Name: Centre for Policy Development

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an industry or advocacy organisation, professional association or peak body

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Aboriginal Community Controlled; Aged care; Child and Family Health Services; Disability; Early childhood education and care; Health; Veterans; We have deep knowledge and experience with early childhood education and care; and Foundational Supports. We also have broader experience that cuts across care sectors.

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   The participant did not respond to this question.

2. What are the reasons for your answer?

   The participant did not respond to this question.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   The participant did not respond to this question.

4. What are the reasons for your answer?

   The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   We have extensive experience with people- and place-centred collaborations and collaborative service delivery on-the-ground and at a system level. This includes working with commissioning agencies, analysing service delivery systems, and convening leaders across the sector. Along with partners, we founded the Western Melbourne Jobs and Skills collaboration, which brought together education providers, local councils, employers, and regional bodies in Melbourne's West to lead a coordinated approach to enhancing local employment. As part of our research and knowledge translation work,

CPD regularly meets with a diverse range of governments, service providers, researchers, and other actors in the care sector and hears their concerns about existing approaches to commissioning. Combined with our previous work in employment services, namely Regional and Community Job Deals and our inputs to the Inquiry into Workforce Australia Employment Services, we propose creative approaches to commissioning, contracting, and funding that would better facilitate integrated service delivery.

At the most basic level, we understand collaborative commissioning to be multiple parties coming together to jointly commission services under a single contract. This might involve multiple funders commissioning together, such as joint-funding from multiple government departments or a collaboration between Primary Health Networks and Local Health Districts. In our view, practitioners, service users, and communities must also be involved in the collaborative commissioning process. This sometimes occurs via surveys, focus groups, and other standard consultation methods, as was the case with the Northern Sydney Patient-Centred Co-Commissioning Group. However, where possible, practitioners, people with lived experience, and communities should be directly involved in the governance structures of the collaboration, such as via membership on steering groups or lived experience and/or practitioner advisory groups. This allows them to have real decision-making power and be involved throughout the commissioning cycle, including design, procurement, contract management, and evaluation. In addition to collaborative commissioning, there are other complementary funding approaches that enable its success. These include:

1) Relational contracting, which places greater emphasis on agreed processes for ongoing and often informal communication compared to a traditional contract. South Australia's Child and Family Support System (CFSS) employs relational contracting. In CFSS, government contract managers are in constant, often informal, communication with providers, such as via regular phone calls. Rather than punishing providers for sub-standard performance, the Department of Human Services (DHS) leverages their mutual trust with providers to help them improve practice. DHS has adjusted performance indicators based on provider feedback several times to reflect best practice and the realities of service provision. CFSS has seen an increase in engagement rates from families in recent years and, in speaking with stakeholders across the system, there is clearly strong trust and cooperation between actors.

2) Long-term funding with periodic renewals, ideally up to 10 years. Our Town in South Australia and Communities of Focus, which operates across Australia, are two place-based initiatives with 10 years of funding. This long-term funding provides the stability to work with communities and build collaboration networks over time, which are essential components of a collaborative commissioning approach. It also allows those involved to learn better and more efficient ways of working together and avoids the wasted effort of reestablishing relationships when a new provider is contracted, which can occur with shorter funding cycles. It also means that organisations can spend more time delivering services and developing their workforce and less time on cumbersome grant and tender processes. The recent Community Sector Grants Engagement Framework by the Commonwealth Department of Social Services encourages long-term funding agreements through operational guidance for staff, the Department of Finance's Commonwealth Grants Community of Practice, a review of whole-of-government

guidelines, and public reporting on whether agencies are implementing long-term funding.

