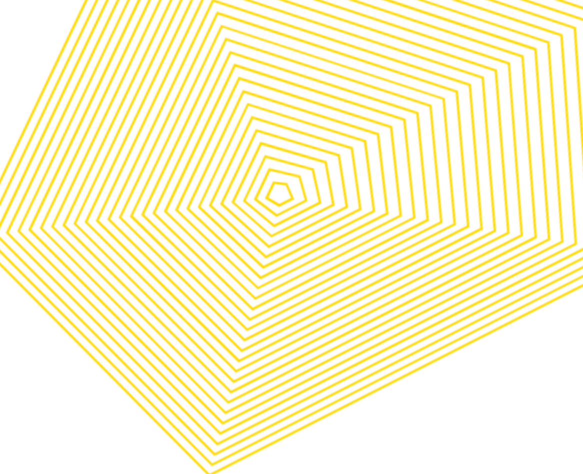

Commissioning Homelessness Services: A Review of Possible Approaches

A report prepared for:

Homelessness NSW

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Executive Summary

Contracts for providing Specialist Homelessness Services (SHS) in New South Wales, which were due to expire on 30 June 2024, are being extended until 30 June 2026. The extension provides an opportunity for the homelessness sector, including peak bodies, service providers, people with lived experience, and other stakeholders, to shape the ways services are commissioned, as a way to improve the effectiveness of services for people experiencing homelessness, and to help end homelessness.

How services are commissioned sets foundations for service delivery. **Commissioning** refers to a cyclical process through which government funders identify need in the community; prioritise how those needs might be met; plan, design and engage services to meet need; and manage performance and evaluate outcomes. Procurement, which involves government tendering, and contracting, which establishes legal agreements to bind parties, are parts of the broader commissioning process.

The report seeks to inform and empower the sector to contribute to the design of the new commissioning arrangements. It draws on Australian and international literature to look beyond dominant models of contracting, such as direct contracting with government to identify, and explore the range of alternatives through which governments and the sector can work together to secure and sustain a supply of quality services, and ensure they are co-ordinated to meet need.

The report explains the range of options and factors to be considered when commissioning services. It does not recommend or prescribe a specific approach, but promotes understanding from a range of perspectives to identify opportunities for change. It recognises that the ways service systems are organised, resourced and reformed may be highly contentious. Indeed, the NSW homelessness sector has first-hand experience of the ways changes in approaches to commissioning can impact business operations, staff retention, service continuity and sector relationships, especially when driven via top-down approaches. The sector was left highly cautious about future commissioning models after the 'Going Home Staying Home' reforms and the recontracting of services in 2014. The current reform process provides opportunities to shape what commissioning looks like and potentially lead to a more stable and sustainable model of service delivery – beneficial to clients, to providers, and to government.

Configurations of contracting

Service providers and government share a commitment to improving outcomes for people requiring services and supports. To do this, service systems can be organised and resourced in various ways. Determining an appropriate approach requires careful consideration of strengths and limitations of different models and their efficiency, effectiveness, and implications for government, providers and clients.

Models of contracting matter. Under the standard model of **direct contracting,** a single funder contracts a single organisation to provide services, usually via competitive tender. Compared with government provision, 'purchaser-provider' relationships can improve efficiency, and can be quick to establish, allowing funders to respond to changing needs. However, contracts can have high transaction costs for providers who must respond to tenders, and many providers lack power when

negotiating individually. Further, when contracts are not well co-ordinated across services and systems, they can contribute to overlaps, fragmentation and gaps in services for clients. When contracts end or providers change, it can be disruptive for clients and for staff.

Often, service providers will have direct contracts with multiple funders, each with different service and reporting requirements, which can be administratively burdensome. **Co-commissioning**, also referred to as joint or collaborative commissioning, provides a potential solution. Funders work together to jointly plan and fund activities to maximise resource efficiency and reduce overlaps. Co-commissioning may involve strategic planning or co-procurement which can help improve coordination among funders, and streamline relationships for providers. Co-commissioning can reduce administrative overheads for both funders and providers, and can make it easier for clients to navigate and access services. Co-commissioned services can also address client needs more effectively, as it recognises complexities and intersections between them.

Under a **prime provider** model, funders engage a lead contractor to directly provide services and manage a supply chain of other, subcontracted, service providers. Where multiple providers operate, it allows funders to hold one, rather than multiple contracts, reducing oversight costs. Prime provider models can be helpful for funders where they do not have a local presence, as the lead provider can engage the right mix of services, including small specialist, localised providers. There are risks however that the prime provider could control supply chains and use their direct relationships with funders opportunistically, impacting on smaller, subcontracted providers.

Under an **intermediary** model, the intermediary subcontracts services but does not deliver them directly. Intermediaries help reduce the number of contracts that governments must manage. This approach can lead to better outcomes than direct contracting, as intermediaries can apply their strong local knowledge and content expertise, and strategically commission services to reduce fragmentation.

Alliance contracting involves providers collaborating to respond to a tender, with the funder issuing one contract to the alliance, either to a lead provider or the alliance (if members come together to form a new entity). The alliance is likely to be established prior to entering into a contract with the funder, unlike the prime provider model which contracts the prime provider to deliver and contract services as required. Alliance contracting is often associated with cooperation, collaboration and value creation among partners. Risk is shared across alliance partners.

Individualised funding may be an option for some types of support. Rather than government bulk buying services, government provides eligible individuals a voucher or budget (often referred to as a package) based on an individual needs assessment. Eligible clients are then able to choose what services to purchase and from what provider. Once established, government needs to provide market stewardship (to ensure services are available to meet the needs of consumers) and oversight. For service providers, individualised funding can contribute to financial instability as funding shifts as clients move between services. Further, client payments may not cover organisational overheads. Individualised funding also shifts the administrative burden to clients.

Finally, **government provision** of services may be warranted, either on its own or as part of a mixed procurement strategy. Governments can use services to effect change and operate in the public interest, such as providing services equitably, ensuring stability, and providing accountability to the public. Government may also bring previously contracted services back in-house when

market provision fails, where the market is unable to respond, or to serve particular groups. However, government provision requires technical capacity, and can be less flexible and locally responsive.

The models of contracting described above are indicative of the main types of contracting models and can be used alone or in combination. Every model of contracting has strengths and weaknesses for funders, providers, and clients.

Considerations across the commissioning process

To work well, commissioning requires that services are adequately resourced, that there is accountability, trust and positive relationships, and that focus on clients is maintained. For providers, it is important to recognise that governments work within jurisdictional and policy siloes and short funding cycles. Governments also have strict procurement rules and accountability requirements, which will shape procurement processes and contract content. For government, it is important to recognise the tension service providers face between competing and collaborating with other service providers, and that services navigate costly procurement processes, work with limited overheads, and are required to address rising levels of need. Small, locally based organisations in particular face challenges in covering highs cost of participating in procurement processes and remaining viable.

Ultimately, no single approach to commissioning can resolve all problems of the service system. All provide opportunities and have limitations, which are experienced differently by different groups. All models require supportive operating environments and safeguard mechanisms for clients and staff, including complaints processes, and effective service quality standards and employment regulation. The appropriateness of different models will depend on many factors, including service type, market capacity and relationships, funding duration, lead time, and the capacity and preparedness of government and service providers.

Opportunities for change

The extension to contracts means that before the next phase of commissioning commences, the NSW homelessness sector has an important opportunity to shape a new approach. Increasingly, governments appear to recognise the importance of developing stable, sustainable and effective service systems, which are accessible for clients and do not require them to retell their stories – i.e. are trauma informed. Commissioning provides an opportunity to set strong foundations for a future system. This report provides information to empower the sector to work alongside government to approach commissioning in ways that are different, and in ways that make a difference.

