New Horizons: The review of alcohol and other drug treatment services in Australia

Final Report

July, 2014

Alison Ritter
Lynda Berends
Jenny Chalmers
Phil Hull
Kari Lancaster
Maria Gomez

Drug Policy Modelling Program
National Drug and Alcohol Research Centre
UNSW

Disclaimer

This is an independent report.
While many experts provided valuable data, advice and opinions, the views expressed here are solely those of the researchers. The Review Advisory Committee members have not seen the report. The Review Advisory Committee and the Department of Health provided ongoing and thorough feedback but all conclusions have been drawn by the researchers alone.

Acknowledgements

This substantial research project would not have been possible without the extensive support of and collaboration from a number of key organisations and individuals. The state and territory health departments all gave freely of their time and provided us with data and shared their valuable experiences in relation to AOD treatment funding. The peak bodies in each jurisdiction

HRV	Harm Reduction Victoria
ICD-10	

PM&C	Prime Minister and Cabinet (department of)
POCA	Proceeds of Crime Act
QNADA	Queensland Network of Alcohol and other Drugs Agencies
QuIHN	Queensland Injectors Health Network
QuIVAA	Queensland Intravenous AIDS Association
RMHC-NMDS	Residential Mental Health Care - National Minimum Data Set
SACOSS	South Australian Council of Social Services
SACS	Social and Community Services
SAIN	South Australian Intravenous Network
SANDAS	South Australian Network of Drug and Alcohol Services
SFA	Standard Funding Agreement
SMSDGF	Substance Misuse Service Delivery Grants Fund
STO	State / Territory Office (Commonwealth)
VAADA	Victorian Alcohol and Drug Association
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WASUA	West Australian Substance Users' Association

disadvantage, limiting the capacity for the Commonwealth to exercise decision-making and acquit its responsibilities in relation to equity.

The transfer could be made through a single (block) grant. Allocations to each state/territory could be based on a formula inclusive of the overall rate of AOD problems, the extent of unmet demand for treatment and the context for service delivery. The Commonwealth could take into account equity issues in its allocations of funds to each state/territory, consistent with its role in ensuring minimum service levels and equity of access to AOD treatment across Australia. At the same time, this option may compromise the mandate to ensure equity in the short-term given that once the three- or five-year allocations are made, the Commonwealth has no further funds to distribute in emergencies or in situations where future inequities arise.

The major concern expressed by key informants (across government and non-government) to the Review is the potential loss of these currently dedicated AOD treatment funds. There is a fear, based on past history, that the funds will be potentially lost within state/territory systems. It would require careful quarantining of the funds and mechanisms to ensure that the funds were expended according to the original Commonwealth intention (that is the purchase of AOD treatment and capacity building). On balance, we consider this to be a high risk option, despite its attractiveness.

An alternative to the single block grant transfer of funds to the states/territories is for the Commonwealth to employ an Activity Based Funding model. Experts have expressed significant concern as to the suitability of the ABF system for non-admitted care and more specifically for AOD treatment. A feasibility study would be required to fully explore the possibilities and implications of an ABF-type mechanism within AOD treatment (Chapter 14).

Overall, the transfer of the funds to states/territories would remove the checks and balances that occur with two separate funders. Having two funders facilitates diversity, it enhances the competitive pressure on governments, it creates opportunities for national priority setting, and it disperses the decision-making power (protecting AOD treatment services against single government funding driven by moral panics or political whim).

On balance, our analysis suggests that the transfer of funds to states/territories as a single block grant is high risk. A move to Activity Based Funding requires feasibility assessment. We thus return to the position where the Commonwealth directly engages in the planning and purchasing of AOD treatment and capacity building.

As referred to above, we draw a distinction between strategic and technical planning, and delineate the Commonwealth as responsible for strategic planning (in concert with states/territories) and the states/territories responsible for technical planning (in concert with the Commonwealth). To achieve meaningful change across policy and practice, planning should be

types, population groups and locations for funding (Chapter 13). Under this option, the Commonwealth would fulfil its responsibilities in providing leadership in planning and setting national priorities.

The development of a Strategic Plan would lay the foundation for future comprehensive technical planning built from solid data. We have found that there is a current lack of needs-based planning data (notably the current treatment investment mix and impacts of capacity building). The collection, collation and analysis of planning data will provide a foundation for technical planning into the future.

There are three options for the Commonwealth to select the AOD treatment providers: through competitive selection processes; through individually-negotiated arrangements (often based on historical agreements); or through an accreditation and/or registration process. There are also

which occurs in the context of grants to states/territories (discussed above). A fixed unit price would facilitate transparency about the price for service types, enabling competitive processes to focus on quality. The development of unit costs will take some time, and would not be available in the short-term.

Monitoring processes need to account for the complexities of the funding environment and strive for contract management that is meaningful, respectful, and useful for both services and government, operating in an ongoing cycle of improvement and sector development.

In the situation where organisations are jointly funded by the Commonwealth and state/territory, the contract management and performance and financial monitoring is best undertaken jointly. This reduces administrative duplication for government and reduces the work-load of funded

The future

What are the most appropriate planning processes and mechanisms?

What are the possible purchasing models (e.g. competitive processes, activity-based funding, fee for service)? What are the potential varieties of grant arrangements, including funding accountability (reporting requirements, payment by results)?

How should Commonwealth funds be best used (e.g. targeted to gaps, special initiatives, adding intervention capacity to existing systems, general)?

What process of planning, purchasing and contracting services would best meet needs, in terms of efficiency, simplicity and the ability to fill gaps?

Defining the scope of the review

Responses to alcohol and other drugs can broadly fall into three pillars: supply reduction (reducing the supply and availability of alcohol and other drugs); harm reduction (reducing the harmful consequences associated with alcohol and other drug use, without necessarily reducing use per se); and demand reduction (preventing the uptake of alcohol and other drugs and reducing the demand in people who currently consume).

This Review is concerned with demand reduction only. Demand reduction in general has two components: preventing uptake (prevention) and reducing current use (treatment), although it is widely acknowledged that prevention and treatment are part of a spectrum; whereby some prevention aims to intervene with the goal of preventing the development of ongoing and problematic consumption in those who have already commenced substance use. Some frameworks refer to primary, secondary and tertiary prevention, where primary prevention is concerned with preventing commencement of use, secondary prevention is concerned with reducing the likelihood that someone will develop a problem associated with their consumption, and tertiary prevention is treatment for those with an established problem.

For the purposes of the Review, we consider only tertiary prevention (which we refer to as treatment). Originally the Review scope

purchasing of AOD services for Aboriginal people. As such, a separate team from the National Drug Research institute, Curtin University, inclusive of Aboriginal people, undertook the review of Aboriginal and Torres Strait Islander AOD treatment services. Their report is provided separately.

AOD treatment in Australia is provided across two systems of care: the specialist AOD treatment system and through the generalist health service system. The specialist treatment service system provides withdrawal, psycho-social therapies, residential rehabilitation, and pharmacotherapy maintenance. The generalist service system provides a similar array of treatment types – for example GPs provide pharmacotherapy maintenance and brief interventions; clinical psychologists (funded through Medicare) provide psycho-social therapy (counselling); general hospitals provide withdrawal services; and welfare services (such as homelessness services) can also provide psycho-social therapy. Thus it can be difficult to distinguish the specialist from the generalist system given that service types are not a distinguishing feature. The generalist sector, therefore, tends to be distinguished by its setting – primary care (GP practices) and general hospitals. As will be seen in the coming chapters, we consider both specialist and generalist services together for the first part of this report – that is we examine the funding sources, amount of funds and types of services across both systems. There are two reasons for this: firstly, we want to contextualise the specialist system and consider any options for the Commonwealth in light of the total picture of AOD treatment in Australia. Secondly, it is difficult to firmly distinguish these sectors given the extent of cross-over in service delivery, and the separation may hold less a

Providing background information on the Review and forwarding the Rapid Assessment Kit for the jurisdiction
Becoming familiar with the policy context for the jurisdiction, including major reforms that may be under way

Funding arrangements

- Procurement arrangements and tendering processes – how it works, timelines for tendering/procurement; current, proposed, under reform
- Contracting arrangements (how are services funded, what models are in existence; length of contracts); current, proposed, under reform.
- KPIs and monitoring of funding – requirements
- Types of funding: capital v. recurrent grants; targeted etc?
- Are there a number of funding (grant) schemes with different types of arrangements in place? What are the implications of these different arrangements? For you? For the NGO sector?
- Challenges associated with having multiple funding sources, eg Government, philanthropic, donor, Federal and State

We worked collaboratively with the Commonwealth Department of Health, and the Review Advisory Committee (described below) to enable the successful completion of data collection activities in a timely fashion. This involved both formal meetings and information liaison as the project unfolded. Jurisdictional representatives from Departments of Health provided invaluable support for the project.

An expert advisory committee was established by the Department to provide advice and guidance to the Review (see Appendix A for a list of members). The committee met three times during the project period; early, mid, and late. The initial meeting was an orientation to the Review and the various components involved. Subsequent meetings focused on interim findings regarding specific elements of the Review and problem-solving oriented discussions to 'workshop' the interpretation of findings.

The Review was also supported by a group of 'critical friends'; senior experts with extensive policy knowledge who were tasked to provide frank, blunt, and profound advice on the Review approach and on difficult areas as they arose (Appendix A includes a list of these members). The group met once during the project and they provided advice and feedback electronically and via telephone on an informal basis.

Participants in the rapid assessment consultations

We combined this collaborative approach to data collection with the careful consideration of stakeholders best placed to facilitate our access to information important for the Review along with professional experience to enable astute commentary on the issues under study. Their expertise informed the inclusion of representatives in areas critical to the Review and they provided advice on the tentative list of participants that had been formulated.

Participants in the rapid assessment consultations were from:

The Commonwealth Department of Health and other Australian Government agencies

Communication

In addition to formal data collection and governance aspects of the Review, there were two major strategies for sharing information and receiving feedback from the broader AOD constituency. The first involved the preparation and dissemination of a series of ten working papers, as shown in Figure 1.1, above. Each working paper focused on a particular aspect of research for the Review, for example on funding, current service utilisation, or pay for performance (a full list is provided in Table 1.3). Following feedback on draft papers from the Commonwealth the papers were updated and posted on the Drug Policy Modelling Program (DPMP) website, with an invitation for comment. In

Literature sourcing

A literature search was undertaken to locate peer-reviewed research articles and key grey literature documents relating to planning, funding and contracting of the alcohol and drug treatment field (October 2013). Three main groups of search terms were used:

Alcohol and drug disorder related terms
Treatment-related terms
Terms relating to funding, grants, contracting and economics.[5]

Searches were made of both title and abstracts and also by identifying relevant database indexing terms in six broad-based databases and citation indexes: PubMed, EconLit, Scopus, PsychINFO, Australian Public Affairs Information Service (APAIS), and University of NSW library search platform, which searches across multiple academic databases. Searches were also made of three databases which concentrate on collating reviews of health and social services sector evidence: the Cochrane Library, the Campbell Collaboration, and Health Systems Evidence. In addition searches were made using relevant index terms in four drug and alcohol specific databases: The National Drug and Alcohol Research Centre Library (Australia), Project Cork Online database, the National Drugs Sector Information Service (NDSIS) Drug Database, Virginia Commonwealth open source alcohol and drug database.

More than 2,500 potentially relevant articles were identified initially. The abstracts of these articles were printed and reviewed by two reviewers. Followi

producing the chosen outputs, regardless of the value of those outputs in relation to achieving outcomes (Smith & Papanicolas, 2012).

Equity is to do with the fundamental right of opportunity for all individuals; the right of every individual to have a fair chance to live a full and healthy life (Whitehead, 1992). In relation to AOD treatment this principle can be expressed as equal or

We use the three principles (effectiveness, equity and efficiency) as overarching and the seven grant administration principles for specificity, and in the Part 2 chapters examine the alignment of our analysis with these principles.

Our values

Research is not value neutral. Each of us brings a particular set of knowledge and experience to our research work that shapes the approach taken and the interpretation of findings. In the interests of transparency, we have summarised the values held by the project team. This is an important way to raise our awareness of possible bias and to be clear regarding the context impacting the research endeavour.

PART 1: THE CURRENT LANDSCAPE

Chapter 2: Context

This chapter considers some important contextual points for the Review:

- The history of AOD treatment funding in Australia
- AOD treatment value-for-money and the importance of funding processes
- Public sector management
- Federalism and the structure of Australian healthcare

History of AOD treatment funding

There are few documented histories of alcohol and other drug treatment in Australia (Rankin, 2003; Room, 1988). This brief summary has been prepared with input from a number of experts and with reference to the two papers but is an unofficial and un-validated account. 'Alcoholism' treatment as we know it today (which was preceded by Inebriates Acts and institutional solutions between 1870 and 1950) appeared bifurcated. In the non-government sector, the "Foundations" (such as the now Australian Drug Foundation) were established in the 1950s and saw the beginning of counselling and support services (along with community education and research functions). For example, in the 1970's the Victorian Foundation on Alcoholism and Drug Dependence (now the Australian Drug Foundation) ran a counselling and referral service in partnership with the Church of England. At the same time, government hospital services provided 'alcoholism clinics'. In many states, alcohol and other drug treatment was largely provided as part of government-

began to be a clear focus. In this context, GPs became important providers; funded by the Commonwealth through Medicare.

It is difficult to accurately ascertain the history of Commonwealth funding for AOD treatment, but it a

5. Treatment outcomes.

Research evidence has shown a relationship between funding processes (including the source of the funds and the way they are distributed) and AOD treatment outcomes. For example

of operating, cultural change in and across organisations that foster new and better ways to provide services, and the creation and management of knowledge and innovation (Shergold, 2008). There is considerable capacity for the co-creation of public value through collaborative approaches (Shergold, 2008). Rather than leaving the market to shape public interventions, public policy is developed and delivered through a relationship-based model of participatory governance, where "the exercise of power is becoming more diffuse and opaque"

general revenue assistance (including GST payments), to be used by the States for any purpose;
National Specific Purpose Payments (National SPPs) and National Health Reform funding to be spent in the key service delivery sectors; and
National Partnership payments to support the delivery of specified outputs or projects, to facilitate reforms or to reward those jurisdictions that deliver on nationally significant reforms.

Under the IGAFFR, there are two main types of agreements between the two levels of government:

The text below provides some context and detail for the various funding flows depicted in the diagram. We start with examination of the bottom left hand corner of the diagram, the Commonwealth AOD treatment funding flows.

Other funding sources

The diagram represents the major funding sources and those which we can confirm as funders of AOD treatment. Other funding sources, however, have been mentioned to us (without any details as to the specificities of the funding). These include:

- Mental health funding
- State-based mining royalties
- Local government.

undertaken so as to extend capacity building beyond mental health and into areas where there was need for

over three years). The organisation also receives income through client fees for other programs, and occasional donations corporate donations (but does not have any fee for service programs).

Chapter 4: The amount of AOD treatment funding in Australia

Introduction

This chapter provides an estimate of the total spending on alcohol and other drug (AOD) treatment in Australia and the respective contributions of different funders. This has not been attempted before – and hence should be seen as a first attempt which can be built on in subsequent research. As with any such exercise in estimating expenditure, the data are often missing, or come in ways that are not directly comparable. Despite the methodological challenges, it is an important research task and provides fundamental information for any analysis of AOD treatment funding in Australia. The full details can be found in Working Paper # 7.

The estimate of total AOD treatment funding includes both AOD treatment funding for the generalist sector (hospital services (public and private), primary care services through GPs, the Better Access and ATAPS programs and the Pharmaceutical Benefits Scheme) and AOD treatment funding for the specialist sector (both government specialist and NGO specialist).

Our intention is to contextualise the Commonwealth investment in relation to all AOD treatment funding – whether that be funding provided to the specialist sector, or funding provided to general health services for the treatment of AOD problems[36]. We can separately identify the specialist sector expenditure (see below), within the context of total expenditure.

The spending estimate pertains to our definition of treatment, as "that which is directed towards an individual regarding changing his/her AOD use" (United Nations Office on Drugs and Crime, 2006). This means that any funding directed towards the following interventions is included:

criminal justice system and into appropriate education, information and counselling services. The analysis of IDDI is complicated. There are three reasons why it is not possible to include IDDI in this analysis: 1. A proportion of the funds go to police and courts and are not expended on treatment per se; 2. The funds are transferred treasury to treasury and not separately identifiable with the national health funding pool; 3. States and territory governments also fund diversion programs, and dou

Table 4.5: Expenditure split between generalist AOD treatment settings and specialist AOD treatment settings

Sector	Amount	Percentage
Specialist	$ 629,842,630	55%
Generalist	$ 515,146,067	45%
	$ 1,144,988,697	

Note:
"Specialist" includes: state/territory health department AOD funding, Commonwealth NGOTGP and SMSDGF funding
"Generalist" includes: hospital funding (public and private), primary care funding (Medicare), PBS, DVA, ATAPS, and Better Access.

Finally, if we take the specialist sector expenditure only ($629,842,630), 21% of this is funded by the Commonwealth ($130,281,000) and 79% funded by states/territories ($499,561,630).

Reflections on the results

Clearly the states/territories make a substantial financial contribution (49% of all funding; 61% of government funding, and 79% of the specialist funding). The hospitals are the second largest contributor (see Table 4.1, 26.2%). Perhaps surprisingly the primary care (Medicare) and medications (PBS) spending is relatively small when compared to the other estimates (4.3% and 7.8% of the total, Table 4.1). The lower amounts for primary care, though, reflect the relatively lower costs of primary care treatment compared to hospital-based settings. Further analysis which combines the cost estimates with the number of patients or episodes would be required to evaluate the investment mix.

The NGOTGP and SMSDGF investment (combined) is greater than Medicare ($53m; 4.5%) and PBS ($99m; 7.8%). This is somewhat of a surprise, but reinforces the critical importance of these two funding sources for the provision of AOD treatment in Australia. Clearly AOD treatment relies on both Commonwealth and state/territory investments through the specific AOD treatment programs.

Client contributions (fees and co-payments etc) at $85m are a significant source of funds for AOD treatment. However, relative to other health care in Australia, they may represent a smaller proportion than expected. Duckett & Willcox (2011) reported that 17% of total Australian healthcare spending was individual out-of-pocket expenditure. Although they go on to note that "this funding distribution varies widely across different types of health services" (Duckett & Willcox, 2011, p. 41).

How much is $1.26 billion dollars relative to all Australian healthcare spending? Where the total Australian healthcare expenditure is $140.2billion (Steering Committee for the Review of Government Service Provision, 2014) this means that AOD treatment represents 0.9% of total health care spending. One way to interpret this percentage is to look at the relative burden of disease. The burden of disease for alcohol and illicit drugs is 1.9% (Begg, Vos, Barker, Stevenson, Stanley, & Lopez, 2007). This is a reasonable comparator because the burden of disease takes into account all health disorders. If one assumes that healthcare resources should in some way be loosely distributed according to the weight of the burden of disease (a significant assumption), then AOD treatment should represent about 1.9% of the total healthcare budget, which would amount to $2.5 billion dollars (effectively a doubling of the current expenditure).

How does the $1.26 billion estimate compare to the social costs of alcohol and other drugs? Collins seminal work, last calculated for 2004/2005, estimated annual social costs to be $56 billion. This included tobacco. If we remove the tobacco estimate, the resulting social cost for alcohol and other

drugs was $24 billion (page xi). The Australian AOD treatment spending therefore represents a mere 5% of the social costs.

It is useful to draw some comparisons with Mental Health (MH) funding. The data are summarised in Table 4.6.

Table 4.6: Expenditure comparisons between MH and AOD

	Mental health treatment	AOD treatment
Expenditure estimate	$7billion	$1.26billion
Per person spending	$309.00	$58.70
Prevalence rate (NSMHWB)	20%	5%
Burden of disease	11.3%	1.9%
% of total Australian healthcare expenditure ($140.2billion)	5%	0.9%
% of expenditure by Commonwealth (compared to states)	36.5%	39%

For 2011/2012, MH funding was $7 billion dollars (government recurrent expenditure, Steering Committee for the Review of Government Service Provision, 2014) ie seven times greater than that

possible that our figures remain over-inclusive, and hence the hospital funding estimates are greater than in reality.

The medical service estimates not funded by state health departments focussed on GPs in primary care and excluded specialist Medicare services provided by psychiatrists and physicians. Many clients with AOD problems see a psychiatrist or physician, rather than a GP. These are not captured here

The analyses using the BEACH data (Medicare estimates, PBS estimates, pathology estimates and client co-payments based on healthcare card holder status) assume that the BEACH sample is representative of GP presentations for AOD.

Not all private costs could be included

Estimates for philanthropy were difficult. Detailed analysis of the extent to which AOD services, and which types of services rely on private donations and philanthropy is an important consideration for the viability and sustainability of the AOD treatment sector in Australia.

The above estimates do not include capital works funding, yet capital works is a vital part of providing AOD treatment, especially for residential services. Future assessment of AOD treatment funding in Australia should consider how to appropriately estimate capital works costs. On a related but distinct point, housing services are another cost associated with the provision of AOD treatment services (where the capital asset is not owned by the agency). Housing services provide funds to enable residential care for people in AOD treatment. These have not been included.

As noted elsewhere, private hospital services (not recorded within the national hospital minimum dataset) have not been able to be included. Likewise AOD treatment funded by Department of Social Services (federally) or state-based departments of social services/family services/community services.

We reinforce that while extensive work has gone into the estimates provided here to facilitate better understanding of AOD treatment funding in Australia, it is a first attempt. We strongly encourage further research to enable improved estimation of the amounts of funding for AOD treatment in Australia, not confined to health and built from better data sources when they become available.

Conclusions

We have found that:

Compared to the prevalence rate of AOD problems in Australia and the extent of the burden of disease from AOD problems, the investment in AOD treatment appears small.

The overall expenditure on AOD treatment in Australia, inclusive of both specialist and generalist AOD treatment was estimated at $1.261 billion.

From this total, the Commonwealth's contribution is 31%; state/territory governments' contribution is 49% and private contributions is 20%.

If we remove the private contribution (philanthropy and client co-payments), the Commonwealth contribution is 39% and the state/territory contribution is 61%, and the total expenditure is $1,007,977,579.

Chapter 5: The Commonwealth AOD treatment grant schemes ς the NGOTGP and SMSDGF

As noted earlier, the Review aims to deliver options for a set of planned and coordinated funding

What is being purchased: description of treatment and capacity building;
Investment mix by the Commonwealth; and concluding with
Relationship between the Commonwealth and state/territory investments

The Non Government Organisation Treatment Grants Program (NGOTGP)

Table 5.1: NGOTGP funds for 2012/2013

Data source		Notes
Original spreadsheet provided to the review team (Aug 2013)	$49,476,157	
Data provided to review team by the STO's	$48,013,938	
As listed on the Murray motion (pro rata yrs)	$49,306,020	$54,236,622 incl GST
As listed on the DoH grants list	$60,377,024	$66,414,726 incl GST

Improve physiological and psychological health; and
Improve social functioning for people attending treatment for substance misuse" (NGOTGP Guidelines, p. 5).

The funding guidelines have some internal inconsistency, for example (p. 5) "Projects funded under the NGOTGP must: provide capacity for reducing and treating illicit drug use" which suggests the fund is focused on illicit drugs rather than alcohol. However later the key objectives specify "improve drug and alcohol treatment service outcomes" (p. 5) and the fund is clearly inclusive of alcohol and other drugs.

Grants may cover, but are not limited to, "counselling, outreach support, peer support, home detoxification, detoxification and withdrawal, rehabilitation, therapeutic groups or communities" (NGOTGP Guidelines, p. 4).

Specific priority areas for funding were not listed in the Guidelines. The priority areas/objectives of the fund were not revised in the 2012 round of competitive tendering.

The NGOTGP Guidelines specify that, "funds will be made available through an open grant round" (p. 3). There are no alternate funding mechanisms (such as targeted rounds) listed in the Guidelines, which is an important difference to the guidelines for the flexible funds that include the option of open, targeted, one-off and procurement mechanisms.

There are mandatory requirements in the Guidelines (p. 10), which comprised the first level of assessment in the 2012 funding round. These mandatory requirements were:

That the application addresses all procedures for submitting an application;
The application is from an organisation that is eligible for funding (see below);
The capacity of the applicant and of the proposed project meets the key objectives and aims of the NGOTGP Program;
That the applicant exhibits financial viability – through provision of the applicant's audited financial statement and profit & loss statement for the previous financial year;
That the applicant identifies the type(s) and level(s) of insurance held by the applicant.

The NGOTGP Guidelines specify that an eligible organisation must be a "non government organisation" (p. 4). The examples provided in the Guidelines comprise, "a non government organisation; an incorporated body under state/territory legislation; or a community based not-for-profit organisation" (p.

existing services were not successful. The processes that occurred at this time to redress this, with some servic

The primary objective of the SMSDGF is to "better promote and support drug and alcohol treatment services across Australia to build capacity and to effectively identify and treat coinciding mental illness and substance misuse" (p. 3, Guidelines, 2011).

