ROOFTOP SOCIAL

Commissioning and Contracting for Better Mental Health Outcomes

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Prepared for

Mental Health Australia

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Executive summary

During 2014 Mental Health Australia undertook extensive consultation with its members to identify barriers to, and potential enablers of, a more effective and efficient Australian mental health system. A key issue arising from those consultations was the way in which commissioning and contracting arrangements can either help or hinder the delivery of services to support better mental health outcomes.

Accordingly, in late 2014 Mental Health Australia engaged Rooftop Social to examine a range of ways in which commissioning and contracting arrangements might be improved and better congruence achieved between policy and implementation. The study involved a review of published and unpublished literature in Australia and elsewhere, guided by consultation with relevant practitioners and specialists. The team was advised by Professor Gary Sturgess of the Australian and New Zealand School of Government, who is an internationally acknowledged expert in this field.

Done well, commissioning can ensure high-quality public services that deliver real value for money... Done poorly, commissioning risks providing services that alienate and disempower, that are inflexible and over-departmentalised, that privilege short-term cost-efficiencies over long-term public benefit, and that ultimately offer poor value for money.

New Economics Foundation

The study team prepared an interim discussion paper which was considered at a full-day workshop convened in Sydney in May 2015. Those who participated in that workshop included a range of stakeholders drawn from the not-for-profit and mental health fields, across most of the States and Territories, together with a number of experts and specialists from government and from academia.

Discussions at the workshop were followed up by further work on written sources, and telephone interviews with a number of the participants and some others whom they suggested. *It should be noted that the findings and recommendations of this report are the work of the study team, and do not necessarily represent the views of any individuals or organisations consulted.*

Mental Health Australia anticipates that the findings will have relevance for how government responds to several important policy processes, including the Competition Policy Review, the White Paper on the Reform of the Federation, the National Review of Mental Health Services and Programmes, and the finalisation of arrangements for full rollout of the National Disability Insurance Scheme.

1. Current failings and need for reform

There are serious shortcomings in current commissioning and contracting practice in the field of human services, including mental health services. These include:

- siloed government decision making without reference to an appropriate guiding strategy
- short-term contracts and insecurity of funding that undermine service providers' capacity to plan ahead and to ensure workforce stability and service continuity
- poor risk management practice leading to excessive red tape and inappropriate transfer of costs and risk
- onerous compliance and reporting requirements that do not reflect the level of funding allocated or the risks involved, and which contribute little to the achievement of project goals
- lack of consistency in reporting and data requirements and failure to make good use of information gathered

- inequitable conditions such as the right for governments to terminate contracts without due cause and lack of compensation for cost increases resulting from changes in policy
- failure to provide a role for the community sector in contract negotiations or at the stages of policy development and program design
- the sheer volume of contracts that community-based organisations have to manage.

The Productivity Commission considered such issues at length in its 2010 report on the *Contribution of the Not-for-Profit Sector*, and made a series of recommendations for reform which, if implemented, would have represented important improvements within the existing commissioning and contracting framework. Those recommendations included the following:

> *Australian governments should urgently review and streamline their tendering, contracting, reporting and acquittal requirements in the provision of services to reduce compliance costs. This should seek to ensure that the compliance burden associated with these requirements is proportionate to the funding provided and risk involved.*
>
> *The length of service agreements and contracts should reflect the length of the period required to achieve agreed outcomes rather than having arbitrary or standard contract periods.*

Contractual and reporting requirements do not appear to lead to improved outcomes for clients. Indeed, many NFPs considered that the information and data they are asked to provide seemingly disappears into the 'ether' with little or no tangible effect.

Productivity Commission

The Commission placed considerable emphasis on the need for governments to work cooperatively with the community sector to maximise the value of its role and to capitalise on its motivation and expertise.

Commonwealth, State and Territory governments have, to varying degrees, displayed awareness of commissioning and contracting problems and introduced some improvements over recent years. This work has been piecemeal, however, and there remains a clear need for further progress.

An underlying concern is the power imbalance that effectively makes the relationship between government and service provider one of master and servant, with the non-government sector having little room to contribute or negotiate. This is despite governments across the political divide repeatedly acknowledging the unique role of the community sector and stating an intention to increase that role over time.

2. Outcomes-based contracting

Aside from reforms to existing commissioning and contracting practice, a rather different approach aims to go beyond the typical practice of contracting for *inputs* and *outputs*, to focus instead on *outcomes* sought and achieved. This concept has attracted increasing international attention in recent years; in Australia both governments and the not-for-profit sector have shown some interest in outcomes-based contracting as a means of implementing policy more effectively and improving service effectiveness. The recent Harper *Competition Policy Review* also identified some of the potential benefits of an outcomes

Poorly framed or overly stringent standards or requirements become unnecessary cost drivers that distract the service providers' resources and focus from the areas of most importance.

Australian Council of Social Services

approach.

Adopting outcomes-based contracting in mental health is not, however, a simple matter, and moves in this direction need to be considered, gradual and flexible. Key challenges include the difficulty of translating broad policy objectives into a small number of outcomes that might realistically be achieved by an individual service provider, and that are reliably measurable at reasonable cost and within an appropriate timeframe. These challenges are especially evident in an area as complex as mental health.

Other issues include difficulties around attribution and the risk of introducing perverse incentives, along with the question of how, if payment is made dependent on outcomes, poorly capitalised NFPs might cope with deferred or uncertain payment. Such challenges are particularly daunting in an area as complex as mental health, and there are few examples to date of outcome-based contracting being used in this field in Australia or internationally.

Given the difficulties involved in moving to a pure outcomes model, some kind of hybrid approach (for example contracting for a mix of outputs and outcomes) may be more realistic. Any system of *payment based on achievement of outcomes* would need to be approached with particular care.

Like all activities, social service delivery involves risks. Government should attempt to allocate these risks in a way that maximises performance, efficiency and accountability. Part of the problem with some of the current arrangements is that risks are misallocated… Current accountability and red tape issues are so process focussed as to render some services compromised in achieving efficiency and effectiveness.

Productivity Commission

The literature suggests that outcome-based payment arrangements may be most suitable for relatively simple situations where the links between inputs, outputs and outcomes are reasonably straightforward and uncontroversial, or where one or two simple outcomes can be agreed on as fulfilling policy objectives. Such situations are not typical in the commissioning of community-based mental health services.

3. An agreed strategic framework

Through the COAG process and after wide consultation, an Expert Review Group has developed *National Targets and Indicators for Mental Health Reform*. These could be considered by COAG and all governments as a possible framework for planning, decision making and resource allocation. Once endorsed by government, national targets and indicators could offer systematic guidance on policy and investment, and could be used to link national priorities with the nature and objectives of specific programs and projects. This would represent a positive step towards improving the current commissioning and contracting system.

A key difficulty in moving to outcomes-based contracts in community mental health is the problem of identifying mental health outcomes that a single organisation could sensibly be expected to achieve. Although the National Targets and Indicators provide a considered framework for planning mental health services in Australia and clarifying the outcomes that the community wants, the outcomes that it points to are meaningful at the level of governments rather than individual service providers, and it is not easy to see how they can be adapted for use as contract outcomes. This is an area that calls for further detailed consideration by both government and the community sector.

4. Devolution to third parties

There are several other approaches that may help improve the quality of human services commissioning and contracting. One of these involves devolution of responsibilities to a third party which is independent of the agency ultimately providing the funding. An Australian example has been the creation in Western Australia of a Mental Health Commission which is independent of the Health Department and which is responsible for service commissioning and contracting.

Another example of devolution is the use of one non-government organisation to organise and oversee service delivery at local level by other NFPs; this is usually called either a *lead contractor* or a *prime provider* approach; in the latter situation the lead agency itself may be one of the service providers. A related notion is that of the *integrator* – 'an organisation strategically deployed by the commissioner with specific responsibilities for mapping and then assembling a network of local providers to achieve agreed outcomes'. This is essentially the role played by lead agencies in Australia's Partners in Recovery program (see below).

5. Cross-portfolio and cross-jurisdictional approaches

Another important challenge lies in the fact that the nature of mental illness typically requires a range of responses that *do not respect conventional portfolio boundaries*. For example, financial and other implications may arise not only for health agencies but also for housing, employment, police and corrections authorities. Many reviews and enquiries have pointed to the need for policy to be developed and resourced in a coordinated way across relevant portfolios. There is, however, little Australian experience of this kind of collaboration in human services.

In Australia, mental health issues also cross jurisdictional boundaries between the Commonwealth and the States and Territories. However, there is no machinery to routinely address the need for cooperation and collaboration among jurisdictions in response to mental health needs.

Some of the disincentives to cross-portfolio thinking are financial, since a policy or program initiated in one area of government may have significant parts of its financial pay-off in a different portfolio (or indeed different jurisdiction). This issue might be addressed in various ways; for example, central agencies like Treasury or Finance Departments could consider using existing internal processes – such as Regulation Impact Statements – to identify the potential impacts of policy changes on human services outcomes, including impacts that may be significant across portfolios and jurisdictional boundaries.

The greatest progress to date has been made in Western Australia, where in 2010 the government set up a Partnership Forum to help develop more productive relationships between the public and community sectors; the Forum comprises both senior public servants and community sector representatives and is independently chaired. In 2011 the government introduced a *Delivering Community Services in Partnership Policy* (DCSP) which sought to address a number of the difficulties discussed above. The aim of the policy is 'to improve outcomes for all Western Australians through a genuine partnership between public authorities and the not-for-profit community sector in the funding and contracting of sustainable Community Services'. It emphasises the government's desire to contract with the NFP sector 'in a manner that supports sustainable service delivery and recognises the importance of ongoing organisational viability', and seeks a more productive working relationship based on 'trust, collaboration, accountability and sustainable service delivery.'

6. Coordination in service delivery

Provision of good quality mental health services requires *cooperation and collaboration among service delivery agencies*, many of which are not-for-profit community organisations. Community-based organisations may have a disposition to work together, but this cannot be assumed, and commissioning agencies need to consider the extent to which tenders and contracts should *require or privilege collaborative approaches* and take account of the additional costs that may be incurred.

Partners in Recovery (PIR) is a major national program, funded for three years by the Federal Department of Health and due to expire in 2016, which is designed to achieve better coordination among mental health service providers in the interests of the client. PIR aims to:

> *better support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way.*

It aims both at improving quality of service for the individual client and also at system change. PIR is the subject of a detailed evaluation by Urbis Pty Ltd, which can be expected to generate important lessons for good practice and ways of achieving ongoing collaboration among service providers working with mental health consumers and carers.

7. High trust commissioning and contracting

Contracts within the private sector typically depend at least as much on trusted relationships as on the letter of the law. Unduly detailed and legalistic contracts can be counterproductive, since they suggest lack of trust and an adversarial relationship; over-specification can mean that one gets performance only to the letter of the contract.

This has obvious relevance for the relationships between government and community sector organisations, since the latter will often be motivated by commitment to a particular cause or client group, and their readiness to 'go the extra mile' may well be a significant ingredient of service quality.

The Productivity Commission has emphasised the importance of reducing the red tape that tends to accumulate over time because of 'the propensity for government agencies to focus on contractual rather than relational governance'. It argues that there needs to be a stronger focus on 'relational governance' in order to 'build a stronger sense of trust between government and providers'. While a market-based approach to government purchasing of services from the NFP sector is not inconsistent with good relationships, says the Commission, effort needs to go into improving the quality of engagement and building a stronger sense of trust.

> ***Commissioning agencies must consider the importance of funding certainty and security as well as reducing the administrative burden imposed on organisations that are continually required to bid for services and funding.***
>
> WA Delivering Community Services in Partnership Policy

Service agreements between governments and NFPs in Australia, however, have frequently been *detailed, prescriptive and legalistic*, with negative results. By contrast, the New Zealand Government has in some human services areas introduced *high trust contracts* that involve a collaborative and consultative approach, cross-agency cooperation, simple outcome-focused contracts and up-front payments. To be eligible for such a contract community organisations need to have a good record in service delivery, strong community links, strong governance and accountability arrangements and a record of working well with other agencies.

8. Competition and contestability

Competition has increasingly been introduced into government outsourcing of human services delivery. When poorly implemented, this has the potential to distort the process by focusing on what can be easily measured rather than on what really matters, and to weaken the community sector and undermine its contribution. The WA *Developing Community Services in Partnership Policy* notes that the routine or unreflective use of competitive tendering in community services has seen:

> *precious organisational resources diverted into, and often wasted on, bureaucratic bidding and reporting processes that culminated in pseudo commercial contracts and onerous accountability across the board… these requirements added to 'red tape' and detracted from the real aim of the not-for-profit community sector – the delivery of services to those who need them.*

Instead, the DCSP proposes contracting with the NFP sector in an appropriate way 'that supports service delivery and recognises the importance of ongoing organisational viability', acknowledging the importance of funding continuity and appropriate contract duration.

In this context it is essential to recognise the difference between competition and *contestability* – that is, the *credible threat* of competition. This is a crucial distinction in public administration and human service delivery, because applying competition principles in a simplistic way (especially when narrowly focused on price) can lead to instability and unpredictability that undermine service quality and continuity.

Contestability offers a means of maintaining pressure on service providers to keep up or improve performance, while also maintaining the constructive relationships between commissioner and provider that are important in ensuring congruence between policy and service delivery. It also assists government agencies, as 'stewards' of the system, to maintain a healthy supply chain of potential service providers.

Contestability recognises the importance of relational aspects in social and economic organisation. Successful management of a corporate supply chain, particularly in the delivery of complex services, cannot occur if there is excessive churn among suppliers… Contestability offers a way for public service commissioners to ensure that existing providers are delivering value for money without scrapping the value that lies in interpersonal and inter-organisational relationships.

Prof. Gary Sturgess

While broadly endorsing the adoption of competition and choice principles, The Harper Competition Review notes that because of the particular nature of human services, which 'serve important social objectives', and the fact that 'users of human services can be among the most vulnerable and disadvantaged Australians... the scope to use competition or market-based initiatives may be more limited than in other areas'. Harper emphasises at several points that the application of competitive principles in the human services sector needs to be approached over time and with some caution.

9. Individualised funding

The scale of impact of the National Disability Insurance Scheme (NDIS) in mental health is not yet clear, but it appears that the bulk of community mental health services will not be funded through the NDIS; Mental Health Australia believes that the majority of people with moderate to severe mental illness will not be eligible for NDIS support. If this is the case and if present policies remain in place, the level of coordination required in the planning and provision of mental health services will not be delivered by way of individualised funding.

The effective operation of a system of individualised funding requires knowledgeable and well-informed clients or consumers. Finding one's way around complex systems and understanding the quality and implications of alternatives may be difficult for anyone, but there are additional complexities in the area of mental health, since an individual's illness or disability may substantially impair his or her capacity to make good choices. The difficulty is compounded by the sporadic nature of some mental illness and the fact that changes in capacity can occur unpredictably and sometimes very rapidly.

Human services reform must focus not only on users but also on providers, whose ability to respond positively to policy change will be an important factor in ensuring that Australians continue to enjoy access to high-quality human services.

Harper Competition Review

Individualised or unit funding, almost by definition, brings greater transparency to the system, and is of course intended to empower service users to exert more control over their lives. On the other hand, a program like the NDIS has the potential to cause significant disruptions in service availability and delivery, and could in some cases put at risk the positive relationships and social capital that have been created and sustained through more traditional funding arrangements. The benefits associated with the move to individualised funding must therefore outweigh these risks if the NDIS is to have an overall positive impact on mental health outcomes.

10. Ways forward

This report has implications both for the community mental health sector itself and for the Australian, State and Territory governments. Chapter 7 provides suggestions for improving the way governments commission mental health services, based on the evidence available in the literature and on feedback from stakeholders. Some of the more significant and pressing recommendations include:

- developing clear policies acknowledging that NFPs represent an essential supply chain for the delivery of human services and that governments have a responsibility to help maintain that supply chain in a healthy and productive state
- taking action on the 2010 Productivity Commission recommendations relating to changes in NFP commissioning and contracting arrangements, including the recommendation that the Department of Finance develops a suitable set of guidelines for the contracting of human services
- based on experiences with Western Australia's Delivering Community Services in Partnership policy, adopting mechanisms to improve government/NFP relationships such as longer-term contracts, indexation of payments, equitable contract provisions and mutually respectful, collaborative approaches
- exploring options for promoting cross-portfolio approaches to mental health services, for example through the use of pooled funding and other innovative approaches to financing
- examining the feasibility and implications of moving away from activity or input requirements towards outcome-based contracting, while exercising appropriate caution in considering any introduction of payments related to the achievement of outcomes.

1 Introduction

Over the course of 2014, Mental Health Australia undertook extensive consultation with its members to identify the barriers to, and potential enablers of, a more effective and efficient Australian mental health system. One of the key issues identified through those consultations was the way in which funding arrangements can either help or hinder the delivery of services to support better mental health outcomes for clients.

There is considerable international interest at present in issues relating to more effective commissioning and procurement of human services – particularly in the context of increasing demand and limited or dwindling resources. As the United Kingdom's New Economics Foundation sees it, 'Providing services in the same way, while demand increases and resources dwindle, is not a sustainable option' (p9). Commissioning, it says:

> *…plays a central role in transforming the way public services are designed and delivered. Done well, commissioning can ensure high-quality public services that deliver real value for money…. Done poorly, commissioning risks providing services that alienate and disempower, that are inflexible and over-departmentalised, that privilege short-term cost efficiencies over long-term public benefit, and that ultimately offer poor value for money.* (p11)

In Australia, the kinds of conditions placed on funding – from Commonwealth-State arrangements through contract design, management and reporting – have implications that flow through to services and to consumer and carer experiences. Many current approaches are inefficient, misaligned and increase red-tape for providers, restricting innovation, flexibility and coordination in the delivery of front line services. Mental health and other human services are frequently subject to funding uncertainty, with adverse impacts on service continuity for clients and on operational costs and workforce stability.

Mental Health Australia believes that there is broad agreement in the mental health sector that improved approaches to commissioning and funding are a necessary (though not sufficient) condition for positive system change. One option that is gaining increasing attention across the social sector is funding mechanisms that emphasise the achievement of *outcomes*, rather than simply requiring delivery of specified activities and inputs. In principle, a clearer focus on outcomes would be a welcome development in mental health, as it aligns with central concepts of a contributing life, recovery and the importance of working towards holistic, whole-of-life outcomes through person-centred approaches. Moving to outcomes-based contracting is not a simple matter, however, and there would be particular challenges to be worked through in a mental health context.

To explore such issues further, Mental Health Australia commissioned this study into how different approaches to funding might support better mental health outcomes. Conducted between January and June 2015, the study relied chiefly on a review of Australian and international literature, published and unpublished, guided by consultation with relevant experts and practitioners; the researchers were advised by Professor Gary Sturgess of the Australia and New Zealand School of Government, who is an internationally recognised specialist in public administration with particular expertise in the areas of competition, contestability and outcomes-based commissioning and contracting. These initial sources were supplemented by additional, mainly Australian, material that was identified as the study progressed.

In consultation with Mental Health Australia, the study team prepared a discussion paper which was considered at a full-day Review Workshop convened in Sydney in May. The 26 people who participated in that review are listed in Appendix A; they included a range of stakeholders drawn from the not-for-profit and mental health fields, across most of the States and Territories, together with a number of experts and specialists from government and from academia. Discussions at the Review Meeting were followed up by further work on written sources, and telephone interviews with a number of the participants and some others whom they suggested. *It should be noted that the findings and recommendations of this report are the work of the study team and do not necessarily reflect the views of Mental Health Australia or any of the individuals who were consulted.*

Mental Health Australia anticipates that the findings of the study will have relevance for how government responds to several important policy processes, including the Competition Policy Review, the White Paper on the Reform of the Federation, development and implementation of the Fifth National Mental Health Plan, and the finalisation of arrangements for transition to full rollout of the National Disability Insurance Scheme. More generally, Mental Health Australia hopes to build on this work to promote changes over time to the way government agencies do business with the non-government sector so as to get maximum value from the ongoing government investment in mental health.

During the course of the study the Australian Government released the National Mental Health Commission's Final Report from its *Review of Mental Health Services and Programmes*. In absorbing and interpreting the complex findings and recommendations of that Report – including its references to funding mechanisms, contract terms and contestability in commissioning – it is again apparent that government and service providers need to come to grips with the various issues considered in the following pages.

Beyond the immediate policy landscape, it is hoped that the project's findings may spur further, more detailed work to identify, trial and refine approaches to commissioning for improved mental health outcomes. From Mental Health Australia's perspective, future work would ideally take place through partnerships between the mental health sector and relevant government agencies, including central agencies mindful of the cross-portfolio dimensions of these issues.

2 Conventional commissioning and funding arrangements and opportunities for improvement

2.1 Current practice

> *'Over the last few decades there has been a marked expansion in the extent to which NFPs, and more recently for-profit providers, are being funded to deliver human services on behalf of government.'*
>
> Productivity Commission 2010, *Contribution of the Not-for-Profit Sector*, p300

In Australia, funding of human services delivery has increasingly involved competitive submissions or tenders in response to a brief or offer from a Commonwealth or State/Territory Department. Successful tenderers or grantees are required to sign an agreement with the Department which specifies in greater or lesser detail what they are required to do to in order to earn payments (e.g. provide supported living services of some kind, or develop a specialised employment service, or facilitate service access for a disadvantaged group). Sometimes there are numerical targets to be met, such as a specified number of clients to be served.

