomes and experience) capture an individual's outcomes (quality of life and pain levels) and their experience with the provider (chapter 11, box 11.3). In practice, PROMs can be used in a number of ways.

- First, PROMs can directly measure whether dental services are improving patients' wellbeing.
- Second, while each user's experience may vary, public reporting of outcome measures in simple, user-driven categories (for example, 'pain went down', 'gave good advice') could inform user choice more directly than complicated clinical measures. As Tan Nguyen, president of ADOHTA noted, clinical information may not be relevant to the majority of users of public dental services (ADOHTA sub. 398). Outcome-related information can be translated to metrics that would be of use to individuals, such as star ratings reporting performance against select criteria (the choice of criteria should be informed by their usefulness for patients and the reliability of simplified measures).

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- Third, PROMs can be combined with other data to provide insights into which elements of service provision contribute to behavioural change. For example, the data could reveal whether those dental practices that ‘gave good advice’ or ‘made it easy to get an appointment’ saw greater long-term reductions in oral disease for their users. As noted in chapter 11, provider self-improvement based on published performance data can be a powerful driver of improved outcomes.

### *The level of reporting*

Outcome measures could be collected and reported for individual dental professionals or at the clinic level. For some dental clinics, there will be only one dental professional, so any data reported will cover the clinic and the clinician. In 2013, approximately one-third of private sector dentists worked in a sole practice (AIHW 2015c). Larger dental clinics may employ a range of dental professionals, including dentists, oral health therapists and dental therapists, in different mixes to provide bundles of services. This can lead to complications in understanding how the work of one dental professional contributed to a patient’s outcomes.

Initially, outcome reporting should take place at the clinic level until complications such as these can be worked through. The experience in hospitals, particularly in England and the United States (chapter 11), suggests that moving to an individual level is possible over time. Individual-level reporting will require the support of the profession — who could benefit from information that would support dissemination of clinical best practice and efforts to compare their work to peers.

### *Stakeholder concerns can be addressed*

As outlined in chapter 11, a common argument against provider or clinician-level reporting of outcome measures is that it encourages ‘cherry picking’ of lower risk patients. Similar concerns were raised by cohealth for public dental services (sub. DR584). However, there is little evidence of widespread avoidance of high-risk patients for hospital specialists (chapter 11). In addition, there are a number of ways to address potential concerns.

- Measuring the relative change in a patient’s oral health (comparing their pre- and post-treatment status), rather than reaching a given absolute level would help ensure that the focus is on the outcomes that arise as a result of the service provided, not the underlying characteristics of the users.
- Governments could develop appropriate risk-adjusted benchmarks that account for differences in the mix of patients to ensure that any comparisons are robust. The benchmarks could be developed and implemented in collaboration with the dental profession to ensure its support.
- Results could be presented in a way that does not overemphasise minor differences. For example, ‘funnel plots’ are used to illustrate risk-adjusted hospital mortality rates (box 11.8 in chapter 11). Governments could use safeguards that accompany the data to

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provide additional protection, with the appropriate safeguards depending on the intended audience. For example, while providers could have access to a detailed benchmarking report that shows its performance relative to its peers, access for users could be restricted to more aggregate data that only reports whether the provider is meeting a certain threshold.

### *Implementation*

Governments will need to ensure that outcome measures are relevant, measureable and can be incorporated into practices' standard workflow in order to reduce administrative costs and facilitate adoption.

Central to developing desirable outcome measures is to engage those with implementation skills, knowledge and experience during the development process. Initial test sites, with relevant stakeholders closely engaged, could identify success factors and gain acceptance of the measures. The development process could also include the gathering of baseline data from some demographically and geographically distinct test sites. These data could inform the development of benchmarks that can provide the basis for comparisons of the relative performance of providers.

All jurisdictions, including the Australian Government, should be involved in the testing and implementation of outcome measures and participate in outcome-focused reporting (NT Government, sub. 593).

Governments should use a consistent set of outcome measures to develop a nationally consistent outcomes framework. A nationally consistent framework would improve accountability, promote the sharing of best practices across jurisdictions, and aid system-level outcome evaluations.

#### RECOMMENDATION 12.2

The Australian, State and Territory Governments should establish outcome measures for public dental services that focus on patient outcomes and include both clinical outcomes and patient-reported measures.

Governments should build on the work done by Dental Health Services Victoria on outcome measures, with a view to developing and implementing a nationally consistent outcomes framework.

### *Further steps*

A step beyond reporting outcomes would be to link them to remuneration for providers. The Victorian Auditor-General's Office noted that the current output-based funding model rewards more complex and time-intensive treatments and does not encourage providers to

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carry out preventive activities (VAGO 2016). Linking funding to outcomes can provide the incentive to undertake beneficial preventive services that would otherwise not be remunerated. DHSV recommended that the funding of public dental services be based on outcomes:

Regardless of whether the government implements greater competition and contestability in the dental industry, the payment system should be focused on providing performance based reimbursement. (DHSV, sub. 465, p. 11)

There are many examples of health systems paying for outcomes (box 12.6). The National Health Service in England is trialling a model that includes payment for outcomes for dental services (box 13.2).

### **Box 12.6      Paying for health outcomes**

Payments that reward quality and performance in health care are widespread across OECD countries. In 2012, nearly two-thirds of OECD countries reported having at least one performance payment scheme in place. Such schemes are being used across a growing range of healthcare settings, including primary care, outpatient specialist services and hospital services. The variety of examples from around the world illustrate the feasibility of applying an outcomes payment scheme to public dental services, as is being trialled in England (box 13.2).

#### **Sweden**

The Stockholm County Council includes an element of payment for outcomes for spinal surgery. Up to 10 per cent of the clinic's total payment for the surgery is based on patient responses to a single question in a follow-up survey, one year after surgery: how is your pain now compared with before the operation? The payment is case-mix adjusted; part of the payment is based on the difference between the statistically expected results (based on patient characteristics) and the actual results. Seven other Swedish counties are developing models similar to the spinal surgery example for other health conditions (including diabetes and breast cancer).

#### **Portugal**

In Portugal, payment for about half of the primary care providers in the country is based on their performance against a set of 22 quality and efficiency indicators. Indicators cover four domains: access; clinical performance; efficiency; and perceived quality. There is a standard set of 12 indicators that is determined nationally, with the remainder selected regionally or by the providers themselves. The scheme has been in place for more than 10 years, starting with a pilot in 2005.

Primary care providers that do not participate in the pay-for-performance scheme also report similar sets of indicators. Comparisons of the results between the participating and nonparticipating providers show that better access to care, and higher clinical performance and efficiency in the participating providers (OECD 2016). It should be noted, however, that since provider participation is voluntary, self-selection effects could be driving results.

*Sources:* ICHOM (2017), OECD (2016a), Swedish Society of Spinal Surgeons (2014), Wohlin (2014).

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Programs that include outcomes-based payments typically contain four elements (Cashin 2014).

- The measures that will be linked to payment. Cashin (2014) observed that successful programs (those that had a net positive effect on health system performance) use measures that focus on improvements in specific areas of performance. If the measures are too general, it may be difficult for providers to pinpoint areas for improvement.
- The basis for payment, or how achievement against the measures is determined. Achievement can be measured by reaching set targets, improvement over time, or ranking providers relative to each other. Cashin (2014) noted that measures that rank providers do not create meaningful incentives for poor performers.
- The means of delivering the payment. Payments can be offered as a bonus or could work as a penalty; they can be paid to institutions or individuals and can incorporate non-financial incentives (such as publication of results).
- The source of data to support the program. Data can be extracted anonymously from digital health records or can be specifically collected.

Simply linking payments to outcomes does not guarantee improvements for users (PC 2015a). For example, a focus on incorrect metrics can lead to perverse outcomes (box 2.5). Providers may focus on meeting specific measures as part of their monitoring requirements to the detriment of overall user outcomes. Careful design of such schemes can influence their success. For instance, including PROMs and clinical outcomes in the outcomes framework could better align the incentives of providers with those of their patients.

A general conclusion of a review of 12 outcome (or performance) payment schemes across the Organisation for Economic Cooperation and Development (OECD) was that the incentives they create can have greater value if they strengthen key elements of health system governance — such as a greater focus on system objectives, more accountability and performance feedback loops (Cashin, Chi and Borowitz 2014). The results suggested that the emphasis in such programs should not be on the performance measures and incentive payments alone, but rather on using comprehensive approaches where the indicators and incentives play a supportive rather than a central role.

In the context of improving user choice to public dental services (chapter 13), consumer-directed care could incorporate outcome measures in the payment structure for public dental providers. The potential use of outcome measures in payment models is discussed further in chapter 13.

## **A digital oral health record**

Public dental services face difficulties in tracking patients over time, following patients between public clinics (or between hospitals and clinics) and following patients treated in

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the private sector (even when they are publicly funded). There is also little integration with the broader health system.

A digital oral health record could address these problems, while supporting user choice, assisting service planning and supporting more coordinated care for patients.

The Commission's *Efficiency in Health* research paper outlined some of the benefits of electronic health records:

Electronic health records offer the potential to improve patient care and care coordination by facilitating the sharing of information between health care providers, including on patients' diagnoses, tests and medications, and by reducing duplication in tests and procedures. A single, centralised health record would also help consumers to keep track of — and exercise control over — their own care, while simultaneously being a valuable information source for researchers. (PC 2015a, p. 79)

Governments endorsed the inclusion of oral health information in electronic health records in the National Oral Health Plan:

Effective integration of health information systems supports improved capacity to plan and deliver care and to assess service quality, efficiency and health outcomes. Shared health information and records support increased consumer focus and enable more coordinated care. (CHC 2015, p. 33)

Some State Governments have already begun introducing digital oral health records. In 2016 the Queensland Government introduced a system that allows public dental clinics to enter and store all clinical information in a state-wide database. Information recorded includes patient's medical history, tooth charting, treatment planning, clinical notes, referrals and medication lists (Queensland Health 2016). Costs in Queensland have included upgrades to IT infrastructure, adapting local business practices, training staff in each dental clinic and providing on-site support.

A centralised, state-wide electronic information system to capture clinical activity is used in New South Wales. Paper records are used for patient's medical history, diagnosis and test results as the electronic system does not yet have the capacity to record full medical histories. A study of a random sample of clinical records in New South Wales found the electronic records to be more reliable than the paper records (Masoe et al. 2015).

Government initiatives to improve oral health records within their public dental systems will not, on their own, provide the link to the broader health system or the private sector.

The Australian Government's My Health Record (MHR) could provide the link. My Health Record is a web browser-based electronic health record that contains a summary of a patient's health information. As at 5 October 2017, 69 per cent of public hospitals and health services were connected to the MHR system (although connection does not imply actual use) (Digital Health Agency nd). Inquiry participants, such as AHHA (sub. DR 561) and ADOHTA (sub. DR526), supported including oral health information in MHR to improve the connection between public dental services and the wider health system. Some work has

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already begun in this area — Queensland (sub. 592) has commissioned a project that will provide integration functionality to enable automatic data transfer from its electronic oral health record system to the MHR system.

Participation in MHR is currently voluntary for patients and providers, but is transitioning to an opt-out system over 2017-18 and 2018-19 (Australian Government 2017b). The Department of Health estimated that 98 per cent of the population will have an MHR by 1 December 2018 (Department of Health 2017m).

Digital oral health records may also enhance the benefits of user choice. A portable dental history would enable a patient to switch providers more easily as they can be assured that the new provider will have the same information as their previous provider. Such a record would be consistent with the comprehensive right for individuals over their own data, as recommended in the Commission's *Data Availability and Use* inquiry (PC 2017a). Portable records could avoid duplication of initial diagnostic processes (providing existing diagnoses are sound and recent) and tests like x-rays. This would require private providers that treat public patients to also participate in digital oral health record systems.

The ADA (2016) has supported an opt-out system for patients for MHR but cautioned that electronic health records could create administrative burdens for dental practices. The ADA argued that many dental practices have limited resources to deal with security and data quality requirements that governments may impose. The ADA advocated for dental practices to receive financial assistance to adopt the changes required to implement electronic health records.

Notwithstanding the potential benefits from the widespread use of MHR, there are some limitations to the system. At present, it:

- does not contain a full health record, with much information (including hospital data) retained on local systems
- is not fully interoperable with existing software used by many health practitioners.

These limitations, if not addressed, could restrict the ways MHR could be used. For instance, ideally the MHR could be used to assist identifying patients at high risk of oral disease when they make contact with public dental services, but this would depend on both the completeness of a patient's medical history and interoperability between MHR and dental triaging systems. The ADA (sub. DR545) noted that the MHR system does not currently constitute a set of medical records upon which medical practitioners can rely.

The full potential of MHR may be realised over time, with some improvements already underway. By May 2018, registration processes for health providers will be online and fully automated (Department of Health 2017k). As the system becomes easier to use for health professionals, and more patients enrol in it, governments could consider the potential to use MHR as the vehicle for portable oral health records.

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In the first instance, public dental services should work to digitise their own oral health record systems and ensure linkage between jurisdictions. (The Commission notes that some jurisdictions have already commenced this process.) This should be done with a view to the longer-term goal of incorporating oral health records within the MHR system.

**RECOMMENDATION 12.3**

State and Territory Governments should implement comprehensive digital oral health records for public dental services as soon as practicable. Once implemented, these systems should be incorporated within the My Health Record system.

## **Better understanding the needs of the service user population**

Different people face a range of different barriers to accessing dental care. Higher rates of oral disease among some population groups could indicate that they have additional needs that are not being addressed effectively within the current system. At a national level, governments have identified four such population groups: people who are socially disadvantaged or on low incomes; Aboriginal and Torres Strait Islander people; people living in regional and remote areas; and people with additional or specialised healthcare needs (CHC 2015). However, data in this area is lacking:

At present, population oral health data are not routinely collected or available and service level data are inconsistent. Therefore, there is a limited ability to monitor the oral health status of Australians, especially amongst the Priority Populations, and to evaluate existing programs and new initiatives. (CHC 2015, p. 45).

The Commission's recommendations 12.1, 12.2 and 12.3 are aimed at providing governments with data sources that would improve their understanding of the needs of the eligible population. Adopting these recommendations would enable governments to: improve their stewardship of public dental services; and make evidence-based decisions about how best to engage with people at high risk of oral disease, including users who only seek care when they require urgent treatment. For example, digital oral health records could be used to develop a picture of those who present to other health services, especially hospitals, with oral health problems.

As a first step, governments could look at broad population groups that are *not* seeking to use public dental services. In their audit of access to public dental services in Victoria, the Victorian Auditor-General's Office observed that, while only a small proportion of the eligible population seeks to access public dental services in that state, the government had no mechanism to identify the specific barriers that result in this low take up (VAGO 2016).

Governments could also improve their understanding of population needs by making better use of data they already hold. The Commission's (PC 2017a) report on Data Availability and Use identified health data as an underutilised resource due to impediments and distrust around data use, and recommended a new framework for granting access to publicly funded

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datasets. Researchers in Victoria are developing a model to assess the oral health risk at the community level by drawing on existing datasets (de Silva et al. 2016). The researchers identified a range of existing survey and routinely-collected data that can be used to identify communities at high risk of developing oral disease.

Put together, a systematic use of both existing and new data would enable governments to better identify those cohorts within the user population at high risk of oral disease (including those who do not currently present to public dental services) that would most benefit from the application of broader reforms to the public dental system (chapter 13).

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## 13 User choice and contestability in public dental services

### Key points

- Greater user choice should be coupled with a shift in the focus of public dental services towards more preventive care. This can be achieved by introducing a consumer-directed care scheme which allows eligible patients to choose a dental clinic that would become responsible for their care for a defined (three year) period.
- Implementing the Commission's proposed consumer-directed care scheme requires a:
  - risk-based allocation model that targets services to users at high risk of oral disease
  - payment model that blends: a risk-weighted capitation payment; outcome payments for improving the oral health of patients; and activity payments for urgent and more complex treatments that cannot be readily brought within the enrolment payment.
- The consumer-directed care scheme would improve the effectiveness of public dental services for users by:
  - triaging patients according to their risk of oral disease (while retaining governments' ability to prioritise urgent and general care)
  - paying dental providers in a manner that encourages them to focus on preventive care and achieving outcomes for users rather than the number of treatments provided (as occurs under fee-for-service arrangements)
  - introducing top-up arrangements that, with consumer safeguards, could allow patients to pay an extra fee to access a wider range of treatments
  - providing patients with consumer-oriented information (clinic locations, waiting times, and published outcome measures) to enable them to choose their provider.
- Governments should commission services for people not able to choose between alternative providers, for example, in remote areas and for people with complex needs. Governments should improve commissioning processes by:
  - introducing greater contestability to select providers that can best meet patients' needs and encourage innovative approaches to service delivery
  - using an outcomes framework to focus on improvements to people's oral health.
- Governments should undertake service planning to better understand patients' needs and identify how to lower barriers for, and engage with, people at high risk of oral disease who may only present to the public dental or health system when they require urgent care.
- Reforms to introduce greater user choice and contestability require a major shift in the way that public dental services are funded and overseen, and a staged long-term implementation path.

