ISBN: 0 642 27164 X

The Industry Commission acts as the Secretariat for the SCRCSSP. The Industry Commission is amalgamating with the Bureau of Industry Economics and the Economic Planning Advisory Commission to form the Productivity Commission, which will continue the role of Secretariat for the Committee.

Secretariat
Steering Committee for the Review of Commonwealth/State Service Provision
Industry Commission
LB 2 Collins Street East Post Office
Melbourne VIC 8003

Level 28
35 Collins Street
Melbourne VIC 3000

Telephone: 03 9653 2100 or free call: 1800 020 083
Facsimile: 03 9653 2199
E-mail: gsp@indcom.gov.au
http://www.indcom.gov.au/research/service.htm

This report comprises three case studies dealing with significant recent reforms affecting the delivery of government funded services in specific jurisdictions.

Both this report and its companion — the annual *Report on Government Service Provision* which monitors service performance — are produced to help jurisdictions learn from each other. The Review was initiated in July 1993 by the Prime Minister, State Premiers and Territory Chief Ministers. It now operates under the auspices of the Council of Australian Governments.

Case studies are presented here on the following reforms:

- a shift to purchasing of community services in South Australia;
- output based funding of public acute hospital care in Victoria; and
- competitive tendering and contracting of prisons in Queensland.

Surveys collated information on similar developments in other jurisdictions.

This is the first of a series of publications planned by the Steering Committee focusing on implementation issues. The services covered by the Review command a large share of the nation's resources and have a major effect on the quality of life of the recipients. It is therefore vital that the effectiveness and efficiency of service delivery continues to improve.

The focus of the case studies is on: how the reforms were implemented; why each option was chosen; and how these decisions affected the reform. Implementation challenges of reforms obviously differ across jurisdictions and services, but there are many common issues.

The work does not try to be exhaustive; the case studies do not examine every implementation issue faced by the participating agency. The aim of the report is to help build up a body of knowledge about the broad principles and approaches to these reforms rather than provide a detailed guide. Further, the report does not evaluate the decision to undertake the reform. Other bodies have the role of evaluating government policies.

The case studies and the surveys have been prepared by the Secretariat on behalf of the Steering Committee with the full cooperation of the agencies involved. The Secretariat relied primarily on the experience and information provided by the participating agencies. Outside commentators also provided helpful comments and advice.

The Steering Committee would like to thank all those who assisted with this important project.

Bill Scales, AO
Chairman

TABLE OF CONTENTS

ABBREVIATIONS

ACHS	Australian Council on Healthcare Standards
AN–DRG	Australian national diagnosis related groups
CEO	Chief executive officer
COAG	Council of Australian Governments
CPI	Consumer price index
CSO	Community service obligation
DRG	Diagnosis related group
FACS	Department of Family and Community Services (South Australia)
HACC	Home and community care program
NACON	National Anglican Caring Organisations Network
PSMC	Public Sector Management Commission
QCSC	Queensland Corrective Services Commission
SACOSS	South Australian Council of Social Services
SAAP	Supported Accommodation Assistance program
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
VACS	Victorian Ambulatory Care System

1 INTRODUCTION

This report consists of three case studies which examine the implementation of:

- a shift from grant funding to purchasing of community services in South Australia;
- output based funding of public acute hospital care in Victoria; and
- competitive tendering and contracting of the management of correctional centres in Queensland.

A survey of developments in these service areas in the other jurisdictions was also undertaken.

The focus is on implementation

The focus is on how the reforms were implemented: the key issues; the options that were available; why a particular option was chosen; and how that choice affected the reform. The case studies do not evaluate the decision to undertake the reform. Other bodies have that role and it is not an appropriate one for the Steering Committee.

... and what can be learned from the experience of these agencies.

The case studies and the survey illustrate how different jurisdictions chose to adopt different approaches to addressing somewhat similar issues, albeit for different services. In many cases, other jurisdictions and service areas face the same or similar choices. The experience of the case study participants therefore provides insights for other policy makers and managers.

Each case study sheds light on the challenges of implementing these reforms and how the particular environment affected the process. The funding arrangements, budgetary pressures and other policy changes all affected key implementation decisions. The characteristics of the service, the provider market and the agency also needed to be considered.

There are clearly considerable differences between the services and the time each reform has been in place. In Queensland, the contracting of correctional centres has evolved over the past seven years, while in South Australia the move to a purchasing relationship with providers of human services commenced only two years ago.

Each reform has changed relationships between providers and purchasers

But there are also similarities. Each reform has fundamentally changed the relationship between the purchaser of the service and the providers. In each case, the expectations of both parties has been made more explicit, and moved closer to a contractual basis. Other common issues included: whether services could be defined in terms of outputs rather than inputs and processes while ensuring quality standards; how providers could be monitored effectively; and how an appropriate structure of rewards and sanctions could be created?

As a result of the changing relationship between purchasers and providers, greater effort has been directed in each service area to specifying the service and monitoring the outputs (and to a lesser extent outcomes). This has highlighted the shortcomings in the performance information that existed before each of these reforms, and how a consequence of each reform has been the introduction of incentives to improve specification and monitoring.

... and created an environment that facilitates further reform.

The initial stages of the reforms have also facilitated and, in some cases, created additional pressure for further reform. Both casemix funding and the transition to a purchasing relationship facilitate greater competition amoung providers. The explicit agreements between the purchaser and provider, as introduced with private correctional centres, are being extended to publicly run centres.

Developing general principles and guidelines requires more work.

In the longer term, it may be possible to develop general guidelines for many of the practical implementation issues associated with these reforms. To some extent, such an approach has been developed for reforms such as the corporatisation of government business enterprises where the experience and analysis stretches over a number of years and includes the examination of similar issues in a wide range of settings. It is hoped that the case studies in this paper, and those which follow, will contribute to the similar development of principles and guidelines for social infrastructure.

These case studies were undertaken by the Secretariat on behalf of the Steering Committee. Given that the focus was on implementation, the case studies rely on departmental publications, internal documents and information provided by departmental officials involved in implementation. The Secretariat met with some providers, client groups and other stakeholders to clarify the key issues but did not conduct wide ranging consultation necessary for a comprehensive evaluation of the reforms.

A survey of the agencies responsible for community services, acute care hospitals and corrections was also undertaken. This provided information on how the approach taken by the agencies participating in the case studies compares with that of those in the other jurisdictions. This is intended to place the reforms examined in the case studies in a more general context.

Together, the case studies and the survey material should add to the understanding of the way in which reform in government service provision is being carried out throughout Australia, and of the implementation choices that governments are making in response to their particular challenges.

2 PURCHASING HUMAN SERVICES IN SOUTH AUSTRALIA

The South Australian Department of Family and Community Services (FACS) has traditionally funded organisations from the community sector, who are undertaking activities consistent with FACS's objectives on a grant basis. FACS has been transforming its relationship with these organisations by purchasing specific services from providers rather than subsidising their activities.

2.1 This case study

This case study examines how the South Australian Department of Family and Community Services (FACS) (box 2.1) introduced a purchaser/provider relationship with the community sector which FACS previously grant funded. The focus is on how it designed these changes, with particular emphasis on how specific environmental factors affected implementation.

This is one of several closely related changes in the way FACS operates. Since 1990, FACS has been refining policy priorities in terms of client needs, location and preferred types of services. A 1995 restructure broadly along funder/purchaser/provider lines affected both developments. (Appendix A provides information on the arrangements in the other States and Territories.)

The aim of the case study is to provide insights that other jurisdictions and service areas considering a purchaser/provider arrangement can use to inform their implementation decisions. Consequently, the effect of other important changes in the broader policy environment are considered at some length, but primarily to understand their effect on implementing a purchasing relationship.

Box 2.1: Department of Family and Community Services

South Australia's *Family and Community Services Act* 1972 sets out the Department's objectives as:

a) to promote the welfare of the community generally and of individuals, families and groups within the community; and

b) to promote the dignity of the individual and the welfare of the family as the bases of the welfare of the community (Part 2, Division 2, Section 10).

FACS's services can be placed in a continuum. At one end, the more preventative services focus on strengthening and supporting families. At the other end, the aim is to respond to children, families and vulnerable adults in crisis (FACS 1996d). During 1995–96, FACS investigated over 7000 notifications of child maltreatment, and provided supported placements for over 2500 children (SCRCSSP 1997). Its emergency assistance counselling service received almost 29 000 calls, and made nearly 21 000 emergency financial assistance payments. Over 1500 children and adolescents were admitted into secure care (FACS 1996b).

FACS provides community services directly, funds external service providers on a grant basis, and purchases services. FACS's expenditure was over $225 million during 1995–96, including $63 million in wages and other operating expenditure, $94 million in grants including payments to foster carers, and $65 million in payments for concessions which FACS administers (FACS 1996b). More than half of the grants are made under the joint Commonwealth/State funded Home and Community Care program which is still largely based on funding providers on a grant basis. The focus of this case study is on programs which have moved to a purchasing framework, amounting to about $30 million annually. About half of the $94 million in grants are made to non-government providers and half are made to local government or other South Australian Government agencies such as health services.

2.2 The reform

Reform had an internal and external dimension.

The restructuring of FACS in 1995 changed its relationship with external providers in two separate but related dimensions. First, the Department reorganised and separated the roles and responsibilities of inhouse service providers from those of inhouse purchasers of the services of external providers. Second, for some of the services it funds (with annual expenditure of about $30 million), FACS redefined its relationship with external providers to ensure that FACS is

seen as a purchaser of services, rather than just a supplier of funds (box 2.2).

Box 2.2: Relationships with external providers ofhuman services

*Grant funding*relationships are typically characterised by:

- competition for funds through informal processes;
- few, if any, explicit performance or output measures;
- one-off or annual funding commitments;
- renewal of funding based on the previous year's expenditure; and
- service characteristics and access criteria not being explicit.

*Purchase of service*relationships are typically characterised by:

- more explicitly defined selection criteria for providers which can include price and/or quality;
- explicit performance measures;
- multiple year contracts;
- renewal of funding based on re-examination of client needs and service costs; and
- the purchaser specifying the service characteristics and access criteria.

The main effect of restructuring along purchaser/provider lines is to provide:

- greater clarity about the respective roles and responsibilities of FACS and affected external providers;
- greater transparency in the allocation of funds among services and providers; and
- more explicit performance criteria and, through improved monitoring, greater transparency in the comparative performances of providers.

Box 2.3: The internal restructure of FACS

Before the recent restructure, some departmental divisions were responsible for particular programs (for example, family and community development and young offenders), while others were responsible for field services in each of three regions. Each division controlled policy development, relationships with external providers and service provision by departmental employees in its area of responsibility (see attachment 2.1).

The rationale for the 1995 internal restructure was:

> ... to provide for a clear separation of responsibilities, to avoid conflict of interest and thereby create clearer accountability and clarity of customer focus (FACS 1995b, p. 5).

The South Australian Commission of Audit (1994) made strong statements about the need to separate accountabilities across the public sector, particularly around funder, purchaser and provider responsibilities. Following the restructure:

- the Policy and Development Division (about 19 full-time equivalent staff) provides policy advice (the funder role);
- the Community Services Division (26 staff) and the Office of the Aging (22 staff), which includes the Home and Community Care Unit, purchase services from external providers; and
- the Field Services (609 staff) and the Residential and Youth Services Divisions (274 staff) are responsible for the delivery of services — such as the investigation by social workers of child protection cases and the operation of juvenile detention facilities — by departmental units (see attachment 2.1 for FACS's full structure) (FACS 1995b, p. 5). The Field Services and the Residential and Youth Services Divisions are also responsible for 'operational policy' (including determining the specifications and targeting individual services) as well as the delivery of those services to external clients.

This restructure has not yet developed as far as creating a formalised purchasing framework for departmental units providing services to external clients.

2.3 Related developments

A number of related changes in FACS activities have affected the implementation of purchaser/provider arrangements,

including changes in:

- the internal structure — separating the funding, purchasing and providing roles within FACS to clarify responsibilities (box 2.3);
- policy priorities — changing the distribution of services across the State and the service mix to better target families and individuals most in need;
- the selection of providers — where possible introducing competition, largely on the basis of quality; and
- combinations of services and numbers of providers.

Services are also being restructured.

For some programs FACS has also decided to combine related services, with the effect of having fewer but larger providers as part of the progressive review of policies and the purchasing of services. The shift to purchasing services has some influence on this decision to the extent that the number of providers increases the cost of developing more explicit agreements and monitoring.

A decision to increase the range of services available has made developing service specifications a larger task. In addition, specifying some services has been made more complex by the decision to allow clients more choice as to the service they receive.

Introducing competition into aspects of selecting providers for some services has also made specifying services a more complex task. If the characteristics of the provider are an integral element of the services — for example, it may be important that the provider have strong links to the client community — this needs to be specified in the tender documents. If specifications unnecessarily favour one provider over another, then they hinder the selection of the best provider. However, where FACS faces only one potential provider of a service, it may not be essential (although still desirable) to define the characteristics of the provider explicitly.

The decisions to reallocate funding across services, to combine services in different ways, to select fewer providers to deliver some services, and to introduce competition into some aspects of the selection process have all affected the environment in which FACS has moved from funding on a grant basis to purchasing services. Not least, they have contributed to greater uncertainty among providers. The effect of these developments on implementing a purchaser/provider arrangement is addressed in the discussion below.

2.4 Deciding what to purchase

Becoming a purchaser has required FACS to be more specific about what it is actually buying. In the past:

> ... [the] distribution of funds was largely determined by a submission driven process in which prospective service providers defined the service needs in terms of client groups, amount and location and stated in a fairly general way how they intended to respond to them. Grants of funds were allocated to groups based on assessments of competence of the organisation and the quality of the submission, as well as on priorities broadly abstracted from the department's legislated mandate to provide or ensure a range of services for the community. (FACS 1996a, p. 5)

FACS, providers and clients are all stakeholders in the process.

Three parties have an interest in what is purchased: - FACS as the purchaser, providers (usually from the not-for-profit sector), and individuals as current or potential clients of the services. FACS's corporate plan states that a key purchasing strategy is to 'ensure that policy and funding plans are outcome and output focused for customers' (FACS 1996d, p. 11).

But incorporating external stakeholder views can be difficult.

FACS has found it difficult to incorporate client views in a way that is comprehensive and representative when it is considering changes to the broad nature of services and the ways in which they are purchased. Client input is needed, first at the broad policy level and second at the service planning level when service specifications are developed. So far, more progress has

been achieved at the policy development stage than the service specification stage[1].

During the development of new policies, the Policy and Development Division consults with clients, advocates of clients, and providers. It has made ad hoc use of surveys, although it has some concerns about the cost-effectiveness of client surveys when the client group is uncomfortable asserting their views or not a voluntary client of a service.

At the service specification stage, FACS now consults more widely — including potential as well as the existing providers — but has not developed a systematic approach for including client views. However, FACS is trialling methods of including a client perspective when monitoring providers and programs in both the Youth Supported Accommodation Assistance program and family development services.

Most client groups do not have advocates who are independent of providers. FACS has made direct contact with clients but this can be difficult and costly. Moreover, FACS argues that reaching the right people and ensuring it asks the right questions is a far from straightforward process for many of its funded services.

2.4.1 Clarifying responsibilities

Laurie (1994) described how the roles and responsibilities between purchasers and providers are arranged in theory, but noted that the relationship was often not quite so arms length in practice when contracts are with the voluntary sector. FACS considers that its restructuring has gone a long way in clarifying the respective roles of the Department and external service providers.

[1] The only jurisdiction with existing mechanisms to measure client satisfaction is Western Australia (appendix A, p. 114)

Table 2.1: The roles of purchasers and providers

The Purchaser	*The Provider*
Prioritises recognised needs	Bids for the service
Decides how the service should be delivered	Proves it can provide the service
Decides who should provide the service	Provides the service
Monitors the service to ensure specifications are met	Evaluates its work
Evaluates providers and whether the service meets it objectives	

Source: Laurie 1994

The first issue is how to define the service

The first issue for the purchaser is how to define the service to be delivered by the provider. Kettner and Martin (1993) suggested that there are broadly two approaches: documenting design specifications, which are more input focused; or documenting performance specifications, which are more output or outcome focused. The differences are illustrated in table 2.2.

Table 2.2: Components of design and performance specifications

Design specifications		*Performance specifications*	
Inputs	*Throughputs*	*Outputs*	*Outcomes*
• staff numbers • facilities • equipment • funding • client numbers • other resources	• processes • tasks • methodologies	• measures of service volume	• measures of client impact

Source: Kettner and Martin 1993

Kettner and Martin noted that:

> One of the principal benefits of performance contracting[2] is that the expectations of the contracting parties are clarified in terms of deliverables. Establishing precise expectations is the first step in designing human services contracts that work efficiently and effectively. (1995, p. 49)

[2] Performance contracting is defined as 'a contract that uses performance specifications and ties at least a portion of a contractor's compensation to their achievement' (Kettner and Martin 1995, p. 48).

FACS has used both design and performance specifications in some agreements, but design specifications only in others. A dual approach — specifying both funding levels and broad measures of service volume — has been necessary, partly as a result of the paucity of quality indicators. Detailed specifications of processes or tasks have not been used.[3]

FACS is now clearer about what it wants

Greater clarity about what FACS wishes to purchase can reduce the flexibility that some providers had previously. In the past, the inputs which could be purchased by providers with FACS funding were tightly specified (for example, how much was to be spent on salaries and how much on administrative expenses) but the use of those inputs was much less constrained. Service agreements are now clearer about what services FACS wishes to fund, and what it does not. The aim, in part, is to reduce what FACS perceived as overlap with the services of other providers, including its inhouse services. However, the South Australian Council of Social Services (SACOSS) raised concerns about whether these similar services really reflect overlap, and whether gaps are now emerging in the range of services.[4] Whether these gaps eventuate will depend on whether FACS is able to renegotiate service agreements as any such gaps become evident.

... and is slowly developing better output measures.

FACS is seeking to develop more refined output measures for its services; many services are still primarily specified in terms of processes or tasks and funding levels. The tighter specification of output/outcome measures in the future should be facilitated by the monitoring regimes for newly contracted services. This monitoring is providing more information on outputs (and on outcomes where possible) than was available in the past.

---

[3] Use of output funding mechanisms varies across services and jurisdictions (appendix A).

[4] SACOSS expressed these views during discussions with the Secretariat of the Review of Commonwealth/State Service Provision.

FACS's approach to specifications varies

Where a competitive process has been used to select providers, FACS's approach to developing service specifications has differed depending on the service and the market.

- If FACS has a fairly clear idea of the types of services that could be provided, it has provided specifications (including for the process or task), against which potential providers have submitted tenders.
- If FACS is uncertain as to the different or innovative approaches that could be adopted, it has been less specific about the service specifications, relying on the tenderers to outline the service they might offer.

... allowing providers to suggest how services might be specified.

FACS has taken the second approach in selecting providers of alternative care services (which includes counselling and other services for families in crisis and out-of-home placement for children). This has a number of benefits and costs. If it is difficult to specify the service in terms of outcomes or outputs, this approach ensures that the provider who may be able to deliver the service using alternative processes can present those options. However, FACS recognises that the cost of preparing tenders may rise if tenderers have to present greater detail on service delivery. Furthermore, the more flexible approach may result in the comparative elements of tenders being less transparent, making it difficult to choose the right provider.

FACS could have chosen to adopt the first approach but also accept non-conforming tenders as a way of combining the strengths of both approaches. It has not done so to date.

FACS is letting four tenders for alternative care. South Australia is divided into two metropolitan and two rural franchises. It is possible that the successful tenderers will offer four very different service proposals, reflecting the different approaches of the providers and the needs of the areas they serve. As a result, four very different service agreements may be negotiated and four different approaches used in each of the regions, although providers will share common performance measures. This could provide FACS with

excellent data with which to compare each provider's approach.

The target group is now identified more explicitly

The purchaser must prioritise recognised needs. FACS considers that target groups of grant funding were often only defined in very broad terms. As part of defining what it is purchasing, FACS has sought to be more explicit (and more targeted, given the changed policy priorities) in its approach. Various approaches have been used, including:

- determining which individuals are eligible;
- specifying the criteria for access, which is administered by the provider; or
- specifying the target group in broad terms, which is interpreted by the provider.

... although the precision varies.

An example of the first approach is that FACS social workers will usually determine which children should be placed in foster care under the new alternative care arrangements. In contrast, providers will decide who is eligible for the counselling and rehabilitation elements of the Gambling Rehabilitation Service now that FACS has specified the target group as 'those members of the community who are experiencing difficulties as the result of problem gambling associated with gaming machines' (FACS 1996f, p. 2) — an example of the third approach.

There may be benefits in some instances in providing a more intensive service to fewer people, but for many services there is insufficient information to develop rigorous targeting criteria. Better profiles of clients and improved monitoring of outcomes should assist with this task, as well as adding to the information on provider performance.

Resources devoted to each element of a service are still based on input type controls

A second issue in terms of determining priorities is the share of resources devoted to each type of service. Many of the services that FACS purchases contain different elements. For example, providers of the Gambling Rehabilitation Service are required to offer financial counselling, therapeutic counselling, family counselling and community education services. FACS wants to ensure that it, rather than the provider, determines the priority of each service element.

FACS will rely on input controls to guide priorities:

> The funding model [for alternative care] incorporates a split between funding available for out-of-home placement and family preservation services. This is to protect the commitment to activities and outcomes in both areas of activity. Contracted agencies [external providers] will be required to account for their financial performance for each area in order to avoid cost shifting. (1996c, p. 36)

... although this has some shortcomings.

This approach has a shortcoming, albeit a seemingly unavoidable one at this stage. There is a practical challenge in allocating precise costs to each activity when resources are shared. It is inevitable that resources (such as staff and facilities) will be shared because those links are part of the rationale for co-locating several services with one provider. The development of better output measures will increase the feasibility of specifying the mix of outputs rather than inputs for each service.

2.4.2 Community goodwill — a dimension of quality

The introduction of competitive selection of providers has added an extra dimension to the challenge of service specification.

As a provider, the community sector can offer advantages over governments or for-profit providers in some circumstances. The Industry Commission noted in *Charitable Organisations in Australia* that, among its other advantages, the community sector offers goodwill:

> The goodwill established by an organisation is the recognition by

> the wider community of the organisation's credentials and trust in its performance. Long-established organisations have developed this goodwill, in some cases over more than a century. More recently formed organisations dealing with problems such as family breakdown, have developed community networks that governments could never achieve and which are critical in developing sound, long-term solutions to complex social problems. (1995, p. 360)

The need to maintain these dimensions of quality may explain some of the views FACS has about competition being used in funding decisions. For example, in the *Contracting in Community Services: Position Paper*, FACS stated that:

> While the department is certainly interested in eliminating unnecessary costs, it is considered too risky for consumers and financially vulnerable, yet important, sections of the provider market to encourage price based competition in most foreseeable circumstances. (1996a, p. 14)

If it is difficult to specify the dimensions of quality offered by the 'financially vulnerable' providers, it may be appropriate to constrain competition. As the Industry Commission noted:

> If a CSWO [community social welfare organisation] chooses to use some of its own resources to gain the tender [under price based competition], governments will not be covering the full cost of the service they require. This approach will tend to favour larger, well-established CSWOs, which are more capable of obtaining resources from the general community. (1995, p. 97)

However, while it may be difficult, if community involvement can be specified — for example, by requiring that the board of management be made up of local residents — then price based competition should not drive out providers with local links. Performance can be measured against these community objectives, to some extent, by means such as community satisfaction surveys.

2.4.3 Using for-profit providers

The role of for-profits is still being considered

In the past, for-profit providers would not have been interested in delivering many of the services that FACS funded. Traditionally, FACS provided sufficient funding to cover only a portion of the full cost of many activities performed by the community sector. This was partly to reduce the cost and thus allow more services to be funded, and partly because it was seen as important for services to attract material community support as a means of ensuring that they were responsive to local needs.

However, as the nature of the services and providers FACS has funded has changed, so has the potential for for-profit providers to become involved (although this has not yet happened)[5] The greater targeting of those with highest needs has led to FACS funding more services which attract less volunteer and material support from the community. As a result FACS has needed to make a greater contribution to the services' costs. Some smaller, stand alone providers in these service areas receive almost all their money from FACS.

... with some stakeholders expressing concerns

SACOSS expressed concerns about allowing for-profit providers to compete for human services contracts.

> The question of whether contracts should be let to for-profit providers in areas where service has traditionally been undertaken by not-for-profit providers essentially comes down to the issue of whether the provider can produce an equally effective service which is delivered to the same group of clients and potential clients. Evidence from the USA suggests that for-profit providers are only interested in the relatively lucrative areas of service delivery to middle class people and that service to the more disadvantaged falls back upon the government and not-for profit providers.
>
> An unintended consequence of opening up service provision to for-profit-providers is that more expensive and higher quality

[5] NSW, Tasmania and the ACT allow for-profit providers to compete with not-for-profit providers to supply out-of-home placement and family support services, while, at this stage, Victoria allows for-profits/providers to compete for family support services. The other jurisdictions do not permit for-profit providers to compete to supply these services (appendix A, tables A.2 and A.4).