The six priority areas (see above) were referred to in the 2012 funding round; and they reflect the history of the

Partnerships
Trustees on behalf of a Trust
State/territory or local government
Where there is no suitable alternative, an individual or jointly or separately individuals.

In the SMSDGF Guidelines, it notes that applicants in an open funding round for SMSDGF need to demonstrate:

Identified need
Relevance to current government policies and priorities
Value for money
Capacity to deliver quality outcomes.
(Fund Guidelines, Nov 2011, p. 9).

The Fund Guidelines (p. 10) note that Assessment panels will be established to assess applications and then provide advice to the "Funding Approver", who will consider whether the proposal makes an "efficient, effective, ethical and economical use of Australian government resources" (p. 10). The final decision for SMSDGF grants is made by the Minister (or his/her departmental delegate).

Threshold Criteria specified in the ITA (p. 18) for the 2012 round were the demonstration of the organisation's "capacity, expertise and infrastructure to effectively undertake the proposed project". In 2012, each application was rated (on a five point scale) against the threshold criterion, with a minimum score of 2 (out of 5) representing "good quality", and allowing the application to proceed to the next stage of assessment.

There were four assessment criteria: Need; Capacity to deliver; Sustainability and Organisational capacity.

1. Need. Applicants had to describe existing alcohol and other drugs services that they provide, nominate the activities proposed to be funded, the target population group and how the proposal "meets the needs of the target group" (500 words). As with the NGOTGP there were also questions in relation to consistency with the National Drug Strategy; consistency with state/territory treatment guidelines; and other organisations and stakeholders. The SMSDGF also included questions about "unmet community need(s)" that the proposal would address; how those needs have been assessed and how the proposal "complements other similar services, activities and resources in the Applicant's local area".

2. Capacity to deliver the project. Applicants were asked to provide information about the project objectives, activities, timelines and measures to achieve the objectives as well as their financial management expertise and monitoring and reporting activities.

3. Sustainability. This criterion required applicants to identify if the proposal was dependent on other funding submissions and to identify how the "project outcomes are sustainable and can be continued after the SMSDGF funding is expended".

4. Organisational capacity. To address this criterion, applicants had to describe the governance of their organisation, accreditation, staffing (qualifications) and staff recruitment, outcomes of previous grants and the organisation's capacity to comply with reporting requirements.

In addition to the specific assessment criteria as detailed in the application form, the ITA also stated (p. 8) that "In assessing an Application ... the Fund Assessment Panel may consider the Applicant's financial viability and the risk of the Application", and that the Panel may seek any information from

any other source, whether or not the individuals or organisations are nominated as referees (p. 8). Contact details for two referees were requested from applicants for the 2012 SMSDGF funding round.

Attachment A1 of the Fund Guidelines (Nov 2011)

services from the same organisation reflects some quality assurance. Finally, co-funding provides Commonwealth leverage in relation to state/territory planning and purchasing. Thus , we view co-funding of an organisation as the preferred arrangement for the Commonwealth.

However, an alternate perspective is that there is higher risk with co-funding if the state/territory government withdraws its funding. This would leave the Commonwealth with the responsibility of maintaining the service (by substituting Commonwealth funds for state/territory funds) or funding the service to close down. The financial impact increases the larger the state/territory investment[48]. In the organisational co-funding scenario there is also a risk of over-burdening the organisation with dual-reporting requirements (inconsistent with Commonwealth Grant Guidelines – proportionality principle). Thus there are both relative advantages and disadvantages to co-funding between the Commonwealth and states/territories. Where the Commonwealth is the sole funder, there are also risks: if the Commonwealth decides not to continue funding the organisation it risks attracting the wrath of the public if the service closes as a consequence. The likelihood of closing depends on the ability of the organisation to source other funding; which likely depends on the size of the organisation and the amount of Commonwealth investment.

A related issue for co-funding is sector sustainability. We assume that it is important to have a clearly defined and high quality specialist AOD sector in Australia. To achieve that end, funds should be concentrated within specialist services and it is therefore sensible for both the Commonwealth and state/territory to fund the same organisations.

The third issue is duplication. As we note elsewhere (Chapter 12), there are a number of definitions of duplication. Here we are concerned with funding duplication ('double dipping'). The distinction between an organisation and a project/service is critical here. The analyses that follow examine the

		concordance). Not able to use funding data.
QLD	As above	List of funded NGOs from: Queensland Health Grant Funding Recipients 2012/13, Available at: http://www.health.qld.gov.au/ Cross-checked against RA data. Includes all Health funding (not limited to AOD).
VIC	As above	List of funded NGOs from: Victorian Health Policy and Funding Guidelines 2013-14. Part 2: Health Operations, State of Victoria, Department of Health, 2013. Includes all Health funding (not limited to AOD).
WA	As above	List of funded NGOs from RA dDC q6IMC q66.871 634 re'

# of unique organisations Fund 2&3	93
% co-funded by S/T - overall (of unique org's)	67% (152)

% co-

% co

Table 5.9: For NGOs funded by the Commonwealth the contribution of state/territory health departments to those NGOs

	Commonwealth	State	TOTAL:	% Commonwealth
NSW	$31,872,958	$36,193,523	$68,066,481	47%
NT	$14,070,226	$31,475,598	$45,545,824	31%
QLD	$24,503,105	$24,890,658	$49,393,763	50%
ACT	$3,354,158	$8,641,705	$11,995,863	28%
SA	na	na	na	-
TAS	$4,506,447	$2,544,587	$7,051,034	64%
VIC	$18,444,617	$70,863,000	$89,307,617	21%
WA	na	na	na	-
TOTAL				36%

Note: for NSW, Vic, NT, Qld all health funding is included from the Annual Reports, whereas for Act and Tas only AOD funding is included.

Given the problems with the data, little of detail can be said except that it does show that states must be investing in organisations that the Commonwealth does not invest in, given that in the budget analysis (Chapter 4), the states/territories contribute 79% to specialist, whereas here it is approximately 64% (however arguably a not dissimilar figure). There are variations by state/territory – the ones that ha3(er664.9 79.344 12.84 reW* nBT/8(o)-bf9.84 reW* 88001 128114.869s,g)5(an)4(i (C)11(o)5(m)-4(

		minimum 7% mean 73% median 78%	
VIC	47	maximum 100% minimum 3% mean 58% median 55%	22 out of 47 (47%),
WA	20	Data not available	
NT	23	maximum 100% minimum 4% mean 42% median 32%	5 out of 23 (22%)
TAS	9	maximum 100% minimum 27% mean 63% median 61%	2 out of 9 (22%)

As can be seen, there is a range within each jurisdiction of the proportion of Commonwealth funds of the total organisation funds (ranging from 100% i.e. all Commonwealth, to 2% of the funds being Commonwealth) by individual organisation.

NSW, Qld and Victoria stand out – around half or more of the Commonwealth funded services are funded at 70% or greater by the Commonwealth. So even though the yes/no analysis did not look too bad, this more detailed (but still fraught data) analysis, suggests that there are a significant number of organisations in NSW, Queensland and Victoria that are reliant on Commonwealth funding (they receive 70% or greater of their total funds from the Commonwealth). For the record, the number of agencies (remembering that this analysis did not include every organisation) is:

NSW: 37 agencies
Vic: 22 agencies
Qld: 20 agencies

As compared to those jurisdictions where the investment mix is more balanced between state and Commonwealth at the individual organisational level:

ACT: 0 agencies
NT: 5 agencies
Tas: 2 agencies

At a minimum, this would suggest that the Commonwealth be aware of/alert to re-commissioning activities in these jurisdictions.

What is purchased: description of treatment and capacity building

The Commonwealth purchases both direct care (specialist treatment and supporting treatment functions) through the NGOTGP and the SMSDGF, as well as what is termed 'capacity building' projects. Before describing the amounts of funding to treatment and capacity building, we provide an outline of both of these activities.

Direct care (specialist treatment services and supporting treatment functions)

Specialist services are synonymous with what are regarded by many key informants to the Review as "core" AOD services. We use the term 'core AOD treatment' to refer to these elements, which are evidence-based and make up the essential parts of an AOD treatment pathway. The service types are: withdrawal, rehabilitation, psycho-social therapy (counselling), and maintenance pharmacotherapy. Withdrawal management (detoxification) involves either medicated or non-

Case example: Organisation A ς a specialist AOD treatment service
(The full case example can be found in Chapter 17)

The organisation has a long history of residential rehabilitation service delivery (particularly within the therapeutic community model) and is a large, well established, specialist AOD treatment provider within its jurisdiction. Since its initial establishment as a residential rehabilitation treatment service, the organisation has expanded its service delivery purview and aims to "provide a comprehensive range of community-based treatment and support services to address alcohol and other drug problems, along with any associated mental health, vocational, health, relationship and family issues".

It was estimated that 55% of the organisation's activities are state funded (primarily through the state Department of Health, but sometimes also Department of Education and Justice etc.); around 25% of activities are Commonwealth funded (historically and variously through the Department of Health and Ageing, FACSIA,

The aims, objectives and functions of drug user organisations include: addressing and representing the health needs of people who use illicit drugs and people on opioid pharmacotherapies through a health promotion and disease prevention approach; preventing the transmission of blood borne communicable diseases such as HIV/AIDS and hepatitis C among people who inject illicit drugs; promoting the provision of high quality, accessible and relevant services to people who use illicit drugs and people on opioid pharmacotherapies throughout Australia; as well as promoting and protecting the health and human rights of people who use illicit drugs and people on opioid pharmacotherapies (for full list of aims see Australian Injecting and Illicit Drug

2000; Kaplan, 2000; Loureiro, 2011; National Centre for Education and Training on Addiction, No date; Potter & Brough, 2004; World Health Organization, No date);
A focus on achieving long-term outcomes, sustainability, and enhanced abilities to problem-solve and adapt to change (Crisp et al., 2000; Hawe et al., 2000; LaFond et al., 2002; Loureiro, 2011; Substance Abuse and Mental Health Services Administration, No date; United Nations Economic and Social Council, 2006; United Nations Educational Scientific and Cultural Organization, 2006);
An emphasis on partnership and collaboration between services, organisations and systems (Crisp et al., 2000; Department of Health and Ageing, 2011; Hawe et al., 2000; National Improved Services Initiative Forum, 2010; NSW Health, 2001; Substance Abuse and Mental Health Services Administration, No date);
An emphasis on stakeholder and community engagement (Crisp et al., 2000; LaFond et al., 2002; Loureiro, 2011; McDonald, Schultz, & Chang, 2013; Substance Abuse and Mental Health Services Administration, No date; United Nations Development Programme, 2008; United Nations Economic and Social Council, 2006);
A conceptualisation of the role of institutional funders as enablers of change, by empowering and strengthening the capabilities of organisations and communities to respond effectively to new challenges (Crisp et al., 2000; Loureiro, 2011; United Nations Development Programme, 2008).

The way that the Commonwealth Department of Health has historically understood the concept of capacity building in the context of the AOD sector can be ascertained through its development of the Improved Services Initiative (ISI). The ISI aimed to build capacity to effectively identify and treat coinciding mental illness and substance abuse ('comorbidity'). This initiative formed part of the

and the sector. We conceptualise capacity building as operating through three separate but related process streams:

1. Priority topic or client target population
2. Organisational or institutional capacity building
3. Intra- and inter-sectoral systems of care.

The first stream relates to capacity building regarding a particular *priority topic* or *client target population*. This could include a focus on building workers' knowledge and competencies in relation to comorbidity, family-sensitive practice, or adapting practice models to be responsive to culturally and linguistically diverse (CALD) populations (for example). Activities could include seminars, placements, mentoring programs, secondary consultations, and implementing new practice guidelines.

Priority topic or client target population (Stream 1)
Organisational or institutional capacity building (Stream 2)
Intra- and inter-sectoral systems of care (Stream 3)

The relative investment in direct treatment compared to capacity building is useful to understand. The table below summarises the investment mix for the Commonwealth (across NGOTGP and SMSDGF, excluding Aboriginal and Torres Strait Islander services, that is Priority 2 and 3 from the SMSDGF).

Table 5.14: Relative investment in treatment and capacity building

	# of projects	% of projects	AUD	% of funding

	Service types being purchased by S/T2	Service types being purchased by Commonwealth in that jurisdiction (NGOTGP)	Service types being purchased by Commonwealth in that jurisdiction (SMSDGF P1)1
	assessment and referral services		
NT	Withdrawal Counselling opioid pharmacotherapy maintenance Residential rehabilitation Telephone information, assessment and referral services	Counselling Residential rehabilitation	Counselling
TAS	Withdrawal Counselling Opioid pharmacotherapy maintenance Residential rehabilitation Consultation/liaison Telephone information, assessment and referral		

Commonwealth funds are for a pilot day program; in another it is for an opioid pharmacotherapy maintenance in the residential service; in another it is funds to support families with their children. In other instances, the data simply indicate that it is a residential rehabilitation service, with no clear delineation of whether the Commonwealth funds are being used for a specific component, or whether it is contributing to the overall service delivery.

There were 41 residential rehabilitation services receiving Commonwealth funds from the NGOTGP and the SMSDGF P1 in 2012/2013. These were services in NSW (n= 20), the ACT (n= 3), the NT (n=1), Qld (n=8), SA (n=2), Tas (n=2), Vic (n=3) and WA (n=2). That is, there is at least one residential rehabilitation service in each jurisdiction receiving Commonwealth funds.

In terms of the proportions of those 41 that were also funded by the state/territory health departments, this was the case for 32 services (that is 78%). The majority of the Commonwealth's investment in residential rehabilitation is therefore also supported by state/territory investment.

Table 5.16: Residential rehabilitation services receiving Commonwealth funding (NGOTGP and SMSDGF P1) and whether state/territory also funded the service

	# of Commonwealth funded services	# co-funded by state/territory
NSW	20	14 (70%)

SMSDGF P1 and SMSDGF P2&3. The jurisdictions where the Commonwealth investment represents 70% or more for a number of individual agencies is in NSW, Vic and Qld (see Table 4).

The state/territory health departments in every instance invest in the full array of AOD treatment

This investment is not inconsistent with states/territories investment. While we do not know the quantum of funds, the most common service type is counselling.
The Commonwealth purchases core service types that align with the states/territories purchasing.
Based on the data available, there is no evidence of 'duplication' to the extent that unmet demand is high, and organisations use Commonwealth funds to deliver more or better care.
In terms of the total funds to Aboriginal and Torres Strait Islander AOD services, the SMSDGF allocated $56,312,052 under Priorities 2 & 3 for the year 2012/2013. The funds within the NGOTGP that went to Aboriginal and Torres Strait Islander AOD services amounted to $6,564,532. This means that of the total $130 million in NGOTGP and SMSDGF for the year 2012/2013, 48% was allocated to Aboriginal and Torres Strait Islander AOD services.

Chapter 6: Existing purchasing mechanisms

Thus far we have considered the funding sources and flows (Chapter 3) and the amounts of funding (Chapter 4), and the details regarding the NGOTGP and SMSDGF processes in 2012/2013 (Chapter 5). Here we consider the detailed purchasing mechanisms for AOD treatment.

In summary, the Commonwealth and state/territory governments currently purchase AOD treatment through a number of different mechanisms:

- Competitive selection processes (grants schemes)
- Fee-for-service (Medicare)
- Activity-based funding (hospitals)
- Block grants, historically driven or individually negotiated
- Transfer of funds to state/territory governments (special purpose payments to states/territories).

grants (Department of Finance and Deregulation, 2013). There are a range of options for competitive selection: open, targeted, and preferred-provider panels. In addition, consortia arrangements can be competitively selected. The key informants, both purchasers and providers of AOD treatment across Australia were very familiar with and had extensive experience of competitive funding processes as they have occurred through the Commonwealth grants schemes and through state/territory processes.

From the purchaser perspective an open competitive selection process is usually considered most appropriate for a higher value or higher risk project (The Chartered Institute of Purchasing and Supply), although how this is defined will differ depending on the sector. Open competition means that new players are free to enter the market (Australian National Audit Office, 2013). From a purchaser perspective open competitive selection processes are therefore well suited to markets with multiple potential providers (Jensen & Stonecash, 2005), as the selection process may result in competition (The Chartered Institute of Purchasing and Supply). Speaking to the advantages of competitive processes from the purchaser's point of view, one key informant noted that "the reform process involves opening up the market to both NGO and private providers in [state] and interstate. Contestability will be tested within an open market, as a driver of service quality". The literature notes not only service quality but potentially reduced costs to the purchaser where there is a genuine level of competition (Bajari, McMillan, & Tadelis, 2009; Jensen & Stonecash, 2005; Rimmer, 1991)

Competitive selection processes have some disadvantages. There is debate about whether competitive processes produce efficiencies (cost savings in service delivery). According to the Australian Productivity Commission competitive grants processes have been shown to increase economic efficiency (Productivity Commission, 2010). However, it is important to note that much of the research on the cost benefits of competitive application processes has been in areas such as waste collection and transport or road maintenance, rather than social services (Jensen & Stonecash, 2005; McDonald, 2002). It has been argued that there is little evidence that competitive processes improving efficiency and effectiveness in the social services context (McDonald, 2002). Economic and public administration research literature indicates that the success of any particular competitive funding process in making savings for the purchaser will depend on the level of genuine competition between service providers (Bajari et al., 2

an organisation met quality standards, accreditation, and so on, could be applied to the Commonwealth grants, such that only organisations on the preferred-provider panel would be eligible to apply for funding. Furthermore, these key informants argued that all existing funded agencies could become the 'preferred-provider panel'. They argued that the market has already been tested (through previous NGOTGP and SMSDGF competitive grant rounds). Further, the

submissions from agencies. It does not support continuity or a sector wide approach to planning" (purchaser).

Consortia

Consortia — with the nomination of a lead agency which then coordinates service delivery on behalf of a range of providers - is a potential model for the choice of providers. Consortia provide the opportunity for providers to work together, and thus to leverage a wide range of resources (McDonald, Murphy, & Payne, 2001), and to share skills and experience (Office of the Third Sector, 2008). Therefore one strength of consortia is that they may provide opportunities for services to apply for projects that would not otherwise be open to them through pooling of skills (Office of the Third Sector, 2008). In theory such consortia models have the potential to produce improved client services and outcomes through better coordinated services, and promote reduced administrative costs through pooling of resources (Office of the Third Sector, 2008). Key informants identified that consortia have the potential to support better coordinated care, more sustainable services and fewer contracts to manage (by the purchaser). As noted by one key informant, "governments like it because they only have to fund one organisation, and can transfer the risk" (provider). Depending on the configuration of the consortia, they may allow better linking of localised planning processes, eg needs assessment, to payments (Robinson, Jakubowski, & Figueras, 2005) and can aim to promote

The Commonwealth led a major new mental health initiative, Partners in Recovery, using competitive grant scheme that was consortia-based. We provide summary details here by way of a case example of this approach.

Partners in Recovery (PIR) case example
(The full case example can be found in Chapter 17)

applications did not have page limits which meant that very long applications were received.

This case example is relevant for considering the way the Commonwealth purchases non-service delivery (or coordinating and capacity building) functions for the AOD treatment sector. In considering the aims of PIR (as expressed in the Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16 Department of Health and Ageing, p. 4)) it is clear that this approach seeks to address issues which are also relevant for AOD treatment services and clients. Indeed, the challenges associated with coordinating care to ensure that vulnerable clients do not 'fall through the gaps' when accessing multiple services across sectors are the same for AOD clients. Of particular relevance is PIR's emphasis on systematically facilitating coordination of services and building links between clinical and community care:
"The ultimate objective of the initiative is to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:
facilitating better coordination of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs;
strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group;
improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group; and
promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.
Through system collaboration, PIR will promote collective ownership and encourage innovative solutions to ensure effective and timely access to the services and supports required by people with severe and persistent mental illness with complex needs to sustain optimal health and wellbeing." (Department of Health and Ageing, no date, p. 4)

In this way, PIR creates a commitment to complex cases at the systems level. This is an issue of relevance in the AOD field, and provides a model for AOD services to provide coordinated and holistic care to clients. The funding, however, is directed towards the *coordination* of system responses for people with complex needs and not funding for service delivery per se. The PIR model builds a network of clinical collaboration, that is, it aims generate coordination across the service system within a local area. The competitive tendering process forced consortium arrangements and required organisations to generate partnerships (which have reportedly been maintained beyond the tendering process). However, in thinking about lessons for AOD, it is worth noting that in the case of PIR this funding was newly-allocated funding and was not provided at a cost to funding existing service delivery, which meant the initiative was positively received by the sector. The information sessions explicitly emphasised that PIR was designed to complement, not replace or usurp, the existing service system.

Key informants who commented on consortia were aware that successful consortia are driven by participants, not by funders (the notion of 'forced marriages' was not supported)[54]. Many key informants had both positive and negative experiences of consortia arrangements and it seems investment in capacity building around consortia leadership, maintenance, collaboration and communication across the AOD sector may be required before such a funding model can be maximised. In general, key informants felt that consortia arrangements were useful in certain circumstances and for some service types but as a general principle applied across all purchasing for AOD they would not work.

[54] Key informants noted the difference between consortia arrangements and mergers. Here the discussion is limited to consortia, and does not apply to organisational mergers. One key informant noted that mergers are not the business of

Summary: Competitive processes

Almost all key informants saw some merit in competitive processes and argued that while competitive processes have a role to play, they should not be the sole mechanism for funding, and they need to be used judiciously depending on the service types, the potential pool of providers, and the particular needs of the sector. For example, competitive tendering may not be the best model to purchase peer outreach. Likewise, some highly specialised services should not be subject to competitive selection processes. "Competitive tendering does seem to be the best (of the worst) options".

Open competitive processes provide a transparent, accountable, and administratively efficient mechanism for purchasing AOD treatment services, and the prospect that competition may increase quality, reduce costs, and encourage new market entrants and innovations. However, service providers often felt that open competition tended to favour better resourced applicants, imposed an excessive administrative burden, and was unsuitable as a base funding mechanism given the tendency to fund the same services over time in a well-tested market: hence preferred-provider panels were preferred to open competitive rounds.

While competitive processes (open or targeted; consortia-based) are the predominant mechanisms by which the Commonwealth and state/territory governments select providers of AOD treatment services, there are other ways in which providers are selected. The next one we consider is individually-negotiated arrangements, often based on history.

Individually-negotiated and/or historical agreements

Historical or negotiated processes are associated with selection of organisations which have provided healthcare services in the past, and the funding amount is usually based on the costs of providing services in previous years (Duckett & Willcox, 2011).

> "Typically the negotiated budget was based on the previous year's budget, with or without a standard adjustment, increasing the budget for inflationary effects, or reducing budgets across the state for deemed productivity improvements."

other funding approaches were preferred (by those who commented) the importance of retaining flexibility for the purchaser was noted (such that a grant can be given out in a crisis situation).

Transparency and fairness are paramount, and as such individually-negotiated selection of providers cannot be a primary mechanism for the Commonwealth. An alternative to both competitive selection and individually-

funding streams and plan comprehensive services; and it reduces duplication of administrative requirements for services. However there are substantial risks associated with this model: loss of funding, loss of checks and balances, concern about some state/territory funding/purchasing processes and the potential loss of diversity if the Commonwealth was no longer a direct purchaser of services.

Thus far we have reviewed the following ways in which providers could be selected: competitive selection, individual negotiation, and transfer to states/territories.. There is a final, fourth option, registration and/or accreditation, which then permits access to a funding pool based on invoicing. We explore this option next.

Registration, accreditation of approved providers

Accredited providers describe a funding approach whereby providers who meet certain criteria (such as registration or accreditation) are eligible to receive reimbursement for services delivered, usually through fee-for-service arrangements. It is a common healthcare funding mechanism in Australia – all GPs operate under this model as individuals who have received 'provider numbers' and are hence funded through Medicare.

Accreditation is usually managed through professional registration board requirements. Processes adopted by professional groups may vary, and one tension is the economic incentive to limit entry. As Duckett & Willcox (2011) note "decisions about standards of entry into the professions are controversial". Thus this model may be perceived as unfair, although it has been argued that this funding approach has lower administrative costs relative to competitive processes. The approach is predicated on a long-standing notion of professional practice. The accredited provider model requires a c

potential for budget over-spending (from purchasers); concern about quality (from purchasers); and the level of financial viability for services (from providers), notably “cash flow” issues. In fee-for-service, costs are driven by demand for service, and if budgets are uncapped the consequence can be budget overspending. Given the extent of unmet demand in AOD this is a highly likely scenario under fee-for-service models.

One key informant was concerned that fee-for-service funding models may be associated with compromised quality. From the client’s perspective, research has shown that fee-for-service models are associated with lower patient satisfaction compared to salaried clinicians (Gosden et al., 2000). In primary care settings, fee-for-service is associated with less preventative care and with shorter consultations (Gosden, Pedersen, & Torgerson, 1999). There is however evidence that fee-for-service can improve quality and outcomes. A Cochrane review (Flodgren, Eccles, Shepperd, Scott, Parmelli, & F., 2011) of payment incentives in primary care settings found fee-for-service payments generally to be effective, and associated with clinical care improvements in seven out of ten outcomes in five studies (four out of ten statistically significant).

