Navigating Health & Social Service Reform

Victorian Primary Care Partnerships

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VCOSS Victorian Council of Social Service

LODDON MALLEE PRIMARY CARE Partnership

About Victorian Primary Care Partnerships

Primary Care partnerships (PCPs) are a Victorian Government funded initiative bringing together health and social services who in partnership utilise a place-based approachs to identify local service issues and develop local solutions. The PCPs work together with their members within a voluntary alliance to improve access and coordination of services, management of chronic disease and integrated prevention and health promotion.

PCPs support local organisations to navigate the ever changing health and social service landscape, while retaining high quality, safe, person centred and evidence based services, which meet the needs of their local community.

This document was prepared by Loddon Mallee PCP in conjunction with VCOSS Policy Advisor Dev Mukherjee with funding provided by the Loddon Mallee PCPs and the Victorian PCPs. It has been adapted by the Victorian PCPs to support PCPs across the state to assist their partner organisations to navigate the shifting sands of the health and social reform environment.

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The Victorian PCPs acknowledge the traditional owners of country and pay our respects to Elders past and present.

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Contents

Executive Summary

Change has been constant for health and social service organisations for many years as governments shift policies and outsource service delivery. Health and social services are required to be more responsive to their service users, communities and funding bodies. At the same time funding has remained tight and demand for services from people with a range of complex needs continues to grow.

Despite all the changes, health and social service organisations' governance bodies and managers are adapting and developing their organisations while continually aiming to produce better results for their service users and communities. This document aims to assist them better understand the complex and changing operating environment.

A business analysis model has been applied to support services to assess the potential impact of external factors on organisational activities and performance in the long term. The model used is the PESTLE framework, which examines 6 types of interdependent environmental factors, they are political, economic, social, technological, legal and environmental.[1] With the use of this framework we have been able to demonstrate that health and social services are significantly affected by changing government policies, social transformations, technological developments, and ever expanding regulatory requirements.

In conjunction to these broad external factors are the impact of multiple health and social reform. These include reforms to disability services, aged care, family violence, vulnerable children and mental health. There are common themes across all of these reforms which present opportunities and challenges to health and social service organisations. System reforms are placing greater focus on providing individuals with greater choice and control over how services are delivered. It is recognised that a place-based approach will be part of a broader strategy to support the successful implementation of these reforms, however, this also has its challenges as services become more centralised.

All these changes have implications for the governance and management of health and social service organisations as well as their service delivery. Some of the significant changes and their implications are outlined below.

Greater competition

Health and social service organisations are facing greater competition arising from increasing service user choice of service providers and competitive tendering. It is intended that competition policies will result in service providers becoming more responsive to service users, increased efficiency and innovation. However, it can detract from collaboration and partnerships which are an important feature of health and social service delivery.

Funding uncertainty

As a result of greater competition and changing government priorities, funding is becoming more uncertain. Some health and social service organisations have responded by seeking to diversify their revenue sources. This presents a risk that organisational attention focuses on revenue generation which can lead to mission 'drift'.

[1] PESTLEAnalysis.com. (2015). An Overview of the PESTEL Framework. [Online]. http://pestleanalysis.com/pestel-framework/ [Accessed: 6 January 2017].

Control by the service user

Client directed care and similar changes are placing greater control over services by service users. This control is meant to provide the service user with similar levels of control over their lives as people not dependent on services for everyday needs. Greater control makes the management and governance of health and social service organisations more complex.

Increased oversight by governments

Government demands for increased accountability is adding to the regulatory burden on health and social services. The independence of non-government health and social services may be compromised by increased oversight by government. The cost of this oversight is often unfunded and reduces capacity for service delivery and innovation.

Progressive universalism

Progressive universalism is the provision of services to all people but at a greater intensity or higher level of service to disadvantaged people proportionate to the level of disadvantage. This is meant to ensure that everyone gets the services at the level and intensity they need and requires organisations to ensure they can provide the necessary services.

Place-based approaches

Place-based approaches are ways of developing and delivering local solutions to local problems. To allocate decision-making to communities and engage local service providers and community members in making decisions regarding complex social problems. Health and social service organisations may face multiple demands to participate in place-based initiatives without the necessary resources being available.

Partnerships

Partnerships are when organisations work together with a common objective. Partnerships are useful for addressing complex issues but are also complex themselves. Partnerships are harder to develop and maintain in a competitive environment and require proper and adequate resources to set up and sustain. By their nature, partnerships require sharing some control with partner organisations so that decisions can be made jointly.

Workforce

Health and social service organisations need a multi-skilled and expert workforce that is culturally competent and able to face complex social problems. Recruitment is likely to become more difficult as the demand for experienced and qualified workers grows, particularly in regional and rural areas. Management and workers may need new skills, knowledge and competencies as service users gain more choice and control.

Outcomes measurement

Governments are seeking to measure the benefits people or groups of people gain from funding programs by measuring outcomes. Measuring outcomes allows governments and the community to understand if programs and services are effective. However, data collection can be expensive and governments need to ensure their own outcome measures are in place before requiring health and social services to measure outcomes.

Closing or ceasing a service

A health or social service organisation may wish to close or cease a service in the light of the complex and changing environment in which it operates. Organisations should seek legal advice under either of these circumstances. Organisations may feel they have an obligation to ensure their service users continue to be provided service by another entity.

Context for Change

The environment in which health and social service organisations operate has been in a constant state of change for many years. This has been driven by changes in government, policy, approaches to government operations and social factors which have increased demands on community services. Health and social service organisations need to adapt and develop in response to such changing circumstances but keep their focus on producing better results for their service users and communities.

The following analysis briefly considers the political, economic, social, technological, environmental and legal factors currently affecting health and social services in Victoria.

Political

Main points

- Significant uncertainties in Commonwealth and State relations have led to disruption of programs and funding in health, education, housing and homelessness.
- Competitive tendering is on the rise at a federal and state level.
- New areas such as public hospitals, public dental health, and housing and homelessness services look set to be opened for competition.
- Continued federal political focus on budget surpluses comes often to the detriment of services and support to those most in need.

Governments affect the operating environment of health and social services through both policy and preferences (the accepted ways of doing things that are not explicitly policy). Below is a description of some of the main political factors currently affecting health and social services.

Shifting Commonwealth-state relations

Over time the Commonwealth government has increased its involvement in a range of policy areas and services that were traditionally state and territory government responsibilities. For example, health and social services are now seen as joint responsibilities between the Commonwealth and state governments.

The Commonwealth government can move into these areas since it has a greater capacity to raise revenue. In recent years it has provided grants for the states and territories to achieve agreed national outcomes through National Partnerships. For example, the National Partnership Agreement has been established to address the rising prevalence of lifestyle related chronic diseases, by laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs in partnership with the states and territories to support healthy lifestyles.

Unfortunately, joint responsibility between the two levels of government can lead to blame shifting for policy failures. Recently, in response to slowing revenue growth, the Commonwealth government has sought to shift costs and responsibilities back to the states and territories in areas such as health, education, housing and homelessness.

In addition, the way National Partnership Agreements have been managed in recent years has been inconsistent and has therefore decreased their effectiveness. There has been constant uncertainty regarding the continuation of the agreements, a decline in the real value of funding through inadequate indexation (adjustment according to the rate of inflation), and uncertainty on responsibility for funding services between the tiers of government. This has disrupted services and affected the lives of already vulnerable people as service providers have been unable to guarantee the continuation of services beyond the life of the agreements.

Greater complexity in Commonwealth-state relations leads to greater uncertainty for health and social service organisations in terms of both funding and policy directions.

Competition for funding

Governments in Australia prefer awarding funding for services through competitive tendering processes or through direct competition by services for service users. For example, in 2014 the Victorian government used an open competitive tender process to select community mental health services and alcohol and drug services. In addition, the NDIS is based on competition between services for service users. Governments use competition in the belief that it drives service providers to provide greater choice and control for service users and to be more responsive to their needs, innovative, and more efficient.

