Australian Government
Productivity Commission

Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform

Productivity Commission Study Report
Overview

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Publications enquiries

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

The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

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).

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The full report is available from www.pc.gov.au

OVERVIEW

Key points

- Greater competition, contestability and informed user choice could improve outcomes in many, *but not all*, human services.
- The Commission has prioritised six areas where outcomes could be improved both for people who use human services, and the community as a whole. Reform could offer the greatest improvements in outcomes for people who use:
  - social housing
  - public hospitals
  - end-of-life care services
  - public dental services
  - services in remote Indigenous communities
  - government-commissioned family and community services.
- Well-designed reform, underpinned by strong government stewardship, could improve the quality of services, increase access to services, and help people have a greater say over the services they use and who provides them.
- Introducing greater competition, contestability and informed user choice can improve the effectiveness of human services.
  - Informed user choice puts users at the heart of service delivery and recognises that, in general, the service user is best placed to make decisions about the services that meet their needs and preferences.
  - Competition between service providers can drive innovation and create incentives for providers to be more responsive to the needs and preferences of users. Creating contestable arrangements amongst providers can achieve many of the benefits of effective competition.
  - For some services, and in some settings, direct government provision of services will be the best way to improve the wellbeing of individuals and families. The introduction of greater competition, contestability and choice does not preclude government provision of services.
- Access to high-quality human services, such as health and housing, underpins economic and social participation.
  - The enhanced equity and social cohesion this delivers improves community welfare.
- Government stewardship — the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives — is critical.
  - Stewardship includes ensuring human services meet standards of quality, suitability and accessibility, giving people the support they need to make choices, ensuring that appropriate consumer safeguards are in place, and encouraging and adopting ongoing improvements to service provision.
- High-quality data are central to improving the effectiveness of human services.
  - User-oriented information allows people to make choices about the services they want and for providers to tailor their service offering to better meet users' needs.
  - Transparent use of data drives improvements in the performance of the system for the provision of human services and increases accountability to those who fund the services.

Overview

Introduction

High-quality human services, such as health and housing, underpin economic and social participation. Access to high-quality human services contributes to the wellbeing of individuals and the welfare of the community as a whole. Community welfare is enhanced by the social cohesion and equity benefits of people having access to a minimum level of human services, regardless of their means or circumstances.

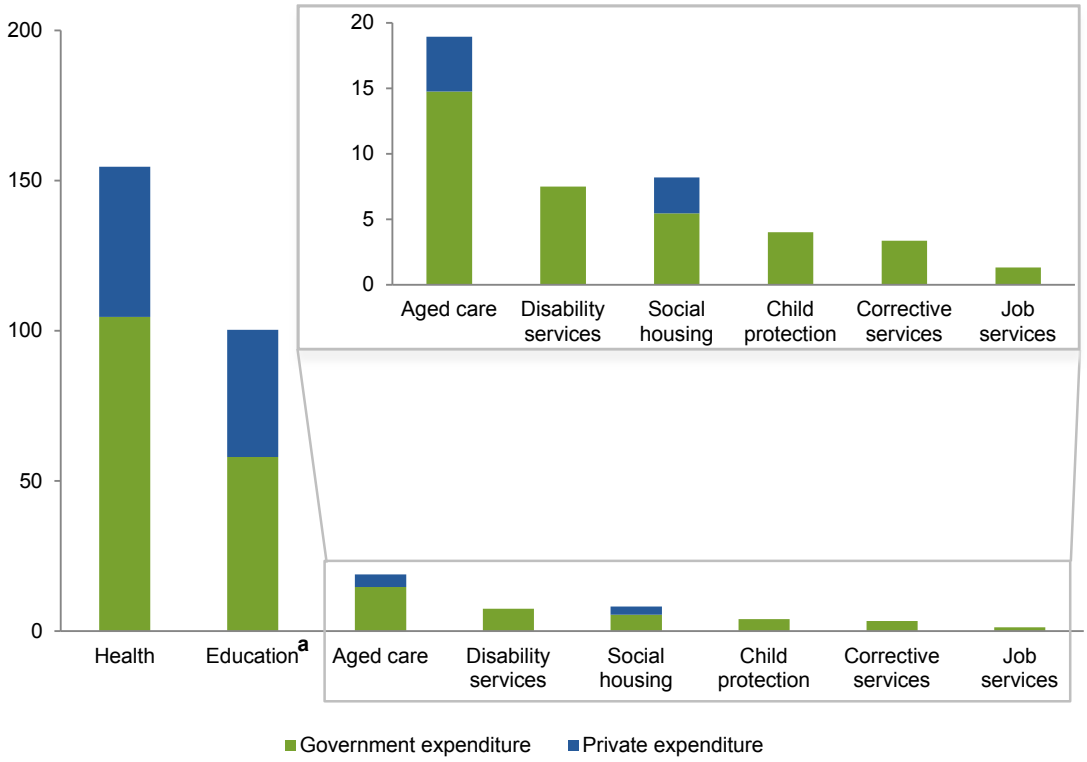
Everyone accesses human services during their lifetime. Many people draw on human services in a reasonably predictable pattern of use. Others will require transitional support to assist with a short-term crisis. Some will have multiple and complex needs and require access to several coordinated services, potentially for long periods. For example, of the 256 000 people who accessed specialist homelessness services in 2014-15, about 28 000 people also required access to mental health, drug and alcohol, or disability services. Of these, about 6000 people accessed two of these services, and a small number required support from all three. People with multiple needs can face particularly high barriers to access — barriers that are often made even higher by difficulties navigating a complicated system of service delivery.

Designing and managing systems to deliver human services is a complex task. Every level of government is involved in funding or delivering human services. Non-government providers include unpaid informal carers, sole traders, cooperatives and mutual organisations, mission-driven organisations that rely on volunteers and donations, and for-profit entities. Each will have a different balance between profit, organisational, social and other motivations. They can be large or small. Some will provide multiple services while others will specialise in specific services, or cater for specific users. The people who are served are diverse in their needs, preferences and capabilities, including their capability to exercise informed choice. Data are critical to system design. Data on service provider costs and performance, and linked data about service users, have the potential to be used for more effective and targeted interventions, and ultimately to improve outcomes from the provision of human services.

Public and private expenditure on human services is significant — almost $300 billion in 2013-14 (figure 1) — with demand projected to grow as people live longer, incomes grow and technological breakthroughs increase the range and number of services available to users. Expenditure provides an indication of costs but does not measure the benefits of human services to an individual or to the community — the social and economic benefits

when a person at risk of homelessness, for example, finds their way to stable accommodation, better health care and, ultimately, fulfilling employment.

Figure 1 **Expenditure on human services**
$ billion, 2013-14



[a] Private expenditure on education is based on ABS government financial data and may include some government payments to private individuals that are spent on education services and are also included as government expenditure on education.

The Commission's task

The Commission has been asked to examine whether the efficiency and effectiveness of human services could be improved by introducing greater competition, contestability and informed user choice. The terms of reference request that the inquiry be undertaken in two parts: the first is to identify services that are best suited to reforms to introduce greater competition, contestability or informed user choice. For the services identified as best suited, the second part of the inquiry is to make reform recommendations that help to ensure all Australians have timely and affordable access to high-quality services that are appropriate to their needs, and that those services are delivered in a cost-effective manner. The final inquiry report will be submitted to the Australian Government in October 2017.

The Commission released a preliminary findings report in September 2016, outlining its initial views on which services should be carried forward to the second part of the inquiry, and sought feedback on those findings. The publication of this study report marks the conclusion of the first part of the inquiry and sets out the Commission's view on the priority areas where reform could offer the greatest improvements in individual wellbeing and community welfare.

The scope of this inquiry

The terms of reference for this inquiry do not define 'human services', or provide a definitive list of which human services are within scope. Instead, the terms of reference list examples of human services — health, education, community services, job services, social housing, prisons, aged care and disability services — that serve as a guide to the scope of the inquiry. Potential reform to existing government 'back-office' systems that support the delivery of human services, such as payments systems, is beyond the scope of this inquiry.