1 Introduction

This report outlines models of commissioning, contracting and procurement, and principles to inform future commissioning of homelessness services in New South Wales (NSW). On 29 May 2023, the NSW Government announced that existing contracts for Specialist Homelessness Services (SHS), which were due to expire 30 June 2024, would be extended to 5 years in duration, expiring on 30 June 2026. The extension provides an opportunity for peak bodies, service providers, people with lived experience of homelessness, and others, to help shape the service system through the next phase of contracting, with new contracts due to commence on 1 July 2026.

This report identifies and explores issues and challenges to consider in developing an effective approach to commissioning, contracting, and procuring homelessness services. It aims to inform and empower advocates to ensure new arrangements will:

- contribute to positive outcomes for people with complex needs
- help build system capacity to support the goal of ending homelessness
- recognise and value sector experiences and priorities, and
- be equitable and sustainable.

To do so, we draw guidance from Australian and international literature.

1.1 Focus and structure of this report

This report draws on academic and practice literature to identify:

- the range of commissioning, contracting and procurement approaches available to help secure an adequate supply of high quality, government-funded services that meet client and community needs

- which models enable co-ordinated or joined-up service provision appropriate for meeting more complex needs, and

- any specific arrangements that may be suited to homelessness services.

Intentionally, the report looks beyond models of direct contracting and subcontracting which are, or have been, the main approaches adopted in the NSW homelessness sector. While homelessness services often work together via joint working agreements with a lead entity contracting directly with government, the report outlines ideas and lessons from a wider range of service systems and overseas, to outline the features, impacts, strengths and limitations of alternatives, and understand challenges and priorities for new approaches. Rather than recommend or prescribe an approach, our aim is to promote understanding of the range of options available in the commissioning of homelessness services.

First, we outline NSW's homelessness crisis and underline the importance of configuring the service system to place people requiring support at the centre and enabling a joined-up response to ensure service effectiveness (Section 2). Section 3 provides an overview of the commissioning

process, which is a broad, strategic, macro-level approach through which governments can secure a supply of services, co-ordinated to meet need. Commissioning cycles are illustrated with an example of Australia's Primary Health Networks (PHNs). Section 4 outlines the various configurations of contracting through which governments and service providers can organise service systems. These include traditional models of direct contracting between purchasers and providers, collaborative and network-based models, such as prime provider, intermediary and alliance models, and co-commissioning which promotes coordinated approaches among funders. Section 5 focuses on the procurement process, identifying considerations relating to process design, service specification, contract management, and measurement, monitoring and evaluation.

1.2 Guide to key terms

The terms commissioning, contracting and procurement are often used in overlapping ways. However, each has different emphasis:

Commissioning, the focus of Section 3, involves a wide range of strategic and operational activities. As Sturgess (2015) articulates:

> Commissioning is the process through which public services are authorised and funded. This begins with decisions about service outcomes and the means through which results will be delivered. Depending on the service in question, it may involve commissioners in the design and management of systems, markets or supply chains. (Sturgess, 2015, p. 13)

Strategic commissioning may include identifying and establishing the level and nature of need in the community; providing resources to secure a supply of services to meet this need (usually through various types of contracting); and evaluating commissioned services to ensure they were delivered in the ways intended, and made a difference against desired outcomes.

Contracting, the focus of Section 4, refers to the ways organisations are drawn together into partnership relationships, and how relationships between funders or purchasers (such as government) and providers (private businesses, NGOs and other forms of organisation) are legally structured, to create supply chains and lines of accountability. Contracting human services can involve various models and configurations of relationships (see Section 4).

Procurement (Section 5) refers to the technical process through which funders select external providers and acquire goods and services (Australian Department of Finance, 2023, p. 6; Sturgess, 2015, p. 13). Procurement includes defining business needs; designing and implementing purchasing arrangements (such as through open or select tenders, or direct negotiation); awarding a contract; setting out the terms of funding arrangements and parties' roles and obligations, monitoring and managing contract and supplier performance; and reviewing outcomes to assess the effectiveness of arrangements (NSW Government, 2022, p. 119). Procurement is usually regulated by government processes. For example, the *NSW Government Procurement Policy Framework* (NSW Government, 2022) emphasises the importance of achieving value for money, operating with probity, transparency and fairness, and delivering positive outcomes for clients and communities. The *NSW Government's Aboriginal Procurement Policy* (NSW Treasury, 2021) seeks to use procurement to create opportunities for Aboriginal owned and run entities, to promote employment opportunities for Aboriginal people, and to promote cultural competences among service providers to meet the needs of Aboriginal clients and communities.

2 Context

Commissioning, contracting, and procurement matter to the ways governments harness and deploy resources to end homelessness. This section provides the context for the study, as a basis for showing how the models governments use to select, engage and pay service providers can affect how funders and providers work together, and their ability to address homelessness.

2.1 The homelessness crisis in NSW

Around New South Wales, communities are contending with chronic shortages of affordable housing, rapidly increasing costs of living, and inadequate government investment in initiatives to expand housing supply and support people experiencing homelessness (Homelessness NSW, 2022). While housing stress is experienced throughout the community, some groups are particularly vulnerable to homelessness, including people in poverty; people living with disability; people experiencing domestic and family violence; people experiencing drug and alcohol issues; Aboriginal and Torres Strait Islander people, young people, older women, and people exiting institutions (hospitals, justice sites) or out-of-home care (Department of Social Services, 2023).

As in other parts of Australia, NSW is experiencing a homelessness crisis. While there is no single definition of homelessness, for statistical purposes the Australian Bureau of Statistics (ABS) classifies a person as homeless if they do not have suitable accommodation, such as when they are living in dwellings which are inadequate (such as improvised dwellings), without tenure, or with no space for social relations (ABS, 2012).[1] According to the 2021 Census, in NSW there were 35,011 people defined as homeless, or 43 people per 10,000 (ABS, 2023). Of these, 42% were people living in ‘severely crowded’ dwellings, 25% were in boarding houses, 14% were in supported accommodation for the homeless, 12% were staying temporarily with other households, 4% were in other temporary lodging, and 4% were in improvised dwellings, tents, or sleeping out (ABS, 2023). A further 33,129 people were in other marginal housing (ABS, 2023, Table 2.2).

Many people experiencing homelessness, or in other marginal housing, spend long periods waiting for support, including for social housing. As of 30 June 2022, there were close to 58,000 people on NSW’s social housing waitlist, with 51,031 applicants waiting for general housing, and 6,519 with complex, urgent needs, waiting for priority housing (NSW Communities and Justice, undated). Wait times differ across areas but there is evidence that delays have been increasing, especially for non-priority applicants, Aboriginal people, and older people (Pawson and Lilley, 2022).

2.2 Specialist Homelessness Services

In addition to social housing, specialist homelessness services (SHS) offer an important support to deliver NSW Homelessness Strategy. SHS is a primary means by which Australian governments support people experiencing homelessness and those at risk of homelessness, and address immediate needs and underlying barriers to achieving safe, stable housing. Rather than providing

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[1] Note that the ABS definition is similar but non-identical to the definition in the SHS dataset, which classifies someone as homeless when in non-conventional accommodation (e.g. on the street), or in short–term or emergency accommodation (e.g. temporarily in a refuge, or with friends and relatives) (AIHW 2022).

ongoing housing (as per public and social housing), SHS are funded to provide a range of supports, which differ between providers. Support may include crisis, long or medium-term accommodation, transitional housing, advice and information, material aid, meals, living skills, and referrals to health services. As in other social services, most providers are NGOs. In 2020-21, 335 agencies providing SHS were contracted to provide assistance to 68,500 people, including the general population experiencing housing crisis, and specific groups such as women and children leaving domestic and family violence, rough sleepers, and young people (NSW Ombudsman, 2022; AIHW, 2022a). Clients of SHS require complex supports. In 2021-22, around a third of SHS clients in NSW (35%) had experienced family and domestic violence, 11% reported problematic drug or alcohol use, and 46% had current mental health issues (AIHW, 2022b). Many were also located away from metropolitan centres; high proportions of SHS clients were located in the Far West and Central and North Western districts of NSW (AIHW, 2022b).