Grants and contracts made by governments for the third-party delivery of social and welfare services, including mental health services, have thus commonly paid for 'promised activity and effort' (Beeck Centre 2014, p7). Payment has been dependent on 'inputs' (e.g. tasks undertaken, staff hours worked) or perhaps 'outputs' (e.g. number of clients seen), rather than on achievement of policy outcomes. (Desired outcomes may of course be achieved, such as a reduction in the incidence of expensive inpatient admissions, and these may be highly relevant to evaluation of the program's effectiveness; however these have not usually been a condition of the contract or a prerequisite for payment.) Accountability in the use of public funds has been a major preoccupation, and over time a great deal of government effort has gone into ensuring that the terms of the contract are adhered to; much of the oversight of such contracts has focused on ensuring compliance with financial and process requirements. This focus remains apparent in the *Commonwealth Grants Guidelines* issued by the Department of Finance in 2014.

2.2 Current problems

This style of commissioning and procurement has been common across human services, including mental health services. Its critics cite numerous shortcomings, for example that:

- it tends to reflect ad hoc decision making by 'siloed' government departments without reference to any larger strategic framework, resulting in sub-optimal use of resources and fragmented, patchy and in some cases overlapping services
- the process is complex and tends towards rigidity rather than flexibility and innovation
- it generates a great deal of red tape, wasting government resources on contract administration of dubious value, and service provider resources on repeated competitive tendering and on mechanical compliance and reporting – often dealing with inconsistent data requirements from different funders, and in some cases providing data that remains unanalysed
- it does not encourage timely responses to emerging problems
- it does little to ensure that basic policy goals are met.

The ill-coordinated effects of such commissioning and contracting arrangements are often made worse by the unpredictability and poor transparency of the processes through which departmental proposals are either approved or denied approval by central agencies such as Treasury and Finance and by committees of Cabinet. The recently published report of the National Mental Health Commission, *National Review of Mental Health Programmes and Services*, paints a bleak picture of Australia's mental health 'system'. It identifies 'fundamental structural shortcomings ' across 'a poorly planned and badly integrated system', 'a hit-and-miss arrangement of services and programmes around the country, seemingly based on no discernible strategy, creating duplication in some areas and considerable unmet need in others', and resulting in 'a massive drain on people's wellbeing and participation in the community.'

The Productivity Commission's 2010 report on the *Contribution of the Not-for-Profit Sector* considers commissioning and contracting issues in some detail. Among the problems experienced by the community sector (of which the non-government mental health sector is a part), the Commission refers to (pp J.5-J.7):

- the short-term nature of government contracts and service agreements (typically less than three years)
- poor risk management practice leading to inappropriate transfer of costs and risk
- excessive compliance and reporting costs, not proportionate to the level of funding allocated and the risks involved
- the degree to which contracts are used to micro manage NFPs (not-for-profit organisations)
- the sheer volume of contracts that community-based organisations have to manage.

Many of the submissions made to the Productivity Commission's enquiry made the point that short-term contracts create uncertainty for providers and are a barrier to effective long-term planning and workforce development and retention, while the reliance of some NFPs on multiple short-term contracts creates a considerable administrative burden. Mission Australia, for instance, noted that:

> *Programs in disadvantaged communities requiring long term place based interventions require a consistent funding stream. On again/off again funding, one and even three year funding agreements, are not always conducive to such long term approaches and sudden funding withdrawal can be disruptive or terminate vital programs without outcomes being achieved* (p J.6).

The submission from Baptistcare WA stated that:

> *No serious community work can be done in short time frames. It shows a distinct lack of understanding about the cultural and physical issues that have to be understood and negotiated* (p 6).

The Commonwealth acknowledges the importance of long-term planning and long-term funding (up to 30 years ahead) in some areas of health – for example in medical education. It can certainly be argued that mental health services are an area where governments should consider far longer term funding and contract arrangements than are currently used. In practice, most *publicly-delivered* mental health services do enjoy reliable ongoing funding, but support for community-based services is much more precarious. There appears to be little logic in this inconsistency of approach.

The Productivity Commission notes (p J8) 'a strong perception among NFPs that poor risk management by government is leading to inappropriate cost shifting', and that 'one manifestation of this is government departments and agencies seeking to eliminate risk by imposing ever more complex contractual and reporting requirements', or red tape. In the words of Catholic Social Services Australia:

> *Like all activities, social service delivery involves risks. Government should attempt to allocate these risks in a way that maximises performance, efficiency and accountability. Part of the problem with some of the current arrangements is that risks are misallocated….Current accountability and red tape issues are so process focussed as to render some services compromised in achieving efficiency and effectiveness* (pp J.8-J.9).

'The frequency of the turnover in government programs (including the creation of new programs) appears to be adding to the compliance burden', says the Productivity Commission; NFPs are 'increasingly having to employ professional staff to deal with the administrative burden of government tendering, contractual and reporting requirement' (p J.9). There is also a perception (p J.10) that:

> *Contractual and reporting requirements do not appear to lead to improved outcomes for clients. Indeed, many NFPs considered that the information and data they are asked to provide seemingly disappears into the 'ether' with little or no tangible effect.*

A recent paper by the Australian Council for Social Service (ACOSS), titled *Improving Community Sector Effectiveness and Efficiency: Priorities for Reducing Red Tape* (July 2012), discusses several other issues

relating to the commissioning of human services in Australia and ways in which improvements might be made. Experience of working with a range of different government agencies, says ACOSS, reveals to the not-for-profit sector that there is a difference between 'legitimate Government requirements' and 'the layers of additional red tape that are unnecessary and duplicative' (p3).

> *(Many) of the processes around contracting are overly burdensome yet fail to set sensible outcome measures or assist in performance evaluation and improvement. Regulation tends to focus on control over the process, often at the expense of ensuring that good outcomes are achieved …. Poorly framed or overly stringent standards or requirements become unnecessary cost drivers that distract the service providers' resources and focus from the areas of most importance to the achievement of … overall objectives.* (p3)

Inconsistency between the data definitions and reporting frameworks required by different government agencies wastes valuable service provider resources and time:

> *Organisations are required to report on the same activities in different ways to different funding bodies …. There are ongoing complaints about different data definitions used by different agencies, even if they are in the same department and same jurisdiction and supporting similar programs.* (p4)

The ACOSS paper identifies specific shortcomings relating to negotiation, service costs and funding:

- negotiation processes are almost non-existent and rarely adequate when they do take place
- there is no clear policy framework for determining the cost and funding levels of government-funded community services
- repeat funding rarely keeps up with cost rises and indexation is inconsistent and inadequate (p1).

Other concerns include:

- social services funding arrangements rarely acknowledging the importance, the risks and the costs of innovation and experimentation
- significant delays experienced in government finalising contracts and making contractual payments
- contracts failing to say how commissioning bodies will respond to policy changes or to changes in the external environment, such as increases in staff Award entitlements
- contracts that give government agencies wide powers to terminate, sometimes without providing reasons, thus undermining providers' capacity to plan ahead, manage cash-flow and offer security to their workers
- concern that 'government service delivery contracts significantly shift the risk to community services organisations without adequate compensation'
- failure to acknowledge reporting requirements as part of the cost of delivering a service (pp2-3).

As these points indicate, one source of concern is the power imbalance that effectively makes the relationship between government and service provider one of master and servant, with the non-government sector having little room to contribute or negotiate. Instead of there being an exchange of ideas and expertise that might work towards clarifying just what needs to be done and the best ways of doing it, government as funder simply prescribes the terms of the contract. This is despite governments across the political divide repeatedly acknowledging the unique role of the community sector and stating an intention to increase that role over time. While governments have, at least in principle, accepted that NFPs are valued partners in the provision of human services, this has not translated into behaviour change on the part of (often junior) public servants charged with outsourcing services and managing contracts.

Poor contracting processes, states ACOSS, can severely undermine the efficiency and effectiveness of the services provided. The *Red Tape* paper argues, for example, that excessive emphasis on competitive tendering, while intended to improve transparency, can have negative impacts such as discouraging collaboration and sharing of best practice, as well as imposing heavy demands and costs on NFPs (see Section 6 below, *Competition, Contestability and Continuity*). It submits that contracting processes ought to aim for:

- *recognition of demonstrated performance in the existing system or elsewhere, not a heavy reliance on quality of submissions alone*
- *balance between the Government and providers in contracting processes*
- *minimal time requirements on community services*
- *minimal disruption to clients that might ensue, either through the contracting process itself or in the transfer of records from established services to new agencies*
- *valuing service and community connections as part of any new or re-contracting process.*

The ACOSS *Red Tape* paper supports (p4) the Productivity Commission recommendations, made in 2010, that:

> *Australian governments should adopt a common framework for measuring the contribution of the not-for-profit sector. Having regard to the diversity of the sector's activities and structures, measurement using this framework should embody the principles of proportionality, transparency, robustness, flexibility, and relevance.*
>
> *To minimise compliance costs and maximise the value of data collected, Australian governments should agree to implement a reform agenda for reporting and evaluation requirements for organisations involved in the delivery of government-funded services.*

It also notes other key Productivity Commission recommendations such as the following:

> *Australian governments should urgently review and streamline their tendering, contracting, reporting and acquittal requirements in the provision of services to reduce compliance costs. This should seek to ensure that the compliance burden associated with these requirements is proportionate to the funding provided and risk involved.*
>
> *Australian governments should ensure that service agreements and contracts include provision for reasonable compensation for providers for the costs imposed by changes in government policy that affect the delivery of the contracted service, for example, changes to eligibility rules, the scope of the service being provided, or reporting requirements.*
>
> *The length of service agreements and contracts should reflect the length of the period required to achieve agreed outcomes rather than having arbitrary or standard contract periods.*
>
> *The Department of Finance and Deregulation should develop a common set of core principles to underpin all government service agreements and contracts in the human services area. This should be done in consultation with relevant government departments and agencies and service providers.*

The Productivity Commission emphasises the need for close cooperation between the government and community sectors in making such reforms, and ACOSS points to the need for service organisations to play a much larger role both in early stages of planning and in the tendering process itself.

The Joint COSS Network submission (November 2014) made to the recent *Competition Policy Review* makes some further suggestions, for instance that service funding should move to long-term cycles, with a minimum of three years, that longer tendering periods should be introduced to facilitate cooperation and collaboration among providers, and that there should be a six-months transitional period for renegotiation of expiring contracts or to facilitate transition arrangements if contracts are not to be renewed. Again it emphasises the importance of consultation with community service providers at the stage of program and service design.

It should be said that many of the difficulties outlined above are also evident in National Partnership Agreements and other funding mechanisms between the Commonwealth and the States. Such inter-governmental agreements have also been criticised as imposing excessive reporting and administrative requirements on the States and Territories, and are frequently of short duration. These problems can have flow-on effects on service providers that are contracted by state/territory governments. (Appendix C to this report discusses some aspects of National Partnership Agreements.)

2.3 Government responses

The Productivity Commission's 2010 report makes it clear that there are many improvements that might be made within the existing framework of commissioning and funding arrangements for human services. It notes that various governments have recognised problems in this area and have made some attempts to improve their commissioning and contracting processes – for example, South Australia's adoption of a longer contracting period for funding of mental health programs, and improved reporting and risk management proposals under Queensland's *Framework for Investment in Human Services.* At the time the present research was being conducted, NSW Health was in the process of introducing Partnerships for Health, an initiative which among other things has implications for the funding of community managed mental health services, with a move away from block grants to a contractual system with clearer deliverables. The NSW Mental Health Coordinating Council (2015) has expressed some concerns and uncertainties about how the new system will operate, and argued the need for community organisations to be adequately supported and resourced in this transition.

At national level, the Department of Finance in 2014 issued revised *Commonwealth Grants Guidelines* which set out seven key principles including *collaboration and partnership*, *proportionality* and an *outcomes orientation*. These guidelines are intended to cover grants of all kinds (including for example a grant to a sporting body to construct new facilities), and at one point they distinguish between grants and the purchase of services. They do not appear to take up the Productivity Commission recommendation that the Department develop a common set of core principles to underpin all government service agreements and contracts in the human services area (see Section 2.2 above).

The 2014 Joint COSS submission to the Competition Policy Review refers to some other recent initiatives that aim to address commissioning or contracting problems in particular fields, such as the Indigenous Advancement Strategy which brings together funding for Aboriginal and Torres Strait Islander services within the Department of Prime Minister and Cabinet.

Part of the mission of the Australian Charities and Not-for-profits Commission (APNC) has been to address inconsistency and unnecessary red tape in reporting requirements for charities (though not for other NFPs). Several elements of its reform agenda:

> *…relate to reviewing and harmonising requirements under government contracts. These include a Commonwealth review of regulatory duplication led by the ACNC, the Treasury and the Department of Finance and Deregulation, the piloting of low-risk grant agreement templates, and changes to the Commonwealth Grant Guidelines.* (ACNC, Not-for-profit reform and the Australian Government, updated September 2013, p19)

As noted in section 5.3.1 below, the Abbott Government has an explicit commitment to rationalisation of government structures and processes and the reduction of red tape – including 'more streamlined and efficient arrangements' in the health sector in particular.

2.4 Western Australia: The Partnership Forum and the Delivering Community Services in Partnership Policy

Recent developments in community services in Western Australia are of particular interest. In 2010 the Western Australian Government set up a Partnership Forum to serve 'as a focal point to build the

relationship between the public and not-for-profit community sector' (WA Government website, Partnership Forum Fact Sheet 1). The Forum's mission is to:

> *Bring together leaders from State Government agencies and the not-for-profit community sector to improve outcomes for all Western Australians through a genuine partnership in the policy, planning and delivery of community services …. The Partnership Forum is working to fundamentally change the relationship between the public sector and the not-for-profit community sector. The goal is to create a strong and genuine partnership built on respect and shared responsibility for building a better society for all Western Australians.* (Government of Western Australia website)

In 2011 the WA Government went on to introduce a *Delivering Community Services in Partnership Policy* (DCSP), which sought to address a number of the difficulties discussed in the previous section of this report. Overseeing the policy is one of the chief responsibilities of the Partnership Forum, which comprises both senior public servants and community sector representatives, and is independently chaired. The stated aim of the policy is 'to improve outcomes for all Western Australians through a genuine partnership between public authorities and the not-for-profit community sector in the funding and contracting of sustainable Community Services' (p2). The operating principles are to be:

- promoting flexibility, innovation and community responsiveness
- encouraging a more productive working relationship between government agencies and the NFP sector, based on 'trust, collaboration, accountability and sustainable service delivery'
- 'clarifying when services are to be put to open tender and when a more targeted non-market based approach is more appropriate'
- reducing red tape
- emphasising the Government's desire to contract with the NFP sector 'in a manner that supports sustainable service delivery and recognises the importance of ongoing organisational viability' (p2).

The policy refers to many of the issues that have been of concern to human services providers across Australia. It offers, for example, *greater community involvement in the planning and evaluation of services* (p3), and *recognition of the contribution of both sectors in the design and delivery of Community Services* (p5). It states that 'contract specifications should focus on outcomes sought and avoid prescribing inputs such as staffing levels and salaries' (p9), and provides that:

> *Recognising the special circumstances that apply to the delivery of Community Services, service agreements should be of sufficient duration to encourage continuity, efficiency and sustainable service delivery*. (p9)

It provides for a funding agency to use a 'Preferred Service Provider' in some circumstances, rather than going to tender, so long as several conditions are met. Agencies 'must recognise and give weight to the history of a service provider's performance and the context in which negotiations arise. A significant aspect of this is 'the need … to maintain service continuity' (p11). Further:

> *In the interests of reducing the compliance burden the DCSP policy suggests that where a commissioning agency has several contracts with the one provider, it should use a 'master agreement' with appropriate schedules attached... It provides that 'all contracting arrangements are to be indexed in accordance with Government policy' ... It acknowledges the importance of funding certainty and contemplates the use of long-term service agreements in appropriate cases: 'Sustainable funding is a key factor of sustainable service delivery and enhances the capacity for Organisations to make long-term strategic decisions, attract and retain human capital, and deliver better value for money outcomes'.* (p15)

The introduction of the DCSP policy was accompanied by a price increase of 15% paid to eligible NFPs from July 2011, to address some immediate funding concerns, and an average 10% funding increase designed to ensure sustainable procurement.

Since 2012 Curtin University has conducted annual reviews of the DCSP policy and related funding initiatives, based on surveys of commissioning agencies and service providers. The 2014 evaluation (see Curtin University, *Evaluation of the Sustainable Funding and Contracting with the not for Profit Sector Initiative and Associated Procurement Reforms*, *2014*) provides detailed information on various aspects of contracting and NFP operations. It reports that by 2014 some two-thirds of service agreements were compliant with DCSP policy requirements. The report does not offer a simple answer to the question of what the new policy has accomplished – partly because it is difficult to identify effects flowing from the policy as distinct from other influences at play. It indicates, however, that over 80% of NFPs report strong, effective relationships with state government agencies, and that NFPs reported improvement across most aspects of workforce management. On the other hand, only about a third of respondents stated that the DCSP initiative had been associated with a positive effect on service quality, with the remainder either being unsure or seeing no change (pp 1-4).

The role of the Partnership Forum continues to evolve, along with implementation of the DCSP policy. Drawing on lessons learned in the early stages of implementation, the Forum has recently issued a set of good practice guidelines. Among the issues to which the Forum has given consideration is the possibility of establishing a joint commissioning board to promote sharing of information and service planning across funding agencies.

2.5 Summary

The NFP sector in Australia identifies serious shortcomings in community service commissioning and contracting practice, relating to such things as:

- siloed decision making without reference to a guiding strategy
- short-term contracts and insecurity of funding that undermine service providers' capacity to plan ahead, and which prejudice workforce stability and service continuity
- onerous compliance and reporting requirements that bear little relation to level of funding or level of risk, and contribute little to the achievement of policy or project objectives
- lack of consistency in government reporting and data requirements and failure to make best use of information gathered
- inequitable conditions such as unilateral rights for governments to terminate contracts and lack of compensation for cost increases flowing from policy changes
- failure to include community sector representation at the stages in of policy development and program design.

The Abbott Government has an explicit commitment to the reduction of red tape and to more rational government structures and processes. The Productivity Commission has made out the case for reform. Various governments have displayed some awareness of the issues, and over recent years have introduced certain improvements. There remains, however, much scope for further progress. The Western Australian Government's Partnership Forum and Delivering Community Services in Partnership Policy represent promising initiatives for change.

3 Outcomes-based contracting

Beyond reforms of the kind canvassed in Section 2, there are some rather different approaches to commissioning and funding that can be considered; this and following sections of this report discuss these in the context of mental health services in particular.

3.1 Outcomes and outcomes measurement

One of the approaches most commonly discussed as an alternative to existing commissioning and procurement arrangements is outcomes-based contracting.

In *The Compass* (2014), Muir and Bennett of the Centre for Social Impact at the University of New South Wales refer to the scale of health and social welfare need in Australia, and argue that:

> *At a time when we spend around $300 billion a year on social purpose and where government resources are becoming increasingly scarce ….more than ever, Australia needs to concentrate on making progress on social outcomes. We need to focus on what we want to achieve, how we will meet these goals and whether, where, and under what circumstances we're making a difference …. Our social progress has been stymied because we haven't concentrated enough on outcomes. Together we've created a social purpose system that has good intentions, but more often focuses, counts and funds what and how much we do, rather than whether we are making a difference.* (p5)

In similar vein, the New Economics Foundation in the United Kingdom observes that 'a lot of money can be spent putting on activities and counting outputs, but unless people are supported to function better, broader change will not be achieved' (p33). The submission by the Joint COSS Network to Australia's Review of Competition Policy (2014) says that 'too often public services are delivered, funding programs designed or regulatory restrictions introduced without a clearly articulated set of outcomes to be achieved' (p7). That submission also emphasises the importance of consultative, inclusive processes in specifying outcomes (see section 6 below).

In the specific context of mental health, Rosenberg and Rosen (2010a) comment that:

> *Australia still lacks a robust accountability framework with which to discern the actual impact of the $5.5 billion we spend on mental health each year. Simply put, we do not know whether this funding helps people get better clinically, find and keep a job, attain stable housing or generally enjoy a good quality of life …. There is no national validated approach to the collection of the experience of consumers and carers. We are 'outcome blind' to the things that really matter. (p85)*

Outcomes, say Muir and Bennett, are 'changes in attitudes, values, behaviours or conditions.' They may be immediate, intermediate or long-term. We can think in terms of outcomes for individual clients or groups of clients, outcomes at the service provider level, or outcomes for the general community. The outcomes framework that has been proposed by the Department of Health and Human Services in Tasmania (see section 4.5 below) takes account of different levels of this kind.

For Muir and Bennet 'the primary purposes of outcomes measurement are to provide evidence of what works and what doesn't, and why and how to improve effectiveness and efficiency' (p24). Indicators for measuring progress towards outcomes, they say, may be either qualitative or quantitative, and a good indicator should:

- be a good conceptual fit
- come from a quality data source
- capture the essentials
- be achievable and measurable
- be able to be tracked over time.

As well as greater confidence that the organisation is meeting its mission and goals, they say, the potential benefits of an outcomes focus for service providers include:

> *…creating a culture of learning and innovation, professional development, better and more meaningful communication, an increased reputation for transparency, trust and efficacy (and the brand value that follows), and sustainability.* (p8)

3.2 Contracting for outcomes

Reduced costs and/or *better services* are often cited as the two main reasons for an increasing interest in outcomes-based payment systems. Obviously there is scope for tension between these two goals in practice, which raises the issue of *value for money* – see section 6.6.

According to a report published by Georgetown University's Beeck Centre in 2014:

> *As the public sector faces increasing economic challenges and diminishing budgets, alongside a rising demand for services, governments have developed innovative and effective ways to identify, objectively measure, and then pay for successfully achieving outcomes in social services and economic development delivery.* (pp7-8)

That report states that 'effective "outcomes-based" grant and contract models are now emerging' in many places (p7). 'Governments at the U.S. federal, state, and local level, and across the globe, are structuring agreements to identify critical social services "outcomes" and pay only when those outcomes are achieved' (p9). 'When implemented effectively, payment structures based on successfully meeting stated outcomes can dramatically increase efficiency, significantly lower costs, and have a profound impact on program success' (p7).