**Table 13.1 Overview of proposed reforms to public dental services**

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<b>Improving data collection and reporting</b>		
<b>Recommendation 12.1</b> State and Territory Governments should report publicly against a consistent benchmark of waiting times.	As soon as practicable	Costs include the difficulty in coordinating across jurisdictions, and administration costs for providers. Increases accountability.
<b>Recommendation 12.2</b> The Australian, State and Territory Governments should develop and progressively rollout means to measure the outcomes for patients.	Development is already underway	Initial test sites are needed to develop measures that are meaningful and practical. Increases accountability and promotes efficiency and quality improvements in services.
<b>Recommendation 12.3</b> State and Territory Governments should adopt digital health records that follow patients in the public and private dental sectors, and wider health system.	As soon as practicable	Costs include adopting new data systems, and costs for users and providers to create and maintain records. Improves the quality and efficiency of the system, particularly in providing additional information for triaging.
<b>Improving commissioning processes</b>		
<b>Recommendation 13.5</b> State and Territory Governments should establish effective commissioning processes to enable contestability for public dental services.	As soon as practicable, following the development of outcome measures	Resources are needed to ensure commissioning capabilities are well developed. In settings where competition is not feasible (including remote provision and populations with complex needs), introducing greater contestability would improve the quality and efficiency of services.
<b>Transition to a consumer-directed care scheme</b>		
<b>Recommendations 13.1, 13.2, 13.4 and 13.6</b> State and Territory Governments should introduce a consumer-directed care scheme using blended payments. Access to consumer-directed care should be based on triaging according to risk. This should provide patients access to: <ul style="list-style-type: none"> <li>those treatments required to attain basic oral health</li> <li>the option to pay 'top-up' fees to access a broader range of treatments</li> <li>tailored information to support them to choose a provider.</li> </ul>	Initial test sites to commence following the development of outcome measures, with full rollout informed by test sites	Initial test sites should evaluate new blended payment and allocation models before a staged rollout. The evaluations should be overseen by a steering group. The test sites and evaluations should be resourced separately from the delivery of public dental services. Patients would have choice over participating providers (public or private clinics) who will care for them for an enrolment period of three years. This would generate incentives for providers to be more responsive to patients' needs. Shifting the focus from treating existing conditions to rewarding targeted preventive care and early intervention would improve the oral health of users and avoid the larger costs from the onset of oral disease.
<b>Recommendation 13.3</b> The Australian Government should introduce a new blended payment model for the Child Dental Benefit Schedule.	Amongst the first elements of the rollout of consumer-directed care	Minor implementation costs, leveraging off broader development of the payment model. Replacing the existing capped benefit with a weighted capitation payment would better target the needs of children at high risk of oral disease and further promote a preventive approach to care.

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For people who access public dental services, choice and outcomes could be improved over the long term by the introduction of a consumer-directed care scheme, coupled with a focus on targeted preventive care. Reforms to improve data collection and reporting, and the outcomes framework, are necessary to underpin these proposed reforms, and to introduce greater user choice and contestability (chapter 12). Table 13.1 (above) provides an overview of the Commission's proposed reforms to public dental services.

## **13.1 Giving users choice through consumer-directed care**

The current emphasis on providing services in the relatively limited number of government-operated clinics constrains user choice over the timing and location of treatment. Under a consumer-directed care approach, users choose which provider receives the funding allocated to them. Offering a choice of convenient locations may also make patients more likely to attend clinics and improve overall health outcomes.

A consumer-directed care approach to public dental services could make greater use of private and public dental professionals, enabling users to have choice over a greater range of providers. Giving users greater choice over their dental provider can also generate incentives for providers to be more responsive to patients' needs as they are only funded when users choose them.

Increased user choice, while beneficial, needs to be coupled with a shift in the focus of public dental services towards targeted prevention. As discussed in chapter 12, most dental conditions are preventable. Timely access to dental care can avoid the larger costs (to users, governments and the community) that arise when oral health conditions are left untreated. Several studies suggest that preventive dental programs targeted to individuals at high risk of oral disease can be clinically and cost effective (box 12.3).

There are some circumstances where user choice would not be feasible such as in remote locations with small populations that cannot support multiple dental providers, or for users with complex and special needs. Governments would need to commission providers to deliver services in these circumstances. Improvements that governments should make to commissioning processes are outlined in section 13.5.

## **13.2 A better way to pay for public dental services**

The services delivered by health professionals, including dental professionals, are influenced by a range of factors such as medical ethics, professional codes of conduct and monitoring. Clinical guidelines based on robust and up-to-date evaluations, for example, can be an important way to promote best practice in delivering clinically- and cost-effective health care (PC 2015a).

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Payment models also affect providers' incentives. The dominant payment models for public dental services in Australia are salaried professionals working in public clinics and fee-for-service vouchers paid to private practices.

Each payment model has advantages and disadvantages (chapter 2).

- Salaried payments are simple to administer (dental professionals are paid the same salary regardless of the number of patients seen or the number of treatments provided) and give funders more control over expenditure. However, salaried payment models have no explicit financial incentive to improve outcomes for patients by improving the quality or lowering the cost of care. Unchecked, this can lead to under-servicing.
- Fee-for-service payments reward dental professionals for activity or work undertaken. As a consequence, providers have a financial incentive to increase the number of services delivered or tests performed, reduce consultation times and recommend follow-up appointments. Unchecked this can lead to over-servicing and undermines incentives for targeted prevention.

In practice, these two models appear to have resulted in different service patterns for public patients treated in the public relative to the private sector.

For example, comparing the Dental Weighted Activity Units provided during a course of care, Dental Health Services Victoria (DHSV, sub. PFR366) found that Victorian public patients treated at a private practice (using a fee-for-service voucher) received 51 per cent more general dental services and 17 per cent more emergency services compared with those treated at a public dental clinic. Participants in the Commission's study report also argued that the relatively high level of servicing contributed to higher costs for treating public patients in the private sector. Dr. Martin Dooland AM (sub. PFR300) suggested that the cost of a course of general dental care was, on average, 30 per cent higher for adults treated in the private sector compared with the public sector.

The increased level of servicing by private practices with fee-for-service vouchers does not, by itself, imply over-servicing. It could equally reflect under-servicing by public dental clinics. That said, inquiry participants, including the Australian Dental and Oral Health Therapists' Association (ADOHTA, sub. DR526) and Taliana et. al (sub. DR553), raised concerns about the quantity and types of treatments provided to public patients under fee-for-service vouchers and questioned the added benefit to consumers of these treatments, particularly under the Chronic Disease Dental Scheme (CDDS). The expansion of the CDDS in 2008 (when the range of eligible services were broadened to include reconstructive services and the spending cap was increased to \$4250 per patient over two years), led to an increase in aesthetic crown treatments (porcelain fused to metal crown), for which Lam, Kruger and Tennant (2015) noted there was limited evidence of the disease-control benefits. The CDDS saw significant waste and over-servicing and was closed in 2012 (Plibersek 2012).

Fee-for-service vouchers — used across jurisdictions often as short-term arrangements to manage capacity constraints in the public dental system — have provided recipients with

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greater choice over the timing and location of treatment. However, they have not been cost effective as incentives have focused on the number of services provided, rather than outcomes for users. As such, exploration of other payment models is warranted.

## Using capitation payments in dental care

Capitation payment models, where health professionals receive a fixed periodic payment for each enrolled patient, can overcome some of the problems with over-servicing under a fee-for-service model (chapter 2). By providing a *fixed budget* over time for each enrolled patient, well-designed capitation arrangements can incentivise providers to reduce costs through providing fewer, or less costly, treatments and ‘investing’ in cost-effective preventive and early intervention care. The British Dental Association stated that moves toward capitation ‘minimise perverse incentives and reward dentists for improvement in oral health’ (BDA 2015).

Capitation payments do have drawbacks. The Australian Dental Association (ADA, sub. DR545) raised concerns about the incentive for providers to *cherry pick* low cost patients under a capitation model. A *risk-weighted* capitation payment, that compensates providers for the additional cost of caring for patient groups with relatively high treatment needs, could help overcome issues with cherry picking. Importantly, the risk adjustment needs to be based on factors that cannot be manipulated by the treating dental professional (risk factors are discussed in box 12.1). If scope for manipulation is present, it is possible for practitioners to focus more on capturing the payments than improving outcomes for their patients. For example, evidence from the United Kingdom suggests that some general practitioner (GP) practices manipulated reporting data on the number of patients who were eligible for certain treatments in order to increase payments (Gravelle, Sutton and Ma 2010).

A further potential limitation of relying on a pure capitation payment is the incentive to undertreat patients to save costs, potentially leaving dental conditions untreated. Patient outcomes will, however, depend on professional standards and consumer safety measures. Such measures, including national registration requirements for dental practitioners, are already in place in Australia (PC 2016a).

Evidence from dental services in Britain, Norway and Sweden and primary care services in Canada indicates that, while patients cared for under capitation arrangements receive fewer treatments overall, these arrangements have not led to under-treatment. In fact, these studies indicate that capitation arrangements encourage health professionals to invest in preventive care for patients (box 13.1).

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## **Box 13.1      Capitation models: a review of the evidence**

### **UK trial of capitation payments for treating children**

Based on a three year clinical trial of children in the General Dental Service in Britain, Holloway et al. (1990) examined differences in treatments received and outcomes for children treated under a fee-for-service model and under a capitation payment model. For children treated under a capitation model, dentists carried out fewer fillings and extractions, took fewer radiographs and saw their patients less frequently than their fee-for-service colleagues. Even though dentists did not restore established carious lesions as readily as their fee-for-service counterparts, there was no evidence that the provision of fewer services resulted in systematic neglect.

In addition to the drop in the number of services, the mix of services provided changed. Dentists in the trial were found to have provided relatively more preventive care under capitation (Lennon et al. 1990). In particular, dentists were more likely to provide advice to parents on controlling dental disease — 36 per cent of children treated under capitation compared with 25 per cent of children treated under fee-for-service arrangements.

### **Norwegian natural capitation experiment in the public dental sector**

Grytten, Holst and Skau (2013) examined outcomes six years after the introduction of a combined per capita and fixed salary remuneration contract for public dental services in Østfold in Norway in 2000. Compared with a salary model, they found no evidence of a fall in the quality of dental care from the transition to combined per capita remuneration. Specifically, the transition did not lead to under-diagnosis of carious lesions, under-treatment or less preventive care for patients.

The authors noted that their results indicated that per capita remuneration is compatible with a dental health promotion paradigm. However, in 2006 the capitation component only accounted for, on average, 20 per cent of gross income. As the incentive effect of the per capita contract was relatively weak, caution must be used in generalising the findings to the private sector.

### **Swedish subscription agreements**

A study of patients treated in eight public dental clinics in the Scania region of Sweden showed that those who chose to enter a subscription agreement (a risk-weighted capitation plan with a three year enrolment period) had on average better oral health than those who entered a fee-for-service plan (Petersson and Twetman 2017). After three years, patients in the capitation plan were more likely to have received additional preventive care than those in the fee-for-service plan. For example, of those patients assessed as high risk at the start of the study, 73 per cent of the subscription patients received additional preventive care, compared with 44 per cent of the fee-for-service patients.

### **Canadian mixed payment models for physicians**

Kantarevic and Kralj (2011) examined the short-term outcomes from the introduction of a blended capitation payment model in Ontario, Canada in 2007. Under this model, for a set of core services, physicians received an age–sex adjusted capitation payment plus 10 per cent of the fee-for-service payment for each enrolled patient.

The authors found that under the blended payment model, physicians provided fewer services and visits, but were more likely to reach preventive care targets. They found no significant difference in patient complexity, indicating that there was no ‘cream skimming’ by providers. They concluded that, relative to an enhanced fee-for-services model, the blended capitation approach may reduce quantity and improve the quality of health care.

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## The enrolment period

Enrolment periods perform a valuable function in capitation models. Paying dental clinics a fee per enrolled patient for ongoing care over a set period strengthens the incentive for clinics to deliver the right treatment at the right time, and to focus on preventing the onset of oral disease.

The incentive for providers to invest in improving a patient's outcomes under a capitation model will depend in part on the length of the enrolment period for the capitation payment. A short enrolment period, such as one year, is not sufficiently long for providers to realise the benefits to them of savings arising from preventive care. In this case, providers may have a strong incentive to reduce their costs by lowering the quantity or quality of treatments provided (Marshall, Charlesworth and Hurst 2014).

The enrolment period should be long enough to ensure that providers can realise savings from investing in preventive and early intervention care for their patients, and to allow measurement of clinical outcomes. For example, in a review of clinical trials, Cooper et al. (2013) suggested that a follow-up period of two to three years was needed to measure the long-term outcomes of primary school-based behavioural interventions for preventing caries (tooth decay). A three year enrolment period should allow sufficient time to see the results of care.

## **Toward a blended model with payments for outcomes**

Concerns with potential under-servicing under pure capitation arrangements could be addressed, at least in part, by measuring and reporting on user outcomes at the provider level. Linking a proportion of provider payments to outcome measures could further strengthen incentives for providers to focus on improving patient outcomes, rather than the delivery of particular treatments.

Measuring and paying for outcomes, if done well, can better align the interests of patients and providers. Chapter 12 (box 12.6) notes that the use of outcomes payments in health care is increasing across the OECD, and that payments are being used across a growing range of healthcare settings. In general, outcome payments are used in OECD countries as add-on payments that sit alongside other payment models. The use of multiple payment forms for the same care setting is known as a 'blended' payment.

Blended payments (with or without an outcomes component) are commonly used in primary health care across the OECD. In a study of payment methods in primary health care, the OECD concluded that blended payments 'worked well to attach specific health policy objectives to delivery, or to balance the negative and positive incentives of different payment mechanisms' (OECD 2016a, p. 12).

In a review of the influence of payments models on the provision of oral health care, Woods (2013) concluded that, at least in theory, a blended payment consisting of a capitation

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component, fee-for-service component and an allowance related to performance (with defined and measurable quality goals) provided the best incentive structures for the delivery of dental services.

The National Health Service (NHS) in England is taking a blended approach to payment models in reforming remuneration in dental contracts (box 13.2).

In reviewing the NHS dental pilots, the UK Department of Health (2015) noted that there was no evidence that patients were undertreated in the pilots. Nonetheless, the Department raised concerns about the perverse incentive to provide less treatment in a full capitation model and the difficulty in developing capitation prices for expensive and less predictable treatments.

Following on from the pilots, NHS re-designed the payment model in a new prototype contract. Under the prototype contract, a blended payment model was introduced to balance the activity and capitation drivers and support the prevention and treatment needs of patients. Activity payments were applied to various treatments in the different prototype models.

Drawing on the experience of the NHS, a blended payment model, that incorporates risk-weighted capitation, outcome and activity payments, would offer potentially significant benefits to the delivery of public dental services in Australia. Specifically, the inclusion of activity-based payments would be suitable for delivering:

- more complex dental treatments where the need for treatment is less predictable and designing a capitation payment is therefore difficult (such as dentures). Activity-based payments in these circumstances may encourage a range of providers to participate in a consumer-directed care scheme
- one-off urgent treatment for: non-enrolled patients; and enrolled patients where the nature of the urgent treatment is unpredictable and unavoidable (for example, loss of a tooth in an accident).

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## Box 13.2      The NHS dental contract trials

Currently the National Health Service's (NHS) dental contracts in England are a wholly activity-based payment — paying dentists for treatment and repair rather than for preventing future disease.

However, this is changing. The NHS is developing a new approach to dental services that could shift the focus of dental services from treatment and repair, towards prevention and oral health. The new approach introduces: a clinical pathway focused on managing risk, providing preventive care and encouraging healthy behaviours; measurement and remuneration for quality of care; and a payment model that supports continued care and a focus on prevention as well as treatment (Steele 2014; UK Department of Health 2015).

### The pilot contracts

The initial pilots commenced in 2011. Rather than being paid based on the units of dental activity, providers were paid a capitation payment, which for some providers was weighted based on a patient's age, gender and the deprivation status of their postcode (Steele 2014).

