

10th February 2017



**Human Services Inquiry
Productivity Commission
LB 2, Collins Street East
MELBOURNE Vic 8003**

Re: Comment on the Productivity Commission 'Reforms to Human Services Issues Paper'

Merri Health welcomes the opportunity to provide feedback on the Productivity Commission Reform to Human Services Issues Paper.

Merri Health creates healthy, connected communities through local health services for people at every age and stage of life. Our approach is holistic, addressing the medical, social, environmental and economic aspects that affect health, with services spanning across children and young people, carer support, chronic disease management, mental health, disability support, dental services, population health and aged care. We've been the trusted health service of local communities for over 40 years.

General Comments arising from the key points summarised in the report are detailed below.

Tailoring reform options

1. Request for Information # 1

Re Figure 1: Characteristics of human services, the "Willingness and capacity of users to exercise informed choice".

This characteristic from a consumer/service user's perspective makes the assumption that they have the capacity and knowledge in which to make informed choices as to what services they require, and/or what services are available to support them. Our experience highlights that many users are not aware of services that can be provided to assist them, and often it is not one service that's required but a combination of services. In this situation the service provider coordinates the required services. With the proposed reform this will potentially fragment services and providers that will add complexity for users as they will need to navigate the system on their own accord. A fundamental issue that must be acknowledged is the requirement of health literacy such that users can make an informed user choice.

The 2006, the Adult Literacy and Life Skills Survey (ALLS) measured the literacy of adults aged 15-74 years including their health literacy. Skill levels ranged from Level 1 (lowest) through to Level 5 (highest). Skill Level 3 is regarded as the minimum required to allow individuals to meet the complex demands of everyday life.

In 2006, 41% of adults were assessed as having adequate or better health literacy skills, scoring at Level 3 or above. Around one-fifth (19%) of adults had Level 1 health literacy skills, with a further 40% having Level 2. These people had difficulty with tasks such as locating information on a bottle of medicine about the maximum number of days the medicine could be taken, or drawing a line on a container indicating where one-third would be (based on other information on the container).

HEALTH LITERACY SKILL LEVELS (a) - 2006



(a) Skill levels 3, 4 and 5 represent adequate or better health literacy.

Source: Health Literacy, Australia (ABS cat. no. 4233.0)

Whilst it is acknowledged the use of health literacy as a measure of ability to apply user informed choice, it does highlight the relevance this has on the ability to make informed choices about purchasing/selecting high quality services.

The issues paper makes reference to “Recent reforms to disability support services are unlocking the ability of people with disabilities to determine what support is best for them”. Whilst acknowledging this as a positive outcome of the NDIS reform, it also must be acknowledged that there have been significant problems with government processes causing significant delays, difficulty in the use of government portals and registering approved providers. These lessons must be considered in the light of any proposed reforms that would need to respond to similar issues on a potentially wider scale.

The “Capacity of providers to innovate”

We support this as a characteristic however highlight that often the guidelines and ‘rules’ put in place by government in relation to funding obligations is what often prevents innovation from occurring as providers are required to function within defined boundaries that prevent or restrict innovation. Any reform should take this into consideration and provide adequate parameters that will facilitate and encourage innovation/s.

Increasing user choice

2. Request for Information # 2

In 2015 the then Victorian Government undertook a recommissioning process for the delivery of government funded mental health and alcohol and other drug (AOD) services across Victoria. There are significant lessons that can be drawn from this process that had dramatic unintended adverse outcomes for clients. The sector in Victoria was left severely ‘damaged’ with consumers, community, workforce and service providers disturbed with the resulting outcomes which transpired into less quantity and quality service provision evidenced by:

- limited provider choice;
- limited services choice;
- siloed focussed service provision;

- poor transition processes for client continuity of care;
- significant permanent loss and reduction in staff expertise and sector 'capacity' and;
- the lack of or limited links with local community by new providers.

The sector engagement process had been very poor as the policy and decision makers were not able to deliver on their statement of principles.