> services are delivered to those with greater personal resources, while poorly funded and lower quality services are delivered to the more needy. (1995, pp. 6–7)

... although these can be addressed through tight contract specification.

These concerns point to the need for tight contract specifications. If FACS specifies that services are for access by clearly targeted groups, and that access is to be adequately monitored, then the higher cost clients should not be adversely affected by allowing for-profits providers. Indeed, where for-profit providers are more efficient, it will be possible to produce higher quality services for the same target group, or to increase the number of people served with the same expenditure.

Some rationale for excluding for-profits in the short-term may be made

Imprecise service specifications may cause fewer problems if the purchaser and provider share similar objectives. Shared objectives are likely to be more important when output and quality specifications (as well as monitoring) are at an early stage of development. It is not clear if for-profit providers will have very different long-term objectives from those of FACS. For-profit providers who make a long-term commitment to enter a particular field will only remain viable if they can demonstrate that they can produce acceptable quality services at a reasonable cost. This suggests that for-profit providers should only be excluded from a lead role in delivering services currently offered by the community sector if the not-for-profit characteristics of providers are likely to be an integral part of the quality of the service — community goodwill, for example.

... but this would impose costs in the longer term.

It may be costly to exclude for-profit providers in the longer term. By excluding providers, who may have access to particular skills, techniques or resources, the cost-effectiveness (and thus the number of clients who can be served) or quality of services may be diminished. For example, for-profit providers have successfully bid in other jurisdictions to supply services similar to some of those that

[6] For example, counselling services such as those offered for gambling rehabilitation are provided by a number of for-profit providers. Victorian local councils also purchase aged care and disability services from for-profit providers (IC 1996).

FACS purchases[6].

Some private providers showed interest in tendering for the alternative care services. For example, a for-profit counselling service was among the 35 providers who inquired about the alternative care service. However, FACS considered that for-profit providers were unlikely to have the experience or interest in providing the full service, and were more likely to provide only part of it under some agreement with another (not-for-profit) provider.

2.4.4 Fostering cooperation among providers

Competition can affect cooperation between providers

Cooperation among providers has the potential to reduce costs and enhance quality and effectiveness. But FACS has also expressed concerns about the potential for greater competitive pressures to hinder mutually beneficial cooperation among providers (FACS 1996a, p. 14).

... but it can be encouraged

Cooperation can be encouraged or, to some extent, enforced through the service specifications. Greater pressure on providers to demonstrate that they are efficient and effective, with or without competition, will enhance the incentives for providers to either cooperate or consolidate. Pressures to use resources more effectively are leading to increased cooperation among service providers in some areas. Some smaller providers are seeking to reduce their administrative costs by entering into forms of service agreements with larger providers. Centracare, a large Catholic provider, has taken a number of smaller Catholic providers under its wing, whereby it provides some services (such as administration and payroll) while the provider retains a degree of autonomy in service design and in their public face.

... or even required.

Payment structures can also influence the degree of cooperation, for example, by rewarding providers who refer clients to other more suitable services when their service is not the most appropriate. Service agreements can also require some degree of cooperation, either in general terms or more explicitly by specifying that providers must attend meetings or

share information with other providers. For example, the funding and service agreement for the Gambling Rehabilitation Service requires providers to:

> Develop flexible and integrated approaches to service provision cooperatively with other agencies. (FACS 1996f, p. 3)

FACS has consciously avoided taking an active role in encouraging mergers or joint approaches to services. Prior to the introduction of a purchasing relationship this would have been seen as an appropriate role for FACS in fostering the development of the provider market. It is now seen as inconsistent with the 'arms length' relationship and greater clarity of respective roles and responsibilities that FACS is seeking to develop with individual providers.

2.5 The purchasing process

2.5.1 Determining the appropriate price and quality

To determine the appropriate price and quality of the services it purchases, FACS has either:

- calculated what it considers to be 'fair'; or
- introduced competition between providers.

The move from grant funding to purchaser/provider arrangements (with measurable price and quality performance indicators) can highlight the support for more costly providers. Grant funding with no explicit performance requirements meant that more costly (to FACS) providers[7] could be implicitly supported by permitting them to provide less or lower quality output. Purchaser/provider arrangements with robust performance monitoring mean that any *de facto* support becomes more explicit, both within FACS and the Government generally.

[7] Such as those in the 'financially vulnerable, yet important, sections of the provider market' (FACS 1996a, p. 14).

A 'fair' price and appropriate level of quality may have to be calculated.

If only one provider is likely to be able to provide a service, FACS has to determine the appropriate price (and thus volume of output if the budget is fixed) and quality. This is somewhat easier to do for an existing service, where FACS knows its previous level of financial support, although there is a paucity of reliable historical data on service volumes.

If a service has not been provided before, at least not in the proposed form, then it is more difficult to determine the appropriate unit price and quality. Tenders for similar services can give some benchmark information. For example, FACS will negotiate with the South Australian Aboriginal Child Care Agency for delivery of out-of-home placement and family preservation services to the Aboriginal community, and competitive tenders for similar services to non-aboriginal clients will provide benchmarks.

If there are no similar services, then FACS can seek to build bottom-up estimates of the costs. This will set the ceiling on the price it is prepared to pay. This process has raised issues as to what items should be included (for example, should funding for an additional project include a contribution to overheads that would be incurred anyway?), how much of each input is required (for example, how many hours, number of staff etc. are needed?) and what is an appropriate price for each input (for example, are experienced staff needed, or can volunteers do the task?).

Some providers have argued that the departmental officers developing the contracts do not yet have the business skills necessary to determine the appropriate costs needed to derive a fair price and thus to negotiate on quantities of services that should be incorporated in service agreements. They believe that agreements on output levels should be viewed as indicative at this early stage as the estimates of reasonable costs are refined.

Competition could be used in a variety of ways.

Where possible, FACS is seeking to introduce a formal competitive process (largely on the basis of quality) to determine more robust benchmarks and to select providers.[8] FACS faced a number of options when using competition to set prices and specify the quality of the outputs of services it wished to purchase. It could specify:

- the minimum quality of outputs and the total funding of the service, with providers competing on both quantity and quality above the minimum level and, thus, partly on unit price;
- the unit price and quantity of outputs (and thus a fixed total price), with providers competing on quality;
- the quality and quantity of outputs, with providers competing on unit price; or
- the total fixed price, with providers accepting *all* referred clients and competing on the quality of the overall service.

FACS has stated that its general intention is to adopt fixed price contracts for service provision, using either the second approach whereby providers are expected to specify output levels, or the fourth approach whereby providers are expected to accept all clients (as they are in alternative care — see section 2.5.2).

FACS has chosen not to have price based competition for most services, so it must estimate what it considers to be a reasonable unit price (where it does not have the information from previous funding rounds) and allow any competition to be based on quality.

Output based funding is a long-term goal.

FACS sees output based funding as the most appropriate means of allocating funds in the longer term for some services. However, it believes, for services such as alternative care, that there is currently insufficient information to calculate

[8] The use of competitive processes to select providers varies across jurisdictions (appendix A, tables A.2 and A.4).

robust

unit costings or the complexity of workloads, or to develop the necessary client outcome measures (FACS 1996c, p. 35).

The absence of unit costing data within FACS does not have to be a major barrier. Adequate quality specifications would allow a competitive process to be used to reveal the appropriate price. Providers may face challenges in costing a new service, but this is no more difficult than determining the quality to offer when the unit price is fixed by the purchaser. However, if providers are to compete on the basis of quality rather than price, then FACS must acquire greater skills to rigorously select and monitor providers on this basis.

2.5.2 Apportioning risk

Clarifying responsibilities and the associated payment structure involves explicitly apportioning or assigning risk. Ideally, risk should be borne by the party best placed to manage or bear it[9].

In human services, risks include demand risk arising from unexpected change in the demand for a particular service. For example, if a provider contracts to supply a service to all referrals for a *fixed total sum*, then the provider will have less than expected costs if demand is lower than anticipated, and greater costs if demand is higher. If the provider contracts for a *fixed unit price*, then the provider faces the risk that its costs will go up or down, or that its clients will become more or less costly to serve (box 2.4).

2.5.3 Determining the contract length

Determining contract length involves

In determining the appropriate length of contracts, FACS considers it has had to balance a number of considerations. Shorter contract terms provide an opportunity to revisit service specifications, ensure flexibility in responding to changing needs or resources, and provide opportunities for

9 Risk arises from uncertainty and can produce a benefit (upside risk) or impose a cost (downside risk).

trade-offs.

new providers to emerge. Longer contract terms allow existing and new providers to justify investments in developing staff, procedures and physical facilities, and provide greater certainty for clients and staff.[10]

Box 2.4: Apportioning risk and alternative care

The proposed basis for contracting the alternative care services is that providers would agree to accept all referrals for a fixed total annual sum over three years. If the quality of the service is tightly specified, then providers will bear the risk that demand is greater or less than expected. Factors that could affect demand are changes in:

- the external environment, such as a recession or an increase in alcohol abuse;
- the characteristics of the service, such as its quality, marketing or accessibility; and
- the criteria for eligibility to the service.

Neither FACS nor the providers can influence the first risk factor, so the issue is who can best bear it. Providers can manage the second risk factor, subject to any constraints specified in the contract. The third risk factor can be managed by tightly specifying it in the agreement. Any change in the eligibility criteria would have to be negotiated with providers, and potentially the total fee would need renegotiating. If not tightly specified in the agreement, FACS's Field Services could potentially lower the criteria. FACS could bear all the risk of changes in demand if it chose to include a unit price component in the contract fee structure.

Under the proposed arrangements, alternative care providers would seem to be allocated considerable risk that they are not best placed to manage or bear. However, this is mitigated by several factors. First, providers can withdraw from the service agreement by giving three months notice if demand greatly exceeds that expected and FACS declines to make additional payments. Second, both providers and FACS expect to have a long-term relationship. Third, the external providers do not bear all the cost of an increase in demand because Field Services is responsible for payments to carers and would thus bear a significant part of the cost of an increased use of the service.

[10] A number of jurisdictions only offer one year contracts, while others offer contracts of up to three years (appendix A, tables A.2 and A.4)

... for which a formal framework has yet to be developed.

A formal framework has yet to be developed to guide decisions, but current thinking in FACS is that longer contract terms (up to five years) may be suitable if:

- there are few competent providers;
- providers need to invest in infrastructure, such as staff, systems, management and/or physical capital;
- service disruption is particularly costly for clients and/or providers; and
- the ongoing need of the client group is relatively stable.[11]

Termination arrangements are also important.

Related to the issue of contract length are the termination arrangements during the contract term. The new more competitive arrangements have led to concerns about the impact of uncertainty, but offer greater notice of defunding. Most providers received annual grants under grant funding, with only the largest providers able to secure three year funding agreements. The decision not to renew a grant could be made without notice. The new service agreements contain clauses generally giving each party three months notice.

Also affecting contract length is the desire to maintain the flexibility to change the bundling of services over time. The ability to rebundle services can be hindered if complementary or substitute services come up for new service agreements at different times. Bundling decisions may need to be revisited at contract renewal time as more information becomes available, as needs change, or as technologies of service delivery evolve. FACS is exploring whether to develop integrated funding cycles so that broad bands of services come up for funding in the same year. Possible bands might include services to families, individuals, youth, and industry and development services.

11 For example, while homelessness is likely to remain a problem, the ethnicity of refugee groups can change. Until recently, most assistance was needed in the Vietnamese community but the recently arrived Bosnian community now has the highest need.

However, the cost of this bundling flexibility can be that undesirably short contracts result when there are delays in finalising agreements. Delays in finalising contracts with a fixed end date have meant that the term has been no more than two years on a number of occasions. FACS largely attributes the problems of finalising the successful contractors to the difficulties of making the transition from one funding model to another.

2.5.4 Considering the cost of contracting

The purchaser/provider processes can influence the desirable scale of an individual provider's service. The cost of preparing specifications and bids and assessing them can be high for individual providers and FACS, as can ongoing supervision and monitoring.

Larger contracts may reduce the cost.

Larger contracts may reduce the burden where (as is typically the case) costs as a share of the contract value decline with larger contracts. Some of the larger providers have expressed concerns that in some cases they have had to go through a full tendering process for relatively small contracts, and that these should be consolidated to reduce the costs of the process. However, larger contracts may exclude smaller providers competing on a stand alone basis, although they need not preclude joint bids.

2.6 Managing providers

There are two key elements to managing external providers: monitoring their performance; and creating incentives (rewards and sanctions) for their performance to improve.

2.6.1 Monitoring external providers

Traditionally the monitoring of grant funded providers reflected the input focus of the agreements. Reporting requirements were

designed to establish whether grants were used for the authorised purpose, with data being collected on inputs and processes.[12]

There are benefits from the move to focus more on outputs

At the same time as FACS has introduced purchasing of explicitly defined services, it has also focused more on monitoring performance. FACS considers that improved output monitoring will enhance:

- planning;
- the accountability of providers, FACS and the Government;
- management within each provider; and
- the identification and dissemination of best practice.

... but it requires developing better monitoring skills and processes

The Community Service Division has introduced performance measures in funding and service agreements for a range of program areas. They are mainly broad measures such as the number of clients or hours of service. Most agreements incorporate standards for the management and delivery of service, but FACS recognises that indicators — including data on both the quality and quantity of outputs — need considerable refining.

... although outside expertise can fill skills gaps.

FACS has drawn on outside expertise to develop some performance monitoring frameworks and indicators. A consultancy was let to develop recommendations for the Gambling Rehabilitation Services, which consulted with stakeholders in the South Australian program as well as examining the frameworks adopted in Queensland and Victoria for similar services (Leahy 1996).

FACS is aware of the need to ensure that providers are not unnecessarily burdened by contract monitoring (FACS 1996a, p. 15). TheGambling Rehabilitation Service consultancy noted that:

> ... concern was expressed by several service providers that the

[12] The frequency and detail of monitoring of providers of similar services differs considerably across jurisdictions (appendix A, table A.6).

> time and effort required to provide the necessary information to measure performance may adversely affect available time for case work and that the level of monitoring required bears no relation to the level of funding provided to the program. (Leahy 1996, p. 1)

Monitoring is still largely input focused

The aim is for greater monitoring of outputs and outcomes to facilitate less prescription of inputs, but there has been only some progress to date. The existing practice is for all funded providers to submit quarterly reports of expenditure. However, because they reveal few insights into performance, they receive little attention within FACS and do not generate any feedback for providers. A new reporting system — which is being trialled with a program for individuals from non-English speaking backgrounds — involves six monthly reports in which providers measure their performance against the targets contained in their service agreements. Providers will receive performance feedback and more intensive follow up if there are problems.

... but there has been some progress.

The Community Services Division (the purchasing division) established a performance measurement and monitoring advisory group in early 1996 to improve this area. The group will oversee the development of a performance measurement framework which will span all contracted services, drawing on the expertise of service providers, academics, peak bodies and FACS itself. The group is focusing on mechanisms for measuring effectiveness, efficiency and service quality. Two research projects are under way on how to best measure the performance of youth supported accommodation and family development services.

Determining the ideal time to clarify performance indicators for a purchase agreement is an issue being addressed after FACS's experience with funding a Gambling Rehabilitation program. The approach for that program was to sign service agreements, then develop performance indicators. This allowed service providers to get the service up and running before indicators were developed, but greatly reduced the bargaining position of FACS. It also took considerably longer to finalise indicators than expected. The initial funding

agreement, however, was for only one year, so providers were encouraged to help develop the monitoring instrument before agreements were renewed. If the initial agreements had been longer, the development of indicators may have been considerably delayed.

There may be scope for using the approaches of other jurisdictions.

The challenge of reducing the diversity of performance monitoring approaches adopted across services and jurisdictions is also reflected in Gambling Rehabilitation Services. The approaches adopted for similar services in Queensland and Victoria were examined, but the costs and benefits of adopting another State's approach or developing a joint approach do not appear to have been canvassed. For example, both Victoria and Queensland have adopted the same questionnaire to measure the severity of a client's gambling problem, allowing service performance to be considered in the context of the nature of the client base. FACS adopted an alternative instrument which was considered superior by South Australian practitioners. This may hinder comparisons across States and the ability to learn from approaches used in other jurisdictions.

More diverse services will make monitoring outcomes more important.

Moves to develop a broader range of services for clients will affect the monitoring task. As the range of outputs becomes more diverse, simple output indicators will be less useful for assessing providers and the level of services received by clients. The monitoring of outcomes of combinations of services will need to be enhanced to ensure that the effectiveness of services improves.

2.6.2Using rewards and sanctions

In principle, FACS could reward or sanction external providers in a number of ways, including:

- making bonus payments or applying penalties;
- increasing or decreasing the monitoring of outputs or processes; and
- purchasing more or less in future contracts.

The service agreements concluded to date do not contain a provision for bonus payments. However, FACS can apply penalties through the breach procedures outlined in some agreements.

Continuing the funding will be the primary means of rewarding the community services providers and ceasing funding will be the primary penalty. Annual renewal of grants meant that this avenue has always been open to FACS, but it was difficult to publicly justify the penalty of not renewing a grant when the basis for the initial grant was not well defined. More tightly defined purchasing contracts should ensure that any decision not to select or continue funding a particular provider can be more rigorously defended. The more objective evidence of actual performance should come from transparent performance criteria and effective performance monitoring.

2.7 Transitional issues

The transition from funding on a grant basis to purchasing services has not involved significant changes for some services. However, as noted above, the transition for some other services has been part of their larger restructure. The restructuring has increased the uncertainty faced by these providers, thereby creating greater pressure for timely processes.

There is a trade-off between creating certainty and consultation.

In restructuring its relationship with existing providers, FACS has faced a difficult trade-off between the providers' need for certainty and their desire to be consulted. High levels of uncertainty make it difficult for providers to retain staff and make medium-term plans, but they value consultation which can delay decision making.

The limited experience with purchasing and contracting among FACS's staff and decisions on how to manage the resulting skills gap have also slowed the process. A decision was made to draw the contract management team from the existing staff of FACS, although some use has been made of

outside expertise, including consultants. This has meant that the inhouse team has had to develop improved skills.

2.7.1Reducing transition and transaction costs

FACS has largely developed its own contract specifications and monitoring tools, rather than adapting those of other service areas or jurisdictions. This ensures that they meet FACS's particular requirements, but can add to the transition costs that FACS and its providers incur in moving to a purchasing relationship. The costs are ongoing if this approach leads to less clear specifications or more imperfect monitoring tools.

There are further costs if competition is used to select providers. Greater upfront costs of understanding the service specifications and participating in the process discourage entrants and thus:

- diminish the effectiveness of competition; and
- increase the impact if individual providers fail.

If it is relatively easy for providers of other services or from other States to enter a service area, then potential providers will place competitive pressures on the incumbents and provide some insurance if an incumbent provider fails. If there are relatively high barriers to entry, then it may be necessary to have more incumbent providers by limiting the contract scope (and thereby failing to reap some economies of scale if they exist) to ensure effective competition.

Standardising processes or specifications can reduce the cost.

Adopting, where possible, procedures or practices similar to those used in other markets will reduce barriers to entry. As the Industry Commission noted:

> Standardisation may also lower the costs of submitting tenders for those who bid for more than one government contract, since they avoid the training and administrative costs required to deal with a variety of contract formats.
>
> Standard contracts provide a base contract, flexible enough to facilitate the incorporation of service or organisation-specific requirements, while reducing the need for individual agencies to

> reinvent the wheel. (1996, p. 335)

FACS will need to explore the potential to further standardise elements of the tendering process. This may mean foregoing some of the benefits of having procedures or practices tailored to FACS's particular needs. In addition, FACS will need to ensure that it retains sufficient information on the activities to adequately brief potential entrants about the characteristics of the services and the risks faced by providers.

2.8 Emerging issues

The transformation of relationships between FACS and external providers into purchaser/provider arrangements puts structures in place which embody the South Australian Government's '..expectations for greater accountability, clarity of purpose, focus on performance and ... the push for further savings and efficiencies' (FACS 1995b, p. 1).

FACS is acquiring the skills to specify complex human services and to monitor providers against those specifications. As noted earlier, the steps taken to date in the internal restructuring of FACS have not yet extended to creating a purchasing framework for departmental units providing services to external clients. Nor did it extend to transforming the relationship with the majority of providers in the Home and Community Care program. As FACS gains experience with contracting in these areas and as the benefits become apparent, the costs and risks of extending this approach to internal providers and the jointly funded programs decline.

2.8.1 Moving other providers to a purchasing environment

Other providers remain grant funded

As mentioned earlier, FACS has so far adopted both aspects of the purchaser/provider arrangements — the separation of responsibilities and the implementation of a contractual relationship — for only some of the programs it funds. For example, the providers of services under the Home and Community Care program (who receive annual grants of

almost $60 million) are still largely grant funded.

... while the internal providers are still input funded.

FACS is taking some steps along the path which would enable the purchasing framework to be extended to internal providers. The first task in doing so is to specify the service. FACS is undertaking a pilot project looking at ways of addressing this issue for child protection. Three of the 19 FACS district offices are trialling a UK model to improve practice standards and the monitoring of outcomes of child notification cases. The methodology ensures that certain information is collected in a consistent format, and that it is collated using a computer software package. This offers improved output and outcomes data on which to base future service agreements.

If FACS continues its policy of outsourcing internally provided services as opportunities arise, then more services may be contracted in the future. This may increase the urgency in developing service specifications. During the Industry Commission's inquiry into *Competitive Tendering and Contracting by Public Sector Agencies* (IC 1996), a number of participants suggested that service specifications for the first contract were rarely perfect. Yet as the agency gains experience and skills in this area, the likelihood of poor specification diminishes. The Industry Commission concluded that it:

> ... considers that this 'learning curve' may have important implications for the phased introduction of CTC [competitive tendering and contracting]. Indeed, agencies should take into consideration the likely improvements in service specifications over time when making decisions on putting services to tender. The potential for such improvements also suggests that agencies should introduce service specifications for internal providers in preparation for the possible introduction of competitive tendering. (1996, p. 327)

Better specifications and monitoring skills reduce the risks of introducing competition among providers, and increase the potential benefits.

2.8.2 Exposing inhouse providers to competition

Competitive neutrality has not yet been a major issue.

At this stage, competitive neutrality has not emerged as a key issue because the main effort has been to foster some appropriate competition within the community sector, rather than between inhouse and external providers (box 2.5). However, this may be more of an issue in the future given that FACS's business plan states that one of its strategies is to:

> ensure there is appropriate competition for functions where there is no justifiable rationale for Government as a sole provider. (1996d, p.11)

Box 2.5: Factors influencing the choice of services to expose to competition.

FACS chose to first introduce competition for services that are currently provided externally rather than for the internally provided services. It considered:

- *current legal constraints*. It is unclear under existing legislation to what extent FACS can delegate the powers to administer some functions currently done internally, such as child protection investigation and case management of children under the care of the Minister.
- *review of functions*. Some internally provided services are under review and introducing contracted providers could constrain policy flexibility. In contrast, the reviews have already been undertaken for a number of externally provided services, reducing the cost of any constraint on policy flexibility caused by contracting.
- *service-specific factors*. Service specifications, standards and levels of outputs for some internally provided services are considered too imprecise for contracting. The consequences of service failure for many of these services is high, and FACS has no experience in managing them when the service is delivered by external providers. In contrast, with services currently provided externally, FACS is already bearing the risks of external provision and must only ensure that changes do not unnecessarily increase these risks.
- *market-specific factors*. The internally provided services have not been purchased in the past, so the existing provider market may be undeveloped. This depends on whether similar services are purchased by FACS or other agencies in South Australia or elsewhere.
- *agency-specific factors*. FACS has yet to develop the contract management skills (and/or acquire them from outside) to select providers and supervise them for the higher risk services.

Nevertheless, FACS has been outsourcing internally provided services as opportunities arise. Examples are the transporting of young offenders and alternative care placement services.

... but may emerge if inhouse services are subject to CTC and if inhouse bids are accepted.

Issues of competitive neutrality in bid preparation and selection processes would become a more significant issue if FACS moves to more direct competition between internal and external providers. FACS's Field Services has only participated in a competitive process once, when it competed with providers from the community sector to provide the coordination and development service for the Gambling Rehabilitation program. The Director of the Community Services Division (the purchaser) absented himself from any executive discussion in the bid preparation, and officers of FACS from the respective purchasing and provider divisions were instructed not to discuss the process with each other. However, an unsuccessful bidder expressed some concerns about the costing of the inhouse bid and about whether 'Chinese walls' that preclude information flows can be particularly robust in an integrated department.

Costing will then become larger issue.