A small element of the payment was based on the quality of care provided (as measured against the Dental Quality and Outcomes Framework (DQOF) (box 12.5)). However, problems with the robustness of the clinical data meant that performance payments were not included in the initial two years of the pilot.

Moving from an activity-based system to a capitation approach was expected to lead to a fall in treatments per patient and an increase in the number of patients seen (when providers are rewarded to take on more patients). However, the NHS pilots saw both the number of treatments per patient and the number of patients fall. This was attributed to a range of factors including 'initial learning curve' difficulties and clinical and administrative (including data systems) issues. In addition, contract payments for some providers in the pilot were not dependent on the number of patients cared for (UK Department of Health 2015).

### The prototype contracts

The second stage of reforms developed a prototype payment model which is intended to form the basis of a new system for NHS dental contracts. While still including payments for capitation and quality to drive continued care with a focus on prevention, the prototype model also includes activity payments (for particular treatments) (UK Department of Health 2015). Two contract types are being prototyped:

- blend A where *capitation payments* are used as the basis of remuneration for oral health reviews and preventive care, and *activity payments* are used for all treatments
- blend B where *capitation payments* are used as the basis of remuneration for oral health reviews, preventive care and routine treatment, and *activity payments* are used for more complex treatments.

A *quality* remuneration adjustment, based on relative performance against the DQOF, is included in both contract types. Urgent care for a *capitated patient* does not count towards a practice's activity level.

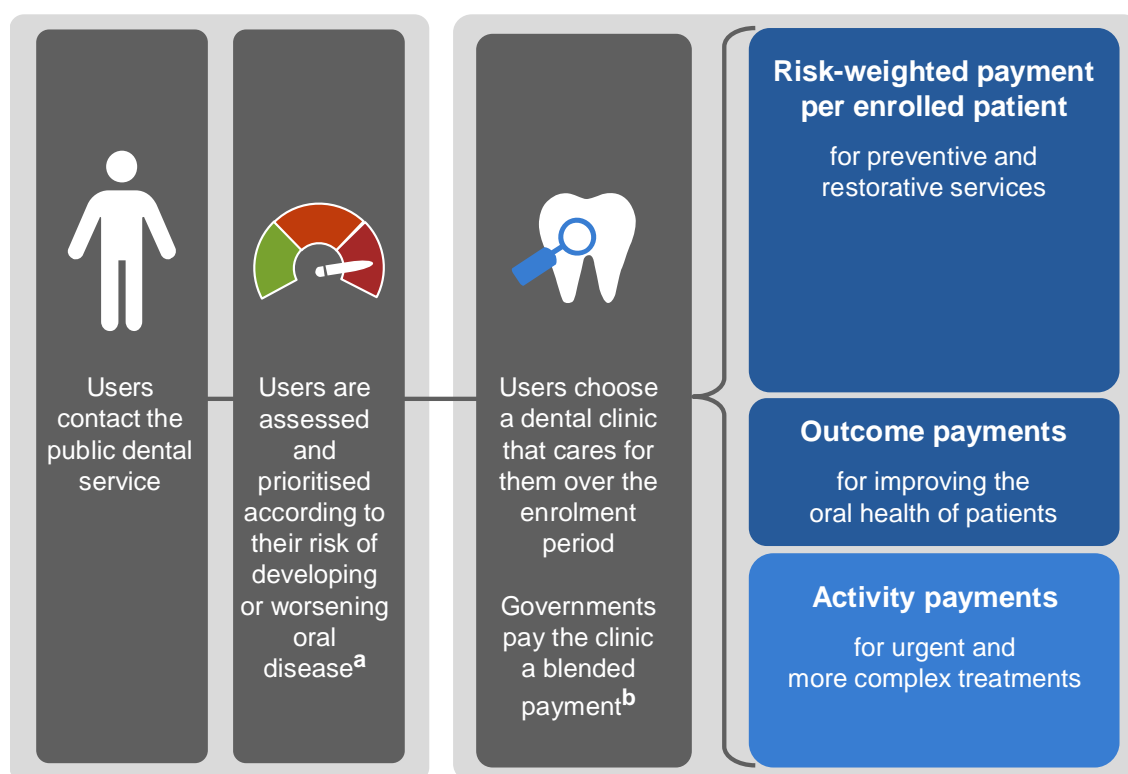
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## The proposed consumer-directed care payment model

The Commission considers that public dental users, and the community more broadly, would benefit from the introduction of greater choice alongside a blended payment model that rewards providers for improving outcomes for users. Figure 13.1 outlines how this blended payment would work within the broader consumer-directed care scheme. Access to the scheme would be managed via a risk-based waiting list and users would be provided with information to support their choice of dental clinic (section 13.4 details the risk-based allocation model that targets services to users at high risk of developing or worsening oral disease).

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Figure 13.1 How providers would be paid under consumer-directed care



<sup>a</sup> Urgent care should remain the priority for public dental services. After urgent care needs have been met, general care should be provided in line with the proposed blended payment model. Figure 13.2 illustrates in detail how consumers would be allocated funding under consumer-directed care. <sup>b</sup> The figure is a stylised representation of the blended payment model. The relative share of the enrolment, outcome and activity payments would be determined following evaluations from the initial test sites (section 13.6).

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Under a consumer-directed care scheme, governments would pay public or participating private providers a combination of:

- risk-weighted capitation payments, for preventive and restorative services, to provide continued care for a public patient over a defined enrolment period. These should be paid at regular (say, monthly) intervals

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- outcome payments to reward providers for the quality of care provided. Governments could pay providers for achieving interim (annual) outcomes based on patient-reported outcome measures, and a final outcome payment (based on both patient-reported and clinical outcome measures) at the end of the enrolment period
  - activity-based payments for urgent and more complex treatments where the need for treatment is less predictable and, therefore, cannot be readily brought within the capitation payment.

Where participating providers operate multiple clinics, governments may make payments to the overarching provider (for example, a corporate group or government dental network) for administrative simplicity.

Enabling people to have more choice over their dental provider is an important reform but further benefits could be achieved if this choice was coupled with a greater focus on preventive care. One way to achieve this is for dental clinics to be responsible for the care of a patient for a defined period. This requires balancing a user's ability to choose a different provider against the benefits derived from continuity of care by a single provider.

The Commission's proposed consumer-directed care reforms strike this balance by giving users the choice over their dental clinic (either public or a participating private clinic) for an ongoing three year enrolment period. The Commission also notes that continuity of care in health services is associated with improvements in both patients' outcomes and satisfaction (van Walraven et al. 2010).

In some cases it may be necessary and appropriate for patients to change provider, such as when the patient moves cities. Therefore, there would need to be provisions made for patients to change providers in certain circumstances. (Scope to change providers exists within other capitation models overseas — see, for example, New York State Department of Health (2015).) In these circumstances, users would need to weigh up the costs from interrupting their continuity of care with the benefits of changing provider. Allowing some scope to change providers would address concerns raised by the ADA (sub. DR545) that consumers would be *locked* in to a particular provider for the duration of the enrolment period.

### The efficient price of service delivery

Introducing consumer-directed care to public dental services in Australia would require State and Territory Governments to consider how the efficient cost of providing services varies for different population groups, and in different settings. For example, children are likely to have different treatment needs from adults. If payments to providers are not weighted to reflect such variations, there is a risk that providers would avoid high-cost patients where capitation-based payments would not cover their costs. This can give rise to equity concerns and undermine the effectiveness of public dental services as a safety net.

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Payments to providers under consumer-directed care should reflect the efficient cost of delivery (chapter 1). The ‘efficient cost’ concept already forms the basis of activity-based funding (ABF) of public hospitals in Australia, where the Independent Hospital Pricing Authority (IHPA) determines the National Efficient Price (NEP) for services. The NEP for hospitals is based on the average cost of an episode of care (a set of services). Each episode is weighted according to its complexity. The efficient price is then multiplied by the weighting to calculate the payment for each specific episode.

Similarly, IHPA should set efficient prices (including risk-weighting) for public dental services, drawing on dental expertise through consultations with governments and providers. IHPA would need to consider a separate efficient price for both activity-based payments (for an episode of care) and capitation payments (for care across the enrolment period). Outcomes payments could be set separately by the Australian, State and Territory Governments.

Efficient prices need to account for the cost of necessary care, plus a margin, based on effective and efficient administrative and clinical processes (Porter and Kaplan 2016). Efficient prices would also need to take account of the cost of capital to maintain competitive neutrality (a ‘level playing field’) between public and private providers (chapter 2). The cost of teaching and training activities, and the means of remunerating for these costs, should also be given consideration. Such concerns are not unique to public dental services. In the context of public hospital services, IHPA is currently developing a teaching and training classification system, which is expected to be completed in 2017-18.

Calculating the efficient capitation payment would have similar data requirements as ABF for hospitals. In the context of ABF, IHPA (sub. DR560) noted that the development of efficient pricing would require:

- a clear definition of scope of services and providers that are to be funded
- patient-level data including demographic data, as well as data on how patients were diagnosed, treated, and the associated cost
- classification codes that relate the type of patient treated (for example, whether the patient was admitted for emergency care or for subacute care such as rehabilitation) to the cost of treatment.

IHPA (sub. DR560, p. 2) stressed that ‘detailed, patient level cost data is crucial to the implementation of ABF’. To this end, governments should work with IHPA to immediately commence development of a costing standard for public dental services, and to start collecting patient-level activity and costing data as soon as possible.

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#### RECOMMENDATION 13.1

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

- risk-weighted capitation payments for preventive and restorative services for enrolled patients that incentivises the provision of clinically- and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)
- outcome payments, incorporating payments for clinical and patient-reported outcomes
- activity-based payments for urgent and more complex treatments (such as dentures). The dental treatments that would be eligible for activity-based payments should be limited to those that cannot be readily brought within the capitation payment.

State and Territory Governments should ensure that under the scheme:

- patients are offered choice of provider (public or private clinic) who will care for them for a defined enrolment period of three years
- users are able to change provider in certain circumstances, such as when moving city.

#### RECOMMENDATION 13.2

The Australian Government should direct the Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, to immediately commence development of:

- a costing standard for public dental services
- efficient prices for consumer-directed care payments.

### **13.3 Better targeting high-risk children under the Child Dental Benefit Schedule**

In addition to the State- and Territory-run public dental schemes, the Australian Government funds a separate Child Dental Benefit Schedule (CDBS). The CDBS targets the oral health of young Australians at an age where preventive measures can be most effective (Australian Government 2016c). The CDBS contributes to the cost of dental services, up to a cap of \$1000 of benefits over two years for basic dental services for children in families receiving certain Australian Government payments, such as Family Tax Benefit Part A. Parents of children eligible under the CDBS are able to choose their provider, either from the public or private sector, that is paid on a fee-for-service basis.

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The ‘one size fits all cap’ ensures the ongoing sustainability of the schedule (Australian Government 2016c) but it does not reflect the varying needs of the eligible population. Of those children commencing treatment under the CDBS in 2014, while the majority (71 per cent) used less than half of their cap in the first year, 8 per cent reached or were close to reaching their benefit cap.

For children with complex treatment needs, an appropriate course of care may reach the \$1000 cap well within the two years. Indicatively, the National Oral Health Alliance (NOHA 2017) estimated that over a two year period: children at low risk of dental caries were likely to need between \$410 and \$460 of care; whereas the top 10 per cent of children at high risk of dental caries were likely to need up to \$2050 of care.

More broadly, there is no mechanism in the current scheme to ensure that children are receiving treatments that are both clinically and cost effective, and that expenditure on the CDBS represents value for money for both patients and the government.

The Commission considers that the CDBS should be transitioned to the blended payment model, including the use of risk-weighted payments, outlined above. Children’s dental care generally focuses more on prevention than that of the general population, making them better suited to treatment under capitation models (ADA 2017). As such, the transition of the CDBS to the blended payment model should be one of the first aspects of the rollout of consumer-directed care (after the scheme has been finalised). The Commission’s blended payment model would both encourage preventive care and provide children at high risk of oral disease with individual funding that reflects their care needs. As discussed in chapter 12, poor oral health can track strongly from childhood to adulthood. Better targeting of services therefore could have lifetime benefits for individuals and, potentially, for the health system.

For eligible children, access to the CDBS is demand-driven and, therefore, does not require any allocation mechanism to determine when users can access services. However, transitioning to the proposed blended payment model would require that patients:

- enrol with their chosen provider for a specified period (three years)
- undergo a clinical assessment to determine the appropriate risk-weighting for patients and to create a baseline record of their oral health status (to measure clinical outcomes).

The Australian Government should request that IHPA develop specific risk-weighted capitation payments for the CDBS.

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#### RECOMMENDATION 13.3

The Australian Government should introduce a new blended payment model for the Child Dental Benefit Schedule once the consumer-directed care scheme has been finalised. As described in recommendation 13.1, under the blended payment model participating providers should receive:

- risk-weighted capitation payments for preventive and restorative services for enrolled children
- outcome payments, incorporating payments for clinical and patient-reported outcomes
- activity-based payments for urgent and more complex treatments that cannot readily be brought within the capitation payment.

The Australian Government should replace the existing capped benefit with a capitation payment that is weighted to reflect the oral health care needs of eligible children.

### 13.4 Allocating funding to patients

Consumer-directed care enables users to choose their provider. This can be delivered either through a demand-driven funding model (like Medicare or the CDBS) or a constrained funding model. State and Territory public dental services currently operate under a constrained funding model. The Commission does not propose to change this. Consequently, an *allocation model* would be needed to determine when an eligible user can access publicly funded dental services.

#### Prioritising access to care based on risk

Currently, despite having different risk levels, public patients on the waiting list for general care are largely treated on a ‘first come, first served’ basis:

... risk is not currently categorised when people go onto the waiting list — so their condition may deteriorate over time, rather than preventing the worsening of the most serious conditions. As is done in other parts of the health system (notably, for elective surgery patients) dental patients — both hospitalised and in the community — should be prioritised in accordance with risk triage categories and with guidelines for such prioritisation and triaging. (DHSV, sub. 465, p. 10)

In a general health context, waiting lists — where they take into account the urgency of care required and the risk of worsening conditions for patients — can be an efficient way to ration access to services (Gravelle and Siciliani 2008, 2009). The same is true for dental services. In a public dental context, well-managed waiting lists should not result in the significant deterioration of the oral health of patients while they wait to receive care.

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Using a centralised waiting list in each jurisdiction, rather than a clinic-by-clinic approach, would facilitate more effective triaging of patients according to their escalating risk of oral disease across the eligible population in an area (that is, target those users whose oral health stands to benefit most from earlier access to preventive care).

Governments could also use a centralised risk-based waiting list to manage the share of service delivery allocated to urgent and general care. Urgent care should remain the priority for public dental services. After urgent care needs have been met, State and Territory Governments should provide general care in line with the Commission's blended payment model. Public performance reporting on the extent to which patients in each risk category (for both urgent and general care) are treated within clinically acceptable waiting times (chapter 12) would give governments important information on funding priorities.

Under the Commission's model, a patient's risk of developing or worsening oral disease would need to be assessed. Risk assessments would serve three purposes:

- first, to identify patients in need of urgent care and to prioritise those patients at high risk of developing oral disease within a risk-based waiting list
- second, to assign patients to the most appropriate risk-weighted capitation group
- third, to create a baseline record of patients' oral health status to measure clinical outcomes at the end of the enrolment period.

Ideally, risk assessments would be undertaken by a trained professional that is independent of the treating dental clinic to ensure that the assessment is an accurate record of the patient's oral health status. However, independent clinical assessments would draw resources away from the overall provision of public dental services.

