



Australian Government
Productivity Commission

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

Productivity Commission
Preliminary Findings Report
Overview

September 2016

This preliminary findings report has been prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

© Commonwealth of Australia 2016



Except for the Commonwealth Coat of Arms and content supplied by third parties, this copyright work is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/3.0/au>. In essence, you are free to copy, communicate and adapt the work, as long as you attribute the work to the Productivity Commission (but not in any way that suggests the Commission endorses you or your use) and abide by the other licence terms.

Use of the Commonwealth Coat of Arms

For terms of use of the Coat of Arms visit the 'It's an Honour' website: <http://www.itsanhonour.gov.au>

Third party copyright

Wherever a third party holds copyright in this material, the copyright remains with that party. Their permission may be required to use the material, please contact them directly.

Attribution

This work should be attributed as follows, *Source: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Preliminary Findings Report.*

If you have adapted, modified or transformed this work in anyway, please use the following, *Source: based on Productivity Commission data, Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Preliminary Findings Report.*

An appropriate reference for this publication is:

Productivity Commission 2016, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*, Preliminary Findings Report, Canberra.

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).

Opportunity for further comment

The purpose of this report is to seek feedback from participants on the Commission's preliminary findings, and any further issues that should be considered before the public release of the study report in November 2016. The Commission welcomes further written comment on the preliminary findings in this report, and will undertake consultations and hold roundtables to facilitate feedback from participants to inform the preparation of the study report. Interested parties are welcome to put forward services they consider should be recommended for reform in the second part of the inquiry. The due date for submissions is 27 October 2016.

Further information on how to provide a submission is provided on the inquiry website: www.pc.gov.au/inquiries/current/human-services/make-submission#lodge

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 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;
 - (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]

Contents

Opportunity for further comment	iii
Terms of reference	iv
Contents	vii
Overview	1
1 Introduction	3
2 Roles for government in the provision of human services	5
3 Competition, contestability and user choice	7
4 The Commission's framework	11
5 Services identified for reform	14

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's preliminary finding is that there are six priority areas where introducing greater competition, contestability and informed user choice could improve outcomes for people who use human services, and the community as a whole.
 - The Commission's view is that reform could offer the greatest improvements in outcomes for people who use social housing, public hospitals, specialist palliative care, public dental services, services in remote Indigenous communities, and grant-based 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.
 - The purpose of this report is to seek participant feedback on the Commission's findings before the public release of its study report in November 2016.
- 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.
- Access to high-quality human services, such as health and education, underpins economic and social participation.
 - The enhanced equity and social cohesion this delivers improves community welfare.
- Government stewardship is critical. This 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.
 - Data improves the transparency of service provision, making it easier for users to access the services they need, and increases accountability to those who fund the services.
 - Governments are better able to identify community needs and expectations, and make funding and policy decisions that are more likely to achieve intended outcomes.

Overview

1 Introduction

High-quality human services, such as health and education, 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, about 28 000 people who accessed specialist homelessness services in 2015 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 drew support from all three. Services to support people who have complex needs will generally be more successful at achieving intended outcomes if they are coordinated around the needs of users and their families.

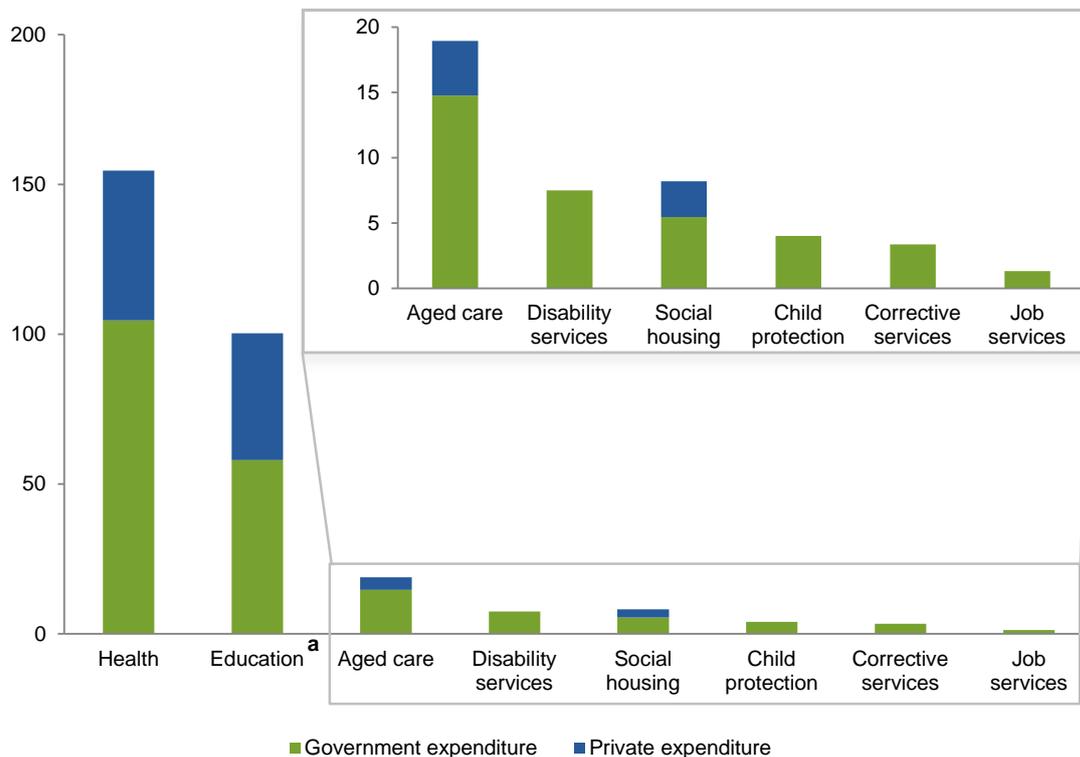
The design of systems to deliver human services is a complex task. Every level of government is involved in funding or delivering human services. Non-government providers include unpaid informal carers, sole traders, mission-driven organisations that rely on volunteers and donations, and for-profit entities that have a footprint over multiple jurisdictions and service areas. The people that are served are diverse in their needs, preferences and capabilities, including their capability to exercise informed choice. Data systems have the potential, if used effectively and cooperatively, to better target services to diverse users.