Determining the appropriate costing formula involves difficult conceptual and practical issues. The formula adopted is likely to become more contentious if inhouse bids are prepared should FACS subject previously internally provided services to competitive tendering and contracting. As the policy notes:

> The Residential and Youth Services Division will provide community residential care services. That Division and Community Services Division will enter into integrated planning to ensure the most appropriate and effective incorporation of these services into the range of alternative care options. The Policy recognises the option for these services to become contracted, and it is a requirement of the Government that the Department explore the feasibility of that option during the first funding period. (FACS 1995a, p26)

This service must therefore be reviewed before 2000.

For-profit providers may show more interest if and when services currently produced by FACS's Field Services Division and Residential and Youth Services Division are put

out to tender. For example, many juvenile detention centres in the United States are operated by for-profit operators, including some of the operators who manage adult correctional centres in Australia.

2.9 Conclusion

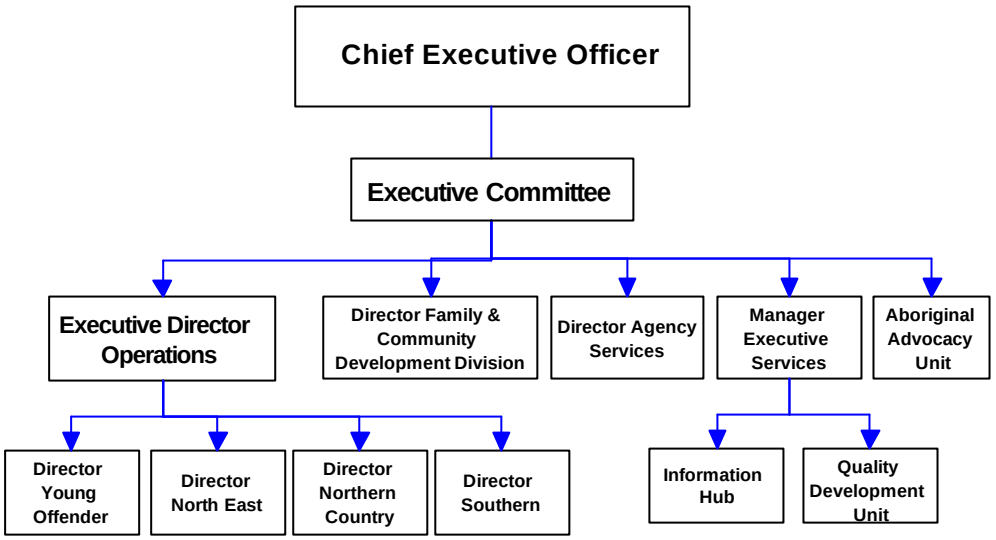
FACS's move to purchaser/provider arrangements for delivering some services has driven the development of more explicit specifications of those services. The move to a purchasing relationship with external providers has complemented the parallel reforms of greater targeting and competitive tendering. It has also led FACS to be more explicit about the essential characteristics it wants from each service and its providers, and it may better clarify when not-for-profit providers should be favoured over for-profit providers. However, FACS has yet to develop a systematic approach for considering clients' views as well as the providers' views when formulating service specifications.

Some characteristics of human services make them more complex and difficult to define and measure. But this process must be done well for the move to a purchasing relationship to be effective. It can be costly, although the costs to FACS and its providers will be reduced if greater experience leads FACS to better standardise specifications and processes and/or to better recognise what can be adopted from other service areas or jurisdictions. This appears to be happening, and will be important to the ability of smaller providers to participate in the new purchaser/provider arrangements.

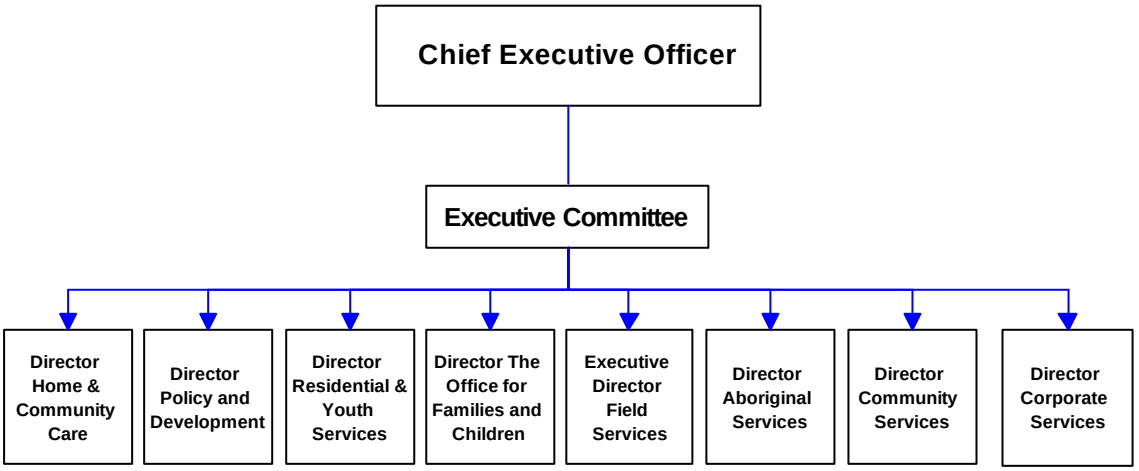
The reforms in FACS's relationship with external providers — with more explicit specifications and performance monitoring, and a greater role for competition — will create greater pressure for similar reforms of inhouse services.

Attachment 2.1: Department structure

Organisational Chart as at June 30, 1994



Organisational Chart as at June 30, 1995 (Current)



Sources: FACS (1994, p. 7) and FACS (1995b, p. 7)

3 CASEMIX FUNDING OF PUBLIC HOSPITALS IN VICTORIA

Public hospitals in Victoria were traditionally funded on an historic cost basis — that is, on the basis of the previous year's expenditure. In 1993–94, the then Victorian Department of Health and Community Services moved to output based funding for acute inpatient care which is a significant part of hospital services.

3.1 This case study

This case study examines how Human Services Victoria (formerly the Department of Health and Community Services) developed and introduced an output based funding component for a complex human service. The case study focuses on how the Department designed these changes, how environmental factors affected implementation, and what lessons are to be learned.

3.2 The reform

On 30 June 1993, the Victorian Government introduced funding of public hospital inpatient services which is directly based on the level and composition of output (measured in terms of 'casemix')[1].

This funding arrangement was designed to provide explicit incentives for hospitals to improve efficiency, in contrast to the previous funding system which focused on inputs and processes of service delivery (box 3.1).

[1] Casemix is the mix and number of patient care activities undertaken by health services providers (AIHW 1996). It can describe a wide range of health activities, including admitted patient care, non-admitted services and other forms of non-inpatient care.

Box 3.1: Victorian public hospitals

Public hospitals are an important part of the health system. In Victoria, over 150 separate public hospitals treated more than 845 000 admitted patients and provided over seven million occasions of non-admitted service in 1994–95, at a cost of $2.4 billion (SCRCSSP 1997).

Because many of Victoria's hospitals were established by charities and other organisations independent of Human Services Victoria, they have traditionally had a considerable degree of autonomy. Today, most hospitals are government owned although some are owned by charitable organisations. Government owned hospitals are run by metropolitan network and rural hospital boards of management independent of the Department.

Before casemix funding, the level of recurrent funding was largely based on levels in the previous year, while capital expenditure was allocated directly by the Government on the basis of submissions.

3.2.1 Incentives and disincentives

The broad objective of casemix funding is to improve the efficiency and effectiveness of hospital services, whatever the budgetary environment. Guterman et al. (1988) suggested that such funding systems change '... hospital behaviour by directly altering the economic incentives facing hospital decision makers' (p67).

In Victoria it was expected that efficiency and effectiveness would be promoted by:

- a greater focus on costs and benchmarking, with hospitals encouraged to understand the costs of treating patients;
- increased output to address waiting time concerns;
- the increasing shift of resources to efficient hospitals from those that are less efficient. According to the Department, this would occur as hospitals assessed their services against the State average for quality and cost, and as they competed for additional throughput funding (DHCS 1993b p.6); and

- increased specialisation, with hospitals expected to focus more on those services for which they have a comparative advantage.

To facilitate these objectives, more information would be available to hospitals and the Department on the services provided to admitted patients and the costs of those services. This information could be used to highlight where performance could be improved.

While casemix funding provides incentives for providers to operate more efficiently, there can be unintended side effects. Some are intrinsic to any output based funding mechanism — such as heightened incentives for hospitals to exaggerate complications associated with a case and to encourage unnecessary admissions — while others — such as cost shifting and reducing the quality of care — are partly the result of environmental factors influencing decision making.

3.3 Environmental factors

The two most significant factors influencing when and how casemix funding was introduced were: the desire to encourage increased efficiency within the public hospital system; and a commitment by the new government to cut expenditure.

Outside factors affected policy development.

There was a perception within the Victorian Government that inefficiencies in Victoria's public hospital system meant that there was scope for significant improvement in efficiency and that there were savings to be made. Although based on imperfect information, interstate comparisons of hospital performance suggested that Victorian hospitals were more costly to operate than those in other states. For example, the Victorian Commission of Audit (1993) found that Victorian hospitals were nine per cent more costly to operate those in NSW (p. 81).

Box 3.2: Issues of casemix funding

The introduction of casemix funding presented issues for Human Services Victoria, public hospitals and other health service providers which needed resolution before casemix funding could be successfully introduced. These are outlined below:

Human Services Victoria:

- determined the appropriate grouping system;
- developed a pricing system, including establishing the price, selecting cost weights, and determining which components of cost are fixed and variable;
- developed an outlier policy;
- developed a quality management policy;
- developed measures to prevent gaming;
- decided what accounting system is to be used; and
- developed transitional funding arrangements.

Further down the track, the Department:

- developed a policy for psychiatric, geriatric and post-acute patients and children; and
- developed measures to address cost shifting.

Public hospitals:

- identified true costs by upgrading coding systems and information systems;
- identified and introduced quality measures; and
- identified and introduced efficiency measures:
  - to reduce staffing levels for a given level of output;
  - to increase same day provision;
  - to move nursing home type patients to more appropriate forms of care;
  - to improve clinical protocols (that is, pre-admission, admission and discharge practices);
  - to encourage organisational restructuring through clinical budgeting; and
  - to improve teamwork and coordination.

Other service providers identified measures to care for patients who have been discharged earlier than they would have been under the previous system.

To achieve budget savings, the Government, at the same time as introducing casemix funding, cut funding to the acute care program by 10 per cent over the two year period 1993–94 and 1994–95. This was in addition to a four per cent cut in 1992–93 (Health Solutions 1994, p. 37.)

The Department considered that budget cuts of this size would be a significant shock to the public hospital system in Victoria. Moreover, it considered an across-the-board cut to all hospitals would place too much pressure on the costs of efficient hospitals (perhaps resulting in a decline in the number and/or quality of services) and not enough pressure on inefficient hospitals (Duckett 1994). The Department felt that funding according to casemix was a more equitable way of imposing budget cuts and achieving the desired efficiency improvements.

Extensive work had been done on casemix development.

Other environmental factors had a more direct effect on the development of the funding system. First, early policy development work on casemix funding can be traced back to the mid-1980s. For example, in 1985, the then Health Commission of Victoria commissioned a report on the applicability of an American classification system in the Australian context (Duckett 1994). Moreover, the Commonwealth Department of Health and Family Services had been funding the development of the necessary policy tools and technical infrastructure to introduce casemix funding for Australian hospitals since the late 1980s (through its Casemix Development Program)[2]. The availability of this preparatory work influenced the decision to focus on acute inpatient services. Second, the imperfect information about the achievable costs of supplying hospital services at the time casemix was introduced influenced the price setting process. These factors are discussed in sections 3.4 and 3.5.

[2] The Economic and Budget Review Committee Report (1992) on Health Service Agreements recognised the benefits of casemix and the work which had been done by hospitals and the Department recommended a phased introduction of casemix funding for Victorian public hospitals.

3.4 Specifying outputs

The first challenge in designing an output based funding system is to define output. For medical services, it could range from an episode of care (for example, from pregnancy to three months after birth) to an individual service (such as a day in hospital).

The Department focused on hospital services.

In Australia, there are many providers — for example, general practitioners, hospitals, nursing homes, community health services, etc. — but little integration of services, partly because the responsibility for funding services is split between the Commonwealth Government and the State and Territory Governments. Services are not integrated at the provider level, so it is difficult to accurately identify from their records the start and finish of an episode of care such as pregnancy through to birth.

The Victorian Government decided to focus on services provided by public hospitals because:

- these services accounted for most of its health expenditure;
- it directly controlled the funding arrangements; and
- output measures were readily available.

3.4.1 Defining hospital outputs

Funding changes applied to acute inpatient services.

Duckett (1994) identified four major outputs of hospitals: admitted patient services; non-admitted patient services; teaching and research; and other services. The principle of payment by case need not be confined to acute inpatient care. Episodes of illness and/or care have also been defined and categorised with respect to non-acute and outpatient care. However, it was decided in Victoria to initially concentrate on casemix definition and funding in the acute inpatient field because:

- it is the most expensive treatment setting, both in terms of cost per case and total resource use[3];
- a report prepared by Scotton and Owens (1990) as part of the Casemix Development Program outlined a process for implementing casemix funding for acute inpatient services. By contrast, the policy developed for non-inpatient and other services was not as far developed, and the short implementation schedule precluded more development work in those areas; and
- acute inpatient episodes are more easily defined in principle and are more straightforward to administer in practice, because the beginning and end of an episode are constituted by formal admission to, and discharge from, registered short-term hospitals.

Funding for outpatient services continued on an historical basis (adjusted for the budget reductions), as did funding for other inpatient services. Teaching hospitals received a grant to cover training and development expenses. Other grants were paid to cover other hospital services provided such as rehabilitation and organ transplant programs. Psychiatric services delivered in hospitals continued to be funded through a separate program[4]. Capital expenditure was also excluded from casemix funding. The issue of incorporating capital into case payments is discussed in section 3.9.1.

3.4.2 Classifying outputs

The next step was to consider the output definitions to be used. Unlike other human services, providers of hospital services are able to produce a wide range of outputs (in this case, treated patients). Fetter and Hines (1996) suggested that a sensible starting point is to try to group patients into common classes.

[3] It is estimated that inpatient services accounted for almost 78 per cent of total recurrent funding in 1994–95 (SCRCSSP 1997, p. 219).

[4] Output based funding mechanisms are at different stages of development for these activities. Victoria has developed its own ambulatory care classification system (see section 3.9.2) and the Commonwealth is developing a system for psychiatric services (Duckett 1995).

The most well-known classification is based on diagnosis related groups (DRGs). It was developed at Yale University and adopted by the United States Government in 1983 to fund inpatient care of Medicare patients.

A new classification system was developed for Australian hospitals.

The Victorian Department of Health and Community Services and clinicians from across the country worked with the Commonwealth Casemix Development Branch to modernise and standardise US DRGs for use in Australia. The Australian National Diagnosis Related Groups (AN–DRG) Version 1 was released in October 1992 (then comprising 527 classes) and used by Victoria in 1993–94.

The AN–DRG classification system groups together people with similar diagnoses and similar resource usage, but the costs of treating individual patients will still vary. That is, some patients have treatment costs that lie at either end of the standard distribution.

This problem may partly arise because outputs are not well defined initially. The ability to deal with patient complexity was one shortcoming identified with the first version of the AN–DRG classification system: the grouping was mainly determined by length of stay, and it did not take account of patient attributes. Version 3 of the system has sought to overcome this problem by including other factors when defining groups — most notably the age of the patient. The result was an increase in the number of AN–DRG groups (box 3.3).

3.4.3 Defining quality

There has been considerable debate about the impact that casemix funding may have on the quality of acute inpatient services. It is difficult to include quality standards as part of the defined output, largely reflecting the fact that many variables (external and internal) affect the well-being of patients.

Box 3.3: AN–DRG Version 3

Version 3 of the AN–DRG classification system was introduced into Victorian hospitals in 1996–97. It included an extra 140 categories to better deal with patient complexity. For example, all fractures of the hip or femur were grouped together under version 1. In version 3, fractures of the hip or femur were disaggregated to identify fractures with complications; fractures without complications for people younger than 75 years of age; and fractures without complications for people older than 75 years of age. Similarly, skin grafts for injuries were split into three separate groups: skin grafts for injuries to lower limbs; skin grafts for injuries to hands; and skin grafts for other injuries.

It has been argued that pressures to improve efficiency may result in providers lowering costs and quality by discharging patients early or by replacing resources with lower cost, less effective substitutes. On the other hand, it has also been argued that the quality of services may rise as providers become more efficient and improve resource management.

The incentive for providers to maintain or improve service quality can be increased when, among other things, casemix funding is linked with mechanisms to promote competition among providers. In this instance, quality becomes an important component of product differentiation as providers compete for clients.

In Victoria, a number of mechanisms were put in place to ensure the quality of services, such as monitoring the quality of care and introducing an element of competition. These are discussed in sections 3.5 and 3.6.

3.5 Setting the level and structure of prices

Until the mid-1980s, information on the costs of Victoria's public hospital services was based on notional costs. The Department recognised the need to improve costing information and move towards clinical costing models. To this end, a significant proportion of the State's funding from the Casemix Development Program was spent on expanding the

information infrastructure of hospitals. The Department later used this information to develop its policy for casemix funding.

3.5.1Determining the price

The price paid for each unit of service ultimately influences the behaviour of providers. In determining the price, the Victorian Government aimed to achieve efficiency gains and to increase the level of throughput (thereby reducing waiting lists).

The Department of Health and Community Services had two options when determining the price paid per output: it could let the market set the price, or the price could be set centrally.

In setting the price, the Department considered

Allowing the market to set the price would involve providers (public hospitals) bidding for services. This approach has the advantage of leading to a more efficient allocation of resources, but to be effective, it needs a functioning market environment for hospital services. At the time casemix funding was introduced, the Department took the view that there was no developed market and that the necessary efficiencies could be achieved through a centrally determined price per unit of output.[5] Three issues had to be considered:

- the structure of the price;
- the price level; and
- how to adjust the price to take account of variations among outputs.

... the structure of the price

Hospitals have high fixed costs and produce numerous joint products. Moreover, some costs are more directly related to short-term changes in output than are others. For example, an increase in the number of patients treated may result in increased nursing and pharmaceutical costs but, because of

[5] The price is determined centrally in all jurisdictions that use casemix funding (appendix B, table B.5).

indivisibilities, may not affect overhead costs such as administration.

The pricing system developed for Victorian hospitals was based on this concept of various components of cost being more or less directly related to small changes in output.

Hospitals receive a fixed payment per standardised separation[6] — based on the minimum number of patients they expect to treat in a year — which covers general operating expense. They also receive a variable payment per standardised separation which covers pharmaceutical costs, medical and nursing costs and theatre costs. Hospitals exceeding the minimum specified at the beginning of the year receive only the variable payment for the additional output. This provides the incentive to expand output without putting undue pressure on the capped health budget.

Initially, half of the costs associated with treating a patient were assumed to be fixed and half were assumed to be variable (Duckett 1994). The Department recognised that this balance would change over time because:

- budget cuts were targeted at the fixed component of the price (because overheads presented the most scope for efficiency improvements); and
- the proportion of funding accounted for by variable payments would increase as hospitals responded to other incentives introduced to increase throughput (Duckett 1994).

For 1993–94, variable costs accounted for 57 per cent of the payment made per standardised separation. By 1996–97, this share had risen to 66 per cent (DHS 1996b).

[6] A separation refers to the discharge of a patient. Adjustments are made to reflect differences in treatment costs. (These adjustments are discussed in later sections.)

... the level of the price

The price level that was determined by the Department of Health and Community Services was influenced by the total level of funding available to it which, in turn, was affected by the Victorian Government budget position and the Commonwealth/State funding arrangements (that is, the Medicare Agreements between the Commonwealth and State Governments). This limited the amount of money available for public acute care services in Victoria.

The Department also had to decide whether the price should be set according to average performance or at some margin over 'best practice' performance. A price based on average performance could have problems. It assumes that every provider is able to produce services close to the average; that is, it assumes that each provider will have some services which they produce at a cost higher than average and some which they produce at a cost lower than average. However, there may be instances where a provider has costs above the average for all services. If that provider remains uncompetitive and is forced out of the market, then the average becomes lower and more providers may be forced to leave.

To avoid this problem, the Department initially set a price based on a margin over best practice using cost data from hospitals throughout Victoria and other states and territories[7]:

> The amount used as the basis for determining payments to hospitals was essentially derived from the cost structure of the most efficient hospitals in the State ... A relatively small number of hospitals, of all size and types, was able to treat patients at a lower cost than this and therefore this price was seen as achievable and fair. (Duckett 1994, p34)

The Victorian Government recognised that best practice may vary according to the location, scale and type of hospital. For example, the price for ordinary care payments per standardised separation was increased for rural and isolated hospitals (by $14 and $35 respectively). The Department of Health and Community Services considered that this increase recognised

[7] A number of methods were used to establish the level of the price across jurisdictions (appendix B, table B.5).

the extra transport costs incurred by these hospitals when transferring their patients to larger hospitals for treatment.

The Department also recognised that teaching hospitals incurred extra costs which were attributable to unmeasured additional services. In this instance, however, the Department decided to fund those services directly rather than provide an indirect subsidy for each patient.

... and the cost weights of each DRG.

Because hospitals are able to produce a large number of different outputs, cost weights are used to determine the amount to be paid to hospitals for each different DRG. Cost weights are used to adjust the basic price to reflect the different costs associated with treating patients with different diagnoses[8]. In effect, cost weights act as 'exchange rates' and allow the strategic and operational decisions about the mix of services supplied to be made at the level of the hospital and their clinicians.

The challenge is to use a credible set of resource weights. Jackson et al. (1994) suggested that:

> An accurate estimate of cost relativities between types of cases is essential to the fairness of any case payment system. Fairness, in turn, is fundamental to ensuring that the payment system does not create incentives to provide some forms of care at the expense of others, thus distorting access to the full range of hospital services which may be needed. (p1.)

Victoria had the options of: using US cost weights; using a set of national cost weights for AN–DRGs developed by the Commonwealth Government; or using its own set. It was decided that US cost weights would not be appropriate in an Australian setting. Thus, because the national cost weights were unavailable for the first year of casemix funding, Victoria

[8] For example, a hospital treating a patient diagnosed with a condition which has a cost weight of two will receive twice the standard payment. Similarly, a diagnosis with a cost weight of 0.5 will attract half the standard payment. These are referred to as DRG weighted separations and reflect the standard costs associated with a particular ailment.

used its own set to apply to the Australian version of DRGs.[9] A sample of 10 per cent of total admissions in 1992–93 (obtained from five hospitals) was used to produce these weights.

National cost weights were released in August 1993 (two months after the introduction of casemix funding in Victoria), and a study undertaken by Health Solutions (1994) found about 80 per cent comparability between the Victorian weights and the national weights. The Victorian Government has continued to develop its own set of cost weights because, as explained by the then Director of Acute Health Services in Victoria, Dr Michael Walsh (1995):

> ... in comparison to the KPMG national weights, our cost weight studies use hospitals that we know have got reliable clinical costing systems in place. We believe that the data [are] more reliable, so for that reason, we use our own. (p.7)

A second cost weights study was released in 1996 using a sample of almost 50 per cent of total admissions in 1994–95 (obtained from 16 hospitals), leading to greater confidence in the results.

There have also been changes in the way that certain costs have been allocated. In 1995–96, for example, the Department of Human Services recognised that there were problems with the supply of prosthetic cost data. Adjustments were made for the 1996–97 cost weights.

For a number of reasons, it may be desirable to revise cost weights regularly.[10] These include changes in technology, changes in clinical practice, changes to the patient mix within each DRG, and changes necessary to correct any shortcomings in the funding system. Moreover, there is a relatively low direct financial cost of collecting the information.[11] However,

---

9 Most jurisdictions use the national cost weights (appendix B, table B.4).

10 Victoria, NSW, Queensland, Tasmania and the NT adjust their cost weights annually (appendix B, table B.4).

11 The Department estimates that it spends approximately $250 000 each year on cost weight studies out of an annual budget of $2.1 billion for acute health services in

changes must be weighed against the lack of certainty created by frequent changes which could alter the incentives for long-term investment.

3.5.2 Funding exceptional cases

Risk management poses challenges

Within every DRG, there are likely to be a number of cases with costs significantly above or below the average. It is important to develop a policy to take account of these exceptional cases (also known as outliers) because they may expose purchasers and providers to considerable risk. For example, high cost patients may expose providers to financial risks because the standard payment for that treatment may not cover all reasonable expenses. On the other hand, making full payments for low cost patients may expose the purchaser to the financial risk of overpaying providers.

Not adjusting for exceptional cases may adversely impact on the mix of patients. For example, not adjusting for high cost patients may provide hospitals with incentives to restrict the number of high cost patients treated and to focus their efforts on low cost patients. Similarly, payments that are too high for low cost patients (especially same day cases) could encourage providers to treat patients as inpatients rather than outpatients.

... and adjustments must be considered carefully.

