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RESEARCH ARTICLE

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Understanding the costs of co-commissioning: Early experiences with co-commissioning in Australia

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Abstract

Public services, such as health and other human services, are increasingly being delivered by third-party providers (providers) under contract to public sector organisations (PSOs). While often advantageous to PSOs, this creates a fragmented service context which is difficult for consumers to navigate. Further, providers often deliver services under multiple contracts to multiple funders, with high reporting requirements, high administrative costs, and low operational sustainability. Policymakers have encouraged co-commissioning—where PSOs come together to jointly commission services—to increase the efficiency and effectiveness of outsourcing. This article seeks to understand the costs of co-commissioning in Australia, and consequently the enablers and barriers to co-commissioning. This qualitative study is based on the early experiences of co-commissioning by one of 31 Primary Health Networks (PHNs). Using transaction cost economics (TCE) theory, the study explains how the PHN started co-commissioning services with other PHNs, before co-commissioning with other types of organisations. The PHN also co-commissioned relatively simple activities first, before moving on to more complex services. The

insights provided using TCE theory help explain why co-commissioning is initially complicated (and costly), requiring time to understand both the services to be commissioned and the governance requirements of each party involved. While initial transaction costs may be high when co-commissioning, this may reflect organisational learning and capacity development costs - therefore, costs are expected to reduce over time.

KEYWORDS
co-commissioning, commissioning, contracting, outsourcing, primary health care

Points for practitioners

- Fragmentation in policy and funding also leads to fragmentation of human services and high costs to service providers.
- Co-commissioning is where multiple funders pool funds and strategically commission services together.
- Co-commissioning offers a way to reduce fragmentation and reduce costs to service providers, potentially offering better public value.
- Co-commissioning can initially take time and resources to establish.
- Over time, as organisations learn, the cost of co-commissioning reduces potentially offering benefits to funders, providers, and service users.

1 | INTRODUCTION

Human services,[1] such as health and social care, are increasingly being delivered by third-party providers (providers) under contract to government; this can be attributed, among other things, to political, economic, strategic, and practical considerations (Butcher & Dalton, 2014; Gallet et al., 2015; Hood, 1995; Kurunmäki, 2009). In Australia, multiple Federal and State/Territory public sector organisations (PSOs) outsource the delivery of a large range of human services to multiple providers, creating a poorly planned and fragmented service system which is difficult for consumers and other stakeholders (such as carer, general practitioner, or other service provider) to navigate and access (Australian Government, 2017; NZ Productivity Commission, 2015; Silburn & Lewis, 2020).

Where clients require more than one service, there is also a risk of poor coordination of care (Stafford & Stapleton, 2017), a need for care coordinators (Dessers & Mohr, 2020), difficulty for funders/providers in attributing outcomes to one program (Kominis & Dudau, 2012), and a lack of government accountability for services delivered (Bovaird, 2016; Gallet et al., 2015). This fragmentation of services also impacts service providers who operate under multiple relatively short-term contracts, report to multiple funders, incur high administrative costs (PwC and Commissioning NSW, 2020), and experience high operational risk (the latter evidenced in the collapse of several providers in the United Kingdom; see Sasse et al., 2019).

Faced with increasing pressure on public finances, and a recognition that multiple agencies buy the same or similar services from providers (possibly leading to inefficiencies as well as service fragmentation), the public sector has started to encourage co-commissioning—where funders come together to jointly commission services (PwC and Commissioning NSW, 2020). Co-commissioning should lead to better, more integrated services, potentially achieving outcomes not possible in isolation, while reducing fragmentation as services become consolidated (PwC and Commissioning NSW, 2020). Further, co-commissioning can improve how organisations work together and reduce the differences between service models (e.g. between health and social models of services [Dickinson et al., 2013; Field & Oliver, 2013]). Co-commissioning is not necessarily easy—commissioning with one other party involves transaction costs (Booth & Boxall, 2016; Robinson et al., 2016), costs which are potentially magnified when commissioning with multiple parties. Different organisations are likely to have different commissioning policies and processes, and are likely to be affected by power or relational imbalances (PwC and Commissioning NSW, 2020)—particularly evident between different levels of government. As such, organisations may need to be encouraged or incentivised to co-commission services (Milward & Provan, 2003).

Transaction cost economics (TCE) is a theory which helps us understand the costs (hazards) of contracting. TCE theory assumes contracting hazards will occur because of human nature—rationality may be bounded by cognitive competence, and opportunism may arise (Williamson, 1979, 1985). The extent of contracting hazards is determined by transaction attributes (the nature of the activity being contracted); transaction attributes are identified as asset specificity (specific assets that cannot be redeployed), uncertainty (difficulty specifying and measuring activities; disturbances to activities), frequency (one-off or recurrent contracts), and probity (integrity) (Bates, 2022; Bates et al., 2022; Williamson, 1985). The way the same services are contracted by one organisation may, because of human nature, vary from another organisation due to both their cognitive competence and risk appetite in relation to opportunism. Therefore, when activities are contracted by multiple parties through co-commissioning, complications may arise due to the variations in governance arrangements and the risk management practices of each party.

While established in the United Kingdom (Checkland et al., 2018; Greener, 2015), co-commissioning is relatively new in Australia and has not been considered in depth in the commissioning literature (Gardner et al., 2016; Robinson et al., 2016). Examining how this is operationalised in Australia contributes to the evidence base for co-commissioning for a wide range of funding agencies. This article empirically examines one organisation's early experiences and learning in co-commissioning services and, relative to other commissioning activities, seeks to understand the costs of co-commissioning in Australia and the enablers and barriers to co-commissioning.

The empirical setting is the commissioning work of a Primary Health Network (PHN) operating in NSW Australia. The PHN Program, contracted by the Department of Health (DoH), specifically asks PHNs to consider co-commissioning primary healthcare services with other stakeholders. Co-commissioning has also been identified as a priority by PHN staff—both in terms of co-

commissioning with other PHNs and with other PSOs and non-government organisations (De Morgan et al., 2022). Given the slow initial uptake of co-commissioning in the PHN Program's early years, and further efforts introduced to promote co-commissioning in primary health, this article uses a case study of one PHN's early experiences with co-commissioning to (1) understand the need for co-commissioning of primary healthcare services in Australia, (2) identify enablers and barriers to co-commissioning, and (3) identify considerations for future co-commissioning. This improves our understanding of the costs of co-commissioning human services.

This article first establishes the conceptual framing of TCE theory which identifies the characteristics of parties to transactions, along with a definition of co-commissioning and an explanation of the research setting. This is followed by the research methods. The results and implications clearly identify the high initial costs associated with co-commissioning activities, but note that these costs appear to decline as the organisation learns more about the co-commissioning hazards. The article concludes by identifying contributions to policy and practice of co-commissioning, contributions to the evidence base of TCE theory, and the study limitations and opportunities for further research.

2 | CONCEPTUAL FRAMING

This study uses TCE as the theoretical lens to understand the costs of contracting and in particular, the costs of co-commissioning. Given the different terms used in academic and practice literature, this section also provides a definition of co-commissioning. This is followed by an explanation of the empirical context.

2.1 | Understanding the costs of contracting

TCE theory provides insights into the cost of contracting by considering *parties to the transaction* (bounded rationality and opportunism) and the *nature of the transaction* (asset specificity, uncertainty, frequency, and probity) and how they interrelate (Williamson, 1979, 1985). TCE theory can provide insights into whether to contract a service (if costs are too high, then the activity should be internalised), and depending on the nature of transaction costs, how the activity should be organised.

TCE assumes contracting hazards will occur because of human nature—in particular, due to bounded rationality and opportunism. Rationality may be bounded by cognitive competence where people and organisations may intend to be rational but are limitedly so based on incomplete knowledge and difficulties of anticipation; this results in incomplete contracts due to the prohibitive cost of anticipating every eventuality (Williamson, 1985, p. 45). Opportunism (self-interest seeking with guile) is where people and organisations seek to maximise outcomes (Simon, 1997; Williamson, 1979, 1985); examples of opportunism include 'adverse selection, moral hazard, shirking, [and] sub-goal pursuit' (Williamson, 2000, p. 601). Examples of opportunism are evident in the outsourcing of human services including 'creaming' where clients are targeted who require less support and 'parking' where clients with high-level needs are underserviced (Carter & Whitworth, 2015; Dickinson, 2016). Opportunism can be minimised where parties interests, objectives and values align (Brown et al., 2006; Considine, 2003; Kettner & Martin, 1990; Williamson, 2000). Governance structures (contracts) are used to minimise bounded rationality and safeguard against opportunism, the extent of which is determined by the transaction characteristics present

(Williamson, 1985, p. xiii). The organisation of governance structures is likely to be more complex when co-commissioning, even with other PSOs (Hodges et al., 1996), as bounded rationality and opportunism are likely to vary for each party.