Under current arrangements, many people find their need for housing and homelessness supports remain unmet. Demand for SHS outstrips supply. Often for example, people experiencing crisis and with ongoing needs are placed in short term purchased accommodation such as boarding houses, motels, hostels, backpackers and caravan parks where ongoing supports are unavailable (Batterham et al., 2023).

Unmet need for social and affordable housing underpins other needs, and generates costs in terms of homelessness, stress, mental health issues, domestic violence, reduced educational achievement, reduced disposable income, and lower wellbeing (Nygaard, 2022). Many people experiencing or at risk of homelessness require other supports in addition to housing, to reduce their vulnerability and risk of homelessness, and to address the impacts of lack of affordable housing, including health, justice, disability, mental health, child and family welfare, alcohol and other drug, justice, and other supports. However, as Homelessness NSW has identified, “current practices across the system are disconnected and uncoordinated, despite having deep linkages and interdependency” (2023, p.7). Addressing homelessness requires more coordinated approaches, including among government agencies and across levels of government, and among specialist and mainstream services, to reorient services around prevention and early intervention, and to promote collaborative working (Department of Social Services, 2023; Spinney et al., 2020).

2.3 Building a service system to address homelessness

The 2023 Report on Government Services (Productivity Commission, 2023, Table 19A.1) indicates the vast majority of recurrent government expenditure on SHS goes to agencies for service delivery (96.7%) with the remaining 3.3% spent on government administration. Most homelessness services are delivered by non-profit or other private sector organisations, under outsourcing arrangements. Such arrangements are widely adopted in human service systems to increase efficiency and enable governments to pursue strategic or practical goals such as improving system flexibility and responsiveness (APSC, 2009). In other areas of housing policy, government has maintained a role, such as through the provision of public housing via Housing NSW.

Governments periodically reconfigure service systems in attempts to ensure expenditure is effective and outcomes are met. One reason is to ensure services are reaching people with complex support needs, who often find the service environment is particularly difficult to navigate and access. While the most common approach by government is to separately contract a set of

services, strategic commissioning processes have been considered a way to improve service coordination and effectiveness, by increasing the emphasis on consultation and engagement, data and evidence, to ensure needs are identified and met. Commissioning processes can be used to implement system-wide reforms, and promise better change processes and outcomes, through a more collaborative approach.

Models of engaging external service providers can be highly contentious. Under NSW Government reforms in mid-2014, known as the 'Going Home Staying Home' reforms, a series of separate contracting arrangements were used in an attempt to improve system emphasis on prevention and early intervention, and crisis and post-crisis support (valentine et al., 2017). The total homelessness services budget was recontracted through a two-stage competitive tendering process, some of which was condensed into a very short period of time (KPMG, 2015, p.17). There were wide differences in the sector's readiness and preparedness to respond, and their ability to form partnerships to be able to respond to the request for tender. The number of new entrants were constrained to reduce impacts on existing providers, and small services that did not partner with larger providers found it difficult to compete (KPMG, 2015, p.18). The total number of contracts issued more than halved (KPMG, 2015, p.18) and some stakeholders reported the changes undermined cooperative relations in the sector and were also disruptive for clients (KPMG, 2015, p.19). The process undermined trust in government, and the sector remains highly cautious about future commissioning.

More recently, the *NSW Homelessness Strategy 2018-23* sought to reset strategic directions and promote greater collaboration, placing people at the centre, through service integration, person-centred approaches, and outcomes-based commissioning (NSW Government, 2018). Consultations were undertaken to develop an *SHS Outcomes Framework*, with DCJ piloting an approach and releasing a blueprint (Insight Consulting Australia, 2019; NSW Government, 2021). Although the agenda has been disrupted by COVID-19, DCJ has restated its commitment to using commissioning approaches to identify, measure and drive outcomes from SHS providers (NSW Government, 2021).

Many homelessness organisations, affected by rising operating costs, have called for expanded investment and longer funding duration, reflecting wider community sector recognition of the inefficiencies and insecurities arising from inadequate funding, short term contracts, and uncertain renewal processes, which can undermine organisational sustainability (Blaxland and Cortis, 2021). Homelessness NSW, among others, has called for 5-year contracts to enable certainty and innovation (Homelessness NSW, 2022). The extension of current contracts goes some way towards achieving this; however, the approach to be adopted in 2026 is unclear.

Despite repeated failures of contracting, including those examined in a series of Royal Commissions, public inquiries have continued to recommend outsourcing human service delivery (Productivity Commission, 2010, 2011, 2016, 2019). However, it is difficult to design and configure contracting models in ways that meet the needs of funders, ensure services meet the needs of all client cohorts, support collaboration, and provide security and stability for clients and service providers, while preventing opportunistic provider behaviour or profiteering. It can be difficult for governments to specify what services should look like in contracts, particularly given the individualised nature of supports often required to support people often presenting with complex needs. Further, it can be difficult to measure outcomes given they may be short, medium and long term and may be difficult to attribute to one particular service. This can make it difficult for

government to reliably secure these services at desired levels of quality and quantity (Bates, 2022). Approaches are evolving however, including to ensure client needs are better identified and met, to focus on outcomes rather than inputs, and to incorporate a wider range of procurement and contracting models to facilitate relationships and ensure services remain accountable. In the following sections, we outline the range of approaches, to inform consideration of models appropriate for homelessness services.

In doing so, it is important to note that approaches to commissioning, contracting and procurement are unlikely to solve all issues in a service system. All models and approaches have strengths and weakness and adopting any model requires weighing up values and priorities. Any approach must comply with the regulatory environment, including the provision of accessible complaints mechanisms, service quality standards, and employment regulation. Any model also depends on adequate resourcing. A recent study, which captured perspectives of over 300 community service CEOs and senior managers (including from homelessness services), showed that only 9% found the government funding they received covered the full costs of service delivery. Only 13% said organisational overheads, such as administration, management and IT were adequately funded, and only 6% considered indexation arrangements to be adequate (Cortis and Blaxland, 2023). No commissioning, contracting or procurement process will work in the context of resource inadequacies.

3 Commissioning services to address homelessness

This section describes what constitutes a commissioning process, and how commissioning can be used to target public resources to address homelessness, including by using collaboration and data to enhance focus on outcomes, and prevent service gaps, particularly for people with complex support needs.

3.1 Overview of commissioning processes

Commissioning is a broad, strategic approach to ensuring government resources secure services that meet individual and community needs. Commissioning developed as an approach to address the fragmentation arising from contracting separate services. It offers a way to better meet needs at a population level, by enhancing the focus on outcomes (Smith et al., 2017). There is ‘no one way to do commissioning’ (Dickinson, 2015, p.3). However, commissioning is usually conducted in ways intended to engage key stakeholders to consider which services are needed by populations; use evidence and consultation to determine which proposed services will fill gaps and complement (or overlap with) existing services; and identify any risks associated with the service (such as sustainability), whether organisations have capacity to deliver the services, and whether outsourcing is acceptable to stakeholders (PwC, 2019). In the context of commissioning human services in NSW, the terminology of commissioning has been adopted in recent years as a way to shift from transactional purchaser-provider approaches, towards more strategic and collaborative partnerships between government and non-profit providers (Mason, 2018).