Furthermore, as highlighted in the issues paper, previous reforms undertaken in the VET sector led "to providers reducing costs, rather than increasing quality, impeded opportunities for collaboration, and imposed unduly burdensome administrative and compliance costs to providers". With the proposed reforms the same risk exists as there is potential for providers to 'cherry pick' specific services and more complex users potentially face difficulty in accessing services in a coordinated way. The other consideration is the unintended consequence that competition brings to the market where traditionally organisations may work in collaboration and in various alliances and networks, a competitive environment dramatically affects this that has an economic loss associated with the benefit existing networks and partnerships deliver.

Introducing greater competition and contestability

3. **Request for Information #3**

- *"whether, and how greater competition or contestability could lead to improvements in the quality, equity, efficiency, responsiveness and accountability of service provision"*

For this to be achieved, the same standards, accreditation requirements, performance indicators and quality indicators must be equally applied to the entire service system. This is highlighted that at present many not-for-profit organisations must meet both government policy requirements that are mandated, in addition to various compliance requirements (accreditation) that are not required of for profit providers. This doesn't create an 'even playing field' as there are cost implications in meeting many of these requirements that not all providers are required to equally meet.

- *"how reforms should be implemented and evaluated"*

We would strongly advocate that any reform is made in a staged approach and that where reforms have an overlap with other parts of the service system that there is a clear understanding had of the implications that one reform will have on other parts of the service system. Evaluation criteria should be identified upfront ahead of any reform being implemented so that service providers, consumers and government are all aware of what the expectations are.

Government stewardship

We disagree with the statement made in the issues papers that suggest potential for government stewardship to potentially be spread across three levels of government. The implications of this is that the service provider will face significant increased burden of reporting and operational management in

delivering services that also have a cost implication for providers in order to meet these requirements. This suggestion seems overly bureaucratic and complex.

4. Request for Information #4

- *The Commission is seeking information on government stewardship arrangements for the priority areas.*

Current funding models are rigid and do not allow for flexible and tailored services design that is client centred and outcome focussed; current design is output focussed. Funding models should allow for innovation and the flexible creation of care packages that provide holistic health care across service domains to meet both short and long term client goals.

Innovation should not be confused with effectiveness. Government, in partnership with universities, need to focus on producing a suite of outcome measurement tools and integrated client management software systems to capture outcome information. Future service planning needs to be informed by 'evidence based' research and 'practice based' evidence. Our experience and knowledge is informed by the services and programs our clients want and need to support their health and life goals.

Thorough literature review and consultation with current service providers and co-design with service users would ensure that future reforms are based on evidence and best practice models.

Public Dental Services

The model of public dental service delivery

5. Request for Information #22

- *'whether existing eligibility criteria and the level of assistance for public dental services enable equitable access to care.'*

Current eligibility criteria assist to reduce barriers to access dental services with priority given to some at risk people groups who do find accessing dental services more difficult. However, this does place more strain on government dental services as they have less capacity to see non-priority patients and often results in ballooning waiting lists. Longer waiting lists do impact the ability for government dental services to deliver timely dental services, resulting in some patients having poor oral health outcomes. Patients who have severe dental problems but don't fall into a priority access group miss out on receiving timely treatment. Problems are often left to worsen to the point where the only suitable option is to extract a tooth, which may not be the best oral health outcome for the patient. The level of assistance and funding and the current model of care are inadequate to allow services to provide dental care to both at risk people groups and clinically at risk individuals.

- *‘the extent to which the current emphasis on government provision of public dental services limits the responsiveness of services to user preferences over the timing and location of treatment, and the type of services provided’*

Public Dental services are poorly placed to respond appropriately to user preferences to the timing and location of treatment. While most patients who are in pain are seen in a timely fashion, longer waiting lists have meant public patients are forced to wait for treatment that they would prefer to have done immediately. Due to extended waiting lists and a lack of funding, the type of services that are delivered in public clinics are more restricted than what is delivered in private clinics. High cost services such as dental crowns and dental implants are rarely done in public clinics as these services can be substituted for dental restorations or dentures, which are not as strong and are less comfortable.