The nature of the transaction also affects the hazards or costs of contracting. Transaction attributes are identified as asset specificity (specific assets that cannot be redeployed), uncertainty (difficulty specifying and measuring; disturbances), frequency (one-off or recurrent contracts), and probity (integrity). Primary healthcare services are likely to have low contractibility as they require significant investment in human capital and systems (high asset specificity); are often idiosyncratic, making them challenging to specify and measure and difficult to program (high uncertainty); are likely to be subject to disturbances impacting both service needs and service delivery (high uncertainty); are likely to be contracted for short periods due to government funding cycles (high frequency); and are likely to be subject to probity requirements arising from the source of funding as well as clinical governance requirements (high probity) (Bates, 2022; Bates et al., 2022).

Much attention has been given to the nature of the transaction environment, contracting parties, and the different transaction characteristics in terms of how they shape control choices (for an example, see van der Meer-Kooistra & Vosselman, 2000). Applying TCE theory to co-commissioning allows us to further explore the hazards or costs associated with having multiple buyers involved in the transaction—that is variations in bounded rationality and opportunism—and how those hazards may be managed.

2.2 | Understanding co-commissioning

There are various terms used in the academic and practice literature (including policy, guidance reports) to describe instances where multiple funders jointly contract a third party to deliver services. One practice paper produced by PwC and Commissioning NSW describes 'joint commissioning' occurring on a spectrum from seeking consistency to coordination to collaboration, involving 'skin in the game… whether that be co-funding arrangements, shared risks or other in-kind contributions; shared accountability and decision-making; and formalised partnership arrangements' (PwC and Commissioning NSW, 2020, p. 5). Others use the term co-commissioning to describe the engagement of citizens in the commissioning process (Loeffler & Bovaird, 2019)—rather than co-funding—more akin to collaborative commissioning described elsewhere (Koff et al., 2021).[2] Others acknowledge the terms co-commissioning and joint-commissioning are used interchangeably (DoH, 2016). The DoH, for the purposes of the PHN Program, describes joint commissioning as follows:

> In the PHN case, joint commissioning would be the process by which two or more organisations would commission or procure services or outcomes that they had collectively agreed as being important. This might be from joint, pooled or bundled funding and would typically be underpinned by a single contract with common performance and payment arrangements. Such an arrangement is likely to reflect an agreement by the bodies on a common interest/purpose/need for which outcomes or services would be commissioned. (DoH, 2016, p. 6)

While co-commissioning could refer to collaboration across the commissioning process, for the purpose of this study we understand co-commissioning to mean when two or more organisations

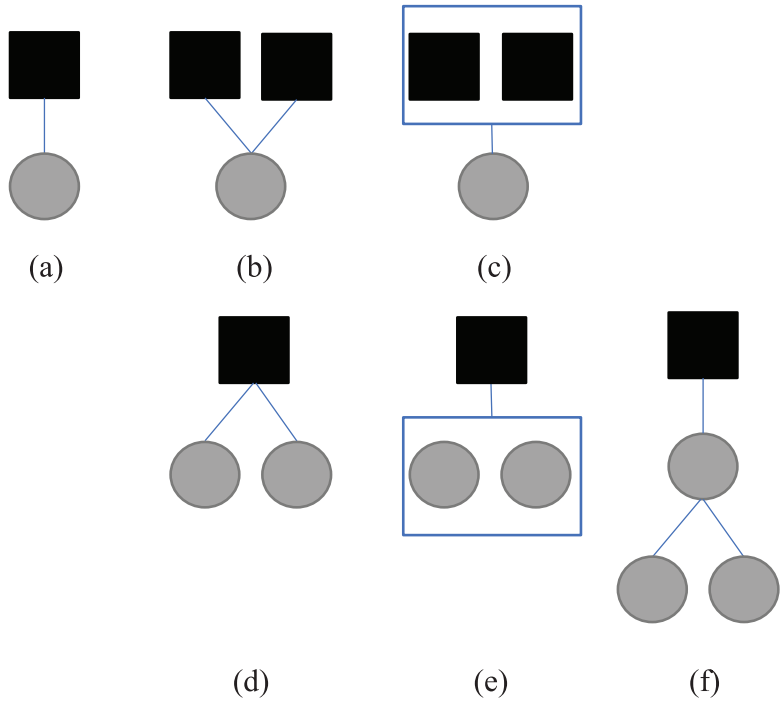

FIGURE 1 Configurations of contracting. Squares denote public sector organisation funders, circles denote providers, and lines denote contractual arrangements. Configuration (a) shows one-to-one funding, configuration (b) shows multiple funders of one provider, configuration (c) shows co-commissioning, configuration (d) shows purchasing from multiple providers, configuration (e) shows alliance contracting, and configuration (f) shows the prime contract/prime provider model. Configurations can also be used in combination, such as (c) and (e). Configurations can be used on their own or in combination. Other configurations, such as providing consumers with vouchers to use in the market, are not included here. [Colour figure can be viewed at wileyonlinelibrary.com]

procure services together under one contract. This is different to some models of commissioning often discussed in the literature (shown in Figure 1 below) where one funder contracts multiple providers to deliver the same service (notably, this can be done individually, through an alliance contract between all providers, and through a prime contract or prime provider model which outsources the contract management to another party who may or may not also deliver services [Figure 1d–f, respectively]; see Addicott [2014] for a full description of each).

2.3 | Understanding the context

The healthcare context in Australia is complex (see overview in Figure 2 below). The Commonwealth Government provides financial mechanisms that underpin different aspects of the healthcare system (Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme, co-funding of state/territory hospitals, and other subsidies and pensions); is responsible for specific policies and program areas (PHNs, aged care); and develops national health strategies as it deems necessary (e.g. mental health). State and territory governments manage and jointly fund hospitals, and provide emergency, preventative, and community services often through Local Health Networks/Districts (LHNs/LHDs)[3] and Aboriginal Community Controlled Health Organisations.

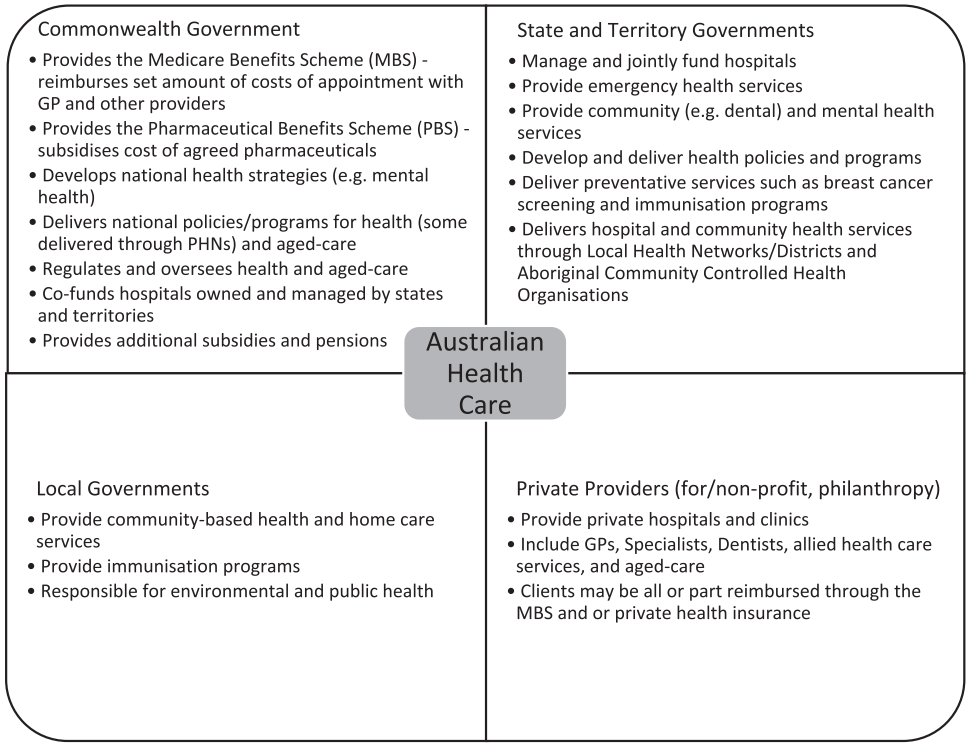

FIGURE 2 Overview of the Australian health landscape. *Sources*: health.gov.au/about-us/the-australian-health-system (accessed 18 July 2023), and Henderson et al. (2018).