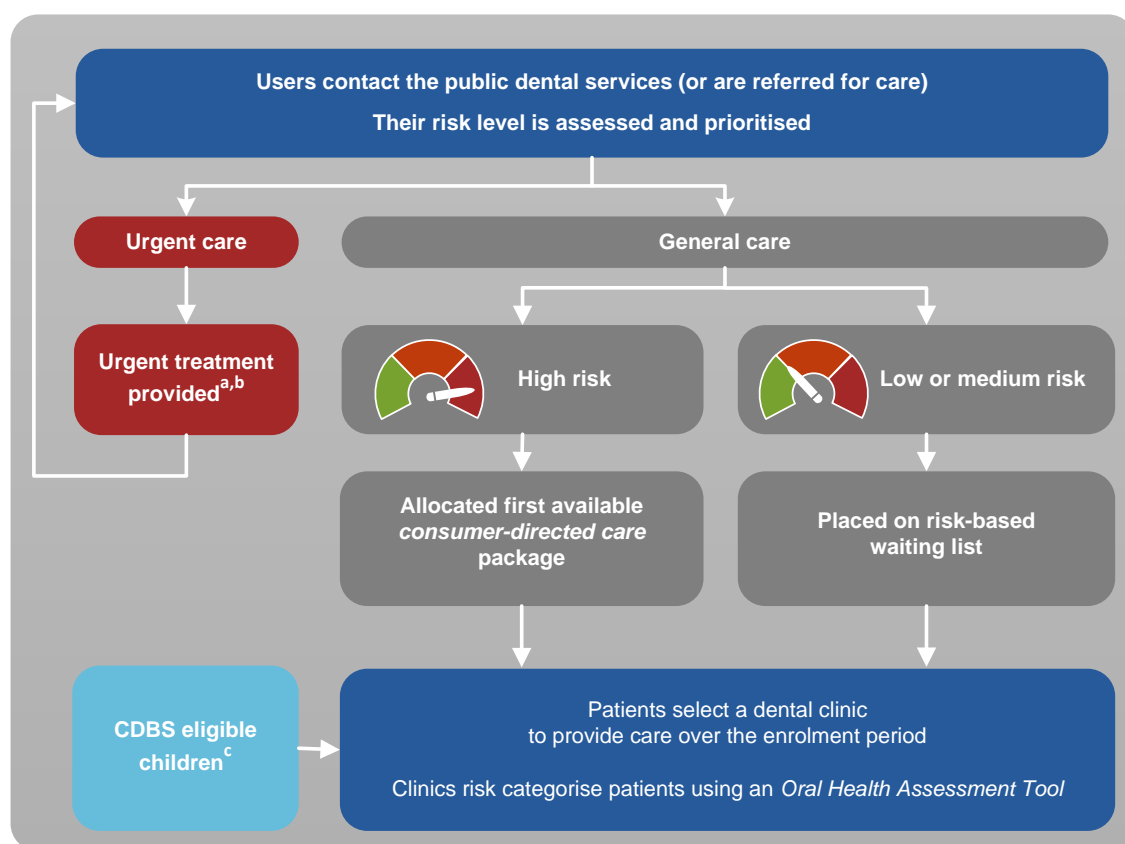
Balancing these considerations, the Commission proposes a two-staged approach to assessing patient risk, involving:

- an initial assessment by the central public dental service
- a clinical assessment at the patient's chosen dental clinic, assisted by an *Oral Health Assessment Tool* and monitored by stewards.

The Commission's proposed allocation model is outlined in figure 13.2. Box 13.3 provides an example of how the proposed reforms would work in practice for users under this allocation model. A somewhat similar assessment process already occurs in Queensland, where users seeking treatment for a problem are filtered through an initial phone assessment, followed by a clinical assessment (box 12.4).

In addition to waiting lists, co-payments can be used as a means to manage access to a service (chapter 2), or to supplement available funding. The allocation model for consumer-directed care provides a means to manage access to services on both clinical and funding grounds. As such, the use of co-payments is not a necessary feature of the consumer-directed care scheme proposed by the Commission, but is a matter that should be considered by each jurisdiction.

Figure 13.2 How eligible users would access consumer-directed care



<sup>a</sup> Under the proposed consumer-directed care reforms, public dental patients would receive urgent care at either dental hospitals or participating public or private clinics (where providers will be paid an activity-based payment). <sup>b</sup> Following urgent treatment, patients would be referred back to public dental call centres to be risk assessed for general care. The nature of their need for urgent care will factor into their risk assessment for general care. <sup>c</sup> As access to the CDBS is demand-driven for eligible children, it does not require the initial risk assessment processes for allocation of funding. However, once patients under the CDBS select a clinic, they would still undergo a clinical assessment and be risk categorised.

## The initial risk assessment

When patients first request or are referred for care, the public dental service (independent of any particular provider of dental services) should conduct an initial risk assessment over the telephone (or online). The initial risk assessment would allocate the patient to urgent care or a risk-based waiting list for general care. Initial phone-based assessments are widely used for triaging urgent cases. Further, there is evidence that, for general care, phone risk assessments are a good proxy for determining a person's relative priority for access (Jones 2014). Such assessments use a combination of indicators of relative disadvantage, self-reported treatment needs, and oral health status.

Telephone-based risk assessments could draw on existing information to improve their accuracy. Sources of such information include patients' dental records, referrals from other

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health professionals and digital oral health records that are linked to other parts of the health system (chapter 12).

Public dental services could actively work with patients who are on the waiting list to improve their oral health literacy and behaviours that may affect their risk factors. The ADA suggested that patients on the waiting list should be put on a maintenance program so their dental health does not deteriorate (trans., p. 17). DHSV also proposed using waiting lists to stop further deterioration and provide behavioural interventions tailored to people's capacity to change (trans., pp. 245–248). Any such programs should be supported by robust evidence of their positive effects, and an assessment of their costs relative to other interventions.

### Clinical assessments

At a patient's first appointment with their chosen dental clinic, the clinic should assess their risk level with the assistance of a digital Oral Health Assessment Tool. This tool should be linked to the patient's digital oral health record.

Work is currently underway to develop a similar risk stratification tool to assist Health Care Homes service providers to identify and risk stratify patients (Department of Health 2017g). This represents a more cost-effective means of setting a baseline for patients than independent clinical assessments — the contract for the Health Care Homes risk stratification tool, including software and support, was awarded for under \$900 000 (Department of Health 2017c). Given the narrower range of risks for dental care, developing an Oral Health Assessment Tool is unlikely to be more complex than the Health Care Homes tool.

As with the Health Care Home trials, dental clinics should be required to link the outcome from the Oral Health Assessment Tool with clinical and patient-reported data through the My Health Record system (chapter 12). Stewards should use this data to undertake ongoing monitoring and targeted auditing of the use of the Oral Health Assessment Tool (and subsequent treatments and outcomes) to ensure the integrity of results. Public dental services should monitor discrepancies between the initial risk assessment and the outcome of the Oral Health Assessment Tool for patients as part of the continual improvement of both processes.

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### **Box 13.3      What consumer-directed care would mean for users**

#### **Jane wakes up with a mildly sore tooth**

Under the current model of provision, Jane rings her local public dental service, describes her symptoms and, as she is not in need of urgent treatment, is placed on a waiting list. Jane does not know how long she will wait for treatment, but might be advised of the average waiting time to access dental care. Nine months later, when eating one day her pain worsens and she starts to avoid certain foods and struggles to sleep, affecting her performance at work. She calls the local public dental service again and is given an urgent appointment. Jane travels to the public clinic 10 km away, and is seen by a different dentist to the one she had seen on a previous visit.

Under the Commission's proposed system, Jane would contact the public dental service (the central manager of the waiting list), answer a questionnaire about her symptoms and be asked for permission for the public dental services to review relevant information from her My Health Record. Based on Jane's clinical oral health assessment from past public dental visits and her self-reported oral health, she is informed that her oral health is unlikely to deteriorate quickly, that the clinically benchmarked time for her condition is 6 months and that she would be placed on the waiting list. When Jane reaches the top of the waiting list for her risk level, she would receive a call from the service informing her: that she is now able to book an appointment at one of the nearby dental clinics; of possible treatments; and likely co-payments (if any).

Using the information provided to her by the public dental service, in this example, Jane would be able to choose between two clinics — one clinic close to her work, the other further away from her work and home, but with slightly better reported outcome measures. Upon making her choice, Jane would be informed that she would be cared for at her chosen dental clinic for the three year enrolment period. In addition to dealing with the immediate problem, this care could also include advice on ways to prevent any further tooth decay and any follow-up appointments in the enrolment period.

After one year with her chosen clinic, Jane would be invited to complete a survey about her patient experience and the quality of her care.

#### **John has no dental pain, but is at high risk of tooth decay and gum disease**

John has been prescribed medication that causes dry mouth as a side effect. He also smokes, and does not visit the dentist regularly. His doctor recommends he see a dentist, in case the dry mouth is affecting his oral health. Under the current system, John contacts the public dental service and is placed on a general care waiting list, possibly waiting up to three years for an appointment.

Under the Commission's proposed scheme, John would contact the public dental service, who would ask John some simple questions that reveal his multiple risk factors. The call centre asks for John's permission to review his My Health Record. The call centre can see that John was admitted to hospital two years ago for a dental related infection. This information, together with John's questionnaire identifies him as being at high risk of tooth decay and gum disease. John would be provided with information on how he can make an appointment with a participating dental clinic of his choice.

In this example, John could call three clinics and choose the one that can offer an appointment on his day off. When John visits the clinic he would be seen by an oral health therapist, who would undertake an initial oral health assessment, develop a treatment plan and give him some advice on how to care for his teeth.

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## The scope of eligible providers and services

Consumer-directed care should be open to public and private providers

The Commission's proposed consumer-directed care scheme should be applied to public clinics and open to private providers, who can opt-in to the scheme.

Providers would need to satisfy a number of conditions to participate in the scheme, including (at a minimum) holding a Medicare provider number (to facilitate payment) and being registered with the Dental Board of Australia (as all dental practitioners must be). Importantly, as discussed above, dental providers would need to track and report on the oral health status and services provided to public patients in their care, as well as any co-payments charged over the enrolment period. In order to do this, participating providers would need data systems (such as My Health Record (MHR)) that can 'talk' to government systems.

Payments for the ongoing costs of caring for enrolled patients would be covered by the efficient price, which the Commission proposes would be set by IHPA (section 13.2). Participants have argued that the traditional single-person private practice does not enjoy the economies of scale that the public sector does, and as such has higher costs than the public sector (DHSV, sub. 465). If this was the case, then these private dental practices may not opt-in to the consumer-directed care scheme.

However, the private dental sector appears to be evolving and moving from a delivery model typically comprising one dentist and one assistant per practice, to a larger practice with a more diverse group of dental professionals (Solomon 2015). Private health insurers and chains are increasingly setting up and running large dental practices. Bupa, for example, owns and operates over 140 dental clinics across Australia (Bupa nd). In 2015 the Pacific Smiles Group, which provides fully serviced surgeries to independent dentists, operated 42 Pacific Smiles Dental Centres and 7 nib Dental Care Centres across Australia (Pacific Smiles Group 2015).

This shift away from the traditional single dentist practice means that, increasingly, private dental practices may achieve cost savings from economies of scale (including by employing a greater number of dental and oral health therapists). As such, the number of private providers willing to opt-in to the model may grow over time.

Eligible services should be limited to clinically- and cost-effective treatments

Not all dental treatments are clinically and cost effective. Given the information asymmetries common to many medical treatments, expert analysis of which dental treatments should be publicly funded is needed to balance the funding needs across patients.

In the past, the inclusion of treatments in public dental voucher schemes has not been based on a comprehensive review of clinical evidence to determine the *value for money* of these treatments (Tan Nguyen, sub. 398). In contrast, publicly subsidised medical services must

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undergo a cost-effectiveness analysis through the *Medical Services Advisory Committee* to be listed on the Medicare Benefits Schedule.

Only those treatments proven to be both clinically and cost effective and required for a patient to attain basic oral health should be eligible under the payment model. For the purposes of the Commission's model, 'attaining basic oral health' should include treating disease, managing pain and discomfort, restoring function and treating and managing trauma. A process similar to that undertaken for the Medicare Benefits Schedule (expert analysis of effectiveness on a procedure-by-procedure basis) should be used to identify eligible treatments. The schedule of eligible treatments should evolve in response to the development of new and effective treatments.

### Giving users more choice over treatments they receive

Consumers should have control over the treatments they receive.

While the consumer-directed care scheme would be limited to treatments necessary to attain basic oral health, patients may benefit from being able to choose to pay extra (a 'top-up' fee) to the provider to access a wider range of treatments. These arrangements could, for example, allow individuals to choose to pay a top-up fee for a more expensive filling that better matches the colour of their teeth.

Where public dental patients do exercise choice over treatments, they should be supported with consumer-oriented information and expert advice from their dental practitioner so that they can weigh up the costs and benefits to them of 'top-up' services. Stewards should ensure that adequate and effective safeguards exist for consumers.

Achieving the benefits of greater user choice over the treatments public dental patients receive would require that:

- patients pay the difference in treatment costs (the 'top-up' fee) directly to the provider
- the more costly treatments are at least as clinically effective as the basic treatment
- patients are informed of the costs and benefits of different treatment options.

Allowing top-up payments brings a risk that consumers could be encouraged to choose more expensive (but no more effective) treatments. This is a risk that exists in the private market now. Careful monitoring of patient-reported outcomes and of top-up payments could assist in ensuring that such exploitation of consumers does not occur. The experience of top-up arrangements in the hearing services scheme (box 13.4) stresses the importance of not only developing effective consumer safeguards and consumer-oriented information in the system (discussed below), but also of incorporating outcome measures in the payment model. In particular, the payment models should incorporate patient-reported outcome measures to better align the incentives of the provider with the patient.

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### Box 13.4      **Top-up arrangements for hearing services**

Top-up arrangements for the hearing services scheme vouchers allow patients to choose to be fitted with a hearing aid with additional features beyond those necessary to achieve a satisfactory rehabilitation outcome. Under that scheme, patients pay the difference in cost to the provider. The provider's contract and deed states that they must not encourage a patient to select a top-up device where there is no benefit for the patient (mpconsulting 2012).

Stakeholder feedback to a 2012 review of the regulation for hearing services raised concerns over the risk that vulnerable clients were being encouraged to purchase more expensive hearing aids when there was little or no clinical need for such devices (mpconsulting 2012). However, there were varying views from stakeholders to the 2012 review of hearing services on the extent to which this risk was playing out in the scheme.

More recently, the Australian Competition and Consumer Commission (ACCC) sought evidence relating to issues around the sales of hearing aids. Information provided to the ACCC identified practises in the industry aimed at selling more expensive hearing aids, including sales performance measures based on, among other things, the number of 'top ups' for consumers with vouchers under the scheme:

Some hearing clinics encourage clinicians to sell more expensive hearing aids by setting sales targets, paying commissions to clinicians, having arrangements that favour certain brands or are owned by companies that manufacture hearing aids. (ACCC 2017a)

The ACCC released guidance material to assist with informed choice and requested that operators review their programs and performance measures (ACCC 2017b).

## **Information needs**

### **Information for the eligible population**

To get the full benefit from the Commission's proposed reforms, the eligible population needs to know that they are eligible to receive publicly funded dental services, and that they would benefit from preventive and early intervention care.

Evidence suggests more effort is needed on both fronts. A 2016 online survey of 417 people living in New South Wales and experiencing (or at risk of) poverty found that:

- about 38 per cent of respondents were not able to afford dental treatment. This was much higher than the share of respondents (17 per cent) who reported being unable to afford medical treatment
- of those families with dependent children responding to the survey, about 42 per cent reported not being able to afford a dental check-up for their child (NCOSS 2016).

All children (under 18 years old) are eligible for public dental services in New South Wales. As such, the NSW Council of Social Services (NCOSS) concluded that an underlying issue for children was awareness of, not eligibility for, programs. To address this, NCOSS (2016, p. 18) recommended that 'the NSW Government should invest in communication efforts to ensure all families are aware of the dental health services available for their children'.

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Issues with a lack of promotion and low take up have also been identified under the CDBS — only 30 per cent of eligible children accessed services in 2014 (ANAO 2015; Australian Government 2016c). A review of the CDBS chaired by the Commonwealth Chief Medical Officer found that, by relying on the *myGov* website, the scheme had not been promoted effectively (Australian Government 2016c). The review recommended that hard copy notifications also be sent to eligible families, with hard copy follow-up notifications for eligible families that have not accessed services.

In addition to a lack of awareness of their eligibility for public dental services, some users simply do not seek timely access to dental care.

Despite all children being eligible for public dental services in New South Wales, dental conditions were the leading cause of potentially preventable hospitalisations for children (under 20 years old) in 2015-16 (Health Stats NSW 2017). More children were hospitalised for preventable dental conditions in 2015-16 than for asthma or ear, nose and throat infections.

This supports the case for providing the eligible population with targeted oral health information on the benefits of:

- personal behaviours that support good oral health
- preventive and early intervention dental care that can avoid or halt the progression of oral disease.

At an individual level, oral health promotion interventions, such as screening and assessments, can build people's awareness and ability to better look after their own oral health. Importantly, such interventions can also help identify those at high risk of oral disease who may not engage with dental or other health services until their condition has severely deteriorated.