- *‘the scope to improve accountability through more public reporting, including on patient outcomes and cost effectiveness’*

Currently, public reporting is mainly centred on quality of care reports issued by agencies. Clinical outcome information is distributed to services to assist with continual quality improvement but this is not available for public viewing. Public reporting on this information may not be appropriate, as this information doesn’t necessarily indicate how well an agency is performing. For greater accountability through public reporting to be achieved, an agreed set of oral health outcomes that better indicates overall service performance needs to be decided to report on. Currently, the research is varied on how to measure levels of oral health, which can make it challenging to determine cost effectiveness. A standard set of measurements of oral health needs to be agreed on before agencies are able to adequately publicly report on.

- *‘The quality and efficiency of public dental services, and how this differs across public and private providers, regions and jurisdictions’*

It is difficult to know the how public dental services compare with private providers, as private providers do not keep any records regarding quality and efficiency. In comparison, public dental services are sent information regarding performance in some clinical indicators compared to their region and to the state by our state governing body (DHSV). These clinical indicators include rates of retreatment and rates of post-operative complications. This information is used by our service to assess our clinical performance and used as a basis for continual quality improvement. Agencies are accountable to maintain a high standard of quality as outlined by the agreed funding arrangement with DHSV.

Giving users greater choice

6. Request for Information #23

- *‘whether increased choice would lead to better outcomes for users’*

Currently, public dental services in Victoria have a number of additional requirements that are considered mandatory that private practices are not subject to, creating an uneven playing field and

rendering public dental services uncompetitive. Additional requirements include reporting to DHSV on both productivity and on clinical quality indicators, as well as ensuring the service is appropriately accredited according to the national standards. This adds not only an administrative burden, but also extra requirements in terms of training costs. These requirements are in place to ensure the safe delivery of services to the public. Private practitioners are not subject to any of these conditions.

If users were given more choice regarding providers, a regulatory system would need to be in place where both public and private services are accountable. The concern is that if private practitioners do not have any of these regulations in place, it is impossible to know if this would result in better outcomes for users.

- *'lessons from current and past voucher schemes in Australia'*

Our service has recently been given some funding to use voucher schemes to engage the private sector to see a large quantity of patients who were on our waiting list. Whilst this allowed us to reduce our waiting lists, there are a number of limitations. Numerous patients have noted they would prefer to continue to be seen at our service as their 'records are all here' and 'our service is familiar to them'. A number of patients have had to return to our service as their treatment needs were greater than what the voucher could accommodate, requiring our clinicians to re-examine the patient and sometimes leads to confusion with the patient being told different messages regarding their oral health. This lack of continuity of care has resulted in frustration from both the patient and our service.

We have also noted a lack of accountability and responsibility that some private providers have taken towards the care given under the voucher. The private dentist has told some patients that further problems need to be addressed at the public clinic, despite the work being done by the private dentist. This has resulted in our dental service having to address the problem initiated by the private dentist. There also have been issues with poor clinical handover between the two services. Currently there is no audit process to scrutinise the work done in these vouchers. This lack of accountability means there is no way to evaluate or report on the outcomes of the work being delivered through the issuing of vouchers.

- *Whether additional regulations and monitoring arrangements are required to protect consumers*

Public dental services have a robust system of regulation and monitoring as governed by DHSV. This includes compulsory practice accreditation according to the national standards, regular monitoring and reporting on productivity and some clinical quality indicators. Private practitioners are not subject to these levels of regulation and monitoring; only being subject to practitioner regulations as governed by AHPRA.