2. What are the benefits of pursuing greater collaborative commissioning?

There are many benefits of collaborative commissioning for service quality and resource efficiency, especially when paired with relational contracting and long-term funding. While collaborative commissioning comes with some costs to build and maintain the collaboration, when implemented well in appropriate contexts, the improved outcomes and more efficient allocation of resources the collaboration enables will outweigh these costs, especially over time. Some key benefits of collaborative commissioning are:

Improved coordination

Collaborative commissioning can improve the coordination of services in a specific area, improving productivity by avoiding duplication and providing more effective, joined-up care to clients. This is because bringing together funders, providers, and the community as part of collaborative commissioning allows these actors to better understand the range of services in the area and any unmet community needs. From there, the group can make use of the diverse levers they possess to collectively redirect resources to the services that are most needed.

Better service integration

Collaborative commissioning can improve the integration of different services to better provide holistic support to service users. This improves the quality of services as they more effectively address interconnected client needs and improves efficiency as resources dedicated to system navigators (staff who help clients navigate the service environment) can be redistributed towards improving the quality of care directly. One way service integration can occur via collaborative commissioning is through better referral pathways between service providers. This can emerge as practitioners from different disciplines build up a shared understanding and become aware of other practitioners they can refer clients to in various situations. This shared understanding might be built through communities of practice, which are common in collaborative commissioning initiatives. These forums also give providers the direct relationships necessary to make the actual referral. Another way service integration can occur is as commissioning entities design more flexible and diverse care pathways for clients in their location. For example, the Northern Sydney Patient Centred Co-Commissioning Group (PCCG) is a collaborative commissioning project between the North Sydney Local Health District and the Sydney North Health Network, alongside consultation with practitioners, consumers, and the wider community. Based on linked state and federal data and the broad consultation, the PCCG redesigned care pathways to better connect GPs, geriatricians, Hospital in the Home clinicians, and Geriatric Rapid Response teams.

Community empowerment

Collaborative commissioning can better enable community empowerment, especially when community members are directly involved in the governance structure and when those community members have lived experience of the care system in which the commissioning takes place. Giving community members genuine decision-making power means that service design and procurement are more likely to reflect what is wanted and needed on the ground. This improves productivity by ensuring resources are dedicated to interventions that will actually make a difference for service users. In addition, simply

including community members in decision-making helps them build their capabilities and grow relationships that they can then leverage for future change, reducing dependency on government-funded services.

Continuous, shared learning

Collaborative commissioning can enable continuous, shared learning. This creates ongoing quality improvement and consolidates learning across the collaboration rather than wasting effort on multiple, disconnected learning processes. Continuous, shared learning is enabled by collaborative commissioning because the governance body can bring together best practice from the various actors involved and then share those learnings across the collaboration. It also discourages the competitive mindset that currently causes actors to keep best practices to themselves, limiting the extent to which good practice is shared and iterated on. CPD regularly encounters this theme in our stakeholder conversations and it is a key benefit noted by Bates, Harris-Roxas, and Wright in their 2023 paper on the topic. Shared learning can be further enabled by long-term, relational contracting. Sustained funding provides the timescale and stability for funders and providers to evaluate long-term impacts and invest in improvements that might take years to be fully realised. A relational contracting approach allows contract managers to work with providers that are underperforming to improve the quality of their care without the fear of immediate repercussions. It also allows the commissioning entities to share learnings in more ongoing ways and adjust performance indicators based on what they have learnt to be best practice for the target location or cohort.

Reduced administrative burden

The most common funding issue raised when talking to service providers is the administrative burden associated with funding. This burden arises from having to reapply for funding on usually short contract cycles, frequently from multiple funders with their own separate recommissioning processes. The time and resources spent on this administrative work takes away from the direct delivery of care, especially when so many care sectors are already fiscally constrained. Having multiple funders commission collaboratively under a single contract cuts down the number of contracts that providers have to administer. Administrative burden can be further reduced by using long-term contracts, cutting down how frequently providers need to reapply for funds, and relational contracting, where less-burdensome and more informal mechanisms can be used to manage the contract.