The recent Productivity Commission's report 'Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform (2016)', has identified some further areas for greater competition such as public hospitals, public dental health, and housing and homelessness services.

This policy approach will have a profound impact on the operations of health and social service organisations and hence on the service users and communities they serve, the implications of these impacts are discussed throughout this document.

Preference for budget surpluses

In Australia, there is a clear government preference for budget surpluses because they are seen as a positive political strategy. The preference is to achieve surpluses through restraining expenditure rather than increasing taxation rates or other revenue measures. Such a preference overrides economic concerns and the needs of people, business or the environment. For example, the Australian government deeply cut spending on critical health and social services in the 2014-15 and 2015-16 budgets by $13 billion per annum. The 2016-17 budget failed to reverse these cuts.[2] The substantial cuts resulted in service cuts for many health and social service organisations.

By contrast the Victorian government made substantial investments in health and social services in the 2015-16 and 2016-17 budgets. In particular, additional funding was provided to services for vulnerable children, education, family violence and health.[3] This additional expenditure could occur because of strong revenue growth from payroll tax and land transfer duty (stamp duty).[4] Revenue growth is expected to exceed expenditure growth over the next four financial years, allowing for increased budget surpluses at the same time as increased

[2] Australian Council of Social Service, *2016-17 Budget Analysis*, http://www.acoss.org.au/wp-content/uploads/2016/05/ACOSS-Budget-Analysis-2016-17_FINAL_small.pdf, 2016.
[3] See VCOSS, *Budget Policy Snapshots*, http://vcoss.org.au/state-budget-2016-17-analysis, 2016.
[4] ibid

expenditure. However, if revenue does not grow as expected it is likely the Victorian government will limit expenditure growth to maintain budget surpluses.

Preference for budget surpluses has shifted funding in significant ways, with many Commonwealth government programs either terminated or reduced. Even where programs have been kept, funding has not matched cost increases (due to no indexation) nor increases in needs and expectations.

Economic

Main points

- Uninterrupted growth.
- Labour market shifts are resulting in more part-time work.
- Health and social service organisations are having to diversify sources of income.
- For-profit providers are providing more competition in aged care, disability services.
- Not-for-profits lack access to finance for investment available to for-profits.

Economic conditions directly affect the living standards of most people. During times of strong economic growth, the health of the labour market improves (unemployment falls, underemployment falls, the participation rate increases, average real income increases and working hours increase). In addition, government revenue increases are often matched by increased expenditure and/or tax cuts.

For the least well off individuals the benefits are often less direct. For those unable to work, some government spending may be used to increase the income of pensioners and beneficiaries but this is not common.

Not-for-profit health and social services are also affected by economic conditions. Rising government revenue allows for increased expenditure on health and social services. Further, if personal incomes are rising and people feel wealthier they are more likely to donate to charity or participate in fund-raising activities.

When economic growth is low or negative, unemployment and underemployment rise, the participation rate falls, average real income and working hours stagnate. Demands on health and social services may grow and income (from governments, fund-raising and donations) is likely to stagnate.

Poverty and increasing inequality

Australia has had an unprecedented 25 years of almost uninterrupted economic growth[5] and rising average incomes and wealth.[6] Despite this, inequality income and wealth has increased[7] and the proportion of people living in poverty remains high at 13.3 per cent of the population.[8]

[5] Australian Bureau of Statistics (ABS), Australian National Accounts: National Income, Expenditure and Product, 5206, 2016.
[6] Australian Council of Social Service, Inequality in Australia: A nation divided, ACOSS, 2015.
[7] ibid
[8] Australian Council of Social Service, Poverty in Australia 2016, ACOSS, 2016, p.8.

As health and social services tend to focus on the most disadvantaged, the demand for services continues to grow despite continuous economic growth.

Changing labour market

The way in which people are employed and the industries that employ them have changed substantially over the past few decades. Part-time work has become more common with the proportion of the workforce employed part-time doubling between 1978 and 2016.[9]

During the 1980s there was a substantial increase in the proportion of the workforce employed on a casual basis.[10] The level of casual employment has stabilised at around 20 per cent from the late 1990s onwards.[11] New business models such as Uber and Airtasker (the 'gig' economy) may increase this type of employment. A new business called Hireup appears to have a similar model, allowing people with disability to hire support workers through an online portal.[12]

Employment in health and social services (called the health and social assistance industry) grew by an average of 3.9 per cent each year between 2006 and 2016, compared to 1.7 per cent across all industries.[13] The health and social assistance industry is the largest industry in Australia and now employs more than 1.5 million people or 12.8 per cent of the total Australian workforce.[14] This substantial growth is projected to continue into the foreseeable future.[15] For regional and rural communities this growth may benefit local employment.

Health and social services are likely to face substantial competition for skilled and experienced employees into the future as demand for services grow even if government expenditure does not grow with this demand.

There may be pressure to increase the 'flexibility' of the workforce in response to greater service user choice and control as part of the new models of service provision, such as the NDIS.

New sources of income

In response to limited government funding growth or even cuts, health and social service organisations are turning to alternative sources of revenue to fund services. Fund raising, social enterprise and philanthropic funding are used by many health and social service organisations to provide services not funded by government. Social enterprise has seen substantial growth in recent years.

While alternative sources of revenue can bring many benefits, organisations face increased uncertainty when earning revenue from social enterprise. Like any business, demand for the goods or services sold may decline, new market entrants may sell competing goods or services or the input cost may change. Operation of a social enterprise may also detract from the core mission of the organisation.

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[9] 15.4% of the workforce was employed part-time in August 1978 compared to 31.7% in 2016. Source: Australian Bureau of Statistics, *Labour Force Australia*, 6202, 2016.
[10] Wooden, M & Richardson, S, 'FactCheck: has the level of casual employment in Australia stayed steady for the past 18 years?', *The Conversation*, 23 March 2016.
[11] ibid.
[12] See https://hireup.com.au
[13] Australian Bureau of Statistics, *Labour Force Australia, Detailed Quarterly*, 6291.0.055.003, 2016.
[14] ibid
[15] Community Services and Health Industry Skills Council, Environmental Scan 2015: Building a Healthy Future: Skills, Planning and Enterprise, 2015.

Organisations need to be cognisant of how their clients maybe portrayed in the pursuit of community fund raising or charity. In advertising, images are often distorted, depicting people with a disability or disadvantaged group as pitiable and pathetic in an attempt to raise money. This results in representing them as a burden on the community rather than a potentially contributing and valued member of the community.

Increased private competition

As a result of government policy but also of increasing demand for services, more organisations are offering health and social services. There is now greater potential for competition from 'for-profit' service providers in some sectors (e.g. aged care and disability services). Not-for-profit health and social services have some competitive advantages over 'for-profit' providers (e.g. community connection, surpluses returned to service provision, and charity status). Local services are also competitive as they are familiar, accessible, there may be a sense of community ownership and they are governed by local board members. However, for-profits also have advantages such as access to capital.

Increased competition may have benefits for service users but presents some challenges for health and social service organisations. Competition may hinder collaboration between organisations supporting the same service user group.

Varied access to finance

Finance, as opposed to funding, is either debt or equity capital paid into an organisation with the expectation that it will be repaid with interest. Finance is usually used to expand service provision by buying real estate or essential equipment (e.g. vehicles). Some of the large health and social service organisations that operate viable social enterprises or have sufficient assets have access to finance from conventional lenders (e.g. banks). However, many medium and small organisations are unable to borrow money because they cannot use government funding to repay loans. The lack of finance limits their ability to expand, innovate and develop.[16]

Social

Main points

- Population growth in Australia is uneven with some areas in population decline.
- Changes in the distribution of population must eventually result in changes in the distribution of funding.
- The ageing of Australia's population will increase demand for age pensions and for health and aged care spending.
- Health and social services may struggle to provide culturally appropriate services to small migrant communities in rural and regional areas.
- Expectations that health and social needs will be met by service users are rising.