Roles for government in the provision of human services

Governments take an active role in the funding, provision and stewardship of human services. This recognises that markets, as price and quality-setting forums, often struggle to deliver an appropriate level or distribution of these services across the community.

Markets for human services are fundamentally different to those for other services. For example, the 'size' of the market for many human services is largely determined by the level of government expenditure. Who is able to access services is — at a broad level — decided by governments and can be targeted to users through eligibility criteria or open to all through universal access arrangements. Users rarely face the full cost of service provision. The level of funding assistance from governments to service users varies — up to 100 per cent of the cost of provision for some services and for some users.

The nature of funding flows from governments to service providers and users — who receives the funding, when and on what basis — is a significant driver of outcomes from the provision of human services. For example, outcomes for service users, and the community more broadly, will differ depending on whether access to a service is demand-driven or if there is a fixed funding constraint imposed by governments. Some services are funded through payments to suppliers, while for others funding is placed in the hands of the consumer. Payments to service providers can be based on meeting outcomes agreed between governments and providers, or on the basis of activity.

Careful design is needed to ensure the incentives of providers and users are aligned; and that government objectives are met. At the extreme, user co-payments for a service may lead some users to go without the service, but services that are provided free to users could lead to overconsumption from a social perspective.

Governments have a stewardship role

Governments' stewardship role in the delivery of human services is broader than overseeing the market. Government stewardship relates to the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives. These functions include identifying policy objectives and intended outcomes, and designing models of service provision. Stewardship also includes developing regulatory and institutional arrangements to underpin service provision that is responsive to users, accountable to those who fund the services, equitable, efficient and high quality. Even in highly devolved delivery systems, governments retain ultimate responsibility for ensuring services deliver their intended outcomes.

With governments' involvement in the provision of human services comes the expectation from the community that those services meet a minimum standard. If governments do not adequately discharge their stewardship function, the effects can be damaging to service users, providers and governments. Australia's recent experience with the vocational education and training (VET) FEE-HELP scheme demonstrates what can happen when governments fail to discharge their stewardship role well (box 1).

Box 1 Vocational education and training reforms

Reforms to the VET sector illustrate the potential for damaging effects on service users, government budgets and the reputation of an entire sector if governments introduce policy changes without adequate safeguards.

In 2009, the Australian Government introduced the VET FEE-HELP system of income-contingent loans for higher-level VET courses. Initially, these loans were only available to students undertaking education and training through VET providers that had credit transfer arrangements with a higher education institution. In 2012, the Australian Government expanded the scheme so students undertaking courses at other VET providers could access VET FEE-HELP loans. The number of approved providers doubled between 2012 and 2014 to nearly 250, but no requirements were put in place for providers to demonstrate that they were delivering high-quality education. While consumer choice was expanded, the Australian Government did not fully anticipate the stewardship issues that would emerge.

The number of students accessing VET FEE-HELP increased almost fivefold from 2012 to 2015, mainly due to a substantial increase in the number of full-fee paying students enrolled in private training providers and accessing loans. Combined with a lack of accessible information, the weakening of price signals from the removal of upfront costs contributed to large increases in average tuition fees — which more than doubled for students eligible for VET FEE-HELP.

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). Under the influence of high-pressure marketing, thousands of students signed up for courses that they had little prospect of completing. Even among those who did complete their qualifications, many were unlikely to have considerably increased their employment prospects or potential earnings.

(continued next page)

Box 1 (continued)

Individuals were left with large debts that many are unlikely to ever repay, and the Australian Government incurred a large fiscal liability. The Australian Government has since tightened the criteria for education providers accessing government funding, with the intention of weeding out low-quality providers. In October 2016, the Government announced its intention to replace VET FEE-HELP with a new VET Student Loan scheme. The proposed scheme will increase consumer safeguards by tightening access to eligible courses, capping loan amounts, and requiring students to demonstrate their understanding of the loan and course progression. A new VET student loans ombudsman has also been proposed. Increased monitoring of providers will include a focus on student completion rates and employment outcomes, and strengthened compliance and payment conditions.

Better oversight of providers and tighter controls on service users' access to government funds under VET FEE-HELP would have had administrative costs, but could have helped avoid other costs that ended up being much larger.

Some recipients of human services can be vulnerable, with decisions often being taken at a time of stress. The need to ensure the development and implementation of appropriate consumer safeguards is an important aspect of the stewardship role and will be a key focus for the Commission in this inquiry.

Stewardship of human services also includes evaluating outcomes to identify effective practices, and making ongoing improvements to policies and programs to disseminate innovations and improve service outcomes. This aspect of stewardship is challenging. The ability to accurately define and measure outcomes varies significantly across the different human services. These difficulties mean that models of service provision and programs for evaluation need to be carefully designed and appropriately resourced.

Governments' objective should be to improve outcomes for users

Several submissions revealed a tension between the value of funding 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. Participants argued that not-for-profit providers deliver additional social capital, pointing to the community focus of such organisations, their sense of mission, and the use of volunteers to support service delivery. Some participants were concerned that service models which draw on competitive pressures threaten the ability of not-for-profit providers to generate these broader benefits.

The Commission agrees that not-for-profit organisations can provide social capital. In its 2011 inquiry into *Disability Care and Support,* the Commission recognised the benefits to social capital that can accrue through, for example, the fundraising and volunteering activities undertaken by (often small) not-for-profit community organisations. Similar conclusions were reached in the Commission's 2010 report on the *Contribution of the*

Not-for-Profit Sector, which found that not-for-profit providers can deliver benefits to the community that extend beyond the direct benefits to the recipients of human services.

Additional benefits, such as those potentially offered by not-for-profit organisations, should be considered by governments when determining how best to maximise community welfare from the provision of human services. Where governments have objectives that are broader than improving outcomes for individuals and their families, these objectives should be transparent, both in terms of outcomes and funding decisions. Each type of provider, whether they are for-profit, not-for-profit or government providers, will have distinct capabilities and motivations. Maximising community welfare from the provision of human services does not depend on adopting one type of model or favouring one type of service provider over others.

Competition, contestability and user choice

Informed user choice places users at the heart of human services delivery. With some exceptions, the user of the service is best-placed to make choices about the services that match their needs and preferences. Putting this power into users' hands lets individuals exercise greater control over their own lives. The increased agency this creates has merit. User choice can also generate powerful incentives for service providers to be more responsive to users' needs. Competition between multiple service providers for the custom of users can drive innovation and efficiencies. Competition and user choice are already common across a range of human services including general practitioners (GPs), private dental services and childcare centres. More competition and user choice is being introduced in other human services, such as disability services.

It will not always be the case that users are well placed to make their own decisions. People vary in their ability to make informed choices about the services they need or want, as does the level of assistance and user-oriented information needed to support user choice. Not everyone can, is willing to, or should exercise choice. Very young people or people living with some types of mental illness, for example, may not be well-placed to make decisions — although some will have agents or carers who are able to make decisions on their behalf. There are also circumstances when a user's agency is explicitly removed, such as being placed under a court order to attend drug rehabilitation.

Competition between multiple service providers is not always possible or desirable. As an alternative, where there would be net benefits, governments can seek to mimic competitive pressures through contestable arrangements to select providers, or to replace a poor provider with better performers. These providers could be from within government (ideally separated from the commissioning body) or from outside government, with contractual arrangements specifying the terms under which the service should be provided. A contestable market (including one with a single active provider), with a credible threat of replacement, can enable the better performing service providers to expand their service offering and keep current providers on their toes. Under the right conditions, contestability can deliver some, or even many, of the benefits of effective competition.

Increasing competition and contestability is not an end in itself. Rather, competition and contestability can be part of a system that encourages providers (and governments) to be more effective at achieving outcomes for service users by improving service quality, using innovative delivery models (box 2), expanding access so more people get the support they need, and reducing the costs to governments and users who pay for those services. Competition, contestability and user choice do not have to be applied simultaneously. User choice can be introduced where services are commissioned using contestable processes to select multiple providers. Competition to provide a service may be used when there are sufficient suppliers, while contestability can be used for the same service where competition would be ineffective, for example, due to thin markets in regional and remote areas.