On the disadvantage side, the critical issue with registration/accreditation of select providers is the need for defined entry criteria. The subsequent fee-for-service payment arrangement to those selected providers may provide few incentives for efficiency, since over-servicing may be rewarded (Jegers et al., 2002; Langenbrunner & Liu, 2004). (Jegers et al., 2002; Langenbrunner & Liu, 2004). Setting the fees at the most appropriate level is a critical issue for this model and can prove difficult; reimbursement levels also require regular review over time (Jegers et al., 2002). Inaccurate price setting can potentially disadvantage either purchasers or providers (Center for Substance Abuse Treatment, 2006; Jegers et al., 2002). Fee-for-service models have relatively high administration costs (for example when compared to block grants), since they require investment in efficient administrative systems for regular invoicing and payments (Jegers et al., 2002; Langenbrunner & Liu, 2004).

Whilst in theory, fee-for-service promotes increased service access, this funding metho2(t)-3(7256)-5((chr)4(an)4([(i

Choice of payment mechanism

At present there are four ways in which the Commonwealth and state/territory governments could provide the funds:

1. Through a block grant (lump sum)
2. Through a price per unit of activity
3.

level of activity that it is purchasing. Use of a national price, rather than individual state prices, also provides a national benchmark to services to assess efficiency of service delivery.

This highlights one feature of the Australian public hospital funding/payments system – it occurs in the context of shared funding between Commonwealth and states and territories. Therefore an important feature of activity-based funding is that it provides transparency about what the Commonwealth is paying for when funding is transferred to states/territories or to local hospital networks.

Is the Australian hospital ABF funding model relevant for AOD treatment funding in Australia? Yes, to the extent that currently, inpatient hospital services for AOD DRGs are being paid for through this system. Not all activity in AOD treatment within hospitals is, however, covered and the extent of

activity

The volume of DTAUs has been calculated based on the total resources assigned to each catchment and current met need (ie, 2012-13 client numbers for the treatment streams included in Stage One). See Chapter 17 for details of two catchments. Providers will be able to vary the mix of activities as only 80 per cent of their total allocation of DTAUs will be tied to specific activities. The remaining 20 per cent will be available for flexible use across all activity types delivered by the service, “as long as the total mix of services delivered by

efficient hospitals – to achieve greater economy for government funders (Sherbon, 2013). Such trade-offs are to an extent a political value judgement about system priorities rather than being solely technical funding issues (Sherbon, 2013).

Given the extensive use of ABF, the Victoria model for AOD, and the move by the IHPA to develop activities and NEP for mental health, it seems that the Commonwealth should take seriously the notion of providing NGOTGP and SMSDGF funds through a version of ABF. Indeed, some AOD treatment i

There are inherent difficulties in setting a national price in a country like Australia, where states and areas within states are so different and there are multiple funders. In a state with the population

Capitation

Capitation provides payment to a healthcare organisation per head of population. In the USA, managed care organisations are capitation models. The managed care organisation is given a sum to deliver care (usually over a year) to a fixed population and payment is usually prospective (Horgan & Merrick, 2001). There are few examples of capitation in Australia, but the new Disability Scheme appears to be a version of capitation (set amount per). Capitation has been defied as:

> "Providers receive a periodical (mostly annual) lump sum per patient under their supervision during a certain period (mostly a year). The total income for a provider is a function of the number of patients enrolled on the list, irrespective of the number of performed activities and contacts." (Jegers et al., 2002, p. 266)

We reviewed capitation models in Working Paper # 10, and provide a brief summary here. Capitation is not a funding model that is generally used in Australia (see Duckett & Willcox, 2011 for some history of attempts at capitation in Australia). The majority of the research literature on

threatened service survival, and findings on the impact on client outcomes have been mixed. Like other fixed cost models setting prices is complex and data intensive.

The fourth and final funding mechanism model is payment for outcome, which we turn to next.

Payment for outcome

Payment for outcome is defined as:

> "payment for providing a pre-specified level or change in a specific behaviour or quality of care." (Eijkenaar, Emmert, Scheppach, & Schoffski, 2013)
>
> "…those in which the price, level, or nature of reimbursement are tied to future performance measures of clinical or intermediate endpoints ultimately related to patient quality or quantity of life."(Carlson, Sullivan, Garrison, Neumann, & Veenstra, 2010, p. 180)

Payment for outcome should be distinguished from price per episode (or ABF) – neither price per episode nor ABF explicitly link the payment amount to health outcomes. We have separately extensively reviewed pay-for-performance (a common term for outcome-based payments) in both the general healthcare and AOD literature — see Working Paper # 5. Here we provide a brief summary of the advantages and limitations of this model. The key advantage of payment for outcomes is that this system provides explicit financial incentives for improved patient health outcomes (Eijkenaar, 2013; Eijkenaar et al., 2013), or for quality care (Eijkenaar et al., 2013). In practice pay-for-performance has often been implemented in healthcare generally based not on direct measures of patient outcomes, but on process measures of health system performance: for example delivering a certain number of tests to patients, or reducing waiting times (Eijkenaar et al., 2013; Emmert, Eijkenaar, Kemter, Esslinger, & Schoffski, 2012). Therefore, although payment for outcomes encompasses a range of possible payment types, at the process-based end of the spectrum it can be seen as a type of activity-based funding, and at the other end of the spectrum it is client health outcomes funding, with blended systems in the middle (Maynard, 2012). Often in practice, only a proportion of the overall funding is subject to payment for outcome (Eijkenaar, 2013), therefore it cannot currently be seen as a standalone purchasing model.

There have been a res0s0n as[(p)(Thers)15(0)u f37] TJ-3(h)3(a)12(0 1 359.11 427.25 Tm[( )]ctr-3(h)3(a)12(T1 0 0 1 142

In considering the options for the Commonwealth, detailed in Chapter 14, the current processes within each state and territory and the Commonwealth provide important background information. We turn to this next.

State and territory AOD treatment funding processes

The purpose of this Review was not to evaluate the state and territory purchasing processes. However, some basic information about how the states and territories approach their purchasing, and the associated timelines is important information for the Commonwealth.

The section below summarises our understanding of current state/territory purchasing processes. As can be seen below, there are substantial differences between how the states and territories purchase services for the government sector compared to the non-government sector. There are also inter-state differences. (This information is also summarised in Chapter 11, along with planning and contracting arrangements for each jurisdiction).

In the NT, government services are funded on a recurrent basis. The providers are the existing historical government services. Non-government services in the NT use individually-negotiated processes to select the NGO providers, and a block grant approach for funding, with contracts generally for 3 years. There is some competitive tendering (for example, minor grants and capital works). Prices for services are not fixed, and are based on historical amounts funded and/or negotiated with individual providers. At the time of the site visit, it was suggested that a competitive process would be implemented in 2014, to "move toward submission-based funding" and open up

The competitive process, if effective, needs to be designed with consideration of the pool of potential providers and it should be well-resourced. A12(o3(esis)10(l)]p)14(ent)-5(pd)3 3(e-2(t-5(n)3(s(t)-3ia

Chapter 7: Meeting needs ç current service utilisation

An understanding of the numbers of people in alcohol and other drug (AOD) treatment in relation to the numbers of people in need of treatment is integral to planning. It is a challenging task to estimate the extent of unmet demand for treatment (See Working Paper # 1).

This chapter has three aims:

1. To document the amount of AOD treatment provided in Australia (over a one-year period)
2. To describe the characteristics of treatment recipients
3. To estimate the number of people in receipt of treatment in one year.

It draws from Working Paper # 8, which provides the technical details for the current service utilisation analysis. Previous chapters have illustrated the many types of treatment providers in Australia and the various distinct sites of treatment provision from publicly accessible institutions like hospitals, and freely-accessible phone treatment lines and online services, to private rehabilitation centres and private psychiatrists. They have also shown the range of institutions (government, non-government and private) that fund AOD treatment. There is no population-level survey in Australia of AOD treatment usage. . We rely on the funders and treatment providers for data on treatment utilisation. As a consequence, we were not able to document all treatment.

Amount of AOD treatment providedtrent /TBT1prov (t)10(0 1 477.94 726.46 Tm[2h)181o)5(u)4(n)4(t >>MCID 11>>BD

BEACH data (Annual estimated encounters with a GP)

Table 7.2 sets out the estimates of annual encounters with a GP for drug (medicinal and non-medicinal) and alcohol use disorders. We excluded encounters associated with drug use disorders where an opioid substitute was prescribed, since these will be covered under opioid pharmacotherapy treatment using the NOPSAD data. An encounter with a GP does not necessarily tr( )] TJETBT1 0 0 1 72.0ppharmacotheraper

Table 7.7: Closed inpatient treatment episodes (separations) provided by hospitals by principal drug of concern and by sex and age of client at end of treatment episode

		Women**		Men	
Other drug treatment*	Age at separation		%		%
	5-14				

OSR 2011/2012

In 2011–12, Aboriginal and Torres Strait Islander substance use s

50% of alcohol treatment recipients were aged 25 to 44 years, with fewer than 20% were younger than that. Men comprised almost three-quarters of treatment recipients for other drugs (72%). In this case almost 60% of treatment recipients were aged from 25 to 44 years. However, close to 30% of other drug treatment recipients were younger than that.

*Table 7.11: Estimated service contacts for AOD treatment with government-operated community mental health care services by sex and age of treatment recipient, 2010/11**

		Women	Men
Other drug treatment	Age		%
	<14	1.1	0.9
	15–24	26.7	31.1
	25–44	58.9	59.1

(Pirkis, Harris, Hall, & Ftanou, 2011, Table 5, p. 24). If we assume that 8% of these were for AOD treatment; this results in 240,356 AOD consultations with 53,732 clients.

The latest evaluation report for ATAPS, undertaken in 2012 shows that between July 2003 and December 2011, 14,505 clients with alcohol and drug use disorders were referred to ATAPS services, representing 7.4% of all 196,227 referrals for which diagnostic information is available (Fletcher, King, Bassilios, Reifels, Blashki, Burgess, & Pirkis, 2012: Table 17, p36). Note that multiple diagnoses could be made for each referral[71]. Of the total referrals made in that 8.5 year period, 78% received services.

In the 2010–11 financial year 42,649 referrals were made and 33,994 (80%) of these referrals received sessions of treatment (199,531 sessions). Information on referrals for alcohol and drug use disorders was not supplied for the 2010–11 financial year. We assume that 7.4% of the referrals that received sessions and 7.4% of the sessions were associated with AOD treatment ie 2,516 referrals and 14,765 sessions.

Summary: amount of treatment received

Table 7.12 summarises our estimates of the quantum of AOD treatment provided in Australia across settings, where that treatment provision is documented in administrative data sets or in official surveys reported here. Comparison of the quantum of treatment provision between treatment settings is complicated by the various ways in which treatment provision is measured, from encounters with GPs, sessions with allied health professionals for people with mental health problems and contacts with government-run community mental health care agencies, to episodes of opioid pharmacotherapy treatment which can last from a matter of days to ten years or more. Nonetheless it appears that most treatment episodes occur in GP settings, followed by the treatment provided through the Better Access initiative. In total, a little over 1.6 million episodes/sessions of AOD treatment are provided each year.

In terms of our counting approach,

Treatment setting	Data source	Number of treatment episodes/contacts	Type
funded under the Substance Use Program			
Treatment provided in government run community and residential mental health care agencies	CMHC-NMDS RMHC-NMDS	140,125 59	Contacts
Treatment provided by allied health professionals through Better Access scheme	Pirkis, Harris, Buckingham, Whiteford, & Townsend-White (2007) and information provided by authors.	240,356	Consultations
Treatment provided by allied health professionals through ATAPS scheme	Fletcher et al. (2012)	14,756	Sessions of care
		1,615,714	

It is interesting to briefly reflect on this quantum of treatment care. In previous research (Clemens & Ritter, 2008; Ritter, Berends, Clemens, Devaney, Bowen, & Tiffen, 2003) the most commonly referenced data on treatment utilisation is the AODTS-NMDS, and on occasions hospital separations are included (eg, Fischer, Clavarino, & Najman, 2012). Alternately, self-reported rates of treatment seeking (through the NSMHWB) have been used to assess treatment utilisation (eg, Slade, Johnston, Teesson, Whiteford, Burgess, Pirkis, & Saw, 2009b) with attendant limitations. The methodology used here is more comprehensive than either of these approaches, and unsurprisingly it appears that the amount of AOD treatment utilisation may have been underestimated (at least in relation to our count of episodes of care/encounters/separations). It is salutary that, while it is not sensible to add the numbers together (comparing apples and oranges) the total figure is substantially higher than what mig a a l'

to consider treatment over an entire year because a per annum measure matches the diagnostic window for the prevalence estimation. By far the most complicated task is the conversion from episodes of care to treatment recipients, closely followed by the need to count each treatment recipient only once.

Estimating the number of people in receipt of AOD services in one year

In this section, we report the findings of the first attempt to estimate the numbers of people in receipt of AOD treatment in any one year in Australia. We hope that our work can be built upon by other researchers as we advance the science of this exercise. It is a vitally important exercise because episodes/contacts/separations are meaningless in and of themselves if they cannot be matched to numbers of people. No population rates for treatment can be determined; nor can the relationship between the number of people with the diagnosed disorder (a per annum estimate) be compared to the number of people in receipt of treatment without such conversions.

There are no previously-published conversion rates, and we are working across different datasets, each of which requires its own conversion rate (ie, there is not one metric to use). In addition, there are many ways of thinking about the conversion.

There are four adjustments that need to be done:

1. Convert from quantum of treatment episodes to number of treatment recipients within each dataset
2. Adjust for double-counting of treatment recipients across agencies providing treatment
3. Convert treatment recipient count from a single day (or month) period to an annual figure (only applies to some data)
4. Adjust for double-counting of treatment recipients across datasets.

We do this in two steps. The first step, incorporating adjustments 1, 2 and 3, works within a single dataset. The second step (adjustment 4) deals with the double counting of treatment recipients that occurs across datasets.

In most instances, the episodes of care are annual figures (with the exception of the opioid pharmacotherapy treatment reported in NOPSAD), so we are largely dealing with per annum

Table 7.13: Summary - Converting from episodes to people

Treatment setting	Data source	Number of episodes, contacts, people	Method for converting from episodes to people	Formulae/conversion rate	Details	Number of people
Treatment provided by GPs	BEACH	826,000 Encounters	a) General population average # of GP visits per annum b) OTP as the multiplier;			

The results are given in Table 7.14. Summing across all data sources the estimated range for the sum of the number of individuals in receipt of AOD treatment in any one year in Australia is: 262,806 (38,240 + 33,249 + 28,848 + 66,762 + 32,565 + 6,894 + 53,732 + 2,516) to 486,495 (175,745 + 116,811 + 31,470 + 66,762 + 32,565 + 6,894 + 53,732 + 2,516). The high level is almost double the low level; with the divergence due to variation in our estimates of GP clients and clients of government-funded AOD treatment agencies. Two of three of the GP client estimates are reasonably close, at the high end. However three of our four estimates for government funded AOD treatment agency clients are closer to the low end of those estimates.

Regardless, some people receive care from multiple providers (between datasets) and hence there is a further adjustment that needs to be made for double-counting between (rather than within) datasets. We turn to this next.

Table 7.14: Plausible ranges of numbers of individuals within each dataset

Treatment setting	Possible ranges for number of unique individuals (within each dataset)
GPs	a) 165,200 b) 175,745 c) 38,240
Government funded specialist AOD agencies	a) 33,249 b) 116,811 c) 61,448 d) 33,938
Hospitals	a) 31,470 b) 28,848
OST treatment	66,762
Agencies funded under the Substance Use Program (OSR)	32,565

Our resultant estimate of the number of Australian in receipt of AOD treatment in any one year ranges from 139,213 to 234,153.

We identified one study with which to validate our estimate. Clemens & Ritter (2008) surveyed telephone callers to an AOD telephone counselling and referral helpline in Victoria. They found that of a total of 549 callers, 44% had attended some form of AOD treatment in the last 12 months. Of that 44%, 24.7% had received treatment from publically funded AOD agencies (ie AODTS-NMDS service). This means that AODTS-NMDS clients should represent about 24.7/44 or 56% of all treatment recipients. In our estimate AODTS-NMDS clients represent 24% to 50% of all clients for the low and high estimates of the base-line pool respectively. This suggests that the estimate based on the high estimate of the baseline pool might be more reflective of reality.

In relation to the second aim, characteristics of treatment recipients, our analyses confirmed what is well known in the AOD sector; that the majority of treatment sessions were provided to men; the proportions ranging from 52% of GP encounters to 68% of episodes provided by government funded specialist AOD agencies. In the few data sets where principal drug of concern was identified, alcohol tended to be the principal drug of concern for most of the treatment sessions, ranging from 46% of government funded specialist agency provided episodes to 72% of inpatient hospital episodes. Few treatment recipients were younger than 25 years of age – one quarter or less in most data collections. People receiving alcohol treatment were significantly older than those seeking treatment principally for other drugs.

In relation to the third aim, we find that there is no one simple way to convert from episodes of care to people across the multiple datasets. Even in the few data sources that report the number of

receive specialist AOD treatment within the same year, there will still be a number unaccounted for in the figures reported here.

As we have pointed out, we urge more research in this area. Refinement of the methods used here and development of datasets that contain unique identifiers (to translate from episodes to people, as AIHW is currently undertaking with the AODTS-NMDS) will improve the ease of estimating treatment utilisation and the validity of the estimates. We should care about the number of people who receive AOD in treatment in Australia – not the least because AOD is a significant health and social problem but because knowing more about who receives treatment will inform us about who does not receive treatment, and how much more treatment we should make available. We turn to this next, examining projected demand for treatment.

Conclusions

For planning purposes we need to know the number of people in AOD treatment. Ours is the first attempt to estimate that number inclusive of generalist as well as specialist treatment.

Previous chapters have charted the diversity of AOD treatment providers and diversity of treatments.

No one treatment works for all people and some people try many forms of treatment to find the treatment and the provider that suits them.

We estimate that approximately 200,000 Australians try some form of treatment over a year. This is an under-estimate because not all treatment is recorded in official datasets.

On average people who use treatment had approximately 8 episodes of care over the year, with those episodes ranging from a session with a psychologist or a GP visit, to a long-term stay in residential rehabilitation.

Between one quarter and one half of the people who try treatment are clients of the specialist treatment sector. We have no way of knowing how many clients are unique to that sector.

Planning needs to acknowledge and accommodate the fact that people legitimately try different modalities of treatment, often provided in different service sectors; and potentially combine those different modalities to create something that works for them.

Figure 8.1: Conceptual schema for DA-CCP

For our purposes here, we are interested in the number of people that DA-CCP predicts as the 'treatment demand population'. DA p(p)C7.<Trhso (r)dasure

proportion of the 41,000 Australians "between treatment" for each age group. The between treatment data was taken from Chalmers et al. (2009).

What becomes apparent is that establishing prevalence for five drug classes across the full population spectrum of ages is difficult, and there is not one single data source that can be used. Where population prevalence rates were used, the Australian population upon which the actual numbers were derived was from the Australian Bureau of Statistics (ABS) online publication *3222.0 – Population Projections, Australia, 2006 to 2101*[77]. The ABS produces three main series of projections. The ABS Series B population projections were chosen as the primary source for the DA-CCP Model on the basis that it provides a prudent 'middle ground' approach to the assumptions underlying the projection.

The final numbers which were used in DA-CCP for the population prevalence are presented in Table 8.2.

Table 8.2: Prevalence of substance use disorders used in DA-CCP (based on 2006 census)

	0-11mths	1-11 yrs	12-17 yrs[3]	18-64 yrs	65+ yrs	Total Pop.
Alcohol	-	-	18,300	916,925	48,090	983,315
Amphetamine	-	-	2,190	73,729	271	76,190

(which in turn relied on the SF12 measure of functioning). The reason the disability weights and subsequent assignment to mild, moderate or severe disability are important is because these then

We sought to examine the three key DA-CCP variables: prevalence rates for the disorders; distribution into mild, moderate and severe (severity distribution); and the treatment rates. Each of these three aspects of DA-

to support one preferred distribution of severity and treatment rate over another. It relies on making expert judgements.

Having explored the possible range of predicted/modelled numbers for total treatment demand we now turn to the polydrug issue.

DA-CCP adjusted for polydrug use

One of the central issues in estimating current treatment utilisation (see Chapter 7) is the extent of potential double counting of individuals within any one year either because they attend multiple services, or because they attend for different drugs over the course of a year. The same is true for DA-CCP inasmuch as the way the model is built it treats each drug independently, thus someone may have both an alcohol and a cannabis use disorder but will not require nor seek treatment for both of those in one year because they will receive treatment which covers both drug types[78]. This is particularly the case as the way DA-CCP counts people is treatment over the course of one year. Thus DA-CCP potentially double counts individuals who receive a course of care over a year which concerns two different drugs. Hence we need to apply an adjustment to DA-CCP to account for this.

The most parsimonious way to do this is to adjust the prevalence rates – that is, we need to reduce the prevalence numbers by those who are dually (or triply) diagnosed. Given our sensitivity analysis has shown a linear relationship between the population prevalence and the resulting predicted

	NSMHWB data)		

We apply these rates of concurrent substance use disorders to the DA-CCP modelled/predicted treatment numbers (reported in Table 8.6) and report the outcome in Table 8.9. (We apply the rates across all age ranges as there are no data about differential rates of concurrent disorder by age group. This is a simplifying assumption).

A = Alcohol disorder (Total treatment numbers: 348,094)
B = Cannabis disorder (Total treatment numbers: 93,716)

Table 8.12: Extent of potential met demand, Australia AOD treatment

	Plausible numbers to be treated	% met demand, where we assume 200,000 receive AOD treatment in any one year
DA-CCP original	594,541	33.6%
DA-CCP accounting for polydrug disorders	503,930	39.6%
Sensitivity analysis 1	519,351	38.5%
Sensitivity analysis 2	662,079	30.2%
Sensitivity analysis 3	483,840	41.3%
Sensitivity analysis 4	756,147	26.4%
Sensitivity analysis polydrug 1	438,719	45.6%
Sensitivity analysis polydrug 2	556,884	35.9%
Sensitivity analysis polydrug 3	412,331	48.5%
Sensitivity analysis polydrug 4	621,946	32.2%

The predicted additional demand (at between 212,000 and 556,000 additional people) may appear large. The prevalence rates used in DA-CCP are for substance use disorders (that is both abuse and dependence diagnoses are included in the original prevalence (need) estimates). Arguably we should only use dependence diagnosis, but this is counterbalanced by the fact that DA-CCP uses disability weights to allocate all diagnoses into mild, moderate and severe disability. This then goes some way to address the abuse/dependence issue and means DA-CCP does not overinflate the severity and assume that everyone with a positive diagnosis needs, and should access, treatment. At the same time, DA-CCP may underestimate demand for treatment because the proportions in the mild group, especially for alcohol and cannabis may be too high, relative to the moderate and severe groups. In addition, the average treatment rate across the entire model is 35% (excluding opioids). This 35% treatment rate is actually very modest, especially when compared to the current actual treatment rate (as reported in NSMHWB 2007) at 24% (Slade et al., 2009b) [80]. Some may therefore argue that DA-CCP sets the bar too low in relation to its prediction of overall demand.

How do these modelled rates of met demand accord with existing Australian literature? This analysis not only provides some intuition about the use of DA-CCP for estimating unmet demand but also allows us to examine the overall validity of our findings in light of other Australian research.

To date, no one has employed the DA-CCP method, and the existing Australian studies all rely on self-reported estimates of need (through diagnostic criteria) and treatment utilisation based on self-report. Therefore we would expect that the projections generated by DA-CCP would be higher because DA-CCP is predicting overall demand, whereas these Australian studies are estimating actual (current or met) demand. The NSMHWB provides a self-reported rate of service utilisation for those meeting substance use disorder criteria – effectively this is a 'met demand' rate. The NSMHWB asks abo m 'd ک nd s i Ĭ

2009b; Teesson et al., 2012), with estimates between 15.5% (harmful alcohol) and 52.4% (any drug dependence). The rates clearly vary by drug class (with alcohol lower than illicit drugs. See Appendix C.

We use these published rates to validate the DA-CCP estimates we generated. We found an overall demand rate (across all drugs) ranging between 26% and 48%. The Slade et al. (2009b) study of the NSMHWB found a current treatment utilisation rate of 24%. This suggests that our low estimate (at 26%) is not unreasonable and at least accords with NSMHWB analysis (notwithstanding the differences in methods). Given this confirmation of the 26% met demand figure, it suggests that unmet demand would be around 500,000 people.