Private services that agree to take vouchers have a duty of care to manage any complications for a 3-month period, but practically there has been difficulty enforcing this. Some patients have preferred to come back to the public dental service, while others have been actively told to go back to the public dental service for future treatment. This has meant that our service often has to treat complications associated with treatment done in the private sector, adding unnecessary costs to the system. Private providers require a greater level of accountability for the services provided to ensure patients are protected. Future solutions may centre on payment methods to private practitioners, which could help drive practitioner behaviour to ensure quality services are being delivered.

- *The costs and benefits of giving public dental patients greater choice and their distribution between users and governments.*

Benefits in giving public dental patients greater choice may include

- Allowing consumers to take more active role in determining health choices and providers of care which could assist in improving health literacy.
- Allow people who have been seeing a regular dentist in private practice who are now eligible for publicly funded dental services to see the same dentist, thus maintaining continuity of care for those patients.
- Private practitioners may be able to see patients more quickly due to greater capacity in the private sector.

Costs in giving public dental patients greater choice may include

- Less control of costs for services to manage complications from treatment provided in the private sector
- Lack of ability to keep private practitioners accountable for the services provided.
- Difficulty for government to report on clinical outcomes of work done in the private sector.

Understanding differences in the cost and mix of services

7. Request for Information #24

- *Differences in the unit cost, number and mix of services provided to public patients, and the causes of such differences.*

There are some small differences between the item code costs of dental services done in public dental agencies via Dental Weighted Activity Units (DWAU) and the Victorian General Dental Scheme (VGDS). Most public dental agencies are able to run their dental practice with these costs. There is no data as to whether private dental services are able to maintain profitability at the VGDS rates. Compared with average unit costs at private services, VGDS fees are approximately 35% lower when compared to average fees issued by private health providers.

The mix of dental services provided to public patients is more restrictive in comparison to what is provided in the private sector. This is due to the limited resources available to the public sector to treat the eligible population, which has forced services to restrict the number of high cost services delivered to public patients. High cost services such as complex root canal treatment and crown and bridgework utilize greater amount of resources and are subject to strict clinical eligibility criteria before being considered in the treatment planning process.

Private practitioners are often unaware of the strict criteria on these services, and are more likely to recommend and invoice for more dental services per patient. Some providers may be willing to recommend certain treatments like root canal treatment that would be deemed inappropriate to be done in the public system. One other example is with oral hygiene instruction, where DHSV has

stipulated that this needs to be at least a 5-minute discussion in order for this code to be claimed. Simply saying 'you need to brush more' is not deemed to be adequate to claim this item code. Private practitioners are unlikely to be aware of this stricter interpretation of this item code and are more likely to claim this item code.

- *Issues that would need to be addressed to ensure that clinically- and cost-effective services are delivered to public patients if there were greater private sector provision of public dental services.*

Greater accountability for work provided in the private sector would be necessary to ensure clinically and cost effective services are being delivered. A fee for service payment model makes it more difficult to hold private services accountable for the work they provide. A more robust system that incorporates some monitoring and evaluation of services performed in the private sector would be required. Solutions to improve continuity of care are also necessary. Currently the voucher system has limitations in maintaining continuity of care, with communication between services poor. Often there is a replication of duties in the examination process, as patients who return from seeing private practitioners often require reexamination, as the treatment plan provided by the private practitioner may not match what is being seen in the mouth.

Greater access to information

8. Request for Information #25

- *Information users would need to make informed choices, how this varies by user group and how this data should be presented and provided.*

Our vouchering process involves giving clients a list of practices that have indicated to us that they are happy to see patients with a voucher. The information includes the practice name, the address and contact phone number. There is no other vetting process of these practices, but it is left up to the client to determine whom they want to visit, with no further information provided. Additional information that may help disadvantaged users, people with high dental fear and those with low oral health literacy may be difficult to obtain and assess. Unless someone has qualifications as a special needs dentist, there is no objective measurement of a clinician's skill in managing people with dental fear.