Commissioning cycles have been defined as ‘a set of linked activities to deliver services and supports for better outcomes, and incorporates needs assessment, priority setting, procurement through contracts, monitoring of service deliver, and review and evaluation’ (www.absec.org.au/commissioning/). By bringing together policy makers, providers and community members, the ideal is that commissioning will secure better outcomes for people with complex needs who require access to more than one system or service. This is an important goal in community service contexts where traditions of fragmented or siloed service delivery have presented barriers to meeting complex needs.

As governments should be consistently focused on identifying needs and ways to meet them with available resources; commissioning should be considered ‘business as usual’. However, commissioning requires increased clarity of purpose and competency to collaborate and understand need, so usually requires a change in culture and ways of working (Dickinson, 2015). Indeed, as Dickinson (2015) points out, rather than a simple extension of outsourcing agendas, commissioning is a way to think strategically about public service delivery and involves value-based as well as technical decisions.

To guide the commissioning process, formal commissioning frameworks and processes have been introduced. Formal approaches are particularly relevant to service areas where there are complex needs, variations across different geographic areas (which would call for different approaches and a different service mix), where there are multiple stakeholders and multiple funders, or where the service context is otherwise complex.

A key strength of commissioning is the coordinated needs assessment stage, which solicits input to identify needs, existing services and gaps, insofar as data permits. It also provides opportunities to clarify values and principles to guide the process. AbSec's commissioning framework, for example, sets out an approach that is led by and includes Aboriginal people, and enshrines principles of co-design, cultural safety, self-determination and accountability (https://absec.org.au/commissioning/).

Commissioning usually commences with a work planning phase which can help prioritise addressing unmet need and set out plans to meet need insofar as policy, funding, and organisational capacity allows. It could be argued that strategies, such as the NSW Homelessness Strategy, are forms of planning that inform this commissioning process. It also provides opportunities to identify how needs (i.e. outcomes) will be met, through different services and or through different configurations or relationships (see Section 4), depending on service requirements. Sometimes, commissioning may appear to default to outsourcing. However, commissioning provides an opportunity to determine appropriate use of market-based approaches. Once a service is deemed contestable (i.e. likely to be more efficiently and effectively delivered outside of government[2]), service offerings from both the public sector and NGOs can be compared.

Commissioning also provides opportunities to draw on the knowledge and experience of service providers and of clients, although there are few documented examples of effective client engagement in commissioning (Davies et al., 2019). Commissioning also offers opportunities to develop organisations and the workforce; to ensure the appropriate mix of providers in specific locations; to address needs of specific cohorts[3]; and to develop cooperative arrangements between funders and providers. However, depending on the duration and management of commissioning cycles, they may also create disruption and instability in service delivery where there are major changes in service provision that impact clients, workers and organisations.

To work effectively, commissioning requires trusting cross-sectoral relationships. Riboldi et al. (2021) found that attempts to implement commissioning approaches in NSW have been undermined by a lack of trust due to histories of non-collaborative arrangements. *Going Home Staying Home* reforms were considered an example of a problematic practice in which competition negatively impacted relationships (Riboldi et al., 2021, p.570). The research identified **four principles for guiding commissioning**:

- putting relationships first (so as to emphasise collaboration)
- letting communities lead (so commissioning reflects community needs)

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[2] Specifically, the Australian Government's Contestability Framework proposes three questions to assess which functions should be exposed to contestability: *"(1) should the government continue this function? (2) could its efficiency be improved? (3) are there alternative means for providing the function?"* see https://www.finance.gov.au/publications/policy/contestability-public-sector

[3] For example, culturally responsive services for Aboriginal peoples, the young and the elderly, services for people with additional support needs such as people leaving domestic and family violence, ex-offenders, people with disability, and/or people leaving institutional settings (including prison, hospital and other settings).

- embedding learning (to ensure continual improvement and adaptation to changing needs and circumstances), and
- investing in people (to ensure resources are adequate for strategic and collaborative activities) (Riboldi et al., 2021).

3.2 An example of a commissioning framework: PHNs

Australia's Primary Health Network program, introduced in 2015, is an example of a formalised commissioning framework established to help reform primary healthcare coordination (see also Box 7). The commissioning cycle is presented in Figure 1 below. It comprises six key steps conducted for each geographic area.

This commissioning cycle includes the development of a Needs Assessment to understand health and service needs within the region and what services currently exist that may meet those needs. This step includes data analysis, public consultations (including consumers, health professionals, service providers, experts and other funders) to confirm needs, identify priorities, and how they may be addressed. An Activity Work Plan is then developed to indicate what services the PHN intends to commission or de-commission over a 12-month period, based on funding available and the capacity of organisations to deliver. The plan is used to report progress back to the funder (in this case the Department of Health). Services are designed and contracted in collaboration with experts, including health professionals and service users. Performance is managed through contract management, with the evaluation of outcomes intended to lead to continual improvement. Services may be recommissioned if effective and need for the service continues. This may be by returning to market, renewing existing contracts, or by using rolling contracts (as is the case for some of the funding PHNs themselves receive).

Collaboration is strongly emphasised throughout the commissioning cycle. This carries through to advocating for the co-commissioning or co-funding of services, recognising the PHN's relatively small budgets relative to other healthcare funders.

Figure 1 PHN commissioning framework

Evaluation
Needs assessment
Monitoring & evaluation
Strategic planning
Procuring services
Managing performance
Annual planning
Shaping the structure of supply
Designing & contracting services

Source: Replicated from DoH (2019): Figure 1, PHN Commissioning Framework available from https://www.health.gov.au/sites/default/files/documents/2021/06/primary-health-networks-phns-commissioning-information-sheet-overview.pdf

3.3 Summary

Commissioning offers an overarching evidence-based process that brings stakeholders together to identify needs, map existing services, and prioritise how to address gaps in services with the resources available. Commissioning also includes the monitoring and reviewing of services to ensure needs continue to be met. It is a strategic, collaborative approach which offers to better use resources to meet need. Within a commissioning approach, there are different options as to how to configure contracting relationships (discussed next in Section 4), and how contracts are specified and managed (discussed in Section 5). While there is no simple formula for effective commissioning, studies underline the importance of collaborative, trustful relationships, and resourcing to enable collaboration, along with genuine community involvement and leadership.

4 Configurations of contracting

Contracts can be configured in different ways, in attempts to achieve efficiency and effectiveness in meeting client[4] needs. Models reflect the services required; the relationships between purchasers, providers, and clients; the structure and dynamics of markets; and the capacity of funders to deliver services or manage contracts. Configurations of contracting may be part of a program's design, or a response by providers. The way contracts are configured can affect service outcomes and the sustainability of the sector.

There are several different ways contracting relationships may be structured, and several considerations which impact on their efficiency and effectiveness, and the potential to offer choice in services from a range of providers (Bennett, 2017). Selecting an approach is not a simple choice but requires careful consideration of context and impacts.

Government direct contracting of a single organisation to provide services remains the standard contracting model in human services. However, over time, public sector organisations have developed alternative models in an attempt to overcome challenges experienced when procuring services directly – including challenges of meeting procurement rules, specifying and managing complex services, working with thick and thin markets (thin markets are where there are a limited numbers of providers in some locations or for some cohorts). Alternative configurations may also be warranted to better leverage the market – depending on its structure (such as a mix of large and small providers), and to improve the amount and duration of funding available.