Clemens & Ritter (2008) for Victoria alone compared the prevalence of substance use to the Victorian treatment rate (as measured by the AODTS-NMDS). The Clemens & Ritter (2008) work used a variety of prevalence data (notably need data, not demand data), but only included AODTS-NMDS as the estimate of current utilisation. This work highlights the importance of drug type. There was much higher met demand for opioids (35 to 62%), than for other drugs including alcohol (2.5 to 6.4%) and cannabis (4% to 7%). Likewise Teesson et al. (2012) found a 36% met demand rate for cannabis, and Slade et al. (2009b) reported a 52% met demand rate for any drug dependence. This points to higher met demand for drugs other than alcohol and the importance of dealing with drug classes separately. We examine this later in this chapter (in the first instance we look at international benchmarking).

International benchmarking

Is Australia achieving a higher, lower or similar rate of treatment penetration as that reported in other countries? Table 8.13 provides a summary of the reported rates of met demand in AOD treatment across the globe. It is important to acknowledge the different methods used across studies. Some of the studies reported in Table 8.13 assess met demand based on a population estimate of need. In general these methods produce lower estimates of met demand (because they do not exclude those that will not seek treatment). The higher percentages are found in studies that use a measure of treatment demand as the base population from which to compare actual treatment numbers. (The methods used by the studies are given in Appendix C).

As can be seen in Table 8.13, the rates of met demand vary between a high of 79% and a low of 4.8%. For the higher figures (79%; 55.8%; 26%) each of these three figures applies to drug use (not alcohol) and largely to opioid use. This is not surprising as met demand for opioids is known to be higher than for alcohol in international literature. (The exception here is the Becker, Fiellin, Merrill, Schulman, Finkelstein, Olsen, & Busch (2008) estimate for opioids in the USA at 15.2%). The low rates generally apply to alcohol (and vary between 5.6% and 21.9%). In general the lowest rates were found in studies that took the prevalence of need (from surveys of diagnostic rates) and applied those to either self-reported rates of treatment use or administrative data). That is, these studies do not adjust for the difference between need (meeting diagnostic criteria) and demand (intending to or appropriate for seeking treatment). The DA-CCP estimates are demand projections (not need projections) and hence will be higher than some of those reported in the below table. That being said, it still appears that our results suggest that Australia may have one of the highest met demand treatment rates for alcohol and other drugs.

We see that the modelled met demand rate is higher for cannabis and other drugs (41% to 48%) compared to alcohol, which is at 27%. This finding is consistent with the literature, and suggests that one of the major gaps is in relation to alcohol. It also suggests that the smallest treatment gap is in relation to cannabis, where around half of demand is currently being met (given the modelling assumptions).

Can we extend this analysis to age groups? Again, we take the AODTS-NMDS and allocate the notional 200,000 people across the age groups as represented in AODTS-NMDS. (See Table 8.14). We then compare this with the DA-CCP modelled estimates by age group; Table 8.16 gives the result.

Table 8.16: Met demand estimate by age group

	All Drugs – estimated current met demand (200,000)	Predicted demand (DA-CCP main model)	% met demand

demand (by unique individuals) is required. Furthermore, these analyses highlight a point already made – that planning requires more than simply a quantitative model to predict demand. The DA-CCP analyses should not be used on their own. Indeed, consistent with all approaches to planning and needs assessment, multiple methods are required in order to gain a full picture of treatment gaps (Eagar et al., 2001). The perspectives and impressions of people working in the field are as important as the mathematical quantifications. We turn to these next.

Key informant perspectives on sector needs and gaps

We conducted interviews with state/territory and Commonwealth government health officials, and

There was a keen understanding of the complexities involved in identifying, and interpreting

more vulnerable to single service providers in each area; not good at providing for all", "there is a need across regional [areas]", and "the [district] does not have many services".

There was also some discussion on the need for modified service models to allow for remoteness. (See also Working Paper # 2). This may involve particular relationships with primary health and include embedding programs in community health. It may include providing community development as part of / alongside the AOD programs.

Good working relationships between different parts Tm1-o3(ealt314(w)e(re)8(pa(tic513(lar)ly(#)9ir)10(o)-p m)3(o)

1. Young people: Key informants perceived a general shortage of appropriate services for young people. Some comments pertained to intervening when drug use was risky rather than entrenched, for example providing for "youth (getting in early)", and "youth programs as a deterrent for VSA (volatile substance abuse)".

A number of key informants spoke about increasing rates of demand for treatment from young people. "There has been more demand, 'across the board', for 18-20 year olds", "[there is a] gap emerging for 16-18 year olds. CAMHS [Child and Adolescent Mental Health Services] is only dealing with people younger than 16". "We know from child protection and youth justice that there is a need for AOD treatment in the 'youth space'".

Services for young people are quite underdeveloped in some locations, for example, "in the youth area there are enormous gaps. There has been no expansion. It is dismal". In addition, there was some commentary on the need for tailored service models, including "tools for young people" and interventions targeting particular sub-groups, such as those in regional areas, "youth in remote settings is an unmet need". Some key informants reflected on the need for a holistic approach toward young people in need of AOD treatment, with the view that, "we need youth workers that operate across AOD, mental

5. Aboriginal and Torres Strait Islander people: In many jurisdictions, key informants commented on

identified regarding access to non-residential structured day programs". In another location a key informant spoke about the short term nature of support for developing day programs and the limited sustainability possible in this context; "'we put lots of energy into day programs but this has lost momentum".

Service capacity to provide counselling was in focus in one location, where problems had been experienced with sole worker programs. Counselling outreach in remote areas was seen as important and needing an appropriate level of resourcing to avoid a sole worker program, which involves "too much pressure on staff". There was also a call for a more continuous program of care for those experiencing withdrawal, involving "case management for clients pre and post detox".

5. Integrated models: Collaboration, continuity of care, and holistic approaches were highlighted as areas needing development. This includes working across different parts of health. Key informants commented on the need for "collaboration across services to increase access", and some felt there should be "holistic [services], to improve overall outcomes".

One further area was raised in discussions about treatment gaps and unmet demand. There was recognition of accommodation problems faced by clients and the fundamentally important nature of secure housing to enable and advance treatment outcomes. Key informants felt that, "the housing shortage is an issue", and "clients need stable housing and employment to be able to then address profound AOD issues". Transitional housing and accommodation post treatment were also regarded as important, for example in the provision of aftercare and post residential rehabilitation.

Summary: key informants perspectives on gaps and unmet demand

In summary, these findings accord with our quantitative analysis. In particular,

- Unmet demand is substantial
- It is difficult to measure
- Existing data have significant shortcomings.

Further, the qualitative data highlight that:

- Key informants have a keen awareness of the importance of and complexities in pursuing a better understanding regarding unmet demand.
- Sector capaci<017Dp/F2 115.17 Tm[(Secto)-7(r)12(c)-2()-2(ap)4(aBT/F2 11.04 Tf1 0 0 1 m.04 Tfnt)14m cl

Pharmacotherapies
Counselling and other outpatient services
Integrated models.

Chapter 9: Planning

This chapter concerns approaches to planning alcohol and other drug (AOD) treatment. It is strongly connected to the preceding chapters on measuring met and unmet demand, but takes us beyond estimating the amount and type of services to examine planning processes.

The chapter starts with introductory comments about planning, its importance, and the goals of planning. A distinction is drawn between 'strategic' and 'technical' planning and these two types or levels of planning are then described in detail. It is through an examination of strategic and technical planning that the potential role of the Commonwealth and state/territory governments comes to the fore. The next section discusses joined-up planning in the context of two levels of government. We then consider important stakeholders to planning other than government. The literature and key informants reinforce the important role that a number of stakeholders including service providers and clients have in planning processes. This leads us to then consider another question — the most appropriate focus for planning (a focus on national, state or local planning). The chapter concludes with a description of current planning processes for AOD treatment in Australia.

There has been much written about planning, and healthcare planning. Planning is "a coordinated and comprehensive mechanism [...] for the efficient allocation of resources to meet a specific goal or goals" (Thomas, 2003, p. 2). Planning has also been described as, "the process of preparing a set of decisions for action in the future, directed at achieving goals by preferable means" (Dror, 1973, p.330, cited in Eagar et al., 2001). It is an explicit process, directed towards the goal of healthcare resource allocation (Fazekas, Ettelt, Newbould, & Nolte, 2010).

Planning must take context into account. As Duckett & Willcox (2011) note, there is no objective assessment of healthcare need, rather any assessment of need or demand exists within a social and political context. In addition, the very ways in which need or demand are defined and operationalised matter (see Working Paper # 1).

Healthcare planning should be considered alongside other public policy decision-making. "Broad political goals, such as ensuring economic sustainability, have to be considered and weighed against the goals of healthcare planning" (Fazekas et al., 2010, p. xiv). The World Health Organization notes: "it is now widely understood that national health policies, strategies and plans have to extend beyond health-care delivery and cover the broad public health agenda [...] and that they have to go beyond the boundaries of health systems, encompassing action on the social determinants of health and the interaction between the health sector and other sectors in society" (World Health Organization, 2010, p. 1).

Planning is not value-neutral, and its goal is to allow resources to be directed. Therefore clarity about the values underpinning planning and the goals of planning are centrally important. Eagar et al. (2001) argue that the intention of planning is to achieve resource distribution that is equitable, efficient and ensures effective delivery. Eagar et al. (2001) identify the following goals of a healthcare plan:

Equity — of access to health care services or of outcome
Accessibility — including geographic, physical, cultural/linguistic
Acceptability of services — to the client group and the community
Affordability of services — T/F7 11.04 Tf1 0 0 1 95.064 175.34 Tm[( )] TJETBTP3(sid)5(ered a)1utgoa19qm/F3

Fuller & Edwards, 2004; Sutton, Maybery, & Moore, 2011; Weiner, Amick, Lund, Lee, & Hoff, 2011).

One final note about strategic planning before we turn to technical planning: a formal governance structure around planning is required. Key informants gave examples where informal communications resulted in better planning, but noted that this relies on accident or on particular individuals. There was strong agreement that a structured formal set of planning processes was required: "[we] need a governance structure around planning with Commonwealth and State working together"' "More structured processes are needed for this to occur".

Technical planning

'Technical planning' in healthcare is often a synonym for health needs assessment. Health needs assessment refers to a systematic approach to the distribution of scarce healthcare resources, based on client need, and treatment effectiveness. In the seminal paper on healthcare needs assessment, Wright, Williams, & Wilkinson (1998) provide the following summary:

> "Health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way.
> It involves epidemiological, qualitative, and comparative methods to describe health problems of a population; identify inequalities in health and access to services; and determine priorities

Despite the significance of DA-CCP in generating estimates of demand for treatment for the first time in Australia, more is required in relation to planning. Three key points are made here: firstly the importance of predictive tools for demand for treatment being married to what is actually happening and the extent of current service utilisation; secondly the importance of geography (which is not dealt with in tools such as DA-CCP), and thirdly, the evaluation of effective planning.

DA-CCP only predicts what ‘should’ be and d Ł Ÿ sh ő , 4

treatment[88]: "The optimal approach would involve the state and Commonwealth meeting and agreeing on what to fund". This succinct quote echoes what we heard from almost everyone who spoke about planning across levels of government.

There was a sense from the key informants that planning had been better coordinated in the past — at least as much as planning entailed funding decisions. We heard from a number of people about

treatment services in Australia has been the subject of a comprehensive project (Bryant, Saxton, Madden, Bath, & Robinson, 2008). Noting that consumer participation is now a standard part of healthcare, Bryant et al.'s review of consumer participation in drug treatment services revealed that consumer participation at the service level was "not uncommon" (p. 130), but engagement in decision-making and planning processes was largely absent.

Aside from the stakeholders discussed above, some key informants reminded us that effective planning needs to move beyond the boundaries of the traditional AOD specialist treatment system because of the strong intersections between AOD clients' needs and other health and welfare services. Some key informants argued that there should also be input from other departments including housing, child protection, childcare and family services, primary health, and community health. These departments are also supporting the AOD treatment client group and vice versa ("we are supporting their clients") and in some cases are funders of AOD services. In some jurisdictions, planning across government portfolios already occurs. It was also noted that individual services should also consider the broader range of stakeholders in their own planning processes. With the complexity of the target group for AOD services it is likely that clients are, or need to be, accessing other services and systems. This requires some level of integration across these systems in the provision of a multi-faceted care model. Careful planning strategies can enable this through the establishment of shared goals, actions, measures, and, in particular, planned communication channels to support effective care provision.

The issue of localism - national, state or local planning?

One of the implicit debates throughout the literature on planning is the most appropriate focus or level for planning, and the extent to which local planning is superior to regional or national planning. There is no doubt that any planning needs to be linked/articulated across levels (as noted earlier). That aside, there is a very real question about the respective role of local versus state versus national planning; and its relationship to strategic and technical planning.

Strategic planning is most likely undertaken at a national level, although it is also important at a

"Identification of the health needs of local areas and development of locally focused and responsive services"

One final level of planning is that which occurs at the individual service provider level. Service planning should occur as a routine part of agency activities (and links to the Quality Framework requirement for services to be active data collectors/evaluators). We note that in the 2012 Commonwealth AOD treatment funding round, services were required to identify how their proposal met the needs of their population (see Working Paper # 4). In the SMSDGF guidelines for the open rounds, applicants needed to demonstrate "identified need". In this sense the Commonwealth relied on the applicants' own needs assessment processes. This is a possibility to consider, although no key informant argued that service level planning would be sufficient by itself.

Current planning for AOD in Australia

It should be noted that while the extent of planning as described below, may seem minimal there are actually very few areas of healthcare that engage in comprehensive planning.

National AOD treatment planning

DA-CCP was not used as a planning tool in the last Commonwealth funding round. The priorities for the two funds (NGOTGP and SMSDGF) were determined on the basis of history. No changes were made to the priorities for the NGOTGP 2012 funding round; the SMSDGF priorities were determined from the original fund sources (see Working Paper # 4).

State/territory AOD treatment planning

There are a variety of processes in AOD treatment planning in jurisdictions across Australia. For our purposes, we focus here on planning for the provision of AOD treatment, rather than the planning that occurs in relation to o

was required. This informed Tasmanian government purchasing of both government and NGO services.

In NSW, we were advised that the Local Hospital Networks are responsible for planning and decision-making about AOD priorities for the government services. The role of the central ministry is in assisting these planning processes, for example the development of models of care for detoxification. Evaluations are used to inform decisions about treatment services. For the NGO services, planning is undertaken on a very small, local scale if at all. There is currently no endorsed NSW Health AOD Plan (it is under development at present).

In the ACT, we were advised that the government uses evaluation data and expert reviews to assess the service system and plan for treatment services. There is documentation regarding the current priorities. One-off planning processes are also undertaken. The ACT conducted a review of treatment service needs. This review included stakeholder consultation. The overarching strategy to help inform treatment planning is the ACT ATOD Strategy (whole of government and community approach).

Conclusions

Key points from the review of the literature, key informant data and our own analysis:

- AOD treatment planning facilitates an understanding of the needs of a population in relation to AOD treatment and provides anning proxTŽUx AODtrehe4.67 i does ch psinnd to AOD tre66.95>BDC efficie

Chapter 10: Accountability: Contract management, performance and financial monitoring

Introduction

The purpose of this chapter is to document and assess the mechanisms by which the Commonwealth demonstrates public accountability for AOD treatment funding through contract (or agreement) management, the ongoing relationship with grant recipients, performance and financial monitoring. The chapter connects with preceding chapters on the existing funding mechanisms and what is being purchased.

The chapter commences with a discussion of accountability for public funding in these domains and what we know of NGO contracting in Australia, before summarising the current departmental reform process in this area. It then describes the accountability mechanisms, beginning with the funding agreement, focusing on the funded organisations' obligations around acquitting grants. It discusses the importance of performance monitoring, and the performance measures that could be used. Subsequently we discuss the ways in which the Commonwealth engages with funded agencies in the process of contract management, and finally examine data on a particular issue of concern to the NGO sector, namely the length of contracts.

The Productivity Commission (2010), p.129 explains that the financial, governance and performance information that is required to acquit/obtain funds (through grants for example) is but one of four types of reporting to government agencies undertaken by the not-for-profit sector. The remaining three include; corporate and financial reporting associated with the legal structure under which agencies are incorporated, requirements of fundraising legislation, and information required for endorsement for concessional tax treatment. The Productivity Commission noted that the requirements vary, often significantly, between the four reporting mechanisms and stressed the cap

Commonwealth contracting of not-for-profits in Australia

Since 1995 there have been seven major reviews of the not-for-profit sector, culminating with the Productivity Commission Research Report on the Contribution of the Not-for-Profit (NFP) Sector released in 2010. This report was commissioned by the Rudd Labor government, as part of its agenda to mend the fraught relationship between the Howard government and the NFP sector involved in human service delivery (see Butcher, 2013 for a discussion). The Productivity Commission (2010), which canvassed the views of the sector and government on a range of issues including those pertinent to this chapter, received a clear message from the sector that government tendering, contracting and reporting requirements "impose a significant compliance burden and constraint on e

funded treatment agencies, whether the treatment provider is a government organisation or a non-government organisation, are required to report to the AODTS-NMDS. A treatment episode is considered closed when:

- the treatment is completed or has ceased
- there has been no contact between the client and treatment provider for 3 months
- there is a change in the main treatment type, principal drug of concern or delivery setting.

There is no consistency in the method of reporting NGOTGP funded activities across the states/territories or even within some states/territories. In the ACT for example, the data are provided to the ACT health department, which then submits it direct to the AIHW. In NSW, there is quite some confusion as to reporting. NGO members of the Network of Alcohol and Drug Agencies (NADA) in NSW provide their data to NADA which provides the compiled data to the NSW health department and thence on to the AIHW. Organisations that are not members of NADA provide their data direct to the NSW health department. In Victoria the data are provided to AIHW via the Alcohol and Drug Information Service, whereas in Tasmania the funded organisations seem to provide the data direct to the AIHW.

In any case, if the funded organisation receives funding from both the Commonwealth and State/Territory the organisation is required to collect data and provide it to the state/territory health department. The state/territory health department provides the data to the AIHW.
It is clear that neither STOs, nor the Commonwealth have access to the data at the individual funded organisation or project level. It is also clear that the data are not used to monitor the performance of funded projects, nor of the grant programs as a whole. The data do not include the performance indicator information reported in Progress Reports; based, as they, are on completed episodes of care. The NGO treatment sector also has concerns with the data collection, in terms of its representation of treatment activity. For example, data on comorbidity treatment are not collected.

A Commonwealth central office key informant explained the current process, “once grant officers are satisfied that the funded organisation has undertaken what it said it would in the Project Plan;

perception that there are a lot of inefficiencies that could be improved with the government contracting. Participants also noted with frustration that rarely do the funder's contract managers stay in their role for very long. Personnel changeover is disruptive, time-consuming and problematic for the continuity of relationships with funders.

A Commonwealth key informant explained that the Commonwealth had recognised the potential for reporting burden and had made deliberate steps to reduce that burden in the last funding round by ensuring that all organisations had the same templates for progress reports for each funded project. The key informant also noted the promise of the introduction of the risk-based approach to contract management to further reduce the cost of contract management and reporting on those projects judged to be low risk.

The double burden felt by organisations funded by both the Commonwealth and state/territory governments is discussed later in the chapter.

Establishing suitable deliverables and performance measures for accountability

Accountability effectiveness depends crucially on setting realistic and suitable performance measures and deliverables (Romzek & Johnston, 2005). In this section we consider what sort of deliverables should be included within a contract for SMSDGF and NGOTGP funding and the role of performance measurement in those deliverables.

Tenbensel et al. (2013) describe four forms of accountability:

- Input accountability, which covers the situation where funding is attached to paying staff, buying materials, and renting office space
- Process accountability represents the situation where accountability is defined in terms of procedural requirements (such as timeliness of service satisfactory completion of reporting)
- Output accountability, where funded agencies provide services that can be counted
- Outcome accountability, where the tangible impact on the community/clientele is monitored.

Alternatively, accountability can be conceptualised in terms of performance measures, which have been categorised into three types by Hall & Rimmer (1994). Activity indicators relate to output accountability and measure the work undertaken (eg, the number of patients treated). Efficiency measures consider the relationship between inputs and outputs (e.g. the unit cost of providing a service). Pertaining to outcome accountability, effectiveness indicators are concerned with the extent to which objectives have been achieved through consideration of outcomes, such as change in treatment recipients' behaviour.

There is significant debate both internationally and in Australia about the advantages and disadvantages of using the various performance measures.
The performance measure should marry with what the government is purchasing. Most commentators argue that, in theory, outcomes should be the preferred focus on the basis that governments want to purchase health outcomes, and should not be concerned with how tho/F2 1o, andngn6(er)h23

purchased: quality of care, cost savings, innovation and continuous improvement. Goldsmith & Eggers (2004) note how hard this can be.

It is also salutary to note that the Australian health care system more generally does not pay for outcomes: activity-based funding is output-based funding (not outcome-based funding); Medicare is also output-based funding (see Chapter 6)[101]. As Epstein (2013) argues, the choice to try to define specific performance metrics or outcome-based goals is problematic in and of itself. Service providers will work to comply with the requirements of the contract, but will ignore other elements of service quality or adherence to broader program goals.

Having said this, we should note the distinction between paying by outcome (setting outcomes as deliverables) and performance monitoring on outcomes. Performance monitoring can be undertaken on outcomes without need for the payment to be contingent on achievement of the outcomes. There are reasons for the Commonwealth to consider outcome-based performance monitoring. It needs to show that the grant funds are achieving 'value for money'. One of the Commonwealth Grant Guidelines principles states that funded agencies should focus on achieving government policy outcomes (Department of Finance and Deregulation, 2013). Granting activities should be designed and implemented so that grant recipients focus on outcomes for beneficiaries while seeking the most efficient and effective use of inputs. As we outline below, there were many amongst the key informants who voiced a preference for measuring outcomes over activity/output for knowing what the funded project achieved..

In our judgement, based on key informant data, the performance indicators associated with the NGOTGP and SMSDGF P1 projects are a hybrid – they are primarily output based (eg, number of clients entering the program, retention rate, bed occupancy rate), although some outcome measures may also be included (eg, number of clients reporting reduced primary drug use, number of clients engaged in training/employment at end of program and three months later)

Funded organisations are asked to list for each of these five goals:

With this focus on performance 'measurement', attention tends to be focused on quantitative measures, to the detriment of qualitative reporting; which both the NGO sector and STOs found valuable. As an STO key informant explained, "narrative content provided in service reports gives context to the services provided and often of local AOD/ service/ regional issues".

Key informants from the NGO sector, as well as some STOs expressed the opinion that reporting should be valuable to the NGO and its Board as well as to the funder. In an ideal world, it was felt, the Commonwealth would work with the NGOs to develop a better system of reporting – to ensure mutual benefit from the process.

A key informant representing the NGO sector expressed the opinion that the Commonwealth's recent funding for suicide prevention "worked well" in comparison to the Commonwealth's funding of AOD treatment. The request for tender material asked "How would you measure success?" According to the informant, this "forced us to get qualitative and quantitative domains (including housing and economic outcomes) and translate these to the funding agreement".

There may be lessons to be learned from the approaches taken by state/territory health departments in monitoring their own treatment provision, as well as NGO treatment provision that they have purchased. As outlined below, both South Australia and Tasmania use output-based indicators in performance monitoring of NGO treatment provision, but both are in the process of developing a set of clinical outcomes for treatment provision provided directly by government.

The South Australian health department uses block grant funding to purchase AOD treatment from the NGO sector. It prescribes what evidence-based treatment is to be purchased before going to tender and purchases agreed quantities of treatment provision from a funded organisation. The organisations are required to report on a quarterly basis on sets of performance indicators and outputs as part of performance monitoring. Drug and Alcohol Services South Australia (DASSA) provides funded organisations with reporting templates specific to each service type (residential rehabilitation, counselling etc). The indicators used by DASSA are output, rather than outcome, based:

When funded organisations report to the AODTS-NMDS on dually-funded projects we heard of some instances where the organisation apportions episodes of care to the two levels of government in the same ratio as the relative funding split. If, say the Commonwealth contributes 40% of funding, then the organisation will report 40% of the episodes to the Commonwealth. In some instances, we heard that organisations that receive joint funding simply expand the funded service, which adds valence to this approach. However, even in the knowledge that there is excess demand for treatment at an Australia-wide level, this approach does not allow for the possibility (for example) that service provision expands to the point where it more than meets demand for treatment in its catchment area. In that case, the final 40% of funding would not have as much of an impact as the first 60% of funding.

Yet an STO key informant, speaking from the perspective of someone with responsibility for monitoring services delivered by individual projects, thought it would be more useful to learn about the overall outcome of a project, rather than the percentage that the Commonwealth funds. In their opinion, "I'd rather know how the overall service is going, not the 10% we fund".

Even so, the Commonwealth needs to ensure the 'value for money' of its own funding, so the extent to which one funder can or should 'claim' the outcome from a funded project is of vital importance. This speaks to consideration of variants of the Activity-Based Funding model as the Commonwealth's payment mechanism (Chapter 6). In the case of a payment mechanism built around Activity-Based Funding, the ability to apportion outcomes to each level of government would probably come down to the relative proportion of funding.