Identifying and connecting such cohorts with public dental services can leverage off existing healthcare and education services that people already access. The COAG Health Council (2015) identified the need for better integration of public dental services and the broader health system. Many members of the non-oral health workforce — including, for example, GPs, maternal and child health nurses, and other care workers and educators in the aged care, disability and early childhood sectors — have more regular contact with the population than dental practitioners. The COAG Health Council noted that these workers have an important role in providing oral health information and referral for dental care in general health and wellbeing checks.

The success of screening (or targeting) activities requires that non-oral health workers have the tools and information needed to identify and refer those at high risk of oral disease. The 'lift the lip' initiative, for example, provides GPs, nurses and other childhood and health professionals with a simple screening and referral tool to identify young children with early signs of tooth decay (Tasmanian DHHS nd). The initiative provided a straight forward

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explanation of how to assess a child's teeth, with images showing early and advanced decay, and information on the referral process.

Once individuals at high risk of oral disease are identified in non-oral health settings, reforms to incorporate digital oral health records within the MHR system (recommendation 12.3) would support effective referral pathways.

There are some parts of the population with particular characteristics where information is not the sole barrier to accessing services. For these, specialist outreach services may be required (section 13.5).

### Information to support user choice

Public dental services should provide user-oriented information to support patients in making an informed choice.

Information on what to expect (in terms of required services and their general costs) and where to find a provider could be delivered through pamphlets and online. The *NHS Choices* website in England allows users to look up a range of information about dentists in their area. Some of the information reported includes whether the dentist is accepting new patients and accessibility information (such as the availability of a hearing induction loop). The site also allows users to leave star ratings and write a review.

Chapter 11 recommends that the MyHospitals website be transformed, drawing on the example of the NHS in England. Public dental services should do the same. This information should be presented in a form that is clear and understandable for the population eligible for public dental services. The information presented on such a website would serve as a broad basis for users, but more specific forms may also be required.

Some people may have difficulty in using or accessing such a website. As such, in addition to a website, information in other forms (for example, pamphlets for community workers aimed at particular groups of the population) could be required to target particular groups. Useful and timely information that is specific to an individuals' needs could also be delivered through the initial triaging telephone conversation and when patients are allocated funding.

Under the proposed consumer-directed care scheme, public dental patients would benefit from being provided with information on the local participating providers (such as clinic locations and any published outcome measures), the enrolment period with their chosen clinic and any co-payments.

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#### RECOMMENDATION 13.4

State and Territory Governments should provide access to consumer-directed care through a risk-based allocation model.

Under the allocation model, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease.

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

- clinically- and cost-effective treatments that are necessary for the patient to attain basic oral health
- 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.

### **Consumer protection**

Consumer protection should be provided to preserve the quality of public dental services, and to protect individual users.

Under the Commission's model, performance reporting required from private and public clinics gives stewards the necessary data to run the system. This would allow stewards to monitor any trends in quality or cost of services within the scheme.

Most government-operated dental clinics are required to gain accreditation against the National Safety and Quality Health Service (NSQHS) Standards, which encompass six areas where it is known that people have been harmed as a result of health care and there is good evidence on how to achieve better outcomes. In contrast, NSQHS accreditation is voluntary for private dental practices. The registration requirements for dental professionals in Australia provide for a base minimum standard of care. In addition, the outcome measures in recommendation 12.2 (and their link to payments) would provide quality signals to users, providers and system stewards.

Nonetheless, there remains a risk of 'bad apples' in any profession. Consumers should be informed at the time of being allocated funding of their avenues for complaint and redress. The outcome of any complaints should also be monitored by governments.

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## 13.5 Improving contestability within public dental services

Consumer-directed care would not be accessible for all users. There are some circumstances where introducing greater user choice is not feasible, such as in remote locations with small populations that may not be able to support multiple dental providers (or even a single provider all year round). For instance, Dudko, Kruger and Tennant (2017) estimated that about 4 per cent of the population eligible for public dental services that live outside metropolitan areas are located more than 50 km from a public or private dental clinic.

There may also be populations in metropolitan areas who have complex and special needs that can only be accommodated by a small number of providers. Victoria, Western Australia and South Australia provide services in a patient's residence if they are homebound due, for example, to disability or dementia (DHSV nd; SA Health nd; WA DHHS nd).

Governments should commission services to meet the needs of people who are not able to exercise choice effectively. 'Commissioning' is an approach to the stewardship of human services that covers the full service cycle, from understanding the service user population and its needs, through to selecting service providers, managing contracts and monitoring and evaluating services (chapter 8).

### Establishing effective commissioning processes

The first step governments could take towards establishing effective commissioning processes would be to separate service delivery from commissioning responsibilities (chapter 2). This separation would improve accountability and remove potential conflicts of interest in provider selection processes that may arise if the agency running the selection process is also competing for selection itself (chapter 7).

Separating these functions may require governments to establish a commissioning agency that would have responsibility for the full range of stewardship functions that are part of the commissioning cycle.

Victoria is the only jurisdiction with a dedicated dental commissioning agency (box 13.7). However, State and Territory Governments do not all need to run their commissioning processes through a dedicated *dental* commissioning agency like Victoria's. Other jurisdictions could run their processes through health departments or regional health districts (like the Local Health Districts in New South Wales). Regardless of the institutional arrangements in each jurisdiction, governments should establish commissioning processes that allow them to focus on their role as system stewards rather than primary service providers.

As noted by the Public Service Research Group (sub. DR572), establishing effective commissioning processes in departments that were previously focused on service delivery

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would not just involve a change in what government does, but also a change in culture that would take time and need significant investment in the right capabilities. Chapter 8 outlines some shortcomings of commissioning processes for family and community services. Without a concerted effort to invest in the right capabilities, there is a risk that public dental services might develop similar shortcomings in their commissioning processes.

Effective commissioning processes would focus governments on their stewardship role, including driving service improvements and encouraging innovation by providing advice around best practices, benchmarking and monitoring outcomes.

Improved commissioning processes would provide opportunities for contestable provision of public dental services in areas where user choice would not be feasible. As distinct from ad hoc contracting, commissioning can achieve better results for service users through systematic approaches to planning, targeting and delivering more effective services.

Governments should improve commissioning processes by:

- undertaking service planning to better understand population needs and lower the barriers people face in accessing services
- taking a more systematic approach to selecting providers that can best meet users' needs, which would encourage innovative approaches to service delivery
- using an outcomes framework to improve the focus on users' oral health.

## **Better service planning**

Governments need to commission services that meet the needs of the eligible population, including people with complex needs, and those that may be unaware of their eligibility or reluctant to seek out dental services. Governments need to understand the service user population and the barriers to effective services, and address them through the commissioning cycle.

For example, the SA Dental Service ran a program that worked to both address barriers to care and engage with eligible people from culturally and linguistically diverse backgrounds, people with mental illness and people in rural locations. The program's explicit aim was to increase access to services by these groups. The SA Dental Service worked with non-government organisations and cultural associations to raise awareness of how dental services can be accessed, including providing information sessions to community groups about oral health and the public dental service. The SA Dental Service also met with key organisations to discuss the oral health needs of their communities and provided oral health training and information to community workers and clients (SA Health 2016).

Outreach to some population groups may need to be based around programs that provide education and oral health promotion, and aim to influence users' behaviour towards healthier choices, including regular dental check-ups.

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Governments should undertake long-term service planning to understand patients' needs and develop strategies and programs to meet these needs. Governments' long-term planning would be hindered if recent policy and funding uncertainty continued (box 13.5).

### **Box 13.5      Dental funding: a case of fillings and extractions**

In late 2012 and early 2013 the Australian and the State and Territory Governments signed the *National Partnership Agreement on Treating More Public Dental Patients*. This National Partnership Agreement provided \$344 million over three years to reduce public dental waiting lists. Another National Partnership Agreement was announced in 2013, and was to provide an additional \$1.3 billion over four years to 2017-18. This announced National Partnership Agreement was delayed by a year and then cut substantially, ultimately only providing \$155 million in one year, 2015-16.

In the 2016-17 Budget, the Australian Government announced that it would be abolishing the Child Dental Benefits Schedule (CDBS) and combining adult and child funding in a new National Partnership Agreement, to be worth \$1.7 billion over four years from 2016-17. In December 2016, the Australian Government abandoned this plan, announcing that the CDBS would remain and that another National Partnership was planned, this time to provide \$320 million over three years.

*Sources:* Australian Government (2013a, 2014a, 2015, 2016a); COAG (2013); Ley (2016).

## **A systematic approach to selecting providers**

Governments currently commission public dental services from non-government providers in some locations, but could seek out further opportunities to introduce greater contestability.

In some places, the best use of resources will be to use a mix of public and private settings. Governments have already acknowledged this in the National Oral Health Plan:

Services can be made more sustainable and affordable when developed and managed using collaborative models that involve the private, public and non-government sectors. Such models can incorporate aspects of resource sharing, training education and research integration, clinical governance and workforce support and mentoring across sectors and regions. (CHC 2015, p. 61)

In practice, governments have used a range of providers to deliver services to remote communities. For example, Western Australia has used fly-in-fly-out services (box 13.6), while DHSV and the Royal Flying Doctor Service Victoria jointly fund a mobile dental clinic that is staffed with assistance from the Australian Dental Association Victoria Branch (DHSV 2016). The Tasmanian dental service has lease agreements in place for private dentists to utilise spare capacity on King Island and in Queenstown (Tasmanian Government, sub. 485), improving the flexibility of the private dental workforce and the utilisation of public dental assets.

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**Box 13.6      Delivery of dental services in remote Western Australia and the Northern Territory****Western Australia**

Western Australia funds a visiting oral health program for five communities in outer regional, remote and very remote areas of the state. The services operate in partnership with Aboriginal medical services and use the local clinics. Dental professionals visit for about a week at a time, with visit frequency determined by clinical need and other community factors. The team comprises a visiting dentist and a local Aboriginal health worker, who acts as both the dental assistant and as patient liaison. Services comprise mostly restorations and extractions to alleviate pain and discomfort.

**The Northern Territory**

From 2009, the Australian Government has funded a series of oral health programs for Indigenous children in the Northern Territory. Implemented by the Northern Territory Government, the programs have been delivered in a variety of clinic types, including community dental clinics, school clinics and mobile dental trucks. Outreach dental teams consist of either a dentist or a dental/oral therapist and an assistant, who travel to communities for one to three weeks at a time. To promote preventive dental care in remote settings, primary health workers (such as Aboriginal health workers and remote nurses) can complete a certificate course in oral health promotion. The course trains them to incorporate oral health screening and education into health checks for children up to 5 years old. The primary care workers are also trained to apply fluoride varnishes, and to be able to refer children to the visiting oral health professionals.

The programs focus on preventive services, with full mouth fluoride varnishes and fissure sealants being provided, in addition to other clinical services (such as fillings or extractions).

The children accessing services have high oral health needs: in 2009 more than 90 per cent of 7 and 8 year olds had tooth decay. Over time, the oral health of children accessing the program has improved. The proportion of 1 to 3 year olds with tooth decay fell from about 73 per cent in 2009 to about 42 per cent in 2015. Most other age groups experienced a reduction in the rate of tooth decay, albeit not as large as the improvement observed for the youngest age group.

*Sources:* AIHW (2017f); Dyson, Kruger and Tennant (2012, 2014).

The NT Government (sub. 593, p. 25) outlined examples of contestable arrangements that governments could consider for implementation in remote areas:

This might include having larger teams provide visiting services for longer periods, utilising contractual arrangements to promote visiting private sector and NGO [non-government organisation] engagement in remote areas, and providing culturally appropriate consumer information.

The benefits from greater contestability and flexibility in how services are delivered are not limited to populations in remote areas. Using primary health workers to deliver oral health promotion, for example, could be an effective way to reach people in metropolitan areas that may not have a history of seeking preventive oral care. As another example, the most effective way to reach people with mobility problems could be to visit them at home. Yet most dental practitioners would not find it economical to purchase portable dental equipment

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for occasional use (CHC 2015). Public dental services could make such equipment available to private providers to increase choice.

As noted above, there are examples of approaches to partnering with the private sector already in use across the country, but they are not widely adopted. Contestable delivery arrangements could be used to encourage innovative approaches, including using tele-health technology, or training other healthcare workers in dental diagnosis and care.

## **Outcomes-based commissioning and relational contracting**

Commissioners of public dental services should develop an outcomes framework (chapter 2) to improve the focus on users' oral health. The framework would apply to both public and private providers offering services to public patients. An outcomes framework would enable outcomes-based commissioning, including outcomes-based program design, monitoring, evaluation and funding (box 8.5, chapter 8). In some settings, governments could draw on the Commission's proposed blended payment model (section 13.2) to design outcomes-based funding arrangements.

The outcomes framework should be based on the clinical and patient-reported measures developed in response to recommendation 12.2. Ideally, governments would use the same frameworks for both commissioned services and the consumer-directed care scheme to enable comparisons between the programs. However, governments may choose to include more context-specific outcome measures in the framework for commissioned services. Some output or activity measures may be good proxies or predictors of health outcomes and could be used in the short term where there is strong evidence of a relationship (DHSV, sub. PFR366). In addition, the scope of commissioned services may lead to different outcomes of interest. For example, governments could measure the effectiveness of outreach services in increasing certain population groups' contact with public dental services.

An outcomes framework could also allow governments' relationship with providers to become less prescriptive and instead focus on innovative approaches to achieving good outcomes for people who use public dental services. More broadly, governments could focus on establishing relational approaches to contract management, in line with the approach in Victoria (box 13.7).

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### Box 13.7      **Relational contracting in Victoria**

DHSV is the only dedicated dental commissioning agency in Australia. It contracts services from Community Dental Agencies (CDAs), which can be independent entities or can sit within larger community health services or hospitals. There are 50 CDAs, with 20 established as independent non-profit companies and 30 established as health services or hospitals. The contracts are renewed on an annual basis (DHSV, pers. comm., 13 April 2017), but largely operate in line with the 'relational contracting' model recommended in chapter 8.

The approach that DHSV takes to monitoring performance involves a high degree of communication with CDAs. Each CDA meets with DHSV's agency relationship team every month to discuss performance against targets and regional and state benchmarks (VAGO 2016). DHSV provides each CDA with monthly, quarterly and annual reports measuring their performance against the indicators in the contract.

DHSV passes on best practice to CDAs in a number of ways. Regional conferences let CDAs share learnings and practices with each other, while annual 'innovation workshops' are organised to discuss new ways to reach priority groups (DHSV 2015). These conferences and workshops aim to both promote service improvements and provide professional development opportunities for the workforce. Despite these initiatives, the Victorian Auditor General's Office (2016) advised DHSV that it needs to take a more active role in coordinating initiatives by CDAs to address barriers to access.

#### RECOMMENDATION 13.5

State and Territory Governments should establish effective commissioning processes for public dental services for those population groups who are not able to choose between alternative providers. This would include introducing:

- service planning aimed at addressing users' needs
- greater contestability where a consumer-directed care approach is not feasible
- an outcomes framework which focuses on users' oral health.

Reforms should commence as soon as practicable following the development of outcome measures (recommendation 12.2).

## 13.6 The reform pathway

Just as consumer-directed care seeks to put the user at the centre of public dental services, the transition to reform should take account of the existing users, ensuring there is continued care for those already accessing (or waiting for) public dental services. The reform process will involve upfront costs, but lead to cost savings and improvements in users' wellbeing in the long term.

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## Managing risk through staged implementation

The Commission's proposed dental reforms should be implemented in a staged manner to reduce the likelihood of unintended consequences. Broadly, this should encompass improvements to data collection and commissioning within the public dental system, followed by the development and rollout of consumer-directed care.

### Implementing improvements to data collection and commissioning

Benchmarking of waiting times and the adoption of digital health records should be implemented relatively quickly.

The current development of outcome measures should continue. In the first instance, they can be used to evaluate the effectiveness of public dental services. In the longer term, outcome measures would assist in targeting new services and, by measuring outcomes for users, refining the payment model. As DHSV noted, outcome measures are key to delivering an effective service for users:

If greater contestability is implemented without outcomes measures we could end up with a more costly, less effective system. (DHSV, sub. 465, p. 9)

Following the development of outcome measures, governments should improve their commissioning processes and examine opportunities for introducing greater contestability in public dental services.

Commissioning of services in certain settings should commence with State and Territory Governments conducting systematic service planning within their jurisdictions. At first, governments could commission services in areas where choice is not feasible, including remote provision and other outreach services. Outcome measures could be used in the contracting process. The full implementation of consumer-directed care is a long-term process. As such, there may also be a role for the broader application of contestability to some general public dental services until consumer-directed care is rolled out.