More recent approaches have increased the length of supply chains, and the distance between the public sector funder and service provider, and ultimately increased the distance between the funder and the consumer. This may have advantages for funders (reducing the number of contracts managed) and for consumers (increasing the flexibility and responsiveness of services provided). Providers may also seek advantages by working collaboratively through alliances. However, indirect contracting approaches may increase administrative overheads through additional levels of oversight and reporting, and have been criticised for decreasing the accountability of government (Bovaird, 2016; Gallet et al., 2015).

The following material sets out and discusses common configurations of contracting used in Australia, supported by examples of how they are used to deliver homelessness and other human services both here and overseas (presented in Boxes). Figure 2 (based on Bates et al. 2023) provides an overview of the configurations or models of contracting evident in Australia, recognising they may also be used in combination. Analysis of each type of model and how they address issues around contracting services and context identified are provided in Section 4.8.

[4] Note that in human services different terms are used by public sector organisations to describe service users. This can include service users, clients and consumers. We recognise that the language of consumers in this context is contentious and that language of 'people with lived experience of homelessness' may be preferred. However, given this report is written to support advocacy for improvements in the commissioning process, we have retained the language used by public sector organisations.

Figure 2 Summary – main configurations of contracting

	Direct contracting, where a single funder contracts a single organisation to provide services. This is a standard purchaser-provider model.
	Multiple funders buy the same service from the same provider. This can be administratively burdensome for providers. An example is provided in Bates et al. (2023) where one small team providing an alcohol and drug treatment service is funded by five different funders, each with different contract and reporting requirements.
	Co-commissioning (also referred to as joint commissioning and collaborative commissioning). This involves multiple funders jointly commissioning services. In practice, the 'co-' occurs on a spectrum across the commissioning cycle and may involve strategic planning or the co-procurement of services. It aims to improve coordination among funders and streamline relationships for providers.
	One funder purchases the same service from multiple providers for example to reach different cohorts or geographic areas. For example, the Commonwealth may contract one organisation in each state or region to deliver the same program to ensure nationwide coverage.
	Alliance contracting, where providers collaborate when responding to a tender and the funder issues one contract to the alliance (often one lead contractor).
	Prime provider model, where the public sector contracts a lead (prime) provider who delivers some services itself and also subcontracts others to deliver services on its behalf. The prime provider has oversight of any subcontracted services leaving the funder having oversight of only one contract.
	Intermediary model, where an intermediary subcontracts but does not deliver services directly.

Note: Based on Bates et al. (2023). Squares denote Public Sector Organisation funders, Circles denote Providers, a Triangle denotes an Intermediary, and lines denote contractual arrangements. Does not include direct service provision or individualised funding (sometimes referred to as micro-commissioning). The configurations may occur in combination.

4.1 Direct contracting of one or more service

Direct contracting, often referred to as a purchaser-provider relationship, is the most common model of contracting, whereby funders directly and separately engage one or more providers to deliver services on their behalf. Often, direct contracts are allocated via competitive tenders; however, purchasers may also engage providers via more restricted or select competitive tenders, or on a relational basis, without a competitive process within the procurement rules and processes established.

Direct contracting creates a simple purchaser-provider split which is seen to benefit government by enhancing opportunities to demonstrate accountability, increase efficiency through competition, and enable innovation and responsiveness to service users (Bovaird, 2016, pp.68–69). An advantage of direct contracts is that they can be quick to establish (relative to other models) allowing funders to respond to changing needs or use resources that become available to address priorities. Direct contracts are often used when trialling new initiatives where funders may need to make adjustments to the service model over time. For example, direct contracting is used in a current pilot project, the Universal Screening and Support Services, which are funded by DCJ as early interventions to prevent youth homelessness, and are currently being trialled in Albury and Mount Druitt.[5] Direct contracts are also useful when funders want to closely oversee service implementation; for example, for a new service model, for a new provider, for services targeting a vulnerable cohort, or when they are expected to have close oversight for other reasons (for example, security, value of the contract, etc.).

The efficiency of direct contracting may be affected by the cost of contract oversight, unclear or fractured responsibilities, exclusion of providers from service development, underdeveloped markets, separation of strategic decisions from operational knowledge, discouragement of collaboration, short-term focus and potentially opportunistic behaviour, and a lack of investment in improving services and systems (Bovaird, 2016, p.69). In purchaser-provider relationships (whether stand alone, or as part of a more complex arrangement), the public sector faces the costs of procuring and then overseeing services contracted; this requires a clear understanding of need and gaps in services, the market, what service model is likely to be effective, and how to contract that service model. It also requires government to ensure providers have transparent information in the tendering and negotiation process, that organisations with service delivery expertise are not lost due to lack of contracting expertise, and that ultimately, an appropriate range of services and service models are contracted to meet need. For clients, the use of single direct contracting can lead to service fragmentation, poor coordination, service gaps, and sometimes, service overlaps may occur where the same cohort is targeted by multiple services (Mental Health Australia, 2015; Productivity Commission, 2016).

The strengths and weaknesses of direct contracting for service providers and clients are summarised in Table 1.

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[5] See https://yesunlimited.com.au/the-albury-project/ and https://www.youtube.com/watch?v=p9sZEWO7mq8 respectively.

Table 1 Direct contracting: strengths and weaknesses

	Service providers	Clients
+	• Opportunity to have a direct relationship with government with the potential to shape the way services are delivered • Chance to respond to new opportunities • Opportunity to be involved in new pilot programs	• Direct contracting may be quicker for funders and providers to establish, so may provide quicker access to services than more collaborative models
–	• Potentially high transaction costs for the provider in terms of responding to tenders, reporting to multiple funders, and renewing contracts • Lack of power in negotiating as individual providers	• Direct contracting may contribute to the fragmentation of services or overlaps, when not coordinated with other services and systems • Direct contracts are typically time-bound and cessation of a contract can disrupt service continuity in terms of staff retention, client recruitment and retention, and relationships with funders and other partners in the service system

Where services cannot be delivered by one provider alone, the public sector may establish multiple direct contracts with other providers to deliver the same program. There may be instances where multiple funders with similar or overlapping objectives purchase the same or similar services from the same provider (see Bates et al., 2023) for an example of one small program team supported by five different funding streams). This creates large administrative costs and uncertainty to service providers, with knock on effects to clients where the focus becomes contract compliance rather than service delivery.

Some purchaser-provider funding agreements may enable more complex contracting arrangements such as facilitating a lead provider to contract other services to support service delivery (prime provider model, Section 4.3), an intermediary model where the commissioning of services is contracted to a third party (Section 4.4), or an alliance model where the contracting relationship is with one member of the alliance (see Section 4.4). A simple purchaser-provider funding arrangement may also mask the pooling and commissioning of services by multiple funders (see Section 4.2).

4.2 Co-commissioning

Co-commissioning, also referred to as joint commissioning or collaborative commissioning[6], is where funders work together to jointly plan and fund activities to maximise the use of resources and reduce overlaps. In reality, the 'co-'occurs on a spectrum across the commissioning cycle. For example, there are potentially more examples of co-planning (such as the development of Regional Strategies that involve shared decision-making rather than co-funding) and co-procurement of services rather than co-commissioning across the whole commissioning framework (PwC and Commissioning NSW, 2020).

[6] See also Collaborative Commissioning NSW Health which is a broader initiative to support value-based health care using a whole of system approach (NSW Health, 2020).

Co-commissioning offers many benefits to public funders, and to service providers and consumers. For funders, it enables cross-portfolio and cross-jurisdictional approaches which can pool funding, reducing the fragmentation of funding and service delivery. Co-commissioning can reduce the administrative overheads of funders (e.g. where different funders were each separately contracting the same organisations) and those of service providers (e.g. where they were previously reporting to multiple funders). Co-commissioning can also make it easier for service users to navigate and access services. Co-commissioning may be easier to implement where funders have shared or overlapping responsibilities and where relationships between funders are strong (Freeman et al., 2021). Correspondingly, it is more difficult where there is an unclear division of responsibilities.