(ACCHO). In addition, private providers and non-profit organisations provide hospitals, clinics, General Practices (GPs), specialists, dentists, allied services, and aged care (where clients may be all or in part reimbursed by the Commonwealth Government or through private health insurance).[4] Each party may deliver services directly or contract providers to deliver services on their behalf. Different actors may have overlapping and constantly realigning agendas.

The PHN Program, establishing 31 PHNs across Australia, was introduced by the DoH in 2016 to 'improve the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes', and 'to improve the coordination of care to ensure patients receive the right care, in the right place, and at the right time'. PHNs were not the first attempt to coordinate primary health care. The 31 PHNs replaced 61 Medicare Locals (established in 2011), which were a consolidation of the 119 Divisions of General Practice (established in 1995) (Horvath, 2014). During this transition, the scope changed from coordinating primary health care to coordinating and commissioning services to meet national health priorities (Henderson et al., 2018; Horvath, 2014). PHNs identify the health needs of their local area, support healthcare providers improve patient care, and address gaps in primary healthcare services to meet the needs of the local population through commissioning services. The DoH established seven priority areas, including mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged care, and alcohol and other drugs (Australian Government, 2022). PHNs work with general practices to improve the quality of care for the general population through practice improvement. The PHN Program is a relatively small program operating in a complex system of health services in Australia across jurisdictions, making coordination, cooperation, col-

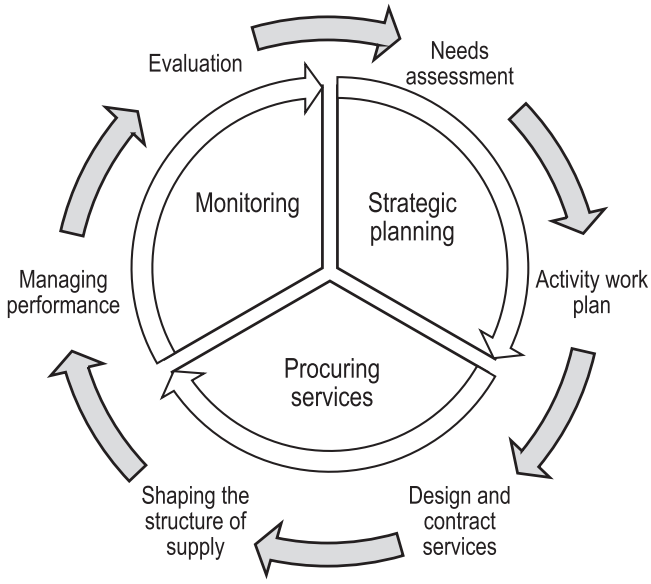

FIGURE 3 The Primary Health Network commissioning cycle. *Source*: DoH (2016).

laboration, and information sharing challenging (Freeman et al., 2021). Taking the provision of mental health services as an example, services may be accessed via Commonwealth services delivered by PHNs, via States/Territories through hospitals and community health services managed by LHNs/LHDs, and via private hospitals, specialists, GPs, and allied health providers (potentially reimbursed through the MBS). Therefore, PHNs need to work collaboratively with other stakeholders to identify and address needs, and leverage other funding available where possible.

Recognising both the fragmentation in healthcare funding and delivery, and the limited funding available to PHNs[5] (Freeman et al., 2021; Lewis et al., 2022), the DoH encourages PHNs to work with other partners (such as LHDs and LHNs) through the commissioning cycle (shown in Figure 3), from identifying needs through to procuring services. Specifically, the DoH encourages PHNs to jointly commission services where 'two or more organisations … collectively agreed as being important' (DoH, 2016, p. 6).

While every PHN has developed needs assessments of primary healthcare services with key stakeholders in their region (UNSW et al., 2018)—the preliminary stages of the commissioning cycle (Booth & Boxall, 2016; Robinson et al., 2016)—there were few early examples of joint commissioning where services are jointly contracted by two or more funders. The first evaluation of the PHN Program as a whole (all 31 PHNs) reported some evidence of 'coordinated commissioning', with PHNs working with state and territory health departments, as well as with other PHNs, in the planning and funding of services (UNSW et al., 2018). The evaluation also highlighted early examples of 'co-commissioning', often by PHNs who had mature relationships with their state/territory counterparts, sometimes facilitated by Memorandums of Understanding, highlighting the importance of relationships that underpin co-commissioning (UNSW et al., 2018). The evaluators reported that some PHNs found co-commissioning challenging as 'it required significant effort to develop a shared understanding and objectives, navigate funding allocations, share data and commence co-planning' (UNSW et al., 2018, p. 48). This is consistent with experiences in the United Kingdom where co-commissioning was successful in defined regions where there were 'long-lasting relationships' (Greener, 2015, p. 11).

Following the first evaluation, several initiatives have been used to promote and encourage co-commissioning. For example, PHNs and state/territory-funded LHNs/LHDs have been tasked with developing and implementing regional plans focusing on integrated mental health and suicide prevention services; this includes 'exploring innovative approaches such as co-commissioning and fund pooling to make better use of workforce and other resources, particularly in areas of workforce shortage' (Integrated Regional Planning Working Group, 2018, p. 52). A more recent example is *Australia's Primary Health Care 10-year Plan (2022–2032)* which includes commitments to further support 'joint planning and collaborative commissioning' between PHNs and LHNs and LHDs across a number of service areas including mental health, hospital avoidance, dementia care, rural primary and community health, after hours, complex chronic condition care, and care of parents and young children in the first 2000 days (DoH, 2022, p. 43). In NSW, NSW Health has initiated collaborative commissioning (working with consumers and PHNs) to support value-based care (Koff et al., 2021).

Given we anticipate co-commissioning to increase the hazards of contracting through increased bounded rationality and increased risk of opportunism across multiple parties, this empirical study seeks to *identify the hazards or costs of co-commissioning* and provide insights about *whether co-commissioning is the panacea to service fragmentation*.

3 | METHODS

This qualitative, single-case study is based within a post-positivist research paradigm (which acknowledges proving causality is problematic) with abductive reasoning to describe and infer the best explanation from what is observed across different sources of empirical data and the established constructs in the literature, while allowing scientific rigour to be applied (Blaikie, 2000; Crotty, 2003; Moon & Blackman, 2014). Theoretical and purposive sampling (Patton, 2015, p. 106) was used to identify an organisation that contracted face-to-face human services—specifically primary healthcare services (see the COREQ tool presented in Appendix A). The case organisation is one of 31 PHNs, funded by the Australian Government Department of Health (DoH) since July 2015, to deliver the PHN Program. The program includes the commissioning of primary healthcare services (including mental health, alcohol and other drug treatment, health screening, and care coordination services) on behalf of the DoH for distinct areas (UNSW et al., 2018).

The CasePHN[6] serves a culturally and socio-economically diverse population in a metropolitan area and is operated by a special-purpose, independent incorporated entity. Data collection commenced in February 2019 and was completed in November 2020, at which time the PHN Program had been running for 3.5 years. At that time, the CasePHN managed more than 120 contracts for service delivery; a within case design focused data collection on three services identified by the CasePHN as working well across the contracting process. The research was approved by the UTS Human Research Ethics Committee and both the CasePHN and individuals participated in this study under informed consent.

The CasePHN entered into a research agreement with the lead author and provided access to staff and the office (to allow for observations). This allowed the CasePHN to be an active participant in the research, from designing the study to validating the findings and facilitating the abductive approach (Blaikie, 2000). The qualitative case study was informed by a document review, interviews, and observations of the contracting relations. Individuals involved in the contracting process, including Service Providers, were purposely invited to participate in the study.

A total of 49 interviews were conducted with 37 participants from the CasePHN (Executives, Managers, and Officers), Service Providers, and other Stakeholders (researchers, consultants, and other NGOs), with one participant having multiple affiliations (see Appendix B). Interviews ranged from 16 to 119 min in duration following the discussion guide presented in Appendix C. In addition, 29 days were spent observing the organisation; this included attending internal meetings, contract meetings, and day-to-day operations. The document review included publicly available documentation, as well as contract material relating to the commissioning activities. All data reported in this article is denoted by its source in italics.

Data were analysed to understand the controls used to facilitate the commissioning and co-commissioning of primary healthcare services. Data were first thematically coded using NVivo starting with the data source, contract relation, and the stage of commissioning process. Co-commissioning was identified by a subset of study participants and these data were further analysed for this article to identify transaction characteristics, how they were managed in different co-commissioning arrangements (compared to direct commissioning), and how this changed over time. Following an abductive approach, findings were then presented back to research participants for verification and then compared with the conceptual framing (Blaikie, 2000). A full description of the study methods, context, findings, analysis, and interpretation is presented in Appendix A; a summary of participants can be found in Appendix B; and the discussion guide is presented in Appendix C.