The implications for funded agencies need also to be acknowledged. As we explained in the introduction to this chapter, the NGO sector has to manage multiple accountability relationships. With more cooperative planning (as discussed in Chapter 9) alignment between jurisdictional expectations of funded projects will be better assured, reducing the potential for conflict in the jurisdictional objectives of funded projects. Where there is overlay in funding (for example the joint jurisdictional funding allows a worker to extend their working hours; or the funded service to extend its opening hours) key informants from the NGO sector also see value in having a single contract to reduce their contract management and reporting obligations.

At the very least, measures could be put in place to reduce the double-reporting requirements. There is support for the need to work with other funders to agree on a single report from the STOs but, as we were told "this is something that needs to be negotiated at higher levels". A Commonwealth key informant from the central office explained that where the state/territory government is investing the majority of government funding to the project the Commonwealth is willing to accept the same type of information that is reported to the state/territory government for its progress report. For example if the agency reports the number of attendances at the agency for a particular project to the state/territory, the Commonwealth will accept this in lieu of another performance indicator that may have been agreed upon in the Action Plan for the Commonwealth. (Duplication is covered in Chapter 12).

Intersection of deliverables and performance measures with purchasing framework

some in the NGO sector were concerned about insufficient feedback from the STOs, others commended the STO for their feedback.

Key informants from the NGO sector valued good relationships with contract managers and some considered face-to-face contact with STO staff as integral to valuable performance monitoring. The sector also values assistance when a project is staring up. The South Australian Network of Drug and Alcohol Services has established a network of NGO AOD treatment services' project managers, and encouraged government contract managers from both the STO and DASSA to attend.

While the flexibility of contract management practices was no doubt valued by the NGO sector it also leads to concerns about "inconsistent treatment". According to central office key informants,

According to an STO key informant, the reports give NGOs time for reflection. The STO is able to identify trends in some regions by analysing information from across the reports, depending on the extent of their funded presence in that region. STO key informants rued the DoH decision to centralise contract management, considered by some to be "moving to a light touch approach". In their opinion it "would be a shame" to discontinue site visits and to cease providing feedback. It is not clear that this will be an outcome of the centralisation process.

Performance measurement to assess accountability of the funding program

In terms of the Commonwealth's responsibility for monitoring the effectiveness of overall program funds – the 'value for money' of programs – a Commonwealth key informant stressed the importance of "monitoring the success of the whole grants scheme". The clear message from key informants was that performance measurement should be from the population-level perspective. The summation of the individual project level measures of outcomes has little meaning. According to McDavid, Huse, & Hawthorn (2013, p. 405), "It is fallacious to assume that knowledge of performance at one level implies knowledge of performance at other levels". As key informants reminded us, the outcomes achieved by their clients are cumulative over their treatment experience. They cannot be considered in isolation of the effects of the treatment that came before; just as the long-term effect of a specific intervention may not be realised for some time. This interplay between the outcomes achieved by the various interventions within the treatment sector is best viewed from the lens of the sector as a whole, in terms of its contribution to reducing the harms of AOD use.

But, as the Commonwealth key informant acknowledged, measures of grants-scheme level outcomes are "difficult to nail". The National Commission of Audit (2014: http://www.ncoa.gov.au/) notes that the change in the Budget reporting framework in 2009-2010 required departments to report achievements against objectives at a program level. In this regard, it expressed concern that the Commonwealth's portfolio budget statements did not detail for Programme 1.3 – Drug Strategy (which includes NGOTGP and SMSDGF P1), the types of activities undertaken and individual performance of the components. While it acknowledged that "some programmes suit the development of straightforward key performance indicators more than others" it felt "that more meaningful and measureable key performance indicators should be developed and maintained" (Appendix Volume 3: 53).

The objectives of the NGOTGP, as outlined in the 2012-2015 Project Plan Template (on which the project level measures of outcome build) are:

> Improve drug and alcohol treatment service outcomes, increase the number of treatment places available, and reduce drug-related harm for individuals, families and communities;
> Increase access to a greater range of high-quality drug and alcohol treatment services and strengthen the capacity of NGOs to achieve improved alcohol and drug treatment service outcomes;
> Fill geographic and target group gaps in treatment provision (e.g. women, youth, families with children, and Aboriginal and Torres Strait Islander people);
> Increase access to a greater range of high-quality alcohol and drug treatment services;
> Support both psychological and physiological health.

Although it is possible that measures associated with these objectives could be developed at the population level; it would be difficult to attribute the impact of the Commonwealth's investment alone, when the NGO AOD treatment sector has myriad sources of funding.

Performance measurement of the SMSDGF P1 in relation to the stated objectives in the 2012-2015 Project Plan Template would be built around supporting AOD treatment services to, for example, develop partnerships with the broader health sector and build capacity to effectively identify and treat coinciding mental illness and substance misuse. These objectives do not lend themselves to measurement in a conventional sense, although it is possible to identify appropriate indicators, by working with management and staff to map tangible outcomes sought by activities undertaken and associated sources of data. This approach would be best undertaken as part of an integrated review process on program effectiveness.

Length of contracts

The length of contracts is a sensitive issue. The NFP sector in general considers that the length of contracts with government is too short; they are inconsistent with the length of time it takes interventions in disadvantaged communities to effect improvement in client outcomes. Short-term and /or irregular funding is not conductive to establishing and maintaining long-term approaches (Productivity Commission, 2010). The Productivity Commission recommended that governments "align the length of the contract with the period required to achieve agreed outcomes" (Productivity Commission, 2010, p. xxiv). There is an argument that this recommendation is of little relevance for the AOD

Case example Organisation A and B
(See Part 3 for full details)

Organisation A
Ideally, participants said that 3 or 4 years would be an ideal length for contracts. Anything less than 3 years was not regarded as enough time (it was said that 2 years is hardly even enough time to collect or document the learnings from the program and for 1-year contracts the focus becomes recruitment and then looking for future funding straight away). That said, participants said that contract length was an important accountability mechanism and that they would not like to see a poorly performing organisations funded for longer than 4 years. However, this depends on the monitoring systems throughout contract.

Organisation B
In discussing contract length, it was noted that although the 3-year funding model is relatively workable, a 5-year model would be better and a “bit more substantial”. Participants suggested that this is what has

requirements for low risk organisations and projects, and to establish consistent contract management and reporting approaches for organisations and projects with a similar risk rating..

The Commonwealth's assurance that funded projects provide 'value for money' is implied through its monitoring of an organisation's progress against the project plan. Yet, there is some concern amongst STO key informants that their ability to monitor value for money is hampered by this approach. The performance measures tend to be output/activity based, and there was a groundswell of support amongst key informants from all sectors for outcome-based reporting; although the consensus view is that the development of suitable measures was fraught. There is movement towards developing outcome measures in several states.

The Commonwealth funds a significant number of organisations that are also funded by the state/territory government. There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an agency. There is an argument that funded agencies having to report to both jurisdictions is not consistent with the proportionality principle.

The Commonwealth is concerned to assess value for money of the grant programs as a whole, but has yet to develop an approach. The National Commission of Audit highlighted the fact that the Commonwealth's Budget Reports have not to date reported on the activities and associated performance measures undertaken as Drug Strategy programs (which includes NGOTGP and SMSDGF P1).

Three-year contracts for AOD treatment service

2

measures was fraught. There is movement towards developing outcome measures in several states.

The Commonwealth funds a significant number of organisations that are also funded by the state/territory government. There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an agency. There is an argument that funded agencies having to report to both jurisdictions is not consistent with the proportionality principle.

The Commonwealth is concerned to assess value for money of the grant programs as a whole, but has yet to develop an approach. The National Commission of Audit highlighted the fact that the Commonwealth's Budget Reports have not to date reported on the activities and associated performance measures undertaken as Drug Strategy programs (which includes NGOTGP and SMSDGF P1).

Three-year contracts for AOD treatment service delivery that do not include interim reviews and the option for renewal / extension are problematic for service establishment, routinisation, and sustainability.

Summary: State/territory planning and purchasing processes

We have sought to succinctly summarise the information about planning, purchasing, contract management and reform across all jurisdictions. It should be noted that this information has not been reviewed by the states/territories to date, and represents our summary form the information we were provided in the rapid assessments.

Planning	Purchasing approach	Timelines and reform	Contract management
Queensland			
Planning structures and processes are evolving in Queensland, following the disaggregation of planning and government services funding and provision from a central to catchment based arrangement (HHS), although AOD services are yet to be fully devolved to the HHS. Queensland is undertaking AOD NGO treatment commissioning at present, although details of planning processes associated with this were not reported to us.	In Queensland, the government AOD treatment services form part of the 17 Health and Hospital Services (HHS) that is the providere fullland		

Planning	Purchasing approach	Timelines and reform	Contract management

Planning	Purchasing approach	Timelines and reform	Contract management
	Unlike South Australia and Victoria, Tasmania does not stipulate the construct of the treatment it is purchasing. Hence its purchase approach is more akin to that of the Commonwealth.		
New South Wales			
In NSW, we were advised that the Local Hospital Networks are responsible for planning and decision making about AOD priorities for the government services. The role of the central ministry is in assisting these planning processes, for example the development of models of care for detoxification. Evaluations are used to inform decisions about treatment services. For the NGO services, planning is undertaken on a very small, local scale if at all. There is currently no endorsed NSW Health AOD Plan (it is und66.84(66.8			

AOD 72 2436.4 Tm0 g[( )] TJETQ EMC /P <</MCI 13 >BDC 6Qq240.53 43)-3(f)43 gnB[(con)-6(s

In Nualuat t

Improved outcomes for West Australians
The Partnership Policy aims to guide procurement processes with the not-

(May, 2012) entitled 'Implementing State Government Procurement Reforms' included sessions on procurement, sustainability and future funding, outcomes, and proposals. Workshops have been held on pricing, procurement, and workshops by service type. Community consultations have occurred or they are under way, to gather information about regional needs and priorities.

The above shows both how the principles and behaviours in the Partnership Policy have directed AOD reform in WA and also that implementation has been consistent with the goals, principles and behaviours of the Partnership Policy, notwithstanding the challenges (see Chapter 17).

PART 2: THE FUTURE ς OPTIONS ANALYSIS

Successive governments have sought to amend, clarify and refine the respective roles of the states/territories and the Commonwealth in health care precisely because of the difficulty in

c) establishing and maintaining nationally consistent standards for healthcare and reporting to the community on the performance of health services;
d) giving effect to the new Commonwealth-State governance arrangements including the establishment of relevant national bodies; and
e) collecting and providing data to support the objectives of comparability and transparency, and to ensure that data is shared between relevant participants in national health care arrangements to promote better health outcomes.

Under this Agreement, the States will be responsible for:
a) system management of public hospitals, including:
b) taking a lead role in managing public health; and
c) sole management of the relationship with Local Hospital Networks to ensure a single point of accountability in each State for public hospital performance, performance management and planning.

Under this Agreement, the Commonwealth will be responsible for:
a) system management, policy and funding for GP and primary health care services; [m]

primary responsibilities related to the National Drug Strategic Framework. These responsibilities were said to involve:

> Ensuring national policy development, coordination and management, in conjunction with the Ministerial Council on Drug Strategy, the Australian National Council on Drugs, the Intergovernmental Committee on Drugs, the national expert advisory committees and the community-based sector;
>
> Managing the workplans of and providing policy assistance and executive support for the Ministerial Council on Drug Strategy, the Australian National Council on Drugs, the

> drive improvement and achieve broad goals such as equality of opportunity and social justice. On the other side, scholars such as Brian Galligan (2008), Cliff Walsh (2006), and Jonathan Pincus (2006) argue that, on the whole, the Australian federation is operating well, with intergovernmental competition and overlap a sign of dynamism and healthy a [sic] sorting of roles. Between these two extremes, are scholars such as Anne Twomey and Glen Withers (2007), Alan Fenna (2007) and Andrew Parkin (2003), who advocate for the maintenance of federal structures, but with a sharper delineation of state and commonwealth roles and responsibilities, and removal of concurrency."

The delineation of roles within federalism is clearly a topic that is currently front and centre in Australia (eg National Commission of Audit). There appears to be a spectrum of options: the Commonwealth could take sole responsibility for service delivery; or primary responsibility with contribution from states/territories; or sole responsibility for the framework for service delivery, with states/territories administering the area with flexibility; or where the states/territories take primary responsibility for service delivery with contribution from the Commonwealth. In general, decisions about roles and responsibilities follow the subsidiarity principle (responsibility should reside as close to the population in need as possible) and fiscal considerations (given vertical fiscal imbalance) (Pincus, 2006). Decisions may also depend on the extent to which uniformity and minimum standards are desirable, the importance of ensuring equity of access to and availability of treatment, and duplication in bureaucracy. We are not going to "solve" federalism, but there is potential for substantial benefit from the Commonwealth and states and territories operating in a more coordinated fashion in the "overlap and entanglement" (Fenna, 2012) of AOD treatment provision in a federal system. Coordination requires cooperation and good will on the part of both the Commonwealth and the states/territories.

This chapter seeks to specify a clear role for the Commonwealth. Before we move to that discussion, however, it is important to acknowledge that even though most scholars (and key informants) have argued for clarity of roles, and role delineation, there are also compelling counter arguments. From the literature, we note that Hollander (2010, cited in Hinz, 2010) argued that duplication, overlap and redundancy can perform useful functions. The imposition of artificial boundaries can reduce the checks and balances in a federated system. These points have been echoed by comments from some key informants:

> "No player wants to be constrained by delineation"
>
> "Scope creep applies both ways – Commonwealth want flexibility to be able to respond/do anything for a local constituency, in same way states and territories want a similar opportunity".

It is possible that when roles are less clearly delineated (ie more nebulous) then cost-shifting becomes harder. (For example it has been argued that the introduction of hospital ABF funding has seen states/territories shifting activities into the ABF frame, whereas under a vaguer or more loosely defined system this may not be as easy).

1. Advancing national priorities

The Commonwealth has a unique role and responsibility to advance areas seen as important *across* multiple states and territories. National health agreements support this role and key informants, particularly from Commonwealth positions, identified national leadership as an important function. In terms of overall Australian healthcare resources, it has been argued that the Commonwealth is

agreement on values, goals and priority areas and it is a good fit with a leadership focus and a national perspective. This is a particular and specific role for the Commonwealth government. (Further discussion of planning and the Commonwealth role is provided in Chapter 13).

This leadership role has the added benefit of supporting the sustainability of the sector; the existence of quality services that are engaged in meaningful, evidence-based activities, in an environment that involves ongoing commitment to service improvement and sector development. While this is a shared responsibility across different levels of government, the Commonwealth's contribution to strategic planning (and allied elements of the mandate we describe here) is vital.

3. Addressing service quality

Service quality is a key mechanism by which positive treatment outcomes are made possible and the focus on outcomes is a foundational element of national policy. The IGAFFR (Council of Australian Governments, 2008a) emphasises a funding relationship that focuses on outcomes. Capacity building is an important way to build service quality and hence improved outcomes.

Mechanisms that preserve organisational capacity and sustainability include supportive policy and sound governance, along with clear management and leadership structures. Capacity building programs in non-profit organisations have helped to: clarify roles and responsibilities; advance understandings of the nature of and necessity for planning; and enhance management and administrative skills. The three streams of capacity building that we identified in Chapter 5 (Priority topic or client target population; Organisational or institutional capacity building; and Intra- and inter-sectoral systems of care) all speak directly to service quality. Capacity building activities across these three streams include funding direct care (AOD treatment), as well as funding workforce development (for example mentoring and clinical supervision) and inter- and intra-sectoral network building.

Key informants at the national level spoke about the Commonwealth role in relation to service quality. They recognised the benefits from having "national consistency and required frameworks of care". The existing national clinical guidelines, facilitated and led by the Commonwealth, have been important contributions here. Financial support to assist organisational readiness for formal accreditation processes has also been well regarded. Key informants noted that this type of national initiative would highlight "values and quality framework, standards for care". There is a strong argument for a nationally consistent approach to support quality services. A quality framework project is currently underway.

The rationale for building organisational capacity is closely aligned with intentions of the NDS regarding workforce development (Ministerial Council on Drug Strategy, 2011). Initiatives in support of workforce development have been an important focus at Commonwealth level across different areas of need, including co-morbidity and cultural competence (for example).

The Commonwealth has a key role in presenting a national perspective on service quality. As noted by key informants, there is scope to see "the big picture" and avoid "blind spots" that may arise in specific locations.

4. Supporting equity

Equity ensures equal or fair delivery of treatment services and equal or fair treatment outcomes. We refer to both substantive equity (treatment outcomes) and procedural equity (access to treatment) here in the Commonwealth responsibility.

the Commonwealth must fund direct AOD treatment where there is a prioritised gap, an emergency situation or a failing by other funders.

The next step in our considerations is the translation of these Commonwealth responsibilities into specific tasks, activities and purchasing decisions. We note that some areas and activities overlap, which is quite appropriate, however it is important to illustrate the dominant activities and focus of purchasing. The table below provides a high-level summary. The next section goes into detail.

Table 12.1: The Commonwealth role and responsibilities for AOD treatment matched to activities and purchasing

Role/responsibility	Types of activities / focus of purchasing
Advancing national priorities	National strategic frameworks Treatment services Capacity building Support for innovation through targeted pilots and other innovations
Providing leadership in planning	Strategic planning at a national level Planning in concert with states and territories Planning toolkits and practical resources
Addressing service quality	Treatment services Capacity building National clinical guidelines Quality frameworks
Supporting equity	Treatment services Capacity building

Options for Commonwealth purchasing

Consideration of approaches to national strategic frameworks, technical planning and other planning processes are detailed in the next chapter (Chapter 13).

Quality framework development is the subject of a separate project.

Here we concentrate on the remaining areas - treatment services and capacity building – but also take these up again in Chapter 14 in relation to purchasing mechanisms, Chapter 15 in relation to accountability, and Chapter 16 which draws all the work together.

As noted in Chapter 5, at present the Commonwealth purchases both AOD treatment and capacity building. The relative investment is 84% treatment; 16% capacity building (when the quantum of funds is used as the metric).

AOD treatment

The following are the core AOD treatment types:

- Withdrawal services
- Residential rehabilitation
- Psycho-social therapy (counselling)
- Pharmacotherapy maintenance

The challenge with this option is deriving sufficient rationale, supported by data, for such a decision.

At present, the NGOTGP and SMSDGF do not appear to fund pilots or innovations over and above service improvement initiatives within the core AOD treatment service types discussed above. Perhaps this is sufficient, although if the Australian AOD sector wants to be cutting edge, then greater attention to innovations and pilots is necessary. We also note that the Proceeds of Crime Act 2002 (POCA) which allowed the confiscated funds to be given back to the Australian community, has funded pilots and innovation, but is now no longer directing funds to AOD treatment.

Key informants (mainly from state/territory peaks, boards, and services) spoke about the need to support innovation, in an area where treatment needs (and evidence) change over time. They felt it was important to maintain sector responsiveness to emerging and changing patterns of drug use and to trial and evaluate innovative models. For example, key informants from a number of

it should be noted that this approach to aligning capacity building with national priority areas may direct funds into an issue which is not regarded as a pressing concern at the local level. As such, an alternate option would be to provide capacity building funds across a suite of priority issues, and allow local areas to mount arguments regarding their particular needs. This approach has the benefit of addressing on the ground issues, but requires astute and joined-up planning so that national priorities remain in focus while maintaining scope for variation to account for jurisdictional needs.

There are compelling arguments for why services should be funded to engage in capacity building, over and above core treatment funds. Given the tight fiscal operating environments of not-for-profit organisations and health services, there is little incentive or flexibility for organisations to engage in quality improvement and capacity building unless they are funded to undertake these activities. Crisp et al. (2000)

provider selection through outsourcing that function to states and territories. Likewise in planning, as detailed in Chapter 13 there is little point in the Commonwealth engaging in planning processes that are then replicated at state/territory level. As we discuss in Chapter 13 a sensible division of planning responsibilities between strategic and technical planning will avoid duplication. In Chapter 15 we consider whether the Commonwealth can use state/territory reporting functions to avoid administrative duplication both for government and for service providers.

The version of duplication that we think represents the gravest concern is the first, 'double dipping'. Clearly governments want clarity about what they are purchasing and that the funds they provide to a service are expended in accordance with the funder's expectations (and not spent on other activities, if the activity being purchased is actually funded by another party). This issue is also discussed in Chapter 5.

If the Commonwealth was funding an agency for exactly the same things as a state health department, this could be duplication. Where that agency then delivered and reported on the same activities to both funders, it is clearly duplication, and we would argue unethical behaviour on behalf of the agency. This kind of duplication is unacceptable. However, there is perhaps a more subtle and complex version of duplication. For example, in the context of excess demand, the state/territory could fund the same organisation to provide the same services as funded by the Commonwealth and the organisation could legitimately expand the service with those additional funds, through for example extending the opening hours; employing another staff member and so on. This is not duplication inasmuch as additional services, more episodes of care or greater service accessibility is achieved with the additional funds. The critical issue is how to ensure that this is measured against the respective funder's investment. We were told of examples where agencies divide their reporting up by funder: specific episodes of care are reported against state funding; whereas other episodes of care are reported against Commonwealth funding. Where the service types differ, this is relatively easy. Where the service types are the same (in the example of expanding the opening hours), this becomes more difficult. It is the responsibility of the funder to ensure accountability measures are in place; and it is the responsibility of organisations to behave ethically, to use the funds for the purposes to which they were given. (The issues associated with effective and efficient contracting and performance monitoring are taken up in Chapter 15).

We do not wish to imply that these issues are easily resolved. Funding provided by two levels of government to an organisation to support their ongoing service delivery activities can be difficult to distinguish. Indeed, as argued in Chapter 5, we see the advantages of co-funding (Commonwealth and state/territory funding of the same organisation) as a strength. But effective planning, formalised communication mechanisms between funders, good contract management, effective performance monitoring and quality assurance (including ethical behaviour by organisations) are ways of managing concern about duplication.

A brief word about cost-shifting; the Commonwealth should not fund AOD activities that would otherwise be the responsibility of states/territories. The Commonwealth grant guidelines note that, "agency staff should minimise opportunities for cost shifting and substitution of effort ie grant money shouldn't be used for activities that would normally be paid for by a state/territory or local government." The exception to this is in circumstances where an emergency situation has arisen, and consistent with the Commonwealth's mandate in relation to equity, the Commonwealth may fund services on an interim or medium term basis, until such time as the state/territory resumes responsibility. The Commonwealth should undertake its responsibilities in relation to the AOD treatment with regard to minimising the potential for cost-shifting. The problem of moral hazard, the unintended negative consequences where the Commonwealth 'picks up the tab' which provides disincentives for states/territories to provide funding, can be potentially avoided if the kinds of

communication, cooperation and collaboration that we are suggesting throughout Part 2 of this report is enacted between the two levels of government.

Conclusion

It is clear that duplication should be avoided, and cost-shifting minimised. Whatever processes the Commonwealth follows, it needs to minimise the chances of duplication and maximise the chances that states and territories feel and take responsibility for AOD treatment. This is important because states and territories are the primary funders of AOD treatment, and the Commonwealth's role is to both provide national leadership for that endeavour and value-add to specific state/territory processes. The responsibilities identified earlier, that is advancing national priorities, leadership in planning, addressing service quality and supporting service equity, can be achieved without duplication.

Summary

The Commonwealth has a unique and specific role in AOD treatment in Australia. The responsibilities comprise:

- Advancing national priorities
- Providing leadership in planning
- Addressing service quality
- Supporting service equity

These responsibilities are fulfilled through investment in direct service delivery and capacity building projects, along with leadership for the nation in planning, quality frameworks and ensuring equity.

There is a continuing role for the Commonwealth in funding direct service delivery. Funding direct service delivery is consistent with the Commonwealth's mandate in supporting service equity, advancing national priorities and enabling service quality.

We have sought to identify any logical distinguishing features of the direct service delivery that would sit well with the Commonwealth (eg specialist versus generalist; service types or population groups) and our analysis has failed to deliver a clear option in this regard for the short or medium term. The significant disadvantages of a primary focus on one service type include creating potential for cost-shifting, reducing leverage with states/territories, running counter to planning processes and compromising the Commonwealth's responsibilities in relation to national priorities, service quality and service equity.

Ideally the Commonwealth would support innovation and diversity through its purchasing of direct service delivery. Funding innovations and pilots may be at the expense of 'core treatment' and given unmet demand, may not be regarded as a priority.

Capacity building is consistent with the Commonwealth's role in service quality, equity and advancing national priorities. Capacity building is a legitimate role for the Commonwealth and provides scope for ongoing sector improvement. A planned approach to capacity building is important, to progress sector development in areas identified as national priorities while allowing for local variations.

The Commonwealth should purchase both direct service delivery and capacity building activities, consistent with this mandate.

Duplication can be avoided with good planning, communication and best practice contract management.

Is planning necessary?