Reforms to improve data collection and commissioning would on their own improve the effectiveness of public dental services in Australia.

### Implementing the consumer-directed care reforms

Once the outcome measures are in use, the consumer-directed care scheme should be developed.

As discussed above, the NHS in England is undertaking a staged 'evolutionary not revolutionary' approach to reforming the dental payment models in England (UK Department of Health 2015). The payment model there has moved from pilots (which commenced in 2011), to prototype models (from 2016) and, depending on the results of

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evaluations, will proceed to progressive rollout from 2018-19. Examining the change in treatments delivered by NHS dentists before and after the introduction of activity-based funding in 2006, Tickle et al. (2011) concluded that changes to financial incentive structures can produce large and abrupt changes in professional behaviours, suggesting that care needs to be taken in the implementation process.

Accordingly, the Commission proposes that the development of the consumer-directed care scheme begin by establishing initial test sites before a staged rollout.

- First, as in England, different ‘blends’ of the payment model should be used at initial test sites. For example, one blend could pay a relatively large share of the overall payment through a risk-weighted capitation payment, and a small outcome payment over a three year enrolment period; a second test site could invert this blend (using a small capitation payment and a larger outcome payment). The effects of different blends on the treatment of different population groups (for example, children or older Australians) should also be tested. This stage should also test the effect of the other elements of the blended payment model (Tasmanian Government, sub. DR590), such as what level of outcome payments would be needed to incentivise providers’ behaviour.
- Once evidence from these sites has been evaluated and a desired payment model finalised, the scheme should be progressively rolled out. Information from the trials should inform the pace and location of the rollout of consumer-directed care, and funding requirements.
  - Rollout should initially occur in public dental clinics (giving governments greater control to further refine the system), after which the system should be opened to all prospective providers.
  - The shift of the CDBS to the Commission’s payment model should be amongst the first elements of the rollout.
  - Consumer-directed care would not be feasible where people are not able to choose between alternative competing providers, for example, for populations with complex and special needs. In these circumstances, governments should continue to commission dental services.
- After one full enrolment period has been completed, the initial outcomes (centred on user outcomes but also including costs, take up and changes in service and provider mix) should be assessed and any changes made to the scheme.

Completing the implementation of this reform package will take time and resources. If done properly, the Commission’s model represents a long-term and systemic reform to the provision of public dental services. As such, the Commission considers that the implementation process (including the test sites and subsequent evaluations) should be provided with specific funding, separate from the ongoing delivery of public dental services.

In the interim, the Commission expects the public dental system to continue to operate as it does now, but enhanced by the information available through benchmarking, outcome measures and digital oral health records.

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#### RECOMMENDATION 13.6

The Australian, State and Territory Governments should transition to a consumer-directed care approach to providing public dental services by first establishing initial test sites before a staged rollout.

- Test sites should commence following the development of outcome measures (recommendation 12.2), and evaluate new blended payment and allocation models.
- Transfer of the Child Dental Benefit Schedule to the blended payment model should be an early priority of the rollout.

## Stewardship of reforms

### Supervision and evaluation of the reform process

The implementation pathway charts a fundamental shift in how public dental services are provided in Australia. As such, it requires careful design and oversight from the governments involved. As noted in chapter 12, to date, public dental services have not been a major policy focus for governments. Several inquiry participants also called for national leadership and coordination in implementing consumer-directed care and underpinning reforms. For example, Dr. Martin Dooland AM suggested that:

... the development of these foundations for the planning of test sites will need very strong national leadership rather than independent action by the State and Territory governments. One possible option would be the re-establishment of the National Advisory Council on Dental Health, or a similar steering group. Central leadership would ideally be provided with the appointment of a national Chief Dental Advisor. (sub. DR494, p. 1)

The Commission agrees that clear leadership is required to steer such comprehensive and long-term reforms. One way to provide leadership would be to establish an implementation steering group with representatives from the Australian, State and Territory Governments. The steering group would need to be appropriately resourced and supported by technical expertise. To ensure a smooth transition from existing arrangements, there may be merit in the steering group being led by an experienced administrator.

Before the commencement of test sites, the role of the steering group would be to oversee the development and adoption of the Commission's underpinning reforms to provide the framework for consumer-directed care. Following that, the steering group's primary role would be to oversee the design, implementation, monitoring and evaluation of outcomes from initial sites and the rollout of consumer-directed care. The steering group should disseminate the findings from test sites to inform the final design of the consumer-directed care scheme.

Frameworks should be put in place before test sites commence to assist the steering group's evaluation function. Specifically, governments should consider the data that would be

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needed from the trials, and the means to collect and analyse it as part of the design and implementation of the test sites. Data and evaluation systems were put in place as part of the NHS dental contract reforms, where the NHS established an *Evidence and Learning Reference Group* with responsibility for gathering evidence and lessons from the pilot models.

After the initial rollout of the Commission's reforms, the steering group could oversee the establishment of annual system performance reporting (using the benchmarking and outcome measure, as well as the outcome indicators identified by the National Oral Health Plan). Such reporting would bring transparency to the system, and prominence to discussion of oral health issues within the broader health system.

### Ongoing stewardship of public dental services

Once the Commission's model is fully implemented, governments (as stewards of the system (chapter 2)) would be responsible and accountable for ongoing monitoring of the activities and performance of providers, and the outcomes for public dental patients. This role would apply to both the consumer-directed care and commissioned service streams of public dental services. Stewards would need to monitor a mix of measures — ones that can quickly highlight potential problems (for example, within the risk weighting or payment models) that need further investigation, and others that can be used to evaluate service effectiveness. Stewards could also be responsible for the ongoing publishing of annual system performance reporting.

For commissioned services, evaluation would help commissioning agencies identify effective practices, disseminate innovations and promote ongoing service improvements. Commissioning agencies would need to monitor the accessibility of services and whether there are emerging gaps in service provision.

Public dental stewards would also need to decide how to allocate funding between the different delivery streams of consumer-directed care and commissioning. Stewards should be able to draw on available data sources to make evidence-based decisions about how to improve system-level outcomes in the most effective way. Stewards should also weigh up the relative merits of other policies, such as oral health promotion, to determine how best to identify and deliver services to high-risk cohorts.

### The costs and benefits of reform

Implementing the Commission's model will involve significant change and cost, but would also lead to significant benefits. While some of these benefits will accrue as cost savings to government, as the Northern Territory Government submitted, it is also important to consider the benefit to users (that is, improvements in their wellbeing):

Public dental services need to be regarded as an investment rather than only a cost. This is important in the context of vulnerable populations, in order to consider the relative value in

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providing general and preventative dental services. This is particularly relevant to remote populations where service delivery costs can be substantial, but health and social benefits provided to disadvantaged individuals and communities are often overlooked in modelling. (sub. DR593, p. 24)

While elements of the underpinning reforms (chapter 12) — including electronic health records in Queensland and the development of outcome measures in Victoria — are already underway in some jurisdictions, progress on these reforms would require co-operation and resources from all jurisdictions.

These underpinning reforms enable several broad improvements to the public dental system.

- Performance benchmarking would improve transparency and accountability, enabling better system-level planning and, at a more detailed level, inform consumer choice.
- Outcome measures would provide better information on the effectiveness of treatments, improve incentives for providers (both within a consumer-directed care and commissioning context), and form the basis for an outcomes framework as part of systematic service planning.
- A digital oral health record would improve the coordination of care, integration within the wider health system and could support user choice through portable data.

These reforms would also give more information and transparency about the needs of the eligible population and the appropriate funding of public dental services.

As described above, implementing consumer-directed care is a long and multifaceted process. The costs involve including designing, coordinating and conducting the test sites and the eventual payment model, and would include the development of an *Oral Health Assessment Tool* for clinical assessment undertaken at the patient's chosen dental clinic. The Commission's model would involve different overhead costs to present public dental services. In particular, not all jurisdictions currently operate a centralised waiting list and resourcing the public dental call centre with staff trained to deliver an initial phone risk assessment may involve additional costs for some.

The use of a risk-based allocation model coupled with a blended payment model could see a shift in the distribution of funding towards preventive care. Identifying and investing in timely access to consumer-directed care for patients at high risk of developing or worsening oral disease would change the mix of dental services provided, towards:

- more preventive care — that reduces the likelihood of developing an oral health problem, minimises the progress of a problem at an early stage, and where oral disease has already taken place, halts the progression of further damage to teeth and gums
- fewer costly and avoidable treatments — both within the public dental sector (urgent treatments and restorative services) and in the broader health system (preventable hospitalisations and GP visits).

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Over time, additional preventive care for patients at high risk of oral disease would result in a reduction in the need for urgent care, in turn enabling a greater focus on preventive care across the system into the future.

In the Commission's view, the benefits from these reforms are likely to outweigh their costs. Primarily, the benefits from consumer-directed care stem from using the allocation and payment models to provide targeted preventive care to those who would benefit most. As outlined in chapter 12, avoiding the development and progression of oral disease would have wider benefits, including improvements to:

- the quality of life and general health of a range of users, including by avoiding hospitalisation for children who need general anaesthesia for extractions, or for patients in residential aged care whose broader wellbeing can be profoundly affected by their oral health
- users' overall wellbeing. Some of these effects may be directly measurable, such as a greater chance of gaining employment or an increase in hours worked. Others (such as pain and the ability for people to eat foods they enjoy) cannot be so easily quantified, but are no less important
- the effectiveness of service provision. Incentives in the payment model would encourage more efficient service provision — both for the salaried public sector and the fee-for-service private sector. For example, clinics would benefit from lowering the cost of service delivery by making better use of the oral health workforce, including dentists and other oral health professionals in a team-based setting.

Where choice of dental clinic is not feasible, improved commissioning processes would result in more effective service provision that is better able to identify and meet users' needs. Compared with the current system, the benefits to users of more effective commissioning processes are likely to outweigh the resources needed to ensure commissioning capabilities are well developed.



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## A Public consultation

The Commission has actively encouraged public participation in this inquiry. This appendix outlines the consultation process for both the first stage (the study report) and the second stage (the inquiry report) of the inquiry.

- Following receipt of the terms of reference on 29 April 2016, an advertisement was placed in The Australian newspaper and an electronic circular was sent to identified interested parties.
- An issues paper was released on 16 June 2016 to assist those wishing to make a written submission to the study report. Following the release of the issues paper, 290 submissions were received.
- A preliminary findings report was released on 22 September 2016 and 105 submissions were subsequently received: a total of 395 submissions were received throughout the study report stage (table A.1). Submissions to the study report are available online at [www.pc.gov.au/inquiries/completed/human-services/identifying-reform/submissions](http://www.pc.gov.au/inquiries/completed/human-services/identifying-reform/submissions).
- The final study report was released on 5 December 2016 and an electronic circular was sent to interested parties. This release marked the conclusion of the first stage and the commencement of the second stage of the inquiry.
- An issues paper was released on 12 December 2016 to assist those wishing to make a written submission to the inquiry report. Following the release of the issues paper, 91 submissions were received.
- A draft inquiry report was released on 2 June 2017 and 112 submissions were subsequently received: a total of 203 submissions were received throughout the inquiry report stage (table A.1). Submission to the inquiry report are available online at [www.pc.gov.au/inquiries/completed/human-services/reforms/submissions](http://www.pc.gov.au/inquiries/completed/human-services/reforms/submissions).
- A total of 598 submissions were received across the first and second stages of the inquiry.
- The final inquiry report was delivered to the Australian Government on 27 October 2017.
- Consultations were held with the Australian, State and Territory Governments, service providers and their peak bodies, employer representatives, community representatives, consumer advocates and academics (table A.2).
- The Commission held public hearings in Canberra, Melbourne, Perth and Sydney (table A.3). The Commission also held roundtables in Brisbane, Canberra, Melbourne, Perth and Sydney over the course of the inquiry (table A.4).

The Productivity Commission thanks all participants for their contribution to the inquiry.

**Table A.1 Submissions<sup>a</sup>**

<i>Participant</i>	<i>Submission number(s)</i>
Aboriginal Health Council of Western Australia (AHCWA)	PFR393, 468
Aboriginal Housing Victoria (AHV)	PFR316
Aboriginal Medical Services Alliance Northern Territory (AMSANT)	274, PFR384, 477 #
Aboriginal Peak Organisations Northern Territory (APO NT)	275, 478 #
Access Ministries	242
ADJ Consultancy Services	PFR356#*
Adult Learning Australia (ALA)	439, DR536
Aged & Community Services Australia (ACSA)	243, 411, DR541
Aged Care Crisis (ACC)	273, PFR387, PFR392, DR525#*
Aged Care Guild	219 #
Aitkenhead, Wendy	78
Allied Health Professions Australia (AHPA)	DR496
Allied Health Professions' Office of Queensland, Queensland Health	DR488
Alzheimer's Australia	431, DR521
Andrew, Dr. Jane and Baker, Dr. Max	140 #
Anglicare Australia	217, PFR391, 445, DR574 #
Argyle Community Housing	DR595 *
Asa, Shannon	208
Aspeling, Audrey	47
Australia and New Zealand Academy for Special Needs Dentistry (ANZASND) and Australian Society for Special Care in Dentistry (ASSCID)	200
Australia Post	PFR319
Australian Acupuncture and Chinese Medicine Association Ltd. (AACMA)	287
Australian Association of Massage Therapists (AAMT)	178
Australian Association of Social Workers (AASW)	DR557
Australian Blindness Forum (ABF)	125, PFR331, 412 #
Australian Chamber of Commerce and Industry (ACCI)	283
Australian College of Mental Health Nurses (ACMHN)	4
Australian Council for Private Education and Training (ACPET)	279
Australian Council of Social Service (ACOSS)	276, PFR377, DR548
Australian Council of Trade Unions (ACTU)	100, PFR334, 429, DR505
Australian Dental and Oral Health Therapists' Association Inc. (ADOHTA)	99, PFR318, 415, DR526 #
Australian Dental Association (ADA)	230, DR545
Australian Dental Association (ADA) NSW Branch	PFR339, 454, DR573 #
Australian Education Union (AEU)	224 #
Australian Government Department of Social Services (DSS)	221, PFR378, 476 #
Australian Healthcare and Hospitals Association (AHHA)	134, PFR306, 427, DR561

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**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Australian Housing and Urban Research Institute (AHURI)	DR495
Australian Institute of Health and Welfare (AIHW)	DR508
Australian Medical Association (AMA)	481, DR589
Australian Nursing and Midwifery Federation (ANMF)	202, 474
Australian Private Hospitals Association (APHA)	PFR381
Australian Red Cross	203, PFR325 #
Australian Services Union (ASU)	85, PFR326, 480, DR575
Australian Unity	94
Australian Women Against Violence Alliance (AWAVA) and Equality Rights Alliance (ERA)	DR552
Azzopardi, Donna	180
Baensch, Dr. Allison	48
Baptist Care (SA) Inc.	123 #
Baptist Care Australia and Churches Housing Inc.	DR532 #
Barnes, Dr. Richard	26
Barry, Laurie	113
Bartlett, Francine	215, PFR354 *
Barwon Health	PFR355 #
Becker, Elizabeth	212
Benetas	DR543
Benevolent Society	129, 457
Best, Pat	65
Bestic, Dr. Jill	159
Better Caring	252
BlueCHP	DR491
Bordignon, Maria	115
Borland, Jody	143
Bowie, Ian	PFR295
Boyce, Evelyn	147
Breast Cancer Network Australia (BCNA)	DR534
Brell, John	51
Brewer, Charlotte	96
Brisbane Housing Company (BHC)	486
Broadbent, Dr. Russel	423 #
Brotherhood of St Laurence (BSL)	286, 479
Bupa	258, PFR380
Burrows, Matt	206
Business Council of Australia (BCA)	PFR371
Business Council of Co-operatives and Mutuals (BCCM)	216, PFR302, 470, DR529