In developing an appropriate policy, it is important to recognise the tradeoff between minimising risks to providers and purchasers and reducing the incentives for better resource use. For example, adjustments for high cost patients effectively fund inputs and weaken incentives for more cost-effective forms of treatment. Similarly, sharply reduced payments for low cost patients could result in providers prolonging stays in hospital to the threshold period (Scotton and Owens 1990). It is also important to recognise the administrative costs of developing a policy and implementing it.

1996–97. Hospitals incur costs in providing data for the cost studies. However, although much of these data are necessary for internal management decision making, other management costs may be incurred in preparing data in the form necessary for the cost weight studies.

A number of approaches for dealing with exceptional inpatient cases use length of stay as a proxy for cost. Exceptional cases are defined in terms of the variance from the average length of stay. A relatively narrow band of standardised patients produces a generous definition of an exception case. This reduces the risk to providers that the price paid per case will not cover treatment costs. But it also results in a far greater number of exceptions to be managed. By contrast, a wide range will reduce the number of exceptions but increase the risk that the payment per patient will not cover all costs (McGuire, Bender and Maskell 1995).

In Victoria, providers receive an additional payment for high stay patients[12] (see box 3.4 for other adjustments for high cost patients), while payments for low stay patients are discounted. However, the Department has continued to modify the method of calculating payments for exceptional cases, perhaps reflecting the difficulties discussed earlier. For example, initially, low stay patients included same day admissions. However, improvements in technology have increased the proportion of patients that can be treated on a same day basis. To deal with this, the Department has established separate cost weights for some same day treatments for 88 DRGs. Other same day treatments continue to receive a fixed percentage of the normal payment.

12 The relative cost weight for a high (or low) stay case is adjusted to incorporate the payment for additional (or fewer) days. This adjusted case is referred to as a weighted inlier equivalent separation (WIES). This forms the basic unit of funding for Victorian hospitals. However, for ease of understanding, this chapter will continue to use the term ‘standardised separations’.

Box 3.4: Other adjustments for high cost patients

While length of stay is a useful proxy for cost, it does not reflect all the other variations in costs which may be incurred by hospitals treating high cost patients. Recognising this, the Department introduced a number of other measures to counteract any distortions created by high cost patients.

- The training and development grant paid to teaching hospitals partly reflects the complexity of the patients treated.
- A supplement is paid for each public patient to account for the increased costs of providing medical services to those patients compared with private patients.
- Hospitals receive a payment for each nursing home type day to cover the costs of non-acute inpatients.
- Hospitals receive an additional payment for the use of mechanical ventilation equipment where this is not already included in the treatment cost.

3.5.3 Improving competition

Casemix funding can have a direct impact on the level of competition among providers if prices are set competitively (that is, if providers have the option of bidding for services). However, by deciding to centrally determine the price for acute health care services, the Victorian Government precluded direct competition among public hospitals.

However, the current system does allow for yardstick competition among providers. Under casemix funding, efficient hospitals (that is, those able to treat patients at or less than the set price) will, in the long run, receive an increasing proportion of the funding set aside for acute health care services. In this way, casemix funding promotes an indirect form of competition among providers. To maintain this form of competition, the Department annually adjusts the cost weights and the price paid per output.

Providers compete for additional patients.

In addition, the Department initially set aside a fixed amount of funding ($39 million) to fund any increase in the number of patients treated.[13] Hospitals were to be funded from the 'additional throughput pool' in proportion to their share of the State's additional activity. The Department guaranteed a minimum payment of $600 per unit of care. The pool was allocated quarterly. The arrangement continued in 1994–95 although an escalating rate of throughput, particularly by larger hospitals, '... threatened the availability of any pool funds for all other hospitals' (Health Solutions 1994). The Department responded by increasing the pool and adjusting the base rate of output of most hospitals.

In 1995–96, a new incentives pool was created, replacing the additional throughput pool to fund patients beyond targets. Increases in throughput at each hospital were funded at a declining rate of payment.

The funding model for 1996–97 split the total forecast increase (or additional throughput) into two pools: option cases (or patients) and bid cases. All are paid at the fully variable rate. Option cases comprise the bulk of the additional throughput and these are allocated to networks (box 3.5) and non-metropolitan hospitals on the basis of demand and past achievement of targets. Networks and hospitals can accept all or some of these option cases. Unallocated option cases and the remainder of the additional patients are defined as bid cases, and hospitals and networks across the state can bid for these extra cases.

Various other measures have also been implemented to improve competition among providers — for example, tendering on the open market for the provision of particular services, such as lithotripsy (a treatment for kidney stones).

[13] Additional throughput or incentive pools are also used in Queensland, SA and the ACT (appendix B, table B.7).

Box 3.5: Metropolitan networks

While casemix funding addresses the issue of improving the technical efficiency of Victorian public hospitals, there is still the issue of ensuring that the right mix of services is available to meet the needs of the community. This was particularly an issue for metropolitan hospitals as the population distribution within Melbourne changed.

To address this issue, the Department abolished the boards of Melbourne's 31 hospitals and created seven networks which encompassed all metropolitan hospitals. The Department hoped to '... facilitate the integration of health services and allow more localised, detailed and rational planning of a range of services for a given community' (Metropolitan Hospitals Planning Board 1995, p. 40).[14]

Networks (which comprise a CEO that is answerable to a board of management) came into effect on 1 August 1995 and hospitals ceased to be legal and financial entities. Networks were made responsible for planning and developing hospital and community based services across a geographical area. Networks negotiate a target level of output with the Department and receive funding on the basis of that target. Networks then deploy resources to hospitals. They can change the mix and level of services across hospitals. Managers at the hospital level are still responsible for each hospital's day-to-day planning, operation and control.

Networks are accountable for the provision of services and so are responsible for performance monitoring. In addition to the information requested by the Department, all networks also collect information for their own monitoring purposes. The networks impose financial penalties for those hospitals not meeting targets, and have the authority to replace the management of a non-performing hospital. In this way, the networks try to encourage better performance.

3.6 Managing providers

The challenges of implementing casemix funding are not confined to developing the appropriate classification systems and pricing structures. They also involve developing systems to ensure that the system is working effectively. This includes monitoring the performance of providers and applying rewards and sanctions. These issues are discussed below.

[14] The Inner and Eastern Healthcare Networks were merged on 1 July 1996.

3.6.1Financial monitoring and coding audits

The Department monitors

Before casemix funding was introduced, Departmental monitoring of Victorian public hospitals focused on inputs and processes with crude output measures. The move to output based funding was accompanied by a range of improved monitoring systems.

... output levels,

Every month, networks provide basic financial information to the Department, such as entity surplus/deficit before and after depreciation, operating fund surplus/deficit and current asset ratio. Networks also supply information on the number of patients treated each month and the estimated cost per inpatient. The casemix of networks is monitored monthly but is not considered a reliable indicator of performance because changes may be seasonal and/or influenced by short-term environmental factors.

... waiting lists and coding practices.

Networks also supply information on access to emergency and elective waiting times. Option and bid targets are monitored to ensure that unmet targets are not being accumulated. The records of hospitals are monitored to ensure that patients are coded accurately. The Department conducts a random audit of 1 per cent of medical records to deter wide scale and systematic upcoding.

In the Department's view, these changes have shifted the focus of monitoring from inputs to outputs, reflecting the nature of the purchaser/provider relationship established.[15]

3.6.2Monitoring the quality of care

The first step in monitoring the quality of care is to specify what is to be expected. Next, the purchaser must decide whether to upgrade existing internal quality assurance (and quality

[15] Most jurisdictions reported that hospitals now supply more detailed information more quickly (appendix B, table B.7).

improvement) requirements, or to add another layer of external review.

Each approach has its problems. According to Owens (1993) hospitals could simply comply with requirements if internal review processes are the only form of quality assurance. Given few incentives to improve quality, hospitals may pay little attention to outcomes.

However, external regulations may stifle existing or future internal review processes. A system that focuses on identifying errors in the process or poor outcomes could be inconsistent with one that emphasises system errors *and* continuous improvement (Owens 1993).

Internal and external processes ensure the quality of services.

It was recognised that various quality controls were already in place in Victorian hospitals, such as processes of medical registration and well-developed peer review and quality assurance processes. However, the Department also imposed external regulations to maintain the quality of services:

- *accreditation.* Additional funds are made available to those hospitals that are accredited by the Australian Council on Healthcare Standards (ACHS). Alternative forms of accreditation, such as ISO 9000, will also be considered by the Department;
- *quality assurance plans* Hospitals that are not accredited will be required to submit their quality assurance plans to the Department; and
- *quality committees.* Quality committees have been established to help create an integrated model for promoting quality in the public hospital system.

Finally, there must be some way for the purchaser to monitor the outputs to ensure that quality is being maintained. In this instance, the Department relies on performance data (measuring

the rate of unplanned readmissions) and patient satisfaction

surveys (box 3.6).[16]

Box 3.6: Patient satisfaction surveys

Human Services Victoria developed a patient satisfaction survey to ensure that the quality of inpatient services in public hospitals was maintained after casemix funding was introduced. About 1 per cent of patients discharged from public hospitals are surveyed about six weeks after their discharge.

The survey asks patients about:

- any problems they experienced while in hospital;
- how much information they were given on their treatment; and
- how clear explanations were about coping at home.

The survey was developed in three stages. Stage 1 involved adapting a questionnaire developed in the United States for local conditions by surveying a small number of patients from two hospitals. Stage 2 involved surveying 5000 patients from 30 hospitals. The process is being reviewed based on these results, including an evaluation of how participating hospitals have used survey results to change processes and procedures. Stage 3 will involve refining the survey and extending it to all public hospitals across Victoria.

Sources: Duckett (1994); DHS (1996d).

3.6.3 Using rewards and sanctions

The funding arrangements developed in Victoria allow for both rewards and sanctions to be applied to public hospitals. The rewards — gaining market share; retaining some of the gains from efficiency improvements; and having autonomy — are each discussed below. A separate section discusses the ways in which the Government may deal with nonperformance.

Gaining market share

Output could be adjusted in two ways under casemix funding. The Department could increase the base level of output to be provided by hospitals and/or pay hospitals that are performing well to increase output beyond their base level. The funding tools used to achieve the latter have changed over time as a

[16] These measures to ensure quality are used to varying degrees by other jurisdictions (appendix B, table B.9).

result of attempts to balance a higher output against a fixed or capped overall budget for hospitals.

Option and bid targets developed for the 1996–97 model clearly reflect the Department's desire to reward efficient hospitals while sanctioning less efficient hospitals. Options, for example, will be awarded, in part, based on past achievement of targets. Those hospitals that have performed well in the past will be given the option to increase their output.

Retaining the efficiency dividend

Under current arrangements, a network or rural hospital may retain the difference if it is able to treat a patient at less than the DRG price. This provides an incentive for managers to enhance efficiency.

There is a risk that the incentives to encourage better resource use may be counteracted when adjustments are made to compensate providers for high cost patients. These issues were important when it came to developing the policy to deal with exceptional cases which was an iterative process (section 3.5.2).

Autonomy

Two of the policy objectives of casemix funding were to develop a system that was free from centralised bureaucratic control and to promote hospital autonomy. Together, it was considered that these would encourage the strengthening of business management skills.

In one sense, the Department considers it has freed the networks and hospitals from bureaucratic control and promoted autonomy by reducing restrictions on how hospital outputs should be produced. However, the Department has increased monitoring of outputs, which may partly reflect the availability of better output measures.

There are three options for dealing with failure: Dealing with hospitals unable to operate efficiently under the new funding arrangements presents problems for the Victorian Government. The Department is usually both the purchaser of services and the owner of infrastructure and, therefore, must rely on administrative decisions to address failure.

... to change management; One option available to the Department is to change the hospital management, but this depends on whether nonperformance can be attributed to individual managers. For example, a hospital may be experiencing problems with meeting budget constraints because of the age of its capital. In such an instance, the Department may provide money (either as a loan or a direct equity injection) to upgrade equipment. Similarly, current problems could be the result of poor decision making by previous management. To overcome such problems, the Department may supply officers or fund consultancies to develop new business plans.

... to increase monitoring; or to close a hospital. A second option available to the Department is to impose more intrusive monitoring guidelines, while a third option is closure. The Department of Health and Community Services indicated that less efficient hospitals may not survive the era of casemix funding:

> As far as possible, the future of each hospital will be in the hands of that hospital and the community it serves. If the hospital cannot provide services efficiently, it should not expect to survive. If a hospital cannot persuade local people to use its services rather than those of nearby hospitals, then again, it cannot expect to survive. (DHCS 1993a, p. 21)

The decision to close a hospital within a network is now made by the network board, in conjunction with the Government. In 1996, the Government announced that, five of Melbourne's hospitals will be closed over time, and that the services will be relocated to more appropriate sites. While casemix funding has made the cost effectiveness of various hospitals more transparent, these closures largely reflect the reorganisation of

services in response to changes in demand and the level of

funding across the metropolitan area.

3.7 Implementation issues for public hospitals

The introduction of casemix funding (and associated budget cuts) represented a major challenge for public acute care hospitals in Victoria.

The first issue facing hospitals was to identify the true costs of providing acute care services. Although hospital information systems had improved significantly in the five years before casemix funding, a survey of hospital CEOs found that 80 per cent felt that their existing information and costing systems were inadequate for coping with the implementation of casemix funding (Health Solutions 1994, p. 118). Therefore, upgrading information systems became a priority for many hospitals in Victoria, particularly smaller and non-metropolitan hospitals.

A second issue facing hospitals was to identify how costs could be reduced to meet the efficiency objective. Labour costs account for approximately three-quarters of all hospital costs, and capital is a relatively fixed resource (at least in the short term), so many hospitals achieved cost savings through staff reductions.

Funding changes affected hospital structures and practices.

The Health Solutions survey found that hospitals had reduced the number of nursing staff and 'hotel' type staff (down 7.9 per cent and 18.8 per cent respectively in 1993–94) by focusing on the provision of acute care services. To do so, hospitals had increased the number of same day cases and lowered the number of nursing home type patients by reducing supportive services and longer stays wherever they could not be funded.

To ensure that cost reductions were not achieved at the expense of quality, hospitals improved their clinical protocols (that is, their pre-admission, admission and discharge practices) and developed formal links with post acute care

services. Thereby, hospitals aimed to minimise the risk of incidences such as premature discharge and patients not having access to appropriate care after discharge.

Some hospitals also enhanced efficiency by changing their organisational structures (box 3.7). Rather than allocating funds along functional lines (that is, administration, nursing, medical, etc.), funds were allocated to clinical activity units. These units have delegated budgets and responsibility for their own casemix.[17] To this end, it was necessary to educate clinical and other professional staff of the validity of the casemix approach. Increasingly, many doctors found it necessary to upgrade their coding practices to ensure accuracy and to derive the maximum benefit from the system (Health Solutions 1994).

Hospitals introduced a range of other efficiency initiatives such as fostering more teamwork and coordination among clinical units, linking resources to service quality, using new staff rostering methods, improving operating room efficiency, and lowering patient transfer costs.

3.8 Transitional funding

The introduction of casemix funding was likely to have a large impact on the amount of funding received by some hospitals. Therefore, some transitional funding was introduced to allow hospitals time to adjust to the new arrangements.

Some hospitals were compensated for the first year.

First, the Victorian Government recognised that it could not develop a perfect funding arrangement for 1993–94. Therefore, funding levels were relatively generous in the first year, with reductions made in subsequent years. Second, less efficient hospitals received an additional once-off compensation payment in the first year. Third, the fixed component of the new funding system provided some stability

[17] In smaller hospitals, restructuring involved greater levels of consultation between doctors and supporting accounting and management staff (Health Solutions 1994, p. 190).

to public hospitals in a time of otherwise dramatic change. Finally, hospitals were given a further once-off payment to encourage early retirement and voluntary redundancies to facilitate the staff reductions (discussed in section 3.7).

Box 3.7: Some provider perspectives

The previous section outlined some of the implementation issues facing Victorian public hospitals when casemix funding was introduced. These included the need to:

- upgrade information systems;
- devolve management and budgeting to clinical units;
- educate professionals; and
- adopt appropriate coding practices.

The importance of these issues varied significantly depending on the size of the hospital.

Discussion with management of Royal Melbourne Hospital (RMH), one of Victoria's major teaching hospitals, revealed that many of its implementation challenges involved behavioural changes, rather than changes to information systems and the organisational structure. Many of the changes needed to encourage the appropriate responses to incentives were taking place before casemix funding. For example, RMH's costing and coding information systems had been upgraded as part of the Department's earlier work on developing casemix policy.

Moreover, clinicians were familiar with coding practices. In the past, coding information was collected primarily for research purposes, albeit less comprehensively. The challenge for RMH was to encourage clinicians to better recognise the link between coding and funding. Making clinicians responsible for clinical budgets was one way of promoting this. According to hospital management, devolution of responsibility was occurring before casemix funding, but the new funding arrangements reinforced the need for this change.

By contrast, many smaller metropolitan hospitals and non-metropolitan hospitals had introduced few organisational changes prior to casemix funding. Introducing information systems and coding practices alone were significant changes for these hospitals.

More recently, the development of metropolitan networks has highlighted the need to clarify roles and responsibilities of networks and metropolitan hospitals with regard to related issues such as management of waiting lists.

Sources: Dr David Campbell, General Manager Royal Melbourne Hospital (personal communication 1997); Health Solutions (1994).

3.9 Future issues

The casemix funding system in Victoria has undergone a range of refinements and enhancements since it was first introduced and this process will continue. Some potential future refinements are discussed below.

3.9.1 Treatment of capital

Excluding capital can cause problems

Hospitals, like most government funded services, have traditionally received separate funding for recurrent and capital expenditure. Financial reporting and costing systems have focused on recurrent expenditure, recorded on a cash basis. The introduction of casemix funding altered the distribution of recurrent funding, but did not initially address how to treat capital. Duckett (1994) noted that this is not ideal:

> All of the costs of capital (borrowing costs etc.), have been met by Government and so from the hospital's perspective, capital has been a free good. This could not be expected to lead to rational investment decisions and capital planning has, to a very large extent, been a political process where hospitals have put in bids for expansion, often unrelated to need, and used political processes to ensure that these projects were funded. Casemix funding, as implemented in 1993–94, has done nothing to redress those perverse incentives. (p.88)

There has been a major effort to shift the basis of government financial reporting, funding and decision making to an accrual basis, so that the full cost (including capital) is integrated into the decision making process. This is important in acute inpatient care because capital costs are a significant component of the total costs.[18]

[18] Indicative estimates from NSW of the cost of capital suggest that buildings and equipment account for about 11 per cent and 4 per cent respectively of the total cost (excluding land) per casemix adjusted separation (derived from SCRCSSP 1997, pp. 218–19).

Duckett (1994) suggested that different approaches may be appropriate for:

- minor works and equipment; and
- land, plant and buildings.

... but there are no easy solutions.

In July 1994, the Department introduced an additional payment as the Government's contribution to equipment replacement costs. Based on each hospital's output level, this was intended to replace the system of annual grants for minor capital work (DHCS 1994b, p. 12)[19]. The aim was to encourage rational economic decisions about equipment purchases, including trade-offs between capital and labour costs. However, as Duckett noted, this payment requires monitoring to ensure that hospitals appropriately provide for depreciation, and that unviable hospitals do not continue to operate by running down their capital stocks.

The treatment of major capital works has not yet been addressed and new projects are still subject to Government approval.[20] Reimbursing all capital costs (including the opportunity cost of capital and depreciation) in the casemix funding formula — in conjunction with a regime of capital charges — would provide a basis for delegating these decisions to the network or individual hospital.

However, including funding for major capital and plant, which are typically lumpy investments with occasional decisions, in annual funding poses some practical difficulties. Issues to be considered include asset valuations and depreciation rates.

---

[19] WA and the ACT have made allowances for depreciation of capital stock. Queensland will introduce a notional capital asset charge from 1 July 1997 (appendix B, table B.5).

[20] Major capital works are defined as land transactions or building work exceeding 10 per cent of the annual revenue of an agency or $2 million, whichever is the lesser amount (DHCS 1995b, p. 5).

If capital is to be included in the output price, then the Department will need to determine how to apportion capital costs across the services to be used.

In addition to these practical issues, the Department is also wrestling with the broad policy implications of incorporating funding for land, buildings and major capital in the casemix formula. Under the current approach, strategic decisions to adjust the Government's investment in a particular area or service are handled at the whole-of-government rather than network level. This is implemented through the Department assessing individual capital investment proposals.

With regard to the level at which investment decisions are made, fully funding capital costs each year would remove one of the tools by which the Department can alter the mix and distribution of services. A funding regime which includes capital, and has uniform prices for outputs across hospitals, should result in each viable hospital or network being able to maintain a stable capital base. A Government wishing to reduce services in an area would have to explicitly specify the reduction in the capital base in the service being cut.

However, funding capital would enhance incentives for hospitals to dispose of surplus assets and reconfigure services, and provide a better environment for deciding on the mix of labour and capital used. For example, newer hospital designs have the potential to reduce operating costs by increasing the efficiency with which nursing staff are used. Given the existing approach to capital investment, such capital improvement allows a hospital to reduce its recurrent costs while not bearing the additional capital costs.

3.9.2Achieving the appropriate mix of services

Initially the Department focused on improving the cost effectiveness of Victoria's acute care services. There is still the issue of ensuring that the best mix of services is available

to meet the needs of the community[21]. This involves achieving:

- the appropriate mix of treatments (for example, hip operations versus heart transplants);
- the appropriate mix of service types (for example, inpatient services versus outpatient services); and
- the appropriate mix of locations (for example, inner city versus suburban).

The appropriate mix of treatments

Palmer (1994) argued that the casemix model used in Victoria could be adapted to fund outcomes:

> If the emphasis on outcomes is restricted to the assessment of the effectiveness of specified treatments and procedures there is ample opportunity within casemix funding to modify the prices associated with each DRG. In the limit those treatments which are demonstrated to be ineffective, or indeed iatrogenic in some cases, would have a zero price assigned to them. In other instances, where the health authorities wished to discourage certain treatments the prices of the relevant DRGs might be heavily discounted. (p293)

'Evidence based' pricing, as described by Palmer, could be used as a means of ensuring that hospitals provide the appropriate mix of services. An alternative would be for the Department to purchase specific services from providers.

However, the Department decided not to use casemix funding to centrally determine the mix of hospital outputs. It was felt that this involved medical and ethical judgements best made by networks, hospitals and their clinicians responding to the particular circumstances of patients and the community.

The appropriate mix of service types

Casemix funding is not being explicitly used to influence the mix of service types available in the community. However, the change in the funding mechanism has had impacts on the mix of service types.

---

21 That is, the Department has still to consider the issue of allocative efficiency.

Given that hospitals receive a payment for every patient they treat, there can be an incentive to admit more people. In this way, casemix funding can encourage inpatient care at the expense of other, perhaps more cost-effective, types of care.

To avoid this, the Department capped the total number of admissions for each year. There are also moves to extend casemix funding to other hospital services, in the first instance to ambulatory and outpatient services. Human Services Victoria has developed a grouping system and cost weights for ambulatory care services in Victorian hospitals.[22]

The Victorian Ambulatory Care System (VACS) is being trialled in a selection of major teaching and/or specialised hospitals (known as Group A hospitals). It will become the basis for funding for all Group A hospitals in 1997–98.

Under VACS, the unit of output is a visit to an ambulatory care service. The visit is then classified to one of 43 groupings that relate to major areas of clinical practice. The cost weights for each group include the cost of the visit and the costs of any ancillary services (such as pharmacy or pathology services) provided to patients 30 days either side of the visit.

As with casemix funding for inpatient services, the price paid per unit of output comprises a fixed payment and a variable payment. However, the system is designed to be relatively neutral in terms of the level of throughput. To avoid an increase in throughput, each hospital is allocated a maximum budget for ambulatory care. Human Services Victoria is working towards linking non-inpatient services with inpatient services, and

[22] The Commonwealth Department of Health and Family Services is also developing an ambulatory care casemix classification. However, the national classification and cost weights were not available for use in 1996–97. Queensland and SA have also developed their own ambulatory care classifications and cost weights. The SA model is also being used in the ACT and the NT (appendix B, table B.3).

introducing incentives to encourage substitution of non-inpatient care for inpatient care where appropriate.

The acceleration under casemix funding of the trend towards shorter lengths of stay in hospital has highlighted the need for other care settings, and in particular the need for post-acute care services. Earlier discharge of patients can shift some of the burden of post-acute care to the Commonwealth Government (via the Medical Benefits Scheme or the Pharmaceutical Benefits Scheme), or to the patient's family (who may be forced to provide additional care). The establishment of a system of healthcare networks should partly address this.

It is the responsibility of networks to better integrate acute care, extended care and psychiatric care as well as to increase the provision of locally available ambulatory care and links with general practitioners. A number of other programs have also been introduced to encourage integrated healthcare funding and delivery. In addition, adopting a broader definition of an output — embracing the full episode of care, not just inpatient care — could reduce incentives to cost shift and influence the mix of service types. However, this would require addressing the variation in the need for follow-up treatment between individuals who have the same primary condition.