Box 2 Telehealth and telecare services: an example of innovative delivery models

Models of provision drawing on digital technology have the potential to improve service responsiveness and the ability of users to access a range of services. In health and aged care, telehealth and telecare technologies are facilitating innovative models of service delivery. Using sensors and communication devices, providers are able to evaluate the status of a person's health through their vital signs, and check and respond to emergencies — all while the person remains in their own home. Telehealth services are also being used in medical facilities and dental clinics to connect healthcare professionals in regional and remote areas with specialists based in capital cities.

Some providers are beginning to develop and evaluate telehealth and telecare technologies in Australia.

- GP2U is an online doctor service that allows users to have video consultations using an app on their smart phone or tablet. After the consultation, the GP2U service can electronically forward the users' pathology requests, specialist referrals or prescriptions for collection from a local pharmacy. About 20 000 patients use the GP2U service each year.
- Curo is a telecare provider that allows users to place sensors in their own home that unobtrusively monitor movement and room temperature. Curo's app interprets this information and alerts care providers and family members when the user completes daily tasks or when the room temperature is too hot or cold. Over time, Curo can determine changes in behaviour, such as waking up later than usual, which can assist providers to tailor services or detect early warning signs.
- CSIRO has partnered with not-for-profit organisations, local health districts and for-profit telecommunications companies to undertake a 12-month trial of home monitoring services for elderly patients with a chronic disease. The results found that users were less likely to need to visit a GP or be admitted to hospital, and users reported improvements in their quality of life and understanding of their condition.

The introduction of greater competition, contestability and user choice may not always be the best approach to reform. One size does not fit all and redesigning the provision of human services needs to account for a range of factors, including: the rationale for government involvement; the outcomes the services are intended to achieve; the nature of the services and the dynamics of the markets in which the services are provided; the

characteristics, needs and capabilities of users; and the diversity in purpose, size, scale and scope of providers. Not all of these factors are clear cut or measurable, and all change over time. Further, reforms may raise or lower government expenditure on the provision of human services and different design options will have different fiscal implications for governments.

Data availability and use

Increased availability and use of human services data is necessary to realise the potential benefits from greater competition, contestability and user choice. To make informed choices, users need to understand the range of services that are available to them. Providers require data to analyse and improve their services. Governments need data to identify community needs and expectations, the demand for services and gaps in service provision. Better data can be used to improve the coordination of services and target service provision more accurately to the people who would benefit from them most. Program design, monitoring and evaluation rely on high-quality data. Governments might better use these data to tailor and improve the programs that are used to deliver services, helping to ensure that the effectiveness of human service provision improves over time. Effective data collection and analysis are not costless. The Commission's draft report for its inquiry into *Data Availability and Use* has made recommendations to address these types of issues.

Many, but not all services, are suited to greater competition, contestability and user choice

Non-government providers have been delivering many human services for a long time. Non-government provision has increased in some sectors since the mid-1990s, including school education, social housing and childcare. In many cases, increased non-government provision has been accompanied by greater access, with users having choice over the service they receive, who provides it or perhaps both.

The government and non-government provision of human services has involved instances of controversy or failure — there are examples of both government and non-government providers failing to meet standards of quality and accountability. Several participants expressed concerns about the provision of human services being subject to greater competition and contestability and, to a lesser extent, user choice. The reasons for participants' concern included that:

- competition, contestability and user choice risk bidding down the cost of delivery and will lead to a reduction in the quality of services — especially where for-profit providers are involved
- the users of human services include the most disadvantaged in the community with vulnerabilities arising from very low incomes, mental or physical illness, frailties due to older age, low numeracy and literacy skills, or a lack of access to the resources and support needed to exercise informed choice

- some providers of human services have taken advantage of vulnerable people (and poor government stewardship), exposing weaknesses in the system and undermining confidence that competition, contestability and user choice can be beneficial to users, and to the community more broadly
- not-for-profit, community-based organisations are better-placed to provide human services — they are closer to the communities they serve and, because they are mission-driven, rather than profit-driven, will reinvest any surplus back into services to support less profitable areas. However, flaws in governments' processes for commissioning services can have negative effects on providers' ability to achieve outcomes for service users
- introducing greater contestability creates incentives for providers to focus their attention on tender applications and for governments to focus on contract management rather than on 'what works' for those in need of support
- Power to Persuade, an organisation that moderates a discussion blog on public policy, noted that competition and contestability have the potential to fragment the human services sector and lead to a loss of provider diversity. The submission also noted that there had been examples of competition and contestability leading to exploitation of, and poor outcomes for, users, and that users of human services are often not well placed to make rational, informed decisions.

Each of these concerns is legitimate but may be minimised or avoided by designing appropriate systems to provide human services. Even with these concerns, measures to empower service users and increase competitive pressures could lead to better outcomes for some service users and communities. The question is when is it possible to design models of service provision that capture one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice. The Disability Council NSW explains this in the context of the National Disability Insurance Scheme (NDIS):

> Choice is empowering and can facilitate greater independence and improve overall quality of life, particularly for people with disability that may have been denied choice and opportunities for self-determination.

A strong theme in submissions was the need to consider how reforms to introduce greater competition, contestability and user choice could improve the effectiveness of the service. Effectiveness can be considered in the context of human services as an overarching concept, incorporating the attributes of quality, equity, efficiency, accountability and responsiveness to determine whether the service is achieving its intended outcomes. Introducing greater competition, contestability or user choice might not improve all of these attributes of effectiveness at the same rate, or in equal measure, for all service users. Many, but not all, human services are suited to this type of reform and options that *generally* offer improvements across this range of attributes will be examined in the inquiry report.

The Commission's framework

To assist with its task, the Commission has developed a three-stage framework to consistently assess the suitability of each service for competition, contestability and user choice reform (figure 2).

Figure 2 **Identifying services best suited to reform**

The framework involves three steps.

- Assessing whether there is scope for changes in policy settings to increase the wellbeing of the community as a whole by improving the provision of human services.

- Examining whether the characteristics of the service user, the service itself and the supply environment mean that improvements in service provision could be achieved by introducing greater competition, contestability and user choice.
- Identifying potential costs associated with introducing greater competition, contestability and user choice, including costs to users and providers, and the costs of government stewardship.

Services identified as best suited to reform

The Commission's assessment of the services presented in table 1 takes into account evidence from a range of sources including contributions from participants through submissions, consultations and roundtables, overseas experience, research undertaken by others and Commission analysis. Case studies from Australia and overseas have been used to inform the assessment of suitability for reform.

Table 1 **Services assessed in this study**[a]

Alcohol and drug services	**End-of-life care**	Mental health services
Allied health services	Family support services and out-of-home care	**Public dental services**
Child and family health services	General practitioners (GPs)	**Public hospital services**
Community health services	Higher education	Primary and secondary schooling
Corrective services	Home-based aged care	Primary health networks
Disability employment services	Homelessness services	Residential aged care
Disability support services	**Human services in remote Indigenous communities**	**Social housing**
Early childhood education and care	Job services	Vocational education and training
Emergency payments	Maternity services	

[a] Services are in alphabetical order. Services in bold are those identified by the Commission as best suited to reform. Commissioning arrangements for family and community services has also been identified as best suited to reform.

In identifying services, the Commission considered a number of factors, including:

- the extent to which services are already subject to competition, contestability or user choice (examples include the provision of GP or optometry services)
- whether reforms to introduce greater competition, contestability or user choice are already proposed, or are underway (examples include disability services, mental health services and vocational education and training)
- whether improved outcomes could be better delivered by reforms other than greater competition, contestability or user choice (examples include school education).

For a number of the services considered by the Commission, competition, contestability or user choice reform could improve service provision for users, and benefit the community as a whole. The services identified reflect the Commission's view of where well-designed reform could offer the greatest improvements in community wellbeing. The assessment has identified six priority areas:

- social housing
- public hospital services
- end-of-life care
- public dental services
- human services in remote Indigenous communities
- commissioning arrangements for family and community services.

In the case of family and community services, governments expend significant resources on services that provide emergency relief and ongoing support to people experiencing hardship. Much of that funding is allocated through contestable processes undertaken by governments but inquiry participants identified common issues with these processes in submissions, roundtables and other consultations. In the Commission's view, there is scope to improve outcomes for service users, and the community as a whole, by reforming the way governments commission service providers to deliver family and community services.