4 | RESULTS

4.1 | The need for co-commissioning

While the objectives of PHN co-commissioning activities are 'top down' from efficiency-seeking policies driving joint planning and joint funding, the need for co-commissioning has also been identified from the 'bottom up', driven by service fragmentation that exists across the Australian health and social care settings that is felt by commissioners, consumers, and service providers (Observations, CasePHN; Freeman et al., 2021).[7] One stakeholder suggested that the fragmentation is so engrained that a 'black swan event' (triggered by financial, workforce, and another driver) would be needed to drive the substantial changes required to resolve the complexity and fragmentation in the operating context (*Stakeholder*).[8]

The fragmented context presents several risks to consumers, including potential duplication, service gaps, and a lack of integration (*CasePHN, Stakeholder*).

> There is potential for duplication, but I think it's something that's more overstated than perhaps what really happens. I think the problem is that you don't get integration that you need, and you do get very real service gaps. And because it's harder to hold any level of government to account for particular services or for meeting the needs of the population, it does allow buck passing to occur. (emphasis added, *Stakeholder*)

The consequence is that in some areas, particularly for highly vulnerable people, 'we're having to introduce these specialised roles to cope with the fact we've now got this service fragmentation' (*CasePHN*). Organisations are working to help integrate services (*Observations*, *CasePHN*) or help different parts of the health and human services system communicate with each other (*CasePHN*).

Fragmentation of funding also impacts service providers who often operate under multiple contracts to different funders, each of which has different reporting requirements (*Observations*). This requires providers to engage and negotiate with different policymakers and funders (J. R. Butcher & Gilchrist, 2016; Henderson et al., 2018). One provider said:

> It's the same work, so really all five contracts that make up the [...] team here, all the workers are essentially doing the same kind of role. ... Having one team but five different contracts is a really unwieldy way of working ... It would make more sense to have one contract that different [funders] all put into. (*Provider*)

The number of contracts in place was further complicated by their short duration. While contracts may be renewed, renewals were not necessarily timely.

> The contracts have not been very long. The five contracts will finish at the end of the financial year. .... Some funders are more proactive in renewing contracts than others. Some contracts end up being backdated as they are renewed late. (*Provider*)

This led to problems retaining experienced staff and maintaining service delivery.

> Staff retention is a bit of a problem obviously when people aren't sure whether the funding is going to be there or not. ... It's tough, and we go through this every time it starts coming near to the end of the contract and people in the organisation start getting nervous... (*Provider*)

This was further complicated by different sources of funding; for example, mental health funding and alcohol and other drugs (AOD) funding have different reporting requirements through national minimum data sets (*Provider*, *CasePHN*, *Observations*).

> ... the structure of [the minimum datasets] is completely different. So there's common aspects between the two, but there's spots that isn't common. ... [so the funder] have given us extra money to employ an admin person because the reporting is so complex for it. (*Provider*)

The data highlight the high transaction costs associated with operating under multiple short-term contracts with different providers from different sources of funding—each of which impacts on service delivery. Costs were associated with having multiple contracting parties, as well as high asset specificity (staffing), frequency (duration and renewal), uncertainty (identifying outcomes), and probity (reporting requirements). Both funders and providers identified the need to co-commission services to reduce some of these costs—currently born by providers and clients, but ultimately reducing public value. As one provider said:

> It would make more sense to have one contract that different funders all put into. Instead of doing five separate reports, we could do one report, and rather than every three months spend most of my time doing reporting, we can look at other things to develop the service and move it forward. ... I would say [this] absolutely impacts on services delivery, because it takes a lot of management just to keep afloat rather

than looking at things we can do that are maybe more innovative moving forward (*Provider*)

4.2 | Early experiences of co-commissioning

Co-commissioning involves a single contract which incorporates the objectives and requirements of each funding party (*PHN Contracting*) and specifies the requirements for the services to be delivered. Co-funding services requires PSOs to agree on activity to be funded and meet the contracting and governance requirements of each funding organisation—something that requires strong leadership and commitment to achieve (PwC and Commissioning NSW, 2020). Data from this case study of early co-commissioning activities suggest this, at least initially, takes substantial time, effort, and resources to establish. In an early example of co-commissioning, the CasePHN joined nine other PHNs to co-commission a psychiatry support line. This required a dedicated program officer to coordinate PHN contracts and manage the Service Provider (*CasePHN*), despite the co-commissioning involving similar organisations (albeit, each with different governance structures and plans). The CasePHN recognised that co-commissioning is more complicated with other types of organisations.

> The minute you've got somebody else in, you've got new governance structures. There are so many more variables. (*CasePHN*)

This reflects the bounded rationality and opportunism present in each organisation.

Another example, again with other PHNs, was co-funding the development of a guide for working with Aboriginal people in the alcohol and drugs sector (*Stakeholder*). Again, those involved recognised the time needed to establish joint funding arrangements and the need to get better at doing this.

> We got five [PHNs] on board. It was not easy. … It took about 9-months to actually get an agreement, [and someone at the peak organisation] was key. [They] worked with me in that process around what each of the PHNs required … and we drafted something that everyone could agree to… We all sit on the governance group, and we meet regularly. It's been a good outcome… but we need to get more nimble around how we do it. (*CasePHN*)

While the outcomes were appreciated by service providers, one provider recognised this approach needed to be translated into the co-commissioning of more complex services:

> It's like a policy piece of work rather than direct service provision. But they figured out a way where everybody is happy with the same piece of work… So for me, that's really promising because then well maybe [they] could all start talking with each other and be happy with some similar KPIs as well. (*Provider*)

CasePHN staff and service providers identified good outcomes from initial co-commissioning work, but recognised the need to improve the process, reduce the time it took, and reduce the administrative costs. CasePHN staff recognised the challenges arising from organisations hav-

ing different resource allocations, different structures, different strategic plans, and different governance requirements (*CasePHN, Stakeholder*).

Interestingly, the evolution of outsourcing public services started with services that appeared easier to contract (such as waste management), moving to more complex services (such as finance, IT, HR), to services that were difficult to contract (such as prisons, disability, aged-care, mental health services [Aulich & Hein, 2005; Johansson & Siverbo, 2011]). This is similar to the co-commissioning described in this case study, which also started with services that were easier to contract, moving to more complex services as knowledge and experience grew.

4.3 | Costs of co-commissioning

Even when partners were willing, early experiences of co-commissioning had to overcome organisational misalignment; study participants recognised parties are 'working with more than one set of rules' (*Stakeholder*), including different policy/priorities, risk appetite, planning/funding cycles, governance, and probity requirements—or simply the need for parties to have control. Misalignment is magnified when co-commissioning with more than one other party, particularly when they are also different types of organisations.

> When it's PHNs, same sort of work environment, [co-commissioning] is challenging. Add the [another type of organisation] to the mix … and then another … (*CasePHN*)

Co-commissioning requires strong relationships between commissioning partners. At the CasePHN, this has taken time to establish due to being a relatively new organisation. This has also been further complicated by a high staff turnover across the sector in the region (*Stakeholder*). One stakeholder highlighted that it is one area where 'regional/rural PHNs and organisations are doing it better, just out of necessity and out of proximity perhaps' (*Stakeholder*)—and possibly also due to greater stability in staffing.

While there were few examples of co-commissioning at the time the study was undertaken, there was evidence of stakeholders 'working together at different points along the traditional commissioning cycle' (*Stakeholder*)—co-planning in mental health and co-funding different activities (*Observations*). This is aligned with the Practice Guidelines which show 'co-' occurs across the commissioning cycle, from planning, using the same language and approach, to pooling funds to contract services (PwC and Commissioning NSW, 2020). As one provider observed, any progress is a step in the right direction (*Provider*).

Research participants identified the initial high costs in understanding the different governance requirements for each organisation (related to the parties to the transaction—bounded rationality and opportunism), which were more complex for different types of organisations. Costs also increased when the services were more complex.

4.4 | Enablers and barriers to co-commissioning

The PHN Program encourages co-commissioning to reduce fragmentation—facilitated by the design of the program (identifying needs, prioritising investment, and procuring services) and their alignment with other funders (LHNs/LHDs). Collaborating across the commissioning cycle provides opportunities to share expertise and knowledge (including data, although this is

not always straight forward), increase engagement, co-design programs, increase organisational capacity, create joint ownership of programs and outcomes—and critically, tailor services to needs rather than policy/funding siloes, and potentially encourage innovation (*PHN Commissioning Guide*; Dickinson et al., 2013; PwC and Commissioning NSW, 2020).