One of the concepts involved is that of transferring risk from government to the service provider. In some instances (as with the replacement of Australia's Commonwealth Employment Service by Job Services Australia) the transfer of risk involves large-scale privatisation, but this need not be the case.

The Beeck Centre report, like much of the literature discussed below, is concerned with government contracting in which some or all of the *payment* which service providers receive is based on their achieving certain outcomes. However, it is of course possible to pursue a stronger focus on outcomes *without attaching incentives or penalties to them.* The Harvard academic Shelley Metzenbaum (2006) discusses performance accountability, largely in the context of the motivation and performance of employees. She attributes significant power to clearly stated, challenging and outcome-focused goals and to good measurement practice in themselves, and argues that in general these may be just as effective without any extrinsic (e.g. monetary) incentives or penalties. In fact the public sector often makes use of targets or standards that do not have sanctions or incentives attached to them; in its January 2014 *Submission to the 2014-15 Federal Budget*, Mental Health Australia notes that:

> *The very presence of well-designed targets and indicators can of itself drive reform, leading ultimately to improved policy outcomes by maximising the impact of existing investments and guiding new investments where necessary*. (p18)

Metzenbaum argues that extrinsic incentives are *unlikely* to work where goals are complicated; where goal attainment is highly uncertain and depends on factors that are difficult to influence through agency action; where goal attainment necessitates experimentation because there is limited knowledge about what sorts of intervention might work; and where there is a long time lag between agency action and social outcome (p47). These conclusions are consistent with a number of other views discussed below – and of course such circumstances are common in mental health.

Advocates of outcome-based commissioning and payment-by-results argue that:

> *Outcome commissioning can improve the level of achievement of outcomes of public services in three main ways. It ensures providers focus on the outcomes that are important to users, creates powerful incentives to achieve outcomes, and gives*

> *providers flexibility, incentives to innovate and ability to personalise services.* (Chris Nicholson 2011, p10, quoting the 2020 Public Services Trust report *Better Outcomes*)

The Harper Review (*Competition Policy Review, Final Report* 2015) also refers to some of the potential benefits of an outcomes approach:

> *An outcomes focus allows service providers to suggest different approaches for achieving the desired result rather than having to demonstrate specific activities, tasks or assets. It allows potential providers to offer new and innovative service delivery methods and helps to encourage a diverse range of potential providers.* (p242)

Outcomes are also relevant in the context of grants made by the Commonwealth to the States and Territories (see Appendix C). Mental Health Australia argues that, beyond basic payments for services,

> *The Commonwealth should provide reward payments for states/territories (and/or regional bodies) that reach specified milestones towards the achievement of national targets for whole-of-life mental health outcomes.* (Blueprint p28)

3.3 Change across systems

Other contributions to the literature on outcomes-based contracting tend to be more cautious in than the Beeck Centre report. Two separate reports on the possible adoption of outcome-based commissioning and funding as a framework for government contracting in general (New Zealand Treasury 2004 and Deloitte 2011, for the United Kingdom) emphasise that this would represent a major shift. The New Zealand report states that for thorough implementation of a 'results focus … all aspects of the wider system will need to be amended, in order to support a general cultural change'; obviously this would be 'a slow process.' Consistent with the Deloitte report, the NZ report also says (p8) that:

> *The nature of outcomes means that more often than not the key goals of government will only be achieved if agencies coordinate their activities. This suggests that a managing for outcomes environment will need to be supported by a culture that allows for improved alignment of resources and 'joined-up' delivery of services …(including, for example) some agglomeration of the structures of the public management system.*

The Deloitte report notes that fairly and appropriately pricing outcomes is no easy matter:

> *A central challenge…is to implement appropriate pricing structures (…that should) vary across different programmes and assign different weightings across a complex performance matrix. They must also adapt over the life of a contract as the complexion of desirable outcomes changes. It is an extraordinarily complex task...* (p13)

The Deloitte report suggests that other necessary changes would include initiatives relating to finance, such as a system for loans to service providers to address the problem of 'backloading 'of payments (that is, the fact that many providers would need funds to carry them over until they had achieved an outcome and could claim a payment).

In Australia in 2013 Dr Peter Shergold presented a major report to the Victorian Government in response to its request for recommendations as to 'how government and non-government service providers can work together to improve outcomes for Victorians' (*Service Sector reform - a roadmap for community and human services reform*). That report puts forward a comprehensive framework for change, with strong emphasis on a holistic approach designed to achieve the best results for clients; shared governance; client choice and empowerment; flexibility; simplifying regulation and processes; an integrated, whole-of-government approach; consultation and collaboration between the government and non-government sectors; collaborative service planning and delivery; early intervention; innovation; and a focus on outcomes and, where possible, outcome-related funding.

> *An outcomes framework should be developed through a partnership between the government and community service organisations. The framework should establish metrics against which the delivery of beneficial social impact will be audited, monitored, measured and reported over time. Individual government departments should clearly articulate the outcomes sought from government investment in the services they fund and, wherever possible, link funding to the achievement of those outcomes.* (p49)

The Shergold report contemplates Victoria shifting 'progressively from funding activities and outputs towards commissioning outcomes,' reducing 'the administrative burden imposed on community organisations through unnecessary and duplicated reporting processes', and developing standardised service agreements and guidelines across government. 'The multiple streams of program funding should be progressively consolidated or linked to give service providers greater flexibility to pursue integrated outcomes' (p5). The report also states (p48) that:

> *The contracting of services to community service organisations should involve consultation on all significant issues, including the development of policy, planning and service design.*

Shergold thus places contracting-for-outcomes squarely in the context of much broader change, including consolidation of funding across government agencies. His report proposes arrangements designed to 'drive the transition to a new way of working,' including a 'partnership advisory committee' and a separate government unit to oversee implementation and to advise and support both government and non-government agencies (pp 48 and 49).

3.4 Program-specific approaches

By contrast with the issues raised in section 3.3, most commentators are concerned less with system-wide change than with the possibility of outcome-based contracting and/or funding for particular projects or programs. Even at this scale, the literature shows that there are challenges to be met. Important among these are:

- the difficulty of identifying one outcome, or a small number of outcomes, that convincingly capture the essence of the underlying policy intention
- ensuring that these outcomes can be tracked and measured in a meaningful and reliable way, at reasonable cost, and within a reasonable timeframe
- ensuring that desired outcomes can be confidently attributed to the activities of the contracted provider
- pricing outcomes in a fair and consistent way that minimises perverse incentives and the risk of 'gaming' (e.g. the temptation for providers to target the easiest or least disadvantaged clients – 'cherry picking ' or 'cream skimming')
- undertaking the consultation and negotiation, pilot testing, adjustment and refinement that successful implementation is likely to require.

There is also the supply chain difficulty of finding service providers who are willing and able to wait for payment until the desired outcomes are achieved, and willing to take on the risk that the outcomes will *not* be achieved. Nicholson (2011) notes that 'The working capital requirements of … (payment by results) will cause problems for Small and Medium Sized Enterprises and the … (community) sector in bidding for contracts' (p6). The Harper Review (*Competition Policy Review*, *Final Report* 2015) suggests that: 'In some cases, innovation and high-quality user outcomes can be encouraged by offering financial rewards for performance above specified targets'.

Some commentators present what might be called a 'black box' model of outcome-based contracting in which those commissioning the service are relieved of any need to oversee or monitor service providers, while the providers themselves are freed from reporting responsibilities and can readily experiment and innovate, since all that matters to either party is the achievement of the agreed outcome. This kind of approach has wide application in the business world, and also no doubt in government contracts for the

purchase of goods such as vehicles or computers. As suggested elsewhere in this report, however, there are various reasons why such a pure outcomes model may be rarely found in the field of human services.

The use of outcome-based contracting in human services

The two human service areas where outcomes-based approaches have been most commonly used to date are *employment services* and *corrections* (one of five international examples that the Beeck Centre report discusses in some detail is Job Services Australia). In his discussion of possible use of payment by outcomes in the field of corrections, Nicholson (2011, p5) notes that:

> *Experience … to date in the UK has been primarily limited to the welfare to work market where success has been varied and limited. Despite this, Payment by Results is increasingly being suggested to be used across a wide range of government policies…*

There appear to be few examples to date of outcome-based contracting being used in *mental health services* - perhaps because of the difficulty of identifying a small number of indicators that are sufficiently simple, clear and salient. A 2012 British report by A4e Insight draws a contrast between the fields of employment and corrections, on the one hand – where it is possible to focus on a single outcome (employment or reduced reoffending) and to use a 'single, auditable proxy measure,' and where the benefits from achieving outcomes accrue wholly or mostly to one government agency - and, on the other hand, more complex policy areas where there may be multiple relevant outcomes, no single measure of success, and accrual of benefits to multiple agencies (p42).

One mental health example discussed in the literature involves the County health authorities in the city of Philadelphia, who introduced an incentive scheme based on bed *occupancy*, rather than bed *availability* as in the past, for residential service providers (Faith and others, 2009). Even this apparently modest scheme took time and effort to introduce, and its implementation was facilitated by several other changes made to the accommodation system. Faith and his colleagues suggest several reasons why mental health authorities may find it difficult to develop satisfactory outcomes-based contracting arrangements, including the following (p401):

- *lack of consensus about what appropriate mental health outcomes to track*
- *financial and operational constraints that limit the ability to monitor contracts adequately*
- *difficulties measuring improvement in client functioning*
- *pressure to produce meaningful evaluations within tight time constraints.*

They also note that there may be controversy around the principle of linking provider reimbursement to client outcomes, and that there may be '*organisational entrenchments that resist the transition from traditional monitoring approaches to those involving measuring performance and outcomes.'*

Payment for outcomes

As indicated above, *delaying payments* until outcomes are achieved raises obvious financial issues for service providers, and in principle could significantly reduce the pool of possible contractors (for example, driving out poorly capitalised small and not-for-profit providers). The overseas literature contemplates various financial arrangements that might help address this - for example some system of loans or bridging finance or the use of social impact bonds. Interestingly, in June 2015 the New Zealand Government announced details of that country's first social bond, which will in fact focus on the mental health sector (*New Zealand Herald*, 1 June 2015).

As Harper points out, the NSW Government has experimented with the use of social benefit bonds in several fields (*Competition Policy Review, Final Report*, p222). However, social finance and impact investing are very much in their infancy in Australia. In 2011 an Australian Senate committee recommended the establishment of a Social Finance Taskforce, whose brief may have extended to considering mechanisms such as social impact bonds. That recommendation has not yet been taken up; on the other hand, the work of the Prime Minister's Community Business Partnership includes an interest in 'the emerging impact investment market'. That Partnership brings together 'leaders from the

community and business sectors to promote philanthropic giving and investment in Australia' (Community Business Partnership website). Among its roles is to consider 'the potential of innovative investment and finance models and structures to support a culture of giving and service', and it has established a working group on impact investing and partnerships. Impact investing, it says, 'can play an important role in more effectively harnessing resources to improve social outcomes for people and communities across Australia', and can 'support innovation in the delivery of services' (website). Government departments and peak bodies such as Mental Health Australia could usefully consult with the Partnership and the working group on the financial implications of the future use of payment for outcomes in human services.

In some cases commissioning bodies have tried to reduce the impact of deferred or uncertain payment by introducing outcome-related incentives (or sanctions) that are quite small-scale ('low-intensity') relative to the contract as a whole, and/or by making them only one part of the payment arrangement - that is, by retaining some payment for activities. The Harper Review contemplates the use of a judicious mix of outputs and outcomes: 'In many cases, it may be preferable to commission services using a carefully specified blend of outcomes and outputs' (*Competition Policy Review* 2015, p243).

One conclusion we might draw from the literature is that outcome-based *payment* arrangements may be most suitable for relatively simple situations where the links between inputs, outputs and outcomes are reasonably straightforward and uncontroversial, and/or where one or two simple outcomes can be agreed on as fulfilling policy objectives. As noted above, placing and keeping an unemployed person in a job would seem a lot more straightforward in this regard than addressing her mental health problems and needs. The Philadelphia scheme mentioned above initially chose to treat one simple measure - bed occupancy - as the basis for payment for its residential service for people with mental illness. (Later it found it desirable to add two other outcome measures – rates of discharge to a lower level of residential care and rates of admission for in-patient treatment.)

Sturgess and Cumming (2011) believe that outcomes-based payments will be suitable in some situations and not others; for instance, 'there are some public services for which the identification and specification of clear and consistent outcomes is extraordinarily difficult' (p17). They suggest that the best opportunities for introducing payment for outcomes arise in situations where there are 'known unknowns.' Where the linkages between inputs and outcomes are close and well understood, they say, there is little point in specifying outcomes and commissioning agencies might just as well purchase key inputs. 'On the other hand, where these linkages are so poorly understood that there is very little agreement about the relationship between effort and outcome, it will be virtually impossible to write a contract that effectively transfers risk' (p9).

> *Payment-by-outcomes seems to work best in circumstances where commissioners already have some confidence about the service models that are likely to work, but lack confidence about the capacity of existing delivery chains to deliver significantly better outcomes. Much of the interest in payment-by-outcome seems to relate to certain kinds of innovation: (i) identification of those beneficiaries for whom particular service models work best; (ii) creation of effective management processes (for example, through joining up fragmented supply chains) enabling services to be tailored to different classes of beneficiary; and (iii) encouragement of much greater* co-production on the part of beneficiaries'. (p9)

Some guidelines

In their 2011 paper Sturgess and Cumming discuss in detail a range of issues raised by outcomes contracting, and offer a 'toolkit' to assist commissioning agencies in thinking through the challenges and how they might be overcome. In terms of the feasibility of introducing outcomes-based contracts in various fields, the tone of their report is 'optimistic, but cautiously so' (Foreword, p6).

The many points made by Sturgess and Cumming include the following (again, several of these echo propositions mentioned above):

- Since program objectives in the public sector are 'often ambiguous, with primary outcomes surrounded by a variety of contextual goals' (p8), ambiguities need to be faced and resolved at an early stage.
- Where it is not possible to reduce performance measures to a relatively small number of clear and consistent objectives, 'it will be difficult to shift the risk of delivery down to operational managers' (p25).
- Payment-by-outcomes is unlikely to work well with policies where there is a long delay between action and outcome - for example in early childhood support programs (p38) – or, we might add, many mental health programs. Further, 'Since the need for long-term investment in intractable social problems is one of the principal reasons why governments become involved, this may be a significant constraint' (p10).
- In principle outcomes need to be readily attributable to the relevant intervention rather than to external factors; on the other hand, it is a mistake for commissioners to be too concerned with the issue of 'deadweight' – that is, those desirable outcomes that may well have occurred without the intervention.
- Performance incentives need not be 'high-intensity, with significant financial risk to the provider;' in some situations, in fact, this may be highly undesirable (p18).
- Successful performance contracting can draw on currencies other than money - such as reputation, organisational culture and professional norms (p30) - in designing incentives and sanctions. For example, publication of a league list of performance may be a powerful motivator in some cases. Furthermore, targets and incentives are only one part of the 'toolkit' available to commissioners of services: 'commissioners are also able to influence the behaviour of providers through the ways in which systems as a whole are designed', (p31) - for example, by the scale of contracts offered or by conditions likely to appeal to some types of suppliers more than others.
- It will rarely be possible to use payment-by-outcome in an undiluted form (p19). For example, if one of the objectives is to stimulate experiment and innovation in service delivery, it will be necessary to limit the level of risk that the provider is asked to take on. Also, contracts may in practice use up-front or progress/milestone payments even where these do not strictly belong within the payment-for-outcomes framework, in part to address cash flow issues for smaller and not-for-profit providers (p37).
- Some flexibility is required in defining the results that will trigger incentives or sanctions. Because it may not always be possible 'to design performance measures that directly drive the delivery of primary outcomes, outcome commissioning seeks to clarify the ultimate ends for which a programme was established, and if necessary, to incentivise the delivery of intermediate outcomes or high-level outputs that serve as surrogates for these primary goals' (p18).

Proceeding with caution

Sturgess and Cumming advise that policy makers need to be patient in this area, 'recognising that any move to high-stake performance incentives and outcome specification will inevitably be a process of discovery, with initial mistakes and misunderstandings' (p9). Along the way they may need to 'adjust the design of the system within which contracts are made' (p8). 'The ideal set of performance incentives cannot be known in advance, but will only be discovered through systematic learning …. commissioners should deliberately create adaptive systems from the outset, where exploration is encouraged and learning is embraced'(p9).

The Harper Review (p243) similarly notes that 'as with any other method of service delivery, great care is needed when moving to outcome-based contracting' – for example because of the risk of introducing perverse incentives. 'Contracting for outcomes may require significant investment by government agencies in specifying what the desired outcomes are. This may involve a cultural shift by both government agencies and service providers' (p242). Other commentators agree that the thinking of both

government and non-government agencies needs to change significantly if major shifts of this kind are made in commissioning and contracting practice.

Given the range of material considered above, we may conclude that it is likely to prove challenging to identify ways in which outcome-based contracting and funding can be applied to mental health services, and that any specific moves in this direction would need to be very carefully thought through. As noted in the following subsection, however, there is an interesting current initiative in Tasmania which could produce some helpful lessons.

3.5 Tasmanian Department of Health and Human Services' Outcomes Purchasing Framework

The Tasmanian Department of Health and Human Services (DHHS) is in the process of introducing an outcomes-focused approach to the purchasing of mental health and other human services from the community sector. It is doing this in a cautious and pragmatic way that reflects awareness of many of the issues discussed above.

In 2014 DHHS published a document introducing its *Community Sector Outcomes Purchasing Framework*. Noting that governments are increasingly adopting a commissioning model for the delivery of health and human services which separates the *system management, purchasing* and *service delivery* functions, it states that the Department is seeking to better align community and human services with this purchaser/provider model and to improve purchasing and performance management across DHHS.

> *Consistent with the purchaser/provider model, there is a growing trend internationally and nationally towards commissioning for outcomes (involving) less of a focus on measuring inputs and activities, and more of a focus on measuring the client outcomes resulting from those inputs and activities.* (p1)

While DHHS believes that it already has in place appropriate systems to monitor some aspects of its grant programs in the community sector, it sees a need to more adequately monitor client outcomes, and the Outcomes Purchasing Framework is a response to this need. DHHS emphasises (p3) the importance of the 'strong mutual commitment to collaboration and co-production' that exists between the government and community sectors. The Department has made a modest grant to the Tasmanian Council for Social Services to support individual organisations in responding to the changes.

The Outcomes Purchasing Framework, which is intended to apply across all DHHS program areas, aims (p4) to:

- achieve better outcomes by promoting an explicit focus 'on defining and measuring the changes we are trying to achieve for clients and the community'
- promote a culture of shared accountability for the achievement of outcomes, 'recognising that the achievement of outcomes is often dependent on factors outside of the direct control of' any given program or provider
- support a consistent and straightforward approach to setting, measuring and improving client outcomes
- support a partnership approach through co-design in applying the elements of the Framework
- minimise the regulatory and administrative burden through consistent and streamlined reporting arrangements
- promote evidence-based continuous improvement.

DHHS makes the important point that an appropriate outcomes framework 'should promote evidence-based dialogue between the purchaser and the provider about ways to improve the achievement of outcomes, rather than a narrow focus on contractual compliance' (p4). It says that the principles underlying its approach to outcomes purchasing will include realistic expectations about provider performance, with outcome targets set through consultation. The process will be trust-based, with both the Department and NFPs 'expected to disclose issues that may impact on the achievement of outcomes

in a timely and transparent manner - with a focus on collaboration to resolve issues' (p5). There is no indication at this stage that payments to service providers will depend on outcomes achieved.

Based on the *Results Based Accountability* model developed in the United States by Mark Friedman, the DHHS approach uses a framework which considers both *program outcomes* and *population outcomes,* and which distinguishes outcomes that are relevant for DHHS itself from those that are relevant for individual programs. It involves a series of *commissioning for outcomes statements* for the various types of program funded by the Department. DHHS plans to make use of the framework as new funding agreements are rolled out.

With regard to mental health services DHHS has, after a process of consultation, confirmed adoption of the 2-page outcomes statement for 'packages of care' that is set out in Appendix B to this current report. The statement is expressed in broad terms that are intended to apply to most mental health services other than residential care. It first lists four outcome domains applicable to the Department itself (for example *Changes are achieved for assisted clients/target groups*), and then six *Program* Outcomes (such as *Clients achieve individual goals in relevant outcome domains*), accompanied by six relevant 'theories of change'. The second part of the statement specifies 'outcome indicators' for each Program Outcome; finally there are notes on applicability to funding agreements, such as '*Subject to cost-effective collection of client feedback'*.

At the level which is relevant for service provider contracts the key outcome indicators appear to be *Proportion of clients that report they are satisfied with the quality and responsiveness of Packages of Care in meeting their needs,* and *Proportion of clients assessed as making progress /achieving their goals – in relevant goal domains.* No percentage targets are attached to these indicators at this stage. It appears that client progress is likely to be judged on the basis of two reports – one from the client and one from a relevant worker. These assessments will of course be subjective, and for various reasons it is not likely to be possible to provide them for all clients; nor, of course, is improvement or lack of improvement for a given client dependant only on the 'treatment' delivered by the service provider (that is, an attribution problem remains). Nevertheless a client 'result' of this kind is a more manageable beast than the larger-scale and longer-term outcomes that are contemplated in some of the literature discussed above, and the Tasmanian experience over the next couple of years may well be useful in identifying ways in which we might move closer to outcomes contracting.