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.

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 reform by introducing greater competition, contestability or informed user choice. For the services identified as best suited, the second part 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.

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 introduction of greater competition, contestability and user choice will not be the best reform option for all human services. This preliminary findings report sets out the Commission's framework for identifying those services that could be suited to this type of reform, and its initial findings as to which services should be carried forward to the second part of the inquiry.

The purpose of this report is to seek feedback from participants on the Commission’s findings, and any further issues that should be considered before the public release of the study report in November 2016. The Commission welcomes further written comment on the preliminary findings in this report, and will undertake consultations and hold roundtables to facilitate feedback from participants to inform the preparation of the study report. Interested parties are welcome to put forward services they consider should be recommended for reform in the second part of the inquiry. The due date for submissions is 27 October 2016.

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.

2 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. 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 — as can the way the funding flows to service providers and users.

The nature of funding flows from governments — who receives the funding, when and on what basis — is a significant driver of outcomes from the provision of human services. Some services are funded through payments to suppliers, while for others funding is placed in the hands of the consumer. Funding 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. Care is needed, for example, to avoid overconsumption of services that are ‘free’ to users.

Governments have a stewardship role

Governments’ stewardship role in the delivery of human services is broader than overseeing the ‘market’. Stewardship encompasses almost every aspect of system design, including identifying policy priorities and intended outcomes, designing models of service provision, and ensuring that services meet standards of quality, accessibility and suitability

for users. 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 the second part of this inquiry.

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 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 vocational education and training (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 reach 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 market 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 at 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.

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

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.

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. These participants argued that using not-for-profit providers delivers 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 that 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.

The Commission considers that 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. Additional benefits — such as those potentially offered by not-for profit organisations — should be considered, but not at the expense of improving outcomes for individuals and their families.

3 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 their hands lets individuals exercise greater control over their own lives and can generate 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) and 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 decisions on their own behalf. People vary enormously 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.

The very young or those with severe cognitive impairment, for example, may not be well-placed to make decisions. 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. 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 provider), with the 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.

Competition, contestability and informed user choice 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 due, for example, to thin markets in regional and remote areas.

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 features, 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 and capabilities of users; and the diversity in purpose, size, scale and scope of providers. Not all of these features 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 government.

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 target services more accurately to the people who need and

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 Inquiry into *Data Availability and Use* will examine these types of issues.

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

Telehealth and telecare services 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.

Innovative service models such as these have the potential to facilitate service provision and increase the benefits from greater competition, contestability and user choice in regional areas, particularly as internet access improves.

- Innovative service delivery models are being used for medical consultations in remote areas and to assist people with disabilities. For example, the not-for-profit telecommunications company Jeenee Mobile has tailored smart phone apps to allow people with a disability to live more independently.
- In a 12-month trial, the CSIRO partnered with not-for-profit organisations, local health districts and for-profit telecommunications companies to evaluate the effectiveness of home monitoring services for elderly patients with chronic disease. Results from the trial in urban and regional areas found that users were less likely to visit a general practitioner or be admitted to hospital, and users reported improvements in their quality of life and understanding of their condition.

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

Non-government provision has been a feature of many human services for a long time. Non-government provision has increased in some sectors since the mid-1990s, including schools, vocational education and training, residential aged care, employment services 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. Participants pointed to the benefits of this, for individuals and the community as a whole.

The government and non-government provision of human services has also involved instances of controversy or failure. Many participants expressed concern about service provision 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 risks 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 are among 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 (rather than profit) driven, will reinvest any surplus back into services to support less profitable areas. However, they are disadvantaged by the time- and resource-consuming administrative processes used to commission services
- 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.

Each of these concerns is legitimate but may be minimised or removed 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 service delivery models that capture one of the clearest benefits of markets — the emphasis on putting power into the hands of individual service recipients through choice. The NSW Disability Council 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 contribute to the effectiveness of the service. Effectiveness is best 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 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.

4 The Commission's framework

To assist with its task, the Commission developed a three-stage framework in its issues paper to ensure a consistent approach to assessing the suitability of each service for competition, contestability and user choice reform (figure 2). It 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, 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.