> I feel like there's opportunities … you don't need to necessarily pool all the funds, but if you can say, for this particular cohort, like people experiencing severe mental illness, for example, let's map out what exists for them, and where are there opportunities … Are we, between all of the different parts of the service system that I described, servicing [people who experience severe mental illness]? Or are we all servicing the same [smaller proportion of that population]? And I would probably say the second one. (*CasePHN*)

Enablers to co-commissioning include having clearly defined objectives, strong relationships, commitment from leadership and staff, dynamic governance, and a commitment to complete the initiative (PwC and Commissioning NSW, 2020, p. 12). While commissioning itself is a relational process and relies on engagement with key stakeholders (Bates et al., 2022; Meurk et al., 2018; Robinson et al., 2016), co-commissioning relies on deep collaboration which requires both time and resources to achieve (Cheverton & Janamian, 2016). The CasePHN, being a relatively new organisation, in terms of region and governance, has taken time to establish new relationships with key stakeholders in its region. This contrasts with PHNs who emerged from Divisions of General Practice and Medicare Locals with existing governance and established regions, and were thereby able to better utilise established relationships (UNSW et al., 2018). As relationships become more established, there is likely to be greater integration and co-commissioning of services (Freeman et al., 2021).

Further, co-commissioning has been encouraged through different initiatives—for example by the NSW Government in terms of encouraging partnerships between PHNs and LHDs in 2019 and then later through collaborative commissioning of value-based health care (*CasePHN*; Koff et al., 2021) and by the DoH through the PHN Program. Within the Program, each PHN was required to develop a joint *Regional Mental Health Plan* and establish associated governance and collaborative mechanisms with key partners (*Regional MH Plan*; *CasePHN*).

> We have no funding, but we have a directive to do this. … it took a good part of 6 months to bring everyone to the table. (*CasePHN*)

Collaboration throughout the commissioning cycle through Needs Assessments, Activity Work Plans, and strategic plans (such as the *Regional Mental Health Plan*) enables PHNs to develop trust with key parties and lay the foundations for future co-commissioning—or at least enable either party to identify and address duplication or gaps in services.

This study also identified potential barriers and costs (and delays) to co-commissioning, many of which related to the differences between commissioning agencies—that is the differences in party characteristics. For example, PHNs are funded by the Commonwealth, whereas other potential partners are largely funded by state/territory governments; this can lead to organisational misalignment particularly where policies and priorities diverge (*Observations*; see also Freeman et al., 2021). PHNs have relatively small budgets compared to state/territory funders, and consequently have little power to leverage other types of organisations. LHNs/LHDs within Aus-

tralia typically have significantly larger budgets, 100–200 times the size of a PHN budget (*PHN Contracting*).

> There is a real resource disparity between the [LHN/] /LHD] and the PHN. I don't know how you resolve that. I don't think it is resolvable, but I do think it therefore means that for the two bodies to come to the table together as equals is quite challenging. Given the very different size and nature of the organisations and the fact that one reports through to the Commonwealth and one reports to the State. Having said that, I think that both [LHNs/] /LHDs] and PHNs from what I can see are really committed to realise those opportunities to work more effectively together. (*Stakeholder*)

However, as one participant added:

> PHNs don't bring a whole lot of money or funding to the table… what they do bring is influence and access to GPs. (*Stakeholder*)

Misalignment in priorities, particularly between the PHN and state/territory health agencies, was also observed in relation to responsibilities, funding allocation, governance, priorities for funding, and where cost savings might be recognised. For example, cost savings may be achieved across the health system through early intervention programs (*CasePHN*), yet funding priorities, allocations, and savings are realised differently by different organisations. Misalignment of geographic boundaries also presents challenges to co-commissioning (Greener, 2015); for example, the CasePHN has more than one LHN/LHD operating within its boundaries creating added complexity compared to a PHN with only one LHN/LHD. Further, providers operating across multiple organisational boundaries are likely to be contracted by multiple PSOs to fund the same services. Organisations were not always misaligned, however. Within this case, there were examples of PHNs and LHNs/LHDs commissioning similar services (*Observations, CasePHN*)—again, highlighting the opportunities for co-commissioning.

This case study identifies the high costs associated with initial co-commissioning activities, but note these costs appear to decline as the organisation learns more about the co-commissioning hazards.

5 | IMPLICATIONS

The study describes early experiences of co-commissioning services by a non-government organisation in Australia (the PHN), and how the organisation learned from early experiences of co-commissioning less complex services with similar organisations, to go on to co-commission with other types of organisations and to co-commission increasingly complex services. While other studies examine variations in contracting models in terms of provider configurations (Figure 1d–f), this study examines different funder configurations (Figure 1c) and how governance requirements of multiple organisations are identified and managed through the contracting process. In doing so, this study identifies several implications for policy and practice, and highlights the value of TCE theory in understanding contracting hazards in public sector outsourcing.

5.1 | Organisational learning about the costs or hazards of co-commissioning

This analysis, drawing on transaction cost economic theory, helps to highlight why co-commissioning can be a complex and initially difficult activity for commissioning organisations to engage in. Time plays a critical role in developing a deeper shared understanding of the characteristics, risk appetite and management, and governance arrangements of the organisations involved. This timeline is no doubt extended by the process of identifying opportunities for co-commissioning and seeking the political or organisational will to engage. While policies may identify the need for co-commissioning, other incentives may be required to promote engagement. This must factor in the time and cost of initial engagement to understand the different parties to the transaction and resolve any differences in governance requirements.

5.2 | Reducing the costs of co-commissioning over time

This case suggests that transactional costs are higher when starting to co-commission services. As noted above, this may reflect the organisational learning, partnership development, and organisational capacity building that needs to be undertaken to realise the full benefits of co-commissioning. These costs are likely to reduce over time, and may also lead to more sophisticated, complex, and sustainable approaches to co-commissioning services. Costs may be reduced by regular co-commissioning and by establishing memoranda of understanding between organisations that facilitate co-commissioning.

5.3 | TCE theory

This study contributes to the literature on TCE theory which largely focuses on for-profit settings and transaction attributes. This study highlights the relevance of TCE theory to public sector settings in understanding the costs of contracting. First, this study helps understand the cost of co-commissioning services with similar and different types of organisations (in effect, keeping the nature of the activity constant). Second, the application of TCE theory shows organisational learning which helps reduce the transaction cost of co-commissioning over time. This is demonstrated with the case organisation first co-commissioning with similar types of organisations, before co-commissioning with other types of organisations. This is also demonstrated by the nature of the activities co-commissioned—starting with relatively simple low-risk activities, and progressing to more complex activities. In both cases, costs were reduced when hazards associated with the transaction parties were resolved.

While TCE theory is usually applied from the buyer perspective, it is also useful to identify transaction costs and implications from the provider perspective. As shown in this study, having multiple contracts for similar or the same service places huge costs on providers and focuses efforts on meeting multiple reporting requirements rather than improving service delivery. PSOs need to be mindful of such transaction costs when commissioning services to ensure the costs are met by the contract.

Finally, TCE shows there are costs associated with every contract. Therefore, in theory, costs can be reduced by having fewer contracts. Co-commissioning is one strategy to reduce the number

of contracts in place; however, this may provide limited savings—especially in the short term. Consideration could be given to reduce this further by consolidating policy and funding streams and reducing overlap between government agencies—both reducing the number of contracts in place and reducing service fragmentation.

5.4 | Other considerations

In the context of Australian primary health care, assuming the continuation of the preference to use markets to deliver many healthcare services, governments have three potential paths. First, they can reduce policy and funding fragmentation as much as possible. Second, government can continue business as usual in commissioning services independently. This may result in high costs in procuring and managing contracts for government, high costs to providers in delivering multiple contracts, and highly fragmented services (and potentially poor outcomes for consumers). Third, governments can bear the costs of fragmented policies and funding within government through co-commissioning. Co-commissioning provides an opportunity to reduce fragmentation and move towards sector-wide design (Silburn & Lewis, 2020). While this may incur costs particularly in the learning phase, as this article shows, the costs of co-commissioning are likely to reduce over time. This is likely to lead to lower costs to providers and less fragmented services. Realistically, governments are likely to use all three options together; however, the balance of the way funding and services are organised has the potential to increase in efficiency over time.

There may be broader barriers to co-commissioning, such as different priorities of different actors even within the same policy area (such as health) in the same geographical context (Kislov et al., 2023). Where this occurs, top-down intervention or incentives may be required—as evidenced by both Commonwealth- and State-based policy interventions in Australia. Co-commissioning, while addressing some of the costs of contracting, is not on its own the panacea to service fragmentation and other problems experienced by clients, providers, and funders caused by other aspects of contracting. Higher level system-wide collaboration in system and service design may be required (Silburn & Lewis, 2020).