The appropriate mix of locations

The Department developed a system of networks to facilitate the hospital system's ability to respond to the longer term needs of the community and maintain quality. This restructuring led to some cuts to the services at major city hospitals, with increased resources devolved to middle and outer suburbs (see earlier discussion of hospital closures).

3.10 Conclusion

Casemix funding of Victorian public hospital inpatient services has strengthened incentives for hospitals to use their resources in the most efficient manner. Hospitals are free to adjust the mix of labour and other inputs they use, although major capital expenditure is still funded on a submission basis.

The introduction of casemix funding coincided with significant cuts to the public health budget in Victoria, and this may have complicated the process and the analysis of the impact — it may have undermined the support of professionals in the field. However, the one-off payments to encourage early retirement and voluntary redundancy may have facilitated the restructuring process, particularly if they created opportunities for those remaining to make significant changes.

Implementing casemix funding for inpatient services has been complicated by factors — all of which are found to a greater or lesser extent in other human services areas — which include:

- the diverse mix of inpatient services produced;
- varying client characteristics which have a significant effect on costs;
- joint production with other hospital services which are less suited to output based funding in the short term (psychiatric care, outpatients, teaching and research);
- variations in scale, age of capital and capital/labour mix;
- inadequacy of the cost information available to both the purchaser and the providers;
- complex interrelationships within hospitals between management and clinicians which affect efficiency; and
- quality which has not been explicitly defined but has been 'assured' by process controls and other mechanisms.

Casemix funding strengthens incentives for hospitals to be efficient by increasing pressures to constrain costs, but it also creates incentives to reduce the quantity or quality of those

outputs which are not well specified. For example, there may be greater incentives to: focus on less costly patients or more financially rewarding cases (thus reducing access); discharge patients earlier (thus shifting costs to other parts of the medical system and to individuals and their families); or reduce the effort devoted to less well specified hospital activities (such as research or outpatients). A major implementation issue is how to prevent or minimise these unintended side-effects of the funding mechanism.

As the Department places greater pressure on providers to constrain costs, it will become even more important to specify the quality of the funded services, and the outputs and quality of other hospital services.

There are a number of further refinements to the casemix funding system in Victoria that may warrant further consideration. For example, the definition of an output for some conditions could be extended to an episode of care. At present, casemix funding focuses on hospital based care at the expense of other forms of care. The Department has addressed this issue by establishing healthcare networks that plan for the integrated provision of health services in a particular area. An alternative approach would be to extend the definition of the output to an episode of care to include other health care services in the casemix funding mechanism. However, current institutional arrangements make such an approach difficult.

The Department could also move towards a greater emphasis on outcome based funding. The funding formula could be applied to alter the mix of treatments, in addition to the current focus on influencing the average cost. While the Department now uses centralised (non-price) controls to influence the mix of treatments adopted, casemix funding provides an alternative approach based on price incentives. Where the Department considered that judgements on the supply of a particular

treatment were best made centrally, it could raise or lower the price of the treatment.

A third refinement could entail including capital costs in the casemix funding formula. Including capital user charges and depreciation would remove some of the disadvantages faced by older hospitals which may have higher operating costs but lower capital costs. This would also free networks to make investments which enhance efficiency by adjusting the mix of capital and other inputs. However, this would also reduce the Department's ability to directly determine the location of additional or replacement capital expenditure. Along with including capital in the funding formula, the Department would need to develop new tools to prioritise location.

4 COMPETITIVE TENDERING OF PRISONS IN QUEENSLAND

The introduction of the private sector into a formerly public sector activity has led to efforts to improve performance in two ways. The Queensland Corrective Services Commission (QCSC) has sought to foster direct competition — that is, competition for market share — initially between private providers, but later between private providers and QCSC inhouse bids. The QCSC has also sought to foster benchmark or indirect competition — that is, competition based on comparisons between providers — between private and public prisons operations.

4.1 This case study

This case study examines the introduction of privately operated prisons in Queensland with regard to:

- how the reform was structured to realise its objectives; and
- what other changes were then introduced to more fully realise the available efficiency and effectiveness improvements.

4.2 The reform

Private management of prisons in Queensland was introduced at the Borallon Centre in 1990 and at the Arthur Gorrie Centre in 1992. A competitive tendering process took place after the centres had been designed and substantially completed, but before operations commenced. No inhouse bids were considered. The contracts were for most aspects of the operations of the centres but the QCSC retained responsibility for ownership and maintenance and a few other services.

More recently, the Woodford Centre was put up for tender. Unlike the Borallon and Arthur Gorrie tender processes:

- the QCSC was instructed to make an inhouse bid; and
- the centre was to be designed, built and maintained by the successful tenderer.

The QCSC inhouse bid for this centre was successful.

Table 4.1: Competitively tendered correctional centres in Queensland

	Approved capacity	*Location*	*Opened*	*Security classification*	*Operator*
Borallon	389	Ipswich	1990	Medium/low	CCA
Arthur Gorrie	458	Brisbane	1992	Remand/reception	ACM
Woodford	600	Woodford	1997	High/medium	QCSC

CCA — Corrections Corporation of America
ACM — Australasian Correctional Management
Source: QCSC

Queensland was first

Borallon was Australia's only privately managed prison when it commenced operations in 1990, although private operation of prisons had recommenced in the United States in 1984, and by 1988 was apparently being considered in NSW and SA (Kennedy 1988, vol. II, p. 50).

...but other States have followed.

Since privately managed prisons were introduced in Queensland, they have also started in NSW (Junee), Victoria (Deer Park and Fulham) and SA (Mount Gambier). Another privately operated prison is scheduled to begin operations in Victoria by the end of 1997 (Men's Metropolitan Prison at Laverton) — see appendix C for further details. Private firms also operate prisons in a number of other countries, including the UK and the USA.

4.2.1 Objectives

The decision to introduce private management into prisons was driven by particular difficulties in the Queensland prison system, rather than as part of a more general government policy of outsourcing.

The QCSC had four objectives in introducing private sector management. These were:

- to stimulate improved performance of publicly managed prisons by facilitating benchmark competition;

- to reduce costs by removing restrictive work practices;
- to introduce cultural and attitudinal change in the management and operation of prisons that would lead to improved efficiency and effectiveness in rehabilitation; and
- to provide comparative information to help assess options for future development (Macionis 1994, pp. 183 –185).

The relationship between the introduction of contracting and efforts to reform working practices was noted by the Public Sector Management Commission which observed that:

> The more recent [than Borallon] arrangement with the Arthur Gorrie centre was not part of a QCSC strategy to enter into contract arrangements. The Government approved the arrangement on the advice of the QCSC after negotiations with the Queensland State Service Union on a site agreement broke down.(PSMC 1993, p. 116)

4.3 Background to the reform

The QCSC is responsible for all adult correctional functions, including supervision in the community and in correctional centres (box 4.1). Impending structural changes to QCSC are discussed below.

Box 4.1: The Queensland Corrective Services Commission (QCSC)

The QCSC has twelve correctional centres, of which ten are operated by the QCSC and two (Borallon and Arthur Gorrie) by private contractors. The new centre at Woodford is operated by the QCSC, having been awarded to an inhouse bid.

Community custody occurs in QCSC operated centres — two centres contracted to not-for-profit operators, and five residential facilities run by community organisations (QCSC 1995a, pp. 31–3).

The QCSC has a budget of $283 million for 1996–97, including payments to contractors (Queensland Government 1996a, p. 188), and is responsible for an average daily prison population of 3122 in secure custody and 15 000 offenders on community based orders (SCRCSSP 1997, pp. 808 and 812). These figures include the two privately managed correctional centres which hold about 33 per cent of the prisoners in secure custody in Queensland (QCSC 1995a, p. 65).

The central office of QCSC provides some services for all

prisons. It is responsible for building maintenance at both QCSC operated and privately managed prisons, and for meeting the operating costs such as rates, electricity and water charges.[1] It also provides dog squad services, routine drug testing, records management, and dental, chaplaincy and official visitors services. In addition, a community corrections officer to assist with assessments is provided from Community Corrections.

QCSC central office provides additional services to QCSC operated prisons — negotiating industrial relations agreements and organising grievances hearings, the recruitment and appointment of officers,[2] training of custodial staff, payrolls, IT support, purchasing, accounts processing, and prisoner escort.

This leaves QCSC prison general managers responsible for the secure containment of prisoners, prison services (food, laundry, cleaning, maintenance of grounds), program development and implementation (education, training, rehabilitation), the maintenance of sentence management records, capital purchases (up to a set limit), and human resources (leave processing, promotions, rostering).

In December 1996, the Minister for Police and Corrective Services announced that the QCSC will be split into two organisations from 1 July 1997 — one to 'purchase' prison services and the other to 'provide' services. The purchasing arm will retain the QCSC name, the coordination of sentence management and overall control of the provision of corrective services(including setting policy in conjunction with the QCSC Board). The service provider, which will operate the publicly run prisons, will be a Government owned corporation known as Queensland Corrections (QCORR) (Queensland Government 1996b).

---

1 The more recent Woodford tender required the operator to be responsible for the maintenance of the centre.

2 Correctional centres outside South East Queensland recruit their own staff.

4.4 Defining the service

What to contract

The initial advice to Government to competitively tender and contract the management of a correctional centre came from the 1988 Kennedy Report. To implement the policy, the QCSC needed to decide:

- what the scope was for outsourcing each of the services delivered through prisons; and
- how the individual services that could be outsourced should be combined.

The services to be considered ranged from asset management, to education services and security, to discipline and sentence management.

4.4.1 Determining what services to contract

... involved considering the risks

Deciding which components of prisoner services could be outsourced involved identifying the risks of contracting each component, and assessing the cost of these risks. The underlying risk was that the selected provider would fail to provide the required service to the required standards at the contracted price.

This assessment required an understanding of:

- the additional risks involved in proceeding with competitive tendering and contracting, compared with the risks of internal provision;
- the magnitude and potential costs of each risk; and
- whether these risks could be reduced or avoided, and at what cost.

... and the market.

The Kennedy Report, which recommended the creation of the QCSC and the private operation of Borallon, identified discrete services that could be purchased from the private sector and thus be subject to competitive tendering and contracting. These services included:

- education programs for prisoners;
- health care services and especially ‘general practice’ services;

- audits of management and operations;
- legal services;
- consultancy services including computing, industrial relations and management advice;
- psychological assessments and counselling; and
- staff recruitment and training (Kennedy 1988, p. 91).

In addition, Kennedy recommended that tenders be called for the entire operation of correctional services at Borallon. However, he noted:

> I would expect the best approach *for the moment* would be for Queensland to continue to own the property, and to lease it out. (Kennedy 1988, p. 97) [emphasis in the original]

The QCSC retained ownership.

The QCSC adopted this approach to asset management and retained ownership of contracted correctional centres. It gave the following reasons:

- The Government can affect the total level of demand through policy decisions and, as the only buyer of prison services, can also affect the demand for the services of any one prison. Thus, it can better manage the risks associated with changes in demand for prison services than could a private owner.
- By retaining ownership, it is less complex to change providers. Thus, the potential for provider capture is reduced.
- By purchasing the design and construction services in conjunction with operations, most of the benefits of the integration of services are achieved.

Others have argued that another benefit of government ownership is that the combination of the government's taxing powers and high credit rating mean that it could borrow money to finance the asset at a lower cost.

Some private providers, however, prefer private ownership with operation because:

- it ensures the operator has control over maintenance, particularly that which affects security; and
- it gives the operator greater freedom to make capital improvements which lower operating costs.

On the question of the costs of borrowing, the Economic Planning Advisory Commission's *Private Infrastructure Taskforce Report* argued that:

> ... [the] governments' lower cost of funds largely reflects the fact that taxpayers are providing an implicit guarantee for project risks under public ownership. Thus, it concluded that much of the difference in the public and private cost of capital is apparent rather than real. (EPAC 1995, p. 37)

On balance, the QCSC considers that the benefits of retaining ownership outweigh the loss of the potential efficiency gains.[3] However, it now accepts the view that the operator should be responsible for maintenance. For this reason, the operators of Woodford are responsible for upkeep of the centre, in contrast to the situation at Borallon and Arthur Gorrie, which were tendered earlier.

Given that the QCSC owns the buildings, its decision to be responsible for paying rates and land taxes, even for those centres operated by private firms, is consistent. However, it is less clear why QCSC chose to pay the gas, water and electricity costs when the private operators have control over the use of these resources. The QCSC changed its approach for Woodford where the operator pays these costs, and this approach will be adopted for QCORR.

[3] Victoria is the only jurisdiction where private operators own the prison buildings (appendix C, table C.2)

Regulatory services remained inhouse.

The QCSC has kept other services inhouse — for example, the development of sentence management guidelines and the provision for a community corrections officer to assist with assessments. The QCSC has determined that they should not be delegated because the decisions on these guidelines and supporting services determine the nature of a prisoners confinement. This approach has been taken further in the UK, with public sector employees having the responsibility for administering discipline in privately run prisons (Harding 1997, p. 40).

The QCSC considers that most of the remaining services are either regulatory functions (such as auditing, appointment of official prison visitors and drug testing) or most cost-effective when shared across centres (such as the dog squad). It is anticipated that with the introduction of corporatisation, a separate, stand alone contract for Transport and Escort (including the dog squad) will be let.

4.4.2 The scope of each contract

The decision by QCSC to keep inhouse some services considered to be central agency responsibilities still left a large number of discrete services which they considered suitable for outsourcing. These services include: the containment, supervision (including discipline) and transport of prisoners; the administration of sentence management policies; the delivery of education and industry programs; health services; food and other hotel-type services; and the general care and management of the prison.

In Queensland these services are combined into a single management contract for each centre.[4] In other jurisdictions overseas, some of these services have been contracted separately: for example, the delivery of education and health care has been separately contracted in a number of public UK prisons.

The QCSC argues that several considerations were balanced in making this decision because the larger contract scope means greater potential to:

- reduce the level of competition;
- facilitate more integrated and thus more efficient or effective operations;
- reduce the costs of selecting and monitoring providers; and
- reduce the scope for disputes about responsibility and thus enhance accountability.

Combining a number of services in one contract also permits a provider to offer innovative solutions regarding the integration of related or complementary services. For example, the private operators require their officers to patrol around, rather than monitor from fixed posts (as was common in QCSC prisons), and have advocated designs more conducive to that form of operation.

If the services to be provided under the contract are large in total, small players could be excluded — reducing the number of contenders and possibly reducing competition. A larger contract scope will only reduce competition, however, if specialised providers are not able to readily form a consortium to make joint bids, or if there are barriers to entry by other providers.

[4] NSW, Victoria and SA also have single management contracts (appendix C, table C.2).

The QCSC does not consider that competitive pressures have been compromised in Queensland as a result of the decision to combine services. The number of expressions of interest to bid for contracts to deliver prison services have ranged from five for the Borallon tender to seven for the Arthur Gorrie tender, with five in the case of the design/construct/manage Woodford tender.[5]

4.4.3 Defining the services

As noted above, the operations of a correctional centre include a number of distinct services — containment, supervision, programs, employment opportunities, the provision and maintenance of buildings. Service requirements can generally be specified by documenting either the required process (or design) characteristics of the particular component of the overall service (design specifications) or the required levels of contractor performance (performance specifications) (table 2.2).

Performance specifications allow contractors to choose how to achieve the desired outcomes or outputs. They also shift an element of the risk, with the contractor benefiting from any cost savings and bearing any additional costs. The value of this depends upon which party is best able to manage the risk.

Design specifications offer a higher degree of certainty in terms of tendered solutions and provide a consistent basis for bid evaluation. Further, if output specification and monitoring is not well developed, then monitoring contractor performance may be easier under design rather than performance specifications. The QCSC faced a trade-off between these risks and returns when formulating its specifications.

In early contracts, the QCSC mostly specified the service in terms of inputs and processes. More recently, while many aspects of the service must still be defined in terms of inputs or

[5] Most jurisdictions have had five firms respond at the expression of interest stage (appendix C, table C.4).

The QCSC is moving to more output focused specifications

process (for example, staff at certain levels must hold specified qualifications), there have been attempts to focus on outcomes and outputs. Examples include: escapes, penalties for positive results from drug testing 'higher than the average random urinalysis results for the Principal's other correctional facilities' (QCSC 1995b) and 'the standard of health care [for prisoners] is to equate with that available in the community' (QCSC 1995c).

... as it develops experience.

The QCSC considers the move to output based specifications is feasible because:

- it is now better able to monitor outputs/outcomes and thus manage risks; and/or
- it has gained a greater understanding of the extent of risks as it has developed a better understanding of the contractor's abilities.

The QCSC could expect to gain further efficiency benefits through this approach because those elements best managed by the provider are no longer centrally mandated.

The QCSC has also had to ensure that it does not frame tender specifications in a way which unduly favours particular providers. If the existing provider has a large influence, then there is a danger that the specifications will describe current practices rather than the desired outputs or outcomes. This may preclude innovative alternative approaches, and entrench the existing provider when it is the only provider that knows the full cost of operating under those specifications.

This issue did not emerge with the letting of the Borallon and Arthur Gorrie contracts, but was an issue for Woodford because there was an inhouse bid. The QCSC consulted with other potential bidders before formulating the final specifications. However, concerns emerged about the timing of

[6] 'Chinese walls' are administrative arrangements put in place within organisations to avoid conflicts of interest between the different parts, particularly through reporting lines and the sharing of information.

construction of 'Chinese walls' around the inhouse bid. Unsuccessful bidders objected to several QCSC staff being involved in both developing the specifications and preparing the inhouse bid (ACM 1996 p. 1; Codd Partnerships 1996, p. 1).[7]

4.4.4 Determining the length of contract

Considerations in determining the length of a contract include:

A number of factors influence the ideal contract length

- who owns the assets and whether the assets have alternative uses;
- the predictability of service demand — which is not under the control of the contractor and, in the case of prisons, is outside the control of the principal;
- the predictability of service costs — which are more directly related to the actions of the contractor;
- the conditions for renewal of the contract; and
- the processes for amending the specifications.

... including ownership of the assets

The QCSC felt able to let relatively short contracts because it retained ownership of the prisons. Longer contracts are more likely to be appropriate where the contractors are required to recoup the investment over the period of the contract. The economic life of a prison is likely to be at least 20 years, and it has few alternative uses.

... and the purchaser's ability to monitor quality.

The original contract for Borallon was for three years with a further option for two years, able to be terminated by either party with three months notice without need to show cause.[8] The relatively short period of notice of termination was also a way of reducing the risk of an unacceptable quality of service.

Contracting can constrain

A government may be concerned that a contracted relationship will mean that it loses flexibility to implement policy changes

[7] NSW and Victoria have not permitted inhouse bids. SA permitted an inhouse bid for the Mt Gambier prison (appendix C, table C.3).

[8] NSW and South Australia also have three month notice periods (appendix C, table C.6).

policy flexibility

or respond to unanticipated situations (such as a rapid rise in the prison population).

... depending on the relationship between the parties.

This, however, has not been the experience of the QCSC. The contract for Borallon is written to allow amendment by agreement in writing by both parties. The ease with which the contract could be renegotiated, and the goodwill between the parties, meant that when the QCSC faced a rapid rise in prison numbers in the early 1990s it was able to negotiate the introduction of two prisoners per cell and more cells at Borallon. These steps were achieved more quickly at Borallon under the contractual relationship than at the QCSC operated centres.

4.4.5 Addressing economies of scope between policy advice and service provision

Maintaining information flows is important

The introduction of external providers created two distinct roles within the corrections service in Queensland — the role of purchaser and that of provider. Having retained responsibility for developing and refining policy (and consequently assessing its effectiveness), the QCSC central office needed to maintain information flows between its policy makers and the providers (external and inhouse) implementing these policies.

... and a number of measures can help.

The QCSC has partly addressed this issue by having monthly phone conferences of public and private prison general managers with the Director General after board meetings. In NSW and Victoria information flows are enhanced by regular meetings, while in SA there is daily contact through the on-site monitor.

The QCSC also considers that it has enhanced the policy debate by:

- releasing considerable information about its relationships with the providers and about their performance;
- seeking independent advice from commissioned reports/inquiries (such as the Kennedy Report) and

management consultants; and

- sponsoring research projects by academics.

An example of the QCSC's use of outside expertise is the plan to conduct a longitudinal study on the impact of the Sexual Offenders Treatment program on levels of reoffending. This study will be undertaken by a PhD student on a QCSC funded fellowship (QCSC 1996, p28).

4.4.6 Maintaining cooperation among competing providers

Each prison is part of a larger system.

Prisoners are part of an integrated prison system and move from high to lower security close to the end of their sentence or from low security to higher security as a result of breaches. Consequently, prisoners move both ways within the security classifications and often between prisons. Prisoner management in each prison can be improved if prisoner records are kept up to date and if prisoner information is shared. Therefore, there is some incentive for each prison management to maintain adequate and up-to-date records which are transferred with prisoners between prisons. The QCSC has not yet experienced any particular difficulties in this area.

However, there is little incentive for competing prison managements to share innovations that reduce the costs of operations, although it may be difficult to keep some innovations secret. There is some incentive for private providers to share information which will enhance their reputation in other States (thereby increasing the possibility of winning future contracts) or which increases the likelihood of their existing contract being renewed. This may have contributed to Australasian Corrections Management's efforts to share details of its suicide prevention program with QCSC centres.

4.5 Selecting and managing providers

4.5.1 Issues for the purchaser

The task facing the QCSC as the purchaser of the contracted services is to ensure that:

- the tender specifications, evaluation and selection processes are, and are perceived to be, fair; and
- they select the best bid.

To ensure fairness, and the perception of fairness, it is necessary that the specifications do not unduly favour one competing firm over another, and that the selection criteria (and their rankings) are transparent. Ensuring a perception of fairness is a relatively straightforward process when there are only private firms bidding for the contract.

The tender evaluation task for the QCSC was to assess the competing bids on the basis of value for money. In December 1988, the QCSC called for expressions of interest to contract manage Borallon. Five organisations submitted comprehensive proposals, two of which were asked to submit formal tenders. The contract decision was not made on price alone, and the higher bidder, Corrections Corporation of Australia, won the contract as the best qualitative tender based on the programs it offered. Australasian Corrections Management won the Arthur Gorrie contract but again not on the basis of price alone — it was the second lowest priced bid.

Inhouse bids increase the importance of a transparent process

The transparency of the tender process became a significant issue for the first time when Woodford was put out to tender. Two private tenderers were shortlisted and there was an inhouse bid. Given that the organisation involved in deciding the winner and managing the contract was also bidding, the fairness of the process was likely to be questioned. The issues that arose were the fairness of:

- the process by which the tenders were evaluated (including whether the inhouse team had an unfair advantage in meeting the criteria because the bid was prepared by

QCSC); and

- the basis on which the QCSC tender was prepared — particularly how costings were made (in relation to liabilities like superannuation and to services provided by head office) and how tax advantages were equalised.

The basis of the QCSC tender was not made public, so the perception of a lack of fairness could not be directly addressed.

... including the guidelines for preparing the inhouse bid.

The tender documentation specified that contractors would be responsible for paying sales tax on any items which they would own (for example, vehicles). However, the treatment of a number of other costs have not been made public, including: the basis on which head office costs were apportioned; whether QCSC and other resources available to the inhouse bid team was included in the bid; and how bid preparation costs were accounted for in the costing of the bid.[9]

Bid preparation costs can be substantial. Codd Partnership, a party to Australasian Correctional Services consortium bid for Woodford, claimed that the cost to each consortium assembling a design, construction and management bid for Woodford was around $750 000 (Codd Partnerships 1996, p. 3).

Furthermore, the inhouse cost estimates were predicated on a union agreement to a change in work practices. The QCSC had obtained the union's written agreement to the work practices contained in the bid but did not finalise a registered industrial agreement until after the QCSC was selected as the successful bidder.[10] This would not be a concern unless there was doubt

[9] The basis by which the QCSC apportions overheads, including that used in the preparation of the Woodford bid, has not been publicly released.

[10] The inhouse bid team were able to convince the union that the bid could only be successful if working practices were reformed. The union has agreed to revised working practices in exchange for higher starting salaries in the Woodford Correctional Centre agreement. If the work practices were not adopted, the QCSC believed that it could not operate the centre within the tendered sum.

regarding the QCSC's ability as a service provider to deliver in accordance with its tender bid — for example, it is not uncommon for winning tenderers to be required to put quality assurance procedures in place before commencing operations rather than before being awarded the contract.

When the integrated QCSC acts as both the purchaser and a competing provider of prison services, these competitive neutrality issues and concerns about their resolution would be difficult to overcome, increasing the risk of private bidders being deterred from participating in future tenders.

Future perceived conflicts of interest should be reduced with the expected separation of the purchasing functions from the provider functions of the QCSC, and the QCSC's corporatisation from 1 July 1997 (Queensland Government 1996b).