In identifying services, the Commission had regard to a number of factors, including:

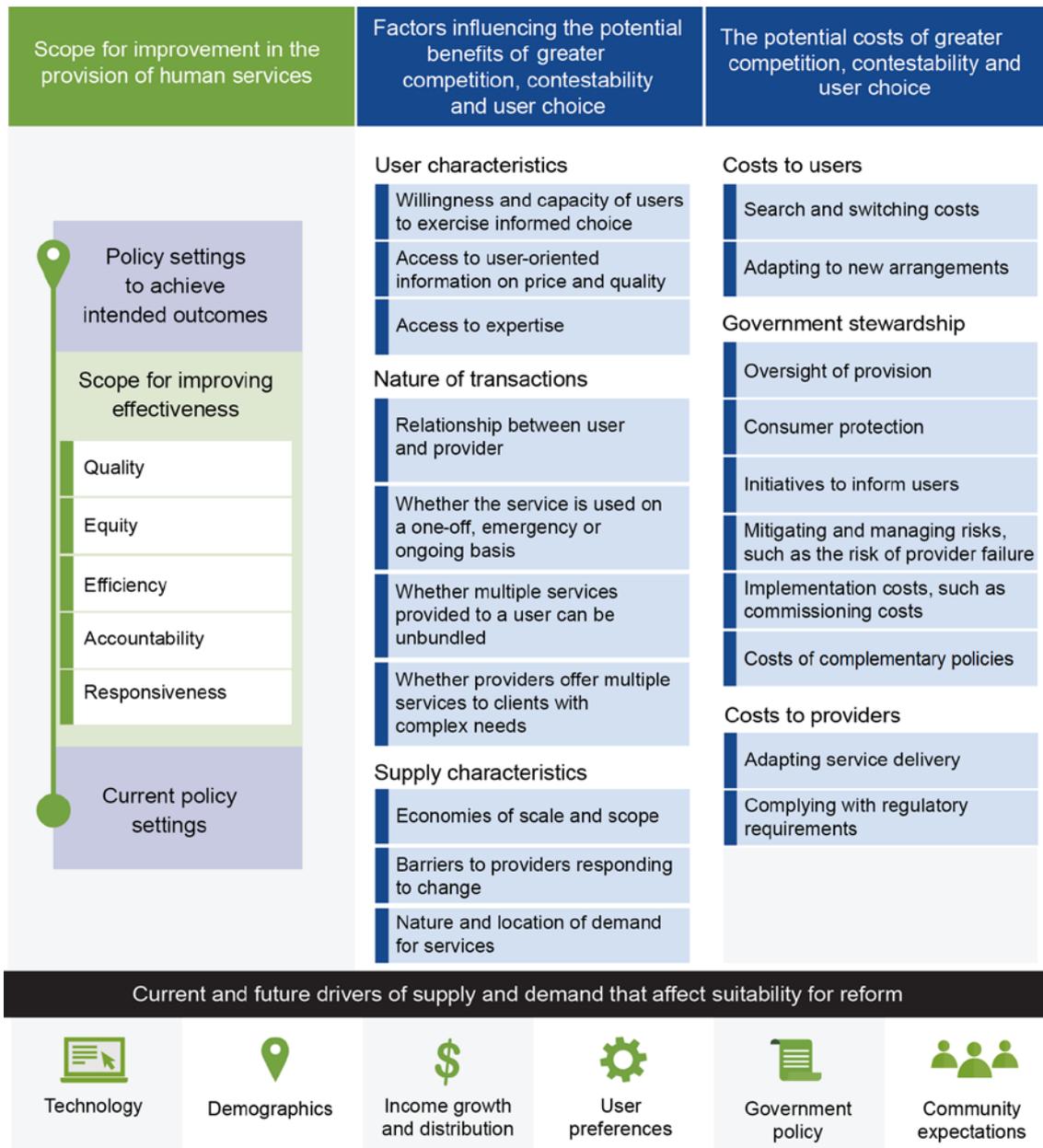
- the extent to which services are already subject to competition, contestability or user choice (examples here include the provision of GP services)
- whether reforms to introduce greater competition, contestability or user choice are proposed, or are underway (examples here include disability services, 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 here 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 preliminary 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

- specialist palliative care
- public dental services
- human services in remote Indigenous communities
- grant-based family and community services.

Figure 2 Identifying services best suited to reform



These priority areas 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.

Table 1 Services assessed in this study^a
In alphabetical order

Alcohol and drug services	Family support services and out of home care	Mental health services
Allied health services	General practitioners (GPs)	Public dental services
Child and family health services	Grant-based family and community services^b	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	Specialist palliative care
Early childhood education and care	Job services	Social housing
Emergency payments	Maternity services	Vocational education and training

^a Services in bold are those identified by the Commission as best suited for reform. ^b Includes alcohol and other drugs services, community-based mental health services, family support services and out of home care, and homelessness services.

The importance of ongoing reform and evaluation

There are six priority areas for reform identified in this report. These reflect the Commission's preliminary views on the highest priorities for the Commission's current task. However, many other services could also benefit from reform. 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 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. If implemented, these reforms 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, in home-based aged care, reforms are being implemented to offer greater choice for service users. Other areas, such as the NDIS and early childhood education and care, are also under reform. All warrant continued scrutiny and evaluation to ensure the potential net benefits of those reforms are captured.