When commissioning and co-commissioning services, funders should also consider contractual elements, such as contract duration and its timely renewal (if appropriate), as each affects staff retention, service continuity, and service outcomes. Performance metrics and reporting requirements need to be designed to meet the needs of consumers, providers, and funders, without imposing undue costs. The cost of collecting and reporting data, and infrastructure costs associated with this, should be reflected in the contract. This can potentially be managed by having common IT infrastructure (Greener, 2015) to support service delivery and easy reporting; however, there are risks that this leads to the use of multiple systems when infrastructure provided does not meet the needs of service providers, and 'obviously the less systems you can use the better' (*Service Provider*). Finally, the way services are commissioned and managed can determine and be determined by the expertise and knowledge of commissioners and service providers, the types of relationship between them (such as the ability to use bureaucratic *and* relational controls), affecting the identification and resolution of risks, opportunities to innovate, and ultimately the effectiveness and efficiency of services (Bates et al., 2022; Regmi & Mudyarabikwa, 2020; Silburn & Lewis, 2020).

6 | CONCLUSIONS

Based on the current context of primary healthcare delivery in Australia, this paper identifies the need for, and the enablers and barriers to, co-commissioning using examples from a case study of the early experiences of one PHN. While co-commissioning conceptually provides a mechanism to combine limited resources, avoid duplication, and reduce fragmentation of health services, co-commissioning needs to consider the different characteristics of partner organisations—in particular, the governance requirements, risk appetite, and different knowledge of each party. For co-commissioning to be successful, these factors need to be understood and addressed. This could be addressed initially at an organisational level, for example through memorandums of understanding, rather than resolved on a contract-by-contract basis.

While the ideal may be to co-commission based on the whole commissioning cycle, the reality may be somewhat different. This paper illustrates that collaboration occurs at different levels across the commissioning process—indeed, co-planning and co-funding may occur separately. In some ways this helps explain why the terminology used in the academic and practice literature varies between collaboration, co-funding, co-procuring, collaborative commissioning, and co/joint commissioning—each of which may contribute to the overall aims of increasing the efficiency and effectiveness of primary healthcare services. Perhaps the co- is the most important element.

This study draws from data collected from a single case study organisation and its early experiences of co-commissioning. While the findings relating to the transaction costs of commissioning with other parties are likely to resonate with other commissioning agencies, the findings reflect the maturity of the PHN and the maturity of its relationships with commissioning partners—as well as their broader understanding and experience of implementing commissioning processes (Meurk et al., 2018). While co-commissioning has progressed since the data were collected, with further examples of co-commissioning and collaborative commissioning by PHNs and other funders (Koff et al., 2021), the insights provided in this paper provide useful insights to inform and strengthen co-commissioning practice by providing an understanding of the organisational and operational considerations when co-commissioning services—not just for PHNs, but also for other commissioning agencies. Future research may consider whether co-commissioning is able to reduce fragmentation, improve service co-ordination, provide efficiencies for services, and improve outcomes for service users.

This study highlights the useful insights TCE theory provides in understanding the costs associated with different forms of public sector commissioning. Future research (and indeed practice) in public sector commissioning could use TCE theory to conceptualise other potential models to reduce fragmentation and increase public value by understanding the costs associated.

As this article shows, neither commissioning or co-commissioning is unlikely to be the panacea to service fragmentation on its own (Addicott, 2014; Field & Oliver, 2013; Silburn & Lewis, 2020). This article highlights there are multiple opportunities for the public sector to reduce risks and costs associated with contracting and increase service outcomes—co-commissioning being one tool—benefitting governments, service providers, and the community. Other opportunities may stem from direct service provision or re-organising healthcare funding more broadly to ensure systems are designed with the consumer in mind.

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CONFLICT OF INTEREST STATEMENT

Michael Wright has had multiple primary care appointments with the Royal Australian College of General Practitioners and Primary Health Networks. Shona Bates and Ben Harris-Roxas declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support this study cannot be publicly shared due to the potentially identifiable nature of the data and the requirements of ethics approvals.

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ENDNOTES

[1] 'Human services' is a term commonly used in Australia to describe both financial supports and services provided by governments to enable and support social and economic participation, address inequality, and contribute to the well-being of individuals and the broader community (Productivity Commission, 2016). In terms of services delivered, human services include health, social welfare, justice, education, and housing and in some cases may overlap different policy areas and agencies. For example, mental health services can be provided across most service areas.

[2] Note that the term 'collaborative commissioning' also appears in the literature in relation to health care. This refers to improving the quality of commissioning to support 'value-based health care' by working with consumers, providers, and data custodians in the commissioning cycle—not necessarily co-funding activities and therefore is not discussed here (Koff et al., 2021).

[3] LHDs operate in New South Wales, while LHNs operate in other states and territories. To provide anonymity for the CasePHN, the term LHN/LHD is used throughout.

[4] See www.health.gov.au/about-us/the-australian-health-system (accessed 12 April 2023).

[5] By way of comparison, for 2020–2021 financial year, the Australian Institute of Health and Welfare (AIHW) reported $220.9bn was spent on health; this includes $73.4bn spent on primary health with $33.5bn provided by the Australian Government, $12.3bn provided by state and territory governments, and $27.6bn provided by non-government sources (Data source: https://www.aihw.gov.au/reports-data/health-welfare-overview/health-welfare-expenditure/overview, accessed 18 July 2023). In 2019–2020, the CasePHN (one of 31 PHNs) was allocated $47.6m to deliver the program for one region.

[6] CasePHN is used to retain the anonymity of the case organisation. Similarly, the number of contracts managed and the amount of funding allocated have been rounded to protect the identity of the organisation. To ensure anonymity, interview participants are identified by participant group only.

[7] Service fragmentation is not limited to Australia. A study by Milward and Provan (2003) examining agencies supporting people with severe mental illness found service fragmentation ranged from 32 to 44 per city in the four cities included in their study.

[8] Note, this interview took place in July 2019—prior to the start of the COVID-19 pandemic.

REFERENCES

Addicott, R. (2014). *Commissioning and contracting for integrated care*. The King's Fund. http://www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf

Aulich, C., & Hein, J. (2005). Whole-of-government approaches to outsourcing and market testing by the commonwealth government. *Australian Journal of Public Administration*, *64*(3), 35–45.

Australian Government. (2017). *Senate inquiry: Delivery of National Outcome 4 of the National Plan to Reduce Violence Against Women and Their Children 2010–2022*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/NationalPlan/Report

Australian Government. (2022). *Department of Health Annual Report 2021–22*. Author.

Bates, S. (2022). How an intermediary model manages the tension between low contractibility and probity when outsourcing human services. *Australian Journal of Public Administration*, *81*(4), 513–648. https://doi.org/10.1111/1467-8500.12540

Bates, S., Wright, M., & Harris-Roxas, B. (2022). Strengths and risks of the Primary Health Network commissioning model. *Australian Health Review*, *46*(5), 586–594. https://doi.org/10.1071/AH21356

Blaikie, N. (2000). *Designing social research*. Polity Press.

Booth, M., & Boxall, A. (2016). Commissioning services and Primary Health Networks. *Australian Journal of Primary Health*, *22*, 3–4.

Bovaird, T. (2016). The ins and outs of outsourcing and insourcing: What have we learnt from the past 30 years? *Public Money & Management*, *36*(1), 67–74. https://doi.org/10.1080/09540962.2015.1093298

Brown, T. L., Potoski, M., & Van Slyke, D. M. (2006). Managing public service contracts: Aligning values, institutions, and markets. *Public Administration Review*, *66*(3), 323–331.

Butcher, J., & Dalton, B. (2014). Cross-sector partnership and human services in Australian states and territories: Reflections on a mutable relationship. *Policy and Society*, *33*(2), 141–153. https://doi.org/10.1016/j.polsoc.2014.05.001

Butcher, J. R., & Gilchrist, D. J. (2016). Introduction. In J. Butcher & D. Gilchrist (Eds.), *The three sector solution: Delivering public policy in collaboration with not-for-profits and business* (pp. 3–21). ANU Press.

Carter, E., & Whitworth, A. (2015). Creaming and parking in quasi-marketised welfare-to-work schemes: Designed out of or designed in to the UK work programme? *Journal of Social Policy*, *44*(2), 277–296. https://doi.org/10.1017/S0047279414000841

Checkland, K., McDermott, I., & Coleman, A. (2018). Primary care co-commissioning: Challenges faced by clinical commissioning groups in England. *British Journal of General Practice*, *68*(666), 37–38. https://doi.org/10.3399/bjgp17x694325

Cheverton, J., & Janamian, T. (2016). The Partners in Recovery program: Mental health commissioning using value co-creation. *Medical Journal of Australia*, *204*(S7), 38–40. https://doi.org/10.5694/mja16.00124

Considine, M. (2003). Governance and competition: The role of non-profit organisations in the delivery of public services. *Australian Journal of Political Science*, *38*(1), 63–77.