3.6 Department of Social Services Data Exchange

At Commonwealth level the Department of Social Services announced in 2014 its intention to introduce a Data Exchange, the framework for which again derives from the *Results Based Accountability* model, and which has much in common with elements of the Tasmanian scheme. (Both DHHS and DSS were assisted by the Sydney consulting firm ARTD.) The Data Exchange seeks to 'streamline reporting requirements, automate reporting processes and shift the focus of performance measurement from outputs to more meaningful information about service delivery outcomes' (DSS website, *A new way of working: grant funding in DSS – Using SCORE to report outcomes*). Beyond a short list of mandatory items, 'service providers can choose to report an extended data set to the Department in exchange for regular and relevant reports' – 'a partnership approach'. The optional items include four outcome indicators such as *Client Circumstances* and *Client Satisfaction.* Service providers remain free to collect relevant information in whatever fashion they choose, but are asked to report it to the Department using a uniform five-point 'SCORE' scale so as to generate consistent and comparable data.

At this stage the objective of the DSS initiative is to improve the quality and consistency of client data generated by service providers, rather than to play a role in commissioning and contracting, but the availability of reliable data is one key requirement for a system of outcomes-based contracting.

3.7 Summary

The most obvious difficulty in moving to outcomes-based contracts for community mental health service providers is the difficulty of identifying mental health outcomes that a single organisation could sensibly

be expected to achieve. The *National Targets and Indicators* discussed in section 4 of this report provide a considered framework for planning mental health services in Australia and clarifying the outcomes that the community wants. However, the outcomes that it points to are meaningful at the level of governments rather than individual service providers, and do not readily lend themselves to adoption for use as contract outcomes. To state the obvious, it is not realistic to contract a community service provider in Queensland to reduce smoking rates among Australians, or Queenslanders, with a mental illness. Nor would it seem very useful to contract it to reduce smoking rates among its own clients. For one thing, this would not fit easily with the kind of holistic and person-centred services that NFPs are trying to provide. For another, there would still be problems of attribution; while these might sort themselves out over a period of years and over large numbers of clients, this kind of outcome does not seem to offer much help in the short term. *Client satisfaction* is more obviously relevant to the performance of a single contractor, but we would not normally say that 'satisfied clients' is the outcome we want a provider to achieve.

The Tasmanian scheme avoids some of these issues by taking a more generic approach. It proposes a framework that can be applied across the whole field of human services, and which also takes account of the different roles of governments and service providers. It puts a focus on *progress for the individual client against his or her specific goals* – something that we might perhaps call a 'result', if not an outcome. Time will tell how far this can take us towards a system of outcome-based commissioning and contracting.

Other challenges remain, including the difficulty of transferring financial risk to a poorly resourced not-for-profit sector. Here the Harper Review perhaps offers another clue when it suggests that service providers could be rewarded for *performance above specified targets* (see above, section 3.4). Offering some kind of bonus for the achievement of an outcome, rather than threatening non-payment for failure, could make it easier to experiment with outcomes-focused contracting.

4 A strategic framework for mental health services

Before discussing some further possibilities for improving commissioning and contracting practice, we turn to the matter of a strategic planning framework for mental health.

In the words of a 2011 evaluation of community care mental health initiatives that was commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs, Australia's service system for mental health is fragmented, and the range of services is:

> *patchy across the nation with rural and remote areas particularly problematic. The service system is difficult to negotiate for clients, with poor connections between curative and community services. Traditional service patterns have largely been clinically driven and socially disadvantaged areas, even in large cities, are not well served.* (Courage Partners, Working with Australians to promote mental health, prevent mental illness and support recovery, March 2011)

The *Blueprint for Action on Mental Health*, produced by Mental Health Australia in November 2014, likewise refers to the fragmentation and patchiness of mental health services and policies, observing that in practice Australia does not have a 'mental health system' in any meaningful sense:

> *For the most part … services are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal for improved mental health outcomes.* (p8)

As noted in section 2.2 above, the findings of the National Mental Health Commission's *Review of Programmes and Services* reinforces these observations.

Whatever the specifics of the commissioning and procurement arrangements adopted by Commonwealth and State/Territory governments, the value of mental health initiatives could be greatly enhanced if agreement could be reached on a broad strategic framework to drive and guide planning and implementation. Australia has a Fourth National Mental Health Plan (2009-2014) which sets out some key principles such as a partnership approach across portfolios and jurisdictions, a strong emphasis on prevention, and the importance of coordination and continuity of care. A more specific framework has subsequently been drafted, however, in the form of the *National Targets and Indicators for Mental Health Reform,* prepared in 2013 by a COAG Expert Reference Group. This document represents a consensus reached across a wide group of stakeholders in mental health and related fields, and is designed to be endorsed and adopted by all jurisdictions.

The *National Targets and Indicators* document offers a 10-year vision for Australia that aims for:

- reduced prevalence of mental illness and of suicide
- greater understanding of and improved attitudes towards mental illness, resulting in changed behaviour
- more adequate and appropriate spending on mental health, particularly community services, prevention and early intervention; an interim target is that the proportion of health budget spending on mental health should be at least 13%, 'which is equal to the burden of disease'.

The *Targets and Indicators* identify six broad goals or 'domains' which can be summarised as follows:

- more people will have good mental health and wellbeing
- fewer people will experience avoidable harm
- among those people who do have poor mental health:
  - more will have better physical health and live longer
  - more will lead a meaningful and contributing life
  - more will have a positive experience of support, care and treatment
  - fewer will experience stigma and discrimination.

For the domain of *physical health* – to take one example – the document sets out the following *target* as suitable for adoption by governments:

> *Improve life expectancy of adults with a mental illness to achieve parity with adults without a mental illness. Particular focus should be on:*
>
> - *reducing smoking rates of adults over 18 years with a mental illness by 30% in four years and 60% in 10 years*
> - *increasing the proportion of adults over 18 with a disclosed mental illness who are screened every 12 months for physical and dental health issues by 40% in four years and 90% in 10 years.*

The document goes on to specify three *indicators* that can help measure progress made in the physical health domain:

- the gap in life expectancy between people with severe mental illness and the rest of the population
- the self-reported smoking rate among people with mental illness compared with rates for those without mental illness
- the proportion of the population with mental illness who are screened annually for physical and dental health issues and receive intervention, follow-up and medication review.

Targets and Indicators of a comparable kind are spelled out for each of the other five 'domains.' In the domain of living a meaningful and contributing life, for instance, the Indicators include:

- the proportion of people with mental illness and/or their families and carers reporting timely access to mental health related services
- the proportion of the population with mental illness in employment as a ratio of the employment rate of the general population.

Among other things the *Targets and Indicators* offer a starting point for consideration of the kinds of *outcomes* that might ultimately be used in the commissioning and contracting of mental health services, as discussed in section 3 of this report.

The 2015 Final Report of the National Mental Health Commission's Review of Programmes and Services recommends that a National Mental Health and Suicide Prevention Plan be developed, agreed and implemented by the Commonwealth and the States and Territories, in collaboration with people with lived experience, their families and support people. Such a plan could perhaps incorporate the National Targets and Indicators, which themselves derive from an extensive consultation process.

5 Other possible approaches

This section of the report discusses a number of other possible approaches to improving commissioning and contracting practice in order to achieve better policy and service outcomes.

5.1 Devolving responsibilities to a third party

5.1.1 Western Australian Mental Health Commission

Both the Commonwealth and several of the Australian states have in recent years set up Mental Health Commissions. While there are significant differences in the roles and powers of these various commissions, each in some way reflects a response to the 'parlous state of mental health care in Australia' and a willingness to use new structures in an effort to drive change (Rosenberg and Rosen 2012a). One element in the thinking behind some of the commissions has been that a new body without a long institutional history may be able to offer a fresh perspective on the role of long-established medical and residential models of care. Rosenberg and Rosen refer to the potential of a new structure of this kind 'to break open old debates, old service models and old ways of thinking' (p87).

In the context of the present report, the 2010 initiative of the Western Australian Government in setting up a Mental Health Services Commission independent of the State Health Department is of particular interest. The Commission is not itself a service provider, but its responsibilities include:

- *articulating key outcomes and determining the range of mental health services required for defined areas and populations across the state*
- *specifying activity levels, standards of care and determining resources required*
- *identifying appropriate service providers and benchmarks and establishing associated contracting arrangements with both government and non-government sectors*
- *purchasing of services and supports for the community*
- *ongoing performance management and evaluation of key mental health programs in Western Australia.*

(Mental Health Commission, *Annual Report 2010-2011*, p6)

The Commission's role in policy, planning and purchasing of services is reportedly unique in the world. It is able to play a significant part in 'facilitating new partnerships between government organisations and also between government and nongovernment organisations' (*Annual Report* 2010-2011, p3), and it is said that its separate status makes it easier for the Commission to encourage cross-portfolio and cross-sector initiatives than it would be for the Health Department itself to do so. The work and role of the Commission are still evolving, but its independence from the Department, which is itself a service provider, has the potential to make for innovative decisions about resource allocation.

Rosenberg and Rosen (2012b) note the argument that:

> *Some of the existing paradigms of funding and service are so entrenched that unless a new commission has unfettered purchasing authority to decide what is bought and from whom, old ways of doing business will simply continue and reform will not eventuate.*

On the other hand they make the observation that since 'purchasers can be seen to have a vested interest in demonstrating the benefit of what is bought,' the service purchaser role 'precludes the commission from independent oversight of the system as a whole (p195).

5.1.2 Prime Provider models

The *prime provider* or *lead contractor* approach involves government contracting with a lead organisation which then takes responsibility for organising and managing the delivery of services through a group of appropriate subcontractors, e.g. local community-based organisations. A related notion is that of the *integrator*: 'an organisation strategically deployed by the commissioner with specific responsibilities for

mapping and then assembling a network of local providers to achieve agreed outcomes' (O'Flynn and others, p10). This is very much the approach being used in Australia's *Partners in Recovery* program (see section 5.4 below). Appendix E discusses the prime provider approach in more detail.

The United Kingdom's Work Programme (welfare to work) is a significant example of the use of a prime contractor model. In Australia, at a smaller scale, the Brotherhood of St Laurence has played a prime provider role in several programs including the national Home Interaction Program for Parents and Youngsters (HIPPY - see Sturgess 2015, p27), the Work and Learning Centres program for disadvantaged jobseekers in Victoria and the DSS/ANZ Bank Saver Plus program (see O'Flynn and others, pp 18, 29-31).

The potential advantages of a prime provider approach include local and smaller providers being involved in programs in which they may not otherwise have been able to participate, enabling them to benefit from the expertise and experience of the prime provider, and freeing them up to focus squarely on improving services, since the prime provider has taken on most financial and management responsibilities. From a government agency perspective such an approach may reduce administrative and monitoring costs and create opportunities for it to focus more clearly on broader strategic issues. Prime contractors may be able to manage larger contracts which offer some economies of scale. Being unencumbered by standard bureaucratic processes, they should in principle be better placed than government agencies to promote flexibility and innovation, while at the same time bringing more practical experience and empathy to their relationships with subcontractors (see O'Flynn and others, pp14-16).

There are also possible downsides, however, which may include governments becoming dependent on a limited number of key organisations which could fail or exit the market, and smaller organisations being crowded out or having their potential development limited. Discussing United Kingdom experience with the prime contractor model, Nicholson (2011) argues that:

> *Government needs to be cognisant that adopting a certain payment mechanism and contracting structure will fundamentally affect how the supplier market is structured. In particular government needs to think actively about provider market development so that it does not develop into a small oligopoly of providers.* (p28)

Other risks or possible downsides are uneven levels of expertise among those selected as lead contractors; governments assuming that all not-for-profit agencies can readily work together despite significant differences in structure, organisation and mission; shifting of costs and risks onto the non-government sector; and duplicating regulatory and accounting structures which already exist at government level (Productivity Commission 2010, p J16).

One challenge for commissioning departments, say O'Flynn and her colleagues, is 'to balance service devolution with maintaining a close watching brief on the health of the service provider network' (p16). In one sense, a prime provider approach might be seen as an answer to declining capacity and expertise within government (the 'hollowing out' issue referred to elsewhere in this report). At the same time it could obviously exacerbate this problem. 'As policy makers become further removed from direct service delivery, there is a danger that they start to lose touch with critical issues that impact not only on future policy decisions but also on the actual structure of service delivery systems' (p17).

5.2 Work across portfolios and across jurisdictions

5.2.1 Cross-portfolio issues

Commissioning and funding of human services has typically involved contracts between a single government agency and a single service provider. Yet addressing mental health needs will often require action well beyond the scope of a single portfolio - for example involving physical health, housing, training and employment, alcohol and other drugs, and legal and justice issues.

The KPMG report (2014) that was commissioned by the National Mental Health Commission as part of its recent review addresses this issue, stating clearly that 'Investment strategy should be developed across portfolios' (p18):

> *The level of complexity associated with mental illness requires a multifaceted response to improving health outcomes, including health and community care, informal care, housing, substance abuse treatment, job training, and education.*
>
> *These services are developed across a range of government portfolios, and therefore investment in optimal care should be developed within a strategy that coordinates a broad range of programs, planners, and funders.*
>
> *Benefits from optimal care also impact a number of government portfolios…Given these portfolios will receive the benefits from optimal care, there is also an incentive to invest in optimal care. Similarly, externalities created by mental illness, such as police, justice and housing costs, and the potential benefits from optimal care, means jurisdictions should also have an incentive to invest.* (p95)

While acknowledging that it is not a straightforward matter the Productivity Commission, also, has raised the issue of funding streams being joined up within and across levels of government (*Contribution of the Not-for-Profit Sector*, 2010, p312).

There are few mechanisms in Australia for promoting a cross-portfolio approach to delivery of human service issues (one example, however, is the requirement that initiatives designed to Close the Gap in Indigenous services be developed across agencies and across jurisdictions). In human services there has been little use of options such as joint commissioning or the pooling of agency funds to address complex needs. It is interesting to note, however, that Western Australia's Partnership Forum has given some consideration to a possible mechanism for promoting cross-agency commissioning.

Some of the disincentives to cross-portfolio thinking are financial, since a policy or program initiated in one area of government may have significant parts of its financial pay-off in a different portfolio (or indeed different jurisdiction). In its November 2014 *Blueprint*, Mental Health Australia recommends (p28) that:

> *Treasury and/or Finance Departments of all governments should use existing internal processes – such as new policy proposals and Regulation Impact Statements – to identify the potential impacts of policy changes on mental health outcomes, including impacts that may be significant across portfolios and jurisdictional boundaries.*
>
> *Treasury and/or Finance Departments of all government should also reconfigure their Budget rules in order to allow Ministers to account for savings in one portfolio as a result of investment in another portfolio, and to better recognise down-stream savings that stem from government investment in areas such as psycho-social services, employment supports and securing stable housing.*

It has sometimes been suggested that individualised funding, as being introduced in the new National Disability Insurance Scheme (NDIS), offers a way of addressing the issue of coordination across portfolios. It is not at present clear, however, that the NDIS will fund the bulk of community mental health services, with many people with moderate to severe mental illness likely to be ineligible. If present policies are maintained, the level of coordination required in the mental health arena is unlikely to be delivered via individualised funding.

The rationalisation of functions, greater emphasis on inter-agency coordination, and simplification and consolidation of bureaucratic structures in appropriate cases are all consistent with the Australian Government's concern to 'ensure that government services are as efficient and well targeted as possible' (The Hon Mathias Cormann, *Smaller and More Rational Government 2014-15*, May 2014, p11). The Abbott government is committed to creating 'more coherent and effective government structures' and to 'simplifying the coordination required for cross-agency work'. It sees a particular need to 'consider

opportunities for more streamlined and efficient arrangements to drive much needed productivity and performance improvements in the health sector'.

5.2.2 Issues across jurisdictions

In Australia's federal system many areas of social policy, including mental health, cross jurisdictional as well as portfolio boundaries. One of the central aims of the Australian Government's current work on the *Reform of the Federation* is to help in -

> *clarifying roles and responsibilities between different spheres of government and the need for all levels of government to coordinate action to ensure the best possible results for citizens …. Reform of the Federation must deliver concrete improvements in the way services are delivered.* (Reform of the Federation White Paper, 2015, p1)

However, there is at this stage no machinery to promote day-to-day consultation or collaboration among Australia's governments on mental health or most other human services.

KPMG (2014) points out that costs and benefits for various scenarios of mental illness involve savings and costs distributed in different ways between the Australian Government and the States and Territories (p17). While fragmented or poorly coordinated services obviously create difficulties for clients, Mental Health Australia also notes that there are also direct costs for governments themselves:

> *Without the right coordination within and across governments, current inefficiencies and avoidable costs will be retained. Contrary to conventional wisdom, the Commonwealth bears a substantial proportion of this risk. Poor mental health outcomes do not just result in additional demands on (state-funded) hospital systems; they also reduce labour force participation rates and increase reliance on welfare …. poor mental health outcomes also present major financial risks for States and Territories, which (in addition to running hospitals) fund prison systems, homelessness services and other crisis interventions.* (Mental Health Australia, *Blueprint*, November 2014, p9)

With regard to mental health, one practical step towards improving coordination across jurisdictions would be for all governments to adopt the *National Targets and Indicators* discussed in section 4 above.

5.3 Coordination among service providers

At the service delivery end, a group or partnership of provider agencies may well be better placed than a single organisation to offer the mix of services that a client with mental illness may require. Good communications and linkages among service providers are also obviously important in avoiding duplication, sharing of information and good practice, and ensuring that clients have effective access to the most appropriate range of services. Indeed, the concepts of 'wrap around services' and 'no wrong door', while not easily achieved in practice, are the embodiment of success in mental health service delivery.

A number of recent Australian initiatives seek to improve the quality and effectiveness of mental health services by bringing together funding agencies and/or encouraging partnerships and collaboration among provider agencies. An important example is Partners in Recovery (PIR), a three-year national program which is funded by the Federal Department of Health and which:

> *…aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way.* (Department of Health website, *About Partners in Recovery*)

PIR aims both at improving quality of service for the individual client and also at system change. Its ultimate objective is to improve mental health responses and outcomes by:

- *facilitating better coordination of clinical and other supports and services to deliver person centred support 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 need by the PIR target group and*
- *promoting a community based recovery model to underpin all clinical and community support services.*

In setting up this program the Department of Health did not rely on competitive tenders but invited each Medicare Local region across Australia to put together a suitable consortium. Contracts were signed with 48 consortia, each with a lead agency such as a major non-government organisation or the Medicare Local itself.

PIR is designed to run until 2015/16, at which point, on the latest available evidence, it will be 'cashed out' as part of the Commonwealth's general financial contribution to the NDIS (that is, funding will not continue to support mental health services in particular). It is not yet clear what mechanisms will succeed PIR to encourage collaboration cross the broad range of services which assist people with a mental illness.

Government can support and promote collaboration through the way they commission services - for example by allowing sufficient tendering time for separate organisations to develop suitable arrangements to work together, and by encouraging or requiring collaborative responses.

Cooperation among NFPs is closely related to cooperation between government and the NFP sector generally. One of the perceived benefits of the WA Mental Health Services Commission, for example, is that it is well placed to establish and maintain close and constructive relationships with a wide range of service providers:

> *The WA Commission has pursued much closer relationships with peak community sector organisations, including consumer and carer organisations as well as NGO psycho-social service providers, and is now focusing on regularly re-engaging with public sector providers. These groups report much closer relations with the commission than they felt they previously enjoyed with the WA Department of Health.* (Rosenberg and Rosen 2012b, p197)

In its 2010 report *Contribution of the Not-for-Profit Sector*, the Productivity Commission places considerable emphasis on the need for governments to *work cooperatively with* the community sector to maximise the value of its role and to capitalise on its motivation and expertise. In relation to contracting for services, as noted earlier, it identifies factors such as poor risk management practice, unduly short contract periods and 'heavy handed contractual and reporting requirements' (p297) as adversely impacting on the relationship between governments and NFPs, and ultimately on service quality.

The topics of cooperation and collaboration are discussed in more detail in Appendix F to this report.

5.4 Co-production

The term *co-production* refers to the active participation by users and clients in the design and delivery of services, and also to the involvement of service providers and client groups, with government, in developing policies and designing programs. The United Kingdom's New Economics Foundation (NEF) describes co-production as 'an assets-based approach to public services where professionals and citizens share power to plan and deliver support together' (*Commissioning for outcomes and co-production,* p31), and where the skills, knowledge and experience of both are capitalised on to produce higher-quality results.

Commissioners of services, as the NEF report points out, can promote co-production in two main ways: first by ensuring that the *commissioning process* itself is open to consumer input, and secondly by *commissioning for co-production* – that is, encouraging their service providers to work productively with the people who are intended to benefit from their services (p34).

5.5 Relational contracting and high trust contracts

Legal contracts are fairly blunt instruments for managing relationships and expectations. In the commercial world the parties' mutual interest in maintaining useful business relationships and protecting their reputations may be much more important than the specifics of any contract between them (Macauley 1963). Unduly detailed and legalistic contracts can be counterproductive, since they imply lack of trust and an adversarial relationship; over-specification may mean that 'one gets performance only to the letter of the contract.' (Macauley, p15). Bohnet, Frey and Tuck (2001) refer to trust being 'crowded out' by inappropriate contractual terms or excessive legalism (p141).

In government contracts for services in Australia, however, the perceived political risk of something going wrong has been a prominent concern, and highly detailed and prescriptive contracts have increasingly become the norm. Shergold refers to 'a culture of risk aversion in the public sector' (2013, p22), and identifies a need to reduce contractual rigidity, red tape and micromanagement. Detailed and legalistic contracts may in part reflect the 'hollowing out' of public sector expertise that has resulted from successive governments' efforts to reduce the cost of the public service: if the public servants responsible for commissioning a service are not confident that they are on top of the issues, they may well try to protect themselves and their political masters by requiring the contract to be as prescriptive and watertight as possible. Some stakeholders consulted during this study used the term 'gotcha contracts' to characterise this phenomenon.