The Australian Government has also committed to reforming the provision of mental health services, including making the delivery of mental health services more contestable, evidence-based and person-centred. The Commission supports the intention of these important reforms, but notes that it is too early to evaluate their effectiveness.

5 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. About 400 000 households live in social housing. Recipients of social housing support, 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 to 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 to 20 per cent for other working-age recipients of an income support payment.

Over time, there has been a shift in the demographics of people receiving support through the social housing 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 support. It has also resulted in funding pressures on the system. The disconnect between the level of subsidy social housing tenants receive and that received by tenants in the private rental market through the Commonwealth Rent Assistance payment has also increased over time.

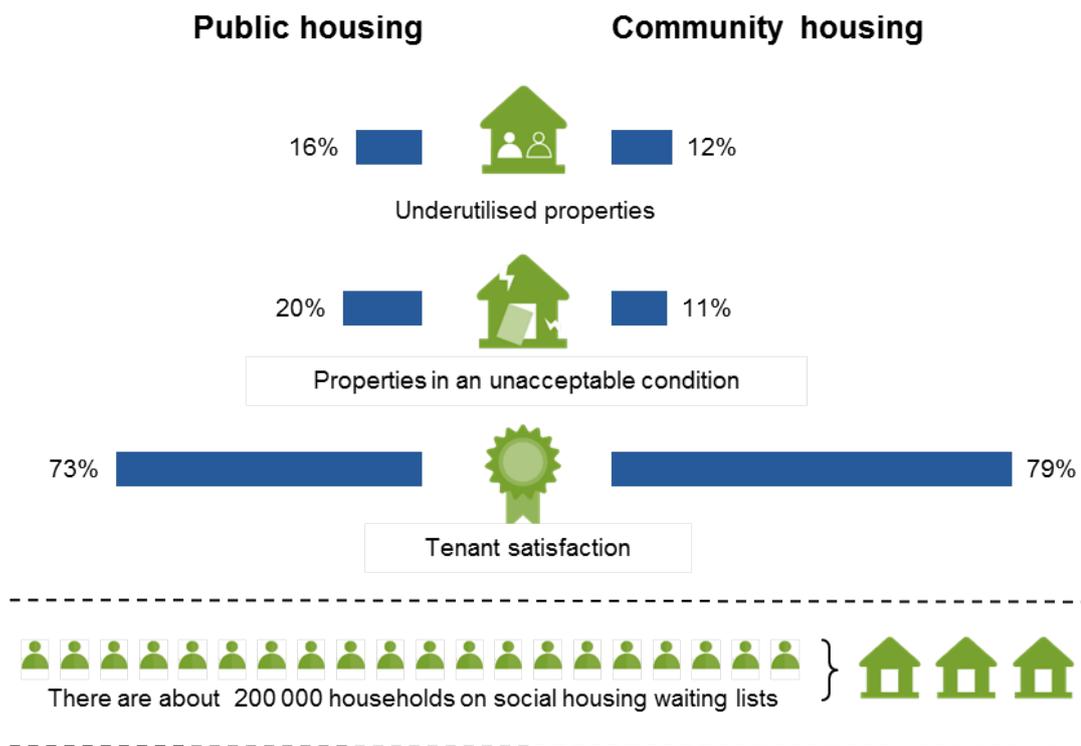
Making judgments on the number of households assisted through the social housing system depends on a range of factors, and international evidence suggests that there is no ‘right’ level of social housing. The level of social housing needed will depend on interactions with

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 service providers and make informed decisions about which providers — including both government and non-government providers — would be best-placed to manage social housing.

Figure 3 Indicators of public and community housing, 2014^a



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

Offering more choice to social housing tenants

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

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. Efforts to improve users’ choice of home have led to a range of benefits overseas. 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 has been used to identify the housing characteristics that tenants prefer, and to target areas of high demand and need.

Under the current social housing system, demand for social housing far outstrips supply, limiting the properties available for prospective tenants to choose from. Approaches have been implemented overseas that provide a 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.

PRELIMINARY 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 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. Community housing providers outperform public providers on some indicators, including tenant satisfaction and property maintenance.
- 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 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, including quality standards and professional training requirements. Greater contestability and user choice could place indirect pressure on hospitals, as part of a broader suite of reforms, to improve outcomes.

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).

As was the case overseas, potential reforms to introduce greater user choice in Australia would need to be supported by user-oriented information. Without it, low levels of health literacy would reduce the willingness and ability of public patients to make informed choices. Providing greater choice at the point where individuals are referred to a specialist by their GP might be another 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 (figure 4). Thus, greater choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.