Crotty, M. (2003). The Foundations of Social Research Meaning and Perspective in the Research Process. Sage Publications.

De Morgan, S., Walker, P., Blyth, F. M., Marks, L., Rychetnik, L., Nicholas, M., Sanders, D., & Wilson, A. (2022). Health and service needs, priorities and initiatives of primary health networks related to chronic pain. *Australian Journal of Primary Health*, *28*(5), 417–427. https://doi.org/10.1071/PY21209

Department of Health (DoH). (2016). *Primary Health Networks (PHNs): Designing and contracting services guidance*. https://www.health.gov.au/resources/publications/primary-health-networks-phns-designing-and-contracting-services-guidance

Department of Health (DoH). (2022). *Australia's Primary Health Care 10 Year Plan 2022–2032 (Issue October 2021)*. https://www.health.gov.au/sites/default/files/documents/2022/03/australia-s-primary-health-care-10-year-plan-2022-2032-future-focused-primary-health-care-australia-s-primary-health-care-10-year-plan-2022-2032.pdf

Dessers, E., & Mohr, B. J. (2020). An ecosystem perspective on care coordination: Lessons from the field. *International Journal of Care Coordination*, *23*(1), 5–8. https://doi.org/10.1177/2053434519896523

Dickinson, H. (2016). From new public management to new public governance: The implications for a "new public service". In J. Butcher & D. Gilchrist (Eds.), *The three sector solution: Delivery public policy in collaboration with not-for-profits and business* (pp. 41–60). ANU Press. http://press.anu.edu.au/publications/series/australia-and-new-zealand-school-government-anzsog/three-sector-solution

Dickinson, H., Glasby, J., Nicholds, A., Jeffares, S., Robinson, S., & Sullivan, H. (2013). *Joint commissioning in health and social care: An exploration of definitions, processes, services and outcomes*. https://espace.curtin.edu.au/handle/20.500.11937/47025

Dubois, A., & Gadde, L. E. (2002). Systematic combining: An abductive approach to case research. *Journal of Business Research*, *55*(7), 553–560.

Field, R., & Oliver, J. (2013). *Effective commissioning in health and social care (Post-qualifying social work, leadership and management handbooks)*. Sage.

Freeman, T., Baum, F., Javanparast, S., Ziersch, A., Mackean, T., & Windle, A. (2021). Challenges facing primary health care in federated government systems: Implementation of Primary Health Networks in Australian states and territories. *Health Policy*, *125*(4), 495–503. https://doi.org/10.1016/j.healthpol.2021.02.002

Gallet, W., O'Flynn, J., Dickinson, H., & O'Sullivan, S. (2015). The promises and pitfalls of prime provider models in service delivery: The next phase of reform in Australia? *Australian Journal of Public Administration*, *74*(2), 239–248.

Gardner, K., Davies, G. P., Edwards, K., McDonald, J., Findlay, T., Kearns, R., Joshi, C., & Harris, M. (2016). A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: Implications for Australian policy. *Australian Journal of Primary Health*, *22*(1), 40–49. https://doi.org/10.1071/PY15148

Greener, M. (2015). Co-commissioning: The architecture of integration (Policy Profile). *Practical Diabetes*, *32*(1), 10–11a. https://doi.org/10.1002/PDI.1913

Henderson, J., Javanparast, S., MacKean, T., Freeman, T., Baum, F., & Ziersch, A. (2018). Commissioning and equity in primary care in Australia: Views from Primary Health Networks. *Health and Social Care in the Community*, *26*(1), 80–89.

Hodges, R., Wright, M., & Keasey, K. (1996). Corporate governance in the public services: Concepts and issues. *Public Money and Management*, *16*(2), 7–113.

Hood, C. (1995). The "new public management" in the 1980s: Variations on a theme. *Accounting, Organizations and Society*, *20*(2–3), 93–109.

Horvath, J. (2014). *Review of Medicare Locals (Issue March)*. Australian Government Department of Health and Aged Care.

Integrated Regional Planning Working Group. (2018). *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services (Issue October)*. https://www.health.gov.au/sites/default/files/documents/2020/11/joint-regional-planning-for-integrated-mental-health-and-suicide-prevention-services-compendium-of-resources.pdf

Johansson, T., & Siverbo, S. (2011). Governing cooperation hazards of outsourced municipal low contractibility transactions: An exploratory configuration approach. *Management Accounting Research*, *22*(4), 292–312.

Kettner, P. M., & Martin, L. L. (1990). Purchase of service contracting. *Administration in Social Work*, *14*(1), 15–30.

Kislov, R., Checkland, K., Wilson, P. M., & Howard, S. J. (2023). 'Real-world' priority setting for service improvement in English primary care: A decentred approach. *Public Management Review*, *25*(1), 150–174. https://doi.org/10.1080/14719037.2021.1942534

Koff, E., Pearce, S., & Peiris, D. P. (2021). Collaborative commissioning: Regional funding models to support value-based care in New South Wales. *Medical Journal of Australia*, *215*(7), 297.e1–301.e1. https://doi.org/10.5694/mja2.51243

Kominis, G., & Dudau, A. I. (2012). Time for interactive control systems in the public sector? The case of the "Every Child Matters" policy change in England. *Management Accounting Research*, *23*(2), 142–155.

Kurunmäki, L. (2009). Management accounting, economic reasoning and the new public management reforms. In C. S. Chapman, A. G. Hopwood, & M. D. Shields (Eds.), *Handbooks of management accounting research* (Vol. 3, pp. 1371–1383). Elsevier.

Lewis, V. J., Macmillan, J., & Harris-Roxas, B. (2022). Defining community health services in Australia: A qualitative exploration. *Australian Journal of Primary Health*, *28*(6), 482–489. https://doi.org/10.1071/py21265

Loeffler, E., & Bovaird, T. (2019). Co-commissioning of public services and outcomes in the UK: Bringing co-production into the strategic commissioning cycle. *Public Money and Management*, *39*(4), 241–252. https://doi.org/10.1080/09540962.2019.1592905

Meurk, C., Harris, M., Wright, E., Reavley, N., Scheurer, R., Bassilios, B., Salom, C., & Pirkis, J. (2018). Systems levers for commissioning primary mental healthcare: A rapid review. *Australian Journal of Primary Health*, *24*(1), 29–53. https://doi.org/10.1071/PY17030

Milward, H. B., & Provan, K. (2003). Managing the hollow state: Collaboration and contracting. *Public Management Review*, *5*(1), 1–18.

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167–1177. https://doi.org/10.1111/cobi.12326

NZ Productivity Commission. (2015). *More effective social services*. Author.

Patton, M. (2015). Qualitative Research and Evaluation Methods: Integrating Theory and Practice. Sage Publications. Thousand Oaks California.

Productivity Commission. (2016). Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform (Issue September), Available at https://www.pc.gov.au/inquiries/completed/human-services/identifying-reform/report

PwC and Commissioning NSW. (2020). *Supporting Innovation and Outcomes through Joint Commissioning (Issue July)*. https://www.pwc.com.au/services/infrastructure-and-urban-renewal/commissioning-and-delivery-reform/joint-commissioning/joint-commissioning-report.pdf

Regmi, K., & Mudyarabikwa, O. (2020). A systematic review of the factors—barriers and enablers—affecting the implementation of clinical commissioning policy to reduce health inequalities in the National Health Service (NHS), UK. *Public Health*, *186*, 271–282. https://doi.org/10.1016/j.puhe.2020.07.027

Robinson, S., Dickinson, H., & Durrington, L. (2016). Something old, something new, something borrowed, something blue? Reviewing the evidence on commissioning and health services. *Australian Journal of Primary Health*, *22*(1), 9–14. https://doi.org/10.1071/PY15037

Sasse, T., Guerin, B., Nickson, S., O'Brien, M., Pope, T., Davies, N., Brien, M. O., Pope, T., & Davies, N. (2019). *Government outsourcing: What has worked and what needs reform*. www.instituteforgovernment.org.uk/government-contracting

Silburn, K., & Lewis, V. (2020). Commissioning for health and community sector reform: Perspectives on change from Victoria. *Australian Journal of Primary Health*, *26*, 332–337. https://doi.org/10.1071/PY20011

Simon, H. A. (1997). *Administrative behaviour: A study of decision-making processes in administrative organisations* (4th ed.). The Free Press (Simon and Schuster Inc.).