This tension between trust and legalism has obvious relevance for the relationships between government and community sector organisations, since the latter will often be motivated by commitment to a particular cause or client group, and their readiness to 'go the extra mile' may well be a significant ingredient of service quality. Performance that goes beyond contract requirements in this sense is sometimes called an 'invisible' output.

As previously noted, the Productivity Commission's 2010 report emphasises the importance of reducing the red tape that tends to accumulate over time because of 'the propensity for government agencies to focus on contractual rather than relational governance' (p306). There needs to be a stronger focus on 'relational governance' in order to 'build a stronger sense of trust between government and providers' (p317). 'A market-based approach' to government purchasing of services from the NFT sector is not inconsistent with good relationships, says the Productivity Commission, but effort needs to go into improving the quality of engagement and building a stronger sense of trust (p318).

The New Zealand Government has been alive to this issue, and in some human service areas has introduced what are referred to as 'high trust' contracts. The Ministry of Social Development website on *High Trust Contracting* says that:

> *High trust contracting is a new approach towards the way government funds the community social services sector. It enables community organisations to focus more on the families they serve and less on ticking boxes, complex paperwork and reporting.*

Under high trust contracting there is:

- *a short, simple funding agreement*
- *payment of funding up front, in annual instalments*
- *meaningful, outcomes focused, year-end reporting*
- *a focus on outcomes – results are agreed on and described*
- *flexible service delivery – enabling providers to better meet the needs of families in their local community*

- *a customised approach – recognising the holistic needs of families and ensuring that the contract reflects this.*

To be eligible for a high trust contract, community organisations need to have a strong and trusted relationship with government. According to the Ministry of Social Development website, this means that they must:

- have a good track record in delivering the services they have been contracted to provide
- be a viable organisation – with strong governance, good management systems and effective and meaningful reporting systems
- be an integral part of their community – connected, trusted, and providing the services that the community needs
- work well with other agencies in their community - both government and non-government
- be high performing, and understand what it takes to help their clients make a difference to their lives.

The principles that guide the funding relationship include respecting and valuing each other's expertise; acting with integrity and good faith; recognising accountabilities; and having open, transparent, honest and timely conversations. The New Zealand high trust contracts also address the need for coordination across different arms of government:

> *bringing together all the services funded by the different Ministry business groups – Family and Community Services, Child, Youth and Family, Work and Income and Ministry of Youth Development - into one short, simple contract.*

It would clearly be useful for governments in Australia to look closely at the New Zealand experience with high trust contracting, and to identify opportunities to trial similar approaches in their own human programs, including mental health services.

High trust contracting is discussed in further detail in Appendix G.

5.6 Investment in prevention and early intervention

As noted earlier, one observation frequently made about the commissioning and funding of mental health services in Australia is that most resources are directed towards costly late-stage services at the expense of prevention and early intervention. For example, the Joint COSS Network submission to the Review of Competition Policy (2014, p8) states that:

> *It is a truism that 'prevention is better than cure,' but one that is often not practised by governments when funding tries to deal with the consequences of social problems, rather than addressing their causes. This not only reduces people's quality of life, but is often economically inefficient …. Health funding … is overwhelmingly skewed towards acute and clinical care when preventive and primary care is likely to be more effective at improving population health …. Communities and social services struggle to attract the resources necessary to invest in preventive approaches, particularly within existing budget rules across government, despite the very clear evidence that such investments can significantly improve social outcomes whole also providing tangible relief to budgets over the long-term*.

In 2014 consultants KPMG undertook financial modelling for the National Mental Health Commission, to assess the impacts of reorganising mental health care over time and across individual care pathways, moving from 'the current mental health pathway' to an '*optimal* care pathway'. This was done through detailed examination of seven different mental illness scenarios, considered over a 9-year period. Among other things KPMG drew on detailed discussions with a range of specialists in mental health care. KPMG's modelling takes account of both *direct* health-system costs and benefits, and *indirect* impacts relating to such things as housing, social security payments, productivity and employment. This is important because of the 'complex interdependencies of mental health care' (p18).

The results of KPMG's work are presented in a report dated November 2014, *Paving the way for mental health.* It finds on the one hand that optimal care is cost-effective over time, and on the other that the most cost-effective interventions are prevention and early intervention:

- 'Optimal care can improve health outcomes and is cost-effective over time …. Investment in optimal care typically requires up-front costs to increase access to services across all severity levels. However, optimal care also improves health outcomes, which reduces the need to use services over time, and reduces indirect costs related to mental illness, such as productivity loss….' (pp 11, 13).
- Due to the potentially high levels of functional impairment caused by severe mental illness, and the intensity of support individuals may require, preventative and/or early intervention care is of utmost importance. For those with a mental illness, the most cost effective care is early intervention (p21).
- Early treatment for mental illness through increased use of community and primary care services can yield significant benefits ….upstream services deliver better outcomes at lower cost over time than those with a higher focus on downstream acute services (p12).

As one way of starting to promote investment in prevention/early intervention, the 2014 COSS submission to the Competition Review suggests changes to budgeting rules to enable the development of 'Community Investment Funds' which would have the express purpose of developing and resourcing long-term preventive programs.

A related though not identical challenge is how *desirable experimentation and innovation* in human service delivery can best be supported; again it is sometimes claimed that existing funding and accountability practices tend to discourage these. The Western Australian Partnership Forum is once again of interest here, since one of its arms is a Social Innovation Grants Program, launched in 2011. This program specifically offers grants 'to enable not-for-profit community sector organisations to develop and trial new ways of delivering human services to meet the diverse and complex needs of the community' (Partnership Forum website). Community organisations can submit grant applications at any time.

5.7 Combining approaches

The various changes and challenges that are discussed in this report can be pursued individually, but there are also potentially strong linkages among many of them. The package of reforms offered by Western Australia's *Delivering Community Services in Partnership Policy*, for instance, covers such issues as trust and collaborative relationships, greater community sector involvement in service planning and evaluation, reduction of the compliance burden, situations in which it may be desirable to move away from competitive tendering, funding and service continuity and the importance of ongoing organisational viability.

As noted in Appendix G, New Zealand's Whanua Ora program draws together, in a high trust arrangement, a focus on outcomes, consultation and collaboration, cross-portfolio co-operation, local partnerships, simpler contracts, use of outcome-related incentives, plus devolution of some commissioning responsibilities to third parties. In his report to the Victorian government in 2013, Dr Peter Shergold places outcomes-based contracting within a context of other changes such as a holistic approach designed to achieve the best result for the client, greater community sector participation in decision making, simplification of regulation, early intervention, and sharing of resources across government portfolios. The 2015 Harper Review links outcomes-based contracting and payment-by- outcomes with contestability and with co-production as elements of an improved system of service provision.

6 Competition, contestability and continuity

6.1 Introduction

The rise of managerialism in government over recent decades and the increasing outsourcing of government responsibilities have brought an emphasis on competition for contracts, seen as necessary to promote efficiency and to ensure that contractual and other relationships are transparent and free from taint of fraud or other malpractice. This has meant, among other things, repeated arms-length tendering by would-be service providers. In its submission to the Productivity Commission's Review of Competition Policy (2014), the Joint COSS Network notes that 'competition policy has increasingly shaped the way governments as well as the private sector operate' (p3). In the United Kingdom the New Economics Foundation sees approaches such as competitive tendering, payment by results and prime contracting as representing:

> *…a broad shift in values towards a price-based, competitive and 'measurable' system of commissioning and procurement with the assumption that more competition will lead to better value.* (p45)

If poorly implemented, says the NEF, this shift has the potential to distort the process by focusing on what can be easily measured rather than on what really matters, and to weaken the community sector and undermine its contribution. However, skilled commissioners can use competitive tendering wisely to for a range of positive purposes, such as focusing on value rather than simply price, promoting productive partnerships, supporting co-production, and encouraging entry to the market by new providers or consortia (pp 46, 47).

6.2 Competition and human services

The Joint COSS Network submission (2014) to the Review of Competition Policy raises a number of concerns about the role of competition in government contracting for human services. Among other things it argues that:

- There are challenges in reconciling competition policy with the role of community organisations in supporting community health and wellbeing. 'The central challenge is how to foster principles of competition in an environment that is, at its core, about relationships' (p4).
- 'Increased competition may undermine the success of partnership based, community focused and integrated service models' (p4).
- Within a contestable market there remains 'a key role for regulation' to prevent the erosion of quality (p3).

The COSS submission observes (p1) that the aim of competition policy should be to improve rather than worsen social outcomes for people and communities. This echoes the emphasis in Western Australia's *Delivering Community Services in Partnership Policy* (2011), that the WA Government desires to contract with the NFP sector in an appropriate way 'that supports service delivery and recognises the importance of ongoing organisational viability' (see section 2.4 above).

The COSS Network sees the potential pitfalls around competitive tendering in human services as including:

- lack of information made available to communities and little or no opportunity to participate in decisions about proposed services
- short tendering timeframes which disadvantage poorly resourced organisations and militate against developing suitable partnership approaches which might offer better services and better value for money
- inadequate timeframes to renegotiate contracts and lack of appropriate transition when funding is reduced or removed (p6).

The WA *Developing Community Services in Partnership Policy* tellingly describes the problems created in the past by the routine use of competitive tendering, saying that this:

> *…saw precious organisational resources diverted into, and often wasted on, bureaucratic bidding and reporting processes that culminated in pseudo commercial contracts and onerous accountability across the board. As a consequence, these requirements added to 'red tape' and detracted from the real aim of the not-for-profit community sector – the delivery of services to those who need them.* (p14)

Recognising some of the complexities of applying competition principles to contracting for human services, governments in Australia have developed certain practices designed to reduce possible downsides. For example in the Job Services Australia program, as noted elsewhere, 'star ratings' are awarded by the commissioning department on the basis of past provider performance, and these ratings are used in making decisions about extending or automatically renewing contracts.

> *At the end of the third Job Network contract in 2006, all contracts of providers performing to a satisfactory standard were renewed for another three years. However, six-monthly reviews allowed commissioners to replace poor performers throughout the period of extension, thereby maintaining pressure on providers to continue to deliver high quality services* (Sturgess and Cumming, p56).

While practices of this sort may depart from pure competition principles, 'Commissioners get a great deal of additional effort for free when providers believe that good performance will be recognised when contracts come up for negotiation' (Sturgess and Cumming, p44).

Consistent with the various concerns mentioned above, the nature and role of competition in contracting for human services needs to be carefully considered. The Harper Review (*Competition Policy Review, Final Report*, March 2015) endorses the adoption of competition and choice principles in the domain of human services. It notes, however, that because of the particular nature of human services, which 'serve important social objectives', and the fact that 'users of human services can be among the most vulnerable and disadvantaged Australians …. the scope to use competition or market-based initiatives may be more limited than in other areas' (p218).

Contestability

Sturgess emphasises that while the terms 'competition' and 'contestability' are sometimes used as if they were synonymous, there is in fact a key difference between them (see for example *Contestability in Public Services; An Alternative to Outsourcing*, 2015). Contestability is not *competition per se* but rather *the credible threat or possibility of competition*. This is a crucial distinction in public administration and in human service delivery, because applying competition principles in a simplistic way (especially when narrowly focused on price) can lead to instability, unpredictability and 'churn' that undermine service quality and continuity. This distinction is recognised in the Harper Review (pp239-40):

> *Over recent years, governments have looked at different approaches to commissioning human services. Approaches have moved from early, less sophisticated attempts at competitive tendering towards approaches reflecting contestability and some degree of user choice …. Newer approaches focus more on collaboration and contestability rather than strict competitive tender processes.*

Sturgess points out that, unlike straight-out competition, contestability is compatible with retaining the *constructive relationships* that are essential in translating policy into effective service delivery:

> *Contestability recognises the importance of relational aspects in social and economic organisation. Successful management of a corporate supply chain, particularly in the delivery of complex services, cannot occur if there is excessive churn among suppliers….Contestability offers a way for public service commissioners to ensure that existing providers are delivering value for money without scrapping the value that lies in interpersonal and inter-organisational relationships.* (2015, p28)

In commissioning and contracting, government agencies thus have to find a balance between keeping service providers 'on their toes' and allowing competition to operate in a disruptive or destructive way. The Harper Review endorses the value of a diversity of providers in the delivery of human services, while also recognising the importance of maintaining some certainty and continuity for providers and services. In relation to the duration of service agreements, its report says that governments should 'specify contracts with duration periods that balance the need to afford providers some level of certainty without excluding potential competitors for extended periods of time' (p250). As argued in section 2.2 above, governments could well consider the development of quite long-term agreements in areas of mental health which require significant investment, experiment and/or long-term planning (see also section 6.3.2 below).

6.3 Applying competition principles

6.3.1 Hastening slowly

The Harper Review emphasises at several points that the application of competitive principles in the human services sector needs to be approached over time and with some caution:

> *Like any changes to public policy, implementing changes to human services needs to be well considered. Human services have a lasting impact on people's lives and wellbeing, increasing the importance of 'getting it right' when designing and implementing policy changes*. (p250)

It quotes a submission from the Productivity Commission: 'Experience with market-based instruments in human services … in Australia suggests that such mechanisms often require refinement over time to promote improved outcomes'. (The establishment of a market-based system for employment services in Australia is sometimes cited in this context.) It also quotes a statement by Catholic Social Services that 'Governments need to develop sector adjustment policies so that the professional capability of the sector is not jeopardised by the introduction of competition policy' (p251).

Some recent experience in Queensland illustrates the importance of gradualism and periods of adjustment in this context. There the Newman Government took a decision to move from a system of block grants to competitive tendering in a number of fields, including community-based mental health services, and a Request for Offer (RFO) was issued that sought to implement that change. This evidently met with a strong negative response from the not-for-profit sector, and the RFO was withdrawn. There followed extensive consultation and co-design between the sector and Queensland Health, with key issues being continuity of services and management of risks. Led by the peak body Queensland Alliance for Mental Health, the not-for-profit providers argued the need for a more flexible approach and for an appropriate period of time for them to adjust to a new way of operating. The end result was a replacement RFO which invited providers to submit simple tenders covering a three-year period, during which existing services could continue while the providers would also be entitled to use funds for organisational redevelopment that could better equip them for a future contestable market.[1]

6.3.2 Contract duration

The Harper Review notes the importance of issues around contract duration and timeframes for tendering. Among other things it agrees with the Joint Councils of Social Service Network that 'tendering timelines should allow sufficient time for collaboration, the formation of consortia and innovative service design'. It also states that:

> *For relational services, a stable and predictable regulatory environment, including through sufficiently long contracts, will be important in the contracting and*

[1] It will be useful to follow the progress of a current study designed to track how Queensland NFPs react and respond to the introduction of competition. See J Durham and A Bains, 'Research Protocol: a realist synthesis of contestability in community-based mental health markets', *Systematic Reviews* (2015) 4:32.

> *procurement phase. Moving away from very short-term contracts allows service providers to invest in necessary infrastructure, systems and 'front line' staff.* (p243)

Contract duration is one variable that commissioners can use either to boost or to modify the role of competition. Sturgess and Cumming say that too long a contract period can weaken competitive pressures and tend to thin out the market. On the other hand, too short a period not only raises the prospect of churn but can limit incentives to experiment or innovate: 'the duration of the contract may be one of the few protections that providers have to secure a return on transformational initiatives that require some investment in research and development' (p55). With longer-term contracts, as suggested above, commissioners can always reserve the right to terminate if minimum performance standards are not met. 'Contract scale – the size of the population being served – is another variable that commissioners can adjust to increase market depth and encourage new entrants' (p56).

As noted elsewhere, the Productivity Commission has recommended that contract duration should be appropriate for the scale and complexity of the task in question. Given the nature of mental health issues, there is a case for considering far longer contract terms for some community mental health services.

6.4 Government as steward

The Harper Review highlights the need for governments to maintain what it calls 'a stewardship role' in the provision of human services (p224). 'Market stewardship is about governments' overall role in human services systems', including policy design, funding, regulation and provision. It means that they have a 'responsibility to invest in overseeing the impact of the policy in the market', responding to findings and where necessary making adjustments to 'funding, investment in sector development and regulation settings' (p224, quoting a submission from National Disability Services).

If markets are to be contestable, another key government responsibility must be to ensure that there is a skilled and reliable supply-chain of providers for them to draw on in service delivery. Accordingly:

> *Human services reform must focus not just on users but also on providers, whose ability to respond positively to policy change will be an important factor in ensuring that Australians continue to enjoy access to high-quality human services.* (Competition Policy Review, p251)

The Western Australian *Delivering Community Services in Partnership Policy*, discussed in section 2.4 above, notes (p15) that 'Public authorities play an important role in building the capacity of the community sector to respond to community needs,' and the contents of the policy illustrate an appropriate role for government as a 'steward' working to support rather than undermine its NFP supply chain. Among other things the DCSP policy clearly acknowledges the importance of funding continuity:

> *Short-term contracting arrangements and regular transitions between service providers can have a profound and damaging effect on service users*
>
> *Sustainable funding is a key factor of sustainable service delivery and enhances the capacity for Organisations to make long-term strategic decisions, attract and retain human capital, manage operational risk, and deliver better value for money outcomes*
>
> *Commissioning agencies must consider the importance of funding certainty and security as well as reducing the administrative burden imposed on Organisations that are continually required to bid for services and funding'.* (p15)

Sturgess also makes the point that:

> *Many public service systems are like corporate supply chains rather than markets – interactions are relational rather than transactional, and commissioners have an ongoing responsibility for the overall functioning of the supply side.* (2015, p16)

That is, like private sector businesses, government agencies have an interest in protecting the health of their supply chains, and this interest is unlikely to be well served by contractual arrangements that

constantly pit one provider against another. Some stakeholders commented that governments seem much more aware of the importance of this in their ordinary business arrangements (for example in their contracts for the supply of telephone and IT services and the like) than in the arrangements they make for the delivery of human services. In the case of community mental health services, of course, the supply chain that governments need to protect consists largely of not-for-profit service providers.

6.5 Price and value for money

One of the concerns frequently raised by the NFP sector relates to commissioning agencies' over-reliance simply on price in the selection of winning tenders. (One factor in this may be the adverse publicity that government departments on occasion receive when, in one field or another, they do opt for something other than the lowest tender.) While price must of course be one criterion, it is argued that better results would be achieved in the human services if contracting agencies were more alert to other matters going to *quality*, such as the tenderer's track record and the nature of its links and relationships with the relevant community or target group. The Harper Review quotes the Joint COSS submission as follows (pp 239-40):

> *Competitive price tendering undermines the integration and co-ordination of services; favours larger, more established services over smaller agencies and community groups; and measures efficiency in terms of low cost, when the measurement of social and economic outcomes requires a far more nuanced approach and a capacity to identify preventive benefits over long periods.*

The Harper Review itself comments that 'Tendering can focus on price at the expense of other factors, including fairness and responsiveness to needs' (p244). While seeking to enhance diversity in service provision, it is also concerned 'to preserve and enhance' the contribution of NFPs (p 247), and it notes the proposition that NFP providers can bring to their relationship a with service users 'the value of social capital and community service contributions'. It makes the point that 'these 'value added services can be overlooked in traditional tender processes'. (p239)

The New Economics Foundation (p6) quotes the United Kingdom Treasury on the definition of *value for money*:

> *Value for money is defined as the optimum combination of whole-of-life costs and quality… of the good or service to meet the user's requirement. Value for money is not the choice of goods or services based on the lowest bid.*

The Foundation relates the issue of cost and value to what it sees as the desirability of moving towards outcome-based contracting:

> *Asking providers to show how they will deliver against service- and community-level outcomes shifts the direction of public funding so that it promotes increased value, rather than just forcing prices down.* (p22)

In short, in preparing tender specifications relating to human services, and in selecting successful tenderers, commissioning agencies need to be clear that they are seeking value for money rather than necessarily the cheapest possible price, and to articulate what kinds of additional benefits (including unquantifiable and less tangible benefits) would be seen to have most value. Further, successive reviews, inquiries and reports on mental health (including most recently the National Mental Health Commission's *Review of Services and Programmes*) have emphasised the importance of achieving better integration within and across systems; yet service contracts rarely require or incentivise efforts by providers to carry out the work necessary to achieve such integration.

6.6 Individualised funding and the National Disability Insurance Scheme

Australia is in the process of introducing a major new program, the National Disability Insurance Scheme (NDIS). In essence this will provide individualised funding for eligible clients, to enable them to make their own decisions and choices about the services they need. The NDIS will ultimately have a significant impact

on the way that disability services are provided and used, including services for people with a psychosocial disability associated with mental illness. The NDIS raises a number of issues that are relevant to the subject matter of this report.

Clinical and support services

In the area of mental health the NDIS is not intended to cover clinical services, but rather support services such as those relating to self-care and day-to-day living, domestic assistance, transport, health and wellbeing programs, respite for carers, specialist employment support, tenancy and specialist housing support, crisis support, and case management and coordination. In the words of the NDIS website:

> *The NDIS will be responsible for supports that are not clinical in nature and that focus on a person's functional ability, including supports that enable a person with a mental illness or psychiatric condition to undertake activities of daily living and participate in the community and social and economic life. The provision of all other services and supports, in particular, clinical services, will remain the responsibility of the health system….*

Thus the NDIS will not be responsible for funding clinical acute, ambulatory or rehabilitation care, clinical residential care or early intervention support of a clinical nature. While the distinction between clinical and other support is clear in principle, it may not always be simple to apply in practice in the mental health sphere.

Coordination of services

In its report for the National Mental Health Commission, KPMG notes that individualised funding offers one possible way of achieving improved coordination of services. The scale of impact of the NDIS in mental health is not yet clear, but it appears that the bulk of community mental health services will not be funded through the NDIS; Mental Health Australia believes that the majority of people with moderate to severe mental illness will not be eligible for NDIS support. If this is the case and if present policies remain in place, the level of coordination required in the planning and provision of mental health services will not be delivered by way of individualised funding.