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Butterworth, Matilda	22
Cabrini Palliative Care	PFR343
Cameron, Dr. David	162
Camp, V R Edward	DR487 #
Campbell, Steven	290
Cancer Council NSW	DR537
Carers Australia	259
Case Health	251 #
Catholic Health Australia (CHA)	236, PFR350, 440, DR567
Catholic Social Services Australia (CSSA)	226, PFR315, DR533
Catholic Social Services Victoria (CSSV)	272
Central Australian Aboriginal Congress (CAAC)	PFR382, 430 #
Central Queensland Financial Counselling Service (CQFCS)	119
Centre for Excellence in Child and Family Welfare (CFECFW)	PFR383
Centre for Health Economics Research and Evaluation (CHERE) - University of Technology Sydney (UTS)	DR516
Centre for Policy Development (CPD)	124 #
Centre for Social Impact (CSI)	448
Chaney AO, Fred; and Gray AM, Bill	DR489
Children's Ground	DR562
Churches of Christ in Queensland (CofCQ)	PFR357
Churches of Christ in Qld, CSIA, The Services Union, Qld Community Alliance, QCOSS and UnitingCare Qld	446
City Futures Research Centre (CFRC), University of NSW	DR506
City of Sydney	DR540
City of Whittlesea	DR519
Clarke, Prof. Rufus	400
Cluney, William	112
Coburn, Sandra	DR558
Cochrane, Dr. Fiona	169
cohealth	240, DR584
Collins, Isabell	199
Combined Pensioners and Superannuants Association (CPSA)	121, PFR364, DR542
Commisso, Rosanna	209
Commonwealth Ombudsman	PFR314, 402 #
Community and Public Sector Union (CPSU) and State Public Services Federation Group (SPSF)	253, PFR375, 416, DR528
Community Colleges Australia	264
Community Council for Australia (CCA)	193, DR585
Community Employers WA (CEWA)	126, PFR368, 403, DR564

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**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Community Housing Limited (CHL)	DR551
Community Housing Providers for Queensland (CHPs for QLD)	PFR359
Community Mental Health Australia (CMHA)	PFR304, 399, DR498 #
Community Services Industry Alliance (CSIA)	192, PRF395, 410, DR507 #
Consumer Action Law Centre (CALC)	260
Co-operatives Victoria	PFR310, 396
COTA Australia	456, DR556
Council of Private Higher Education (COPHE)	280
Council of Single Mothers and their Children, Victoria (CSMC)	435
Council to Homeless Persons (CHP)	270, PFR349, 434, DR522 #
Cox, Dr. Kevin	482
Crain, Dave	165
Damé, Tricia	449
Darby, Dr. John	188
Darebin City Council	214
Davidson, Dr. Bob	PFR353
Davill, Nicole	41
Davison, Andrew	15
Day, Helen	156
Deering, Patricia	225
Dental Health Services Victoria (DHSV)	PFR366, 465 #
Department of Health	DR569
Disability Advocacy Victoria (DAV)	231
Disability Council NSW	118
Doctors Reform Society Australia (DRS)	144
Donaldson, Janine	157
Dooland AM, Dr. Martin	PFR300, DR494 #
Doss, Dr. Arockia	1 #
Douglas, Claire	60
Down, Judi	36
Early Childhood Australia (ECA)	PFR342
Egerton, Thorlene	117
Electrical Trades Union of Australia (ETU)	229, PFR324
Elliott-Rudder, Megan	63
Equality Rights Alliance (ERA)	PFR346, 471
Esots, Jenny	73
Family & Relationship Services Australia (FRSA)	PFR370, DR554
Family Life	57
Federation of Ethnic Communities' Councils of Australia (FECCA)	25, 433

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Financial Counselling Australia (FCA)	PFR372
Fletcher MP, Hon Paul	DR594 #
Flood, Joe	DR578 #*
Flower, Beryl	137
Fong, Jenny	29
Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)	PFR333
Franklin, Jacqueline	103
Funder, Dr. John	211
Fyfe, Angela	190
Gabriel, Julie	111
Gaggin, Patricia	23
Gamble, Carole	81
Gilkerson Legal	PFR394 #
Gillson, Robert and Gillson, Janet	185
Gilmour, Anne	201
Goldfields Individual & Family Support Association Inc.	DR570
Good Shepherd Australia New Zealand (GSANZ)	282, DR517
Goodfellow, Tony	20
Goodstart Early Learning	255
Gray, Donna	70
Grey, Dr. Stephen	PFR292
Gruner, Barbara	187
Gunn, Dr. Andrew	6
Hall, Stafford	11
Hallahan, Nicole	13
HammondCare	PFR330, 407, DR515 #
Hanscombe, Norman	82
Haven; Home, Safe (HHS)	DR568
Health Care Consumers' Association (HCCA)	239
Health Consumers' Council (WA)	447
Health Performance Council (HPC) SA	437, DR503
Health Workers Union (HWU)	472
Healthshare	DR591
Heilbronn, Stan	53
Hendrickx, Leonardus	150
Henry, Gabrielle	146
Hill, Dr. Christine	89
Hills, Dr. Ian	88
Hobart District Nursing Service Inc.	419, DR581
Hogg, Elizabeth	39

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Home Modifications Australia (MOD.A)	228
Homelessness Australia (HA)	149
Homelessness NSW	175, 452, DR520
Hooper, Ron	163
Hope Community Services	204
Hornagold, Margaret	246
Hudson, Prof. Bob	182
Humanist Society of Victoria (HVA)	PFR345
Hunt, Verena	68
Illawarra Forum Inc.	238, PFR309, 444, DR550
Incerti, Kate	141
Independent Hospital Pricing Authority (IHPA)	PFR322, DR560
Independent Planning & Coordination Services Pty Ltd.	PFR358
Independent Schools Council of Australia (ISCA)	179, 426
Independent Schools Victoria (ISV)	58
Indigenous Affairs Group - Department of the Prime Minister and Cabinet	265
Indigenous Eye Health, The University of Melbourne	425 #
Infrastructure Partnerships Australia (IPA)	PFR367 #
Inner South Community Health Services (ISCHS)	244
Institute for Healthcare Transformation, Deakin University	DR587 #
Ireland, Dr. Anthony	DR527
Irving, David	12
Jacobs, Prof. Keith	3, PFR296
Jesuit Social Services (JSS)	284, PFR336, 420, DR530
Jobs Australia	268
Johnson, Guy; Scutella, Rosanna; Tseng, Yi-Ping; and Wood, Gavin	PFR299 #
Jolley, Dr. Gwyn	72
Jones, Jackie	161
Jones, Krishna	19
Justice Action	101, PFR317
Kain, Diana	168
Kane, Jill	197
Keena, Daren	44
Keleher, Trina	56
Kenisciehad, Kaijin	114
Kerr, Robert	2 #
Kirkham, Pat	160
Kolosovs, Lisa	133

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Kyd, Michael	171
Launch Housing	PFR373
Lavery, Anne	59
Leading Age Services Australia (LASA)	177, 463, DR512 #
Little Company of Mary Health Care Ltd. (Calvary)	DR547
Little Haven Palliative Care	458, DR579 #
Local Government NSW (LGNSW)	PFR338
Lochner, Sheri	93
Lodge, Teresa	164
Luckie, Paris	76
MacKenzie, Colin	75
Macular Disease Foundation (MDF) Australia	95, PFR335, 424
Maddocks, Prof. Ian	116
Mallee Track Health and Community Service (MTHCS)	PFR294, 397, DR499 #
Mamalis, Elle	18
Marlow, Sarah	DR490
Marsh, Prof. Ian	288 #
Marshall, Linley	195
Martin, Paula	66
Mascarenhas, Dr. Lester	184
Massage & Myotherapy Australia	409
Mathew, Rob	77
Mbanza, Rogers	35
McAuley Community Services for Women	241
McCall, Marguerite	74
McCarthy, Cheryl	105
McCluskey, Miriam	64
McCormack, Fay	21
McCreath, Sally	189
McGinty, Jared	107
McGrath, Sandra	14
McLeay, Dr. Graeme	166
McLoughry, Kim	34
McMullan, Kim	9
McMurdo, Dr. Rob	79
McPherson, Graham	DR492
Melbourne City Mission	DR510
Melvin, Robert	106
Mental Illness Fellowship of Australia (MIFA)	DR549

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Merri Health	PFR307, 418
Mid North Coast Human Services Alliance (MNC HSA)	220
MIGA	432
Miller, Dr. David	83
Miller, James	62
Mission Australia	277
Mitchell, Leigh	97
Morgan, Craig	108
Morley, Dr. Tom	49
Mornington Peninsula Shire	DR493
Motor Neurone Disease (MND) Australia	DR513
Municipal Association of Victoria (MAV)	256, 443
Muswellbrook Shire Council	PFR365
Name Withheld	24
Name Withheld	37
National Aboriginal Community Controlled Health Organisation (NACCHO)	227
National Congress of Australia's First Peoples (NCAFP)	DR565
National Council of Single Mothers & their Children (NCSMC)	441
National Disability Services (NDS)	262, PFR363, DR518
National Health Leadership Forum (NHLF)	475
National Mental Health Commission (NMHC)	DR577
National Mental Health Consumer and Carer Forum (NMHCCF)	PFR389
National Oral Health Alliance (NOHA)	DR511
National Rural Health Alliance (NRHA)	269, PFR385, 428, DR502
National Seniors Australia	PFR360
National Shelter Inc.	232, PFR369, 466, DR582
Nayler, Tracey	98
Nepean Community & Neighbourhood Services (NCNS)	191
Neyland, Nita	42
Nguyen, Tan	398
Nicholls, Taraeta	148
North Richmond Community Health (NRCH)	PFR320 #
Northern Territory Government	DR593
Northern Territory PHN	DR598
NSW Department of Family and Community Services (FACS)	484
NSW Government	122 #
NSW Meals on Wheels Association Inc.	7
NSW Nurses and Midwives' Association (NSWNMA)	247
NSWFHA, CHCSA, CHFV, CHIA, CHPs for QLD, Shelter Tas and QShelter	406

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
NSWFHA, CHCSA, CHFV, CHIA and PowerHousing Australia	PFR328
NSWFHA, CHCSA, CHFV, CHIA, PowerHousing Australia and Shelter Tas	235
NSWFHA, CHCSA, CHFV, CHIA, PowerHousing Australia, Shelter Tas, CHPs for QLD and QShelter	DR539
NT Department of Treasury and Finance (NT DTF)	261
O'Donnell, Carol	PFR301 #
O'Reilly, Stuart	91
O'Dowd Austen, Lee	453
Old Colonists' Association of Victoria (OCAV)	DR501
Older Women's Network (OWN), Mackay Branch	PFR298
Opportunity Child (OC)	DR535
Optometry Australia	5
Ostrowska, Milena	153
O'Sullivan, Anne	183
Paech, Jason	16
Palliative Care Australia (PCA)	PFR329, DR500
Palliative Care Outcomes Collaboration (PCOC)	PFR308
Palliative Care Australia (PCA) and Palliative Care Outcomes Collaboration (PCOC)	417
Pande, Dr. Divya	158
Parkes, Vanessa	136
PeakCare Queensland Inc.	128
Penrith Homelessness Interagency (PHI)	413
Penrith Youth Interagency	PFR362
Pickard, Dr. Marion	102
Power to Persuade	PFR390
Pike, Bradley	483
Pirone, Christy; Brown, Margaret; Moy, Dr. Chris; and Drummond, Dr. Christine	DR559
Powles, Anne	196
Prader-Willi Syndrome Association of Australia (PWSAA)	PFR348
Public Service Research Group, University of New South Wales, Canberra	DR572
Push for Palliative	DR538
Q Shelter	PFR352
Queensland Nurses and Midwives' Union (QNMU)	DR504
Queensland Advocacy Inc. (QAI)	442
Queensland Government	DR592 #
Queensland Network of Alcohol and other Drug Agencies (QNADA)	PFR312
Queensland Nurses' Union	405
Quiggin, Prof. John	PFR303
Ramsden, Robert	135

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
Real Estate Institute of Australia (REIA)	PFR340
Refugee Council of Australia (RCOA)	271
Regan, John	104
Ricketts, Michelle	84
Rigutto, Gemma	50
Roberts, Julie	167
Rose, Sally	67
Rosenblatt, Jennafa	45
Rosenthal, Stanley	181
Ross, Kathleen	33
Royal Australasian College of Physicians (RACP)	473, DR580
Royal Australasian College of Surgeons (RACS)	PFR374, DR598
Royal Australian College of General Practitioners (RACGP)	8, PFR337, DR524
Royal Flying Doctor Service of Australia (RFDS)	174
Rumbalara Aboriginal Co-operative (RAC)	401
Ruzzene, Nora	145
Sandon, Terry	55
Sarkies, Mitchell	80
Save the Children Australia	222 #
Scantlebury, Lynda	213
Schien, Dr. Michael	52
Schizophrenia Fellowship of NSW (SF NSW)	PFR332
Schmidt, Dr. Malgorzata	186
Scott, Prof. Anthony; Yong, Associate Prof. Jongsay; and Mendez, Dr. Susan	87
Scott-Mills, Nicholas	210
Seldon, Prof. H Lee	170
Service, David	289
Settlement Council of Australia (SCoA)	278
Sex Workers Outreach Project (SWOP)	172
Shaw, Josephine	46
Shelter Tasmania	233, PFR344, 422
Shelter WA	PFR341
Sheridan, Jeanette	451
Silberberg, Prof. Jonathan	194
Silberstein, Dr. Nicholas	90
Silver Chain Group	176, DR509
Skappel, Robert	130
Slatyer, Beth	154
Smith, Catherine	218

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number</i>
Smith, Greg	71
Smith, James	139
Smith, John M.R.	142, 414
South Australian Government	281, 460, DR571
Southern Migrant and Refugee Centre (SMRC)	263
Southern Youth and Family Services (SYFS)	234, PFR327, 436, DR555
Spicer-Wensley, Merriwyn	138
St Vincent de Paul Society National Council	285
St Vincent's Health Australia (SVHA)	207
Steen, C	10
Stephenson, Una	86
Stevens, Natalie	205
Strahan, Merinda	17
Strutt, Sue	198
Swain, Paul	404
Taliana, Dr. Raul; Peck, Prof. Chris; Stephen, Dr. Soni; Tam, Dr. Patrick; Lenard, Dr. Andrea; Dando, Dr. Julia; and O'Connor, Danny	DR553
Tasmanian Government	PFR297, 485, DR590 #
Tattersall, Karl	40
TEAMhealth Inc.	250
Tenants Union of Victoria (TUV)	DR563
The Australian Centre for Social Innovation (TACSI)	155
The Bridge Youth Service, Connect GV, FamilyCare and Primary Care Connect	266, PFR388, 461, DR576
The Centre for Independent Studies (CIS)	152, PFR347, DR544 #
The Fred Hollows Foundation	467
The GroundSwell Project	DR566
The Salvation Army	DR523
The Smith Family	257, 469
Thomas, Dr. Murray	DR588
Thomas, Kerry	30
Toner, Dr. Phillip	254
Toora Women Inc.	245
Triple P International Pty Ltd.	127
Truscott, Karen	32
Tweed Shire Council	PFR311
United Voice	237
Uniting Church in Australia, Synod of Victoria and Tasmania	173
UnitingCare Australia	249, PFR313, 459, DR514
van Kessel, Sister Susan (Lucy)	69

(continued next page)

**Table A.1** (continued)

<i>Participant</i>	<i>Submission number(s)</i>
van Someren, Rachel	109
Varkey, Shobha	151, PFR291
Vaughan, Andrea	132
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	455 #
Victorian Alcohol and Drug Association (VAADA)	248, PFR305
Victorian Allied Health Professionals Association (VAHPA)	PFR361
Victorian Healthcare Association (VHA)	PFR376, 464, DR531
Victorian Multicultural Commission	120 #
Victorian Primary Care Partnerships (VicPCP)	DR546
Villis, Angela	43
Vision 2020 Australia	462
Vision Australia	28, PFR321, 421 #
Volunteering Australia	DR586
Voss, Diana	450
WA Regional Services Reform Unit (WA RSRU)	PFR351
Wall, Terry	110
Walshe, Sue	54
Warwick, Anne	131
Western Australian Council of Social Service (WACOSS)	DR583
Western Australian Department for Child Protection and Family Support (CPFS)	PFR386
Western Australian Government	DR596
Western Australian Prison Officers' Union of Workers (WAPOU)	267
White Ribbon Australia	223
Whiting, Paul	27
Wicks, Genevieve	61
Worrall, Hugh	31
Yfoundations	PFR379, 438, DR497
Youngcare	PFR323
Youth Affairs Council of South Australia (YACSA)	408
Youth, Family and Community Connections Inc. (YFCC)	92, PFR293

**a** PFR before a number denotes that the submission was lodged subsequent to the release of the preliminary findings report in the study report stage. DR before a number denotes that the submission was lodged subsequent to the release of the draft report in the inquiry report stage. An asterisk (\*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

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**Table A.2      Consultations**