Should the Commonwealth engage in planning? This may seem like a facetious question, but there are reasons why the Commonwealth may wish not to plan. The current status quo, the absence of formal planning processes at the Commonwealth level, has facilitated a highly flexible and responsive process to purchasing AOD treatment, and a focus on addressing key gaps. Arguably, the Commonwealth's role is to fill gaps in the AOD treatment service system (see Chapter 12). Knowing where those gaps are requires a planning process, but at the same time, filling gaps may occur in a non-systematic fashion. Indeed, key informants observed that "gap filling can be seen as ad hoc, random, driven by multiple informal processes". This can be the very nature of gap filling, especially when those gaps arise unexpectedly. The Commonwealth most recently did not use pre-defined formulae for fund distribution. This is consistent with the desire by the Commonwealth to distribute funds based on gaps and areas of highest need. [113] Planning processes that result in the full allocation of resources can inhibit "gap filling". Balancing gap filling with strategic, thoughtful, long-term planning is a challenge.

Another consideration that applies to AOD treatment planning is the current context. At present we have an absence of formal planning processes. It is generally true that when purchasing decisions appear to be fragmented, people call for consistency (indeed, most key informants argued for increased attention to planning which informs purchasing decisions). When there is comprehensive planning, however, people argue for localised exceptions.

There may be risks associated with planning. Some key informants reflected on the role that political decisions can play in funding decisions, and suggested that effective planning processes may place the sector at lower risk of political decision-making. Other key informants argued that political decision-making was an inherent part of the process. The risk of planning, as argued by one key informant, is that it takes the politics out of funding AOD treatment and it is actually the politics that gives AOD treatment the best chance of being funded.

Does planning run the risk of stifling local innovation? This speaks to the question of what planning results in, and the extent to which these products are highly prescriptive. Some key informants reflected on this issue – noting the problem of having both clarity and rational plans to inform resource allocation, at the same time as maintaining a level of flexibility for tailoring decision-making and for innovation. Key informants acknowledged the importance of flexibility and discretion, but at the same time also argued for systematic, rigorous, and scientific approaches to funding decisions built from comprehensive medium and long-term planning.

It could also be argued that because the potential treatment gap is large, perhaps planning is not required, that is, we can maintain the status quo of an absence of formalised planning. This line of

Build on efforts to increase the range of, access to and links between evidence-based treatment and other support services.
Develop and implement quality frameworks for treatment services.
Sustain efforts to increase access to a greater range of culturally-sensitive services.
Improve access to screening and targeted interventions for at-risk groups such as young people, people living in rural and remote communities, pregnant women and Aboriginal and Torres Strait Islander peoples.
Increase awareness, availability and appropriateness of evidence-based telephone and internet counselling and information services.
Strengthen the capacity of the primary healthcare system to manage prevention, early intervention and treatment of tobacco use and harmful alcohol use.
Create incentives for people who misuse drugs or are dependent to access effective treatment and to make healthier choices.
Encourage family members to access and make use of support services to help improve treatment outcomes for clients.
Explore 25 EMC 11.0f(and)5(im)-5(p)3(l)13(em)4(en TJ E397.7tm)-4(a)12(ry)-na2 566.83 Tm [(tr

these are specific to AOD treatment.[114] A specific treatment strategy would be consistent with the current NDS structural priority of "treatment planning" and the actions specified, such as "develop planning models for treatment services that anticipate needs". Thus it would sit underneath the NDS

secondary and tertiary treatment (that is exclude primary prevention explicitly). Some may argue that this sidesteps the relationship between prevention and treatment (which is true), but if the purpose of the national treatment strategy was clearly allocative planning for tertiary treatment, the policy priorities regarding prevention as compared to treatment could be taken up elsewhere[117].

The other significant consideration in defining the scope of a ten-year nationally endorsed AOD Treatment Strategy is the extent to which it also engages with other sectors (see key informant comments in Chapter 9). This is a difficult issue. On the one hand, for simplicity and focus we would argue that other sectors not be involved in the first iteration of the national treatment plan. This is more likely to ensure its successful passage through to sign-off, and is advantageous in relation to the level of specificity that can be achieved at a strategic planning level (ie greater specificity because of more confined scope). On the other hand, as we noted in Chapter 9, planning should extend beyond AOD treatment in the health context ("go beyond the boundaries of health systems"(World Health Organization, 2010, p. 1). It can be argued that effective planning needs to move beyond the boundaries of the traditional AOD specialist treatment system because of the strong intersections between AOD clients' needs and other health and welfare services. The areas of intersection include mental health, housing, child protection, childcare and family services, primary health, and community health. Thus the boundary for a National AOD Treatment Strategy needs careful consideration. If it extends beyond the AOD treatment service system the development of the strategy will be more complicated, with more stakeholders, and with increased risk of being less specific. One option is to follow a two-step process: in the first instance concentrate on AOD treatment alone, and in the next step broaden that out to include all the support and inter-sectoral

considering. Aside from specific expertise requirements, we note that other strategies are developed

level can only identify broad priorities – the actual funding decisions within each region require a different level of planning data and acumen.

Before examining the options for technical planning there are two important considerations. The first is duplication of effort. Given the resources required for effective planning, consideration should be given to using existing planning processes. A number of key informants reinforced the

The third, and only remaining option is for the states/territories to lead technical planning with the Commonwealth at the table –

A greater level of technical planning is required in order to translate these overall priority gaps into specific services by location in each jurisdiction.

Pre-defined allocations

Technical planning can lead to pre-defined allocations: that is specific amounts allocated for certain population groups, or for certain geographic regions. The pre-defined allocations would direct resources to the identified gaps and areas of highest need.

The Commonwealth needs to consider whether the adoption of pre-defined allocations is a sensible strategy for the NGOTGP and SMSDGF grant rounds. There are two ways in which pre-defined allocations could work:

1. Allocations of fund amounts to states/territories
2. Allocation of fund amounts to population groups or service types.

Pre-defined allocations of fund amounts to each state/territory is possible[118]. The allocations would be determined based on a formula, which would take into account the overall rate of AOD problems, the extent of unmet demand for treatment and other variables, such as remoteness/rurality and socio-economic disadvantage. It is important that the Commonwealth invests in every state/territory, and pre-defined fund allocations would ensure this (noting however this has not been a problem in the past). The advantages of a pre-defined allocation largely reside with the states/territories knowing the Commonwealth contribution. This is likely to enhance their planning, and reduce the likeli 0 0o tatty tw6(o)-5(u)3(nd)5(t)8(o)-5(nt)1g

priority setting that occurs when AOD treatment and equity of access is considered at a national level. Further review of whether the advantages outlined here for pre-defined allocations are able to be realised is required.

Resourcing planning: what data and tools are required?

Planning takes considerable time, and requires sufficient resources. The consequences of not taking sufficient time and adequately resourcing the planning process can be negative. From one key informant reflecting on reform in his/h

Epidemiological data about the nature of the disorder
Information on services, what exists, location, specification of activities
Data on current treatment utilisation and trends
Workforce data.

Existing investments by the Commonwealth (for example in the AODTS-NMDS, and the NSMHWB) could be more strategically used to support an explicit technical planning agenda.

Relationship to Principles

The purpose of planning is ultimately to achieve positive health outcomes for people with alcohol and other drug problems. Good planning will lead to effective, efficient and *value for money* purchasing decisions, which in turn will lead to the best possible coverage of services, in the places where need is the highest, and articulated with other funders. The options explored in this chapter for the Commonwealth are consistent with the principles of *robust planning and design*, notably that planning occur in a joined-up fashion with stakeholders. This approach to planning also demonstrates the principle of *partnership and collaboration*, given the engagement of all stakeholders in the planning processes. The approach considered here also has regard to *proportionality*. We do not think it would be appropriate for the Commonwealth to directly engage in its own technical planning – this would not be proportionate to its current investment in AOD treatment. The ten-year National AOD Treatment Strategy speaks directly to the principle of *governance and accountability*. As proposed, the strategy would clearly specify the roles and responsibilities of the various funders, facilitating subsequent accountability.

Summary

A nationally endorsed ten year National AOD Treatment Strategy would provide the framework for future funding decisions that are co-ordinated across two levels of government and follow clearly specified role delineation.
Technical planning, led by states/territories with Commonwealth engagement, would provide the basis for specific funding decisions in each funding round.
Specification of priorities and the application of pre-defined allocations to priority areas within each grant round would provide transparency to states/territories and applicants, enhancing the likelihood of value for money investments by the Commonwealth.
National leadership by the Commonwealth on the roll-out of planning tools would be consistent with the Commonwealth mandate and be an important step forward in technical planning.
Likewise, national leadership on guidelines for AOD treatment planning and data would provide the future basis for effective, efficient and equitable AOD treatment services based on areas of highest need.

Chapter 14: Commonwealth purchasing mechanisms

This chapter considers how the Commonwealth should purchase services. In Chapter 6 a distinction was drawn between the choice of provider and the choice of payment method.
There are four options for the Commonwealth to select the AOD treatment providers:

1. through competitive selection processes
2. through individually-negotiated arrangements (often based on historical agreements)
3. through an accreditation and/or registration process
4. through transfer to states/territories.

There are also four options for the Commonwealth in relation to how to provide the funds:

1. through a block grant (lump sum)
2. through a price per unit of activity
3. through a capitation model
4. through payment for outcomes.

This chapter considers each of these options. In the first instance, we provide the summary conclusions from Chapter 6:

> Multiple purchasing mechanisms are in play at present. For example, the Commonwealth currently purchases AOD treatment through four mechanisms: competitive processes (grants schemes), fee-for-service (Medicare), activity-based funding (hospital services), and transfers to states/territories (special purpose payments).
>
> The way in which AOD treatment is currently purchased by the Commonwealth and states/territories through the NGO sector is predicated on models that exist for social welfare services, not those for health. Thus, governments purchase social welfare services, such as employment services, and homelessness services, largely through competitive grant schemes. Arguably, alcohol and other drug treatment services have simply been subject to these social welfare processes because the providers are NGOs. However, if one considers AOD treatment as a health service, then the usual mechanisms for health funding (such as ABF or fee-for-service) would be more appropriate.
>
> It is useful to distinguish the mechanism by which the provider is chosen (eg: competitive selection, historical or negotiated, preferred-provider, or via accreditation/registration processes) from the mechanism by which the payment occurs (block grant, activity/episode-based, capitation and outcome-based).
>
> Each of these has advantages and disadvantages. Existing literature and key informants to the Review have informed our analysis of the relative strengths and limitations.
>
> Competitive processes to select the providers of AOD treatment are widely used. These approaches have a number of general advantages, particularly transparency and fairness. There is also a perception that competition is a driver of quality and may involve reduced price. However, there are a number of disadvantages that apply to AOD. A limited number of potential providers exist. Funders risk undermining sector viability through processes that do not account for a) organisational characteristics (eg, size and capacity to write proposals) and b) the vulnerability of organisations to uncertain funding arrangements.
>
> The competitive process, if effective, needs to be designed with consideration of the pool of potential providers and it should be well-resourced. Assessment panels need to include experts

Table 14.1: Commonwealth payment mechanisms

effectively determine the supply. For people with AOD problems, who are highly marginalised, this is unlikely to be effective (and would only work if there was real choice). There are other reasons why this model is not feasible for the Commonwealth:

- It is associated with fee-for-service, resulting in an uncapped budget situation and thus potential Commonwealth overspending
- Fee-for-service provides payment for occasions of service, rather than episodes of care and is thus a less refined mechanism (Australia has championed the move from occasions of service to episodes of care through the ABF model, regarded as a superior way of purchasing healthcare)
- AOD treatment requires a number of contacts or occasions of service – it is not the same as a single visit to a GP
- None of the states/territories purchase AOD treatment through this particular process of selection of providers and hence there is less likely to be synergy between the Commonwealth processes and the state/territory processes
- Fee-for-service is not a sustainable model for an AOD NGO unless it is done in concert with other forms of base funding, particularly for smaller and more rural services
- It requires an invoicing/payments administrative infrastructure (eg MBS).

Reserving individually-negotiated selection as a fall-back option

It has become clear that the selection of providers based on individually-negotiated arrangements is not an ideal model (see Chapter 6). It is associated with a lack of transparency, can be subject to political whim or idiosyncratic decision-making (rather than part of a planned approach) and, perhaps most importantly, as the standard or prevailing approach it is inconsistent with the Commonwealth Grant Guidelines for general funding rounds. Furthermore, whatever process the Commonwealth chooses for selection of providers needs to be one that has a level of coordination and communication with states/territories. This would be hard to realise for this option. For these reasons, this is not the preferred option for the Commonwealth to use for the NGOTGP and SMSDGF.

That being said, some level of flexibility is required such that the Commonwealth can respond to crisis situations in a flexible manner and be afforded the opportunity to select a provider through this mechanism. This is consistent with the current funding guidelines for the flexible funds, whereby

Pincus (2006) provides a succinct summary of the advantages of federated arrangements (ie two

Engender distrust and divisiveness among the limited specialist service providers that are available.

Open competitive selection processes are questionable for situations where the Commonwealth is purchasing services that are highly specialised and provided by a limited number of organisations that have long-standing networks with related services and systems. This is where targeted competitive processes are better suited.

Targeted competitive processes may be appropriate for the Commonwealth when:

The pool of potential providers is constricted/limited (eg rural/remote, highly specialised services)

There are specific gaps (highly specified ITA)

It is existing funding

When funders have worked in a partnership arrangement with sector representatives to lay the ground work for sector change and this is enacted through the targeted competitive process (refer to the WA partnership case example for illustration).

Limitations of the targeted competitive process include:

Potential unease at the seeming lack of transparency in the process

discussion about preferred provider panels obviates the need for strong accountability and for decisions that are based on merit.

Clear cooperation and coordination with states and territories would be required for this option: preferred providers under a Commonwealth scheme would perforce need to be considered as preferred providers by states/territories (even if the states/territories did not explicitly use this

Provider selection	Preferred/suitable when:	Limitations:
state/territories	jurisdictional level) is preferred; Consistency between jurisdictional purchasing processes and mechanisms is sought; There is confidence in the jurisdictions; To avoid "programmatic confetti", perceived 'duplication' and potentially increase the value for money in purchasing.	more vulnerable to reduced funding; Removes the checks and balances that occur with two separate funders.

Choice of payment mechanism

As noted at the outset, there are four possible payment mechanisms: block grant, price per unit of activity/episode, capitation and outcome-based payment (see Chapter 6). We can immediately rule out capitation — this is not a feasible model in Australia for AOD treatment purchased by the Commonwealth. We also think that there are serious limitations to the application of outcome-based funding, as discussed next.

Outcome-based funding — only for incentivising aspects of practice

Our review of outcome-based funding (see Chapter 6 and Working Paper # 5) noted the confusion about this approach, and the varying terminology. To be clear, there is a vast literature identifying the payment of bonuses to individual health staff for achievement of outcomes as an additional incentive to healthcare practice. The evidence in this regard is somewhat supportive, but a recent systematic review found that controlled studies were less supportive than uncontrolled studies (Houle, McAlister, Jackevicius, Chuck, & Tsuyuki, 2012). A recent randomised trial of individually targeted incentives in alcohol and drug treatment found improvements in processes of care but no significant effect on outcomes (Garner, Godley, Dennis, Hunter, Bair, & Godley, 2012). The other way in which outcome-based payment has been reported is in relation to tying the outcomes to the core contract for service delivery at the service/organisational level. This is the UK experience with "payment by results" – organisations are paid for the services they deliver based on the achievement of specified client outcomes, including alcohol and drug abstinence, improved employment, reduced crime and improved social integration (UK Government, 2013). In the case of AOD, process measures such as increased admissions, longer lengths of stay, and improved referrals have been linked to target payments (McLellan et al., 2008). There is currently limited and mixed evidence to support this model of payment (UK payment by results, or US pay-for-performance) for core treatment services

A brief comment about Western Australia is warranted, as they describe their approach to purchasing as an outcomes-based approach. In WA, an extensive collaborative process has occurred between government, service providers, consumers and the community to arrive at a sustainable model for the future of AOD treatment (in fact it is much broader than just AOD treatment). (See case example given in Chapter 11 for a description of the partnerships process). As a result of this consultative process, a model was determined for government purchasing of services, which is described as outcomes-based. There is clear specification of the outcomes that the government is seeking to achieve. These outcomes are defined through a collaborative planning approach involving government and potential providers that occurs prior to the procurement process. Different approaches to competitive processes are utilised dependent on the type of service involved. The organisations subsequently selected as service providers are then paid through a service agreement, which uses a block grant approach, with clearly specified deliverables. That is, in WA the organisations are not paid per outcome achieved. This distinction may seem subtle but is essential in understanding the difference between a commitment to outcomes (which is shared across the entire sector, and should be a primary concern of the Commonwealth and any other purchaser) and the choice of a payment method focussed on outcomes.

The use of outcome payments may be appropriate for the Commonwealth in the following circumstances:

- For specific, additional components of a contract over and above any core component
- To purchase improved care practices, specifically identified as national priorities
- To incentivise specific aspects of clinical care (eg use of an assessment tool) or clinical supervision (eg, bonus payments if the organisation can demonstrate that all clinicians receive at least once monthly individual supervision from a supervisor with more than 5 years direct AOD clinical experience).

Outcome-based payments are not appropriate for:

below) could be sufficiently specified. If it were determined that an ABF-type payment mechanism was not feasible in the short or medium term, block grants with clearly specified performance indicators are likely to be the most parsimonious option. For capacity building, block grants are

establish the system. Under hospital-based ABF, the specification of the 'activity' has involved analysis of large datasets of representative service types, lengths of stay, occasions of services, activities (bed days, FTE and so) which is then statistically analysed for clusters (bundles of related groups) which share similar cost structures. In light of the technical complexity, we cannot yet determine the feasibility of ABF or a variant as specified above. Research is required to fully evaluate these three options and to draw final conclusions about the feasibility of this approach.

The questions that would need to be answered in a feasibility analysis include (in no particular order):

Of the three ABF options above, which is most feasible and able to implemented with the end goal of improving health outcomes?

Is there sufficient evidence to suggest that an ABF model i

Is this too much to expect of the funder? There is certainly a level of administrative resolve required to tailor the funding mechanism appropriately. This means there is a higher load of policy work, and the potential for confusion in the sector. Clear communications about what is purchased by which method, and under what payment regimen, would be required. Is the sector ready for this level of sophistication - and is the Department of Health able to resource such a process?

Over and above consideration of the Commonwealth deploying mixed methods based on planning processes and what it is purchasing, there is also the possibility (referred to above) that the Commonwealth uses mixed methods depending on the individual jurisdiction within which it is purchasing. Thus, if a jurisdiction uses a unit cost payment method for AOD treatment, the Commonwealth could consider adopting that for services purchased in that jurisdiction, and so on. This substantially increases the level of complexity for the Commonwealth (and would again require significant administrative resolve and clarity of communication). Indeed, if the Commonwealth were to seriously consider following the individual jurisdictional processes, then it would be preferable to adopt the option of transferring the funds directly to the states/territories for them to subsequently lead and manage the purchasing processes (which they no doubt would do consistent with their own current purchasing arrangements).

Given the national mandate (see Chapter 12) it is also true that the Commonwealth has a leadership role and part of its purchasing decision-making (whether that is selecting providers or the payment method) could set the standard for all jurisdictions to follow. This would be consistent with a national leadership role, and serve the AOD sector well. The Commonwealth demonstrates its leadership and national role by setting the standards for and conducting purchasing (and planning) in such a way as to be a best practice model for other jurisdictions.

Relationship to principles

The purpose of purchasing is ultimately to achieve positive health outcomes for people with alcohol and other drug problems. Referring back to the principles in Chapter 1, the Commonwealth should seek funding processes that are effective, efficient and equitable. In relation to the options and issues discussed in this chapter, the principles of grant administration (see Chapter 1) are highly relevant. These are:

1. Robust planning and design
2. Collaboration and partnership
3. Proportionality
4. An outcomes orientation
5. Achieving value with public money
6. Governance and accountability
7. Probity and transparency.
   (Department of Finance and Deregulation, 2013)

Whatever the choice of purchasing mechanism, robust planning is required. This means engagement with states/territories and necessary groundwork (such as the feasibility study of ABF(pla)3(n)3(n)3(in)5(g)4(is)-2(r(

noted above (such as one-off grants) can be less than transparent and subject to probity concerns. As will have been apparent, we consider these as less strong options. Competitive processes, notwithstanding their limitations and context-specific strengths, can provide transparency, probity, and achieve value with public money. The trade-off can be collaboration and partnerships, especially between the grant provider and the service provider. Attention to communication processes and a foundation partnership approach (as we explored in the WA case example, see Chapter 11) will reduce the risk of compromising those principles under a competitive selection process.

Conclusions

At the risk of over-simplifying what is a complex set of decisions, our analysis concludes that:

Chapter 15: Ensuring accountability through contract management and value for money

This chapter considers how the Commonwealth should ensure accountability through contract management and value for money of its funding programs.

Chapter 10 reviewed the relevant literature and considered key informant perspectives about accountability. The conclusions drawn were:

The Commonwealth's contract management, performance and financial monitoring practices are under reform, along with other aspects of the Commonwealth's grant enabling processes. The reforms are intended, amongst other things, to increase consistency in contract management and monitoring practices across all Commonwealth funding and reduce the contract management and monitoring burden on funded organisations, in line with the principle of proportionality.

The contribution of ongoing relationships between STO contract managers and funded NGOs to the success of the funded projects should not be underestimated. However, there is variability in the approaches taken by STOs and the ability of the STO staff to undertake these responsibilities.

NGOTGP and SMSDGFP1 projects are block funded. The Commonwealth distributes tranches of the agreed funding amount to funded organisations. The delivery of those tranches is contingent on the funded organisation meeting obligations, primarily the provision of progress reports against an agreed upon Project Plan and associated financial reports at 6-monthly intervals over the life of the grant. There has been variation in the extent to which the STOs assess the submitted progress and financial reports before funding is delivered. In some cases it is automatic. In other instances funding was delayed on account of inadequate progress reporting. The extent to which the performance measures included in the Project Plans are considered as deliverables is contested.

Organisations funded under the NGOTGP and SMSDGF (treatment services) are also contracted to report against the AODTS-NMDS or OSR. There is no consistent approach to the process of reporting in each jurisdiction, and it is not clear whether all treatment funded by government is recorded. The Commonwealth does not use these data to assess the value for money of individual projects. Nor are the data considered useful to assess the value for money of the NGOTGP or SMSDGF as a whole. Some key informants from the NGO sector were concerned about the burden of work undertaken by NGOs to meet their contract obligations, particularly smaller organisations. This has salience in view of our finding that the NGO sector does not have a clear understanding of how the Commonwealth uses its Progress Reports. The Commonwealth's grant management reform process, , particularly the establishment of a 'Risk Rating Process', is intended to substantially reduce reporting requirements for low risk organisations and projects, and to establish consistent contract management and reporting approaches for organisations and projects with a similar risk rating..

The Commonwealth's assurance that funded projects provide 'value for money' is implied through its monitoring of an organisation's progress against the project plan. Yet, there is some concern amongst STO key informants that their ability to monitor value for money is hampered by this approach. The performance measures tend to be output/activity based, and there was a groundswell of support amongst key informants from all sectors for outcome-based reporting; although the consensus view is that the development of suitable measures was fraught. There is movement towards developing outcome measures in several states.

The Commonwealth funds a significant number of organisations that are also funded by the state/territory government. There are inherent difficulties in apportioning outcomes to particular sources of funding within a project, or even particular sources of funding within an agency. There is an argument that funded agencies having to report to both jurisdictions is not consistent with the proportionality principle.

The Commonwealth is concerned to assess value for money of the grant programs as a whole, but has yet to develop an approach. The National Commission of Audit highlighted the fact that the Commonwealth's Budget Reports have not to date reported on the activities and associated performance measures undertaken as Drug Strategy programs (which includes NGOTGP and SMSDGF P1).

Three-year contracts for AOD treatment service delivery that do not include interim reviews and the option for renewal / extension are problematic for service establishment, routinisation, and sustainability.

The questions considered in th

2005, p. 438). This is also integral to satisfying the probity and transparency principles (Department of Finance and Deregulation, 2013). Ensuring consistency in what triggers the Commonwealth's release of the tranches of funding is key; that is, how the progress reports are monitored and assessed. The Commonwealth's ongoing reforms are intended to further standardise and streamline grants management and monitoring processes; while allowing STO staff some flexibility in their day-to-day management of contracts. The demands of contract management and reporting on

Nonetheless, assessment of the 'value for money' of a grant program as a whole, requires a population-level analysis relating to the objectives of the program rather than the level of activity, such as is undertaken for the Report on Government Services (ROGS)

For core AOD treatment, which by its very nature needs to be long-standing, agencies require secure funding to make a commitment to enduring effective service provision and continuous quality improvement. This requires planning. A regular competitive tendering process every three years is time-consuming and costly for agencies. We learnt that it can take away from the provision of treatment services and is not equitable; making it more difficult for small agencies to compete with larger ones. It inhibits agencies from planning and makes it difficult for agencies to attract and keep quality staff, which has the flow-on effect of discouraging agencies from training staff. We heard from some in the NGO sector that once trained in AOD treatment, AOD workers can find conditions

Relationship to Principles

The purpose of contract management and monitoring is to ensure that the community obtains the best ‘value for money’ from public money; the goal being to maximise the health outcomes for

Where possible, combine Commonwealth's project-level performance monitoring efforts with state and territory governments when a project is jointly funded.

to commence a longer-term reform agenda, coupled with the need for shorter-term decisions in order to proceed with the 2015 grants round.