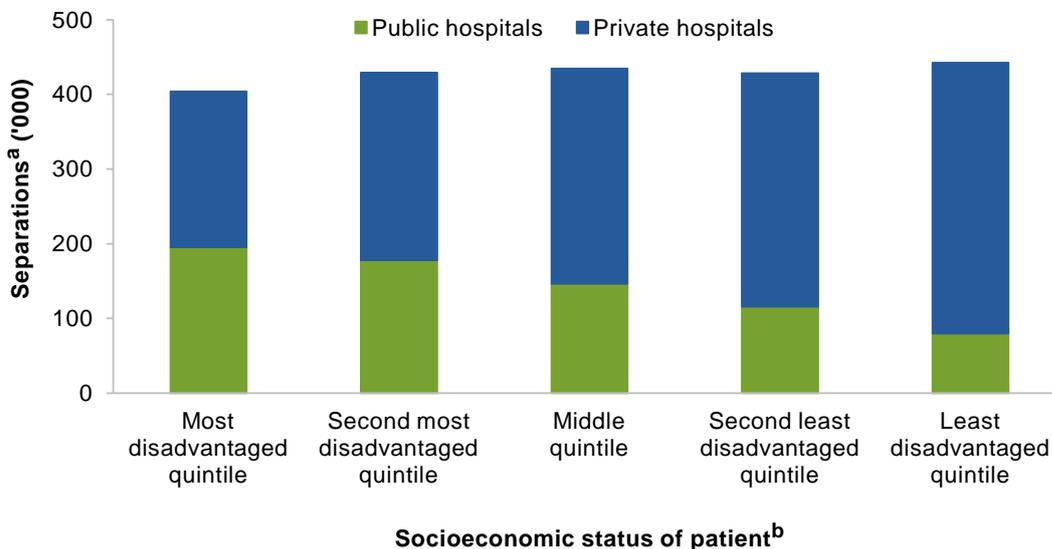
Box 4 Overseas examples of choice and information provision

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 — including Canada, Sweden and the United States — 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.

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 a reform should not be taken lightly — 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.

PRELIMINARY FINDING 4.1

Introducing greater user choice and contestability in public hospital services could, as part of a wider range of reforms, lead to better outcomes for patients.

- Australian hospitals generally perform well against those in other countries. There is still scope for many to improve outcomes for patients, and to lower costs, by matching the practices of better-performing hospitals within Australia.
- Greater user choice in public hospital services could disproportionately benefit disadvantaged groups that up until now have had fewer choices than other Australians.
- Other countries have shown that user choice can benefit patients when they have access to useful consumer-oriented information on services and referring practitioners support them in making decisions.
- 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.

Specialist palliative care

Specialist palliative care refers to medical care that focuses on relieving the symptoms of a life-limiting illness, rather than treating the underlying causes of that illness.¹ It is provided to patients whose physical, social, emotional and spiritual needs exceed the capabilities of primary care providers. This covers both inpatient care provided to patients admitted to a hospital or a standalone palliative care facility, and community-based care provided in the home or in a residential aged care facility. In 2015, more than 40 000 people across Australia accessed specialist palliative care services.

Management of symptoms, including relief from pain, and support provided by social workers, counsellors and volunteers, can make a significant difference to the wellbeing of patients and their families at a time of high stress.

There is scope to improve outcomes

Australia's palliative care services are well-regarded internationally and, on at least some measures, patient outcomes have improved over recent years. Yet there remains scope for improvement. The range and quality of services available varies across jurisdictions, and between urban and non-urban areas. Indigenous Australians, and people from culturally and linguistically diverse backgrounds are likely to be underserved, as are people suffering illnesses other than cancer even though they have many of the same palliative care needs.

A lack of comprehensive, publicly available national data about expenditure, patient activity and patient outcomes hampers accountability. Coordinating services, determining costs of care, appropriately allocating funding and evaluating measures designed to improve service provision are all made more difficult by the lack of adequate data.

Increasing user choice about the setting, timing and availability of care

The development of a chronic life-limiting illness is emotionally taxing and psychologically distressing for patients, carers and loved ones. In this environment, making choices about palliative care arrangements may be difficult.

Much has been made of survey findings that consistently show that most people would prefer to receive care and die comfortably at home, yet most palliative care patients die in hospital. The reality is more complex than this and, as death approaches, a person's preferred place of death can change. Palliative care patients can become concerned about the effect that the caring task has on their loved ones and may choose to use inpatient

¹ The focus of palliative care is on providing support to people with life-limiting illnesses, not to hasten or postpone death. Assisted suicide and euthanasia are not considered part of palliative care and are not examined as part of this inquiry.

services closer to the end of life. These changing preferences highlight the importance of user choice as to the setting, time and availability of care.

The characteristics of users can pose challenges to implementing user choice for palliative care patients. While patients with cancer tend to have fairly predictable disease trajectories, often with full cognitive and communicative capacity until close to death, other patients have less predictable trajectories of deterioration in cognitive and physical functioning. While some patients receive months of palliative care and repeated episodes of care, others may have no contact with specialist palliative care services until their last days of life. This limits the ability of some patients (and their families) to plan ahead and express preferences for care.

The inability of users to express preferences directly would, to some extent, be addressed if carers, relatives and medical professionals were well informed about user preferences and engaged in discussions about palliative care from the early stages of illness. Taboos about discussing death can prevent this from happening. Patients often rely on medical professionals to initiate conversations about palliative care, many of whom are inadequately trained about, and intimidated by, holding such conversations.

Greater user choice between providers would need better supports

Greater user choice between providers raises additional challenges. As with other forms of healthcare, patients receiving specialist palliative care services can have difficulty judging the quality of services available to them. Palliative care does not involve a single transaction of a well-defined service and making like-for-like comparisons between providers is difficult.