The objectives of the tender evaluation processes adopted by QCSC were to use clear evaluation criteria and ensure that a fair evaluation was made.

The Tender Evaluation Committee for the Woodford Centre supplied tenderers with detailed information on the criteria to be used and the procedures in place to ensure probity (box 4.2). An advisory team from the QCSC provided expert advice to the committee. To ensure the fairness of the tender evaluation process, an independent chairperson and a probity auditor were appointed. Steps taken to address criticisms about the fairness of the bid preparations included separating (by setting up 'Chinese walls') the inhouse bid team from the teams that advised on the evaluation of the bids. (Although, as noted earlier, there was some overlap between those who prepared the specifications and the inhouse bid team.)

An independent probity audit by the accounting firm KPMG did not raise any concerns. However, during an inquiry by the Queensland Parliament's Public Works Committee into the

An independent probity auditor was used.

construction of the new Woodford Correction Centre, a number of submissions by unsuccessful bidders raised concerns about the tendering process. Some made specific suggestions including: that QCSC staff involved in preparing the specifications should not be involved in preparing QCSC bids (Australasian Corrections Management 1996); that the secretary of the Tender Evaluation Committee should not be a career officer in the QCSC when it bids (Codd 1996); and that the Tender Evaluation Committee should include suitably qualified private sector representatives (Barclay Mowlem 1996).

Box 4.2: The Woodford Tender Evaluation Committee

The *Invitation to Tender* and *Conditions of Tender* provided to each tenderer contained the following information:

> Tenders will be assessed by an independent Tender Evaluation Committee chaired by Mr Tony Ayers, Secretary to the Department of Defence. Other members of the Committee are senior executive officers of the Treasury Department, Office of the Cabinet, and the Administrative Services Department.
>
> The Committee includes Professor Patrick Weller, the Chair of the Queensland Corrective Services Commission. In accordance with probity procedures, Professor Weller will have no part in preparing the Commission bid or any discussions of the bid at Board level.
>
> The Committee after assessing the tenderers will make their recommendations directly to the Minister. The Committee will be advised by officers from the Commission, Treasury Department, Office of the Cabinet and the Administrative Services Department. Officers from the Commission and the Administrative Services Department who will advise the Committee are not allowed to discuss tender matters with other officers of their respective departments.
>
> To ensure probity is applied in all aspects of the tender process, the Minister has appointed a probity auditor from one of the large accounting firms. This auditor is independent of both the Commission and the Committee and reports directly to the Minister.
>
> In concert with the probity auditor, procedures have been adopted to ensure equitable dealings with all tenderers. These procedures are attached for your information.

Source: QCSC (1995c, pp. 29–30.)

The Public Works Committee examined the issues raised, concluding that the tendering process was fair and that the QCSC did a credible job in running the tender process. It did recommend, however, that guidelines be developed to improve

the quality of the tendering process. These included guidelines on the cost treatment of services provided by QCSC head office, tax exemptions, and how to equalise for the requirement that private firms make a return on their investment.

The existing institutional structure, where the QCSC performs both purchaser and provider roles, made it difficult for the QCSC to resolve all the tenderers' concerns. The restructuring of corrective services in Queensland into separate purchaser (QCSC) and provider (QCORR) agencies, consistent with National Competition Policy (box 4.3), will make such competition policy concerns easier to address.

Box 4.3: Inhouse bids and National Competition Policy

In addition to reviewing legislation, the Competition Principles Agreement sets out circumstances when the structural reform of public monopolies should be examined. The agreement states:

> Before a Party introduces competition to a market traditionally supplied by a public monopoly, it will remove from the public monopoly any responsibilities for industry regulation. The Party will re-locate industry regulation functions so as to prevent the former monopolist enjoying the regulatory advantage over its (existing and potential) rivals.

Source: COAG (1995, p. 6.)

Monitoring is crucial

Monitoring is important in accounting for the overall contract performance, and in addressing public concerns about service quality and the treatment of prisoners. There is a trade-off for the purchaser between supporting the provider selected (whether public or private) and ensuring that performance is independently and rigorously evaluated.

... and has a number of

Full-time on-site monitors were placed at the Borallon and Arthur Gorrie Centres for about a year; monitoring is now more ad hoc although there are major regular audits.[11] The

[11] More detailed and frequent monitoring may be necessary during a new prison's start-up period. Both Arthur Gorrie and Woodford experienced significant teething problems.

elements.

challenge to the QCSC is to ensure that the monitor remains independent of the providers (both public and private) that are being evaluated. The independence of the monitor will depend on such factors as the status of the monitor and their lines of reporting.

Monitors in Queensland are typically below the organisational status of the centres' general managers. In the absence of separate purchaser and provider agencies, they report to an integrated agency. This reporting line will change with the separation of the functions into QCSC and QCORR from 1 July 1997.

A different approach is used in the UK. Monitors have status equivalent to the general manager of a prison and report to the Home Office, which is independent of the prison system.[12]

The effectiveness of the QCSC internal audit process will also be influenced by:

- the number of staff (resources) available for monitoring the contract;
- the frequency of monitoring;
- the detail of monitoring; and
- the follow-up to the monitor's report.

The contract for Borallon specifies that the QCSC may appoint a monitor (whose salary shall be paid by the QCSC) to monitor the performance of the contactor. The monitor has access without restriction to the records of the provider for that prison.

In addition, each prison (both public and private) is subject to an operational audit every 12–18 months. A team of seven to eight QCSC auditors may take up to a week to complete the audit, with the objective of ensuring that the management of

[12] The frequency, detail and form of monitoring varies considerably across jurisdictions. For example, SA has a Department of Correctional Services official on-site, while Victoria and NSW rely on monthly meetings and reports (appendix C, table C.7).

the prison have operationalised the performance specification standards. The results of the audit (whether in full or in part) are not made public.

Monitoring currently focuses on management's compliance with the minimum levels specified in the contract. However, in assessing the policy of introducing contractors, and the performance of individual providers, the Public Sector Management Commission has argued that:

> It is important that performance at a level above the minimum levels required be taken into consideration. While the margin between Borallon and Lotus Glen may be narrowing, Borallon appears to be providing a service above the minimum standard and is demonstrating an approach to correctional management that other correctional centres might emulate to their advantage. It is important that the quantitative and qualitative bases on which private contract management is assessed are given full consideration and that the criteria used do not focus entirely on minimum standard compliance and budget. (PSMC 1993, p. 119)

In addition, official prison visitors have access to prison records and are available to independently investigate inmate grievances.

Rewards and sanctions

Purchasers can reward or sanction a provider in a number of ways, including:

- making bonus payments or applying penalties;
- increasing or decreasing the extent of monitoring of outputs or processes; and
- purchasing more or less in future contracts.

The QCSC has specifically:

- varied the intrusiveness of monitoring — for example, the intensity of monitoring was increased at Arthur Gorrie when there were initial operational problems and a number of deaths in custody; and
- purchased more or less in subsequent contracts — for example, the initial Borallon contract was renewed for a further five years without a tender process.

Further sanctions for nonperformance are available to the QCSC. It also has veto power over the appointment of the general manager of a contracted prison.

Similar rewards and sanctions for successful inhouse bids are available. There may be scope to:

- improve or reduce the pay and conditions of the workforce and/or management;
- increase or reduce the autonomy of management (by varying the nature or frequency of monitoring of expenditure, the degree of responsibility delegated or the tenure of management); and
- continue or cease operations.

The QCSC can remove its prison general managers without notice, but it is more difficult for the QCSC to apply effective sanctions to prisons which they operate unless they have the real alternative of contracting them to private management. The QCSC may be limited in the number of existing prisons which it would contract out given commitments to, and the costs of redundancies for, the existing workforce.

4.5.2 Issues for the provider

Effective benchmark competition

An aim of QCSC in introducing private management was to facilitate benchmark competition — to stimulate improved performance of publicly managed prisons by comparing their performance with that of contracted providers on the basis of cost and quality of service. To be successful, such

benchmarking needs good comparative information. It also needs mechanisms to translate benchmark information about achievable performance into changes for the providers not subject to competitive tendering.

The QCSC has released cost comparisons of the Borallon and Lotus Glen Correctional Centres and has been refining these over time. However, there is debate about whether the differences between the two prisons in prisoner mix, location and scale allow a valid comparison, as well as about the methodology used for apportioning central office overheads.

More generally, in December 1993, the Public Sector Management Commission noted that more comprehensive work needed to be done:

> The Review has found that no comprehensive evaluation of the performance of contract managed centres or their comparison with QCSC operated centres has been undertaken. Some cost comparisons have been made but these need to be further developed over time. The private contracts are closely monitored in terms of minimum performance standards. However, there is insufficient basis for establishing the effectiveness of contract management in the corrective services system. The Review recommends such an evaluation be undertaken. (PSMC 1993, p. 8)

No publicly available evaluation has been undertaken but the QCSC confidential Annual Performance Assessment provides some information for benchmarking the service quality of individual prisons (both public and private): escapes, deaths in custody, assaults, major incidents, industrial relations, budget overruns and programs.

The second element of benchmarking — mechanisms to translate information about achievable performance into change for the nontendered prisons — is less clear. The benchmark information has strengthened the QCSC's position in enterprise bargaining and its ability to assess the performance of its general managers.

The QCSC identified practices and conditions that lead to gaps in performance between contracted and QCSC prisons. These

include:

- delays in adopting case management of prisoners and structured days;[13]
- the difficulty of introducing 12 hour shifts to QCSC prisons;[14]
- a high incidence of industrial disputes;
- high levels of absenteeism or sick leave;[15] and
- the difficulty of terminating the employment of poorly performing prison employees.

While the Woodford contract was based on significant improvements in work practices, there have been significant delays in translating these practices to other QCSC prisons. The initial contracts for two new facilities are to be assigned to the new QCORR only if there is agreement to introduce Woodford style work practices (Queensland Government 1996b).

The service specification and negotiation that will be needed with a separate purchaser (QCSC) and provider (QCORR) may provide an ongoing process whereby the nontendered prisons can be encouraged to adopt improved practices identified through benchmark competition.

The confidential Annual Performance Assessment allows QCSC general managers to compare their performance with similar prisons. This may help translate performance by private sector prison managers into improved performance by the nontendered prisons. However, implementation depends on

13 A structured day regime ensures that prisoners are able to participate in employment, educational and therapeutic programs and recreational activities.

14 It was agreed in September 1995 to introduce 12 hour shifts at Woodford. Agreement to introduce them at other QCSC operated centres was achieved in May 1997 as a result of enterprise bargaining.

15 The QCSC annual reports publish the number of sick days per employee (up from 7.3 in 1994–95 to 8.0 in 1995–96) and time lost in disputes (up from 361 shifts in 1994–95 to 1464 in 1995–96).

whether managers can change work and managerial practices.

4.6 Addressing community concerns

The QCSC also recognised that it needed to address the accountability aspects of services in which the private sector was involved, as well as standard contracting issues. These aspects included which detention functions should be delegated by the state, and what information should be made available about how well delegations are being performed.

Some have raised ethical concerns.

Groups opposing the introduction of private management of prisons have raised concerns including:

- whether the role of government decision making in denying people liberty should be delegated;
- the ethics of for-profit firms being involved in imprisonment;
- the profit incentive leading operators to shave the quality of the service (for example, in the quality of food for prisoners and in rehabilitation programs);
- a conflict between society's desire to minimise the incidence of imprisonment (for example, through rehabilitation) and a private operator's desire to maximise the size of the total market (Brown 1994, p.96); and
- the possible erosion of terms of pay and conditions of prison staff from public sector standards.

Concern about the profit motive is evidenced by the more muted opposition to the contracting of community corrections centres to not-for-profit providers, compared with the opposition to for-profit firms operating secure correctional centres. As the Public Sector Management Commission noted:

> Contracted community corrections have not been subject to the same level of public scrutiny as their correctional centre counterparts. This may be because they are smaller and less subject to major incidents. Another factor could be that the operators are for the most part church or community organisations whose motivation is not perceived as profit-based. Whatever the reason, they are generally accepted as legitimate

> service providers. (PSMC 1993, p. 121)

However, another interpretation is that the participation of church or community organisations is more accepted in corrections because they have acquired community goodwill through their other activities.

The QCSC chose to retain inhouse activities that relate to the nature of the prisoners' confinement (such as sentence management guidelines and prison visitor services).

Concerns about for-profit organisations compromising quality were addressed by the QCSC in its decisions about service specification and monitoring (described earlier).

As for the concern that a firm could seek to expand the prison population by limiting its efforts to rehabilitate prisoners (and thus contribute to a larger market for its services), the incentives for it to do so depend on the extent to which these actions will reduce their market share. Australasian Correctional Management claims that it has been successful in winning contracts because it:

> ... was able to demonstrate that the experience and knowledge of its parent company Wackenhut Corrections Corporation (WCC) would provide 'best practice' correctional management and inmate rehabilitation initiatives aimed at reducing recidivism, in a cost effective manner. (Diplock and Calabrese 1994, p. 109)

4.6.1 Information to the public

The QCSC has sought to address community concerns about the quality of prison services by disclosing information about private prison operations. At a more detailed level, the QCSC has been making more material publicly available with each successive round of contracting.[16] The first Borallon contract (1989) and the Arthur Gorrie contract (1992) were not released, but the second Borallon contract (1995) only allowed

[16] NSW, Victoria and SA have not released their contracts to the public (appendix C, table C.6).

for confidentiality of:

- the amount of any performance security;
- the insurance amounts; and
- any other commercially sensitive information.

The contract explicitly provided that:

> The Performance Specifications and Minimum Performance Standards pertaining to the Contract shall be made freely available to the public. (QCSC 1995b, p. 26)

More recently, the Woodford *Invitation to Tender* and *Conditions of Tender* stated that:

> The name of the tenderer and tendered lump sum and subsequent Contractor and contract sum shall be subject to public disclosure. Any other information provided with the tender which the tenderer desires not be subject to disclosure shall be clearly endorsed — "In confidence" — by the tenderer. (QCSC 1995c, p. 30)

Limited information relevant to private prisons is also provided in documents such as the QCSC annual reports which publish prisoner numbers and escapes from both public and private prisons.[17]

4.7 Conclusion

The benefits from introducing private operations of prisons come from both better performance at the individual centre, and any flow-on of better working or management practices to other centres. Achieving the former largely depends on good tendering practice, but blockages to achieving the latter have been less tractable.

[17] Limited information is also provided in NSW, Victoria and SA (appendix C, table C.7).

Introducing private management to the Borallon Centre provided the QCSC with what it considers to be a well run centre at a fair cost. However, the benefits did not flow on to the working practices at the other centres. The operation of the Arthur Gorrie Centre was put out to tender when the QCSC's negotiations with its own workforce broke down. Again, the QCSC gained what it considers to be a well run centre, with an alternative approach to management and working practices, for a fair price.

The incentives for the QCSC's workforce to agree to changes in working practices were strengthened by allowing an inhouse team to bid for the Woodford Centre. The QCSC selected what it considered the best bid — the inhouse bid. This bid was only viable because the inhouse bid team was able to reach agreement with the union on what it considers to be significantly less costly working practices — a benchmark for QCSC operated centres. However, direct competition between inhouse and external bidders in the tender process raised concerns about competitive neutrality. Furthermore, the QCSC has not been able to readily introduce these improved working practices to its other centres.

The QCSC has now created a formal purchaser/provider arrangement. The new public sector provider was granted the right to operate two replacement centres conditional on introducing Woodford style working arrangements.

A SURVEY OF COMMUNITY SERVICES

This appendix examines aspects of the administration of government funded services providing:

- child protection;
- out-of-home placement services for children; and
- family support services.

See box A.1 for a description of services.

The appendix provides information on the extent to which the changes introduced in SA (which are dealt with in detail in the case study) have been introduced elsewhere, and how they are being implemented.

The information covers:

- the extent to which external providers are used for these services;
- whether the community services department had introduced purchaser/provider arrangements for internal provision;
- funding mechanisms for internal and external providers;
- whether service agreements are used to formalise the relationship between the community services department and internal and external providers;
- how monitoring is used to assess performance;
- how under-performing service providers are managed.

Information was not collected on other government funded community services. Not covered were services for the aged (for example, the Home and Community Care program), the Supported Accommodation Assistance program services for people with a disability, or child care services.

Information was collected from the relevant department in each State and Territory by the Steering Committee Secretariat

through telephone interviews based on a standard survey.

Box A.1: Description of services

Child protection: These services aim to assist families to provide safe and nurturing environments for children, and to ensure the safety of children when families are unable to fulfil this role. They include responding to allegations of suspected child abuse and neglect; undertaking investigations subject to legislative provisions; issuing care and protection orders; and supervising children subject to a statutory order.

Out-of-home placements for children: These are arrangements for children to live with people other than their parents for reasons of safety or family crisis. The main service components include: placement of children in residential or foster care/other home-based care; support of children in placements, including case management; recruitment, training and supervision of carers; and care in placement. The scope of services for this survey are those arrangements where there is departmental intervention and government funding.

Family support services: These range across prevention services, services aimed at stabilising a situation and alleviating its effects, and services that aim to address an immediate crisis situation. They include emergency financial and in-kind payments, parenting skills courses and counselling.

In all jurisdictions, government funded services in this area are supplied by both government and non-government providers, although the proportion has differed between services and across jurisdictions[1].

Some jurisdictions are increasing the provision by non-government providers. Victoria's current policy is to contract out all services with the exception of child protection services, except where outsourcing is detrimental to the service (that is, the service is less effective or less efficient). It should be noted that already 68 per cent of the total budget for out-of-home

[1] The Tasmanian Government is in the middle of a major restructuring that may affect the nature of service delivery.

care and placement support services is contracted to the non-government sector. The policy in NSW is that new out-of-home placement services will be tendered or will be provided by government if no non-government provider is able or available to tender, for example, in rural and remote areas. In Queensland, a two year program to phase out internal provision of out-of-home placement services commenced in January 1997.

In many jurisdictions, the relationships between government funders and providers — both external and internal — are being altered. In many cases, where there are internal providers, governments are introducing structures which separate the roles of purchaser and provider. For example, for child protection services in NSW, agreements to be established between the central office and each Community Services Centre by December 1998 will set out the objectives of the service and how funding is determined, and will allow reporting on trend data and compliance by each Centre. In Queensland, resource agreements between central program areas and regional services, to be introduced in 1997, will specify outputs to be achieved with allocated resources. In Victoria, the purchasing and providing roles in the department are currently being separated, with internal providers being organised into business units.

Across all jurisdictions, the involvement of non-government providers has been lowest in child protection services, explained in large part by the statutory nature of the services. Some changes, however, are being considered. For example, by the end of 1997, Victoria will have completed a review of the youth and family services system to assess, among a range of other factors, whether aspects of the child protection program should be contracted. Issues include: whether child protection services should continue to be solely provided by the government; whether case management functions that are contracted to non-government organisations should be increased; whether the department should (and could) accredit providers with the on going case management of children subject to statutory orders while retaining delegation; and, whether such a provider should exercise such delegations

currently restricted to statutory child protection functions.

Box A.2: Inputs, Outputs and Outcomes

The *Report on Government Service Provision: 1995* published the following definitions.

Inputs: The resources used by a service area in providing its service. Resources include land, labour and capital.

Output: The services provided by a service area. For example, one of the outputs of public acute care hospital is a treated case.

Outcome: The impact of the service on the status of an individual. While a service provider can influence an outcome, external factors can also apply. For example, a desirable outcome for a school would be to add to the ability of students to effectively participate in, and interact with, society through their lives. Similarly, a desirable outcome for a hospital would be to improve the health status of an individual receiving a hospital service (SCRCSSP 1995, p. 36).

A number of States and Territories are moving from input based to output based budgeting or funding, both for the funding of individual services and at a whole - of - government level. However, as yet, robust common definitions have not been agreed. The tables in this survey report the responses from the each jurisdiction, with footnotes providing additional information where this may illuminate the approach to defining outputs that has been used.

Table A.1: Internal and external provision of out-of-home placement services[+]

	Funding split	*Internal provision*				*External provision*		
	Internal: External	*Purchaser /provider*	*Main funding basis*	*Service agreement coverage*	*Performance indicators*	*Main funding basis*	*Service agreement coverage*	*Performance indicators*
NSW	70 : 30[1]	no	input	0	no	input	100%[2]	no
Vic.	32 : 68	no	input	0	yes	output	76-100%	yes[3]
Qld	85 : 15	no	input	0	no	input	90-100%	yes[8]
WA	70 : 30	no	input	0	yes	output and outcomes[4]	100%	yes
SA	48 : 52	no	input	0	no	input	75%[5]	no
Tas.	90 : 10	no	output[6]	100%[7]	yes[8]	output	100%	no
ACT	33 : 67	no	output	0	yes[9]	output	100%	yes[10]
NT	90 : 10	no	input	76-100%[11]	yes	output	76-100%	yes[12]

+ Services covered include: NSW ~ foster care and residential care; VIC ~ all out-of-home and placement support services; QLD ~ residential care, shared family care;
WA ~ group, residential and foster care as well as recruitment, assessment, training review and support of foster/group carers, and adoption services; SA ~ foster care;
TAS ~ departmental family group homes and foster care; ACT ~ residential care and foster care; and NT ~ foster care and cottage homes.

1 Indicates service provider split from client data. Comparison of government and non-government costs of service provision is not accurate due to structural differences.

2 Fourteen per cent of service agreements are via contracts with the remainder letters of agreement .

3 Process and input performance indicators, as well as output specifications and standards (see table A.6).

4 Outcome measures include the degree of improvement in client performance.

5 As of April 1997; currently all provision is subject to open tender to be completed by July 1997, resulting in some providers not having new service agreements in place.

6 Output states the type of service provided (for example, support services to communities, families and individuals) and the deliverable service (for example, adoption services to clients).

7 Agreements are between the corporate office and each region within the State.

8 General performance indicators concentrating on output measures (for example, number of clients; beds provided).

9 Output measures are for the whole of the program rather than for particular providers or types of service provision.

10 Performance indicators are input based (for example, ratio of inputs to output) and output based (for example, level of output).

11 There are service agreeme nts with foster carers recruited, trained and supervised by the department. Departmental cottage homes do not have service agreements.

12 Includes the number of children in care, the number of carers, and the availability of providers for departmental case reviews.

Table A.2: Arrangements for out-of-home placement services

	Existing services competitively tendered	*New services competitively tendered*	*Length of service agreement*	*For-profit providers can compete with not-for-profits*	*Inhouse providers can compete with non-government providers*
NSW	17%	yes	3 yrs	yes	no[1]
Vic.	no[2]	yes	1 yr[3]	no	no[4]
Qld	no	no[5]	1 yr	no	no
WA	no	yes[6]	3 yrs[7]	no	no
SA	no[8]	yes	3 yrs	no	no
Tas.	no	yes[9]	1 yr[10]	yes	no
ACT	no	yes	1 yr	yes	no
NT	no	no	3 yrs	n/a	no

n/a not applicable

1 Inhouse providers can provide services if the external tendering process is unsuccessful.

2 Currently all new services or services that have had significant redevelopment are subject to tender processes, before the development of the new program purchasing framework.

3 Treasury guidelines only permit the department to enter into 12 month contracts. However, as part of the new purchasing arrangements it is expected that services purchased via competitive tender will have three year contracts.

4 Capacity for inhouse tenders will be considered a part of the service redevelopment process and subsequent development of the program purchasing framework.

5 A small number of services will be tendered following the reform process this year.

6 A request for pr oposal process is initiated.

7 The services are to be reviewed annually, in accordance with the Non-Government Funding Guidelines manual.

8 As of April 1997; currently all provision is subject to open tender to be completed by July 1997.

9 Department determines funding level and awards a tender on the quality, organisational experience and standards of the submitting agencies.

10 While most contracts are for 12 months, the department has the capacity to offer three year contracts once certain standards are met by the service provider.

Table A.3: Internal and external provision of family support services

	Funding split	*Internal provision*				*External provision*		
	Internal: external	*Purchaser/ provider*	*Main funding basis*	*Service agreement coverage*	*Performance indicators*	*Main funding basis*	*Service agreement coverage*	*Performance indicators*
NSW	0 : 100[1]	n/a	n/a	n/a	n/a	output	76-100%	yes
Vic	0 : 100	n/a	n/a	n/a	n/a	output	76-100%	no
Qld	20 : 80[2]	no	input	no	no	input[3]	90-100%	yes[8]
WA	30 : 70[2]	no	input	0	yes	output, outcome[4]	100%	yes
SA	50 : 50[5]	no	input	no	no	output	100%	yes
Tas	10 : 90[6]	no	output[7]	100%	yes	input	100%	no
ACT	0 : 100	n/a	n/a	n/a	n/a	output	100%	yes[8]
NT	40 : 60	no	input	yes[9]	no	output	76-100%	no

n/a not applicable

1 As part of a continuum of child protection and family support, the government provides financial assistance, respite care, counselling and child care to vulnerable families.

2 This estimate includes to all family support services, provided as part of a child protection res ponse.

3 As service agreements or contracts are renewed or tendered, annual block grants will specify expenditure by components, negotiated between the agency and the Department.