The priority areas identified by the Commission as best suited to reform are diverse — in the type and number of users and providers, the settings and circumstances under which services are provided, their reform history, the current application of competition, contestability and user choice, and the level of expenditure contributed by governments and users. The policy design challenge in each will be unique.

The importance of ongoing reform and evaluation

There are six priority areas for reform identified in this report. Many other services could also benefit from reform, but the areas identified reflect the Commission's views on the highest priorities for the Commission's current task. For example, there is considerable scope to improve outcomes by promoting competition, contestability and user choice in the provision of residential aged care services. The Commission's *Caring for Older Australians* inquiry into the aged care sector in 2011 made recommendations, such as replacing the system of discrete care packages across home-based and residential care with a single integrated and flexible system of care entitlements that would improve outcomes for users of residential aged care services, and the community as a whole.

Reforms are underway to introduce greater competition, contestability or user choice to other services included in the scope of this inquiry. For example, greater user choice is being introduced in home-based aged care. Other human services, such as disability supports through the 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.

The Australian Government has also committed to reforming mental health services, including making the delivery of mental health services more contestable, evidence-based and person-centred. The Australian Government also noted that funding should target, and support, the choices of the individual user based on the level and type of need. The Commission supports the objectives of these important reforms, but notes that it is too early to evaluate their effectiveness.

Services identified for reform

Social housing

Shelter is a basic human need. Housing assistance provides a safety net for those that are experiencing homelessness, or who face high barriers to sustaining a tenancy in the private rental market, and plays an important role in increasing their quality of life. Housing assistance can take three broad forms.

- Assistance with the costs of housing (through subsidised rents, such as those received by social housing tenants, or through income support payments).
- Support to access or maintain a tenancy (such as support for people with a mental illness or poor tenancy records, which make holding a private rental tenancy difficult).
- Transitional support for people to move into the private housing market from social housing or the social housing waiting list.

The Commission's focus is on services to people receiving support through the social housing system, and those who require support but are currently unable to access it. A number of services, assets and processes make up the social housing system, including the ownership and management of properties, the allocation of tenants to specific homes, and some tenant support services. Social housing covers both public housing (properties managed by state government housing authorities) and community housing (properties owned or managed by non-government providers). The Commission will consider the operation of the social housing system, as well as the interaction of the system with broader housing assistance policies, such as the effect of Commonwealth Rent Assistance on the demand for social housing.

About 400 000 households live in social housing. Recipients of social housing assistance, who are also likely to access a number of other human services (box 3), have reported through the National Social Housing Survey that they are in better health, are better able to improve their employment situation, and have better access to the services and supports they need once settled in stable accommodation.

Box 3 Characteristics of social housing tenants

Compared with the general population, tenants of social housing are more likely to be female, Indigenous, Australian-born, from single-person households, and have a disability. Tenants are likely to access a number of other human services, most commonly health and medical services (two-thirds of all tenants), and mental health services (one-fifth of all tenants).

Three out of four working-age social housing tenants who are in receipt of an income support payment (such as Newstart Allowance or Youth Allowance Job Seeker) have severe or significant barriers to employment. Employment participation rates are low — nationally in June 2013, about 10 per cent of working-age public housing tenants in receipt of an income support payment were employed, compared with 20 per cent for other working-age recipients of an income support payment.

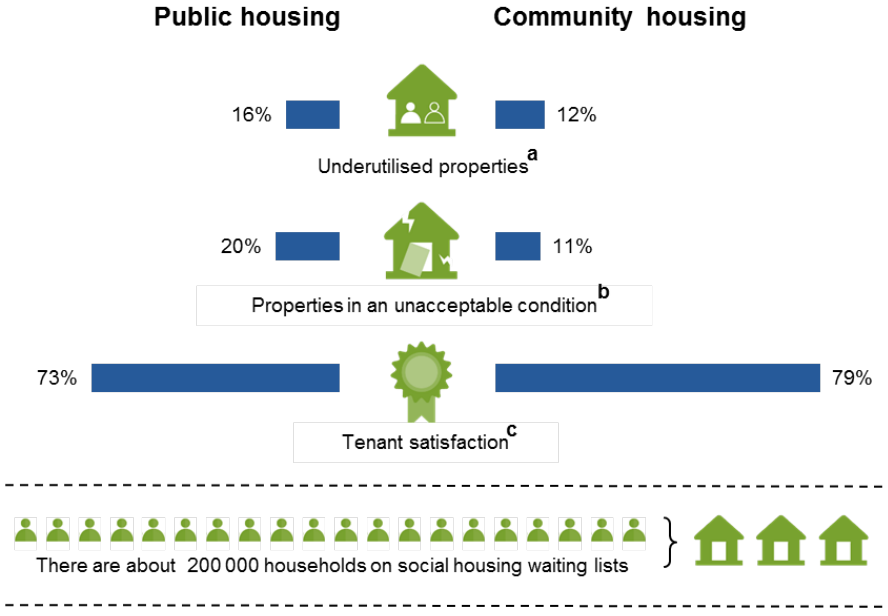
The focus of the social housing system has changed profoundly over time in Australia. There has been a shift in the demographics of people receiving support through the system — from working families to recipients of income support who have additional barriers to entering the private housing market. This, combined with the long-lived nature of housing assets, has resulted in a growing mismatch between the characteristics of the social housing stock and those receiving assistance. It has also resulted in funding pressures on the system. A mismatch also exists between the level of support delivered via the income support system through Commonwealth Rent Assistance and the income-based rent model used in social housing. This mismatch is undermining the effectiveness of housing assistance in Australia.

A wide range of social housing systems exist internationally. In some systems, social housing makes up a significant proportion of the total housing stock, while in others (like Australia) social housing represents only a small percentage of the total housing stock. There is no benchmark for the 'right' level of social housing in an economy. The level of social housing needed will depend on interactions with broader government policy, including the level of income support provided, the objectives of the state and territory governments that have responsibility for the policy area, and the amount of affordable housing available for people to rent in the private market.

Most social housing is provided by government entities

Government entities manage four out of five social housing properties, with the remainder managed by not-for-profit community housing organisations. About 20 per cent of social housing managed by governments (public housing) is not in an acceptable condition, property underutilisation is high, and prospective tenants face long waiting times before they receive housing (figure 3). Limited data on tenant outcomes restrict the ability of governments to monitor and assess the performance of service providers.

Figure 3 **Indicators of public and community housing, 2014**



[a] Underutilisation refers to the percentage of properties that have at least two more bedrooms than the number of tenants living in them. [b] 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. [c] Tenant satisfaction is the percentage of people who reported being satisfied or very satisfied with their housing.

Offering more choice to social housing tenants

The current social housing system limits the ability of tenants to choose their home. Once applicants reach the top of the waiting list, they are generally allocated a home based on their preference for the area in which they would like to live and their broad characteristics. The suitability of a property can be a question of timing and luck. Tenants cannot hold out for a preferred property because those that reject two offers of housing, or sometimes even one, are relegated to the back of the often long waiting list.

Many people who enter social housing are likely to be capable of exercising choice over their housing options — although some may need additional support to be able to exercise informed choice and maintain a tenancy. In other countries, efforts to improve users' choice of home have led to a range of benefits. Tenants are more likely to stay in the same area, invest in the local community, and have stable accommodation. Data collected from choice-based systems have been used to identify the housing characteristics that tenants prefer, and to target areas of high demand and need.

Demand for social housing outstrips supply. This has resulted in long waiting lists and waiting times. Approaches have been implemented overseas to provide greater choice of home, even where there are supply constraints. Reform options could also be explored in

Australia to address supply constraints and increase the housing options available for prospective social housing tenants.

FINDING 3.1

Introducing greater competition, contestability and user choice could improve the effectiveness of the social housing system in meeting tenant needs.