The Figures provided in this chapter are a schema of the options and paths. These are necessarily simplified and should not be read in isolation from the accompanying text. The text outlines the contingencies for the options, the strengths and weaknesses of the options and the associated outcomes. There are more details regarding the planning options in Chapter 13, the purchasing options in Chapter 14, and the accountability options in Chapter 15. The shorter-term path has been configured with the 2015 funding round in mind, but taking this path does not and should not preclude taking action along the longer-term path.

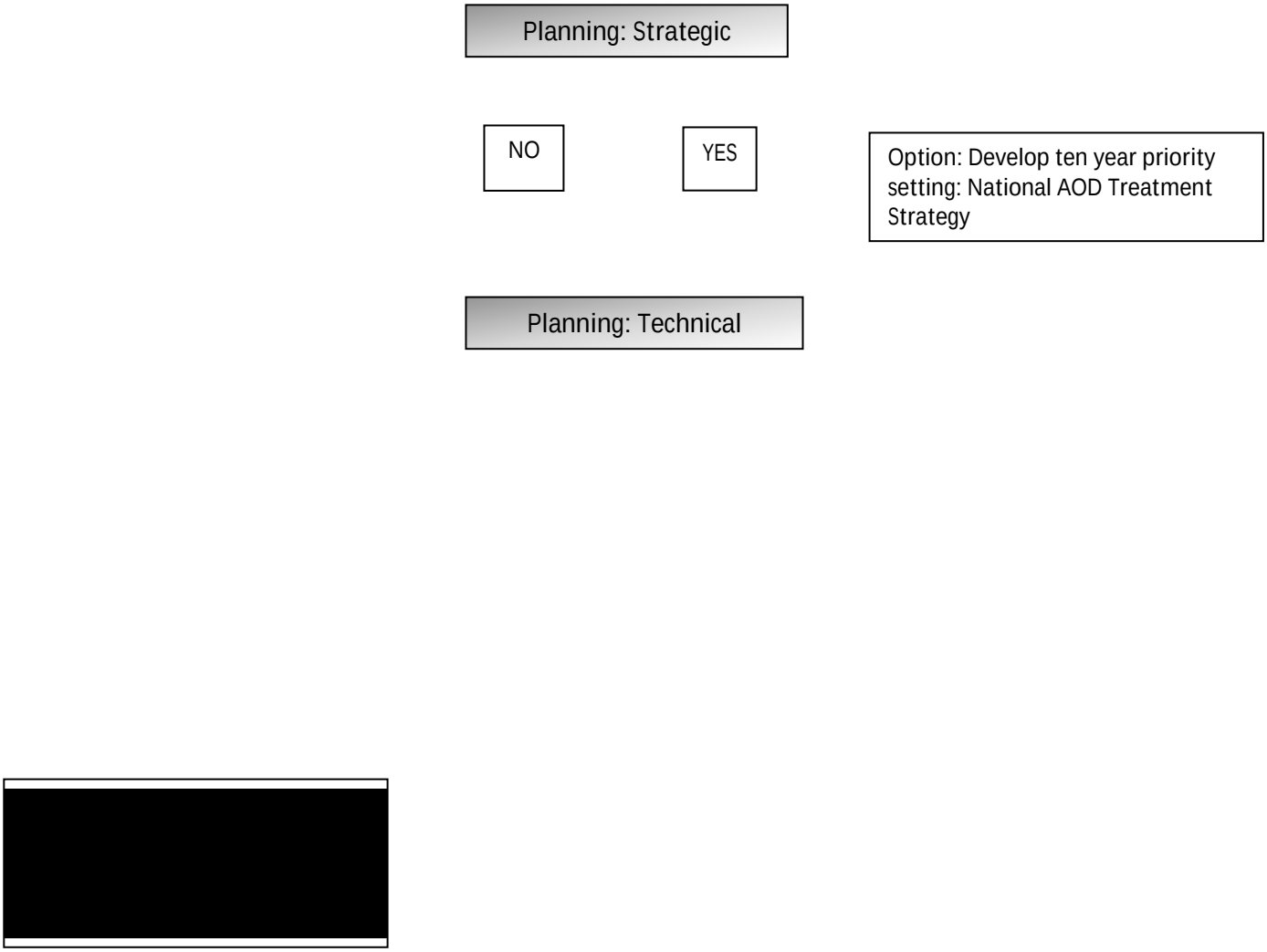
Commonwealth planning, purchasing and accountability

Planning processes

Figure 16.1 provides the decision-tree for planning, with the shorter-term and longer-term paths. It should be noted that progress can begin on the longer-term options, while the shorter-term options are deployed for the 2015 grant round.

In the longer-term, a nationally endorsed ten-year AOD Treatment Strategic Plan would specify the roles and responsibilities of each funder (state/territory and Commonwealth) and identify the priority service types, population groups and locations for funding.

Figure 16.1: Decision tree: Planning



funding mechanism). A competitive process (open, preferred provider, targeted or selected) can then be undertaken. The choice between the different competitive processes is determined based on what is being purchased and an assessment of the likely number of potential providers (for treatment and for capacity building), as well as their experience and links with other parts of the sector. The development of unit costs will take some time, and would not be available in the short-term.

In the short-term, an immediate question is the extent to which the priorities for 2015 grant round (as determined by the short-term path represented in Figure 16.1 above) result in a similar or different array to what is currently being purchased. Where there is little difference, and states/territories consider that the current Commonwealth investment articulates with their plans, the principle of proportionality would suggest that a highly targeted processes (such as selecting preferred providers based on current contracts) be undertaken. A minor review of current contracts/providers would allow adjustments where there are problems with services, changes in other funding resulting in viability concerns, or where the need for the project no longer exists.

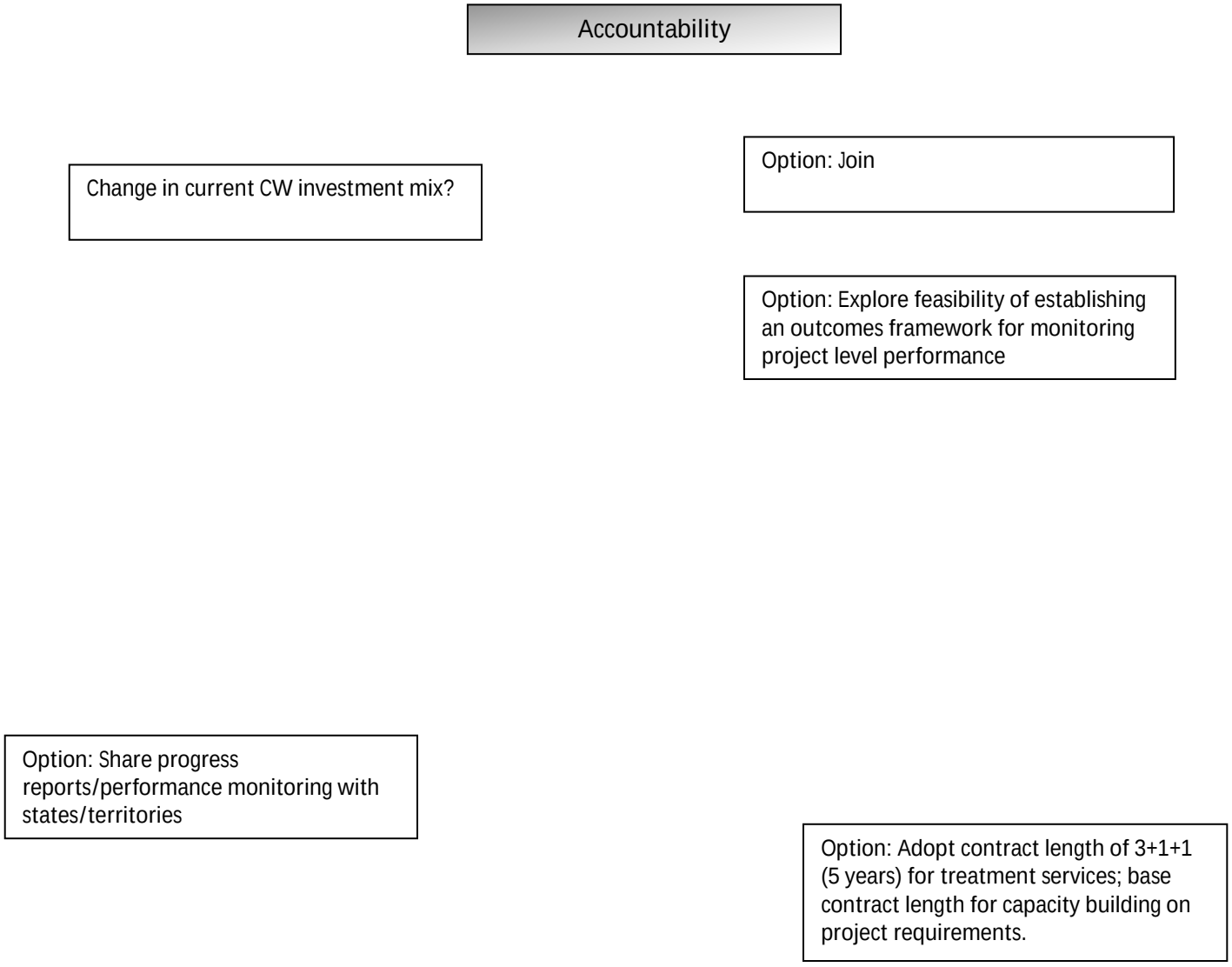
Where the 2015 priorities differ from current provision or there is an interest in purchasing from services not currently funded, a competitive process is an option. The choice between the different competitive processes is determined based on what is being purchased and an assessment of the likely number of potential providers (for treatment and for capacity building). For capacity building projects a targeted process may be preferable depending on assessment of the potential provider market. Clear specification of the priority areas for the grant round and engagement of states/territories in the assessment and selection process are important parts of the competitive processes in the short-term.

Contract management and performance monitoring processes

The decision-tree/schema for accountability differs from the others inasmuch as there are fewer contingencies (Yes/No options) here; rather, there are simply options to implement (see Figure 16.3).

In the longer-

Figure 16.3: Decision tree: Accountability



As discussed in Chapter 15, the Commonwealth has the option to consider the feasibility of establishing an outcomes framework for performance monitoring at the project level, in cooperation with the states/territories. A feasibility review could also consider the possibility of using the Quality Framework and fixed unit cost per service type alongside activity indicators, rather than an outcomes framework. A suggested starting point is an independent evaluation of the usefulness of the outcome based indicators for the 2012-2015 funding round.

Option: Explore feasibility of establishing an outcomes framework for monitoring project level performance

In terms of showing the value for money of the programs themselves, the Commonwealth could consider developing population level measures of program outcomes, based on the objectives of the

NGOTGP and SMSDGF P1 schemes. The NGOTGP objectives have parallels with the ROGS indicators for health programs (see Chapter 15). Collaboration with the states/territories would be beneficial for this work, as all levels of government need to demonstrate program outcomes.

Chapters 6 and 14, there are two ABF models that may work here: the hospital ABF system (via NHFP payments) and a variation of that, using unit costs as the basis for state/territory payments.

Both of these ABF options have as a key feature that the Commonwealth is involved in providing funding, but not in the determination of the planning or the mix of service types, nor the contractual elements with providers (see Chapter 14). A feasibility study is required before the design and implications of these options can be fully understood (see Chapter 14) and hence they are not options available for the 2015 grant round.

The Commonwealth could use the current ABF hospital funding system to provide funds for AOD treatment. Establishing the diagnostic-related groups and price weights is a highly technical and data intensive process, which would require substantial resourcing. This is some time away, and may not be feasible. Currently for hospital ABF the Commonwealth contributes 36.5% of the national efficient price. We understand that with the May 2014 Federal Budget there may be changes to the ABF system, including the proportion of Commonwealth contribution and the governance structures. In addition, some significant concern has been expressed by experts as to the extent to which the ABF system is suitable for non-admitted care and more specifically suitable for AOD treatment given the large variability in practice and lengths of stay. There are other complexities: do only those AOD

and quality frameworks; and leading national planning processes, and providing planning tools. So the work of the Commonwealth would include leading the ten-year National AOD Treatment

PART 3: CASE EXAMPLES

Case studies are an established social science method that provides an in-depth investigation of complex social phenomena (Yin, 2009). They are useful for describing and understanding 'how' or 'why' something works in a contemporary context (Yin, 2009).

For the purposes of the Review, nine cases were chosen to illuminate aspects of the Review under

funding); 10% of activities are funded through fee for service (primarily through clients' Centrelink contribution to treatment in residential programs, as well as fee for service for training programs which are nonetheless heavily subsidised); and 8-9% of activities are funded through donations, trusts and foundations, philanthropic/corporate support. Participants noted that this final category of funds "fills gaps" and is used to supplement programs and resource capital works, as well as fund discrete programs and innovations (e.g. employment programs; financial counselling; community
s

Although programs may be discretely funded, there is a sense of "cobbling together" the wrap-around services for the client. The organisation aims to provide services in a holistic way for clients. It is the organisation's general practice to engage clients in other specialist community services where possible, and to provide in-house services for those clients who are unable to negotiate external networks/resources and transition them to community supports over time. The organisation works with a complex group of clients, and in the organisation's experience they have seen better outcomes in terms of long term recovery if more services can be delivered in-house for complex clients. This said, the organisation aims to integrate into the community and partners with other services and co-locates to provide holistic and integrated care for clients.

Funding processes

The organisation uses a range of processes for securing and maintaining funding. It was noted that although the program logic of what the organisation wants to deliver is strategic and well-considered, the process of seeking funding from multiple sources is more "ad hoc" given the different trusts, foundations and government departments from which they seek funding.

The organisation e6cw.04 Tf1 ,ut5t04 Tf1 0u.p[(d)3(iff)31

organisation is open to sharing the learnings gained through those meetings, but not all larger organisations are as open with other organisations in the sector.

Partnerships/consortiums

Working with consortiums was regarded as essential to bring about real change in a sector reform environment, and can generate "generosity" between organisations, but one participant noted that it would be "crazy" to be reconfiguring consortium arrangements every few years for tendering purposes.

The organisation which is the subject of this case study had already been leading a process to

the system leads to greater integrated care and case coordination across services. Importantly for funding requirements, the system also produces reports for funders so “we’re not double handling data”. The system has been developed such that reports can be generated in different formats for different departments and funders. One participant noted that the sophistication of the system which had been developed was important not only for administration, but also for the delivery of integrated care for clients: “We work in a messy field, with complex people – there’s going to be mess. It’s just who carries the mess… a lot of the reforms in [the state] are trying to prevent the

waiting on decisions regarding roll-over of contracts with existing funders is incredibly frustrating and problematic for organisations and especially for staff retention. It was said that informing services less than 3 months out regarding whether or not a contract would be rolled-over should not be permitted. Holding over decisions and giving short notice showed “disrespect” to organisations, and it was suggested that in these cases the funding should be rolled over for another year. In an environment where the continuation of funding is uncertain due to short notice decision-making, the organis

are performing well to re-tender every 3 years). This would also alleviate some of the anxiety that goes with not knowing if a program is going to be refunded.

It was also suggested that after a program is established, a preferred provider model would be a better model for the continuation of Commonwealth funding. This would increase efficiency by minimising the data collection, acquittal and reporting requirements of competitive tendering. The rationale for this was that if organisations already have a good track record with the funder and are working within a quality framework, then the government should support that.

The role of Commonwealth funds (NGOTGP/SMSDGF) in relation to NGO providers

Participants suggested that the strength of the Commonwealth funding has always been that regardless of whatever strategy a particular state/territory government may be emphasising, the Commonwealth funding "fills in the gaps and some of the fallout". This could apply geographically, or in terms of particular populations, especially those difficult to reach (e.g. Aboriginal and Torres Strait Islander, CALD), or may encourage the development of niche projects that the state government may not want to take up (for this organisation, this included child and family programs, and residential programs in a state with a low number of beds per capita). The Commonwealth funding allows the organisa ə Ü f o e orga Ư v 6 a ə

Although the participants spoke positively of partnerships, they also expressed some concerns about these partnering processes. It was suggested that because tendering timeframes are so short, agencies were forced into partnering with other agencies who may not share the same philosophy or standards of care. This cM

In discussing procurement and tendering processes, it was suggested that previous reports given to government by organisations should tell the government about an organisation's capacity and

/ l·ăŜ ŜÈl·YˈLJfŜY 5ŜLJl·ŊűYˆŜyű 2₮ ±ŜűŜŊl·yãΩ ! ₮₮l·ŻŊă

The review of Alcohol & Other Drug (AOD) services being conducted for the Commonwealth is exploring a variety of funding models for alcohol and other drug (AOD) treatment. Funding options include block funding, fee-for-service funding and capitation. The processes for purchasing services include competitive tendering and preferred provider panels. This case study sought to explore in more detail one possible funding model, currently being explored by the Department of Veterans' Affairs (DVA). DVA's model of purchasing health care services evolved following the devolution of repatriation hospitals in the mid-

Identify strategic objectives and priority actions to guide mental health policy and programs; and ensure the best possible outcomes for individual mental health and wellbeing."

The strategy underpins a commitment of $26.4 million dollars over four years (in addition to existing funding of $166 million per year

Case example: Partners in Recovery

PIR organisations have access to a flexible fund to purchase services (although it is noted in the *Program Guidelines* that "it is important that in the main, PIR clients access services available within the existing network of service providers, rather than build a reliance on the flexible funding", p.9)[132].

What was the PIR tendering process?

A very specific approach to competitive tendering was used for PIR. The tendering process included

PIR organisation for that Medicare Local geographic region; and enable realistic achievement of PIR objectives within a region."

Lessons for the AOD treatment sector?

PIR provides a highly instructive example of an approach to market which may be worthy of consideration for AOD treatment funding.

In particular, the extensive information and support provided to tenderers by the Department throughout the process is notable. The approach used in the PIR tendering process is uncommon in this regard, and has not been characteristic AOD tendering processes to date. Althouu6a. Alt 371.11 665.620(ecBT1)-3

service delivery, which meant the initiative was positively received by the sector. The information sessions explicitly emphasised that PIR was designed to complement, not replace or usurp, the existing service system.

It is interesting to compare the language and emphasis of the PIR tender documents, with those provided for the Substance Misuse Service Delivery Grants Fund (see http://www.health.gov.au/internet/main/publishing.nsf/Content/6A1EDE4D55F78EF3CA257BF0001C11E4/$File/guide.pdf). Although 'building capacity' is said to be one of the primary objectives of the SMSDGF, cross sector partnership is not nearly as emphasised this this document as it is in PIR. The emphasis of SMSDGF is far more on funding individual service delivery, rather than facilitating coordinated care. This comparison highlights the divergence of these two approaches. This case study thus raises a key question: whether AOD treatment funds should be directed towards service delivery per se, or also provided for capacity building activities which aim to build a network of clinical collaboration across services.

Finally, the emphasis on partnership at the core of the PIR approach sits within the wider context of consumer and community engagement in health (Duckett & Willcox, 2011). As noted in other case studies (see the 'role of drug user organisations in supporting treatment' case study), the principles of participation have been better developed and integrated in the Mental Health sector. These principles need to be strategically and intentionally fostered within the AOD sector to ensure better engagement and improved health outcomes.

> Plan. The achievement of an Episode of Care requires the attainment of at least one significant treatment goal in accordance with the service-type specification (Victorian Government Department of Human Services, 2003, p. 12).

The 2010-

- an equivalent full time worker (38 hours per week);
- a residential service whose outputs are separations per bed per annum based on average lengths of stay;
- a service where a team of workers may be involved in order to deliver the required Episodes of Care; and
- other services (Victorian Department of Health, 2010, p. 7).

In addition to unit prices, indicative amounts of EOC per FTE / bed separation were provided for 2010-11. For example, the activity level performance target for an equivalent 1 FTE of adult

TE

Intake and referral – face to face

Arguably, the approach to purchasing services should sit alongside a process for measuring outcomes – without confusing the two.

The introduction of ABF to Victoria, with a single unit price and total funds set by catchment, brings a level of transparency and clarity regarding what is being purchased and for how much. The level of articulation with the actual cost of service delivery is not apparent and it would be prudent to schedule in reviews and adjustments over time. Importantly, the introduction of the unit price is being accompanied by major structural reforms (e.g., catchment based planning, reduced service types, an indicative outcomes framework, centralised intake and assessment). Major change is difficult and unravelling the advantages and shortcomings of the new model within this context will be challenging. Nevertheless, the ABF model provides a structure that can easily accommodate adjustments each year (i.e., based on CPI, professional agreements, and so on) and allow for changes in service types. Further evolution of ancillary elements of good sector planning will have an integral relationship with the success of this approach to purchasing services.

Case example: the role of drug user organisations in supporting treatment

In this case study, we turn our attention to the notion of 'supporting treatment'. There are many organisations and services within the AOD sector that play a particular role in supporting people who use alcohol and other drugs to reduce the harmfulness of their substance use, and to encourage and support access to treatment. These services and organisations exist alongside the formal treatment service system but perform an essential role in facilitating entry to treatment. The Medically Supervised Injecting Centre in Sydney is one such example. Many needle syringe programs and outreach workers also perform harm reduction and treatment support functions, as do some of the state and territory peak bodies. The Association of Participating Service Users (APSU) is another example of an organisation which provides a number of support functions for people who are engaged in treatment.

Within this broader context, for the purposes of this case study we have chosen to focus on one particular group of organisations that provide supporting treatment functions. The following case study provides an in-depth investigation of peer-based drug user organisations which work with and for marginalised populations of people who inject drugs, and describes the role they play in supporting treatment. We acknowledge that peers may be actively engaged in many alcohol and other drug services and organisations, for example as peer-workers or treatment consumer representatives. As such, this case study of only peers through drug user organisations is not generalisable across the breadth of organisations which support treatment, but rather is illustrative of the role played by one specific group of organisations who support treatment within their charter of representing people who inject drugs.

The focus of this case study is on how peer-based drug user organisations support AOD treatment in Australia, and the associated challenges regarding funding and funding processes for drug user organisations as treatment support providers. We begin by providing the context for our analysis, and then describe six activities that the drug user organisations consulted in this case study identified as core supporting treatment functions. We then describe the associated challenges identified in the case study: funding; contracting and organisational viability; reporting and monitoring; health policy context; and acceptability of the role of drug users in supporting treatment.

Context

There are three key issues which provide the context for this case study: the role of consumer participation in health care as an overarching principle; the effectiveness of consumer participation and peer-based interventions; and, specifically for the drug treatment sector, the marginalisation and stigmatisation of people who inject drugs.

There is an extensive literature on consumer[138] participation in health care. Examples of different models and approaches to consumer engagement in health policy have been documented across developed nations (Tritter & McCallum, 2006). Consumer participation is regarded as a fundamental part of an accountable health system (Duckett & Willd

resources on their drug treatment information webpage (http://www.nuaa.org.au/index.php?option=com_content&view=category&id=9&Itemid=26).

The way treatment access points are integrated into the everyday activities of drug user organisations highlights the importance of long-

Another key activity has been capacity building within the sector to facilitate greater consumer involvement (an activity which overlaps with advocating for better treatment policies, as above). One consumer participation project (the "Change Project" in NSW) was said to have generated significant culture change within the services it targeted including increased quality of treatment delivery, better experiences for service workers, and a more positive experience for treatment consumers at the service.

Research has also been undertaken by AIVL to inform the development of resources to ensure consumer input into treatment services. The 'Treatment Service Users Project' (Australian Injecting and Illicit Drug Users League (AIVL), 2008, 2011) aimed to describe the current arrangements for consumer participation and to determine the extent of support for consumer participation in the planning and delivery of drug treatment services in Australia. The phase one report found that unlike in the mental health sector, there are few examples of consumer participation policies within the drug treatment sector and a lack of understanding within the sector about the meaning and practice of consumer participation. It was also shown that communication gaps about opportunities for engagement exist between treatment providers and consumers. Following these initial findings, the second phase of the project involved a peer-driven action research project which aimed to refine and implement the model of consumer participation in drug treatment services which had been developed, and evaluate its implementation (Australian Injecting and Illicit Drug Users League (AIVL), 2011). These two reports have been a valuable resource for consumer participation in the Australian drug treatment sector and provide one example of how drug user organisations have contributed to capacity building within the sector.