4 Customer satisfaction and worker assessments.

5 Includes internal services not directly related to child protection.

6 Does not include Child Health Services.

7 Output states the type of service provided (e.g. support services to communities, families and individuals) and the deliverable services (e.g. adoption services to clients).

8 General performance indicators are used (e.g. number of families provided with services compared to the number of salary dollars provided).

9 Internal providers have business plans which contain some performance measures. These include timeliness of response to requests, waiting times, degree of service referral, availability of specialists and the length of the contract with clients.

Table A.4: Arrangements for family support services

	Existing services competitively tendered	*New services competitively tendered*	*Length of service agreement*	*For-profit providers can compete with not-for-profits*	*Inhouse providers can compete with non-government providers*
NSW	no	yes[1]	3 yrs	yes	n/a
Vic.	no	yes	1 yr[2]	yes	n/a
Qld	no	no[3]	1 yr	no	no
WA	no	yes[4]	3 yrs[5]	no	no
SA	yes[6]	yes[6]	3yrs	no	no
Tas.	no	yes	1 yr[7]	yes	no
ACT	no	yes	1 yr	yes	no
NT	no	no	3 yrs	n/a	no

n/a not applicable

1 A proposal process is initiated.

2 Treasury guidelines only permit the department to enter into 12 month contracts. However, as part of the new purchasing arrangements it is expected that services purchased via competitive tender will have three year contracts.

3 A small number only of new services are competitively tendered.

4 A request for proposal process is initiated.

5 The services are to be reviewed annually, in accordance with the Non-Government Funding Guidelines manual.

6 Applicable to external providers only.

7 While most contracts are for 12 months, the department has the capacity to offer three year contracts once certain standards are met by the service provider.

Table A.5: Child protection services

	Funding split	*Internal provision*			
	Internal: external	*Purchaser/ provider*	*Main funding basis*	*Service agreement coverage*	*Performance indicators*
NSW	100 : 0	no	input	0	yes[1]
Vic.	100 : 0[2]	no	input	0	yes
Qld	100 : 0	no	input	0	yes[3]
WA[4]	100 : 0	no	input	0	no
SA	100 : 0	no	input	0	no
Tas.	100 : 0	no	output[5]	100%[6]	yes
ACT	100 : 0	no	output	0	yes[7]
NT	100 : 0	no	input	0	no

1 There is broad performance monitoring of the child protection system.

2 There are formal arrangements in operation to contract case management of child protection cases to non-government service providers. Currently, approximately 20 per cent of post-substantiated child protection cases are formally contracted.

3 There is broad performance monitoring. Resource agreements to be implemented in 1997–98 will include performance indicators.

4 This relates to the investigative and assessment components of child protection services. However, some non-government services are funded to provide treatment and intervention services.

5 Outputs state the type of service provided (for example, support services to communities, families and individuals) and the deliverable services (for example, protection and support services for children and families at risk of harm, abuse or neglect).

6 Service agreements between the central office and the three regions provide for very general standards and quality of service.

7 These are output measures.

Arrangements with external providers — some issues

Tighter specifications

All jurisdictions reported that over time there has been a tightening of specifications in service agreements with external providers, but they recognised that there was considerable room for development in the way the level of output, outcomes and service quality are specified.

Tasmania is staging the process of improving service agreement specifications. The department's approach has been to negotiate acceptance of service agreements with the sector before introducing more detailed service specifications as agreements are renewed or renegotiated.

In NSW, current service agreements for out-of-home placements specify minimum levels of use of service by particular target groups. The department plans to introduce an accreditation system for out-of-home placement services covering both internally and externally provided and funded services in 1998.

In Victoria, service agreements for family support services incorporate an individual service plan for each service provided by the provider, including broad specifications of output (for example, client numbers and hours; availability of support services) and inputs (for example, qualifications of staff to be used).

Over time the specifications of output in Victorian out-of-home placement service agreements and the individual service plans have become more detailed. Initially, the total number of beds was the output specified. Now a number and mix of outputs are specified, each with a different unit cost. The targeting of services is contracted via the funding and service agreements with the individual agency, and the department has targeted the client group and core business of each service type.

In the NT, as three year service agreements for out-of-home placements are renegotiated, the department is introducing greater specification of quality of outputs (for example, stability of placement and measures of service quality).

Tasmanian service agreements with internal providers of

family support services specify the types of services to be purchased with the objectives to be met by those services (for example, hours of service delivery expected).

Funding arrangements

In NSW, output based funding is used more for intensive family services (these target protective intervention cases) than for other family support services. In intensive family services, agreements with external providers specify the quantity of the service to be provided (for example, the minimum number of children to be provided with services, hours of input) and outcomes for the clients.

NSW plans to fund non-government organisations to provide foster care according to a unit costing approach. A points system will be introduced from 1998 whereby cases are classified according to the intensity of the case. Each case worker is to be funded to provide a specified number of case types. Funding for each case worker is to be based on case types including overheads (except rent). Non-government organisations will also receive a grant to cover the cost of rent.

In WA, requests for proposals for out-of-home placement services are called on a fixed price basis, in which the department fixes the level of funding available. Non-government organisations bid on the basis of the quantity and quality of the service they can provide in line with the services specifications.

In Victoria, from July 1 1997, a performance based funding system will be implemented to define and better develop the link between agency performance and funding levels. The department views this system as an appropriate transition phase between the current system of single block grant funding and full output purchasing. This establishes a sound platform for the future contestable and competitive tendering framework. This in turn will strengthen the funder/provider relationship being developed between the Government and the service provider agencies.

The system is based on unit prices and negotiated placement targets, with funding for core services calculated by the equation: *placement target(s) x unit price(s)*If a service provider's actual placement performance, as compared with the target, is within a nominated bandwidth, 100 per cent

funding will be maintained. Service provider agencies whose performance is outside the bandwidth may be subject to a funding adjustment.

Victoria has also begun a number of new funding initiatives, introducing more flexible funding packages to purchase individually tailored service responses. A base unit price has been established, but each arrangement is negotiated to meet the clients' care needs. The department considers that this has been particularly successful for new service responses for high risk adolescents in out-of-home care.

In Queensland out-of-home placement services, the current funding mechanism of specified expenditure components (for example, salaries and operating expenses) will be gradually replaced from July 1997. Under the new system, providers will negotiate the breakdown of expenditure by components, rather than have the components determined by the department. In addition, it is proposed that service providers will receive an incentive payment if a certain benchmark of performance is met. This payment would be automatic with the benchmarks and the size of the potential payment agreed beforehand. The benchmark being considered is output based (the number of placements provided) adjusted for client need levels (the degree of difficulty of those placements).

In Tasmania, only new out-of-home placement services will be tendered, on a fixed price basis with specified outputs. The department selects providers on the basis of the expected quality of the service.

Client satisfaction

In all jurisdictions, except WA, no direct mechanisms exist to measure client satisfaction with the services offered or the providers who deliver them. Client feedback is typically provided through grievance mechanisms — for example: in NSW through an independent statutory authority, the Community Services Commission, and an internal complaints mechanism, and through evaluations of child and family teams; and in Tasmania through the whole of government client complaints system.

WA monitors the satisfaction that clients receive when dealing with the Family and Children's Services Department. In addition, it has a system in place to formally survey clients

about their satisfaction with services provided by non-government providers[2]. Client feedback, including satisfaction surveys, is used by providers to evaluate their own performance and for public reporting through the department's annual report.

Client choice

For some services (for example, counselling services and parenting skills programs), clients elect whether to enter the service. If there is more than one provider in an area and places are available, then the client may also choose the provider. In Victoria, individuals who voluntarily seek access to alternative care services may approach an agency directly to negotiate a placement. This can be contracted between the service provider and parent/guardian by way of a child care agreement. In most jurisdictions, clients who must receive a service because they are provided under statutory provisions (for example, the investigation of suspected child abuse and neglect, or the provision of out-of-home placement services for reasons of child safety) may also be unable to choose the provider. However, in WA, clients may be able to choose some intervention and support services provided in a statutory framework.

In Victoria, for statutory clients, the most appropriate service available is determined via the placement coordination units within the departmental regional offices and then negotiated with the individual service provider.

Rewards and sanctions

Several jurisdictions noted that imprecise specifications for many community services, where they existed at all, have made it difficult to establish objectively how well providers are performing.

Financial penalties for under performance have been rare. In WA, sanctions are usually considered inappropriate, although service agreements outline grievance resolution procedures and how monies may be withheld during grievance processes. In most jurisdictions, the only real sanction has been to cease

[2] Yet to be introduced with services provided for out-of-home care.

funding at the end of the period of the grant or service agreement (or, on occasion, to withhold funding during the period). These approaches have also often been difficult to justify, with departments resorting to a redesign of services as a means of revisiting who should be the providers.

In Victoria, under the performance based funding system, performance bandwidths have been determined (for 90–110 per cent residential care programs, 85–110 per cent for home based care programs) and agencies performing within those bandwidths will have 100 per cent funding maintained. Agencies outside the bandwidths may be subject to a funding adjustment. In addition, the existence of any special circumstances which affected a service provider's ability to achieve their placement target is considered before any funding adjustment being made. Payments are adjusted against the annual funding level according to the variation of performance (including special circumstances considered) from the outer parameter of the bandwidth.

Jurisdictions noted that they sought to influence the provider's practices in the absence of more explicit rewards and sanctions. Common approaches included providing support and advice, for example, through discussions with the management or boards of providers. In some jurisdictions it is considered appropriate to encourage changes in a providers' management board, while other jurisdictions would not take this approach because it is an issue for the Committee or Board of Management.

Contracting skills

In the past, department staff developing service agreements and monitoring non-government providers have generally had community development and consultation skills.

More recently, in NSW, staff have been recruited with contract management skills for specialised contracting positions (for example, NSW area based managers of service planning monitoring and evaluation). In WA, the unit with responsibility for ensuring compliance with purchasing of non-government services is required to meet International and Australian Quality Assurance Standards. In Victoria, there is a whole - of - government approach to improved training for contract management skills. This includes Department of

Treasury and Finance guidelines for contracting out (including training guidelines) and the use of a standard training model by all departments.

Within each region of Victoria, management teams are responsible for out-of-home services which are contracted out, while client services teams manage in-house provision.

Competition All jurisdictions reported that they are seeking to introduce more opportunities for using competitive processes to enhance the objectivity of provider selection, particularly for new services. The ACT, the NT and Tasmania noted that there were concerns about likely vigour of competition as a result of their relatively small markets. Other jurisdictions expressed similar concerns about services to rural clients.

Table A.6: Performance monitoring of external providers – out-of-home placements and family support services[+]

	Frequency of written report to department	*Provider reports to the department's:*	*Information contained in the report to the Department*	*Is there a formal process for feedback to providers on performance?*[1]
NSW	monthly[2]	central office	targeting[3], quantity, financial	no
Vic.	monthly	regional office	quality, quantity, financial	yes
Qld	quarterly	regional office	quantity, financial	yes
WA	three monthly	district and central offices	financial	yes
	six monthly	district and central offices	quality, quantity	yes
SA	quarterly[4]	central office	financial	no
Tas.[5]	quarterly	regional office	quality, quantity, financial	yes
ACT	annually	central office	input, quantity, financial	yes
NT	annually	central office	quality, quantity, financial	no

+ Except as footnoted for NSW, Victoria and Tasmania, performance monitoring is the same for out-of-home placements and family support services.

1 A formal process is defined as one where the process is specified and systematic. Meetings held between providers and the department's regional offices do not form part of a systematic or formal performance monitoring process unless there is a clearly specified process of feedback and performance monitoring.

2 Providers of family support services submit annual written reports; in other respects performance monitoring is the same as for out-of-home placements.

3 Non-identifying client data — services provided to each demographic group.

4 A system of six monthly, but more detailed, monitoring with feedback to poor performers is being trialed.

5 Family support services annual reports contain financial data, client data and activity data.

Glossary: Targeting The required minimum share of state wards to total clients.
Input Input based ratios (for example, the ratio of inputs to outputs).
Quantity Measure of quantity of output (for example, number of clients or bed days).
Financial Income and expenditure statements for the funded service.

Quality	Quality measures (for example, service access hours and access of provider to department case workers).
Meetings	Regular one-to-one meetings with providers where performance matters are discussed.

Performance monitoring

All jurisdictions reported that they are refining performance information in concert with the development of tighter service specifications, although progress differs across services. NSW, Victoria and Tasmania commented that output and performance indicators are being specified more clearly in external providers' service agreements as they are renewed, allowing non-performance to be more clearly demonstrated.

In Victoria, the actual agency placement performance and the financial impact of that actual performance, as compared with target performance and negotiated funding, can be monitored throughout the year via a recently implemented agency based data collection system (FACTS).

NSW is introducing a standardised reporting mechanism across services to replace the current unsystematic approach. This system will set down the standard information that is required from all non-government providers. An accreditation process will be introduced in 1998. The sanctions/rewards linked to the process are yet to be determined. However, the system is being designed for service development rather than as a monitoring mechanism in the first instance.

In Tasmania, out-of-home placement providers receive formal feedback on an annual basis when, following self-assessment, they are assessed against standards. Currently, family support service providers do not have formal service standards or outcomes for clients specified in their service agreements. The department reported that this makes performance evaluation difficult.

Table A.7: Publicly available information

	Grant funded providers by services		*Contracted providers by services*[1]		*Specifications in*	*Performance*	*Providers' performance against those indicators*	
	Providers' names	*Level of funding*	*Providers' names*	*Level of funding*	*service agreements*	*indicators*	*By individual provider*	*In aggregate only*
NSW	A	A	A	A	F	F	n/a	n/a
Vic.	E	B	B	B	F	F	no	no
Qld	A	A	A	A	F	F	no	yes (G)
WA	D	D	D	D	yes	yes	no	yes (A)
SA	A	A	A	A	no	no	no	no
Tas.	C	C	C	C	C	C	C	yes (C)
ACT	A	no	A	no	no	yes	no	no
NT	B	A	no	A, B	no	no	no	no

n/a not applicable

1 Contracted services include those covered by a service agreement, including those that have been competitively tendered.

A Published in the department's annual report.

B Organisations make known their source of funding in their own annual reports which, in most cases for larger non-government organisations, is available to the public.

C Information pertaining to grants and contracts is only available upon request.

D Media releases, letters to Members of Parliament, parliamentary questions and on request.

E Community services approved by the Secretary Department of Human Services.

F Freedom of information legislation.

G Information pertaining to performance is available upon request.

B SURVEY OF PUBLIC HOSPITAL FUNDING ARRANGEMENTS

This appendix examines the introduction of casemix funding into the public hospital sector. It provides information on the extent to which the changes introduced in Victoria (dealt with in detail in the case study) are being used elsewhere and how they have been implemented.

The information provided canvasses a range of issues, including:

- the size and structure of the public hospital sector;
- the use of casemix funding;
- the casemix funding model used;
- the structure of hospital costs;
- rewards and sanctions;
- the impact of introducing casemix funding; and
- the transitional arrangements put in place to facilitate reform.

Information was collected from the relevant department in each State and Territory by the Steering Committee Secretariat.

Table B.1: The public hospital sector in each jurisdiction (1994-95)

	Number of public hospitals		*Total separations*	*Recurrent expenditure*
	Teaching	*Non-teaching*	*(000)*	*($ million)*
NSW	10	176	1 215	3 877
Vic.	16	109	845	2 419
Qld	8	174	604	1 588
WA	5[1]	84	337	879
SA	6	70	295	898
Tas.	2[2]	15	77	263
ACT	1	1	55	199
NT	2	3	42	125

1 The Princess Margaret and King Edward Memorial Hospitals are u nder one management.

2 Tasmania currently has 2 teaching hospitals and 15 district hospitals. From 1 July 1997, there will be 3 teaching hospitals and 14 district hospitals, and funding for the teaching hospitals will be based on their casemix.

Source: SCRCSSP (1997).

Table B.2: Use of service agreements

	Service agreements	*Parties to the agreement*	*Agreements specify outputs*
NSW	yes[1]	Department ⇔ Area Health Services	yes[2]
Vic.	yes	Department ⇔ metropolitan network/non-metropolitan hospital	yes
Qld	yes	Department ⇔ metropolitan/regional network ⇔ hospital	yes
WA	yes	Department ⇔ Health Service[3]	yes
SA	yes[4]	Department ⇔ hospital	yes
Tas.	yes	Department ⇔ regional management[5]	yes
ACT	yes	Department ⇔ hospital	yes
NT	yes	Department ⇔ hospital[6]	yes
		Department ⇔ region ⇔ hospital[7]	

1 There are performance agreements between the department and Area Health Services that include performance indicators across a wide range of strategies relating to health improvement targets, access and equity, and quality improvement.

2 From 1997–98, areas receiving funding enhancements will be set output targets based on casemix weighted activity.

3 A Health Service comprises one or more hospitals plus other services, such as community health.

4 From 1 July 1997, agreements with country hospitals will be converted to regional agreements.

5 From 1 July 1997, service agreements will be between the department and hospitals and will exclude district hospitals which are currently under a different program.

6 Royal Darwin Hospital has an agreement directly with the department.

7 The three way agreement applies to the remaining four hospitals in the Northern Territory.

Table B.3: Use of casemix funding

	Activities which are casemix funded			*Reasons for using casemix funding*				
	Acute inpatients	*Non-admitted patients*	*Other*	*Reduce costs*	*Improve access*	*Improve efficiency*	*Transparent funding method*	*Ensure an appropriate mix of services*
NSW	yes[1]	no	n/a	n/a	n/a	yes	yes	yes
Vic.	yes	yes[2]	n/a	yes	n/a	yes	yes	n/a
QLD[3]	yes	yes	sub- and non-acute inpatients	yes	yes	yes	yes	n/a
WA	no[4]	no	n/a	yes	yes	yes	yes	yes
SA[5]	yes	yes	home oxygen retrievals; sub- and non-acute inpatients	yes	yes	yes	yes	yes
Tas.	no[6]	no	n/a	n/a	yes	yes	yes	yes
ACT	yes	yes	sub- and non-acute inpatients[7]	yes	yes	yes	yes	yes
NT	yes	yes		n/a	n/a	yes	yes	yes

n/a not applicable.

1 Casemix is used to guide funding to hospitals at an area level. Area Health Services are allocated a budget based on need (assessed using a population based formula). Areas then determine what proportion of their total health budget is allocated to acute inpatient services. The department has published guidelines on casemix budgeting for areas to use when determining funding for hospitals on the basis of their share of casemix activity.

2 Group A (teaching) hospitals commencing 1 July 1997.

3 Districts receive funding based on need and districts allocate that funding according to the casemix of each hospital.

4 From 1 July 1997, acute inpatient services will be funded according to casemix

5 From 1 July 1997, domiciliary care and district nursing services should be output based funded.

6 From 1 July 1997, acute inpatient services will be funded according to casemix for teaching hospitals.
7 Funded on occupied bed days.

Table B.4: Output classification and cost weight model

	Output classification		*Cost weights used*			*Why use own cost*	*How often variable are changed*	
	National system	*Own system*	*National set*	*Own set*	*Other*	*weights*	*Classification*	*Cost weights*
NSW	acute inpatients			acute inpatients[1]		A, B	National timetable	Annually
Vic.	acute inpatients	non-admitted patients		non-admitted patients; acute inpatients		A, B, C, D	Annually	Annually
Qld	acute inpatients; sub- and non- acute inpatients	non-admitted patients	acute inpatients[2]	non-admitted patients; sub- and non-acute inpatients		A, D	National timetable	Annually
WA	acute inpatients		acute inpatients[3]			A, B, C		Annually[4]
SA	acute inpatients	non-admitted patients	acute inpatients	non-admitted patients		A, B, D	National timetable/ State timetable	Annually
Tas.	acute inpatients		acute inpatients				National timetable	Annually[4]
ACT	acute inpatients	non-admitted patients[5], sub- and non-acute inpatients	acute inpatients	sub- and non-acute inpatients	non-admitted patients[5]	A	National timetable	
NT	acute inpatients	non-admitted patients[5]	acute inpatients		non-admitted patients[5]		National timetable	Annually

1 Based on NSW data in the national set of cost weights with some adjustment made for same day procedures and prosthetics.
2 Based o n the national set of cost weights but with some modification for intensive care units and prosthetics.
3 From 1 July 1997, WA will use its own cost weights for acute inpatients.
4 The department expects to revise cost weights annually.
5 SA classification system and cost weights.

A Own weights are more relevant.
B Own weights are more accurate.
C National weights are out of date.
D National weights have not been developed.

Table B.5: Pricing mechanism

	Department sets price	*Type of funding*		*Basis for setting price*	*Price recognises that some costs vary more directly with changes in output levels*
		Recurrent	*Capital*		
NSW	n/a[1]	n/a	n/a	n/a	n/a
Vic.	yes	yes	no[2]	A	yes
Qld	yes	yes	no[3]	B	yes
WA	yes	yes	yes[4]	C	yes
SA	yes	yes	no	C	yes
Tas.	yes	yes	no	D	no
ACT	yes	yes	yes[5]	D	yes
NT	yes	yes	no	D	yes

1 Where casemix budgeting is used, Area Health Services determine the average price.

2 Providers receive funding for minor capital based on casemix targets.

3 From 1 July 1997, a notional capital asset c harge will be incorporated into the price. This will be replaced with the real capital asset charge from 1 July 1998.

4 From 1 July 1997, the funding mechanism will allow for depreciation of capital equipment.

5 Currently an allowance is made for major plant and equipment (> $5000). From 1 July 1997, the allowance will cover only minor plant and equipment.

A State financial position and interstate comparative costs.

B Average performance of a sample of hos pitals.

C Average performance less efficiency requirements.

D National benchmark.

Table B.6: Adjustment for cost variations

	Adjustment for variations in patient costs		*Reasons for cost variations between hospitals*		*How are cost variations dealt with*		
	Low-stay and high-stay outliers	*High cost equipment*	*Severity of patients*	*Differences in settings*	*Additional payment to teaching hospitals*	*Additional payment to non-metropolitan hospitals*	*Other*
NSW	yes[1]	n/a	yes	yes	yes[1]	n/a	Separate funding formula for hospitals with more than 50 beds is being developed
Vic.	yes	yes	yes	yes	yes	yes	n/a
Qld	yes	yes	yes	yes	yes	yes[2]	n/a
WA	yes[3]	yes[4]	yes	yes	yes	yes	Grant funding for specific health programs
SA	yes	n/a	yes	yes	yes	yes	n/a
Tas.	yes	n/a	yes	yes	yes	n/a	n/a
ACT	yes	n/a	yes	n/a	yes	n/a	n/a
NT	yes	n/a	yes	yes	yes	n/a	Extra payment for hospitals treating less than 10 patients in a particular DRG Severity index for three DRGs

n/a not applicable
1 Included in guidelines for Area Health Services applying casemix budgeting principles to internal hospital funding.
2 Non-metropolitan hospitals compensated for infrastructure costs.
3 From 1 July 1997.
4 Providers receive indirect funding for high cost equipment.

Table B.7: Competition between providers and monitoring of providers

			Impact on monitoring of providers	
	Measures to promote competition	*Funding for additional throughput*	*Increased detail*	*Increased timeliness*
NSW	n/a	n/a	yes	yes
Vic.	Additional throughput pool	B	yes	yes
	Tender pool[1]			
Qld	Incentive pool	B	yes	yes
WA	n/a	n/a	yes	yes
SA	Targeted activity pool; tendering of state pathology services	D[2]	no	yes
Tas	n/a	n/a	yes	yes
ACT	Additional throughput pool; tendering to private sector providers	B	yes	yes
NT	n/a[3]	n/a	yes	yes

n/a not applicable
1 From 1 July 1997.
2 Marginal cost
3 The Northern Territory is working towards establishing an incentive pool in the second year of the new funding arrangements.
A Full payment per person B Full variable payment per standardised separation (or tender price from 1 July 1997)
C Declining variable paym ent per standardised separation D Other

Table B.8: Rewards and sanctions

	Rewards			*Sanctions*	
	Retain efficiency dividend	*Increased autonomy*	*Gain market share*	*Financial penalties*	*Hospital closure*
NSW[1]	n/a	n/a	n/a	n/a	n/a
Vic.	yes	yes	yes	yes	yes[2]
Qld	n/a	n/a	n/a	yes[3]	n/a
WA	n/a	n/a	yes[4]	n/a	n/a
SA	yes	n/a	n/a	yes	n/a
Tas.	yes	yes	n/a	yes	n/a
ACT	yes	yes	yes	yes	n/a
NT	yes	n/a	n/a	n/a	n/a

n/a not applicable

1 Area Health Services are accountable to the department for meeting performance targets in Performance Agreements and for achieving service targets set where enhanced funding is provided. Rewards and sanctions within an area are a matter for the Area Health Service to determine when applying casemix budgeting guidelines.