Information asymmetry between palliative care users and providers could be lessened through the provision of high-quality, consumer-oriented information about the availability and quality of services. While some information on patient outcomes is currently available, it is not provider-specific and is not designed to be consumer-oriented.

Introducing greater competition or contestability

There is substantial variation in the quality of palliative care services across Australia. Despite this, there has been little focus on whether better service models exist. In these circumstances, introducing greater competition, contestability and user choice could improve outcomes. The preferred reform option may vary across regions.

Introducing greater user choice through contestability or competition would require careful design to ensure that the interests of patients and their families are well served. Special measures for consumer protection may be needed given the vulnerability of many palliative care users and the potential magnitude of harm should a service provider act without due care. Arrangements would need to be in place to ensure continuity of care

between providers. More extensive data collection and improved monitoring and benchmarking of provider performance would also be required. Introducing greater contestability could, however, make providers more accountable for their performance and spur the innovation required to lift patient outcomes among poor performers.

PRELIMINARY FINDING 5.1

Placing greater emphasis on user choice could help to better satisfy patient preferences regarding the setting, timing and availability of palliative care.

- The quality of specialist palliative care services is highly variable, there are concerns about patients not being able to access services and there is limited performance reporting, particularly in community settings.
- There is little evidence that service providers are being held to account for relatively low service quality. Introducing greater contestability could make providers more accountable for their performance and spur the innovation required to lift patient outcomes among the poor performers.
- The potential to increase user choice through greater competition between providers or through more contestable arrangements would depend on market size and the ability to cost-effectively provide user-oriented information, among other things. The preferred reform option will likely vary across regions.

Public dental services

Publicly-funded dental services play an important role in improving access to care for people who face financial and other barriers. In 2013-14, public dental services accounted for about 14 per cent (\$1.2 billion) of Australian expenditure on dental care. Of those people (aged 5 and over) who saw a dental professional in 2013, about 84 per cent visited a private practice at their last visit, while most of the remaining 16 per cent last visited a public (including school) practice.

There is scope to improve outcomes

Most public dental services are provided in clinics (and dental hospitals in some jurisdictions) operated by state and territory governments. While users can sometimes choose between different public dental clinics, there can be few of these located close to a patient's residence compared to private dental practices that could potentially provide the service. Access outside major cities is also a concern, particularly for Indigenous Australians, many of whom live in regional and remote areas.

The continuity of care that public clinics provide can be an issue because patients may be treated by a different person each time. Without continuity of care, users could be discouraged from maintaining a favourable visiting pattern, which can eventually lead to more extensive remedial care being required. People from low socioeconomic

backgrounds, who are the predominant users of public dental services, are more likely to have an unfavourable visiting pattern. For some people, an extended period on a waiting list means that a potentially preventive or restorative treatment becomes an emergency case. Dental conditions were the second-highest cause of acute potentially preventable hospitalisations in 2013-14.

A further concern is the lack of published evidence on the efficiency of public dental services. This is symptomatic of a lack of accountability to those who fund public dental services (governments and users through co-payments). It is also evident in the lack of performance reporting on service quality and patient outcomes.

Competition, contestability and user choice could be greater

The most appropriate approach to introducing greater competition, contestability and user choice could vary between regions due to differences in characteristics of the population and geographic dispersion of dental professionals.

Service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics. This could facilitate the development of more flexible and responsive service models. Innovative service delivery may be particularly important in remote areas, which have less than half the number of dental professionals per person than major cities.

More competition and choice could involve using delivery mechanisms that allow users to choose between competing private dental practices. Such mechanisms are already used to some extent in all jurisdictions and this has shown that private dental practices can supply good 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 disadvantaged groups to choose a dentist, possibly through a combination of information provision and person-to-person advice.

PRELIMINARY 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.

- Users could benefit from having greater choice over the timing and location of treatment. Greater continuity of care may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary.
- The uncontested provision of services in government-operated clinics results in limited responsiveness to user needs and preferences. Minimal public performance reporting limits accountability to those who fund services.
- Service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics. More competition and choice could involve using delivery mechanisms that allow users to choose between competing private dental practices.

Human services in remote Indigenous communities

About 85 per cent of Australia is classified as remote or very remote — the physical distance to the nearest town or service centre can be in the hundreds of kilometres. A lack of transport infrastructure, coupled with extreme seasonal conditions, makes travelling those distances uncomfortable and time-consuming at best or impossible at worst. Just over 2 per cent of Australia’s population, including about one fifth of Indigenous Australians, live in remote areas.

Physical isolation underpins many of the challenges to providing high-quality human services to the over 1000 discrete Indigenous communities in remote areas. The cost of providing services in remote Australia can be several times the cost in urban areas due to long distances and travel times, and the lack of scale (more than three quarters of the remote Indigenous communities have a population under 50). Only 36 per cent of remote Indigenous households, for example, have an internet connection (compared to 73 per cent of remote non-Indigenous households). Service providers also face barriers such as difficulty accessing infrastructure, and recruiting and retaining staff.

The remoteness of Indigenous communities is a major reason why these 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. One area of significant difference is language. About 40 per cent of Indigenous Australians living in remote areas speak an Australian Indigenous language as their main language, compared to 2 per cent for Indigenous Australians living in non-remote areas. Another area of difference is culture. 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 in communities and can be challenging for providers to respond to. 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 are not culturally appropriate. The NDIS trial in the Barkly region 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.