Challenges associated with providing these treatment support functions

There were a number of challenges identified by the drug user organisations in undertaking these various supporting treatment functions. These include:

- Funding
- Contracting and organisational viability

Treatment Advisory Committee; Pharmacotherapy Advocacy and Action Team; and the Women and Prisons Group (see http://www.cahma.org.au/represent.html).

In discussing consumer participation, drug user organisations noted that without dedicated funding to sustain these activities, the ability of drug user organisations to continue to perform these

organisations argued that they are uniquely tied to communities of people who use drugs, and this is their core function (not a side-function of another business or service model).
Consortium arrangements were regarded with suspicion by drug user organisations, the perception being that lead agencies disproportionately benefitted from such arrangements. Such arrangements were also perceived to entrench the weaker position drug user organisations, compared to other more powerful agencies in these arrangements. Consortium arrangements were regarded to only be appropriate in situations where the power was shared equally amongst organisations and all organisations shared equal standing in the community. The stigmatised position of people who use drugs, and also the peer-based organisations who represent them, make this difficult.

3. Reporting and monitoring

Drug user organisations recognised the importance of reporting for accountability, and hoped that reports prepared

Participants argued that the capacity building and advocacy roles played by drug user organisations are essential for ensuring consumer participation across the drug treatment sector. It was noted by the drug user organisations that unlike mental health where consumer participation is valued and normative practice at all levels of service delivery and policy deliberation, in the AOD sector drug user organisations are frequently left out or disregarded.

Because consumer participation is not embedded or mandated practice in the AOD treatment sector (as the Treatment Service Users research showed: Australian Injecting and Illicit Drug Users League (AIVL), 2008), there continues to be uncertainty and ideological debate about who should do consumer engagement. This undermines the legitimacy of drug user organisations as expert and experienced providers. The drug user organisations asserted that they are best placed to lead and implement consumer participation programs, build capacity amongst peer-workers and volunteers, and liaise with services. In the consultation, an example was given of one LHD in NSW which was employing a part-time consumer representative themselves within the treatment service, rather than partnering with NUAA to oversee consumer engagement. It was emphasised in the consultation that "this is not [the LHD's] job", and that such arrangements create power imbalances within the service in the absence of the drug user organisation's experience and support. This example highlights the importance of independent support (in accordance with the healthcare literature, where consumer participation mechanisms are generally legislated and independent from the healthcare policy and provider system).

As noted in the context above, the AOD sector is yet to have an agreed and shared language around 'consumers', 'drug users', 'treatment service users' and so on. This lack of agreed terminology (and often lack of person-centred language) creates confusion when talking about 'consumer participation' between consumers of drugs and consumers of treatment. The language of 'consumer' has been borrowed from the mental health sector (which distinguishes between carers and consumers) but from drug user organisations' perspective "the words don't work for AOD". Connected (but not limited to) the issue of appropriate use of language are underlying issues of stigma and discrimination encountered by drug user organisations (and more broadly, the people they represent). Indeed, the word 'consumer' does not covey the expertise required to fill the significant roles performed by drug user organisations, peer-workers and volunteer representatives. One example from the consultation is the highly skilled and dedicated peer-workers who staff the PAMS telephone service. These peer-workers have a depth of expertise and dedication, borne from both training and personal experience. Participants argued that the roles performed by consumer representatives and peer workers are specialist and cannot be performed by "just anyone off the streets".

Drug user organisations felt that there was little appreciation of the expert voice that experience brings, and a lack of understanding or respect for the specialist nature of their role by the AOD treatment and policy sector. Drug user organisations frequently encountered discrimination in the course of doing their job representing their constituents. There was a view that drug user organisations are perceived as being "not palatable", "not expert", "not evidence-based" and "unpredictable" by services and policy makers, despite their decades of effective engagement. Drug user organisations frequently encountered "disrespect and moralism" when sitting on advisory groups and committees. This discrimination was understood to stem from the stigma associated with drug use (and injecting drug use particularly) within society, and affected drug user organisations as a whole.

Text box: ACCHO and Drug User Organisations ς striking similarities

Drug user organisations are arguably similar to Aboriginal Community Controlled Health Organisations (ACCHO's) who are embedded within the community, constituted from that community and have the capacity to deliver services because of the community-controlled nature of the organisation. Drug user organisations are likewise intimately tied to their constituent community (people who use drugs) and provide services from this peer-base.
ACCHOs are controlled by, and accountable to, Aboriginal people in those areas in which they oper97C864 317.n

Sector capacity building

We interviewed the AOD state/territory peak bodies, asking them to reflect on their role in providing capacity building and supporting the Commonwealth's investment in AOD treatment. The responses centred around three main themes:

1. Sector coordination, networking and linkages within and between agencies, and government portfolio's;
2. Support for government implementation (e.g. interpreting national priorities);
3. Support for effective service delivery[145].

1. Sector coordination, networking and linkages

The peaks identified the importance to a national funder of effective and efficient sector coordination and networking. Investment by a national funder in purchasing services, where those services are well networked with others in their state/territory provides the opportunity to maximise clinical learning, to ensure consistent and reliably high quality service delivery which is informed by an understanding of what constitutes good practice, as well as clarity around how each service fits within and contributes to the larger AOD and health and welfare systems (and thus avoids unnecessary duplication of effort).

One example is the regular *Infosessions* held by the Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC). Every six to eight weeks, ATDC hosts a 60

Terms of Reference and presented the findings to the Standing Committee. A record of the proceedings will be shared with the sector.

Peaks may also play an "early warning" role for funders, helping to identify and communicate emerging priority topics or populations of concern. In this way, peaks can act as "sentinel canaries" for government, due to their close contacts with local services on the ground. For example, the ATDC conducts regional consultations and meetings with the membership to identify new and emerging issues. At one such forum, it was identified that a change in the delivery of sexual health services had led to an apparent increase in the number of young people presenting to the local NSP who reported the presence of an STI. As a member of the Hepatitis and HIV working group, the ATDC was able to raise this issue with those managing sexual health services in the state.

Another role for peak bodies is in gathering and synthesising the views of service providers to then feed into national planning and priority setting processes. As representatives of the NGO sector, peaks are well positioned to obtain and synthesise the views of AOD workers and agencies for the Commonwealth.

For example, the Victorian Association of Alcohol and other Drug Agencies (VAADA) has facilitated a number of consultations on a range of issues relating to the state government's planned recommissioning of AOD services in the state, including proposed changes to treatment types, funding models, client management systems and treatment principles. This will be followed up by a range of forums and other supports to the sector after the formal recommissioning process has been completed to ensure system integrity is not unduly compromised during the change management process.

The peaks are also well positioned to develop and refine data collection tools, and synthesise and disseminate this information. For example, the Qld Network of Alcohol and other Drug Agencies (QNADA) provides support to the sector to collect the national minimum data set (NMDS), which includes a telephone assistance line for workers. Through this service, QNADA identified a gap in the NMDS relating to the principal drug of concern codes for synthetic cannabinoids. This issue was raised with the Queensland representative on the AODTS-NMDS working group and a classification code for synthetic cannabinoids was added for the 2012-2013 collection.

The peaks are uniquely placed to observe trends in both patterns of drug use and changes in the treatment seeking population as they emerge, which is shared across jurisdictions via a monthly teleconference of CEO/EO's. In this way, the peaks are able to provide early information to governments of all levels around emerging trends, potential issues and the fidelity of policy implementation, which provides a level of protection to ensure limited funding pools are directed for maximum benefit.

3. Support effective service delivery

The peaks articulated a particular role in supporting effective treatment. This could occur through

standard with the Joint Accreditation System of Australia and New Zealand. In addition, there is now recognition of the value of continuous quality improvement across all AOD services in WA, including 'industry specific' application of evidence based practice. Services in the NT, Qld and SA are currently working with the Standard to shape their service delivery.

Peaks act as conduits to define what is meant by 'good quality' in the AOD treatment system and contribute to improved quality of AOD treatment through developing capabilities at an institutional or organisational level.

The SA Network of Drug and Alcohol Services (SANDAS) provides support to its members in adopting and implementing quality improvement approaches, frameworks and standards relevant to organisational strengthening and the services they provide. In 2013 SANDAS partnered with SACOSS to establish the NGO finance and quality improvement officer network. This network plays a role in systems and contractual aspects of capacity building and provides a forum for both state and Commonwealth funding bodies to more effectively and efficiently communicate and implement changes and seek feedback for their own quality improvement needs.

In much the same way that peaks can provide governments with early information on emerging trends, they are also uniquely placed to provide support to the specialist treatment sector to deliver services which are evidence informed and reflective of good practice.

9ÈúŜyű 2ŦΨăŜŐű2ℕΩ ℕŜLJℕŜăŜyűI٠úλ2yΣ I٠yŘ ℕ2fŜ 2Ť ăúI٠úŜкúŜℕℕλú2ℕè ŦdzyŘλyƎ

The above analysis provides an outline of roles that peak bodies have identified that they currently play or could play in the future. The examples given have been provided by the peaks.
The extent to which the current AOD state and territory peaks have the relevant agencies as members is an important consideration. Examination of the list of agencies which receive NGOTGP and SMSDGF (see Tables 17.7 and 17.8 below) demonstrates that approximately 80% are members of one of the state/territory peak bodies.

List of NGOTGP and SMSDGF funded agencies and their re[)]3(s)8(an)7 erre oe.TB

	Member of a peak body (Y/N)
Assisting Drug Dependents	Y
Bridges Incorporated	Y
Calvary Health Care Riverina Limited	Y
Community Restorative Centre	Y
Eleanor Duncan Aboriginal Medical Service (EDAMS) auspised by	

	Member of a peak body (Y/N)
CatholicCare NT	
Council of Aboriginal Alcohol Program Services (CAAPS)	Y
Drug and Alcohol Services Association Alice Springs Incorporated	Y
Forster Foundation for drug rehabilitation (Banyan House)	Y
Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation (NPYWC)	N

	Member of a peak body (Y/N)
Odyssey House McGrath Foundation	Y
One80TC	Y
On Track Community Programs	N
Orana Haven Aboriginal Corporation	Y
Pius X Aboriginal Corporation	N
Rekindling The Spirit	Y
Riverina Medical and Dental Aboriginal Corporation	N
South Coast Medical Service Aboriginal Corporation	N
South Coast Women's Health and Welfare Aboriginal Corporation (Waminda)	N
St Vincent's Hospital Sydney Limited	Y
[redacted]	

	Member of a peak body (Y/N)
Gindaja Treatment & Healing Indigenous Corporation	Y
GoldBridge Rehabilitation Services	Y
Gold Coast Drug Council (GCDC) Inc	Y
Institute for Urban Indigenous Health Limited	NA
Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare, Resource and Housing	N
North and West Queensland Primary Health Care Association Inc	N
Pormpur Paanth Aboriginal Corporation	Y
Queensland Aboriginal and Islander Health Council	NA
Queensland Injectors Health Network (QuIHN)	Y
Queensland Network of Alcohol and Other Drugs Agencies (QNADA) Ltd	NA
Royal Flying Doctor Service of Australia (Queensland Section)	Y
The Salvation Army	Y
The Gumbi-Gumbi Aboriginal and Torres Strait Islanders Corp	Y
The Uniting Church	Y

Case example: Healthcare planning approaches undertaken by Medicare Locals

The focus of this case study is on the processes of healthcare planning and needs assessment which have been undertaken by Medicare Locals since their establishment. Through the Rapid Assessment, it became evident that the various tools and approaches which have been used by Medicare Locals for conducting planning and needs assessment may be usefully examined in the context of planning for alcohol and other drug treatment, particularly for thinking about ways of assessing and responding to local community health care needs.

The Australian Medicare Local Alliance has hosted information on their website about the Medicare Local Planning Tool (http://www.amlalliance.com.au/policy-and-advocacy/medicare-local-health-planning-tool). The tool has been described as "a simple, online map-based tool that has been designed to help Medicare Locals with their service planning and the maintenance of local health service information. It provides access to a range of validated national population health data sets as well as health services information from the National Health Services Directory (NHSD). It is a tool that will evolve and expand as more data sets are added and underlying health service information is improved and integrated." This tool has been available to Medicare Locals as a service without charge[146]. The tool has been said to assist with planning in the following ways:

- It is a practical, visual tool that will help you to identify and visualise the health and social characteristics of your region - and Australia more broadly, assisting you in your needs assessments and subsequent service planning
- It will act as an easy platform with which you can update and maintain health service information as part of the National Health Services Directory
- It provides a framework to support health program development and analysis
- It draws on national information and data sets including:
  - Education, household, community and economic data
  - Population distributions and projections
  - Indigenous health
  - Mortality
  - Maternal, children, family, countries of birth
  - Prevention, chronic disease, MBS, aged care

Such a tool (depending upon whether appropriate data input is available) may also be relevant for assisting with the planning and provision of AOD treatment.
Based on the policy and advocacy documents and position papers available on the Australian Medicare Local Alliance website (http://www.amlalliance.com.au/policy-and-advocacy), it does not appear that AOD treatment has been a priority area to date.

Needs Assessment

Although the Commonwealth has required all Medicare Locals to undertake needs assessment, various Medicare Locals have presented different opinions about the level of specification and guidance which has been provided to successfully undertake these assessments. In Queensland it was suggested that "the Commonwealth policy documents provide little guidance or contextualisation on how those plans should be developed, or the extent of planning needed to drive effective and equitable health promotion and prevention work of Medicare Locals" (http://www.mnbml.com.au/content/Document/population_planning_report_1213.pdf, p.1). This opinion

(p.9). Again, the needs assessment was developed using extensive stakeholder consultation and data analysis through a collaboration between the SNSBML team and consultants.

Another example of planning processes can be seen in the ACT Medicare Local. The ACT Medicare Local has launched a Population Health Commissioning Atlas (http://www.actml.com.au/Uploads/Documents/ACTMLPopulationHealthCommissioningAtlas_web.pdf). O

Guide to procurement

As reflected in the comments above, the *Partnership Policy* aims to guide procurement processes with the not-for-profit[150] community sector (Government of Western Australia, 2011b). A range of funding and contracting options are included in the *Partnership Policy*, including a definition of the

Having provided an introduction to the purpose and scope of the *Partnership Policy,* we now turn to the ways in which the partnership approach has been articulated and the key parties to the policy.

Partnership as the core

The *Partnership Policy* is based on six partnership principles and six behaviours, which are reproduced in Table 17.9. In brief, the principles involve a commitment to shared outcomes, a collaborative approach to decision-making and working together, a partnership based on mutual trust and respect, with openness and transparency, recognising the value and contribution of both sectors, an enduring commitment to sector sustainability, and a commitment to empowering service users in planning, design and delivery. The behaviours comprise a focus on demonstrable improvements in outcomes, consultation on all significant issues, transparency in decision-making, an interdependent approach to service planning and delivery, working together for sustainability, and engaging citizens in planni

We have identifi

The creation of a Funding and Contracting Services unit in the Department of Finance to support both the public and not-for-profit community sectors;
Establishing a suite of standardised contract templates to reduce the administrative burden;
Coordination of a range of education and training initiatives (targeted at both sectors) to raise the awareness of the DCSP Policy and associated contracting reforms; and
Monitoring implementation of the DCSP Policy with updates provided to the Partnership Forum on the progress of implementation and emerging issues (Government of Western Australia, 2012)

Department for Local Government and Communities
Department of Racing, Gaming and Liquor
Drug and Alcohol Office
Office of Multicultural Interests
Office of Road Safety
Western Australia Police

The Western Australian Network of Alcohol and other Drug Agencies

The state's AOD peak body, the Western Australian Network of Alcohol and other Drug Agencies (WANADA), was established in 1984 and it is an independent, membership driven, not-for-profit

Implementing reform

From policy to procedures

In April 2013, 'Procedural Instructions' were released to accompany the *Partnership Policy*. The procedural instructions include guidelines regarding grants and service agreements along with standardised contract planning, development, and management templates (Government of Western Australia, 2013). Our focus in this case example is on aspects of the process that specifically reflect a partnership approach.

The role and responsibilities of the contract manager include the area of relationship development and management, where "the need for cooperative and non-adversarial relationships with Service Providers is paramount and DAO [Drug and Alcohol Office] will endeavour at all times to maintain open communication and a joint and mutually beneficial approach to problem solving" (Government of Western Australia, 2013, p. 16).

"Continuous dialogue" between all stakeholders is advocated (Government of Western Australia, 2013, p. 16), which includes information sharing and a proactive approach to identifying and resolving areas of potential concern.

A number of other procedural elements are supportive of a partnership approach, for example

There is extensive policy and sector investment in the *Partnership Policy* and in the reform process. DAO said that,

> The partnership forum sits above the minutiae of reform activities. There is a common agenda across government and including the sector. The process recognises the expertise of providers. We [DAO] have been able to maintain sector enthusiasm for the change process.

And service providers commented that,

> The procurement process in WA is well regarded. It involves working in partnership and includes a learning process for all. There has been a strong investment in change management in government, involving lots of training, etc. The new arrangements give NGOs a voice and power in the procurement process. NGOs have equal say. Planning and procurement involves identifying the need, services designing the solution, and a process to determine service delivery.

Purchasing arrangements have allowed for continuity in service provision and the nature of the market. j j w y us

References

Abraham, A., Knudsen, H., Rieckmann, T., & Roman, P. (2013). Disparities in access to physicians and medications for the treatment of substance use disorders between publicly and privately funded treatment programs in the United States. *Journal of Studies on Alcohol and Drugs, 74*(2), 258-265.

Adams, D., & Hess, M. (2000). Alternatives to competitive tendering and privatisation: A case study from the Australian health industry. *Australian Journal of Public Administration, 59*(1), 49-59.

AEDS. (1982). *Alcohol Epidemiologic Data System*

Australian Institute of Grants Management. (2011). *Grantmaking Manifesto*. Melbourne: Australian Institute of Grants Management.

Australian Institute of Health and Welfare. (2012). *Australia's Health 2012*. Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2013a). *Aboriginal and Torres Strait Islander Health Services Report 2011-12*. Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2013b). *Alcohol and Other Drug Treatment Services in Australia 2011–12*. Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2013c). *National Opioid Pharmacotherapy Statistics Annual Data Collection 2012*. Canberra: Australian Institute of Health and Welfare.

Australian National Audit Office. (2013). *Implementing Better Practice Grants Administration: Better Practice Guide*. Barton, ACT: Australian National Audit Office.

Babor, T., Stenius, K., & Romelsjo, A. (2008). Alcohol and drug treatment systems in public health perspective: mediators and moderators of population effects. *International Journal of Methods in Psychiatric Research, 17*(Suppl. 1), S50-S59.

Bajari, P., McMillan, R., & Tadelis, S. (2009). Auctions versus negotiations in procurement: An empirical analysis. *Journal of Law, Economics, and Organization, 25*(2), 372-399.

Barbazza, E., & Tello, J. (2014). A review of health governance: Definitions, dimensions and tools to govern. *Health Policy, 116*(1), 1-11.

Beattie, M., Hu, T., Li, R., & Bond, J. (2005). Cost-effectiveness of public sector substance abuse treatment: Comparison of a managed care approach to a traditional public sector system. *Journal of Behavioral Health Services and Research, 32*(4), 409-429.

Becker, W., Fiellin, D., Merrill, J., Schulman, B., Finkelstein, R., Olsen, Y., et al. (2008). Opioid use disorder in the United States: Insurance status and treatment access. *Drug & Alcohol Dependence, 94*(1-3), 207-213.

Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L., & Lopez, A. (2007). *The Burden of Disease and Injury in Australia 2003* (Vol. PHE 82). Canberra: Australian Institute of Health and Welfare.

Begley, C., Lairson, D., Morgan, R., & Rowan, P. (2013). *Evaluating the Healthcare System: Effectiveness, Efficiency, and Equity*. Ann Arbor: Health Administration Press.

Berg, W., & Wright Jr, R. (1981). Program funding as an organizational dilemma: Goal displacement in social work programs. *Administration in Social Work, 4*(4), 29-39.

Beshai, N. (1984). Assessing needs of alcohol-related services: A social indicators approach. *American Journal Drug Alcohol Abuse, 10*(3), 417-427.

Best, D., Day, E., & Campbell, A. (2007). Developing a method for conducting needs assessments for drug treatment: A system approach. *Addiction Research and Theory, 15*(3), 263-275.

Best, D., O'Grady, A., Charalampous, I., & Gordon, D. (2005). *National Needs Assessment fD*

Brucker, D., & Stewart, M. (2011). Performance-based contracting within a state substance abuse treatment system: A preliminary exploration of differences in client access and client outcomes. *Journal of Behavioral Health Services & Research, 38*(3), 383-397.

Bryant, J., Saxton, M., Madden, A., Bath, N., & Robinson, S. (2008). Consumer participation in the planning and delivery of drug treatment services: The current arrangements. *Drug & Alcohol Review, 27*(2), 130-137.

Busch, S., Meara, E., Huskamp, H., & Barry, C. (2013). Characteristics of adults with substance use disorders expected to be eligible for medicaid under the ACA. *Psychiatric Services, 64*(6), 520-526.

Butcher, J. (2013). The national compact: Civilising the relationship between government and the not-for-profit sector in Australia. In R. LaForest (Ed.), *Government-Nonprofit Relations in Times of Recession*. Montreal: McGill-

French, M., Dunlap, L., Zarkin, G., McGeary, K., & McLellan, A. (1997). A structured instrument for estimating the economic cost of drug abuse treatment: The Drug Abuse Treatment Cost Analysis Program (DATCAP). *Journal of Substance Abuse Treatment, 14*(5), 445-455.

Green, A. (2007). *An Introduction to Health Planning for Developing Systems*. Oxford: Oxford University Press.

Gregoire, T. (2002). The validity of a social indicator approach to substance misuse needs assessment. *Substance Use and Misuse, 37*(3), 357-380.

Haley, S., Dugosh, K., & Lynch, K. (2011). Performance contracting to engage detoxification-only patients into continued rehabilitation. *Journal of Substance Abuse Treatment, 40*(2), 123-131.

Hall, C., & Rimmer, S. (1994). Performance monitoring and public sector contracting. *Australian Journal of Public Administration, 53*(4), 453-461.

Hall, J. (2010). *Designing the Structure for Australia's Health System*. Canberra: The Academy of the Social Sciences in Australia.

Hall, W., Teesson, M., Lynskey, M., & Degenhardt, L. (1999). The 12-month prevalence of substance use and ICD-10 substance use disorders in Australian adults: Findings from the National Survey of Mental Health and Well-Being. *Addiction, 94*(10), 1541-1550.

Hancock, L., & Mackey, P. (1999). Health care funding and rationing in health care. In L. Hancock (Ed.), *Health Policy in the Market State* (pp. 87-112). St Leondards, NSW: Allen & Unwin.

Harm Reduction Victoria. (2014). About PAMS. Retrieved 8 January, 2014, from http://hrvic.org.au/pharmacotherapy/about-pams/

Hoge, M., Jacobs, S., Thakur, N., & Griffith, E. (1999). Ten dimensions of public-sector managed care. *Psychiatric Services, 50*(1), 51-55.

Horgan, C., & Merrick, E. (2001). Financing of substance abuse treatment services. *Recent Developments in Alcoholism, 15*, 229-252.

Horgan, C., Reif, S., Ritter, G., & Lee, M. (2001). Organizational and financial issues in the delivery of substance abuse treatment services. *Recent Developments in Alcoholism, 15*, 9-26.

Houle, S., McAlister, F., Jackevicius, C., Chuck, A., & Tsuyuki, R. (2012). Does performance-based remuneration for individual health care practitioners affect patient care?: A systematic review. *Annals of Internal Medicine, 157*(12), 889-899.

McDonald, K. M., Schultz, E. M., & Chang, C. (2013). Evaluating the state of quality-improvement science through evidence synthesis: Insights from the Closing the Quality Gap series. *The Permanente Journal, 17*(4), 52.

McFarland, B., Deck, D., McCamant, L., Gabriel, R., & Bigelow, D. (2005). Outcomes for medicaid clients with substance abuse problems before and after managed care. *Journal of Behavioral Health Services and Research, 32*(4), 351-367.

Tenbensel, T., Dwyer, J., & Lavoie, J. (2013). How not to kill the golden goose: Reconceptualizing accountability environments of third-sector organizations. *Public Management Review*, advance online publication.

The Chartered Institute of Purchasing and Supply. (No date). Tendering and post tender negotiation Available from http://www.cips.org/Documents/Resources/Knowledge%20Summary/Tendering%20and%20Post%20Tender%20Negotiation.pdf

Thomas, R. (2003). *Health care planning*

Yin, R. (2009). *Case Study Research: Design and methods* (5th ed.). Thousand Oaks: Sage.

Zarkin, G., Dunlap, L., & Homsi, G. (2004). The substance abuse services cost analysis program (SASCAP): a new method for estimating drug treatment services costs. *Evaluation and Program Planning, 27*(1), 35-43.

Zarkin, G., Galinis, D., French, M., Fountain, D., Ingram, P., & Guyett, J. (1995). Financing strategies for drug abuse treatment programs. *Journal of Substance Abuse Treatment, 12*(6), 385-399.