The major social changes in Australia affecting health and social services are population growth and an ageing population. Both require increases in services. However, the distribution of population growth is uneven and this also affects services.

[16] Productivity Commission, *Contribution of the Not-for-Profit Sector*, Research Report, 2010.

Other social factors include cultural diversity of the population, disengagement by certain sections of the population and increased expectation on services.

Uneven population growth

Australia's population grew by about 1.4 per cent in 2015[17] and has grown between 1.4-2.0 per cent per year for much of the past decade.[18] This growth has not been evenly distributed across Australia. Recently, Victoria became the fastest growing state in Australia, with a population growth rate of 1.9 per cent.[19]

Within Victoria, the population of Greater Melbourne grew by 2.5 per cent in 2015 with much of the growth in the outer suburbs.[20] The rest of Victoria only grew by 0.6 per cent,[21] despite some regional centres, such as Bendigo and Ballarat, growing at close to the national level, 1.2 and 1.3 per cent respectively.[22] Further, many rural areas are in decline. For example, population in the Loddon area fell by 1.1 per cent in 2015.[23]

Changes in the distribution of population must eventually result in changes in the distribution of funding. Health and social service providers may struggle to access funding for areas in population decline when demand for services is growing substantially in other areas.

Ageing population

Between 1995 and 2015, the median age of the Australian population increased by three years, from 34 to 37.[24] This is due to relatively low birth rates and increasing life expectancy. During this period the proportion of the population aged 65 and over grew from around 12 per cent to 15 per cent, while the proportion of the population 15 years and younger fell from 21.5 per cent to 18.8 per cent.[25]

Despite the increasing proportion of the population over 65 who are in the labour force[26], the ageing of the population will result in a greater demand for age pensions as well as health and aged care spending.[27] This will place greater demands on the working age population to provide services and care.[28]

Migrant and diverse communities

Over one-quarter (28.2 per cent) of the Australian population was born overseas.[29] The largest group by country were those born in the United Kingdom, followed by New Zealand.[30] Australia's migration programs allow for 190,000 permanent migrants per year.[31] China and India currently provide the highest number of permanent migrants.[32] A substantial number of

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[17] Australian Bureau of Statistics, *Australian Demographic Statistics*, 3101.0, 2016.
[18] ibid
[19] ibid
[20] Australian Bureau of Statistics, *Regional Population Growth, Australia*, 3218.0, 2016.
[21] ibid
[22] ibid
[23] ibid
[24] Australian Bureau of Statistics, *Australian Demographic Statistics*, 3101.0, 2016.
[25] ibid
[26] Australian Bureau of Statistics, *Labour Force, Australia, Detailed*, 6291.0.55.001, 2016
[27] The Treasury, 2015 Intergenerational Report: Australia in 2055, Australian Government, 2015.
[28] ibid
[29] Australian Bureau of Statistics, *Migration, Australia, 2015-2015*, 3412.0, 2016.
[30] Ibid.
[31] Phillips, J. & Simon-Davies, J., *Migration to Australia: a quick guide to statistics*, Research Paper Series 2015-2016, Australian Parliamentary Library, 2016.
[32] Ibid.

temporary migrants also arrive as workers (e.g. through 457 visa) and students. Refugees and asylum seekers make up only a small proportion of annual immigration.

Most new migrants settle in capital cities, particularly Sydney, Melbourne and Perth, with smaller numbers living in regional or rural areas.[33] For example, in the Loddon Mallee region only 9.4 per cent of the population was born overseas.[34] Those settling in non-urban areas are more likely to be from the United Kingdom, New Zealand, the Netherlands and Germany.[35]

Health and social services may have difficulty in providing culturally appropriate services to small migrant communities in rural and regional areas.

Demand for more responsive services

Health care has improved dramatically over the past few decades. New medications and vaccines, surgical procedures and new technologies have reduced mortality rates for several illnesses. As health care has improved, so have expectations that health needs will be met.[36] Such expectations may extend to social services although the evidence is less clear.

Increasing expectations place pressure on health and social services to improve their services and better meet the needs of service users.

Technological

Main Points

- E-health services are becoming more common.
- Common digital identities are set to make access to government services easier.
- Trip Advisor-style online service user reviews are emerging in other services areas, Online start-up 'employment' companies are beginning to compete with traditional health and social services.
- Increased use of online data storage and information has increased the need for data security.

Rapid technological development is leading to new ways of delivering health and social services. It also has the potential to give greater control to service users to select their service provider and even their service workers.

Rise in e-health services

The term 'e-health' refers to many technologies that increase the use of computer and communication technology to support service users. Examples include:

- My Health Record – an online summary of a person's health information. Users can control what goes into it, decide who can access it and share information with doctors, hospitals and other healthcare providers.

[33] Australian Bureau of Statistics, *Australian Social Trends 2014*, 4102.0, 2014
[34] Australian Bureau of Statistics, Basic Community Profiles 2011, 2001.0, 2013.
[35] Ibid.
[36] Grattan Institute, *Budget Pressures on Australian Governments 2014*, Melbourne, 2014.

- However the implementation focus has only included general practitioners and to a lesser extent allied health professionals.

- E-referrals – these allow a referral to be made instantly and to transfer a person's clinical and personal information securely between service providers.

  - There are multiple e-referral systems that are not all compatible. This requires a place-based approach to align the e-referral systems across a region. This is challenging when some services cover multiple regions.

- Tele health – information and communications technologies that can deliver health services, including medical checks and treatments, and transmit health information over any distance.

  - Some of these technologies require investment in equipment, workforce knowledge and skills, IT support and adequate internet speed.

Registration and management of services are increasing use of an internet platform e.g. My Aged Care, NDIS. This requires service users to have a level of computer literacy, adequate cognitive ability, and access to computers and the internet. Access to the internet and mobile coverage is considerably lower in rural and remote areas compared to major cities. This creates an increasing 'digital divide' and limits access to services for those in rural areas or those who cannot afford access to the internet or those who do not have the necessary computer literacy skills to gain access.

Streamlining digital identity

The Commonwealth Government's Digital Transition Office is working on a digital identity framework.[37] This will consolidate multiple identity approaches used by many government departments and agencies to a single approach. Once implemented, users will only need to establish their identity once to be able to use many government services online, with the aim being able to make transactions with government faster and in a more streamlined manner. It is not known at this stage whether state governments and government funded health and social services will use this framework.

Online selection and scrutiny

Consumers are becoming more reliant on online user reviews to assess whether a service or product is suitable. For example, Trip Advisor assists travellers to select hotels. In addition, Clickability (https://clickability.com.au) is a disability service directory with ratings and reviews from service users. It seeks to let users find out about services, share their experiences and connect with others users. There is potential for such a service to assist NDIS participants to select services based on the ratings of other service users.

Online hiring

Technology will create additional competition for health and social services where competition for service users is high. 'Better Caring', a start-up, uses an online portal to allow service workers to choose support workers. 'Better Caring' does not directly employ service workers.[38]

[37] See https://www.dto.gov.au/our-work/identity/.
[38] See https://bettercaring.com.au

Risks to data security

Increased reliance on information and communication technology may yield many benefits but it does not come without risk. Unauthorised access to or corruption of personal information stored on computers, shared and transferred insecurely are significant risks to organisations and service users. Health and social services need to ensure that such data are held, shared and transferred securely and adhere to the Victorian Protective Data Security Standards.

Environmental

Main Points

- Health and social service organisations in regional and rural locations face unique challenges, including recruitment of highly skilled staff.
- Climate change will require health and social service organisations to better prepare for disasters such fires, floods and severe storms.