- There is substantial room for improvement in the current social housing system. There are long waiting lists, poorly maintained and underutilised properties, and a lack of information available to allow governments to select and monitor the performance of government and non-government service providers.
- Four out of five social housing properties are managed by government entities, yet there are a large number of housing providers — both not-for-profit and for-profit — that could perform this service.
- There are currently not enough social housing properties to meet demand, limiting the housing choices available to social housing tenants. Nonetheless, approaches implemented internationally allow social housing tenants greater choice of home. Reform options could be explored in Australia to address supply constraints and increase the housing options available for prospective social housing tenants.

Public hospital services

The Australian health system is complex, with many different, but connected, parts and varying degrees of government involvement in funding and providing services. Policy objectives include equitable access to healthcare, timely delivery of services that meet the health needs and preferences of individuals (both to prevent illnesses and treat them when they occur), and that services are provided as efficiently as possible. An ongoing, and increasingly important, challenge has been to coordinate care that individuals receive across multiple providers, care settings and services.

The Commission considered the scope for greater competition, contestability and choice to contribute to these policy objectives across the numerous types of health services and concluded that this inquiry could add most value by focusing on public hospital services, for the reasons outlined below. While the inquiry will focus on this area, the Commission is mindful that public hospital services do not operate in isolation from other parts of the health system (such as private hospitals) and that coordinating an individual's care can lead to better patient outcomes.

The term 'public hospital services' refers to healthcare that (mostly public) hospitals provide to public patients. This covers many different types of care and can be provided in a range of settings, including specialised units in large hospitals, outpatient clinics, day-procedure centres, and hospital-in-the-home care. Almost 60 per cent of expenditure is on admitted services, with the vast majority of this being acute care to cure a condition, alleviate symptoms or manage childbirth. Even a small percentage improvement in

outcomes from public hospital services, including quality, could deliver significant benefits in aggregate, given the scale of service provision.

There is scope to improve outcomes for patients

On average, Australian public hospitals perform well against those in comparable countries in terms of health outcomes and costs. Nevertheless, there is scope to improve. Equitable access is an ongoing concern for some groups, particularly those in remote areas. Moreover, benchmarking within Australia suggests that many public hospitals could increase their service quality and efficiency by matching best practice among their domestic peers. There are many policy levers that governments already use to improve patient outcomes. Greater contestability and user choice could, as part of a wider range of reforms, lead to better outcomes for patients.

User choice could be greater

The good health outcomes that Australia generally achieves compared to other countries indicate that, from a clinical perspective, public hospitals are typically responsive to the needs of patients. However, public patients are often given little or no choice over who treats them and where. Overseas experience indicates that, when hospital patients are able to plan services in advance and access useful information to compare providers (doctors and hospitals), user choice can lead to improved service quality and efficiency (box 4).

Box 4 Overseas examples of choice and information provision

In England, patients referred to a specialist by their GP have a legal right to choose the hospital or clinic and consultant-led team they attend. They can access a useful website to compare alternatives, and use an online booking service when they have chosen. Quantitative studies have found that following these reforms:

- consumers 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. Among people seeking a coronary artery bypass graft, choices made by sicker patients were more sensitive to reported mortality rates
- hospitals in more competitive locations improved service quality the most — death rates for patients admitted after a heart attack fell the most in hospitals that had more nearby competitors. Hospitals located in more competitive areas also had larger declines in mortality from other causes and lower lengths of stay for elective surgery.

Studies of other countries have also found benefits following the public release of information on service quality. For example, the adoption of public performance reporting in Sweden was followed by a decline in the share of patients requiring an artificial hip repair or replacement to among the lowest rates in the world.

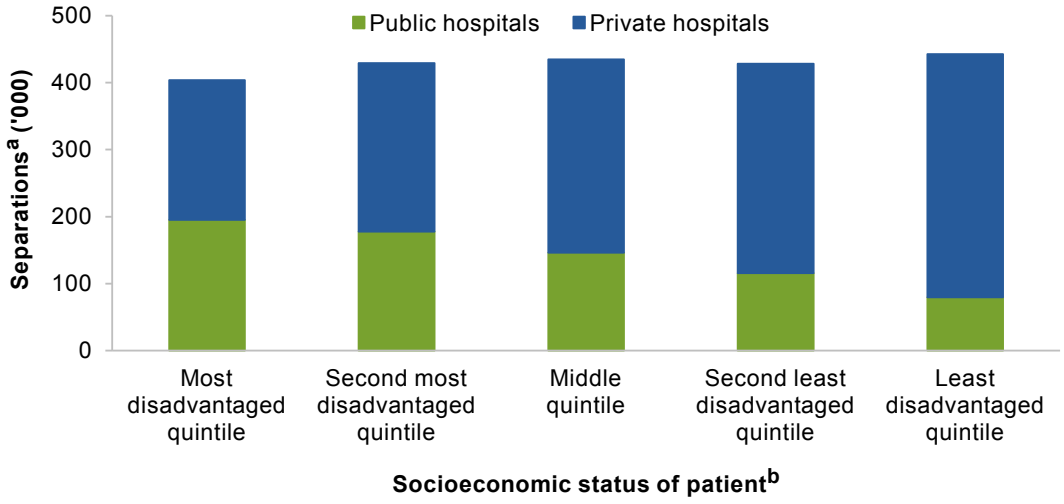
Greater user choice in Australia would need to be supported by more user-oriented information than is currently available, particularly on the clinical outcomes achieved by

individual hospitals and doctors. Overseas evidence suggests that some (but not all) consumers would use such information to seek out better-performing providers (box 4). There is also evidence that hospitals and doctors would use publicly reported data to benchmark themselves against other providers and seek to improve when they are below best practice. The opportunity for third parties, such as health academics, policy think tanks and consumer advocacy groups, to analyse publicly reported data would create further pressure on providers to improve outcomes.

The benefits of user choice would depend on the health literacy of patients because this would influence their ability and willingness to make informed choices. Providing greater choice at the point where individuals are referred to a specialist by their GP might be one way of supporting choice for people with low levels of health literacy. This is broadly the model that has existed in England (although not the rest of the United Kingdom) since 2006.

The most common planned (elective) surgical procedures in Australian public hospitals include cataract surgery, removal of skin cancers and knee replacements. Overall, public hospitals account for about one-third of elective surgical admissions but almost 50 per cent for patients in the most disadvantaged quintile, based on their place of residence (figure 4). This suggests that greater choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

Figure 4 **Elective surgery by sector and socioeconomic status of patient, 2014-15**



[a] A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). [b] Quintile of socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for the area where a patient resided. The index summarises population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

More contestable approaches to commissioning public hospital services

In most cases, services are provided by state and territory governments through local health networks. These networks regularly renegotiate service agreements with their government and this could be used as an opportunity to test more contestable approaches to commissioning services. Such reforms require careful design and implementation — public hospitals and the services they provide are very heterogeneous, with many submarkets, and there are complex links between public hospitals and the rest of the health system, including private patients and private hospitals. There have been difficulties in the past commissioning non-government providers and the lessons from these attempts should not be forgotten. Workforce issues can also pose particular challenges to changing providers. As a result, it may be more feasible to implement contestability as a more transparent mechanism to replace an underperforming public hospital's management team (or board of the local health network), rather than switch to a non-government provider. Another option is to focus on introducing greater contestability for a subset of services.

FINDING 4.1

The Australian health system is complex, with many different, but connected, parts. There is already a high degree of choice and competition for many services, such as primary care provided by GPs and optometrists. A key exception is public hospital services, where greater user choice and contestability could, as part of a wider range of reforms, lead to better outcomes for patients.

- Australian hospitals generally perform well against those in comparable countries but there is still scope for many to improve patient outcomes and lower costs by matching the practices of better-performing hospitals within Australia.
- Overseas experience shows that user choice can lead to improved service quality and efficiency when patients are able to plan services in advance and access useful information. In Australia, this would require more user-oriented information on the clinical outcomes achieved by individual hospitals and doctors. Patients with low levels of health literacy would also need support, such as from their GP.
- Greater user choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.
- There is an opportunity for state and territory governments to test more contestable approaches to commissioning services when they regularly renegotiate service agreements with local health networks. More transparent arrangements for replacing senior management of government-operated hospitals (or local health network boards) in cases of underperformance could also increase contestability. This would not require switching to a non-government provider.