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*Participant*

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**New South Wales**

Australian Dental Association (ADA)  
Aged Care Guild  
Australian Commission on Safety and Quality in Health Care (ACSQHC)  
Australian Council of Social Service (ACOSS)  
Benevolent Society  
Better Caring  
Centre for Independent Studies (CIS)  
Centre for Social Impact (CSI)  
Collaboration for Impact  
Currow, Prof. David; Cancer Institute NSW  
Cutler, Dr. Henry; Centre for the Health Economy, Macquarie University  
Eagar, Prof. Kathy; Australian Health Services Research Institute, University of Wollongong Australia  
Homelessness NSW  
Independent Hospital Pricing Authority (IHPA)  
Independent Pricing and Regulatory Tribunal (IPART)  
Mission Australia  
NSW Bureau of Health Information  
NSW Department of Family and Community Services (FACS)  
NSW Federation of Housing Associations (NSW FHA)  
NSW Government  
NSW Health  
NSW Health Pathology  
Social Ventures Australia (SVA)  
Sturgess, Prof. Gary; Australia and New Zealand School of Government  
TAFE Directors Australia (TDA)  
WentWest PHN  
Western Sydney Local Health District (WSLHD)  
Yfoundations  
Youth Action

**Victoria**

Australian Diagnostic Imaging Association (ADIA)  
Australian Education Union (AEU)  
Australian Services Union (ASU)  
Brotherhood of St Laurence (BSL)  
Business Council of Co-operatives and Mutuals (BCCM)  
Catholic Health Australia (CHA)

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**Table A.2** (continued)

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*Participant*

**Victoria (continued)**

Dental Health Service Victoria (DHSV)  
Disability Advocacy Network Australia (DANA)  
Duckett, Prof. Stephen; Grattan Institute  
Grattan Institute  
Healthscope  
Independent Schools Victoria (ISV)  
Jobs Australia  
Learning First  
National Tertiary Education Union (NTEU)  
Public Pathology Australia (PPA)  
Royal Australasian College of Surgeons (RACS)  
Scott, Prof. Tony; Melbourne Institute of Applied Economic & Social Research  
The Australian Centre for Social Innovation (TACSI)

**Queensland**

Australian Council for Private Education and Training (ACPET)  
Brisbane Housing Company (BHC)  
Brisbane North PHN  
Brisbane Youth Services  
Community Services Industry Alliance (CSIA)  
Head, Prof. Brian; Institute for Social Science Research (ISSR)  
Logan Together  
Merrimott, Prof. Paul; Institute for Social Science Research (ISSR)  
Moran, Prof. Mark; Institute for Social Science Research (ISSR)  
National Shelter  
Parsell, Dr. Cameron; Institute for Social Science Research (ISSR)  
Q Shelter  
Queensland Government  
UnitingCare Queensland  
Western, Prof. Mark; Institute for Social Science Research (ISSR)

**South Australia**

Dooland AM, Dr. Martin  
Health Performance Council (HPC) SA  
National Centre for Vocational Education Research (NCVER)  
SA Dental Services  
South Australian Government

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Table A.2      (continued)

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*Participant*

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**Western Australia**

Aboriginal Health Council of Western Australia (AHCWA)  
Anglicare WA  
Australian Government Department of the Prime Minister and Cabinet (East Kimberley Regional Office)  
Disability Services Commission (WA)  
Oral Health Centre of Western Australia (OHCWA)  
Save the Children  
Silver Chain Group  
Trust, Ian; Empowered Communities  
Western Australian Government

**Tasmania**

Oral Health Services Tasmania  
Tasmanian Government

**ACT**

ACT Government  
ACTCOSS  
Aged & Community Services Australia (ACSA)  
Anglicare Australia  
Australian Government Department of Education and Training (DET)  
Australian Government Department of Employment  
Australian Government Department of Health  
Australian Government Department of Social Services (DSS)  
Australian Government Department of the Prime Minister and Cabinet (PM&C)  
Australian Healthcare & Hospitals Association (AHHA)  
Australian Research Alliance for Children and Youth (ARACY)  
Catholic Social Services Australia (CSSA)  
Chaney AO, Hon Frederick Michael  
Council of Private Higher Education (COPHE)  
Council on the Ageing Australia (COTA)  
Empowered Communities  
Federation of Ethnic Communities' Councils of Australia (FECCA)  
Gray AM, Bill  
Group of Eight Australia  
Independent Schools Council of Australia (ISCA)  
National Aboriginal Community Controlled Health Organisation (NACCHO)

**Northern Territory**

Carers NT  
CatholicCare NT

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Table A.2      (continued)

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*Participant*

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***Northern Territory (continued)***

Central Australia Health Service (CAHS)  
Central Australian Aboriginal Congress (CAAC)  
Central Australian Affordable Housing Company (CAAHC)  
Ltyentye Apurte Catholic School  
MacDonnell Regional Council  
National Disability Insurance Agency (NDIA)  
NT Council of Social Service (NTCOSS)  
NT Government  
Santa Teresa Local Authority

***New Zealand***

New Zealand Productivity Commission

***United Kingdom***

Propper, Prof. Carol; Imperial College  
Street, Prof. Andrew; University of York

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**Table A.3     Public Hearings**

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*Participant*

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**24 July 2017 - Sydney**

Australian Dental Association  
Australian Dental Association (NSW Branch)  
Business Council Of Co-operatives and Mutuals  
Homelessness NSW  
Italiana, Dr. Raul  
Lenard, Dr. Andrea  
Lobb, Reginald  
National Congress Of Australia's First People  
Push For Palliative  
Tam, Dr. Patrick  
The Centre for Independent Studies  
The GroundSwell Project  
Yfoundations

**25 July 2017 - Canberra**

Anglicare Australia  
Australian Healthcare And Hospitals Association  
Baptist Care Australia  
Catholic Social Services Australia  
Churches Housing Inc.  
Community Housing Industry Association  
Dickinson, Assoc. Prof. Helen  
Family and Relationships Services Australia  
NSW Federation of Housing Associations  
Palliative Care Australia  
St Vincent De Paul Society National Council

**27 July 2017 - Melbourne**

Australian Association of Social Workers  
Australian Dental and Oral Health Therapists' Association  
Community Housing Limited  
COTA Australia  
Council to Homeless Persons  
Deakin Institute for Healthcare Transformation  
Dental Health Services Victoria  
FamilyCare  
Hobart District Nursing Service Inc.  
Little Haven Palliative Care  
Victorian Aboriginal Community Controlled Health Organisation

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**Table A.3**      (continued)

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*Participant*

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**28 July 2017 - Melbourne**

Adult Learning Australia  
Australian Services Union  
Health Workers Union

**31 July 2017 - Perth**

Community Employers WA  
Palliative Care Western Australia  
Shelter WA  
WA Council of Social Service  
WA Local Government Association

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## Table A.4     Roundtables

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### *Participant*

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#### ***Family and community services – 12 October 2016, Brisbane***

Aftercare  
Brisbane Youth Service  
Churches of Christ in Queensland  
Community Qld  
Community Services Industry Alliance  
Micah Projects  
Mission Australia  
Menzies, Jenny; Policy Innovation Hub, Griffith University  
Relationships Australia Queensland  
UnitingCare Queensland  
YFS  
youtown

#### ***Family and community services – 17 October, 2016, Canberra***

Catholic Social Services Australia  
CatholicCare Melbourne  
CatholicCare NT  
CatholicCare Tasmania  
Centacare Brisbane  
Jesuit Social Services  
MercyCare

#### ***Family and community services; services in remote Indigenous communities – 19 October, 2016, Perth***

Accordwest  
Anglicare WA  
Baptistcare WA  
Centrecare  
Community Employers WA  
Mercycare  
Mission Australia  
Nulsen  
Parkerville  
Richmond Wellbeing  
Rise  
Ruah Community Services  
Technology Assisting Disability WA  
UnitingCare West  
WA Council of Social Service  
Wanslea

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Table A.4 (continued)

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*Participant*

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***Public dental services – 21 October, 2016, Melbourne***

Australian Dental and Oral Health Therapists' Association  
Australian Dental Association Victoria  
Australian Government Department of Health  
Australian Healthcare and Hospitals Association  
Australian Society for Special Care in Dentistry  
Consumers Health Forum  
NSW Ministry of Health  
NT Department of Health  
SA Health  
Tasmanian Department of Health and Human Services

***Public hospital services – 21 October, 2016, Melbourne***

Australian Government Department of Health  
Bupa  
Medibank Private  
NT Department of Health  
Royal Australasian College of Surgeons  
Royal Australian College of General Practitioners  
SA Health  
St Vincent's Health  
Tasmanian Department of Health and Human Services  
Victorian Department of Health and Human Services

***Public hospital services – 24 October, 2016, Canberra***

Australian Commission on Safety and Quality in Health Care  
Australian Healthcare and Hospitals Association  
Australian Medical Association  
Australian Nursing and Midwifery Federation  
Australian Private Hospitals Association  
Catholic Health Australia  
Consumers Health Forum  
National Rural Health Alliance  
NSW Ministry of Health  
Private Healthcare Australia  
Woods, Prof. Mike - Centre for Health Economics Research and Evaluation, University of Technology Sydney

***Services in remote Indigenous communities – 24 October, 2016, Canberra***

Empowered Communities  
National Aboriginal Community Controlled Health Organisation  
National Congress of Australia's First Peoples

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**Table A.4**      (continued)

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*Participant*

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***Social housing – 25 October 2016, Sydney***

Australian Council of Social Service  
Australian Government Department of Social Services  
Bridge Housing  
Brisbane Housing Corporation  
Housing Action Network  
Housing Tasmania  
Milligan, Prof. Vivienne - University of New South Wales  
National Affordable Housing Consortium  
National Shelter  
North Coast Community Housing Association  
NSW Department of Family and Community Services  
NSW Federation of Housing Associations  
Pawson, Prof. Hal - University of New South Wales  
PowerHousing Australia  
Queensland Department of Housing and Public Works  
SA Department for Communities and Social Inclusion  
St George Community Housing  
Tenants' Union of NSW  
Victorian Department of Health and Human Services

***End-of-life care – 25 October 2016, Sydney***

Agar, Prof. Meera - University of Technology Sydney  
Australian Centre for Health Research  
Australian Government Department of Health  
Australian Healthcare and Hospitals Association  
Bupa  
HammondCare  
McCaffrey, Dr. Nikki - Flinders University  
NSW Health  
Palliative Care Australia  
SA Health  
Silver Chain Group  
St Vincent's Private Hospital Sydney  
Tasmanian Department of Health and Human Services  
Victorian Department of Health and Human Services

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**Table A.4** (continued)

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*Participant*

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***Family and community services – 26 October 2016, Canberra***

Anglicare Australia  
Australian Government Department of Finance  
Australian Government Department of Social Services  
Brotherhood of St Laurence  
Community and Public Sector Union  
Mental Health Community Coalition ACT  
North Western Melbourne Primary Health Network

***User choice and competition in healthcare – 28 February 2017, Melbourne***

ACSQHC  
Australian Government Department of Health  
Australian Healthcare and Hospitals Association  
Australian Private Hospitals Association  
Beauchamp, Dr. Alison - Faculty of Health, Deakin University  
Bupa  
Byrne, Dr. David - University of Melbourne  
Catholic Health Australia  
Clarke, Prof. Phillip - University of Melbourne  
Commonwealth Bank  
Consumers Health Forum  
Cutler, Dr. Henry - Macquarie University Centre for the Health Economy  
Gravelle, Prof. Hugh - Centre for Health Economics, University of York  
Gu, Dr. Yuanyuan - Macquarie University Centre for the Health Economy  
Lambert, Peter - Monash University  
Medibank Private  
Mendez, Dr. Susan - Melbourne Institute  
Payne, Prof. Abigail - Melbourne Institute  
Private Healthcare Australia  
Propper, Prof. Carol - Imperial College, London  
Royal Australasian College of Physicians  
Royal Australasian College of Surgeons  
Royal Australian College of General Practitioners  
Scott, Prof. Anthony - Melbourne Institute  
Sivey, Assoc Prof. Peter - RMIT  
St Vincent's Health Australia  
Victorian Agency for Health Information  
Woods, Prof. Mike - Centre for Health Economics and Research Evaluation, UTS  
Yong, Assoc Prof. Jongsay - Melbourne Institute

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Table A.4      (continued)

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*Participant*

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***Social housing – 16 March 2017, Sydney***

Achieve Australia  
Bridge Housing  
Common Equity  
Evolve Housing  
Homelessness NSW  
Housing Plus  
National Affordable Housing Consortium  
NSW Federation of Housing Associations  
PowerHousing Australia  
SGCH  
Shelter NSW  
Southern Youth and Family Services  
UNSW  
Wesley Mission  
Women's Housing

***Services in remote Indigenous communities – 2 May 2017, Canberra***

Australian Government Department of Social Services  
Chaney AM, Hon Frederick Michael  
Empowered Communities  
Gray AM, Bill – Former Secretary of the Department of Aboriginal Affairs and former CEO of ATSIC  
Queensland South Native Title Services

***Services in remote Indigenous communities, service provider representatives – 2 August 2017, Kununurra***

Anglicare WA  
Community Housing Limited  
Far North Community Services  
Kimberley Community Legal Service Inc.  
Kimberley Aged and Community Services  
Juniper Community Care  
Wunan Foundation

***Services in remote Indigenous communities, government representatives – 2 August 2017, Kununurra***

Shire of Wyndham East Kimberley  
Western Australian Country Health Service  
Western Australian Department of Communities

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Table A.4 (continued)

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*Participant*

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***Services in remote Indigenous communities, government representatives – 2 August 2017, Kununurra (continued)***

Western Australian Department of Housing

Western Australian Department of the Prime Minister and Cabinet

Western Australian Disability Services Commission

***Services in remote Indigenous communities, Indigenous representatives – 2 August 2017, Kununurra***

Binarri-binyja Yarrawoo Aboriginal Corporation

MG Corporation

Ngaringga Ngurra Aboriginal Corporation

Wally, Bev

Warringarri Media Aboriginal Corporation

Yawoorroong Miriwung Gajerrong Yirrgeb noong Dawang Aboriginal Corporation (MG Corporation)

***Social housing – 18 August 2017, Sydney***

Australian Council of Social Service

Australian Government Department of Social Services

Brisbane Housing Corporation

Compass Housing

Evolve Housing

Housing Action Network

Milliagan, Prof. Vivienne - UNSW City Futures Centre

NSW Federation of Housing Associations

Pawson, Prof. Hal - UNSW City Futures Centre

Queensland Department of Housing and Public Works

SEARMS Aboriginal Corporation

Shelter NSW

South Australian Department for Communities and Social Inclusion

St George Community Housing

***Public dental services – 21 August 2017, Melbourne***

Australian Dental and Oral Health Therapists' Association

Australian Dental Association - Victorian Branch

Australian Government Department of Health

Australian Research Centre for Population Oral Health

Dental Health Services Victoria

HCF

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Table A.4      (continued)

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*Participant*

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***Public dental services – 21 August 2017, Melbourne (continued)***

NSW Centre for Oral Health Strategy

Oral Health Services Tasmania

SA Dental Services

SA Health

***Social housing – 21 August 2017, Melbourne***

Aboriginal Housing Victoria

Anglicare

Australian Housing and Urban Research Institute

Brotherhood of St Laurence

Common Equity Housing

Community Housing Federation of Victoria

Community Housing Limited

Council to Homeless Persons Victoria

Husle, Prof. Kath - Swinburne University

National Shelter

Port Phillip Housing Association

Powerhousing Australia

Unison Housing

Victorian Department of Health and Human Services

Wiesel, Dr. Ilan - Melbourne University

***End-of-life care – 22 August 2017, Canberra***

Aged and Community Services Australia

Australia and New Zealand Intensive Care Society

Australian and New Zealand Society of Palliative Medicine

Australian Government Department of Health

Australian Healthcare and Hospitals Association

Australian Institute of Health and Welfare

Blue Care

Calvary

Catholic Health Australia

HammondCare

IRT Group

Leading Age Care Services Australia

Palliative Care Australia

Royal Australasian College of Physicians

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Table A.4 (continued)

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*Participant*

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***End-of-life care – 22 August 2017, Canberra (continued)***

Royal Australian College of General Practitioners

SA Health

Silver Chain Group

Tasmanian Department of Health and Human Services

Victorian Department of Health and Human Services

Woods, Prof. Michael - Centre for Health Economics Research and Evaluation, UTS

***Services in remote Indigenous communities – 22 August 2017, Canberra***

Australian Government Department of Social Services

Australian Government Department of the Prime Minister and Cabinet

Empowered Communities

Gray AM, Bill – Former Secretary of the Department of Aboriginal Affairs and former CEO of ATSIC

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- 2016b, *Counts of Australian Businesses*, Cat. no. 8165.0, Canberra.
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