Where a health or social service organisation operates can affect the nature, cost and quality of the service provided. Organisations in regional and rural areas face different challenges to those operating in metropolitan areas.

Climate change will require health and social service organisations to be better prepared for disruptive events such as fires, drought, floods and severe storms.

Locational differences

Running a health or social service in regional or rural Victoria brings unique challenges. Cost and other factors drive the centralisation of services from small towns to larger population centres. Outreach models of service provision are then used for small towns or areas of low demand. Outreach models may result in lower levels of service or lower quality of service provision due to travel time and costs, potentially reducing hours of service.

Where outreach models are used, it is more difficult to build relationships between service providers, particularly when their main locations are in different regional centres. Further, it becomes harder to align service systems, fill service gaps and remove service duplication.

Interagency cooperation is required to address complex issues. Health and social service organisations participate in multiple networks covering different geographic areas and with different governance and funding arrangements.

Many health and social service organisations report that it is difficult to recruit highly skilled, professional staff in rural and regional areas.

Impact of climate change

Climate change brings an increased frequency and intensity of disasters such as bushfires and floods. Services and infrastructures are in place to support the community and respond in time of crisis. Research indicates that 25% of community service organisations cannot operate at all after a disaster and 50% of organisations will be out of action for a week – at a time when there is increased demand.

Legal

Main Points

- Funding agreements are becoming more complex and leading to additional accountability requirements.
- Increased regulatory burden on health and social services is costly.

There are many legal aspects to establishing and operating health and social services. Consequently, there are multiple accountability requirements including:

- funding agreements and related laws
- registration with regulatory bodies such as the Australian Charities and Not-for-profits Commission (ACNC).

Governance Arrangements

Stephan Duckett's report, 'Review of Hospital Safety and Quality Assurance in Victoria', [39] was in response to avoidable perinatal deaths at Djerriwarrh Health Services and the inadequate clinical governance and response to adverse clinical outcomes. The recommendations seek to amend the Health Services Act 1988 to reflect the high value expectation on safety and quality. It also recommends a number of legislative change to ensure boards are highly skilled, independent, effective and accountable for improving safety and quality of care, regardless of their size or sector.

Although this report is specifically targeted to public hospitals, there are some lessons and directions for all boards of health and social services in relation to ensuring that safety and quality is maintained through reforms, restructures and revitalisation of services.

Funding agreements

Most health and social services are funded through multiple funding streams and hence are accountable to multiple government departments, both state and Commonwealth.[40] The Victorian government has a common Service Agreement covering most health and social services. Over time this agreement has become more complex with additional accountability requirements added due to government policy changes. For example, privacy requirements were changed when the Privacy and Data Protection Act 2014 was introduced.

Regulatory burden

Increased accountability and oversight has added to the regulatory burden felt by health and social services. Multiple reporting requirements lead to duplication and unnecessary accountability. The annual cost of this 'red tape' has been estimated to be $23 million in Victoria.[41]

[39] Duckett, S., Review of hospital safety and quality assurance in Victoria, Melbourne, 2016
[40] Victorian Council of Social Service, More than Charity: Victoria's community sector charities, VCOSS, 2016.
[41] ibid.

Implications for Health and Social Service Organisations of a changing environment

Health and social service organisations operate in a complex, continually changing environment. This has implications for their governance and management as well as service delivery. Organisations need to consider what changes mean for them in terms of the type and quality services they provide and to question whether they can remain viable. They may need to reconfigure their operations to survive. They may need to attract staff with new skills and knowledge to adapt to conditions as they change.

Some of the implications for health and social service organisations of the most significant changes are discussed below.

Greater Competition

Main points

- Choice of service provider is already common in human services but it is being extended in areas where little or no choice existed.
- Competitive tendering is now commonly used by governments to select services but requires an effective commissioning process to deliver benefits.
- Competition between services is increasing because of government policies and service user preferences, including from for-profit providers.
- Competition arising from user choice and competitive tendering has different implications for health and social service organisations.
- Both for-profit and not-for-profit service providers have their own competitive advantages.

Competition arises from increasing the choice of services by service users and competitive tendering. The nature of this competition is different and hence the implications for health and social services differ.

Competition arising from user choice

Choice refers to service users deciding which organisation provides them with supports and services. At present Australians choose their doctor, early education and schools for their children, residential aged care facilities, as well as many other services.

More recently, increased choice of service provider is being introduced to disability services through the NDIS and home care services for the aged. The Productivity Commission has identified additional areas where greater choice could improve service provision.

Increasingly governments are turning to service user choice to improve outcomes from services by driving competition. Competition is meant to make service providers be more efficient, innovative and responsive to service users.

Choosing a service provider can work well under certain conditions, including when:

- Sufficient numbers of service providers offer the same type of service with the capacity to meet needs. However, there cannot be too many providers as this can make it confusing for service users. This can vary by location with rural areas less likely to have sufficient numbers and metropolitan areas may have too many.
- Different providers offer different approaches to the same type of service from which one can choose (e.g. cultural appropriateness). This makes the choice real for the service user.
- Quality controls are in place to ensure minimum standards.
- Prices are affordable or appropriately subsidised by government (including free services).
- Services can be easily and effectively compared.
- Service users have sufficient time to make a choice (e.g. choice in emergency services is not possible).
- Service users can realistically change providers if they are dissatisfied with a provider (i.e. the cost of transferring provider is not a barrier and the process must not be too complex).

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is the system of providing support for Australians with disability, their families and carers. It replaces state and Commonwealth government funding to organisations with individualised funding. The scheme aims to give participants (i.e. people with disability) a significant level of choice and control over the services they require.

The NDIS is being progressively implemented across Victoria. It commenced as a trial site in the Barwon region and is incrementally being rolled out across Victoria.

Implications of user choice

Provided user choice is genuine (i.e. sufficient providers and some product differentiation) and it is relatively easy to switch service provider, then the competition between services has the potential to be vigorous and constant. Health and social service providers will need to provide quality services but also have marketing, sales strategies and a focus on customer service to attract and retain service users.

Where there is a potential role for large private providers (e.g. health insurance companies) to enter the market this competition could be particularly fierce. Private providers have some competitive advantages. They are used to operating in competitive markets and have sales and marketing teams in place. They have access to capital through debt financing and equity raising which can be used to expand service provision. However, not-for-profits also have competitive advantages. Their not-for-profit status exempts them from company tax and Public

Benevolent Institution status provides fringe benefits tax exemption for employees, which can help with recruitment and retention of staff.

There may also be some marketing advantage in being a not-for-profit and a charity since any financial surplus is reinvested back into the service. This can be seen in the superannuation industry where not-for-profit member superannuation funds use "Industry Super" branding to differentiate themselves from for-profit funds. It is not known whether similar branding would work in the not-for-profit health and social service sector.

Competitive Tendering

Primary Health Networks

Primary Health networks (PHNs) were established by the Commonwealth Government to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve the coordination of care so that patients receive the right care in the right place at the right time.

The PHNs model has moved from a partnership platform to a stronger role in commissioning of services e.g. mental health services.

Competitive tendering is where multiple organisations are asked to submit proposals to win a contract to provide goods or services to government or the community. Proposals must conform to the tender specifications regarding the design of supports and services, which may be detailed or general in nature.

Governments now commonly use competitive tendering methods to select organisations to provide health and social services.

For competitive tendering to be successful there needs to be sufficient number of service providers with the required knowledge and capacity to deliver the services in all required locations. The number of service providers will vary from location to location.

The benefits of competitive tendering are seen to include increased flexibility in service delivery, greater focus on outputs and outcomes rather than inputs, and the incentive for suppliers to provide innovative solutions and savings. Whether these benefits are forthcoming depends on the specifications of the tender document and are often not realised because poorly written specifications are inflexible, focus on inputs (costs) and limit innovation. They depend on those selecting the service provider to make the best decision in an unbiased manner.