End-of-life care

Major advances in medical science have enabled Australians to live longer and healthier lives but inadequate attention has been paid to ensuring Australians get the care they desire at the end of life.[1] The best available data suggest that most Australians wish to die at home — perhaps as many as 70 per cent — but few manage to do so (less than 13 per cent). A 2015 survey undertaken by Palliative Care Australia found that not being able to die in one's place of choice was the most common concern about care expressed by Australians who had recently experienced someone close to them die from a long-term illness.

Better satisfying patient preferences regarding the timing and setting of care requires changes to end-of-life care services. As defined by the Australian Commission on Safety and Quality in Health Care, these services include physical, spiritual and psychosocial assessment, and care and treatment by health professionals and ancillary staff, provided to people who are 'likely to die in the next 12 months'. End-of-life care services also include support for families and carers during what is a difficult and stressful time, and care of the patient's body after their death.

Scope to improve outcomes

Australia's end-of-life care services are well regarded internationally, but more could be done to ensure patients receive the right care, in the right place at the right time. End-of-life care could be more responsive to patient preferences with regard to both where care takes place and when it takes place. Access to high-quality care is variable both within and between jurisdictions. There is evidence that Indigenous Australians, and people from culturally and linguistically diverse backgrounds are underserviced, as are people suffering illnesses other than cancer even though they have many of the same end-of-life care needs. A lack of comprehensive, publicly available national data about expenditure, patient activity and patient outcomes also limits the accountability of services and hampers efforts to improve service delivery.

Patient preferences could be better satisfied, and patient outcomes improved, if patients were provided with more choice about the timing and setting of end-of-life care. This could include extending access to high-quality care in different settings, and introducing greater contestability and competition as part of a broad suite of reforms.

Issues to consider in undertaking reforms

Any measures to increase user choice would need to accommodate changing preferences as death approaches (patients can become concerned about the burden placed on their family or carers, and opt to use inpatient services closer to end of life) and the special

1 End-of-life care does not include assisted suicide or euthanasia.

circumstances associated with making choices at the end of life. Development of a life-limiting illness is emotionally taxing and psychologically distressing for patients, carers and loved ones. In this environment, making choices about end-of-life care arrangements is difficult. Unpredictable trajectories of deterioration in cognitive and physical functioning may also limit the ability of some patients (and their families) to plan ahead and express preferences for care. Greater awareness and implementation of advance care planning could help to address this.

Patients will need different medical and personal services as part of their end-of-life care, and so achieving improved outcomes will require change across different services and professions. Deeper integration of end-of-life care within existing service delivery models (including those used in primary and community care, hospitals and aged care facilities) will be crucial. Better coordination across services provided in different settings will also be important.

Introducing greater user choice would require careful design to ensure that the interests of patients and their families are well served. To the extent that this involves changes to the way end-of-life care services are commissioned, the benefits associated with collaboration between services would need to be recognised and arrangements put in place to ensure continuity of care between providers. Special measures for consumer protection may be needed given the vulnerability of users of end-of-life care services, the limited capacity of many users to exercise choice and the potential magnitude of harm should a service provider act without due care. More extensive data collection and improved monitoring and benchmarking of provider performance would also be required.

FINDING 5.1

Many Australians wish to die at home, supported by family, friends and effective care services, but often their wishes are not being met.

- There is scope to improve end-of-life care services by providing users with greater choice about the care they receive, and the setting of care. As part of a wider suite of reforms, contestability and competition could play a role in promoting user choice.
- Efforts to promote user choice would need to address the challenges associated with making decisions at the end of life. Complementary measures would also be required to improve the integration and coordination of care services across a variety of settings, allow for better measurement and monitoring of patient outcomes, and provide protection for vulnerable consumers.

Public dental services

Unlike most other forms of healthcare, governments only fund a small proportion of dental services but, when they do, these services are also typically provided by government. This is in contrast to, for example, eye tests and GP services, where the vast majority of funding

comes from the Australian Government via Medicare, but services are almost always provided by the private sector.

Public dental services act as a safety net by providing access to basic dental care. In 2013-14, public dental services accounted for about 14 per cent ($1.2 billion) of Australian expenditure on dental care. Among people who saw a dental professional in 2013, about 14 per cent attended a public clinic (including school clinics) at their last visit.

There is scope to improve outcomes

Publicly funded dental services play an important role in providing basic dental care for people who face financial and other barriers to access. Such services are often provided in clinics (and dental hospitals in some jurisdictions) operated by state and territory governments. Public dental clinics play a relatively large role in delivering dental services to remote communities. Even so, concerns have been raised about access to dental services in remote areas, including for Indigenous Australians. People living in remote Australia are more likely to suffer from poor oral health and to be hospitalised for potentially preventable dental conditions. More contestable delivery arrangements for public dental services that encourage more innovative and flexible service provision could improve access to dental services in remote communities.

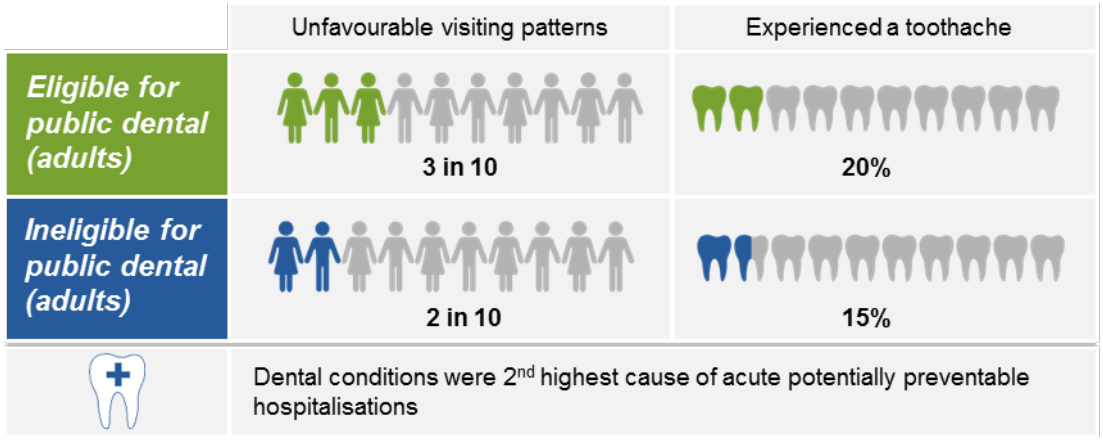
The current emphasis on government provision of public dental services can limit the ability of patients to choose the time and location of their treatment. While users can sometimes choose between different public dental clinics, options may be more limited than if users were able to attend private dental practices. Voucher schemes have been used in some jurisdictions and have provided public dental patients greater choice over the timing and location of treatment, and their dental professional, by making use of private dental practices.

Among other things, greater choice over the timing and location of treatment, and dental professional may encourage some users to seek timely treatment for oral health conditions. Unfavourable visiting patterns, which are slightly more prevalent among adults eligible for public dental services, can ultimately lead to poor oral health (figure 5). Barriers that cause people to leave dental problems untreated are a concern not only for the individuals affected but also the wider community because they can lead to more costly treatment, particularly if the patient requires hospitalisation. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14.

The states and territories publish information on public dental activity levels, overall expenditure and waiting lists. However, there remains considerable scope to further improve accountability to those who fund public dental services (governments and users through co-payments). This includes greater public reporting, on a consistent basis, of clinical and other patient outcomes (such as from patient satisfaction surveys). Accountability would also be improved by releasing more detailed expenditure data, including on the cost effectiveness of public dental services.

Some participants observed that governments have found that public dental services are more costly when provided by the private sector. For example, a submission from Dr Martin Dooland noted that private sector provision was, on average, 30 per cent more costly than public provision for a course of general dental care for adults. Participants attributed the cost difference primarily to private clinics providing more services per patient. Other factors could also be at play, such as cross-sector differences in service quality, economies of scale, and the way costs are measured. The Commission will explore these issues in greater depth in the next stage of the inquiry.