Care services most benefitted by collaborative commissioning

The service quality and efficiency benefits of collaborative commissioning, and whether these benefits outweigh their costs, will vary depending on the kinds of services involved in the collaboration. Some benefits, like reducing administrative burden, will likely manifest for most services. However, collaborative commissioning is especially beneficial for addressing complex social problems where multiple care needs intersect and vary across individuals, places, and time. This is because, as discussed, collaborative commissioning enables coordinated and integrated services that respond to community needs and learn over time. This makes it highly appropriate for the Aboriginal Community Controlled and disability care sectors, where needs vary substantially across individuals and communities. There are also many parts of the aged care, early childhood education and care, health, and veterans sectors that involve high complexity and would benefit substantially from collaborative commissioning, such as for people experiencing multiple vulnerabilities. Further, client needs frequently intersect

across government-defined service systems, which collaborative commissioning plays an important role in addressing.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

There are several barriers that can hinder collaborative commissioning, including marketisation, procurement rules, short-term thinking, and the resources involved in establishing a shared vision and managing relationships.

Marketisation and demand-side funding

Some care sectors are highly marketised and use demand-side funding. This is where funding takes the form of a subsidy for consumers who choose what services they engage, such as early childhood education and care, general practitioners (GPs), and aspects of veterans affairs. This funding approach can be useful where it is effective to standardise services and consumers are the best actor to select between service offerings. However, marketisation and demand-side funding present a barrier for collaborative commissioning. This is because government agencies are especially unlikely to have strong relationships with providers and the community. In addition, the capabilities and ways of working in a highly marketised system are particularly different from those necessary for collaborative commissioning. This funding approach also drives competition between providers, which can hinder collaborative commissioning by encouraging mindsets that discourage collaboration and by creating vested interests against collaborative commissioning as certain providers become especially profit motivated. This being said, collaborative commissioning can still be useful for coordinating and joining up more marketised services, including with services that are less marketised. For example, the Northern Sydney Patient Centred Co-Commissioning Group was able to join up GPs, a more marketised service, with less marketised offerings like Hospital in the Home.

Procurement rules

Some government stakeholders have told us that their government-wide procurement rules and frameworks can hinder collaborative commissioning and other funding reforms. This is because, while these rules and frameworks generally allow for cooperative procurement, there is an over-emphasis on competition and the immediate value for money of each discrete purchase. This is often seen as an objective process, but it incentivises cuts to service quality, system fragmentation, and compliance-focused performance management, rather than the coordinated, empowering, and iterative approach of collaborative commissioning. The previously discussed review of whole-of-government guidelines as part of the Community Sector Grants Engagement Framework is one example of change in this area.

Short-term thinking

Collaborative commissioning can be hindered by short-term thinking across key actors, worsened by performance indicator timelines, election cycles, and media cycles. This is because successful collaborative commissioning requires trust and mutual agreement, which can take time to build. In addition, the costs of collaborative commissioning can initially be high and take time to reduce, as discussed below. Short-term thinking can be addressed through strong leadership and adjustment to performance indicators for staff across the system.

Resourcing a shared vision and relationship management
For collaborative commissioning to be effective and efficient, a shared vision is crucial, but this can take time and resources to establish. Even once this vision is established, resources need to be dedicated to managing and coordinating relationships, especially when community members are included in the commissioning process. Often a full time staff member is needed to manage the logistics of the vision-setting and ongoing collaboration, and it can take specific skills applied over a long period of time to develop the mutual trust necessary for collaborative commissioning. CPD has heard from stakeholders that, even without collaborative commissioning, relationship management already places a strain on the system and can lead to staff retention issues as workers become burnt out.