Implications of competitive tendering

Competition arising from competitive tendering differs from competition for user choice in that the competition is usually limited to the tender period. Some rivalry may remain immediately after the tendering process and when contracts start, however actual competition is likely to dissipate until the next tender period begins.

Competitive tendering processes often lead to larger, state-wide or national organisations winning tenders over smaller, local organisations. This may in part be due to their greater geographical reach with centralised intake models or their greater capacity and skill to write a successful tender submission.

To address this trend, many organisations have been seeking to grow through mergers with like-minded organisations. Others look to consortia and other partnering arrangement to win competitive processes. Sometimes consortia or other partnering arrangements are encouraged by the tender specifications.

As with competition arising from user choice, competitive tendering processes can allow for-profit providers to participate in the market. Decisions about whether for-profits can participate are made by the tendering department or government in the tender specifications. The same competitive advantages regarding user choice apply to both for–profits and not–for–profits (see previous page).

Questions for Governing Bodies

Are we the best placed to provide the services in the request for tender (including the nature of the service, the location of service and workforce requirements)?

Who are we likely to be competing with and how can we maximise our strengths?

Should we be partnering with other organisations to provide the services being tendered?

Do we have the skills in our organisations to write a successful tender submission?

Funding Uncertainty

Main points

- Increased funding uncertainty arises from competition, problematic federal and state government relations and changing government priorities.
- The need for health and social service organisations to diversify income sources adds to the complexity of management and can lead to 'mission drift'.

Increasingly the funding of health and social services is becoming less certain, due to:

- Increased user choice with individualised funding which may result in high turnover of service users and hence changes in funding.
- Competitive tendering processes where contracts are re-tendered at the end of the funding period.
- The nature of federal and state relations particularly with National Partnerships Agreements being changed or ended without consultation nor sufficient notice.
- Changing government priorities and funding commitments.

Individualised funding

Individualised funding is where government funding is attached to the service user rather than attached to an organisation or service. The funding can be used for a variety of purposes limited by the program guidelines, which can be narrow or broad in scope. Individualised funding is a means to enhance choice and control by the service user but is not essential for either.

Individualised funding needs:

1. Knowledge of who is using which service for what purpose.

2. An ability for funding to follow service users when they switch service.

Individualised funding is an easier way for governments to give service users choice of service provider compared to flexible contracts allowing choice.

Individualised funding can be needs-based (i.e. higher for service users with greater needs) which may encourage service providers to take on higher needs service users, provided the level of funding meets the cost of required services.

Where individualised funding comes with user choice, such as in the NDIS and aged care reforms, health and social services may need to make substantial changes to their financial systems and to ensure they are properly funded for the services they need to deliver. As invoices will be paid after services are provided, rather than before, many will need to change their financial management and financial forecasting skills will become more important.

Where governments cease funding or at the end of a contract, services are interrupted even before the funding ceases. Health and social service organisations may lose their staff as they seek positions with more secure funding elsewhere. Organisations need to plan for this and

seek to minimise the risk of contract breaches and reputational damage if services cannot be provided due to staff loss while still under contract.

In response to this uncertainty many health and social service organisations are seeking income from multiple and diverse funding streams to act as a buffer in case one funding stream ceases or declines. As well as obtaining funding from multiple government departments across tiers of government, many organisations are also seeking funding from philanthropic sources (usually for time-limited projects or equipment purchases), through fundraising activities and/or via social enterprises to raise money from business activities.

Having multiple sources of revenue increases the complexity of the operations of the organisation. Managing relationships with government funders and philanthropic donors can take time and resources from the main purpose of the organisation.

Where funding is from multiple government departments and/or funding streams, there will be multiple funding contracts with multiple accountability and reporting requirements. There may be multiple quality compliance obligations and standards to meet. For example, one organisation with an annual income of $10-$12 million makes up to 70 reports each year on its performance and activities for accountability purposes. This takes time and money away from delivering services and addressing vulnerability and disadvantage.

Where an organisation runs a social enterprise in addition to its services, there is a risk of conflict. For example, an organisation may provide a service for different categories of service users, one subsidised by government (either free or low cost for the user) and the other on a full cost recovery basis for unsubsidised users. There may be a financial benefit to the organisation to have more full-fee service users than subsidised ones and users may be encouraged to pay for full-fee places when the subsidised places are taken up.

Organisations will need effective procedures and oversight to ensure appropriate and ethical placement of service users in the correct funding streams.

There is a significant risk of 'mission drift' if revenue becomes the priority over service provision for the community.

Questions for Governing Bodies

How can we manage the funding uncertainty arising from moving to individualised funding systems under the NDIS, Aged Care reforms and other systems?

Do we have diverse revenue streams to ensure continuation in case of changing government priorities?

In seeking new sources of revenue, are we keeping to our mission and values?

Greater Control by Service Users

Main points

- Person-centred services are more responsive to the needs of the service users and can reduce service silos.
- 'Consumer directed care' sees human rights as paramount and enables service users to make decisions about their care and services.
- Co-design is working with people who experience vulnerabilities or disadvantage to create interventions, services and programs that work for them.
- Greater control by service users can make workforce planning and financial forecasting more difficult.

Control is where the service user makes decisions regarding types of care and services and how those services are delivered. There are varying degrees of control by service users.

Aged care reforms

The Commonwealth Government is changing the aged care system to give people more choice, more control and easier access to a full range of aged care services. The changes aim to provide opportunities for people to stay in their homes for longer and reduce their need for residential care. Funding is individualised and based on a person's level of need.

This is a ten-year process that commenced in 2012 with new homecare packages. Since then, the Aged Care Gateway was created to help older Australians find and access the services they need. The Australian Aged Care Quality Agency was established to accredit residential care services and to conduct quality reviews of home care services.

Person-centred services

At the lower end of control, person-centred services provide accessible, responsive and flexible services that meet the needs and preferences of service users and their carers in a holistic manner. The service user is at the centre of the decision-making process and the service users and their family members are considered partners in decision-making.

A person-centred service requires service providers to:

1. Treat the service user as an individual.
2. Protect the service user's rights and dignity.
3. Respect the service user's life goals and preferences.
4. Develop trust between the service user and provider.

Person-centred service provision helps overcome siloed service provision by considering the service user's needs holistically and linking professionals to support all the person's needs.

There is strong evidence that person-centred health services improve health outcomes substantially.[42] There is little evidence yet on its impact on outcomes in other areas but there are great expectations for its effectiveness.

Consumer directed care

Consumer directed care is where the service user identifies goals, develops care plans and devises their service package. This is usually with the assistance of service providers, carers and/or advocates. It differs from person-centred care in that decision-making is vested in the service user rather than where the service provider uses professional judgement albeit in a person-centred way.

In addition to the requirements of a person-centred service, putting service users in control requires service providers to:

1. Become more responsive to users' needs.
2. Retain staff with a diverse range of skills as one service user's needs may be very different from the next service user.
3. Be flexible as service needs change through a user's life.

Co-design

Another form of service user control is co-design. Co-design is working with people who experience vulnerabilities or disadvantage to create interventions, services and programs that work in the context of their lives and reflect their values and goals.[43]

This requires setting aside professional assumptions about people's perspectives and experiences and actively learning from what people say and do. Expertise, professional knowledge and research is then added to consider a range of approaches to social problems.

Family Violence Royal Commission

The Royal Commission into Family Violence made 227 recommendations to the Victorian Government. The Victorian Government responded with a $572 million funding package to address 65 recommendations that were identified as needing immediate attention. There is recognition that no one organisation or part of the community can tackle family violence on its own, and many recommendations are about co-designed joined up responses.

One of the major reform recommendations is the development of Safety Hubs across Victoria. Although currently there is no agreement on what these Safety Hubs will look like there is agreement that there needs to be a place based approach to provide the community context to the service system reform.