Choice

The effective operation of a system of individualised funding requires knowledgeable and well-informed clients or consumers. Finding one's way around complex systems and understanding the quality and implications of alternatives may be difficult for anyone, but there are additional complexities in the area of mental health, since an individual's illness or disability may substantially impair his or her capacity to make good choices. The difficulty is compounded by the sporadic nature of some mental illness and the fact that changes in capacity can occur unpredictably and sometimes very rapidly.

Disruption and adjustment

Individualised or unit funding, almost by definition, brings greater transparency to the system, and is of course intended to empower service users to exert more control over their lives. On the other hand, a program like the NDIS has the potential to cause significant disruptions in service availability and delivery, and could in some cases put at risk the positive relationships and social capital that have been created and sustained through more traditional funding arrangements. New systems of funding and payment will naturally have (and in the case of the NDIS are intended to have) impacts on the way the supplier market is structured. To say the least, introduction of the NDIS will involve processes of learning and adjustment for funders, clients and service providers.

7 Summary and Recommendations

7.1 Summary of issues

7.1.1 Current practice and the need for reform

Over recent decades there has been a marked increase in the extent to which not-for-profit organisations have been funded to deliver human services on behalf of government. The typical situation is that a government department or agency determines what services are to be provided and in what manner, and invites competitive tenders or submissions for execution of the task. The successful applicant or tenderer is required to sign a contract, prepared by the commissioning agency, which specifies what the service provider is required to do, over what timeframe, to meet its obligations and earn payments. The administration of such contracts has involved a strong focus on accountability for the use of public funds, and much government oversight has gone into ensuring compliance with financial and process requirements.

Failings of the current system

The not-for-profit sector has for some time been concerned about failures and shortcomings in the way this commissioning and contracting system operates. The concerns include, for example:

- siloed government decision making without reference to an appropriate guiding strategy
- short-term contracts and insecurity of funding that undermine service providers' capacity to plan ahead and to ensure workforce stability and service continuity
- poor risk management practice leading to excessive red tape and inappropriate transfer of costs and risk
- onerous compliance and reporting requirements that do not reflect the level of funding allocated or the risks involved, and which contribute little to the achievement of project goals
- lack of consistency in reporting and data requirements and failure to make good use of the information that is gathered
- inequitable conditions such as the right for governments to terminate contracts without due cause and lack of compensation for cost increases resulting from changes in policy
- failure to provide a role for the community sector in contract negotiations or at the stages of policy development and program design
- the sheer volume of contracts that community-based organisations have to manage.

Frequent turnover in government programs (including the creation of new programs) adds to the compliance burden.

An underlying concern is the power imbalance that effectively makes the relationship between government and service provider one of master and servant, with the non-government sector having little room to contribute or negotiate. This is despite governments across the political divide repeatedly acknowledging the unique role of the community sector and stating an intention to increase that role over time.

Reform

The Productivity Commission's 2010 report on the *Contribution of the Not-for-Profit Sector* considered commissioning and contracting problems in detail, and made a series of recommendations for reform which, if acted on, would have led to considerable improvement. The recommendations included:

- *Australian governments should urgently review and streamline their tendering, contracting, reporting and acquittal requirements in the provision of services to reduce compliance costs. This should seek to ensure that the compliance burden associated with these requirements is proportionate to the funding provided and risk involved.*

- *The length of service agreements and contracts should reflect the length of the period required to achieve agreed outcomes rather than having arbitrary or standard contract periods.*
- *The Department of Finance and Deregulation should develop a common set of core principles to underpin all government service agreements and contracts in the human services area. This should be done in consultation with relevant government departments and agencies and service providers.*
- *To minimise compliance costs and maximise the value of data collected, Australian governments should agree to implement a reform agenda for reporting and evaluation requirements for organisations involved in the delivery of government-funded services.*
- *Australian governments should ensure that service agreements and contracts include provision for reasonable compensation for providers for the costs imposed by changes in government policy that affect the delivery of the contracted service, for example, changes to eligibility rules, the scope of the service being provided, or reporting requirements.*

The Commission placed considerable emphasis on the need for governments to *work cooperatively with* the community sector to maximise the value of its role and to capitalise on its motivation and expertise.

Commonwealth, state and territory governments have displayed some awareness of the importance of commissioning and contracting problems, and over recent years some changes have been introduced to address particular issues. Except in Western Australia, however, reforms have not been pursued in any systematic way, and there remains a clear need for further progress.

Western Australian provides an important example of an attempt to address the problems in a coherent and collaborative way. In 2011, recognising the need for a stronger and more productive relationship between the public and community sectors, the WA Government set up a Partnership Forum as a focus for work towards this end. The Forum comprises both senior public servants and community sector representatives, and is independently chaired. In 2011 the government introduced a *Delivering Community Services in Partnership Policy* (DCSP), which sought to address a number of the difficulties discussed above. The aim is 'to improve outcomes for all Western Australians through a genuine partnership between public authorities and the not-for-profit community sector in the funding and contracting of sustainable Community Services'. The operating principles include:

- flexibility, innovation and community responsiveness
- a productive working relationship between government agencies and the NFP sector, based on 'trust, collaboration, accountability and sustainable service delivery'
- 'clarifying when services are to be put to open tender and when a more targeted non-market based approach is more appropriate'
- reducing red tape
- contracting with the NFP sector 'in a manner that supports sustainable service delivery and recognises the importance of ongoing organisational viability'.

7.1.2 A different approach: contracting for outcomes

Potential benefits

Implementation of the sorts of reforms recommended by the Productivity Commission would go a long way towards remedying failures within the existing commissioning and contracting system. Over recent years, however, there has been international and Australian interest in a different approach which goes beyond contracting for inputs and outputs to focus on *outcomes* sought and achieved. In Australia this approach has attracted some attention in relation to delivery of human services – from governments which wish to see better congruence between policy and service delivery and to know that limited resources are being used for public benefit, and from the community sector which wants to be more

confident that it is doing the best that it can for its clients. In essence the idea is to move away from funding and counting what we do, to focus on whether we are making a difference.

The recent Harper *Competition Policy Review* discusses some of the potential benefits of an outcomes approach:

> *An outcomes focus allows service providers to suggest different approaches for achieving the desired result rather than having to demonstrate specific activities, tasks or assets. It allows potential providers to offer new and innovative service delivery methods and helps to encourage a diverse range of potential providers.*

A recent report by Professor Peter Shergold for the Victorian Government envisages that state shifting 'progressively from funding activities and outputs towards commissioning outcomes,' reducing 'the administrative burden imposed on community organisations through unnecessary and duplicated reporting processes', and developing standardised service agreements and guidelines across government.

Challenges

Adopting outcomes-based contracting is not, however, a simple matter. The challenges include:

- the difficulty of identifying one outcome, or a small number of outcomes, that convincingly capture the essence of the underlying policy intention
- ensuring that outcomes can be tracked and measured in a meaningful and reliable way, at reasonable cost, and within a reasonable timeframe
- ensuring that desired outcomes can confidently be attributed to the activities of the contracted provider
- pricing outcomes in a fair and consistent way that minimises perverse incentives and the risk of 'gaming' (e.g. the temptation for providers to target the easiest or least disadvantaged clients – 'cherry picking ' or 'cream skimming')
- undertaking the consultation and negotiation, pilot testing, adjustment and refinement that successful implementation is likely to require.

Such challenges are particularly daunting in an area as complex as mental health, and there are few examples to date of outcome-based contracting being used in this field.

There is also the question of how, if *payment* is made dependent on outcomes, poorly capitalised community organisations might cope with deferred or uncertain payment. The overseas literature contemplates various financial arrangements that might help address this - for example some system of loans or bridging finance or the use of social impact bonds. Social finance and impact investing are still in their infancy in Australia. However, the work of the Prime Minister's Community Business Partnership includes an interest in 'the emerging impact investment market'. That Partnership brings together leaders from the community and business sectors to promote philanthropic giving and investment, and it has established a working group on impact investing and partnerships.

Outcomes-based contracting in human services is thus of considerable interest but also raises many difficulties. Any moves towards outcomes-based contracting in relation to mental health services would need to be made in a gradual manner, with time allowed for adaptation, experimentation and refinement. Given the problems involved in moving to a pure outputs model, some kind of hybrid approach (for example contracting for a mix of outputs and outcomes) may be more realistic, at least in the short term. In Tasmania the Department of Health and Human Services is experimenting with an interesting approach which focuses on results achieved in terms of individual client satisfaction and improvement. So far as *payment* for outcomes is concerned, a first step might be to offer *additional financial incentives* for achievement of certain outcomes.

7.1.3 An agreed strategic framework

Through the COAG process and after wide consultation, an Expert Review Group has developed *National Targets and Indicators for Mental Health Reform*. These could be considered by COAG and all

governments as a possible framework for planning, decision making and resource allocation. Once endorsed by government, such targets and indicators could offer systematic guidance on policy and investment, and could be used to link national priorities with the nature and objectives of specific programs and projects. This would represent a positive step towards improving the current commissioning and contracting system.

A key difficulty in moving to *outcomes-based* contracts in community mental health is the problem of identifying mental health outcomes that a single organisation could sensibly be expected to achieve. Although the *National Targets and Indicators* provide a considered framework for planning mental health services in Australia and clarifying the outcomes that the community wants, the outcomes that it points to are meaningful at the level of governments rather than individual service providers, and it is not easy to see how they can be adapted for use as contract outcomes. This is an area that calls for further detailed consideration by both government and the community sector.

7.1.4 Devolution of responsibilities to a third party

Another possible strategy for improving aspects of commissioning and contracting practice is the *delegation or devolution* of responsibilities to a third party which is independent of the agency ultimately providing the funding. One Australian example has been the setting up in Western Australia of a Mental Health Commission which is independent of the Health Department and which is responsible for service contracting. Perceived advantages of this model are that the Commission is in a better position than a government department to promote cooperation and collaboration with, and within, the community sector, and is also better able to break new ground in the planning and funding of services.

Another form of devolution is the use of one non-government organisation to organise and oversee service delivery at regional or local level by others; this is usually called either a *lead contractor* or a *prime provider* approach (in the latter situation the lead agency itself may be one of the service providers). A related notion is that of the *integrator* – 'an organisation strategically deployed by the commissioner with specific responsibilities for mapping and then assembling a network of local providers to achieve agreed outcomes'. This is essentially the role played by lead agencies in Australia's Partnerships in Recovery program.

The potential advantages of a prime provider approach include reduced demands on government for monitoring and contract administration, the opportunity to make good use of the skills of both large and small NFPs (with small, local organisations, for instance, enabled to participate in larger undertakings while being relieved of some administrative burdens), achieving some economies of scale, e.g. in data collection and reporting, and the prime providers being in a better position that a government agency to innovate and to provide practical and relevant support to subcontractors. On the other hand such an approach could in principle lead to government becoming unduly dependent on the services of a small number of large organisations, greater risks being transferred to the not-for-profit sector, and duplication of established monitoring and accountability systems.

7.1.5 Cross-portfolio and cross-jurisdiction issues

Issues across portfolios

The nature of mental illness means that it often requires a range of responses that run across conventional portfolio boundaries. However, there are few mechanisms in Australia for promoting a cross-portfolio approach to human service issues. For instance, areas like mental health have seen little use of options such as joint commissioning or the pooling of agency funds to address complex needs.

This issue is taken up in a recent financial modelling report by KPMG that was commissioned by the National Mental Health Commission. KPMG highlights the importance of whole of government responses, stating that in mental health, investment strategy should be developed across portfolios:

> *The level of complexity associated with mental illness requires a multifaceted response to improving health outcomes, including health and community care,*

> *informal care, housing, substance abuse treatment, job training, and education …. investment in optimal care should be developed within a strategy that coordinates a broad range of programs, planners, and funders.*

While acknowledging that it is not a straightforward matter, the Productivity Commission, also, has raised the issue of funding streams being joined up within and across levels of government. More broadly, the Abbott Government's emphasis on smaller and more rational government supports a greater emphasis on inter-agency collaboration and the simplification and consolidation of bureaucratic structures where appropriate. The Government is committed to creating 'more coherent and effective government structures' and to 'simplifying the coordination required for cross-agency work'.

Some of the disincentives to cross-portfolio thinking are financial, since a policy or program initiated in one area of government may have significant parts of its financial pay-off in a different portfolio (or indeed different jurisdiction). Mental Health Australia has previously argued that:

> *Treasury and/or Finance Departments of all governments should use existing internal processes – such as new policy proposals and Regulation Impact Statements – to identify the potential impacts of policy changes on mental health outcomes, including impacts that may be significant across portfolios and jurisdictional boundaries.*

Treasury and/or Finance Departments could also choose to reconfigure their Budget rules in order to allow Ministers to account for savings in one portfolio as a result of investment in another, and to better recognise down-stream savings that stem from government investment in areas such as psycho-social services, employment supports and securing stable housing.

Issues across jurisdictions

Mental health issues also cross jurisdictional boundaries, and the KPMG report for the National Mental Health Commission notes that costs and benefits for various scenarios of mental illness involve savings and costs distributed in different ways between the Australian Government and the States and Territories. However, there is no machinery to promote day-to-day consultation or collaboration among Australia's governments on mental health or most other human services.

7.1.6 Collaboration among service providers

Provision of high quality mental health services also requires *cooperation and collaboration among service delivery agencies*, many of which are not-for-profit community organisations. Community-based organisations may have a disposition to work together, but this cannot be taken for granted. Governments can support and promote collaboration through the way they commission services - for example by allowing sufficient tendering time for separate organisations to develop suitable arrangements to work together, by encouraging or requiring collaborative responses, and by acknowledging that collaboration and integration may require additional funding.

Some recent Australian initiatives seek to improve the quality and effectiveness of mental health services by bringing together funding agencies and/or encouraging partnerships and collaboration among provider agencies. An important example is Partners in Recovery (PIR), a three-year national program which is funded by the Federal Department of Health and which is designed to achieve much better coordination and collaboration among mental health service providers in the interests of quality of service to clients, carers and families. PIR aims both at improving quality of service for the individual client and also at system change. Its ultimate objective is to improve mental health responses and outcomes by:

- *facilitating better coordination of clinical and other supports and services to deliver person centred support 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 need by the PIR target group*

- *promoting a community based recovery model to underpin all clinical and community support services.*

At present there appear to be no plans to continue PIR beyond 2016. However, the evaluation of PIR by Urbis will hopefully provide useful lessons on good practice and future collaboration.

7.1.7 High trust contracting

Contracts in the private sector typically depend at least as much on *trusted relationships* as on the formal terms of the agreement. In the business world unduly detailed and legalistic contracts can be counterproductive, since they may seem to imply lack of trust and an adversarial relationship; over-specification can mean that one gets performance only to the letter of the contract, and trust can be 'crowded out' by inappropriate contractual terms or excessive legalism. This applies, for example, to employment contracts, where the formal terms cover only a fraction of what employers and employees legitimately expect of each other.

This has obvious relevance for the relationships between government and community sector organisations, since the latter will often be motivated by commitment to a particular cause or client group, and their readiness to 'go the extra mile' may well be a significant ingredient of service quality. In government contracts for human services, however, the perceived political risk of something going wrong has been a prominent concern, and highly detailed and prescriptive contracts have become the norm; there is a tendency for public servants to try to protect themselves and their political masters by requiring the contract to be as prescriptive and watertight as possible.

The Productivity Commission has emphasised the importance of reducing the red tape that tends to accumulate over time because of 'the propensity for government agencies to focus on contractual rather than relational governance'. It argues that there needs to be a stronger focus on 'relational governance' in order to 'build a stronger sense of trust between government and providers'. While a market-based approach to government purchasing of services from the NFP sector is not inconsistent with good relationships, says the Commission, effort needs to go into improving the quality of engagement and building a stronger sense of trust.

Recognising these issues, the New Zealand government has in some human services areas introduced 'high trust' contracts that involve a cooperative and consultative approach, collaboration across different agencies of government, short and simple outcome-focused contracts, up-front payments and flexibility in service delivery. The New Zealand Ministry of Social Development describes high trust contracting as:

> *a new approach towards the way government funds the community social services sector (enabling) community organisations to focus more on the families they serve and less on ticking boxes, complex paperwork and reporting.*

The principles that guide the funding relationship include respect for each party's expertise, acting with integrity and good faith, recognising accountabilities and having open, transparent, honest and timely conversations. (These have much in common with the principles of the DCSP in Western Australia.) To be eligible for a high trust contract, community organisations need to have a strong and trusted relationship with government; among other things this means having a good record in service delivery, having strong governance, good management systems and effective and meaningful reporting systems, working well with other agencies and being an integral part of their community – connected, trusted, and providing the services that the community needs.

7.1.8 Prevention and early intervention

Economic analysis demonstrates the value of investing in prevention and early intervention services. Analysis by KPMG confirms that early treatment for mental illness through increased use of community and primary care services can yield significant benefits, and that upstream services deliver better outcomes at lower cost over time than those with a higher focus on downstream acute services.

Governments thus need to find suitable ways, over time, of promoting early intervention services rather than relying on costly late-stage, acute responses.

As one way of starting to promote investment in prevention/early intervention, the Joint COSS Network has suggested changes to budgeting rules to enable the development of 'Community Investment Funds' which would have the express purpose of developing and resourcing long-term preventive programs.

7.1.9 Competition, contestability and continuity

Good practice

Competition has increasingly been introduced into government outsourcing of human services delivery. If poorly implemented this shift has the potential to distort the process by focusing on what can be easily measured rather than on what really matters, and to weaken the community sector and undermine its contribution. Competitive tendering can, however, be used wisely to for a range of positive purposes, such as focusing on value rather than simply price, promoting productive partnerships, and encouraging the entry of new providers to the market.

The WA *Developing Community Services in Partnership Policy* notes that the routine or unreflective use of competitive tendering in community services has seen:

> *precious organisational resources diverted into, and often wasted on, bureaucratic bidding and reporting processes that culminated in pseudo commercial contracts and onerous accountability across the board. As a consequence, these requirements added to 'red tape' and detracted from the real aim of the not-for-profit community sector – the delivery of services to those who need them.*

Instead, the DCSP proposes contracting with the NFP sector in an appropriate way 'that supports service delivery and recognises the importance of ongoing organisational viability'. (As the Joint COSS Network has observed, the aim of competition policy should be to improve rather than worsen social outcomes for people and communities.) Among other things the DCSP policy clearly acknowledges the importance of funding continuity and appropriate contract duration:

> *Short-term contracting arrangements and regular transitions between service providers can have a profound and damaging effect on service users.*
>
> *Sustainable funding is a key factor of sustainable service delivery and enhances the capacity for Organisations to make long-term strategic decisions, attract and retain human capital, manage operational risk, and deliver better value for money outcomes.*

The Harper Review likewise acknowledges the importance of issues around contract duration and timeframes for tendering, and adds that 'tendering timelines should allow sufficient time for collaboration, the formation of consortia and innovative service design'.

The nature and role of competition in contracting for human services needs to be carefully considered. The Harper Review endorses the adoption of competition and choice principles, but notes that because of the particular nature of human services, which 'serve important social objectives', and the fact that 'users of human services can be among the most vulnerable and disadvantaged Australians …. the scope to use competition or market-based initiatives may be more limited than in other areas'. Harper emphasises at several points that the application of competitive principles in the human services sector needs to be approached over time and with some caution.

Contestability

Although the terms 'competition' and 'contestability' are sometimes used as if they were synonymous, there is in fact a key difference between them. Contestability is not *competition per se* but rather *the credible threat or possibility of competition*. This is a crucial distinction in public administration and in human service delivery, because applying competition principles in a simplistic way (especially when

narrowly focused on price) can lead to instability, unpredictability and 'churn' that undermine service quality and continuity. Again the Harper Review recognises this distinction.

Contestability offers a way of maintaining pressure on service providers to maintain or improve performance, while also maintaining the constructive relationships between commissioner and provider that are important in ensuring continuity of services and congruence between policy and service delivery.

Protection of the supply chain

Many public service systems are like corporate supply chains rather than markets – interactions are relational rather than transactional, and commissioners have an interest in the ongoing health of the sector that they rely on for delivery of services. As 'stewards' of the system (a term used by Harper), government agencies have responsibilities to maintain a strong supply chain of potential service providers. The Western Australian DCSPP similarly notes that 'Public authorities play an important role in building the capacity of the community sector to respond to community needs,' and the contents of that policy illustrate an appropriate role for government working to support rather than undermine its NFP supply chain.

7.1.10 Combining approaches

These various changes and challenges can be pursued individually, but there are also potentially strong linkages among them. The package of reforms offered by Western Australia's *Delivering Community Services in Partnership Policy*, for instance, covers such issues as trust and collaborative relationships, greater community sector involvement in service planning and evaluation, reduction of the compliance burden, situations in which it may be desirable to move away from competitive tendering, funding and service continuity and the importance of ongoing organisational viability. New Zealand's Whanua Ora program (see Appendix G) draws together, in a high trust arrangement, a focus on outcomes, consultation and collaboration, cross-portfolio co-operation, local partnerships, simpler contracts, use of outcome-related incentives, and devolution of some commissioning responsibilities to third parties. The 2015 Harper Review links outcomes-based contracting and payment-by-outcomes with contestability and with co-production as elements of an improved system of service provision.

7.2 Ways forward: recommendations

On the basis of the research carried out for this report, the following recommendations are made - for Mental Health Australia and for national, state and territory governments.

7.2.1 The Australian Government

As previously recommended by the Productivity Commission, the Department of Finance should to develop a suitable set of guidelines dealing specifically with the commissioning and contracting of human services; this should incorporate the range of desirable practices canvassed in this report.