Setting up co-commissioning can be challenging for funders, as each will have its own governance and contracting requirements which must be consolidated into a single procurement arrangement. Early examples of co-commissioning in primary health care show funders learn through experience, starting with services that are relatively easy to contract, before moving to more complex services (Bates et al., 2023). Co-commissioning requires an enabling environment – either through formal policies (as evidenced in health) or memorandums of understanding between public agencies. This provides the foundations for funders to work together.

One alternative to co-commissioning is the consolidation of agencies and the alignment of operational boundaries across agencies – for example, the NSW Department of Communities and Justice is the amalgamation of several other agencies which has reorganised its directorates to align with NSW Local Health District boundaries (Mental Health Australia, 2015). However, contracting may still occur within operational siloes and co-commissioning across directorates may be required.

The strengths and weaknesses of co-commissioning for service providers and clients are summarised in Table 2.

Table 2 Co-commissioning: strengths and weaknesses

	Service providers	Clients
+	• Reduced administrative costs of reporting multiple performance measures to multiple funders for the same service • Reduced contracting costs • Opportunity to deliver one service that meets objectives of multiple policy portfolios – for example, homelessness and mental health, homelessness and justice	• Addresses needs more effectively, as complexities and intersections between needs are recognised • Improves service integration for clients and hence reduces fragmentation of services
–	• May take time to establish the arrangement and include reporting requirements that satisfy all funding partners • As contract gets larger (in terms of requirements and funding), there is a risk of pushing out smaller providers. This has the potential to affect market stability and the sustainability of specialised services	• May take time to establish, delaying when services become available

4.3 Prime provider model

Under a prime provider model, funders engage a lead contractor who provides services directly *and* manages other, subcontracted, service providers, akin to managing a supply chain or network (Gallet et al., 2015; O'Flynn et al., 2014). Prime provider models vary in scope, size, number and size of partners, and governance arrangements. They are potentially useful in diverse markets comprising of one larger and many smaller providers, where the prime provider delivers the bulk of services and subcontracts smaller and specialist providers to deliver services in certain areas or to certain populations. Prime provider models shift responsibility for managing contracts from funders onto the prime provider. The prime provider is usually assumed to be a specialist or service leader who can combine scale with local knowledge and promote good practice, service improvement and innovation with subcontractors (Mental Health Australia, 2015, p.9).

The prime provider model offers several benefits to funders. Where multiple providers operate, it allows funders to hold one, rather than many contracts. The model creates a 'top tier of prime providers to manage subcontractors' (Bennett, 2017, p.129) while encouraging smaller providers to remain in the market. The use of a single contract with the prime provider reduces oversight costs to government as it reduces the number of contracts managed. Further, it shifts responsibility and costs of overseeing contracts with smaller providers to the prime provider. This is useful when the funder does not have a local presence – such as when Commonwealth agencies fund localised services. However, this can cause friction for subcontracted providers who no longer have a direct relationship with government.

The prime provider model can be used in different ways and is usually initiated by the funder. There is also evidence of it being increasingly used to support outcome-based funding (Bennett, 2017), enabling it to potentially facilitate innovation (O'Flynn et al., 2014); and in challenging contexts where there is high uncertainty – particularly as this model gives prime providers and subcontractors opportunities to work together and learn from each other (rather than act in competition). The prime provider model also offers economies of scale, enabling providers to invest in systems to support service delivery (O'Flynn et al., 2014). It has the potential to allow greater flexibility, for example as prime providers are not bound by probity rules of government; however, research shows that any requirements of the prime provider under contract are likely to be replicated in subcontracts (Bates, 2022). For clients, the prime provider model has the potential to offer strong pathways of care across different providers (Billings & De Weger, 2015) as well as greater coordination of services (Gallet et al., 2015).

On the other hand, prime provider contracts are often significant financial arrangements which favour larger organisations with track records in managing contracts. Private sector organisations may have the management capacity but may lack specialised, local knowledge of the services required (Bennett, 2017). Funders also leave oversight of the market to prime providers – while this transfers risk to the prime provider, the public sector loses content knowledge of local circumstances and needs (O'Flynn et al., 2014). This increases the power of the prime provider who retains the knowledge and a position of power in local networks, and risks that control over supply chains and close proximity to funders will be used opportunistically.

The strengths and weaknesses of the prime provider model for service providers and clients are summarised in Table 3.

Table 3 The prime provider model: strengths and weaknesses

	Service providers	Clients
+	• Provides opportunity to scale up innovative programs • Economies of scale can enable investment into systems and establish shared administrative support to service delivery • Relationships may enable sharing of content knowledge, generating innovation and learning • Subcontractors may be contracted more flexibly than if they were contracted directly by government. • Works well when values and service delivery models align, and providers complement each other's services	• Have a choice of providers, and where the model is working effectively, have access to specialised local providers • There are potentially strong referral pathways across different providers and greater co-ordination of services • Provides opportunities to overcome service fragmentation
–	• The prime provider might use its position to hoard funding, select the more profitable component of the work, and increase their market power, potentially cost-shifting to subcontractor and reducing the choice of services available over time • Large commercial contracts require robust financial and governance systems in place to satisfy government. These qualities may be prioritised over content knowledge and service delivery when appointing prime providers • The prime provider is responsible for creating and managing supply chains, and building relationships and consistency, which may deplete the status and security of subcontractors • The prime provider becomes responsible for subcontractors' outcomes, and may consequently replicate contract specifications from the head contract into subcontracts to minimise risk • Smaller subcontractors may be subsumed by larger organisations, leading to loss of power of organisations with localised and specialised knowledge and skill • The model requires a commitment to communicate, build and maintain relationships among partners – this may not be resourced under the contract	• Potential reduction in choice of services should prime provider gain market position, and reduce specialised local services • Unclear who is accountable for service delivery

Prime provider models are evident in many areas of social service delivery, including:

- Together Home (Box 1) whereby Community Housing Providers subcontract SHS or other partners
- Communities for Children (CfC) which is a quasi-commissioning, prime provider, intermediary model (see Box 22)
- 1800RESPECT – the domestic and family violence counselling service (see Box 33).

Additional examples include the United Kingdom's welfare to work program (Bennett, 2017).Previously, headspace and 'Partners in Recovery' used the prime provider model, although headspace is now managed by PHNs through the intermediary model. A report for the Brotherhood of St Laurence (O'Flynn et al., 2014) provides a comprehensive list of primary provider models implemented up to 2014.

Boxes 1 to 3 provide examples of variations of prime provider models in homelessness and other service contexts. There is an opportunity for Homelessness NSW to capture the experiences of perspectives of service providers in relation to the Going Home Staying Home reforms.

Box 1 Together Home

Together Home is a NSW Government initiative aimed at halving street homelessness, using Housing First principles. The aim is to reduce street-sleeping and transition people into long-term stable housing, linked to wraparound support. It is delivered across NSW by 18 Community Housing Providers. Community Housing Providers are engaged by Government to rent properties in the private rental market and house people who street sleep, or have a history of street sleeping. A key feature is that housing and support functions are separated: Community Housing Providers subcontract the support component to Specialist Homelessness Services or other partners, or engage providers via a fee for service model (DCJ, undated). Support providers work in partnership with health and other services to provide person-centred support and support client self-determination. The intention is that separating tenancy management and support functions will help to ensure participants can raise issues with support providers which they may not wish to raise with tenancy managers. While subcontracting decisions should consider client self-determination, they are made by Community Housing Providers and depend on the availability of services and the housing providers' service model. Early evaluation findings indicated the program was reducing rough sleeping and achieving some positive outcomes (Alves, 2022).