Implications of greater service user control

Allowing the service user to identify goals, develop care plans and devise service packages aims to give them the same level of control over their lives as people not dependent on such services. It is an approach that considers the human rights of individuals as paramount.

[42] See Australian College of Nursing, *Person-centred Care: Position statement*, 2014.
[43] VCOSS, Walk Alongside: Co-designing, social initiatives with people experiencing vulnerabilities, VCOSS, 2015.

Greater control by service users over how their services are provided can mean services become tailored to meet their unique needs.

However, there are significant implications for the operations of health and social services. Organisations will need to be more flexible in their services to meet individual requirements as one service user's needs may be very different from the next. This will have implications for the workforce as a diversity of skills will be required to meet the range of needs, including how to elicit and respond to service user's needs which may change over time.

The implications for health and social services relate to workforce planning and budgeting. Given that control by service users must allow for ongoing change, planning becomes more difficult as future service and support needs are not necessarily known in advance. Hiring of staff with the right skills and availability of work hours to meet the need of service users becomes more difficult. This, in turn, makes financial forecasting more difficult.

To mitigate these risks, health and social services may seek to limit the control ceded to service users. This could be by negotiating limits to how much change can be requested in a period of time. For example, a service may negotiate yearly plans which can be adjusted only in minor ways during the year, rather than the service user being able to change monthly. Of course, some flexibility will be required due to unexpected events.

Questions for Governing Bodies

How flexible is our current service delivery to enable greater control by service users?

Do our staff have the skills and training to support greater control by service users?

Are we effectively capturing the requirements and expectations of service users?

Increased oversight

Main points

- Government demands for increased accountability is adding to the regulatory burden on health and social services.
- Independence of non-government health and social services may be lessened by increased oversight by government.

Arising from competitive commissioning via contract management there has been an increasing push by governments for greater accountability of health and social service organisations. Organisations acknowledge and accept the need for accountability for public expenditure but there are concerns that current reporting requirements "are not appropriate, impose compliance costs without commensurate benefits and are lacking any sense of proportion in regard to the size of the organisation or scale of the undertaking".[44]

Health and social service organisations face multiple and duplicated auditing requirements across differing funding streams. There is significant duplication between the Human Services Standards, the Home Care Standards, the Child Safe Standards and the International Organization for Standardization (ISO), particularly with management and governance. Audits may occur around the same time, and cover the same matters, but take no account of each other. Ref: Victorian Council of Social Service, More than charity: Victoria's community sector charities, VCOSS 2015

Organisations are often required to provide data to funding bodies in prescribed formats that may not be useful to inform ongoing monitoring and outcomes measurement.

Financial reporting requirements often do not match the level of funding nor the risk associated with the funding. Large amounts of funding can have minimal reporting requirements if funding is based on clear output measures with limited flexibility. Small amounts of funding based on flexible arrangements can face significant scrutiny and even prior approval. Ref: Victorian Council of Social Services, State budget submission, VCOSS 2016

Implications of increased oversight

Increased oversight by government can lessen the independence of non-government organisations and therefore their ability to advocate for their communities. Health and social service organisations must ensure their continued independence and speak up for their service users and communities.

Time and other resources are put into duplicated accountability regimes with little benefit to service users or organisations. Such resources could be better used in services.

Questions for Governing Bodies

Do we have systems in place to input and access data efficiently for reporting requirements?

Does our governing body, in principle, meet the recommendations the Stephen Duckett review?[45]

[44] Productivity Commission, Contribution of the Not-for-Profit Sector, Research Report, Canberra, 2010.
[45] Duckett, S., Review of hospital safety and quality assurance in Victoria, Melbourne, 2016

Progressive universalism

Main point

- Progressive universalism requires a strong universal system that can intensify service provision for disadvantaged people.

Progressive universalism (or proportionate universalism) is the provision of services to all people but at a greater intensity or higher level of service to disadvantaged people proportionate to the level of disadvantage. For example, since people of low socio-economic status have worse health than people of high socio economic status, a progressive universal approach seeks to reduce these inequalities in health as well as improve health outcomes for all.[46]

Progressive universalism requires a strong universal system (i.e. services provided to all) that can intensify service provision to those most in need. Universal primary services systems need strong links with secondary (i.e. special services for people with particular needs) and tertiary (i.e. complex and intensive services) services.

Victorian state disability plan 2017-2020

The Victorian state disability plan 2017-2020 will be an overarching framework for improving the way mainstream services and environments work for people with disabilities, not just for those supported by the NDIS, but for all people with a disability living in or visiting Victoria. The plan was finalised 1 January 2017.

Implications of progressive universalism

Health and social service organisations that provide universal services need to ensure that these can be intensified or provided at a higher level to the most disadvantaged service users. There needs to be a balance between providing services to all and ensuring the most disadvantaged get the services they require.

Secondary and tertiary services need to ensure they have good links and referral pathways from universal services.

Roadmap for Reform: Strong Families, Safe Children

Victoria's Roadmap for Reform: Strong Families, Safe Children project seeks to develop the service system such that services are better able to:
- strengthen communities to better prevent neglect and abuse
- deliver early support to children and families at risk
- keep more families together through crisis
- secure a better future for children who cannot live at home.

Questions for Governing Bodies

How well are our services connected to universal services?
Do we have strong linkages between universal and specialist services?
What are the implications for data sharing between organisations?

46 Marmot, M., The Marmot review final report: Fair society, healthy lives, University College London, 2010.

Place-based approaches

Main points

- Place-based service design and delivery recognise the importance of local community characteristics and can break down service silos.

Place-based approaches are ways of developing and delivering local solutions to local problems. Governments are increasingly recognising that centralised and 'siloed' decision-making that results in uniform and narrowly focused programs cannot overcome entrenched poverty and disadvantage and other 'wicked problems'. Further, government funding tends to be focused on crises.

Victorian Primary Care Partnerships

Primary Care Partnerships (PCPs) are state government funded, often utilising place-based approach to identify local issues and develop solutions. The PCPs bring together local health and social services who work together within a voluntary alliance to improve access and coordination of services, management of chronic disease and integrated prevention and health promotion.

PCPs support local organisations to navigate the ever changing health and social landscape, while supporting services to maintain a high quality, safe, person centred and evidence based services, which meet the needs of their local community.

Placed-based approaches[47] need:

- a focus on place
- support for groups facing disadvantage
- roles for community members and service users
- effective engagement and communication
- local decision-making
- shared vision and a joint approach
- innovation
- flexible service delivery
- capacity development
- backbone funding and support
- outcomes-focused measurement
- good governance
- long-term timeframes.

Place-based service design and delivery acknowledge the importance of local community characteristics and can help break down the silos created by government departments and programs. These approaches can focus on early intervention and prevention strategies.

[47] For more information about place-based approaches see VCOSS, Communities Taking Power: Using place-based approaches to deliver local solutions to poverty and inequality. 2016.

Children and Youth Area Partnerships

Children and Youth Area Partnerships (Area Partnerships) are working at the local level to more effectively join up social services in Victoria at a system level to support better outcomes for vulnerable children, young people and their families.

Area Partnerships bring together the most senior representatives in a local area from State, Commonwealth and Local governments, the community sector and the broader community, who are most able to make a difference for vulnerable children, young people and their families. In doing so, Area Partnerships will raise the expectations for vulnerable children and young people.

Implications of place-based approaches

A place-based approach requires funding to build the capacity of the whole community, without having agreed outputs and targets at the outset. Outputs, outcomes and targets must be agreed upon early but funding may be needed first. Unfortunately, most government funding comes with outputs and targets set and lacks the flexibility to develop local solutions to local problems.

Place-based approaches also need to evolve over time as new partners come to the table, new activities are developed and new funding becomes available. The initiatives must be flexible and able to respond to changing circumstances, while still focusing on their main goals of helping communities.