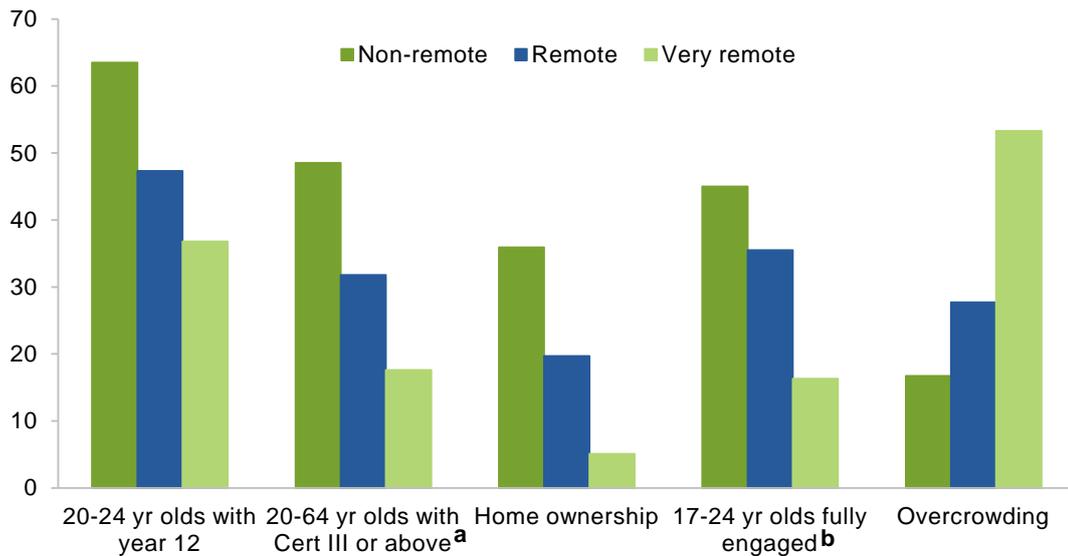
Outcomes in remote Indigenous communities are not meeting expectations

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 5).

The Commission’s early investigations suggest that current arrangements for purchasing and delivering human services are not fully meeting the needs and preferences of Indigenous Australians living in remote communities. Responsibility for service provision is split across governments and departments, and funding is delivered through numerous programs. Problems arise from a lack of coordination across services, including

duplication in some areas, gaps in others, and unclear lines of responsibility across and within governments for identifying and achieving the intended outcomes for people who are receiving the services.

Figure 5 Outcomes for Indigenous Australians, by remoteness
Per cent of Indigenous Australians, 2012-13



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

In its submission to this inquiry, the Aboriginal Medical Services Alliance NT gave the example of a remote community in Central Australia where around 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.

A way forward

There are many economic and social factors that drive outcomes in remote Indigenous communities. The nature of service provision and the characteristics of users mean that the service models that work in other parts of the country will not necessarily work in remote Indigenous communities. For example, introducing greater competition, when there are at best one or two providers, is unlikely to be the most effective model for improving service outcomes for users. This also suggests that governments may need to be more flexible in

their approach to service models and providers, to allow for better ways of working and achieving governments' intended outcomes.

Expectations of a quick fix are unrealistic. More promising, given the issues with current service delivery arrangements used by governments, is the scope to improve outcomes over the long term through better design and implementation of policies to purchase services in remote Indigenous communities. Many services are (at least nominally) contestable, but the arrangements are not delivering the benefits of contestability to the communities themselves, or to governments and service providers. Many of the ideas discussed in the next section on grant-based family and community services also apply to services to remote Indigenous communities. Outcomes should be defined holistically, rather than being narrow and program-driven. Better service provision could involve better coordination, place-based service models, increased community voice in service design and delivery, and stable policy settings.

PRELIMINARY FINDING 7.1

Current arrangements for purchasing and delivering human services are not fully meeting the needs and preferences of Indigenous Australians living in remote communities.

- Improving the quality of services and providing services in a more culturally appropriate way could improve outcomes for Indigenous Australians living in remote communities.
- Better coordination of services to address people's needs could overcome some of the problems that arise from service fragmentation.
- Place-based service models and greater community voice in service design and delivery could lead to services that are more responsive to the needs of people in these communities.
- More stable policy settings and clearer lines of responsibility, could increase governments' accountability for improving the wellbeing of Indigenous Australians living in remote communities.

Grant-based family and community services

Family and community services offer a range of supports to build people's capacity and resilience. Examples include services for people experiencing homelessness, alcohol and other drug abuse, and family and domestic violence. While often grouped under the banner 'community services', government-funded services generally focus on improving outcomes through the provision of specific services for individuals and families, rather than being directed to community-level projects. Hundreds of thousands of people receive 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 the majority 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 grants from several governments.

Government funding for family and community services runs to billions of dollars each year. At July 2016, the Australian Government Department of Social Services reported that it had about 7000 grant 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).