We know from our research that an early shared vision improves coordination and helps maintain motivation. These benefits can be enhanced through open and transparent communication early in the process to build trust and more easily reach agreement. Strong and supportive leadership is essential for this, and demonstrates the importance of recruitment and retention. Dedicated additional funding specifically for building and maintaining relationships helps overcome these costs, as found in research by Purcal and colleagues published in 2011. Additionally, research by Bates, Harris-Roxas, and Wright from 2023 suggests that the costs of collaborative commissioning tend to reduce over time as the collaboration matures and mutual understanding grows.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

The Centre for Policy Development has done considerable work in this area, with several key recommendations that the Productivity Commission can draw on, including:

Banking The Benefits - a report on including second round fiscal effects of policy proposals. If implemented in federal and state budgets, this reform would better reflect the impact of prevention and early intervention programs and, therefore, make them more likely to be supported in the budget process.

Avoidable Costs - a forthcoming CPD report (to be published in the next few weeks) that illustrates the fiscal costs of failing to act early and recommends the establishment of an Avoidable Costs Unit in Treasury that can effectively model savings from prevention and early intervention programs.

There are several key barriers to embedding evidence-based prevention programs into government processes:

Inertia and resistance to change
All bureaucracy, government and non-government, tends to resist change. This occurs because mindsets become engrained, feedback loops reinforce the status quo, and resources are dedicated purely to keeping the organisation running rather than reform. Effective systems change requires a suite of considered initiatives that expand capability and shift mindsets. This is made easier when senior leadership can champion that initiative and gain broad buy-in across the organisation.

Siloing

To truly invest in evidence-based prevention, various systems will need to work together in genuine partnership, especially given that prevention implemented in one sector will have benefits for other systems. However, government departments are frequently siloed, with agencies often arguing over why they should fund an initiative that benefits agencies outside their own. This is especially relevant to statutory agencies, such as the justice system or child protection, that have a legal obligation to meet the demand in front of them. While the siloing of actors, especially government agencies with statutory requirements, can present a barrier to investing in prevention and early intervention, there are examples of such initiatives. For example, the South Australian government created its Child and Family Support System as a middle ground between universal services, like health and education, and child protection services. From our analysis, this seems to be due, at least in part, to the severity of the problem in South Australia, recommendations from the 2016 Royal Commission into the Child Protection System, and strong organisational leadership.

Measurement

Another barrier is that not all forms of care can have their social and fiscal benefits easily measured, and there may need to be more research to build the evidence base around these benefits. Two ways governments already invest in prevention in care sectors are: (1) paying care providers a portion of their funding if they successfully reduce long-term demand for services (e.g., some social impact bonds) and (2) adjusting departmental budgets based on measured savings (e.g., Victoria's Early Intervention Investment Framework). While these approaches provide a level of certainty of success for governments and any co-investors, not all care services can meet the standard of evidence required through these mechanisms, usually for reasons unrelated to the actual success they achieve. Programs that rely on building partnerships, reforming systems, or working with children may take many years before their social and fiscal outcomes manifest simply because that is how long these transformations take. Similarly, some of these outcomes may be difficult to measure with traditional evaluation tools, such as the collaboration networks created by the program or the population-wide effects often intended with prevention-focused initiatives. Finally, many prevention-focused funding initiatives require applicants to provide some estimation or evidence of the anticipated social and fiscal benefits during the application or tendering process. However, not all kinds of care services have the existing evidence base necessary for this due to an underinvestment in research or the timeframe and measurement difficulties just discussed. Resultantly, governments investing in prevention should take a nuanced approach to measuring social and fiscal outcomes and consider how these challenges might unintentionally make otherwise impactful programs ineligible for funding.

Short-term, linear thinking

The benefits of prevention programs can take years and sometimes decades before they are fully realised. Similarly, the relationships between these programs and their impacts are frequently complex, with multiple factors coming together to drive a range of outcomes in nonlinear ways. However, most of the existing mindsets and ways of working are not suited to this. Election cycles, performance indicators, and the media environment emphasise short-term results rather than long-term outcomes. Additionally, as noted by the Australia Public Service Commission in its paper Tackling Wicked