Figure 5 **Oral health indicators, 2013[a]**



[a] Adults eligible for public dental care include people who held an Australian Government concession card. People were classified as having an unfavourable dental visiting pattern if: they visited a dental provider less than once every two years typically to receive treatment for a dental problem; or they visited once every two years typically to receive treatment for a dental problem, but do not have a regular dental provider. Visiting patterns and toothache data are based on the 2013 National Dental Telephone Interview Survey. The reported numbers are statistically significant at the five per cent level.

Potential models for greater competition, contestability and user choice

The preferred approach to reform may vary between urban, regional and remote regions, and between segments of the population. In areas where there is limited capacity to sustain multiple providers, the provision of public dental services could be made more contestable. There are many different models of contestability that could be applied to these services, such as inviting bids from government and non-government providers to operate or manage all or part of the service offering.

Delivery mechanisms that allow users to choose between competing dental practices could be used for populations that generally do not face difficulties in accessing care and are well serviced by the private sector. Such mechanisms are already used to some extent in all jurisdictions and this has shown that private dental practices can supply high-quality services to public patients.

As part of any shift to more choice in the provision of public dental services, governments would need to ensure that they support informed choices for users of public dental

services, possibly through a combination of information provision and person-to-person advice. Governments would also need to monitor the types of services provided, and how these services contribute to clinically- and cost-effective outcomes for individuals and the eligible population.

FINDING 6.1

Introducing greater competition, contestability and user choice in public dental services could lead to better outcomes for patients and the wider community.

- Public dental services act as a safety net by providing access to basic dental care, but there is scope to improve outcomes. Access to services is a concern for certain populations and the uncontested provision of services in government-operated clinics limits responsiveness to user preferences. While governments regularly publish information on public dental activity levels, overall expenditure and waiting lists, accountability could be improved through greater public reporting on patient outcomes and cost effectiveness.
- Users could benefit from having greater choice over the timing and location of treatment, and their dental professional. Greater choice may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary. In addition to initiatives already implemented by governments, encouraging more innovative and flexible public dental services could improve oral health in communities not well serviced by the private sector.
- The approach to greater competition, contestability and user choice should reflect the characteristics of users, availability of dental professionals, and cost effectiveness of alternative models. Service provision could be made more contestable in areas where there may be limited capacity to sustain multiple providers. More competition and choice could involve using delivery mechanisms that allow users to choose between competing dental practices.

Human services in remote Indigenous communities

The inquiry terms of reference ask the Commission to have regard to the challenges facing the provision of human services in rural and remote areas, small regional cities and emerging markets, and the need to improve Indigenous outcomes. These issues will be taken into consideration in the Commission's assessment of reform options in each of the services identified in this report. However, the provision of human services in remote Indigenous communities warrants additional consideration.

About 85 per cent of Australia is classified as remote. These areas are home to just over 2 per cent of Australia's population. In remote areas, the distance to the nearest town or service centre can be in the hundreds of kilometres. Service providers face barriers to effective service provision, such as a lack of and difficulty in accessing infrastructure, and difficulty recruiting and retaining staff. The challenges of remoteness can make the cost of providing services in remote Australia several times the cost in urban areas.

About one in five Indigenous Australians live in remote areas. In 2011, there were over 1000 discrete Indigenous communities in remote areas of which more than three quarters had a population under 50.

Physical isolation is a key reason why remote communities typically cannot access the range of human services that are provided elsewhere, but it is not the only reason. Indigenous Australians living in these communities may also interact with services differently to other Australians, reflecting a combination of factors, including culture and past experiences with government services. About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared with 2 per cent of Indigenous Australians living in non-remote areas. The Australian Government's 2014 Mental Health Review found that Indigenous Australians had poorer access to mental health services, in part because services designed for the broader population were not culturally appropriate. The NDIS trial in the Barkly region of the Northern Territory also identified the importance of providing services in a culturally appropriate way, including through building relationships and trust, and providing tailored information to those accessing support.

Indigenous Australians tend to relocate more frequently than other Australians, which can lead to significant variability in the level and nature of demand for services. For example, services may need to be coordinated between different remote locations and less remote towns to provide continuity of care to people who are mobile and need to access several providers. Technology can also assist in this area. In the Kimberley region, web-based electronic patient records are shared between health professionals, including Aboriginal Community Controlled Health Organisations and hospitals to enable continuity of care for the region's highly mobile population.

Improving outcomes in remote Indigenous communities

Indigenous Australians living in remote communities are more likely to experience poor outcomes than other Australians, including Indigenous Australians living in non-remote areas (figure 6).

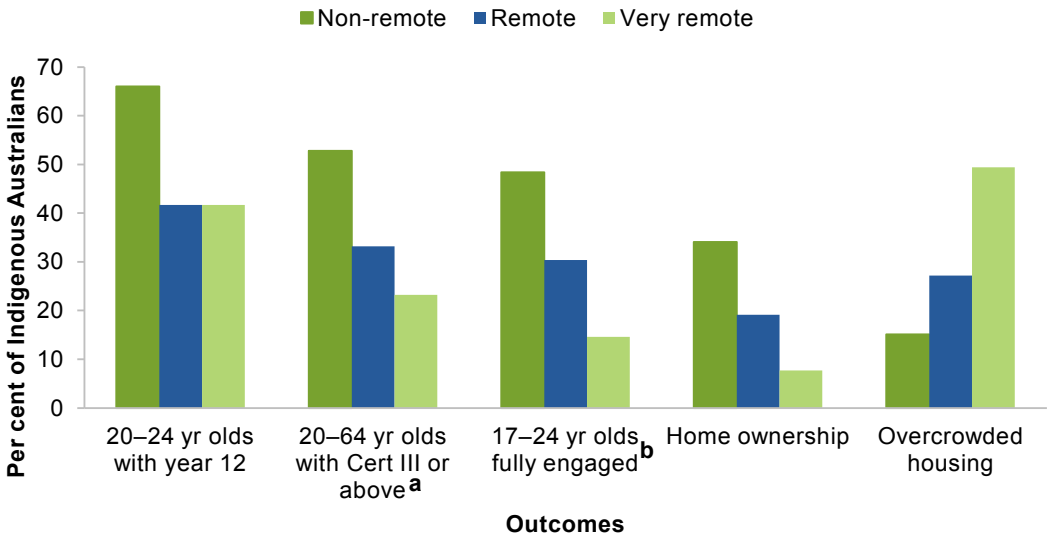
Improvements to arrangements for purchasing and delivering human services for Indigenous Australians living in remote communities could lead to more effective service provision and better outcomes for service users. The service delivery arrangements for people living in remote Indigenous communities are overly complex. Funding and responsibility for service provision and outcomes are split across governments, departments, programs and providers. Although this is also the case in human services more generally, the negative effects of this are stark for remote communities with high levels of service fragmentation, and duplication in some areas and gaps in others.

In its submission to this inquiry, the Aboriginal Medical Services Alliance NT gave the 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 ACCHS [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.

Figure 6 **Outcomes for Indigenous Australians, by remoteness, 2014-15**



a Includes current students. b Fully engaged in post-school education, training and/or employment.

A way forward

Many economic and social factors drive outcomes in remote Indigenous communities. The nature of service provision and the characteristics of users mean that the service models that work in remote Indigenous communities may be different to those that work in other parts of the country.

There is a clear need to improve service delivery in remote Indigenous communities, but expectations of a quick fix are unrealistic. There is scope to improve outcomes over the long term through better design and implementation of policies to commission and deliver services in remote Indigenous communities.

The introduction of greater competition, contestability or user choice could improve outcomes for Indigenous Australians living in remote communities. Competition between

providers will not always be feasible or appropriate in remote communities, for example, when there are few providers, or for all services and service users. In these situations, effective contestability among service providers may deliver many of the benefits of competition. Redesigning arrangements for commissioning services and providers could encourage providers to improve service quality, use innovative service models, expand access so more people get the support they need, and reduce the costs to government and users who pay for those services.

Service responsiveness could be improved by introducing greater user choice, place-based service models, or greater community engagement. Improvements to commissioning arrangements could involve better coordination of service delivery and more integrated services. Many of the ideas discussed in the next section on commissioning family and community services also apply to services in remote Indigenous communities. Regardless of the service model chosen, more stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving the wellbeing of Indigenous Australians living in remote communities.