Flawed commissioning processes

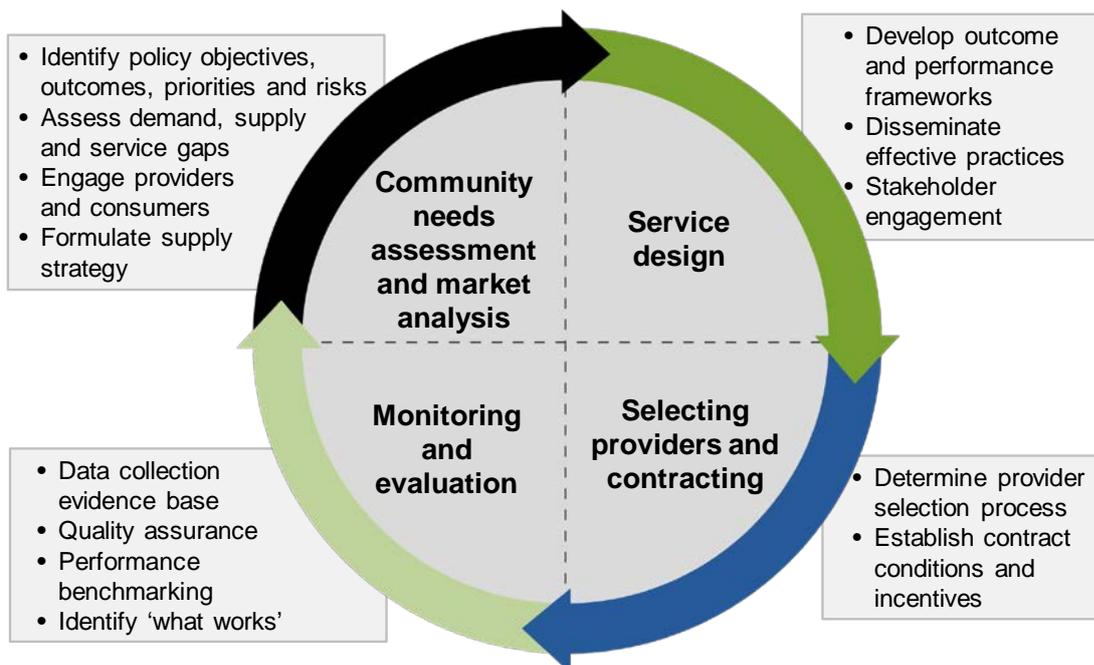
Current approaches to commissioning family and community services constrain the ability of these services to meet the needs of many people. People outside of metropolitan areas, culturally and linguistically diverse groups and Indigenous Australians can face significant barriers to accessing family and community services that meet their needs. People who have multiple, ongoing and complex needs require coordinated assistance across several services, but are inadequately served when the system is fragmented and difficult to navigate.

Funding to deliver family and community services is usually contested through tender processes that entail at least a nominal threat of replacement by an alternate provider. In practice, commissioning processes are often flawed and do not consistently deliver the benefits from contestability that should flow to governments and providers and, importantly, they are not effective at delivering outcomes for users.

- There is generally a lack of an overarching framework based on improving outcomes for service users to inform service planning and determine how objectives should be achieved (figure 6). Governments need to undertake systematic analysis of community needs, gaps in service delivery and risks. Commissioning agencies need to specify policy priorities and the program outcomes that are consistent with achieving these objectives.
- Government engagement with service providers is inconsistent and does not always take advantage of providers’ experience and expertise in program delivery. It is uncommon for providers to be invited to participate in the program design stage. Instead, programs are designed by government agencies that are often remote from the realities of ‘what works’ in family and community services, and the costs of providing effective services. Often what looks good on paper does not translate to the real world.
- Service providers that are funded on relatively short contracts (three years or less), face ongoing uncertainty about their future operations, and have to devote excessive resources to applying for further funding at the expense of delivering frontline services.

- 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. Some governments have experienced a loss of corporate knowledge of how these services work and instead have developed expertise in managing contracts. At the same time, they have created incentives for service providers to become experts in tender writing.
- The current approach to information collection, performance monitoring and reporting can create excessive burdens on service providers but does not deliver the information that is needed to understand how services contribute to achieving outcomes. Better access to data could contribute to governments and providers developing more effective programs and services, coordinating assistance for users with complex needs, and providing user-oriented information to support choice.

Figure 6 **Commissioning services to deliver outcomes**



Better system design

The scope for improving the effectiveness of family and community services largely relates to the *way* they are commissioned by governments, rather than the use of contestable processes. Governments need to take a stronger stewardship role to design and coordinate a system of provision that is helped, rather than hampered, by shared interests across jurisdictions. They also need to develop an outcomes framework against which individual services could be planned, and their performance benchmarked and monitored.

PRELIMINARY FINDING 8.1

Improving the way governments select, fund, monitor and evaluate providers of family and community services could improve outcomes for the users of those services.

- Governments could deliver a better mix of services if they took a systematic approach to identifying what the community needs.
- Engagement with service providers and users at the policy design stage could increase the quality and efficiency of services.
- Contract arrangements that are focused on outcomes for service users could increase the incentives for service providers to deliver services that meet people's needs and provide more scope for innovation in service delivery.
- Better use of data could help service providers and governments identify and disseminate effective practices.
- Measures to support user choice and introduce greater competition between service providers could create incentives for providers to improve services in some areas.