2 Other sanctions include changing hospital management.

3 Apply to incentive pool.

4 From 1 July 1997, there may be opportunities for hospitals to increase their market share through access to the Exceptional Episode Insurance Pool.

Table B.9: Impact of casemix funding

	Changes that maintained or improved quality					*Benefits achieved from introducing casemix funding*				
	Quality specified in output	*Internal review processes upgraded*	*External monitoring* [1]	*Funding for accreditation*	*Quality assurance plans developed*	*Increased efficiency*	*Costs identified*	*Decline in waiting times*	*Trans-parent funding system*	*Increased focus on role of hospitals*
NSW	n/a	yes	yes	yes	yes	yes	yes	n/a	yes	yes[2]
Vic	yes[3]	yes	yes	yes	yes	yes	yes	yes	yes	yes
Qld	yes[4]	yes[4]	yes[4]	yes[4]	yes[4]	yes	yes	yes	yes	yes
WA	yes	n/a	yes	yes[5]	n/a	n/a	yes	yes	yes	yes
SA	yes	n/a	yes[6]	yes	yes	yes	yes	yes	yes	yes
Tas	yes	yes[4]	yes[4]	yes	yes[4]	yes	yes	yes	yes	yes[2]
ACT	yes	yes	yes	yes[4]	yes	yes	yes	yes	yes	yes
NT	yes	yes	yes	n/a	yes	yes	yes	yes	yes	yes

n/a not applicable

1 Using quality indicators, client feedback and/or coding audits.

2 Improved hospital management.

3 Funding bonuses paid for meeting performance requirements.

4 Introduced before casemix funding.

5 The Department provides some assistance to providers to e ncourage accreditation.

6` External monitoring of quality is carried out irregularly. The Health Commission is currently reviewing whether quality should be monitored centrally.

Table B.10: Transitional arrangements

	Compensation payments	*Payments to cover early retirements and voluntary redundancies*
NSW[1]	n/a	n/a
Vic.	One-off payment in the first year	One-off payment in the first year
Qld	To be phased out; payment negotiated at district level	Ongoing voluntary redundancies
WA	To be phased out over a period to be determined	n/a
SA	To be phased out over a period to be determined	Ongoing voluntary redundancies
Tas.	Payments expected to be phased out over three years	n/a
ACT	To be phased out over a period to be determined	One-off payment in the first year
NT	To be phased out over a period to be determined	n/a

n/a not applicable

1 Transitional arrangements are handled by the Area Health Services when applying guidelines on internal casemix budgeting.

C SURVEY OF PRISON CONTRACTING

This appendix summarises how and why private contracting has been introduced into the operations of prisons in Australia. The focus is on the processes involved in contracting and the summary details of the contracts adopted. Its purpose is to provide a context for the more detailed material presented in the case study of competitive tendering of prisons in Queensland.

The information covers: details of the prisons contracted; the services contracted in individual prisons; factors influencing the decision to contract; how inhouse bids were incorporated into contracting out; the tender evaluation process; details of the contract; whether service standards differ between public and private prisons; and the processes in place to share information between private and public prison managers.

Table C.1: The prison system in each jurisdiction (1995–96)

Jurisdiction	*Prisoners*		*Prisons*	
	total	*CTC (per cent)*	*total (no.)*	*CTC (no.)*
NSW	6 300	9	30	1
Vic.[1]	2 400	45	15	3
Qld[2]	3 100	30	15	2
WA	2 200	nil	14	nil
SA	1 400	8	9	1
Tas.	270	nil	6	nil
ACT	110	nil	1	nil
NT	470	nil	3	nil
Total	**16 250**	**17**	**93**	**7**

CTC — prisoners in competitively tendered and contracted centres.

1 As of December 1997.

2 Relates to the two private prisons in operation in 1995 –96. Woodford began operations in 1997.

Source: SCRCSSP (1997).

Table C.2: Contracted services in prisons[1]

	Prison	*Operator*	*Capacity*	*Classification*[2]	*Opened*	*Operator owns*[3]	*Activities contracted*[4]							
NSW	Junee CC	ACM	600	M, L	1993	all except B, L	D	B		C	P	M	Md	S
Vic	MWCC	CCA	125	all	1996	all except L	D	B	F	C	P	M	Md	
	Fulham CC	ACM	600	M, L	1997	all except L	D	B	F	C	P	M	Md	
	MMP	Group 4	600	H	1997	all except L	D	B	F	C	P	M	Md	
Qld	Borallon	CCA	389	M, L	1990	V Ind. Hob.				C	P		Md	S
	Arthur Gorrie	ACM	458	R	1992	V Ind. Hob.				C	P		Md	S
	Woodford	QCSC	600	H,M	1997	V & chattels[5]	D	B	F	C	P	M	Md	S
SA	Mt Gambier	Group 4	110	M,L	1995	V Ind. Hob.				C	P	M	Md	S[6]

1 WA and Tasmania have no privately contracted prison services. All ACT sentenced prisoners have been held in NSW prisons since 1971, except for periodic detainees, prisoners on parole and prisoners on remand.

2 H — high; M — medium; L — low; R — reception and remand.

3 V — vehicles; B — buildings; L — land; Ind. — industries equipment; Hob. — hobbies equipment.

4 D — design; B — build; F — finance; C — containment; P — programs; M — maintenance; Md — on-site medical (excludes off-site hospitals); S — sentence management (excludes prisoner security classification).

5 On corporatisation (1 July 1997) buildings and land will remain with the purchaser QCSC while vehicles and chattels will be the proper ty of QCORR, the operator.

6 Assessment by the Department of Corrective Services prisoner assessment committee.

Factors influencing the decision to contract

New South Wales

Factors that influenced the decision to contract the design, construction and management of Junee Correctional Centre, which opened in 1993, included:

- growth in prisoner numbers and the need for more beds;
- a desire to achieve workplace and industrial relations reforms in the public sector; and
- a desire to reduce budget outlays through efficiency driven by competition.

The NSW Department of Corrective Services also has a program of market testing support services to improve service delivery and reduce costs. A number of non-core functions such as payrolls, legal services, catering, information technology, maintenance and management of vehicles (totalling $26.6 million) were contracted at the end of August 1996.

Victoria

The main reason given for establishing private prisons was to introduce new approaches to design, construction and management of prisons by:

- reducing the costs of new infrastructure;
- reducing costs through improved working practices;
- improving the quality of services to prisoners;
- transferring risk to the private sector; and
- establishing competition between private and public sector providers.

There was a desire to create a private competitive market in corrections, so no inhouse bids have been sought.

Queensland

Industrial relations and work practices in public prisons and the related desire to change the 'culture' in public prisons were important factors in the decision to introduce private management. It was also believed that privately managed prisons would be cheaper to operate than equivalent publicly operated prisons.

South Australia Significant factors included the desire to introduce innovation into the running of prisons and thereby improve the practices in the public prisons. Cost factors were also important, including the desire to reduce budget outlays and public debt through the introduction of lower cost private management.

Factors influencing the decision not to contract

Western Australia There is an agreement with the public sector workforce that there will be no consideration of privatisation until the end of 1997. The potential for private operations and the introduction of private operations in other jurisdictions are considered by WA Corrective Services as having enabled them to negotiate changes in conditions of employment in prisons. These have significantly reduced costs, including the abolition of the 38 hour week and penalties and the reduction of sick leave entitlements by 50 per cent. It is likely that a new prison will be built in the future, and it may be put to tender. It is unclear as to whether there would be an inhouse bid in this circumstance.

Tasmania The Tasmanian Department of Corrective Services believes that the publicly operated prisons have been, and continue to be cost-effective. Moreover, given the small scale of prisons (270 prisoners across four prisons) they would be relatively unattractive to private operators.

The Government has initiated a review by the Treasury and Justice Departments to identify options for the effective and efficient operation of prison services in the medium to long term, including staff levels. The review is due to be concluded at the end of March 1997.

A new 50 bed remand centre (including the police watch house), is to be completed by April 1998. Seeking expressions of interest from private firms for the operation of this centre may be considered.

Australian Capital Prisoner numbers, including periodic detainees, are small (160). The ACT maintains a centre for remand prisoners and a

Territory periodic detention centre. Sentenced prisoners are managed by the NSW correctional system pursuant to an agreement between the NSW and ACT Governments. The Attorney General is reviewing ACT corrective services needs to determine how these needs could be satisfied. All relevant options will be assessed in the course of that review.

Northern Territory In 1991 the NT Government sought proposals from four private firms to privately manage a prison being built to replace the Alice Springs Correctional Centre. However, they did not go to tender because the costs of public sector operators (which were predicated on changes in working conditions and the rostering) were similar to those indicated by private firms.

The NT has no privately operated prisons, but it does contract out its prison based medical services at the Darwin Correctional Centre to Wake Nominees and at its Alice Springs Correctional Centre to the Central Australian Aboriginal Congress.

Table C.3: How inhouse bids were incorporated into competitive tendering and contracting

	Prison	*Inhouse bids permitted*	*Any persons involved in deciding the tender specification involved in preparing the inhouse bid*	*Separation of inhouse bid team from tender evaluation staff*	*Inhouse bid costing guidelines*
NSW	Junee	no	n/a	n/a	n/a
Vic.	MWCC	no	n/a	n/a	n/a
	Fulham	no	n/a	n/a	n/a
	MMP	no	n/a	n/a	n/a
Qld	Borallon	no	n/a	n/a	
	Arthur Gorrie	no	n/a	n/a	
	Woodford	yes	yes: one or two staff	The inhouse bid and tender evaluation teams were kept separate and not permitted to communicate	not public
SA	Mt Gambier	yes	no	Code of conduct and rules of engagement documents provided guidelines to separate the teams	Dept of Defence guidelines and what was done in NSW[1]

n/a not applicable

1 At the time the contract was signed SA guidelines had not been developed.

Table C.4: Details of the tender evaluation process

	Prison	*Firms responding to expressions of interest*	*Tenders submitted*	*Tender evaluation committee membership*[1]	*Independent probity auditor*
NSW	Junee	8	4	A B C D E F	yes
Vic.	MWCC	5	3	A C D	yes
	Fulham	5	4	A C D	yes
	MMP	5	3	A C D	yes
Qld	Borallon	5	3	A B C	no
	Arthur Gorrie	7	3	A B C	no
	Woodford	5	3	A B C D G	yes
SA	Mt Gambier	5	5	A B C F O	yes

1 A — correctional services (client); B — Premiers/Chief Ministers department; C — Treasury; D — public works department; E — independent prisons expert; F — private sector; G — independent chairperson; O — other.

Table C.5: Details about the contracts with the operators

	Service defined	*Common service standards (private and public)*	*Stakeholders involved in determining standards*	*Service specification publicly available*
NSW	Minimum standards; processes where a legislative/ system requirement	differ	none	yes
Vic.	Mix of outcomes and processes	same (as of 1 July 1997)	Correctional Agency; Department of Justice; Treasury	yes
Qld	Mix of outcomes, inputs and processes, minimum standards	same (as of 1 July 1997)	Correctional Agency	yes
SA	Mix of outcomes and processes[1]	differ	Treasury and Crown Solicitor	no

1 Outcomes are called 'results' and are defined in terms of 'intent statements' for prison services which indicate what a prisoner ought to receive — for example, food that is nutritious (instead of the number of pieces of bread). There is a quarterly survey of prisoners, staff and others where prisoners could be asked whether they received these things.

Table C.6: Details about the contract specifications

	Prison	*Duration of the contracts*	*Provision for renewal*	*Term for contract renewal*	*Penalty clauses*	*Monetary penalties*	*Notice period for breaking the contract*
NSW	Junee	5 years	yes	3 years	no	no	3 months
Vic	MWCC	5 years[1]	yes	3 years	yes	yes	C-I-C
	Fulham	5 years[1]	yes	3 years	yes	yes	C-I-C
	MMP	5 years[1]	yes	3 years	yes	yes	C-I-C
Qld	Borallon	3 plus 2 years	yes	5 years	yes	yes	3 months
	Arthur Gorrie	5 years	yes	2 years	yes	yes	3 months
	Woodford	5 years	yes	5 years	yes	yes	3 months
SA	Mt Gambier	5 years	yes	indefinite	yes	yes	0 – 3 months

C-I-C — commercial-in-confidence

1 Duration of the contracts for buildings are for 20 years.

Table C.6: Details about the contract specifications (continued)

	Prison	*Price made public*	*Contract publicly available*	*If yes, what information is not released*	*Contract fee defined*	*Output based component*
NSW	Junee	management fee — yes	no	n/a	Fixed annual component with a price escalation clause	no
Vic.	MWCC	no	no	n/a	Fixed; escalates/reduces based on movements in prisoner population[1]	yes
	Fulham	no	no	n/a	as above	yes
	MMP	no	no	n/a	as above	yes
Qld	Borallon	1990 — yes 1995 — no	1990 — no 1995 — yes	n/a fee, penalties	fixed	yes
	Arthur Gorrie	1992—yes	no	n/a		
	Woodford	no	yes	fee, penalties		
SA	Mt Gambier	no	no	n/a	C-I-C	yes

n/a not applicable

C-I-C — commercial-in-confidence

1 There is also a Performance Linked Fee related to service delivery outcomes.

Table C.7: Contract monitoring

	Contract compliance monitored	*Contract manager meets with the private prison manager*	*Performance indicators used?*	*Performance indicators publicly available*	*Contractors' performance measured against those indicators publicly available*
NSW	monthly meetings; annual reports	monthly	minimum standards for all centres; not performance measures, there are standards	yes	monitors' report published in Annual Report
Vic	monthly reports	formal quarterly, more frequent informal	E, I, SH, Med., Drugs, Emp., Educ., Assault	no	no
Qld	on-site monitor first years; ad hoc and annual audits thereafter	monthly	E, DICs, I, SH, Drugs, Emp., Educ., Assault	no	escapes and DIC
SA	DCS manager and supervisor on-site, monthly meetings and reports, quarterly survey of prisoners, staff and others	daily	E, DICs, I, SH, Hos., Med., Drugs, Emp., Educ., Assault, sick leave	no	no

E — escapes; DICs — deaths in custody; I — incidents; SH — prisoner self harm; Hos. — hospitalisation rate; Med. — medical consultation rate; Drugs — drug tests positive result rate; Emp. — employment rate; Educ. — education enrolments and completions; Assault — assaults on staff

Table C.8: Information flows; differences between public and private prisons; service agreements; and purchaser provider splits

	Public prisons not subject to competition, subject to the same service specifications and monitoring regime	*Non-contracted public prisons subject to formal service agreements*	*Structural separation of purchaser/ provider functions for public prisons*	*Functions allocated between purchaser/ provider*
NSW	no	no	no	n/a
Vic.	yes (from 1 July 1997)	yes (from 1 July 1997)	yes	Provider does not perform sentence management and classification
Qld	no[1]	yes (plan to introduce from 1 July 1997)	yes (from 1 July 1997)	Purchaser retains prisoner classification, sentence management and some transfers
WA	n/a	no	no	n/a
SA	no	no	no	n/a
Tas.	n/a	no	no	n/a
ACT	n/a	n/a	no	n/a
NT	no	no	no	n/a

n/a not applicable

1 However, all prisons are subject to the same legal and legislative requirements.

Skills the purchasing agency had to strengthen as a result of contracting

New South Wales	• Defining service delivery operational standards • Performance evaluation • Contract management and evaluation
Victoria	• Contract monitoring • Collecting good data • Writing standards
Queensland	• Tender specification and evaluation • Contract administration • Contract negotiation
South Australia	• Financial • Contract administration • Contract negotiation • Legal and computer skills.

Processes in place to share information between private and public prison managers

New South Wales	All prison governors attend governors' conferences and workshops where informal networks are also established.
Victoria	There are formal opportunities for all prison managers to provide advice on policy and procedural matters bimonthly. Additionally, prison managers can informally talk with each other.
Queensland	There is a telephone conference of all general managers after monthly Board meetings. Senior managers of public and private prisons have quarterly and annual meetings.

South Australia	Public and private prison managers attend management meetings together. There is informal contact and prison visits by managers to each other's centres. The mechanisms introduced to ensure that innovations in privately managed prisons are transferred include: future plans for exchange of staff between prisons at all levels; and rotation of staff between systems.

REFERENCES

AIHW (Australian Institute of Health and Welfare) 1996, *Australia's Health 1996*, AGPS, Canberra.

ACM (Australasian Correctional Management) 1996, *Submissions Received on the Inquiry into the Construction of the New Woodford Correctional Centre, Submission No. 1*, Brisbane.

Barclay Mowlem 1996, *Submissions Received on the Inquiry into the Construction of the New Woodford Correctional Centre, Submission No. 4*, Brisbane.

Brown, A. 1994, 'Economic and qualitative aspects of prison privatisation in Queensland', in Moyle, P. (ed.), *Private Prisons and Police: Recent Australian Trends*, Pluto Press, Leichhardt, pp. 194–218.

COAG (Council of Australian Governments) 1995, *Competition Principles Agreement*, Commonwealth Government Printer, Canberra.

Codd Partnerships 1996, Submissions Received on the Inquiry into the Construction of the New Woodford Correctional Centre, Submission No. 2, unpublished, Brisbane.

DHCS (Department of Health and Community Services) 1993a, *Casemix Funding for Public Hospitals*, Melbourne.

—— 1993b, *1992–93 Annual Report*, Melbourne.

—— 1994a, *A Guide to Output Based Funding*, Melbourne.

—— 1994b, *Casemix Funding for Public Hospitals 1994–95*, Melbourne.

—— 1994c, *1993–94 Annual Report*, Melbourne.

—— 1995a, *Casemix Funding 1995–96: Discussion Paper*, Melbourne.

—— 1995b, *Hospital Conditions of Funding 1995–96*, Melbourne.

—— 1995c, *1994–95 Annual Report*, Melbourne.

DHS (Department of Human Services) 1996a, *Summary of the Healthstreams Program and Cooperative Rural Health Planning*, Melbourne.

—— 1996b, *Public Hospitals: Policy and Funding Guidelines*, Melbourne.

—— 1996c, *Foster Care Service Plan, 1996–97*, Melbourne.

—— 1996d, *Annual Report: 1995–96*, Melbourne.

Diplock, D. and Calabrese, W. 1994, 'Privatisation and industrial relations: ACM's experience', in Moyle, P. (ed.), *Private Prisons and Police: Recent Australian Trends*, Pluto Press, Leichhardt, pp. 109–22.

Duckett, S.J. 1994, *Reform of Public Hospital Funding in Victoria*, Australian Studies in Health Service Administration, no. 77.

—— 1995, 'After casemix, after purchaser–provider, where next in health care reform?', Speech to the Policy Forum of the Australian Health Economists' Conference, Brisbane, 6 July.

Economic and Budget Review Committee 1994, *Hospital Services in Victoria*, 35th Report to Parliament, Melbourne.

EPAC (Economic Planning Advisory Commission) 1995, *Private Infrastructure Task Force Report*, AGPS, Canberra.

FACS (Department of Family and Community Services) 1994, *Annual Report 1993–94*, Adelaide.

—— 1995a, *A Policy for the Planning, Purchase and Delivery of Alternative Care Services in South Australia*, FACS Policy and Development Division, Adelaide.

—— 1995b, *Annual Report 1994–95*, Adelaide.

—— 1996a, *Contracting in Community Services: Position Paper 1996*, Adelaide.

—— 1996b, *Annual Report 1995–96*, Adelaide.

—— 1996c, *Services and Funding Plan for Alternative Care Services in South Australia*, Adelaide.

—— 1996d, *Community 21: Family and Community Services for a New Century 1996–2000*, Adelaide.

—— 1996e, *Youth Research Project Update*, Adelaide.

—— 1996f, *Gambling Rehabilitation Service: Funding and Service Agreement Terms and Conditions*, Adelaide.

—— 1997, *Calls for Expressions of Interest Guidelines: Alternative Care Services*, Adelaide.

Fetter, R.B. and Hines Jr, H.H. 1996, 'The history and development of Diagnosis Related Groups', In proceedings of the Eighth Casemix Conference in Australia, Sydney, 16–18 September, pp. 131–63.

Guterman, S., Eggers, P.W., Riley, G., Greene, T.F. and Terrell, S.A. 1988, 'The first 3 years of Medicare prospective payment: an overview', *Health Care Financing Review*, Spring, vol. 9, no. 3, pp. 67–77.

Harding, R.W. 1997, *Private Prisons and Public Accountability*, Open University Press, Buckingham.

Health Solutions Ltd 1994, *Independent Assessment of Casemix Payment in Victoria: A Report to the Casemix Development Program in the Commonwealth Department of Human Services and Health*, Commonwealth Department of Human Services and Health, Canberra.

—— and Centre for Health Program Evaluation 1996, *1995 Cost Weights Study: Final Report to the Department of Human Services*, Melbourne.

IC (Industry Commission) 1995, *Charitable Organisations In Australia*, Report no. 45, AGPS, Melbourne.

—— 1996, *Competitive Tendering and Contracting by Public Sector Agencies*, Report no. 48, AGPS, Melbourne.

Jackson, T., Tate, R., Henderson, N., Carlin, J. and Bayliss-McCulloch, J. 1994, *1994 Victorian Cost Weights: A Study of Fifteen Hospitals' Patient-Level AN–DRG Costs*, Technical Report 4, National Health and Medical Research Council, National Centre for Health Program Evaluation, Melbourne.

Kennedy, J.J. 1988, *Commission of Review into Corrective Services in Queensland*, vols. I and II, Government Printer, Brisbane.

Kettner, P. and Martin, L. 1993, 'Performance, accountability and purchase of service contracting', *Administration in Social Work*, vol. 17, no.1, pp. 61–79.

—— 1995, 'Performance contracting in human services: an initial assessment', *Administration in Social Work*, vol. 19, no. 2, pp. 47–61.

Laurie, A. 1994, *Managing Contracts: A Resources Pack*, Directory of Social Change and NCVO Publications, London.

Leahy, R. 1996, *Gamblers Rehabilitation Services: An Information Framework and Strategy*, FACS, Adelaide.

Legislative Assembly of Queensland 1996, *Construction of the New Woodford Correctional Centre*, Report no. 34, Brisbane.

Macionis, S. 1994, 'Contract management in corrections: the Queensland experience', in Moyle, P. (ed.), *Private Prisons and Police: Recent Australian Trends*, Pluto Press, Leichhardt, pp. 179–93.

McGuire, T.E., Bender, J.A. And Maskell, C. 1995, *Casemix Episodic Payment for Private Health Insurance*, AGPS, Canberra.

Metropolitan Hospitals Planning Board 1995a, *Developing Melbourne's Hospital Network: Phase 1 Report*, Melbourne.

—— 1995b, *Taking Melbourne's Health Care Network into the 21st Century: Phase 2 Report*, Melbourne.

Owens, H.J. 1993, *Quality Assurance and Improvement in Australian Hospitals under a Case Payment System*, Australian Hospital Association, Canberra.

Palmer, G. 1994, 'Background and overview' in *Economics and Health: 1994*, Proceedings of the Sixteenth Australian Conference of Health Economists, Australian Studies in Health Service Administration, pp. 291–3.

PSMC (Public Sector Management Commission) 1995, *Review of the Queensland Corrective Services Commission*, Government Printer, Brisbane.

PWC (Public Works Committee) 1996, *Construction of the New Woodford Correctional Centre*, Report no. 34, Legislative Assembly of Queensland, Brisbane.

QCSC (Queensland Corrective Services Commission) 1995a, *Annual Report 1994–95*, Brisbane.

—— 1995b, *Contract: Borallon Correctional Centre*, Brisbane.

—— 1995c, *Design, Construction and Operation of Woodford Correctional Centre: Tender Documentation*, Brisbane.

—— 1995d, *Service Agreement for the Operation and Management of the Woodford Correctional Centre*, Brisbane.

—— 1996, *Annual Report 1995–96*, Brisbane.

Queensland Government 1996a, *State Budget 1996–97: Budget Overview*, Queensland Government, Brisbane.

——1996b, Media Release from the Minister for Police and Corrective Services and Minister for Racing, Brisbane, 13 December.

SACOSS (South Australian Council of Social Services) 1995, *Submission to Industry Commission Inquiry into Competitive Tendering and Contracting by Public Sector Agencies*, Adelaide.

SACA (South Australian Commission of Audit) 1994, *Charting the Way Forward: Improving Public Sector Performance*, State Information Centre, Adelaide.

Scotton, R.B. and Owens, H.J. 1990, *Case Payment in Australian Hospitals: Issues and Options*, Public Sector Management Institute, Monash University, Melbourne.

SCRCSSP (Steering Committee for the Review of Commonwealth/ State Service Provision) 1995, *Report on Government Service Provision: 1995*, AGPS, Melbourne.

—— 1997, *Report on Government Service Provision: 1997*, AGPS, Melbourne.

Victorian Commission of Audit 1993, *Report of Victorian Commission of Audit*, Melbourne.

Walsh, M. 1995, 'Casemix: The Victorian Experience', *Australian Casemix Bulletin*, vol. 7, no. 1, pp. 4–15.