Stafford, A., & Stapleton, P. (2017). Examining the use of corporate governance mechanisms in public-private partnerships: Why do they not deliver public accountability? *Australian Journal of Public Administration*, *76*(3), 378–391. https://doi.org/10.1111/1467-8500.12237

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

UNSW, Monash University, & EY. (2018). *Evaluation of the Primary Health Networks Program Final Report (Issue July)*. http://www.health.gov.au/internet/main/publishing.nsf/Content/69C162040CFA4F7ACA25835400105613/$File/PHN_Evaluation_Final_Report.pdf

van der Meer-Kooistra, J., & Vosselman, E. G. J. (2000). Management control of interfirm transactional relationships: The case of industrial renovation and maintenance. *Accounting, Organizations and Society*, *25*(1), 51–77.

Williamson, O. E. (1979). Transaction-cost economics: The governance of contractual relations. *Journal of Law and Economics*, *22*(2), 233–262.

Williamson, O. E. (1985). *The economic institutions of capitalism: Firms, markets, relational contracting* (1st ed.). The Free Press (MacMillan).

Williamson, O. E. (2000). The new institutional economics: Taking stock, looking ahead. *Journal of Economic Literature*, *38*(3), 595–613.

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APPENDIX A: COREQ TOOL

Following Tong et al. (2007), the table below provides a comprehensive report of the qualitative study, including the research team, study methods, context, findings, analysis, and interpretation.

No.	Item	Description
Domain 1: Research team and reflexivity		
	Personal characteristics	
1	Interviewer	Lead Author
2	Credentials	Bachelor Science, Master of Science, PhD
3	Occupation	Researcher
4	Gender	Female
5	Experience and training	Experienced researcher and interviewer, with over 10 years' experience in undertaking social policy research, and 25 years' experience in public policy. Data were collected as part of a PhD candidature.
	Relationship with participants	
6	Relationship established	None of the interviewees were known to the researcher prior to the interviews.
7	Participant knowledge of the interviewer	Most participants were unknown to the researcher at the time the study commenced. As the researcher was based in the case organisation during the fieldwork period, many participants became known to the researcher.
8	Interviewer characteristics	Established researcher in social policy research and evaluation. This study was instigated by the desire to investigate unresolved issues that had appeared in other studies, and led to this PhD study.
Domain 2: Study design		
	Theoretical framework	
9	Methodological orientation and theory	The study used Transaction Cost Economics as the theoretical lens to identify where costs (hazards) were likely to arising during the contracting of the PHN Program. A qualitative case study was used to inform the study, using abductive form of inquiry given the exploratory nature (Blaikie, 2000). Abductive reasoning enables us to describe and understand the phenomena in the language of participants, check this understanding with participants, and then redescribe this in the language of the discipline. This approach allows to iteratively develop findings and theory in a contextual setting (Dubois & Gadde, 2002).
	Participant selection	
10	Sampling	The case study was selected using both theoretical and purposive sampling. The lead researcher sought a public sector organisation responsible for delivering face-to-face human services in the state, known to outsource services. Services were excluded that had been subject to significant structural transformation (such as disability) and organisational transformation, that did not support the wider population, or that would be unlikely to share research findings when available. Health was identified at both the state and commonwealth level as a potential setting. An outsourcing arrangement was then identified that was of sufficient size and duration to provide sufficient data for the study, appeared to be working well (evidenced by a recent evaluation), and was accessible to the researcher.
		Sampling of participants was purposive, identified in consultation with the case organisation and through snowballing.

(Continues)

No.	Item	Description
11	Method of approach	Potential participants were emailed a letter of invitation to the study. This included the participant information statement and consent form approved by UTS HREC.
12	Sample size	49 interviews, 29 days observations.
13	Non-participation	No potential participants formally declined or withdrew from the study. One invited participant declined an invitation to participate in an interview but answered queries by email.
	Setting	
14	Setting of data collection	Interviews were conducted face to face where possible in the workplace (in a private meeting room). Other interviews were conducted by phone or skype/zoom/teams—particularly after March 2020 and the start of the COVID-19 pandemic. Consent was also sought to observe participants in the workplace. Observations included attending organisational briefings, practice improvement meetings, contract management meetings, and working groups with key stakeholders in the region.
15	Presence of non-participants	No non-participants were present for the interviews.
16	Description of sample	Data collection involved 49 interviews (36 CasePHN staff [*CasePHN*], five service providers [*Providers*], and eight stakeholders [*Stakeholder*] including one participant with multiple roles), 29 observational days in the organisation (*Observations*), attending 15 meetings, and an extensive document review conducted over an 18-month period (February 2019–November 2020). Interviews lasted between 16 and 119 min, with an average length of 55 min.
	Data collection	
17	Interview guide	A description of the scope of the study was provided in advance with the invitation.
18	Repeat interviews	Yes—as part of the abductive approach, several repeat or follow-up interviews were undertaken. Follow-up interviews were also necessary where the interview participant wanted to continue the conversation at another time.
19	Audio/visual recording	Audio
20	Field notes	Yes
21	Duration	Ranged between 16 and 119 min (average 55 min).
22	Data saturation	Purposeful sampling of contractual arrangements from each workstream within the CasePHN and three service types provided under contract. To ensure anonymity, all CasePHN staff who were actively involved in the commissioning process were interviewed for the study.
23	Transcripts returned	No
Domain 3: Analysis and findings		
	Data analysis	
24	Number of data coders	All original coding was completed by the interviewer.

(Continues)

No.	Item	Description
25	Description of the coding tree	Data were coded, using NVivo. This started with (1) the contracting relation; (2) the stage of contracting (as specified in the PHN program documentation); (3) steps in the process of each stage of contracting; and (4) additional codes developed in vivo to categorise data. Using an abductive approach, constructs were presented back to research participants during follow-up interviews and then compared with the theoretical framing from TCE theory (Blaikie, 2000).
26	Derivation of themes	As above, the initial coding themes were established by the commissioning process. Additional themes were derived through open coding of interview transcripts and documents.
		Themes were subsequently discussed and explored further with the two co-authors.
27	Software	NVivo
28	Participant checking	Yes, as part of the abductive approach, initial findings were checked with key staff at the CasePHN.
	Reporting	
29	Quotations presented	Yes, selectively to illustrate findings.
30	Data and findings consistent	Yes, data were triangulated from different sources.
31	Clarity of major themes	Yes
32	Clarity of minor themes	The focus is on higher order descriptive findings, given the exploratory nature of the study. In this article, further clarity is provided of minor themes—in particular, co-commissioning as a subset of the PHNs commissioning activity.

APPENDIX B: SUMMARY OF PARTICIPANTS

Table B1

TABLE B1 Interviews by organisation.

	Interviews (*n*)	Interviewees (*n*)[a]
CasePHN		
Executives	11	5
Managers	13	9
Officers	12	11
Providers	5	5
Stakeholders		
Researchers	2	1
Consultants	3	3
Non-government organisations (NGOs) including peak bodies	2	2
Multiple organisations	1	1
Total	49	37

[a]Variations due to joint interviews and multiple interviews, either as part of the abductive process or due to interruptions.

APPENDIX C: DISCUSSION GUIDE

Interviews took the form of open discussions guided by a series of questions (in bold) and prompts as needed.

What is your role in the organisation and how long have you been in that role?
What is the governance structure of the [organisation/CasePHN]?

- What is the structure of the [organisation] and its goals?
- What is the relationship between [DoH/CasePHN or CasePHN/Provider] and how is it managed? (contact, contract, control, review)
- How does the relationship between [organisations] work in practice?

What is the commissioning [procurement] process?

- What is the process from start to finish? (contact, contract, control, review)
- Who is responsible for the process within the [organisation]?
- What is the commissioning process? (from identifying need to contract completion)
- [How does the CasePHN implement the requirements of DoH when commissioning services?]
- How are contracts managed day-to-day?
- What documents (policies, procedures) govern the process?
- Is there an opportunity to observe all or part of the process?

In relation to managing contracted services between [DoH/CasePHN or CasePHN/Provider]: How was the [service] contracted/commissioned? How is the service being managed?

- What is the service being contracted/commissioned?
- Who at the [funding organisation] was or is involved in contracting/commissioning this service (from going to market through to day-to-day control)?
- How was the contract tailored to the specific service?
- What risks were identified? (type of activity, partner, experience with partner, form/duration of contract, level of specification, governance/monitoring requirements)
- How were the risks managed in the agreement?
- How are the risks managed on a day-to-day basis? (formal/informal controls)
- Does the arrangement include outcome measures?
- What are the resource implications for the [funding organisation]?
- What is working well?
- What is not working well?

What additional controls does [the funder] use to manage services?

- What is the difference between what DoH requires, what the CasePHN requires, and practice?