The Australian Government should set up a social finance taskforce as recommended by a Senate committee in 2011, or else a different body charged with examining ways of financing NFP operations if and when payment-for-outcomes contracting is introduced; the potential role of the Prime Minister's Business Community Partnership should be considered in this context.

7.2.2 All governments and commissioning agencies

Policy and good practice

Governments and commissioning agencies should:

- consider the adoption, at national, state and territory level, of the *National Targets and Indicators for Mental Health Reform* developed through COAG, possibly as part of the national plan on mental health and suicide prevention that has been recommended by the National Mental Health Commission

- act on the 2010 recommendations of the Productivity Commission relating to changes in NFP commissioning and contracting arrangements
- develop clear policies that acknowledge the potentially disruptive effects of unnecessary or too-frequent competitive tendering and which adopt the principle of contestability in its true sense
- adopt policies and develop processes to facilitate community sector involvement in the development and planning of programs and services
- explicitly acknowledge that NFPs represent an essential supply chain for the delivery of human services and that governments have a responsibility to help maintain that supply chain in a healthy and productive state
- use the Western Australian Government's *Delivering Community Services in Partnership Policy* as a checklist of desirable improvements such as longer-term contracts, indexation of payments, equitable contract provisions and mutually respectful, collaborative approaches
- as standard practice, include in tender and contract documents a requirement or a preference for collaborative approaches and for co-production, and recognise the additional costs that agencies are likely to incur in working to coordinate or integrate services
- where an agency has several or multiple contracts with the same service provider, adopt the practice of using a suitable master agreement with a simple schedule for each discrete program
- systematically examine the feasibility and implications of moving away from activity or input requirements towards outcomes-based contracting in community services, while exercising appropriate caution in considering any introduction of *payment*s related to achievement of outcomes
- provide practical and financial support to assist the NFP sector in responding to the various challenges outlined in this report – for example improved data collection and performance measurement and analysis of the feasibility of introducing outcomes-based contracting
- use COAG machinery to develop methods of encouraging systematic consultation and cooperation across jurisdictions on human services design and delivery
- establish joint government/community sector working groups to explore practical ways of introducing a stronger outcomes focus into service commissioning and contracting
- consider what practical steps can be taken to promote cross-agency approaches to commissioning and funding of community mental health services
- adopt the previous Mental Health Australia recommendations on central agencies' identifying the impacts of mental health policies across portfolios and jurisdictions, and budget reconfiguration to account for costs and savings across portfolios and over time (see section 5.2.1)
- develop mechanisms for promoting innovation and experimentation in mental health services
- establish one or more pilot programs to explore the use of pooled funding arrangements for mental health services in particular locations
- establish one or more pilot programs to explore the use of high trust contracting in the mental health field
- encourage and support NFPs working in mental health to improve their capacity around data collection and performance measurement, for example client satisfaction.

Tracking innovative approaches and relevant research

In formulating changes to the way governments manage commissioning and contracting in mental health, relevant departments and agencies should look closely at the following:

- the findings of the Partners in Recovery program as these become available – particularly with regard to the success or otherwise of the lead agency/consortia model in delivering coordinated service delivery for clients of the program.
- the Western Australian experience involving the Partnership Forum and the DCSP policy
- experience in Tasmania with the Department of Health and Human Services' introduction of commissioning-for-outcomes statements
- the national introduction of the Department of Social Services' Data Exchange

- other studies which may yield useful findings include research on the introduction of a competitive framework in Queensland (see section 6.3.1) and the University of Melbourne's research on the prime provider model (see Appendix E)
- approaches to commissioning and contracting in areas beyond the human services sector (eg in Defence) which deliver demonstrated or potential improvements in the nature and scale of collaboration and systems integration, or have been successful in focussing efforts away from inputs and activities and towards outcomes and impacts.

7.2.3 Mental Health Australia

As the national peak body for NFP organisations and service providers in mental health, Mental Health Australia should:

- encourage active consideration among its members of the desirability and feasibility of outcome-based contracting, and about the kinds of outcomes that they might realistically contract to deliver
- encourage discussion of the benefits and disadvantages of prime provider or lead contractor models in the mental health context, and the circumstances in which they may be most appropriate or useful
- encourage and support members to place increasing emphasis on co-production in the design and delivery of their services
- explain to government the importance of providing NFPs with the resources needed to play an appropriate role in these changes and deliberations
- work with other peak bodies to promote discussion of the desirability and feasibility of introducing in other jurisdictions a mechanism similar to Western Australia's Partnership Forum
- encourage state peak bodies in mental health to pursue these matters within their own jurisdictions.

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Appendix A: Participants in the Review Workshop held on 18 May 2015

The study team is grateful for the insights and information contributed by each of these people, including advice on relevant sources to be considered. However, as noted elsewhere, the findings and recommendations of this report are the work of the study team and do not necessarily represent the views of any individuals who were consulted. This workshop was facilitated by Duncan Rintoul (Rooftop Social), with Emma Coughlan (Mental Health Australia) assisting with logistics.

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Anne-Marie Boxal	National Rural Health Alliance
Catherine Lourey	National Mental Health Commission
Darryl Lamb	Anglicare Tasmania Inc.
Elida Meadows	Mental Health Council of Tasmania
Elisa Guerin	Western Sydney Medicare Local
Emily Clay	Mental Health Australia
Frank Quinlan	Mental Health Australia
Garry Hooper	Break Thru People Solutions
Gary Hanson	Australian Institute of Health and Welfare
Gary Sturgess	Australian and New Zealand School of Government
Harry Lovelock	Australian Psychological Society
Helen Lynes	Richmond Fellowship of WA
John Malone	Aftercare
John Schwartzkoff	Rooftop Social
Josh Fear	Mental Health Australia
Julie Webster	Catholic Care
Kristy Muir	Centre for Social Impact UNSW
Marcelle Mogg	Catholic Social Services Australia
Marian Spencer	Black Dog Institute
Paul Senior	Centacare Catholic Family Services
Rod Astbury	Community Mental Health Australia
Sally Sinclair	National Employment Services Association
Scott Bloodworth	Australian Charities and Not-for-profit Commission
Tessa Boyd-Caine	Australian Council of Social Service
Tully Rosen	Mental Health Commission of NSW

Separate telephone interviews were conducted with:

- David Axworthy, WA Mental Health Commission
- Michael Brookes, ARTD consulting, Sydney
- Arthur Papakotsias, Neami National
- Chris Twomey, WACOSS
- Meg Webb, TasCOSS

Appendix B: Tasmanian DHHS outcomes statement for mental health 'packages of care'

Mental Health – Packages of Care

Commissioning for outcomes statement

Program Area: **Mental Health Services**

Sub-program: **Packages of Care**

Sub-program outcomes hierarchy

	DHHS outcomes domains	Program Outcomes	Theory of change
Population outcomes	Changes contribute to improvements in the target population / community	Tasmanians with a mental illness live well and have a full life—in terms of economic participation; social and community connection; stable housing Tasmanians that utilise clinical inpatient and community mental health services have stable life circumstances over the longer-term	▪ DHHS Mental Health Services delivers care to Tasmanians with a severe mental illness through community teams and inpatient settings ▪ For many clients, the effectiveness of these clinical mental health services is dependent on addressing barriers to stable life circumstances including housing, living skills, engagement and participation ▪ The community sector is well-placed to provide packages of support and care by leveraging community resources and linkages to the full range of community support services ▪ Effective packages of care should be tailored to individual client needs and circumstances—and be linked to clear individual goals that are regularly reviewed with the client ▪ This requires working with clients, family members and local support and community organisations to set and plan goals (e.g. action to reduce social isolation; action to improve living skills) ▪ The achievement of individual goals provides the foundations for improvements in life circumstances and the platform for leading a full life in terms of economic participation; social and community connection; and stable housing
	↑		
Program outcomes	Changes are achieved for assisted clients / target groups *(did we achieve what we expected)*	Clients have improved life circumstances in relevant outcome domains Clients achieve individual goals in relevant goal domains	
	↑		
	Services are responsive to the target group and conducive to the achievement of the intended outcomes *(how well did we do it)*	Clients receive tailored, coordinated support that reflects their individual needs and circumstances	
	↑		
	Services are available to targeted clients and communities *(how much did we do)*	Support packages are available for eligible clients with a mental illness	

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Mental Health – Packages of Care

Outcome Indicators

	Outcomes	Outcome Indicators	Application to Funding Agreement PIs
Population outcomes	Tasmanians with a mental illness live well and have a full life—in terms of economic participation; social and community connection; stable housing	▪ Number of Tasmanians with a moderate or severe mental disorder ▪ Proportion of Tasmanians with a moderate or severe mental disorder in ○ Employment, education or training ○ Stable housing or accommodation	-
	Tasmanians that utilise clinical inpatient and community mental health services have stable life circumstances over the longer-term	▪ Proportion of Package of Care clients readmitted to inpatient clinic care following the commencement of the care package—by length of stay [compared to the period before the commencement of the care package]	
Program outcomes	Clients have improved life circumstances in relevant outcome domains Clients achieve individual goals in relevant goal domains	▪ Proportion of clients assessed as having improved life circumstances—in relevant outcome domains ○ Housing ○ Independent living ○ Community participation ○ Physical health ○ Employment, education & training	Subject to development of an appropriate tool for reporting changes in life circumstances / goal attainment (using data linked to existing case management tools e.g. Recovery Star; CANSAS)
		▪ Proportion of clients assessed as making progress / achieving their individual goals—in relevant goal domains	
	Clients receive tailored, coordinated support that reflects their individual needs and circumstances	▪ Proportion of clients that report they are satisfied with the quality and responsiveness of Packages of Care in meeting their needs	Subject to cost-effective collection of client feedback (e.g. using the DREEM client Service Assessment Tool); Dual focus on quantitative and qualitative data – including improvement actions
		▪ Proportion of partner agencies* that report they are satisfied with the quality and responsiveness of Packages of Care in meeting the needs of shared clients *[* Agencies that refer to or receive referrals from the service]*	Subject to cost-effective collection of partner agency feedback; Dual focus on quantitative and qualitative data – including improvement actions
		▪ Proportion of clients from key target groups – ATSI; CALD; Regions	Targets for key groups set to reflect catchment demographics
	Support packages are available for eligible clients with a mental illness	▪ Number of clients – by location; by assistance type	To inform partnership discussions about the implications of the pattern of assistance delivered
		▪ Number of clients approved and waiting for a service	

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Appendix C: Federal/State funding arrangements

The Beeck Center report (pp57-62) discusses Australia's National Partnership Agreements, introduced in 2009, as an example of the use of outcome-based incentives in inter-governmental funding arrangements. These agreements, relating in particular to the areas of health, education and training, were initiated by the Federal Government and open to review and negotiation by the States and Territories. They were designed to respond to long-standing criticisms that conditional grants from the Commonwealth to the States and Territories were often unduly prescriptive and bureaucratic.

The Agreements awarded funding of three different kinds – *project* funding based on time or activity milestones; upfront *facilitation* payments designed to support various agreed reforms; and *reward* payments tied to the achievement of pre-defined outcomes. Together they reflected a shift away from the detailed Commonwealth oversight of conditional funding. Design of the agreements incorporated a number of pragmatic elements designed to reflect the political and governmental complexities and uncertainties; for example, for more ambitious projects, they contemplated reward for *partial* progress towards agreed outcomes. Allowing for changes in government, they involved strong political commitment but were not legally binding (a number were in fact cancelled by the incoming Federal Government in 2013). While offering outcome incentives in certain cases, they did not impose sanctions for failure to meet targets. While open to all jurisdictions, the agreements did not need to be national in scope: individual jurisdictions had freedom of choice as to whether or not to sign up to a given agreement.

As the Beeck Center sees it, results across Australia have been mixed in terms of State and Territory achievement of outcomes – unsurprising given 'the complexity and significant undertaking involved in implementing outcomes-based intergovernmental agreements' (p62). Nevertheless it reports some notable successes, for example in youth education in South Australia.

Mental Health Australia argues (*Blueprint* p28) that:

> *The Commonwealth should provide reward payments for states/territories (and/or regional bodies) that reach specified milestones towards the achievement of national targets for whole-of-life mental health outcomes.*

Appendix D: KPMG modelling of mental health costs and benefits

The National Mental Health Commission in 2014 employed consultants KPMG to undertake financial modelling to assess the impacts of reorganising mental health care over time and across individual care pathways, moving from 'the current mental health pathway' to an '*optimal* care pathway'. KPMG did this through detailed examination of seven different mental illness scenarios, considered over a 9-year period - for instance:

- *28 year old female experiencing post natal depression after the birth of her first child; has contemplated suicide and is at risk of hospitalisation*
- *45 year old male, homeless for past five years, with chronic schizophrenia and no family support.*

Among other things, KPMG drew on detailed discussions with a range of specialists in mental health care.

The results of this work are presented in a report dated November 2014, *Paving the way for mental health*. The modelling takes account of both *direct* health-system costs and benefits, and *indirect* impacts relating to such things as housing, social security payments, productivity and employment. This is important because of the 'complex interdependencies of mental health care' (p18). Among other things the report finds that:

- Optimal care can improve health outcomes and is cost-effective over time (p11). 'Investment in optimal care typically requires up-front costs to increase access to services across all severity levels. However, optimal care also improves health outcomes, which reduces the need to use services over time, and reduces indirect costs related to mental illness, such as productivity loss….' (p13).
- 'Due to the potentially high levels of functional impairment caused by severe mental illness, and the intensity of support individuals may require, preventative and/or early intervention care is of utmost importance. For those with a mental illness, the most cost effective care is early intervention…' (p21). 'Early treatment for mental illness through increased use of community and primary care services can yield significant benefits'; '*upstream* services deliver better outcomes at lower cost over time than those with a higher focus on *downstream* acute services (p12).
- Most clinical experts consulted believed that there should be 'a shift in resources towards more primary and community care', while also recognising that 'there is a gap in care under the current system for some illnesses' (p10).
- 'The accrual of savings over time suggests that estimating the impact of mental healthcare reform on government budgets should take multiple budget cycles into account….' (p14).
- The wide ranging impact of mental illness on the economy suggests that assessing the costs and benefits of mental health treatment requires analysis across all areas of government; the indirect costs are large (p17).
- 'The level of complexity associated with mental illness requires a multifaceted response to improving health outcomes, including health and community care, informal care, housing, substance abuse treatment, job training, and education.' 'These services are delivered across a range of government portfolios, and therefore investment in optimal care must be developed with in a strategy that coordinates a broad range of programs, planners, and funders' (p18).
- The many different services required for best practice mental health care demonstrates that better coordination of services is important; programs such as PIR and Phams respond to this need (p17).
- Costs and benefits for the various mental illness scenarios involve varying implications for the Australian Government and for the state and territory governments (p16).

Appendix E: Devolution of responsibilities to a third party

E.1 Western Australian Mental Health Commission

Both the Commonwealth and several of the Australian states have in recent years set up Mental Health Commissions. While there are significant differences in the roles and powers of these various commissions, each in some way reflects a response to the 'parlous state of mental health care in Australia' and a willingness to use new structures in an effort to drive change (see Rosenberg and Rosen 2012a). One element in the thinking behind some of the commissions has been that a new body without a long institutional history may be able to offer a fresh perspective on the role of long-established medical and residential models of care. Rosenberg and Rosen refer to the potential of a new structure of this kind 'to break open old debates, old service models and old ways of thinking' (p87).

In the context of the present report, the 2010 initiative of the Western Australian Government in setting up a Mental Health Services Commission independent of the State Health Department is of particular interest. The Commission is not itself a service provider, but its responsibilities include:

- *articulating key outcomes and determining the range of mental health services required for defined areas and populations across the state*
- *specifying activity levels, standards of care and determining resources required*
- *identifying appropriate service providers and benchmarks and establishing associated contracting arrangements with both government and non-government sectors*
- *purchasing of services and supports for the community*
- *ongoing performance management and evaluation of key mental health programs in Western Australia.*

(Mental Health Commission, *Annual Report 2010-2011*, p6)

The Commission's role in policy, planning and purchasing of services is reportedly unique in the world. It is able to play a significant part in 'facilitating new partnerships between government organisations and also between government and nongovernment organisations' (*Annual Report* 2010-2011, p3), and it is said that its separate status makes it easier for the Commission to encourage cross-portfolio and cross-sector initiatives than it would be for the Health Department itself to do so. The work and role of the Commission are still evolving, but its independence from the Department, which is itself a service provider, has the potential to make for innovative decisions about resource allocation.

Rosenberg and Rosen (2012b) note the argument that:

> *Some of the existing paradigms of funding and service are so entrenched that unless a new commission has unfettered purchasing authority to decide what is bought and from whom, old ways of doing business will simply continue and reform will not eventuate.*

On the other hand they make the interesting point that since 'purchasers can be seen to have a vested interest in demonstrating the benefit of what is bought,' the service purchaser role 'precludes the commission from independent oversight of the system as a whole (p195).

E.2 Prime Provider Models

A different kind of devolution is the 'lead contractor' or 'prime provider' approach, which involves government contracting with a lead organisation 'which in turn takes responsibility for organising and managing service delivery through a group of subcontractors or providers who are specialised and/or local suppliers' (O'Flynn and others, 2014, p5).

> *The prime provider model introduces a new dynamic into the purchasing arrangements, which involves a not-for-profit or a for-profit organisation taking on a role as purchaser/manager of public services. This creates a three-tier approach… (which) in turn brings new complexity into the relationships between the various*

> *actors and gives non-government organisations … a 'quasi-governmental role'.* (pp 6-7)

A related notion is that of the *integrator* – 'an organisation strategically deployed by the commissioner with specific responsibilities for mapping and then assembling a network of local providers to achieve agreed outcomes' (p10). This is essentially the role played by lead agencies in Australia's Partnerships in Recovery program.

The United Kingdom Work Programme (welfare to work) uses a prime contractor approach, involving eighteen 'larger scale, well-capitalised prime providers, the majority of whom are multinational, commercial companies' (O'Flynn and others, p13).

In Australia the Brotherhood of St Laurence has been involved in several initiatives where it plays a prime provider role – for example:

> *The Australian government contracted with the Brotherhood of St Laurence in 2008 to serve as the prime provider in the roll-out of a parenting and early childhood learning program known as the Home Interaction Program for Parents and Youngsters, in some 50 communities across the nation.* (Sturgess, *Contestability in Public Services*, 2015, p27)

Another example involving the Brotherhood is the Work and Learning Centres program, 'a place-based approach aimed at improving participation in the labour market for disadvantaged jobseekers, particularly those living in public housing' (O'Flynn and others, p14). Under a Memorandum of Understanding with the Department of Human Services (DHS), the Victorian Government in this instance funded the Brotherhood to establish and operate five Work and Learning Centres; the Brotherhood was responsible for 'sourcing, appointing and managing' provider organisations that would be responsible for the day-today operation of each centre (p29). The Brotherhood selected sites and local service providers in consultation with DHS; at each centre the service was intended to reflect local needs and circumstances (p30).

> *Delivery sites were chosen through an expression of interest process with an initial long-list of sites determined by the interagency steering committee. Evaluation of the expressions of interest was considered by DHS and the Brotherhood jointly, taking into account factors such as the concentration of public housing and disadvantage, organisational capacity and local connections.* (p31)

The Brotherhood itself operates one of the centres, which means that it has direct practical experience that it can share with the subcontractors. The operation of the program has been adjusted in various ways over time, for instance to respond to changes within some of the organisations involved, and to wider and more frequent reporting required by DHS.

Other programs involving the Brotherhood as a prime provider include Saver Plus, a matched savings scheme developed with the ANZ Bank and supported by the Department of social Services. According to O'Flynn and her colleagues:

> *All of the Brotherhood's prime provider models work with local community organisations. Clear funding streams and outcome requirements along with support and data systems and reporting give smaller providers certainty and ensure their continued capacity to engage in service delivery. This approach ensures continuity of service, demonstrates trust, promotes collaboration and ensures the prime provider model is delivered through local community organisations that are better placed to engage participants and leverage their existing local connections and partnerships'.* (p18)

The O'Flynn paper notes that prime provider arrangements have in some cases arisen as the result of government initiative, while others have originated with the community sector. Some initiatives of this kind are essentially place-based, but in principle they may operate at national, state or regional level.

Funding may come directly from government, from the private sector, philanthropic grants, donations, fee-for-service payments or a combination of these. 'Specific governance frameworks are often articulated in the relevant government contract or program guidelines and may include an Advisory Committee structure involving relevant stakeholders.' Payment may be structured in various ways 'including block grants, fee for service or payment by outcomes/results' (p7). One attraction of prime provider models is that they can 'potentially combine the benefits of scale via the prime, and local knowledge via subcontractors' (p10). It might also be assumed that a good prime provider will bring more knowledge, awareness and understanding to its relationship with subcontractors than could be expected of a large government body.

The possible benefits listed by O'Flynn and her colleagues include (pp 14-16):

- *increased coordination of and collaboration among local providers*
- *capacity of smaller or specialist organisations to focus squarely on improving services, since the prime provider has taken on the major financial and management responsibilities*
- *greater opportunity for flexibility and innovation, since non-government organisations are 'unencumbered by the bureaucratic processes normally associated with the public sector'*
- *'Prime providers are in a unique position to identify and encourage the spread of good practice among the subcontracted organisations'*
- *reduced administrative and monitoring costs for government, and freeing up of government departments to concentrate on long-term strategic objectives*
- *larger contracts enabling prime providers to create economies of scale and invest in new technologies and management systems.*

However, the authors emphasise that there has been insufficient research to establish the merits or otherwise of the prime provider model relative to other approaches (p12); they are themselves undertaking a review of the Brotherhood's role as a prime provider. One challenge for commissioning departments, they say, is 'to balance service devolution with maintaining a close watching brief on the health of the service provider network' (p16). In one sense, a prime provider approach might be seen as an answer to declining capacity and expertise within government (the 'hollowing out' issue referred to elsewhere). At the same time it could obviously exacerbate this problem. 'As policy makers become further removed from direct service delivery, there is a danger that they start to lose touch with critical issues that impact not only on future policy decisions but also on the actual structure of service delivery systems' (p17).