Problems, government agencies often implement policy through a linear process that moves from identifying a problem to designing a solution to implementing that solution. This becomes problematic when focusing on prevention because the understanding of the problem changes over time as the long-term implications of the intervention are realised and the design of that intervention needs to be adjusted in response. Instead, leadership within government and non-government agencies should promote a mindset of continuous learning and put in place processes for ongoing improvement, such as those we discuss in response to later questions.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

There is a growing body of evidence that prevention-focused programs can deliver long-term social and economic benefits. These initiatives take different forms. Some focus on embedding prevention into how governments make decisions and allocate funding, such as through investment frameworks or budgeting mechanisms, while others involve direct investments in services that reduce future demand on crisis systems. CPD has worked across both fronts, shaping the case for a wellbeing approach to policy making that prioritises long-term outcomes while advocating for investment in universal, high quality early childhood development services (ECD) and people and place-centred social services reform.

The Victorian Government's Early Intervention Investment Framework (EIIF) is an ongoing example of a government enabling investment in prevention and early intervention. New policy proposals through the scheme outline potential long-term savings. If successful, 50% of these anticipated savings are reduced from the budget of the government agency where these savings are calculated to be. The actual savings of successful policies are tracked annually, with the budget of the saving department then adjusted based on the actual savings. This frees up money for and directly incentivises continued investment in prevention. As one successful example, consider Sacred Heart Mission's Journey to Social Inclusion Program, which was funded through EIIF in 2021. Working with Victorians experiencing long-term homelessness, they found that, between 2020 and 2023, 90% of their clients had found stable housing and 60% had reduced their number of hospital bed days compared to before they started the program, reducing costs for both housing and health services as a result.

Internationally, there is a wide range of successful prevention programs. Of particular interest are those at a local government level. In 2011, Wigan council in the United Kingdom responded to funding cuts from the national government with the Wigan Deal. This refocused resources towards partnering with the community to build their capability rather than simply providing demand-driven services. An independent critique by Naylor and Welling in 2019 found that Wigan council had saved £134 million between 2011-12 and 2018-2019. Additionally, they found that the deal positively transformed the organisational culture at the council and that the healthy life expectancy in Wigan improved faster than both its statistical neighbours and England between 2009 and 2017.

Another international example is the range of social investment funds at the municipal level in Sweden. Hultkrantz and Vimefall note in a 2017 paper that, as at 2014, 63 of the 290 municipalities in Sweden had allocated resources to a social investment fund. The specifics varied for each fund, but most involved internal government entities, sometimes

in partnership with external organisations, receiving funds by estimating and tracking the avoided costs of their initiatives. Some of these funds required the savings to be paid back via budget adjustments into the fund to allow the fund to be self-sustaining. There was also variety in the conditions around this payback mechanism, such as whether actors needed to pay back the fund if actual savings did not eventuate. Hultkrantz and Vimefall outline several projects funded through these funds that, at the time of publication, had paid back the initial investment and, in many cases, been integrated into mainstream services.

In terms of direct investment, CPD's Growing Together and Starting Better reports demonstrate that high-quality early childhood education and care (ECEC) is one of the most effective public investments the government can make. Children who access quality early education are more likely to succeed at school, have better health outcomes and participate in the workforce as adults. For every dollar invested in universal ECEC, the long-term returns include increased parental workforce participation, reduced reliance on income support, and lower demand on health and justice systems. These benefits are especially significant for children experiencing disadvantage, making ECEC a critical lever for equity, wellbeing, and productivity.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Broad and Long-term Vision

A government and economy centred on the wellbeing of people and planet would place far greater emphasis on prevention. To truly invest in prevention, in the long run, more than one reform is required. It involves a suite of changes that shift how decisions are made, budgets are structured, and services are delivered. Some of these are system wide enablers (such as new budgeting mechanisms or ways of working) and others involve direct investment in preventative interventions, such as ECD or place-based social services. The prevention initiatives employed by governments should expand beyond the care economy and integrate a range of policy areas. While the government may wish to trial these ideas through specific initiatives, it is essential that this is done within the context of broader reform, where there is a long-term vision. This is because many of the factors shaping demand on the care sector sit outside of the care sector itself. For example, housing support services for rough sleepers might reduce the number of days spent in hospital beds. However, the need for housing support in the first place might be reduced by setting macro-economic policies that reduce income inequality.

