CATHOLIC HEALTH
Australia

10 February 2017

Human Services Inquiry
Productivity Commission
Locked Bag 2, Collins Street East
Melbourne Vic 8003

RE: Productivity Commission Inquiry into Introducing Competition and Informed User Choice in Human Services: Reforms to Human Services

Dear Commissioner,

Thank you for the opportunity to contribute to the second stage of the Human Services Inquiry. As the largest grouping of not-for-profit hospitals and aged care services in Australia, we hope our feedback will provide valuable insight for the Commission through the next stage if the inquiry.

Please see our submission regarding the reforms outlined in the consultation report.

If you require any further information, please contact the Catholic Health Australia Office as we welcome the opportunity to give additional evidence to assist the inquiry in its work.

Your sincerely,

Suzanne Greenwood LLM LLB FAIM MAICD
Chief Executive Officer
M: 0488 020 244
E: suzanneg@cha.org.au

CATHOLIC HEALTH
Australia

Productivity Commission Inquiry into Increased Competition, Contestability and User Choices in Human Services

10 FEBRUARY 2017

SUBMISSION

Catholic Health Australia (CHA) is pleased to respond to the Preliminary Findings Report of the Productivity Commission's Introducing Competition and Informed User Choice in Human Services: Reforms to Human Services. CHA agrees there is room for improving the delivery of public services across all jurisdictions in the six designated areas outlined in this report.

CHA is Australia's largest non-government not-for-profit grouping of health, community, and aged care services accounting for around 10% of hospital based healthcare in Australia. Our members also provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly. CHA values the goal of a health system that respects human dignity, is person-centred, supports vulnerable populations, and supports the appropriate stewardship of resources. Our members invest heavily in expanding services to those in need and represent one of the predominant groups for private hospital services in regional and rural areas.

The opportunities for competition, contestability, and choice in human services are variable across different fields and jurisdictions. CHA acknowledges that where there is a dearth of providers to offer services or the sector is underfunded, opportunities for competition, contestability, and choice in human services may be limited. This is of particular concern in regional, rural, and remote jurisdictions.

CHA recognizes that enhancements in one of the identified sectors could have positive knock-on effects to other sectors of human services that can bring about savings and efficiencies. Due to the overlapping and complex needs of those who access human services, there is a need for better coordination among providers within each area as well as across sectors that build on the existing infrastructure to promote innovation and quality improvements. Using integrated models to coordinate the delivery of services could reveal greater gains from efficiencies in the system.

The rest of this submission focuses on three areas of interest that the Productivity Commission has identified as sectors that could be examined further.

PUBLIC HOSPITALS

CHA agrees with the Commission's observation that Australia's public hospitals perform well in comparison with many other comparable countries. Any improvements to the current health system should be evidence-based and implemented with due diligence so as not to compromise patient outcomes.

Many of CHA's not-for-profit members have a long tradition of providing high quality public hospital services and would welcome the opportunity to contribute further to the provision of public hospital services where it is of benefit to the community. Our members have a particular mission to provide hospital and health services to the most vulnerable.

CHA supports greater provision and transparency of appropriately risk-adjusted performance information. In doing so, we note that the publication of such information often prompts providers to compare their performance with their peers which results in performance improvement – even where consumers themselves do not change provider in response to the provision of performance information.

For example, the publication of device performance information by the National Joint Replacement Registry has often prompted suppliers of relatively poorly performing devices to remove their devices from the market even in the absence of a consumer response.

CHA would also support market testing of discrete packages of hospital services.

We note, however, that to be effective such market testing needs to offer a volume of work that makes it worthwhile for providers to spend the necessary time and expense required to prepare a bid. A market offering would also need to cover a reasonable period of time – say a contract length of 5 – 10 years.

Ad-hoc short-term offerings – particularly to clear long elective surgery waiting lists in pre-election periods are unlikely to the most competitive responses and generally offer little long-term benefit to the community.

The provision of some areas of service provision – particularly services to vulnerable populations such as those with a mental illness, those living in regional areas, indigenous Australians, as well as people with multiple and complex chronic conditions where continuity, collaboration and co-ordination between service providers are required may be less suited to the application of contestability and competition. Certainly the design of any contestability arrangements would need to ensure as far as possible that care to vulnerable groups was not compromised. This could be achieved, for example, by having the payment mechanism cover

a bundled range of services and over a multi-year time frame. Key performance and accountability measures should also focus more on outcomes rather than just outputs or process measures.