Other potential risks or downsides include government becoming over-dependent on a limited number of large organisations, which could fail or exit the market, and the risk of smaller agencies being crowded out or having their growth or development limited. Discussing United Kingdom experience with the prime contractor model, Nicholson (2011) argues that:

> *Government needs to be cognisant that adopting a certain payment mechanism and contracting structure will fundamentally affect how the supplier market is structured. In particular government needs to think actively about provider market development so that it does not develop into a small oligopoly of providers.* (p28)

Participants in the Review Workshop convened by Mental Health Australia in May made the point that the lead agency model had been used successfully in some situations but not others; that is, the model in itself does not solve commissioning or contracting problems. This is consistent with observations made in the Productivity Commission report on the *Contribution of the Not-for-Profit Sector* (2010); 'submissions suggested that the experience of the NFP sector with the lead agency model has been mixed' (pJ.15).

Potential benefits listed by the Productivity Commission include encouraging collaboration and innovation, encouraging clarity around roles, responsibilities and risk management, and assisting smaller NFPs through reduction of their administrative costs by pooling purchasing requirements and sharing support services, reducing costs associated with funding applications or tenders, enhancing program

planning and helping to address some staff retention problems. Possible downsides, on the other hand, include (pJ.16):

- varying levels of expertise among those selected as lead agencies
- 'governments not sufficiently recognising the diversity of the sector and simply assuming all NFPs are able to work together, despite fundamental differences in missions, structures and processes'
- shifting of significant costs onto NFPs, with duplication of regulatory and accounting structures that already exist at government level
- contributing to a 'loss of diversity, to the detriment of community organisations to deliver more specialised services' - particularly in rural and remote areas.

Stakeholders consulted at the Review Workshop held in May drew a distinction between a prime provider which was itself a deliverer of services, and a lead contractor whose role was limited to engaging and overseeing other provider agencies. The former was seen as potentially more problematic because of the possibility of real or perceived conflict of interest.

Appendix F: Cooperation and Collaboration

F.1 Work across portfolios and across jurisdictions

The traditional approach to commissioning and funding of human services has typically involved contracts between a single funding agency and a single service provider, which obviously makes it difficult to address the many inter-related social and welfare issues that go beyond the responsibilities of a single portfolio. 'The interrelated nature of social problems,' say O'Flynn and her colleagues (p9), 'has driven attention on more collaborative approaches that include better coordination of service provision'.

Coordination and collaboration are major issues in the context of mental health services in particular since, as noted elsewhere, people with mental illness may also face challenges concerning their physical health, housing insecurity or homelessness, training and employment, drugs and alcohol, family relationships, social isolation, legal issues and the like. In the mental health sphere it is plain that responsibilities need to be shared in appropriate ways across portfolios and also across jurisdictional boundaries. Rosenberg (2012a) notes that one of the intended roles of the NSW Mental Health Commission was to support co-ordination of whole of government effort in relation to mental health, going beyond the health system to encompass employment, education, justice, housing and the like (p255) – a role that it has been able to carry out with some success.

While fragmented or poorly coordinated services will obviously create difficulties for clients, Mental Health Australia has noted that there are also direct costs for governments themselves:

> *Without the right coordination within and across governments, current inefficiencies and avoidable costs will be retained. Contrary to conventional wisdom, the Commonwealth bears a substantial proportion of this risk. Poor mental health outcomes do not just result in additional demands on (state-funded) hospital systems; they also reduce labour force participation rates and increase reliance on welfare …. poor mental health outcomes also present major financial risks for States and Territories, which (in addition to running hospitals) fund prison systems, homelessness services and other crisis interventions.* (Mental Health Australia, *Blueprint*, November 2014, p9)

KPMG (2014) makes the point that costs and benefits for various scenarios of mental illness involve savings and costs distributed in different ways between the Australian Government and the States and Territories (p17).

One of the central aims of the Australian Government's current work on the *Reform of the Federation* is to help in -

> *clarifying roles and responsibilities between different spheres of government and the need for all levels of government to coordinate action to ensure the best possible results for citizens …. Reform of the Federation must deliver concrete improvements in the way services are delivered.* (Reform of the Federation White Paper: Discussion Paper, 2015, p1)
>
> *The Constitution is almost completely silent on the formal mechanisms by which Commonwealth and State interaction might be facilitated. There was nothing formal set up that brought the Commonwealth and States together to discuss matters of common interest and to thrash out arrangements on how they would interact and cooperate on particular issues. It simply was not regarded as necessary …. Since then the world has changed, the Commonwealth has greatly expanded its role, and collaboration on issues has become more important.* (pp 1-2)

Since 1992 the main 'institutional architecture' used to facilitate Commonwealth/State interaction has been the Council of Australian Governments (COAG), which 'has promoted policy reforms of national significance requiring coordination by all governments, such as the introduction of the National Competition Policy' (*Federation White Paper*, p2). The COAG architecture, however, does little to promote

consultation or cooperation around practical, day-to-day issues such as program design and service delivery.

In the mental health sphere, one practical step would be for the Commonwealth to formally adopt the National Targets and Indicators referred to in section 3 above, and to request all States and Territories to do the same; that would at least provide a common basis for decision making and resource allocation.

Mental Health Australia's *Blueprint* refers to some existing and potential Australian mechanisms for achieving a more effective *cross-portfolio* approach to certain matters:

> *(T)here are various ways in which government decisions can be informed by cross-portfolio considerations. For example, proposals involving additional regulation need to be accompanied by a Regulatory Impact Statement; similarly, initiatives to close the gap in Indigenous outcomes are developed with reference to needs across agencies and across jurisdictions. (p15)*

There appear to be few Australian precedents directly relevant to mental health that involve approaches such as joint commissioning across portfolios or the inter-Departmental pooling of funds. It may be noted that Western Australia's Partnership Forum, however, has given some consideration to a possible mechanism for promoting cross-agency commissioning in human services.

Another possibility is the rationalisation of functions across agencies or structural consolidation among agencies and Departments. In NSW, for example, the former Department of Community Services, Housing NSW and the Department of Ageing, Disability and Home Care have been combined into a new Department of Family and Community Services (FACS). Combining agencies is of course not a solution in itself, for there can be confusion or fragmentation within a single bureaucracy as well as between agencies.

The rationalisation of functions, greater emphasis on inter-agency coordination, and simplification and consolidation of bureaucratic structures in appropriate cases are all consistent with the Australian Government's concern to 'ensure that government services are as efficient and well targeted as possible' (The Hon Mathias Cormann, *Smaller and More Rational Government 2014-15*, May 2014, p11). The Abbott government is committed to creating 'more coherent and effective government structures' and to 'simplifying the coordination required for cross-agency work'. It sees a particular need to 'consider opportunities for more streamlined and efficient arrangement s to drive much needed productivity and performance improvements in the health sector'.

Some of the disincentives to cross-portfolio thinking are financial, since a policy or program initiated in one area of government may have significant parts of its financial pay-off in a different portfolio (or indeed different jurisdiction). In its November 2014 *Blueprint* Mental Health Australia recommends (p28) that:

> *Treasury and/or Finance Departments of all governments should use existing internal processes – such as new policy proposals and Regulation Impact Statements – to identify the potential impacts of policy changes on mental health outcomes, including impacts that may be significant across portfolios and jurisdictional boundaries.*
>
> *Treasury and/or Finance Departments of all government should also reconfigure their Budget rules in order to allow Ministers to account for savings in one portfolio as a result of investment in another portfolio, and to better recognise down-stream savings that stem from government investment in areas such as psycho-social services, employment supports and securing stable housing.*

A number of the recommendations and proposed Strategic Directions set out in the *National Review of Mental Health Programmes and Services*, released in April 2015, relate to the importance of a national approach, improved co-operation among the jurisdictions and better co-ordinated initiatives, e.g.:

> *Recommendation 1 – Develop, agree and implement a National Mental Health and Suicide Plan with the States and Territories*

> *Recommendation 4 – Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention*
>
> *Recommendation 9 – Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher level mental health services and support.*

The KPMG report (2014) that was commissioned by the National Mental Health Commission as part of its review states clearly that 'Investment strategy should be developed across portfolios' (p18):

> *The level of complexity associated with mental illness requires a multifaceted response to improving health outcomes, including health and community care, informal care, housing, substance abuse treatment, job training, and education.*
>
> *These services are developed across a range of government portfolios, and therefore investment in optimal care should be developed within a strategy that coordinates a broad range of programs, planners, and funders.*
>
> *Benefits from optimal care also impact a number of government portfolios…Given these portfolios will receive the benefits from optimal care, there is also an incentive to invest in optimal care. Similarly, externalities created by mental illness, such as police, justice and housing costs, and the potential benefits from optimal care, means jurisdictions should also have an incentive to invest. (p95)*

KPMG acknowledges that this kind of coordination may not be easy to achieve, but suggests that individualised budgets such as those to be used in the National Disability Insurance Scheme (NDIS) represent one possible way of addressing the issue. However, mental illness can often affect a person's capacity to make effective choices, and the episodic nature of much mental illness makes this still more problematic, since decision making capacity can vary rapidly and unpredictably over time. At this stage the extent to which the NDIS will fund community mental health services is unclear, with many people with moderate to severe mental illness unlikely to be eligible. If precent policy is maintained, the level of coordination required in the mental health arena thus seems unlikely to be delivered by way of individualised funding.

The Productivity Commission, also, refers to the proposition that 'governments should consider the possibility of joining up funding streams within and across levels of government', while again acknowledging that this may not be a straightforward matter (*Contribution of the Not-for-Profit Sector*, 2011, p312).

F.2 Collaboration among service providers

At the service provider/service delivery end, a group or partnership of provider agencies may well be better placed than a single organisation to offer the mix of services that a client with mental illness may require. Good communications and linkages among service providers are also obviously important in avoiding duplication, sharing of information and good practice, and ensuring that clients have effective access to the most appropriate range of services. Indeed, the concepts of 'wrap around services' and 'no wrong door', while not easily achieved in practice, are the embodiment of success in mental health service delivery.

A number of recent Australian initiatives seek to improve the quality and effectiveness of mental health services by bringing together funding agencies and/or encouraging partnerships and collaboration among provider agencies. One major example is Partners in Recovery (PIR), a three-year national program which is funded by the Federal Department of Health and which:

> *…aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more*

collaborative, coordinated and integrated way. (Department of Health website, *About Partners in Recovery*)

PIR aims both at improving quality of service for the individual client and also at system change. Its ultimate objective is to improve mental health responses and outcomes by:

- *facilitating better coordination of clinical and other supports and services to deliver person centred support 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 need by the PIR target group and*
- *promoting a community based recovery model to underpin all clinical and community support services.*

In setting up this program the Department of Health announced that it would accept only one bid per Medicare Local region, and invited agencies in each region to form an appropriate regional consortium. Contracts were signed with 48 such consortia, each with a lead agency such as the Medical Local or a major NGO such as Anglicare. Given the possible risk of 'reinventing the wheel' in some instances, they were asked to implement PIR in their regions in a way that would *complement,* rather than overlay, existing support and service systems and any existing efforts to provide coordination of care.

The sectors seen as relevant to PIR's success include primary health and mental health care, State and Territory specialist mental health systems, alcohol and drug services and income support services, as well as education, employment and housing supports. The consortium led by Central Coast Medicare Local in NSW, for example, includes a range of agencies such as Central Coast Local Health District, Lifeline, Uniting Care Mental Health, Australian Red Cross, Coast Shelter, House with No Steps and Central Coast Disability Network.

Richmond Fellowship Western Australia, the lead agency for the Bentley-Armadale PIR program, sees it as providing 'an opportunity to identify gaps in the mental health system and build capacity across all sectors.' Its website describes three pillars of the program as:

- *Care coordination:* PIR provides care coordination through connecting Network Members and the consumer to provide 'wraparound services'
- Flexible funding: PIR has a limited budget that enables the consumer to meet needs that cannot be met within the community's existing resources
- Capacity building: PIR aims to connect, link and build capacity in existing services.

Stakeholders consulted during this study observed that PIR had usefully sharpened the focus on the importance and value of collaboration in the NFP sector. It is sometimes assumed that cooperation comes naturally to the community sector, and there may well be an element of truth in this. However, as the Productivity Commission and others have observed, the sector is extremely diverse and a readiness to work in partnership can certainly not be assumed. Government can support and promote collaboration through the way they commission services - for example by allowing sufficient tendering time for separate organisations to develop suitable arrangements to work together, and by encouraging or requiring collaborative responses. (One stakeholder who was consulted, however, made the comment that 'forced marriages' are no more likely to be successful between organisations than between individuals.)

PIR is designed to run from 2012/13 to 2015/16, at which point funding for the program will (on latest evidence at the time of writing) be cashed out as part of the Commonwealth's financial contribution to the NDIS. It is not yet clear what if any structures or mechanisms will take over from PIR to encourage collaboration across the broad range of services for people with severe mental illness. Consulting firm *Urbis* has been commissioned to monitor and evaluate the national program; when the Urbis reports become publicly available they can be expected to offer useful lessons on good practice and the future of collaboration in community mental health.

Cooperation among NFPs is closely related to cooperation between government and the NFP sector generally. One of the perceived benefits of the WA Mental Health Services Commission is that it is well placed to establish and maintain close and constructive relationships with a range of service providers:

> *The WA Commission has pursued much closer relationships with peak community sector organisations, including consumer and carer organisations as well as NGO psycho-social service providers, and is now focusing on regularly re-engaging with public sector providers. These groups report much closer relations with the commission than they felt they previously enjoyed with the WA Department of Health (Rosenberg and Rosen 2012b, p197).*

F.3 Co-production

The term *co-production* is increasingly used to refer to the active participation by users and clients in the design and delivery of services, and also to the involvement of service providers and client groups, with government, in developing policies and designing programs. In *Commissioning for outcomes and co-production* (20??) the United Kingdom's New Economics Foundation (NEF) describes co-production as 'an assets-based approach to public services where professionals and citizens share power to plan and deliver support together' (p31), and where the skills, knowledge and experience of both are capitalised on to produce higher-quality results.

In its 2010 report *Contribution of the Not-for-Profit Sector*, the Productivity Commission places considerable emphasis on the need for governments to *work cooperatively with* the community sector to maximise the value of its role and to capitalise on its motivation and expertise. In relation to contracting for services, as noted earlier, it identifies factors such as poor risk management practice, unduly short contract periods and 'heavy handed contractual and reporting requirements' (p297) as adversely impacting on the relationship between governments and NFPs, and ultimately on service quality. As we have seen, it emphasises the importance of reducing the red tape that tends to accumulate over time because of 'the propensity for government agencies to focus on contractual rather than relational governance' (p306). There needs to be a stronger focus on 'relational governance' in order to 'build a stronger sense of trust between government and providers' (p317). 'A market-based approach' to government purchasing of services from the NFT sector is not inconsistent with good relationships, says the Productivity Commission, but effort needs to go into improving the quality of engagement and building a stronger sense of trust (p318).

One important contribution to a closer and more constructive relationship would be for commissioning agencies to embrace the value of co-production with the community sector *throughout* the process – including at the stage of policy formulation and program development. While it may not be practical to include individual users and clients in these formative stages, it is both possible and desirable for government to work with the organisations which advocate and provide services for them.

Equally, as community organisations go about the tasks of designing and delivering their own services, they need to make sure that they are drawing on the expertise and insight of those with lived experience of the problems they are trying to address. In the words of the New Economics Foundation (NEF), 'people must be active in achieving outcomes for themselves with the support of others' (p 8). The Australian not-for-profit sector has increasingly recognised this in the mental health field. The NEF argues that as well as improving the quality of decision-making and resource allocation, co-production offers significant benefits to the well-being of the consumers and communities who are involved in the process, for example by increasing their sense of autonomy, efficacy, self-esteem and belonging (see p24). This is of striking relevance to the design and delivery of mental health services in particular, since it is just these things that lie at the heart of many of Australia's policy objectives in mental health.

Commissioners of services, as the NEF report points out, can promote co-production in two main ways: first by ensuring that the *commissioning process* itself is open to consumer input, and secondly by *commissioning for co-production* – that is, encouraging their service providers to work productively with the people who are intended to benefit from their services (p34).

Appendix G: Relational contracting and high trust contracts

Legal contracts are fairly blunt instruments for managing relationships and expectations. In the commercial world the parties' mutual interest in maintaining useful business relationships and protecting their reputations may be much more important than the specifics of any contract between them (Macauley, 1963; Warren Buffet is famously supposed to have said that if you need a contract you are dealing with the wrong person). In Macaulay's seminal article he reports that the business people he consulted tended to say that any problem could be settled 'if you keep the lawyers and accountants out of it' (p11).

In government contracts for services, however, the perceived political risk of something going wrong has been a prominent concern, and highly detailed and prescriptive contracts have increasingly become the norm. In Australia this may in part reflect the 'hollowing out' of public sector expertise that has resulted from successive governments' efforts to reduce the cost of the public service: if the public servants responsible for commissioning a service are not confident that they are on top of the issues, they may try to protect themselves and their political masters by requiring the contract to be as prescriptive and watertight as possible. Participants in the Review Workshop held in May used the term 'gotcha contracts' to characterise this phenomenon. Shergold refers to 'a culture of risk aversion in the public sector' (2013, p22), and identifies a need to reduce contractual rigidity, red tape and micromanagement.

Macauley notes that in the business world unduly detailed and legalistic contracts can be counterproductive, since they imply lack of trust and an adversarial relationship: over-specification may mean that 'one gets performance only to the letter of the contract' (p15). Bohnet, Frey and Tuck (2001) refer to trust being 'crowded out' by inappropriate contractual terms or excessive legalism (p141). This issue has obvious relevance for the relationships between government and community sector organisations, since the latter will often be motivated by commitment to a particular cause or client group, and their readiness to 'go the extra mile' may well be a significant ingredient of service quality. Performance that goes beyond contract requirements in this sense is sometimes called an 'invisible' output.

Similar issues have been discussed in the context of employment contracts. For instance Frey (1993) makes the point that in some circumstances over-tight monitoring of workers can be counterproductive and reduce effort. Bird (2005) argues that 'employment is a relational contract', and that trust, commitment and shared solidarity are important components. He makes the telling observation that 'employers draft contracts for employees to sign, but expect far more than the contract's terms – a solid work ethic, commitment to firm goals, improvement with experience, and a positive attitude' (p215).

The term 'high trust' contracting has sometimes been used in discussing commercial contracts that rely more on the strength of the parties' relationship than on tight legal provisions; to date the it does not seem to have been used much in a human services context. One way in which a satisfactory relationship or performance may be acknowledged by a government agency, however, is by giving a provider with a proven track record some advantage when it comes to contract renewal; in the Job Services Australia program, for instance, providers can earn star ratings for good performance, and a high rating is advantageous when the time comes for renewing or extending contracts.

In New Zealand the term 'high trust' is currently being used in certain social programs, notably Whanua Ora, which aims at better local integration of services funded by multiple agencies (New Zealand Productivity Commission 2014). The focus of this particular program is not individuals but extended families. Whanua Ora is described as a cross-government work program under which 'navigators' support family groups 'to become more self-managing and take more responsibility for their economic, cultural and social development.' The navigators work with families 'to identify their needs, develop plans to address those needs, and broker access to the best mix of services from government agencies and non-government providers' (p32). In co-operation with District Health Boards and others, the Ministry of Social Development has led the development of 'integrated, high trust contracts' for local groups of providers.

> *Integrated contracts aim to bring together in one outcomes-focused document the contractual requirements of multiple funding agencies … (which) requires government agencies to work more collaboratively and makes it easier for providers to work holistically' with clients.* (p32)

The Ministry of Social Development website on High Trust Contracting says that:

> *High trust contracting is a new approach towards the way government funds the community social services sector. It enables community organisations to focus more on the families they serve and less on ticking boxes, complex paperwork and reporting.*

Under high trust contracting there is:

- *a short, simple funding agreement*
- *payment of funding up front, in annual instalments*
- *meaningful, outcomes focused, year-end reporting*
- *a focus on outcomes – results are agreed on and described*
- *flexible service delivery – enabling providers to better meet the needs of families in their local community*
- *a customised approach – recognising the holistic needs of families and ensuring that the contract reflects this.*

High trust contracting also means:

> *…bringing together all the services funded by the different Ministry business groups – Family and Community Services, Child, Youth and Family, Work and Income and Ministry of Youth Development - into one short, simple contract.*

The principles that guide the funding relationship include:

- *respecting and valuing each other's expertise*
- *acting with integrity and good faith*
- *recognising accountabilities*
- *having open, transparent, honest and timely conversations.*

To be eligible for a high trust contract, community organisations need to have a strong and trusted relationship with government. According to the website, this means that they:

- *have a good track record of delivering the services they have been contracted to provide*
- *are a viable organisation – with strong governance, good management systems and effective and meaningful reporting systems*
- *are an integral part of their community – connected, trusted, and provide the services that the community needs*
- *work well with other agencies in their community - both government and non-government*
- *are high performing, and understand what it takes to help their clients make a difference to their lives.*

In 2014 the government announced the appointment of three non-government commissioning agencies for Whanua Ora. These have been contracted for three years, with an option to renew for a further two. One component of these contracts is 'an incentive payment for the achievement of agreed measures' (p32). Thus the Whanua Ora high trust contracts in fact pick up on a number of the other key ideas discussed in the present report - a focus on outcomes and on outcome-related incentives, a consultative and collaborative approach, cross-government co-operation, local partnerships, simpler contracts, and devolution of some commissioning responsibilities to non-government agencies.