Health and social service organisations need to be adaptable and work in partnership with other organisations, the community and governments if place-based approaches are to be successful.

Questions for Governing Bodies

What role does our organisation want to play in place-based approaches?

What influence does our organisation have to effect change in the community?

Is our organisation represented at the table of existing local collaborative partnerships? i.e. Primary Care Partnerships

Partnerships

Main points

- Partnerships are useful for addressing complex issues but are also complex themselves.
- Partnerships are harder to develop and maintain in a competitive environment and require proper and adequate resources to set up and sustain.
- By their nature, partnerships require ceding or gaining some control over partner organisations so that decisions can be made jointly.

Partnerships are when organisations work together with a common objective. These can include formal agreements or informal collaborative relationships. Partnerships arise from progressive universalism (the need for primary, secondary and tertiary services to work together) and place-based governance. Health and social services may seek partnerships independent of government priorities or funding to take on bigger issues, such as overcoming poverty or other complex social issues.

Where partnerships are facilitated under local governance arrangements, local service providers can participate in decision-making relevant to the communities they serve and to help shape the service systems in their area. The extent to which this occurs depends on what and how much decision-making is delegated to local areas and what and how many non-government organisations are invited to participate. Having too much control held by central agencies and/or delegating only unimportant decisions will undermine the effectiveness of the local governance.

Regional Partnerships

Nine new Regional Partnerships have been established by the Victorian Government across Victoria to give regional communities greater say about what matters to them and ensure their voices reach the heart of government. Partnerships seek to increase collaboration between communities, industry, businesses and government to address the most important challenges and opportunities in each region.

Each Regional Partnership is guided by a diverse group of members drawn from local communities, businesses and the three-tiers of government. Priorities will be presented directly to the Victorian Government's Rural and Regional Ministerial Committee.

Implications of partnerships

Collaborative partnerships may be hard to maintain in a competitive environment brought about by government policies focussing on service user choice and competitive commissioning.

Partnerships are complex. So, resources are necessary to enable health and social service organisations to participate in partnerships. Without additional resources, organisations' participation will be limited by their capacity to release staff from their existing responsibilities.

By their nature, they require ceding or gaining some control over partner organisations so that decisions can be made jointly. This can complicate management and governance of health and social service organisations.

Often, health and social service organisations participate in numerous partnerships across a geographic area, often with the same partner organisations. This arises because partnerships usually have a single focus and an organisation has several priorities that partnerships could facilitate. Duplication also arises because different partnerships are based on different geographic areas. An organisation may operate in more than one local government area but have partnerships based on LGA boundaries.

Questions for Governing Bodies

How do we balance the need to partner with other organisations who we may be competing with in some areas?

How do we support partnerships financially, in-kind and/or with the workforce without detracting from our core business?

Who are our partners?

Are we participating in important local and regional partnerships and are we represented appropriately?

Does our organisation advocate on behalf of service users through our membership with peak bodies i.e. VCOSS, VHA

Changing workforce needs and skills

Main points

- Health and social service organisations need a multi-skilled and expert workforce that is culturally competent and able to face complex social problems.
- Recruitment is likely to become more difficult as the demand for experienced and qualified workers grows.
- Service workers and workforces may need new skills, knowledge and competencies as service users gain more choice and control.
- Greater casualisation of the workforce is likely to assist financial stability but may put at risk the important relationship between service users and their care workers.

Individualised funding and funding uncertainty have workforce implications, including pressure on health and social service organisations to grow and maintain their workforce in a competitive labour market. Health and social service organisations need a multi-skilled and expert workforce that can work with people from various cultural backgrounds, face complex social problems and deal with increasing demand.

Implications of changing workforce

Recruiting qualified and experienced staff is likely to become more difficult, particularly in rural areas. Front-line and other staff may need new skills, knowledge and competencies to work in the new environment of choice and control but at a time when training and development budgets are limited due to funding constraints.

Health and social service organisations may need to employ staff with skills and knowledge not previously employed, such as sales and marketing expertise to attract service users.

Finance teams may have to step up their skills in financial forecasting where there is individualised funding in competitive market driven by user choice.

There is significant risk that organisations will increase their workforce by employing casual workers, so they can avoid the risk of paying out permanent or long-term employees when funding is uncertain. This needs to be balanced with the user's preference for stability and relationships of trust with their care workers.

Questions for Governing Bodies

Does our workforce have the skills required to operate in a competitive environment (skills might include sales & marketing and financial forecasting)?

Does our workforce have the skills required to provide client directed care services?

Has our organisation set aside the appropriate resources to support the future requirements for staff development?

Measuring outcomes

Main points

- Measuring outcomes allows governments, service providers and the community to understand if their programs and services are effective, if it is done properly.
- Timely data can assist organisations to improve outcomes that are not satisfactory.
- Reporting processes may be improved if appropriate outcomes measures are used.
- Governments need to establish shared outcome measures, monitoring and reporting and work in conjunction with health and social services to develop these.

Measuring outcomes refers to collecting and reporting information that reflects changes in people's lives. Such measures can be individual (e.g. is a service user better off because of a service provided); across a group of people targeted by a program, (e.g. are people with disabilities better off because of the NDIS?); or across the whole population (e.g. is the incidence of chronic disease increasing, decreasing or not changing?).

Measuring outcomes allows governments, service providers and the community to better understand the benefits or outcomes that people or groups of people gain from particular funding programs. It assists in holding governments and health and social services to account. It provides a basis for change and improvement.

10 Year Mental Health Plan

Victoria's 10 Year Mental Health Plan sets the goal for all Victorians to experience their best possible health, including mental health. The plan's areas of focus are that:

- Victorians have good mental health and wellbeing.
- Victorians promote mental health for all ages and stages of life.
- Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness.
- The service system is accessible, flexible and responsive to people of all ages, their families and carers and the workforce is supported to deliver this.

Each focus area has associated outcome measures.

To assess whether people's lives are improving:

1. Governments need to clearly define what they are trying to achieve through funding programs at a whole population level and target groups.
2. Health and social services need to ensure their services and activities are aligned with the program objectives.
3. All stakeholders need to be committed to and share principles of measurement.
4. Good data needs to be collected at individual, program and population levels and reported consistently over time.
5. Governments and services need to respond if people's lives are not improving.

Measuring outcomes enables health and social service organisations to better understand the impacts of their activities on service users and their communities. It can also allow organisations to focus on the real difference they make in people's lives, rather than on being accountable for delivering specified inputs and outputs. Having prompt measurement processes means prompt feedback can enable organisations or funders to adapt quickly if outcomes begin to deteriorate.

Victorian Public Health and Wellbeing Outcomes Framework

This framework is a whole-of-government and cross sector approach to monitoring and reporting progress in collectively working to achieve better health and wellbeing. It provides local networks and initiatives to use a common language, align priorities and articulates outcomes and indicators, using a social determinant of health lens. This framework also identifies data sources and gaps within the existing data. The government is not solely responsible for collecting and resourcing the data and therefore cannot commit to the continuity and consistency of this data. This could be an issue for longitudinal measures and assessing progress against population health data.

Implications of measuring outcomes

There is potential for improving reporting processes to government funding bodies by replacing reporting on inputs and outputs of service delivery with reporting on outcomes.

Clear definitions and agreement on measures by all parties are needed before outcomes can be used for reporting and funding. Where choice and control are used to select and deliver services then outcomes will vary from service user to service user. It then becomes difficult to aggregate the outcomes to measure the impacts of a government funding program.

Outcomes measures must be practical and offer feedback without involving a significant time lag. Achieving practical and timely outcomes measures may be costly (e.g. information technology systems may need upgrading). Costs may be minimised by organisations working collaboratively to develop systems of data collection and reporting.