FINDING 7.1

Indigenous Australians living in remote areas are more likely to experience poor outcomes than other Australians. Inadequate access to human services is one factor that contributes to these poor outcomes.

- The service delivery arrangements for Indigenous Australians living in remote communities are complex and fragmented.
- Greater responsiveness to community needs through user choice, place-based service models or greater community engagement could improve outcomes.
- Many services are already contestable, but approaches to contestability are poorly designed and are not effective at meeting intended outcomes. Redesign of these arrangements is needed which, coupled with better coordination between governments, could improve outcomes including the efficiency of service provision.
- More stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving service outcomes for Indigenous Australians living in remote communities.

Commissioning family and community services

Family and community services play a broad role within the Australian community. Services generally seek to provide support for people who are in crisis or who are experiencing deep and persistent hardship, while building capacity and resilience. Examples include emergency payments and services for family support, homelessness, family and domestic violence, and alcohol and other drugs. Although many of these services are referred to as 'community services', government funding is not generally aimed at community-level projects, but at improving the lives of individuals and families. Hundreds of thousands of people access these services every year for a variety of reasons

and with diverse needs — some need emergency relief, while others have multiple, ongoing and complex needs.

Providers of family and community services are similarly diverse. Some services are provided directly by governments, but a significant proportion are provided by mission-driven not-for-profit organisations. Providers vary in size. Many small organisations operate in a single location, often with the help of volunteers, and focus on a single service. Some larger organisations provide a range of services across many locations, and receive funding through numerous agreements with several governments.

Government funding for family and community services amounts to billions of dollars each year. In July 2016, the Australian Government Department of Social Services reported that it had about 7000 funding agreements in place for 'Families and Communities' programs, with a combined value of about $2.8 billion. Each state and territory government also allocates hundreds of millions of dollars (and billions in the larger states). The focus in this inquiry is the arrangements that underpin the way governments commission family and community services using contestable processes.

There is scope to improve outcomes

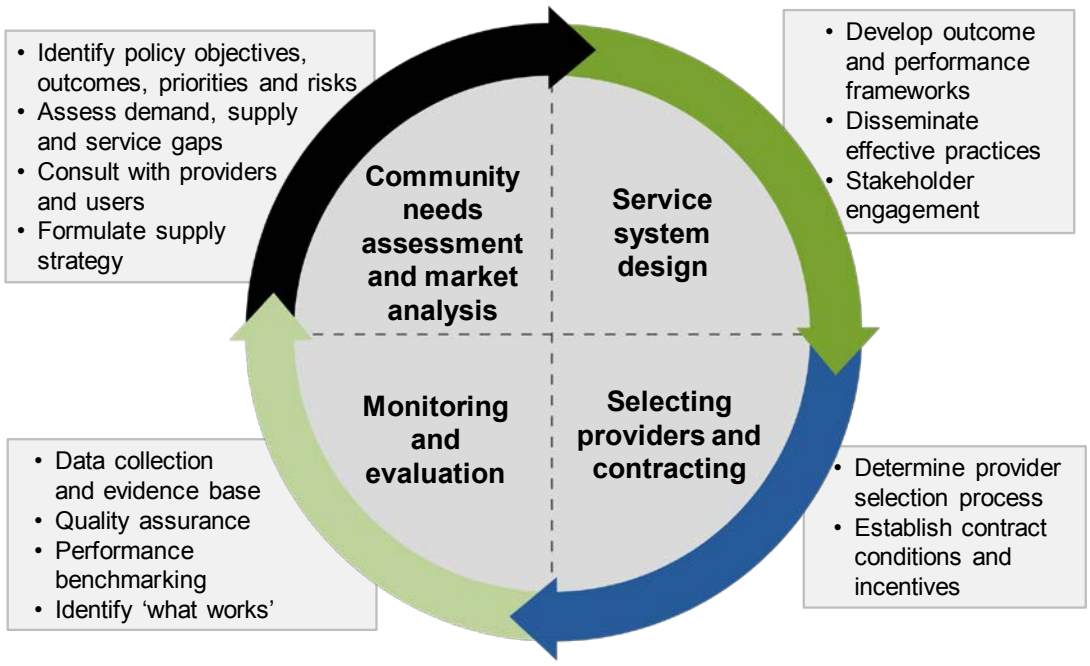
There is scope to improve the quality of many family and community services, make access to services more equitable, increase the efficiency of both the services and the system as a whole, and to achieve a better balance between accountability and responsiveness.

- People outside metropolitan areas, culturally and linguistically diverse groups and Indigenous Australians can face significant barriers to accessing the family and community services that meet their needs.
- People with complex needs require coordinated assistance across several services. For example, a person escaping family violence who needs access to crisis accommodation, mental health support, financial counselling and legal advice is inadequately served when the system is fragmented and difficult to navigate.
- Resources are not allocated efficiently — there are gaps in some service types and locations, and duplication and overlap in others.
- Prescriptive contract terms that focus on managing funding flows (the inputs and outputs of services) rather than achieving outcomes for service users leave little scope for innovation or flexible approaches to service delivery. For example, the Community Council for Australia described how a government response to poor school attendance in a remote community might be to fund home visits by social workers, and to measure the success of the program by the number of home visits. This type of program does not provide scope for other approaches that could be more effective at achieving the intended outcome (higher school attendance).

Increasing the benefits of contestability

Most family and community services are commissioned by governments through processes that entail some degree of contestability — service providers face a threat of replacement. Commissioning is a broad concept, and contestability can be introduced at several stages of the commissioning process, including when governments engage, select and monitor service providers (figure 7). In practice, commissioning processes are often flawed and do not consistently deliver the benefits from contestability that should flow to governments and importantly, they are not effective at delivering outcomes for users. The scope for improving the effectiveness of family and community services largely relates to the *way* they are commissioned by governments, rather than increasing the use of contestable processes.

Figure 7 **Commissioning services to deliver outcomes**



The first stage of effective commissioning is to identify community needs, policy priorities and service outcomes. This stage is essential for effective service planning and creates the framework for contestability between providers. Currently there is no overarching system for identifying community needs and the outcomes that can be achieved by family and community services.

The second stage of the process involves designing systems of service provision that will contribute to achieving outcomes, and the performance frameworks that establish the terms of funding agreements. Governments seldom take advantage of providers' experience and expertise in program delivery when designing systems of service provision. Instead,

programs are designed by government agencies that are often remote from the realities of 'what works'. Often what looks good on paper does not translate to the real world, and contracts specify approaches to service delivery that are inconsistent with achieving high quality services, equity or efficiency.

There are several flaws in provider selection processes and contract management. One is short time frames — service providers can have four weeks or less to submit tenders for funding. Short timeframes to submit tenders is a barrier to providers arranging joint ventures to exploit economies of scale and scope, and reduces the potential gains in quality and efficiency of using contestable processes. Another issue is the length of funding agreements, which generally run for three years or less. Time limits can sharpen the incentives of contestable processes by increasing the threat of replacement, but can also affect providers' ability to deliver and invest in services to improve outcomes for users.

Contract terms often limit providers' ability to develop flexible responses to the needs of service users. Although governments promote the virtues of innovation, when it comes to family and community services they often set highly prescriptive terms that are focused on managing funding flows, rather than on achieving outcomes for users. Prescriptive funding arrangements limit the potential for contestable processes to improve outcomes for service users.

FINDING 8.1

There is scope for improvements in arrangements for commissioning family and community services that could lead to better outcomes for service users.

- A systematic approach to identifying community needs and prioritising services could lead to more equitable and efficient allocation of resources for family and community services.
- Service users are diverse in their needs and characteristics. Some have complex needs and require access to a range of services. Systems of service delivery that are flexible and enable service providers to be responsive to users are necessary to meet the needs of service users. Greater application of choice — of provider or of service — could improve outcomes for some users.
- Improvements to the way governments commission family and community services could capture more of the benefits of contestability, leading to higher quality services, better outcomes for individuals and families and more efficient use of government funds.
- Systems of performance management, compliance and evaluation should provide incentives for providers to focus on outcomes, innovate and disseminate effective practices.