Accessible, linked, and longitudinal data

To invest in prevention, we need to understand the long-term impacts of our policies. This will require increased use of longitudinal data that can track outcomes over many years. The Household Income and Labour Dynamics in Australia (HILDA) Survey, the Longitudinal Study of Australian Children (LSAC), and Ten to Men are examples of this. The long-term impacts of policies manifest in multiple life domains, from health to housing to income. For this reason, datasets need to be linked across portfolios to provide a full understanding of the implications of prevention. We can see this with the Australian Bureau of Statistic's Person Level Integrated Data Asset (PLIDA). Finally, for this linked, longitudinal data (and data more broadly) to be useful, it needs to be accessible for policy makers and presented in a format they can comprehend. An example of this is the digital map of human services being produced by the Department

of the Prime Minister and Cabinet alongside the New South Wales Cabinet Office.

Avoidable Costs Unit

As noted earlier, Australia has made some progress on supporting investment in prevention activities. Victoria's Early Intervention Investment Framework (EIIF) is a leading example of reforming how budgets account for the long-term savings of prevention, while the Commonwealth's Measuring What Matters framework demonstrates a shift toward broader wellbeing indicators for policy design. CPD has outlined how to build on these foundations through a series of publications, including Embedding Progress, Banking the Benefits, and a forthcoming report on preventable failure demand entitled Avoidable Costs. One key recommendation from this report (released in the next few weeks) is the establishment of an Avoidable Costs Unit. The purpose of this unit would be to support more informed, preventative policymaking by developing the capacity to model the long-term costs of late intervention (and therefore savings from early intervention and prevention) and identify avoidable public expenditure as part of the policy development process.

Estimating, tracking, and banking savings

Following Victoria's EIIF and Sweden's various social investment funds, governments should start estimating, tracking, and banking the long-term costs and savings of their policies and use this mechanism to incentivise more funding towards prevention and early-intervention. This could be a key function of the Avoidable Costs Unit we have proposed. It might also be implemented by including these costs and savings into the Budget Process Operating Rules (BPORs) to incentivise ongoing investment. In addition to encouraging investment in prevention, these approaches help ensure that investing occurs in a fiscally sustainable and responsible way.

To maximise the success of this reform, governments should look to existing cases to ensure an effective implementation. Part of EIIF's success is that it has a high standard of evidence for estimating the anticipated savings of the policy, and only 50% of these savings are taken from the saving departments budgets, providing an ample margin for error. In our consultations with the staff running EIIF, we also heard how important it is that Victoria's Department of Treasury and Finance, which manages the framework, partners with other departments to jointly build their data capabilities while listening to and acting on feedback. Simply getting these reforms started in the first place often requires leadership to be brave in the face of crises. Both South Australia's Child and Family Support System and the Wigan Deal in the United Kingdom arose from social or fiscal crises and leaders deciding to try something new rather than maintain the status quo. Given that Australia is predicted to face rising costs in healthcare and social assistance as the average age of our population continues to rise, we require a similar mindset from our leaders across care sectors.

Partnership

Australia's Measuring What Matters framework, EIIF, the Wigan Deal, and Sweden's social investment funds demonstrate that prevention funding is possible at all levels of government in a range of portfolios. Care service users often have intersecting needs and engage with multiple care services simultaneously. As a result, to ensure investment in prevention is successful, it is essential that governments enable partnership across portfolios among the three levels of government and collaborate with non-government actors like private business, social enterprises, non-profits, and the community. There

are a range of ways to achieve this, including interdepartmental bodies, interdisciplinary communities of practice, regional governance bodies, and collaborative commissioning.