Box 2 Communities for Children

Communities for Children is a place-based model, funded by the Australian Department of Social Services and established in 2004, aimed at supporting children and families in 52 disadvantaged communities around Australia. It involves a Facilitating Partner organisation, which establishes and manages local service planning and delivery, working with other 'Community Partners' to provide targeted services to improve relationships, parenting skills and children's health and wellbeing. Guided by evidence and experience and the needs identified by a local committee, the Facilitating Partner develops a Community Strategic Plan and funds Community Partners to provide services. They also submit Activity Work Plans and report against progress (DSS, undated). They are expected to invigorate local planning structures and bring government and non-government stakeholders together to define priorities and co-ordinate service delivery (Cortis, 2008).

The facilitating partners' role has been described as 'quasi-governmental' (Purcal, Spooner & Thomson, 2010), with risk transferred from government to the prime provider. Local relationships and community trust were regarded as important factors in the selection of organisations to play the role of facilitating partners (Earles & Baulderstone, 2012). As risk is borne by the prime provider, local community partners can focus on service delivery. Prime providers can also co-ordinate the local service network. Indeed, early evaluation of the model indicated the prime provider model resulted in better local coordination (Muir et al., 2010).

Box 3 1800RESPECT

1800RESPECT is the National Sexual Assault, Domestic and Family Violence Counselling Service, funded by the Australian Government Department of Social Services (DSS). It operates through a subcontracting network, managed via a prime provider. The prime provider conducts the First Response, and manages the contracts with a panel of specialist not-for-profit providers, which deliver trauma counselling. The prime provider ensures calls are answered and triaged and assesses need, and provides information and referral, and initial counselling. It also undertakes managerial functions in monitoring and managing demand, providing IT infrastructure, maintaining operational policies and plans, ensuring workplace supports including supervision, development and training, and manages complaints and overall quality and responsiveness through the supply chain (Smyth et al., 2020; DSS, 2017). The subcontracting model enables government to work with a single provider, to whom it delegates responsibility for ensuring service delivery by several organisations (Sanderson et al., 2018). The evaluation found that a challenge to the model was that the prime provider conducting the First Response was paid on a cost-per-contact basis, however, as the volume of calls increased, these were increasingly transferred to the NGO trauma counsellors paid on a full-time-equivalent model, shifting costs, while increasing costs for government.

4.4 Alliance models

Alliance models are similar to the prime provider model in that services are provided by an 'alliance' of providers. Due to the way contracts work, this may be enacted by a contract between the funder and one of the alliance partners (hence the similarities with the prime provider model) (Addicott, 2014). However, rather than initiated by government, this model is usually initiated by service providers who may form an alliance to respond to a request for tender to provide services. The alliance is likely to be established prior to entering into a contract with the funder (unlike the prime provider model which contracts the prime provider to deliver and contract services as required). Further, the relationship between providers in the alliance model may be more collaborative.

Alliance contracting is often associated with cooperation, collaboration and value creation among partners (Billings & De Weger, 2015). Risk is shared across alliance partners. Partners may operate under an alliance contract that formalises the relationship and the objectives of the partnership. Alliances are often symbiotic in nature, in that organisations working together are stronger than when working independently. They can be operational (allowing close working), relational (mitigating risk and facilitating expansion) and strategic (enhancing each organisations competitive advantage) (Billings & De Weger, 2015).

Examples of alliance models include the South Australian Homelessness Alliances (see Box 4), the Glasgow Alliance to End Homelessness (see Box 5), and Core and Cluster (See 6).

The strengths and weaknesses of the alliance model for service providers and clients are summarised in

Table 4.

Table 4 Alliance models: strengths and weaknesses

	Service providers	Clients
+	• Provides opportunities for partnerships and collaboration (rather than competition for contracting dollars) • Provides opportunities to compete with larger providers • Organisations do not lose 'power' in the market	• High quality services due to the collaboration between providers • Potentially strong pathways of care across different providers • Able to access local providers or providers that meet specific needs
−	• Funders often require lead contractor – complex contracting arrangements between partners • Relies on trust and cooperation between partners to be successful. Competition between partners may jeopardise the alliance (Billings & De Weger, 2015)	• Relatively fragmented service provision – potentially addressed through common branding of services

Box 4 South Australian Homelessness Alliances

On 1 July 2021 and following broad consultation, South Australia's five regionally-based Homelessness Alliances replaced what was previously a network of 70 programs delivered by over 30 organisations, each separately funded by government. The previous service system was fragmented across cohorts and locations. Clients found services to be disconnected and difficult to navigate. There was no overarching governance structure that encouraged providers to work together to achieve goals (Buchan et al, 2022).

The five alliances sought to create more integrated and collaborative localised networks to seamlessly respond to need. The Alliances bring services together in larger, more cohesive networks, which engage collectively with the South Australian Housing Authority, which is part of each Alliance. As not all needs are best met through the Alliances, government maintained some directly contracted services including to provide niche or geographically spread support, outside of the five Alliances. A state-wide gateway provides an entry point for clients.

Bids for funding were made as an Alliance, through an open tender. There was a requirement to work collaboratively, share responsibility and accountability, bring unique skills and expertise, focus on outcomes and be transparent financially and operationally, and in terms of performance. The Alliances have a 2+2 +2 funding structure, so are renewable every 2 years for 6 years. Government contract managers have manageable portfolios. The Office for Homelessness Sector Integration supports Alliances through Performance Partners, who guide performance and analyse data, and Innovation Partners, who promote connections, research and capacity building, and support the development of new models and approaches (Skinner and Taylor, 2022)

Agreements specify service activities, Key Performance Indicators (KPIs), and Key result Areas. An Alliance management framework sets out the model and governance structure and the role of the senior manager. Alliance leadership teams act like a board. Alliance senior managers focus on the Alliance while others represent their home organisation (McKay, 2022). A lead provider holds and distributes funding between sector participants and hires the manager, who is the primary coordinator and maintains governance. Agreements provide flexibility to adapt services and redistribute funds within the alliance to meet needs.

Box 5 The Glasgow Alliance to End Homelessness

Following a 2016 Strategic Review of Homelessness Services, in May 2019 Glasgow City Council issued a tender to establish an Alliance to work with it to transform homelessness services, and break with traditional purchaser-provider relationships (Homeless Network Scotland, undated). The Glasgow Alliance to End Homelessness commenced in February 2020. It is made up of eight organisations, including Glasgow City Council and has a maximum 10-year term (Homeless Network Scotland, undated). The Alliance is aimed at transformational change through partnership among housing, health and social care providers, public agencies, and people with lived experience. Alliance members work together towards clear, agreed goals including preventing homelessness, prioritising settled homes and reducing use of temporary accommodation, delivering person-centred, joined up services, and creating a city-wide movement for change (Glasgow Alliance, undated; Homeless Network Scotland, undated). People with lived experience are intended to be equal partners in the Alliance.

The Alliance is not a separate legal entity, rather, each partner enters into a contract among themselves setting out obligations. The Alliance commissions most homelessness services in Glasgow. The Council retains statutory homelessness responsibilities including crisis accommodation (Homeless Network Scotland, undated).

Box 6 Core and Cluster

The NSW Government's Core and Cluster program is a new investment in housing and related supports for women and children escaping domestic and family violence, which uses an alliance model. The model allows women to live independently in self-contained accommodation, with access to services such as counselling and legal assistance. It brings together organisations with different specialisations: to provide land (can be government's or NGO's); facility design and construction (must be a community housing provider); organisation that can manage the facility when complete; and a service provider to deliver homelessness and domestic and family violence services (Homelessness NSW, 2023).