Unfortunately, there is a lack of clarity by governments regarding the outcomes many of their social policies and programs are trying to achieve. Health and social service organisations can collect outcomes regarding their service users, but only governments can establish population level outcome measures and targets. Until government sets clear targets and timelines with systems of indicators, then health and social services data will be for their own use.

Questions for Governing Bodies

How do we know we are making a difference?

What do we need to show ourselves, our service users and our funding bodies that we are making a difference?

Are there opportunities to work with our partners to demonstrate outcomes?

Closing an organisation or ceasing a service

Main points

- Legal advice should be sought if organisations face closure or have to shut down a government funded service.
- Organisations may feel obliged to ensure their service users continue to be provided services by another entity.

A health or social service organisation may wish to close or cease a particular service in the light of the complex and changing environment in which it operates.

Implications of closing or ceasing a service

There are legal requirements involved with closing an organisation or ceasing a government funded service (depending on the funding agreement). Organisations should seek legal advice under either of these circumstances.

In addition to legal requirements, organisations may feel they have an obligation to ensure their service users continue to be provided service by another entity. Working with the funding department and the new service provider is critical in these circumstances to ensure smooth transition without interruption of vital services.

Questions for Governing Bodies

When closing an organisation or ceasing a service, how do we ensure that our service users and the community are not disadvantaged?

Collaborative models

(Adapted from NCOSS, Shared Services in the NGO Sector, 2015).

There are a range of formal and informal models by which organisations work together to manage or deliver services, improve consumer experience and achieve efficiencies.

For boards and governing groups, initial questions should be "What problem are we trying to solve?" and "What is best for our consumers and local community?" From there, boards can examine the various options available to them, and identify the appropriate form of collaboration to address their needs.

Model of collaboration	Description	Benefits	Risks	Some questions for Boards
Interagency collaboration and networking **Examples:** Primary Care Partnerships	Informal and formal networks between organisations that can result in development of referral protocols, case conferences, MOUs and joint training.	Maximises organisations' individual resources. Builds strong working relationships between staff. Supports consumer choice and holistic approach to helping families and individuals.	Informal nature can lead to collaboration not being prioritised. Can take staff away from front line service delivery. Can be undermined by competition between providers, such as tendering processes.	• Do we support our staff to prioritise networking? • How might our decision to participate in a tender process impact our collaborative relationships? • Are there other potential partners in our region we should be working closely with?

Consortia, joint venture and partnership **Resources** NCOSS Formalising partnerships kit **Examples:** Bendigo Health-Justice partnership	Two or more organisations formally document an agreement about the role of each agency without merging and creating a new legal entity.	Autonomy, independence and organisational culture maintained Joint funding can be applied for – applying in consortia can strengthen applications Relationships can be negotiated and built gradually.	Efficiency gains may be more limited than merger. Ongoing commitment required to maintaining relationship. One agency needs to lead consortia, taking on greater legal and financial risk.	• Have we identified shared goals and values for the partnership? • Will this arrangement improve our capacity or ability to deliver services? • What are the risks and benefits of taking on/not taking on the lead agency role? • How will we manage any issues that arise in the relationship? • What process will we put in place to monitor the effectiveness of the partnership?
Outsourcing	Organisations outsource functions like financial management, human resources, information technology to specialist services. Usually on a contract or fee for service model.	Access to professional expertise, beyond that possessed in-house. Reduces burden on management and staff team, allowing time to focus on priorities. Helps organisations feel confident about legal, administrative and back-of-house requirements.	May be reliant on consultants or providers without knowledge of organisation or sector. Can be expensive. Professional expertise may not be available in some areas. May result in organisation not developing its own capacity. Can result in double handling.	• Is it more efficient to outsource this function, or is it worthwhile to develop our internal capacity? • Is there an external provider well placed to provide this function? • What are our expectations of the external providers? • What accountability measures will be put in place to monitor the work being outsourced? Who will be responsible for this?

Co-location	Group of organisations from the same region co-locate, sharing premises and other services as formally agreed. Often includes sharing administration, finance and other functions.	Cost savings. Makes it practical to share expensive resources, like IT and audio-visual, training rooms, fleet management. Benefits clients – multiple services at one location. For small organisations, can reduce worker isolation.	Can be expensive to establish. One organisation may need to take on responsibility of lease. Can leave remaining organisations vulnerable if one closes or relocates. Co-location alone (without strong collaborative relationships) may not improve service delivery to consumers. May not be practical – 'virtual hub' may be preferable. Needs clear procedures, especially around client privacy.	• Will co-locating improve accessibility for our consumers? • Have we identified suitable premises? • What formal arrangements need to be in place regarding premises and shared staff? • How will we manage any issues that arise in the relationship between organisations or staff? • How will we ensure our clients rights and privacy are protected?
Shared services **Resources:** NCVO Sharing Back Office Services Why consider shared services?	Group of organisations agree to work together to manage non-client functions, like human resources, finance and payroll, information.	Consolidates purchasing power. Shares skills and expertise across organisations.	Can be an uncertain arrangement, if one organisation chooses to leave. Needs clear procedures around security of information and privacy.	• What functions would be appropriate to share? • What is the process for ending the arrangement? • How will costs be shared? • How will we ensure staff and client information is secure and privacy is maintained?
Managed service organisation **Resources:** NCVO Sharing Back Office Services	Organisations pool their back-of-house expertise and form a new, separate, organisation.	Shares skills and expertise across organisations New organisation assumes responsibility for meeting legal and accountability requirements. Decreases burden on	Can be expensive to establish. May require significant investment of time and resources to establish. Needs clear procedures around security of information and privacy.	• What functions would be appropriate to share? • How will costs be shared? • How will we ensure staff and client information is secure and privacy is maintained?

		individual organisations.	May lose access to tax benefits, such as FBT exemption	
Merger and amalgamation **Resources:** NFP Law Amalgamations & Mergers **Examples:** Launch Housing Cohealth	Organisations join together to become a single larger organisation, merging their governance and administration tasks.	Sharing resources and skills can lead to efficiencies Broader funding base can increase certainty and sustainability for organisations. Can increase profile and strengthen voice Consolidate volunteer capacity – eg fewer board members Can increase reach of organisation.	Complex legal arrangements require legal advice. Potential loss of identify and autonomy for one or both organisations Organisational values and cultures can clash Consumers may feel disengaged from the new entity, or feel less supported Takes time and resources to transition and consolidate new entity – can be a burden on staff and on voluntary board members.	• What are the essential values and attributes of our organisation we want to retain? • How do our values align with the values of the other organisation? • What are the potential impacts on our consumers? • Will a merger increase our capacity or sustainability? • Have we undertaken appropriate due diligence and sought advice? • What is the role of the Board in the process? • Do we need to consult with or get help from stakeholders, consumers, external advisors? • How will we manage, respond to and communicate about the concerns of staff and board about the impacts on their role and work?

Appendix 1: Other state and federal government reform directions

Productivity Commission Inquiry into the increased application of competition, contestability and informed user choice to human services.

This is a two-stage inquiry with the first completed stage identifying those human services that are best suited to increased competition, contestability and informed user choice.

Welfare reform

The Commonwealth government is introducing a Priority Investment Approach to provide people with the opportunity to develop life skills and to participate economically and socially through work. Funding of $96.1 million was announced in the 2016-17 Budget for the Try, Test and Learn Fund. The government will look to fund responses that may include new policies, transforming existing programs and services, better utilising technology, and involving non-government players in welfare design and delivery.

NDIS quality and safeguards framework

Governments have agreed to develop a national approach to quality and safeguards as part of the National Disability Insurance Scheme (NDIS).

Inquiry into abuse in disability services

The Family and Community Committee of the Victorian Parliament inquired into abuse in disability services. The report was tabled in Parliament on 26 May 2016. The Victorian government has until 26 November to present its response.