- *How barriers to greater public reporting on patient outcomes and cost effectiveness could be overcome, including changes needed to collect and provide relevant information to users.*

Currently DHSV collects and analyses data regarding some clinical indicators which could be made public to inform choices. The concern with releasing this data is that it may not be a complete indicator of clinical performance. There may be valid reasons why some services have higher treatment failure rates, which could include the level of health literacy and smoking rates. An unintended consequence of reporting this information could see an agency unfairly targeted or shamed in the public arena. Cost effectiveness is dependent on measuring the appropriate indicator or

outcome. Research needs to be done to determine the best set of indicators that can be appropriately reported on that provide users with the adequate information to make an informed choice.

- *The information needed to monitor and evaluate service providers and the treatments provided to public patients*

Useful information for monitoring and evaluation purposes could include:

- Patient satisfaction (feedback)
- Re-treatment rates (12 month period)
- Post-operative infection rates
- How quickly services respond to emergency calls (triage)

More contestable provision of public dental services

9. Request for Information #26

- *The design of tender processes and management of contracts, such as the length of contracts, the coverage of services, and how to adequately define services and monitor outcomes*

Future vouchering to private clinics should outline in greater detail the terms of the agreement, including obligations regarding patient management, and guidelines for appropriate coding treatment decision-making in line with DHSV guidelines. This may help ensure consistency across both public and private providers.

- *The costs and benefits of more contestable arrangements, and their distribution between users and governments.*

Contestable arrangements could benefit both patients and governments as competition drives service providers to maintain high quality care is being delivered. Some drawbacks of contestable arrangements could come if there is frequent turnover of new management and branding which could cause confusion among public patients as to which service is accessible to them. There are risks to patient welfare if the handover from one provider to another is mismanaged.

Implementing reforms

10. Request for Information #27

The commission is seeking information on the implementation of reforms to increase competition, contestability and user choice in public dental services, including

- *The role of alternative payment models for providers, such as capitation payments and how different models affect incentives for users and providers*

Currently the predominant method of payment in dentistry is fee for service. Alternative payment models such as capitation or value based funding may assist in addressing some limitations in engaging

the private sector to deliver dental services. A capitation model of payment may be able to provide public patients with greater continuity of care. This also assists in ensuring that private providers are accountable for the services that are provided. The problem with a capitation model would be the risk that providers underservice their population and public patients miss out on the dental services they require. Private providers, many used to a fee for service model, may refuse to see public patients if this model of payment was introduced.

Value based funding would match funding with oral health outcomes, which would further increase accountability and help drive positive oral health outcomes. Further investigation is required as to which oral health outcomes would be most suitable to be matched to maximise the effectiveness of this payment method.

- *Changes in how demand is managed*

Given there are significant waiting lists in most public dental services; the question is almost always how to manage increases in demand. Increases in demand are currently managed in a few ways. With limited capacity and funding, an increase in demand often results in waiting lists becoming longer. Lead Agencies do have the option to increase funding to community agencies to either issue vouchers to public patients to engage the private sector to have services provided (short term funding), or provide funding to allow services to provide infrastructure and ongoing service funding to increase their capacity.

- *Whether workforce reforms are needed to enable more effective use of dental professionals in the private and public sectors*

Workforce reform to allow a more flexible approach to using skills in the dental workforce would be welcomed. Dental disease is predominantly a 'lifestyle' disease that is often preventable. What is often neglected in the service delivery mix are important preventative services and oral health education. Dentists are more focussed on delivering quality dental treatment rather than engaging patients to make lifestyle changes. Utilising more auxiliary staff such as oral health therapists and trained dental nurses could help agencies improve the quality of preventative and education services being delivered and see meaningful change to oral health outcomes for the patient in the long term. Workforce reform to help up skill auxiliary staff would help agencies be able to deliver these services. A preventative model of care should help governments ensure that cost effective care is being delivered and paid for.

- *Changes in training arrangements for dental professionals, including possible alternative models of training.*

Public sector dentistry differs from the private sector in the type of patients that are seen. Private sector clinicians may need additional training in how to better handle patients with low health literacy, patients from culturally and linguistically diverse people groups, and patients who are often disadvantaged.