To develop a system for consumers to have an informed choice in their specialist, the Commission would have to assume an extensive data collection and analysis of provider indicators that does not currently exist; the ability to access this information; and a level of health literacy that is not consistent across all jurisdictions and socioeconomic levels. This could disadvantage those in regional and remote areas who may lack internet and technology necessary to access this information (if and when it becomes available).

CHA considers that it is not clear to what extent it is possible to offer public patients a choice of provider – particularly in regional areas. The public hospital system currently faces significant challenges to meet the reasonable access expectations of the public. Offering choice of provider will certainly complicate the provision of services and could exacerbate existing access challenges in some locations. We also note that offering choice of provider may risk undermining one of the key benefits of private health insurance – which could ultimately lead to adding further demand on the public hospital system.

END-OF-LIFE CARE

CHA welcomes the Commission's inclusion of all providers in end-of-life care as it considers all aspects of palliative care, including non-specialist services. End-of-life care occurs across a range of providers and requires a coordinated delivery of services tailored to the individual. Due to the sensitive nature of end-of-life care and variability in needs, CHA recommends any new recommendations around consumer choice adopt a person-centred approach that links health with community services and expands home-care services.

CHA agrees that there is huge variability in the delivery of palliative care services across the country and that those living in rural and remote areas are likely to find it much more difficult to access specialised palliative care services. This is particularly relevant for remote indigenous communities. In order to attempt to fill some of these gaps, one of our members (St Vincent's Health Australia) are funding a demonstration project which will tailor palliative care services that are culturally appropriate to the communities located in the Northern Peninsula Area (NPA), Cape York, Queensland.

Catholic Health Australia service providers have helped lead the way in palliative care and the establishment of hospices. However, funding through the private health insurance system provides only limited cover for specialised palliative care services. Accordingly, many of our members have been obliged to pursue diverse funding agreements with public funders in order to provide a service which is seen as being central to the Catholic ethos in the provision of healthcare.

Some of our members are trialling new palliative care models with health funds for their members notwithstanding funding limitations.

CHA agrees that the lack of data available on palliative care service provision requires improvement. To determine areas for competition and contestability in end-of-life care, comprehensive data on palliative services would be needed to apply benchmarks in assessing the market. Currently there are major gaps in reporting that make it difficult to identify areas for reform. We also recognise that the standards put in place are robust for such a new speciality.

CHA is particularly concerned about increasing access to palliative care services - as many Australians are unable to access any palliative care at all. We therefore would emphasise the need to review and improve the funding available for the provision of palliative cares services; and the need to collect better data in this area before introducing more competition and contestability in this field.

HUMAN SERVICES IN REMOTE INDIGENOUS COMMUNITIES

Apunipima Cape York health Council in north Queensland and CHA have begun a journey of collaborating together towards achieving the goal of closing the substantial gaps in health outcomes between Aboriginal people in Cape York and other non-Indigenous Australians.

As such, we have visited some of these remote communities and spoken to clinicians, health workers, council members and community members about the difficulties that they face delivering services in these remote communities. Major issues raised are the multiple agencies that deliver health services to one community with little or no co-ordination nor communication. The uncertainty of government funding and its short-term and temporary nature means that often successful programs can be ceased and new programs begin without consulting the community. The nature of funding by program also means that there are

significant gaps: for example, lack of funding streams for allied health staff and services is a major problem.

CHA also seeks to support Apunipima in their advocacy work both with the Commonwealth government and politicians to promote awareness of the challenges faced in delivering culturally appropriate, comprehensive and fully financed primary healthcare to the communities of Cape York.

One of the strongest predictors of an Indigenous service providers' success is their ability to build relationships based on trust and a shared understanding within the community. This is often time and labour intensive. In establishing a more contestable market for human services delivery in Indigenous communities, the change or removal of established providers may prove disruptive to the delivery of vital services and undermine and progress that has been made. When applying market principles to the delivery of Indigenous services, the Commission should consider the importance culturally appropriate services play in Indigenous communities in ways that are not easily captured by standard reporting mechanisms.

CHA is very supportive of the Commission undertaking further work in this area as part of Stage 2 of the Inquiry and strongly supports the recommendations outlined in the preliminary findings overview:

- Improve the quality of services by providing them in a more culturally appropriate way (this will require extended consultation with communities and community-controlled services);
- Better co-ordination of services (less agencies and better communication between agencies);
- Place-based service models and a greater community voice in service design and delivery (delivery of services wherever possible close to home after extensive local consultation); and
- More stable policy settings and clearer lines of responsibility could increase governments' accountability (stable funding mechanisms and better evaluation of programs).

CHA looks forward to attending the "User choice and competition in health care workshop" at the end of February and contributing to the next stage of the Inquiry.