Up-skilling of dental nurses to be able to adequately conduct oral health education and assess oral health would help agencies deliver a more preventative model of care. There are currently limited Certificate 4 training courses available. Oral health education needs to be promoted as a viable career path to attract existing dental nurses to up-skill.

Commissioning family and community services

The model of provision for family and community services

11. Request for Information #28

- *The commission is seeking information related to how commissioning arrangements influence the effectiveness of service provision.*

Service integration and collaboration are key principles that need to guide the work of diverse and specific agencies working with clients. The complexity of the service system means that partnership with other organisations is crucial to achieving a comprehensive and seamless service response. A collaborative services approach needs to be embedded by integrated treatment planning, holistic assessments and responses; care planning across sectors and services with consistent client goals. Services need to be supported to share information, expertise and client information in order to work collaboratively towards joint client goals.

Strategic alliances are necessary for co-operation, communication and for the creation of working partnerships to deliver diverse and tailored services and programs to specific cohorts of clients. Services and agencies must collaborate and partner together in order to maximise their resources and best utilise their skills and knowledge. This work needs to be grounded by consistent and complementary government policies and strategically embedded in commonwealth, state, regional and local health plans.

An integrated service approach can optimise access and referral pathways, and enhance service participation. The key to successful collaborations is local knowledge and local relationships and also has the potential for the identification and responsiveness of emerging issues. Currently, there is minimal expectation of collaborative practice, funding agency direction on this requirement would ensure compliance and also provide a mechanism for minimum standard practice and procedural guidelines. Service providers are not funded to collaborate and/or work with other agencies; this work is costly and un-resourced and currently occurs based on the goodwill of agencies due to emerging local, community and individual client needs. Whilst there is widespread recognition of the benefits of collaborative practice responses both on a casework and systemic model, current workloads and time constraints prevent professionals in the sector from making this a priority in their everyday practice.

Commissioning arrangements that can have a positive influence on the effectiveness of service provision include:

- consistent and complementary government policies across sectors, strategically embedded in commonwealth, state, regional and local health plans;
- the resourcing of strategic alliances and partnership formation towards service sector improvements and service coordination models;
- the adoption of flexible funding streams that allow for facilitation of the coordination of services;
- procurement of longer funding agreements that are not output driven but long term outcomes focussed;

- application of flexible funding that allows for innovation and the scope to trial alternative methods of service design that may lead to more effective and efficient client outcomes;
- resourcing the placing of 'out-posted' services and programs in identified programs to ensure sector development, true integration and embedding of service provision across the family and community sector.

Introducing greater user choice

12. Request for Information #29

- *The commission is seeking information on the potential for greater user choice.*

Grant based family and community services are vital components of social responses to marginalised, vulnerable and complex individuals and families with diverse needs that aim to build resilience and capacity to improve functioning and life outcomes. The public value that is created via these programs and services should not be underestimated as social costs are minimised, and improved individual and community outcomes are achieved.

To achieve this, a whole of government and whole of system approach is required, where there is a range of strategies from health promotion, to early intervention, to community based and acute services. Service delivery design and responses should be consumer centred. Consumers should be able to easily access and choose appropriate support when and where they need.

A fundamental element that warrants discussion is the notion of 'choice' and whether the clients that receive these services have true choice. Central to any market environment is the assumption that consumers have and make choices re the products they purchase and consume (utilise). Most clients accessing family and community are driven by need rather than 'choice' and find themselves in very difficult circumstances where their ability to make informed decisions is compromised. Thus we argue that whilst clients accessing these services do not have true choice, client engagement with services is vital to ensure optimal outcomes. Co-design of service provision is essential to increasing user choice and user outcomes.

Furthermore, whilst we support the notion of user choice, this is often predicated on the health literacy and understanding, and competence of navigating the service system. Our experience highlights there are often individuals that cannot undertake such 'navigation' without support. The often marginalised, non-English speaking, newly arrived refugee/asylum seekers, disadvantaged that are significantly challenged to seek help when they need it, often with worse outcomes as a result. Dedicated resources and focus can play an important role in engaging with people who require extra support to engage with services.

Information collection and data analysis is crucial in performance monitoring, service planning and sectorial innovation. Currently data collection is focussed on output achievement and process driven, this needs to be realigned to also focus on true data analysis that provides the catalyst for evidence based interventions that create positive outcomes for individuals and families and real social value including the focus on user engagement and access.

Service fragmentation needs to be tackled via investment in technological infrastructure to support ease of access and integrated service responses. Technological solutions need to be outcome focussed and support care coordination including articulating and managing risk.

Increasing the benefits of contestability

13. Request for Information #30

- *The commission is seeking information on how to improve processes for commissioning family and community services.*

Multiple sector reforms, service contestability, recommissioning and differing priority objectives of service sectors does not always support better client outcomes, rather it results in decreased effectiveness and increased costs. Whilst contestability can bring some benefits such as to encourage efficiencies, effectiveness and innovation, it also undermines sector collaboration, disrupts social capital and utilises resources better spent on direct service delivery. Reforms should not be considered in isolation but rather a whole of system overview is required with a human centred design approach to ensure better and consistent service responses.

Genuine communication and consultation with the non-government sector will assist government in understanding the potential impact of changes for specific recommissioning activities on people and local communities. A commitment to a partnership approach in this sector, increased consultation and discussion between government and non-government stakeholders can only lead to enhanced service delivery. Government representatives need to spend time in local services, and engage with clients and the workforce to hear their perspective on the impact of change. This would not only inform future processes, but would build trust in a transparent process and show value and respect for services and local communities.

The recent Services Connect initiative in Victoria encouraged organisations and local Government to collaborate and work together to design and implement an integrated local service system with a key worker model.

Non-government organisations should be given the opportunity to provide input into government policy and decision-making and share their experiences – both positive and negative – as a learning tool for service enhancements. Feedback should be viewed as constructive rather than destructive.

Implementing reforms to commissioning arrangements

14. Request for Information #31

- *The commission is seeking information to support the implementation of reforms to improve commissioning arrangements.*

To date processes for commissioning are cumbersome and flawed and not considered in their entirety. The key imperative for successful commissioning is the requirement that such an undertaking will improve outcomes for clients, increase service quality and efficiency. All these three principles need to

be aligned and work in unison, reform objectives across government need to align, government departments need to talk and work across and not in silos to ensure a more coordinated services system. This would then transpire in similar practices and service principles with how alignment of specific services would wrap service provision around clients for holistic health care and targeted responses that are outcomes focused.

Core principles underpinning commissioning should ensure that:

- a range of service options for clients is realised;
- continuity of care can be maintained and enhanced;
- there is clear and transparent client and provider information at all stages of commissioning;
- smooth transition periods with adequate time for preparation and planning is catered for;
- thorough assessment of tenders/expression of interests and business proposals occurs and;
- funding bodies provide clear expression of interest specifications.

More resources need to be allocated to support funding bodies to better equip themselves with skills in service design, evaluation and procurement. Funding bodies across both commonwealth and state need to work collaboratively by sharing of resources, tools and information rather than recreating wheels. This would result in more efficiency and reduce the costs associated with planning and service management. Funding bodies need to work in partnership in true co-design principles and methodology with clients and the existing service system to ensure the client is at the centre of service design and delivery, this takes time and a complete re-orientation of how funders and services have traditionally held the role 'expert' with clients.

Summary

Merri Health appreciates the opportunity to comment on the Productivity Commission Reforms to Human Services Issues Paper – December 2016 and is committed to improving outcomes for clients in our community. Merri Health would welcome the opportunity to further share our thoughts and experience on the challenges and opportunities present with the introduction of competition and informed user choice in human services relevant to the concepts articulated in the report.

This feedback is provided by:

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