Procurement is occurring in tranches, with the first two closed, and the request for tender for Tranche 3 closing in early 2024. Projects involve two contracts: a Community Housing Assistance Agreement with Community Housing providers, to cover capital build and maintenance; and a Human Services Agreement with an SHS provider, to cover support services. One lead agency could hold both contracts, or two lead agencies can be involved, to each hold one contract. Subcontracting arrangements must be accepted and endorsed by the Department (DCJ, 2023).

4.5 Intermediary models

In an intermediary model, the public sector contracts another organisation to commission services on its behalf. Unlike a prime provider model, the intermediary does not deliver services. There has been increasing interest in Australia in intermediary models, including establishing regional commissioning agencies, that is, organisations established to contract services (but not deliver them), particularly where the funder is located far away from the service context (such as Commonwealth funders). Governments also see this as an attractive model where there is an opportunity to pool funds from multiple jurisdictions and policy portfolios (for example, for mental health) into one regional commissioning authority who is then given responsibility to commission services using the pooled resources (recognising this could be a government agency or a third party) (Productivity Commission, 2019). Other more informal intermediary arrangements exist,

such as DSS providing the initial funding to NSW Government to then contract homelessness services (for example, the Accompanied Children Support Services contracted by DCJ).

Intermediary models offer benefits to government, including reducing the numbers of contracts it manages thereby reducing administrative costs. The model enables government to appear to be responsive to need, as pushing funding to an existing intermediary is quicker and easier than commissioning complex services. It also reduces the need for content expertise, market stewardship or stakeholder relations at a local level. Better outcomes may arise from localised commissioning by an organisation with content expertise.

Intermediaries become experts at commissioning services as their existence depends on it (Bates et al., 2022). The intermediary will be motivated for services to succeed as their performance is tied to its own contract performance requirements, so will work with services to identify any risk to service outcomes and support the service providers to address any risks. However, there are risks for intermediaries, including if they are heavily reliant on one funder, as the organisation will be at risk if there are any performance issues. It must be highly focused on ensuring providers deliver. An example of an intermediary model is described in Box 7, involving the Commonwealth Department of Health contracting PHNs to deliver the PHN program and commission services.

There are many advantages (and some disadvantages) to this particular intermediary model, outlined in Table 5.

Table 5 Intermediary models: strengths and weaknesses

	Service providers	Clients
+	• Needs and priorities are identified through the commissioning process, providing transparency and early warning about services required • Services are contracted locally – leading to greater proximity to and stronger relationships with funder • Potentially more relational forms of contracting, allowing both parties to identify any risks, manage those risks, problem solve, and also ensure services align across the context (including referral mechanisms into and out of services) • Potentially less fragmented and interrupted service delivery	• Less fragmentation in services where services contracted under a commissioning framework
–	• One step removed from funder, resulting in a time lag between funding decisions and implementation • High set up costs of formal intermediary commissioning agencies, with significant work required to establish intermediaries and determine appropriate accountability arrangements; however, existing funders can also work as intermediaries	• Potential interruptions to services due to time lag in funding transferring through the intermediary • Inconsistencies in services across regions or commissioning units • Potentially uncertain lines of accountability

Box 7 PHNs

The Primary Health Network (PHN) program was established by the Australian Department of Health (DoH) on 1 July 2015, funding 31 PHNs (small often non-government organisations) to, among other things, commission primary health care services in unique geographic areas. Program guidelines require each PHN to use a commissioning framework which requires them to undertake a needs assessment, develop an activity work plan, design and contract services, manage contracts, and evaluate and report on their outcomes. Different steps in the commissioning process provide DoH with an opportunity to check the program is on track. This includes the needs assessment, activity work plan, variance reports against activity work plans, 6-month reports and audited statements, and annual reports and audited statements. DoH also transferred contracting of an existing program, headspace, to PHNs to manage on its behalf. The 31 PHNs contract over 3,000 providers across the country to deliver services. PHNs therefore act as an intermediary between DoH and service providers.

In terms of contracting process, the 31 PHNs were initially established for a 3-year period using a standard funding agreement with a core funding schedule. The original invitation to apply (request for tender) was issued on 29 November 2014, with closing dates for proposals being 27 January 2015. The outcome of the tender process was announced on 11 April 2015, with PHNs coming into operation 1 July 2015. This provided the market little time to respond to the tender or prepare to deliver the program once awarded. The contracts were renewed for a 3-year period in 2018, and then moved to a rolling contract (each year starting a new 3-year funding period) thereafter. In addition to the base funding, DoH issues additional funding schedules to implement specific policies; for example, drug and alcohol treatment, after-hours care, as well as trials of new initiatives. Additional schedules vary in duration and have historically been issued or renewed with little notice (one example being 3 days before the end of the expiry date, another being 15 days prior to expiry) – impacting service continuity for both the PHNs and service providers, and thus clients using services (Bates et al., 2022).

While many of the program requirements stipulated by DoH carry through to the PHN and into service provider contracts (including service design, branding, performance measures and reporting frequency), PHNs employ people with significant content knowledge, who have established good working relationships with service providers, stakeholders and other funders in their geographic area, enabling them to use relational controls (to supplement bureaucratic controls) to ensure the delivery of the program and services (Bates, 2022; Bates et al., 2022).

4.6 Individualised funding

Markets may also be used to extend directly to clients through individualised funding or vouchers, less commonly referred to as micro-commissioning (Bovaird, 2016). Rather than the public sector bulk buying services, they establish a scheme whereby eligible individuals are given a voucher or apply for a budget (often referred to as a package in Australia) based on an individual needs assessment. Eligible clients are then able to choose what services to purchase (within certain eligibility criteria) and from what provider. This assumes: (1) choices are available, (2) the person has capacity to choose, (3) the person can afford the choices they make, and (4) the person can manage their own services (Henderson et al., 2019). Once established, the public sector then has a role in market stewardship (to ensure services are available to meet the needs of consumers) and in providing market oversight (in terms of safeguards to protect against opportunistic providers). Individualised funding results in a contract (or form of agreement, such as a plan) between the government and the individual client, and then potentially multiple contracts between the client and service providers.

In Australia, individualised funding has been predominantly used in disability and aged-care to offer users 'voice, choice and control', including under the National Disability Insurance Scheme. In housing and homelessness, vouchers may be used to subsidise rents (see an example from the United States, in Box 8); however, in these cases the budget is generally managed by providers rather than clients themselves. Brokerage funding is also generally managed by service providers, such as to obtain white goods or service supports. Other than rental subsidies or vouchers for small-budget items such as food or transport (e.g. ACT Throughcare, see Zmudzki et al., 2017) there appear no examples of consumer-directed funding in housing and homelessness. In part this may reflect the highly disadvantaged and stigmatised client populations. The example of the NDIS is in Box 9.

The strengths and weaknesses of individualised funding for service providers and clients are summarised in Table 6**Error! Reference source not found.**.

Table 6 Individualised funding: strengths and weaknesses

	Service providers	Clients
+	• Providers are more flexible in how they respond to client demand	• Offers choice and control to clients
–	• May not cover full cost overheads associated with service operation (based on activity provided as opposed to organisational overheads) • Providers can experience financial instability where clients move between services	• Shifts administrative burden to clients • Additional cost to clients if they require others (e.g. family members) to organise services on their behalf • Clients in rural and remote areas are disadvantaged due to the limited market of providers (and in some cases absence of services) • Individualised budgets may push prices up and affect pricing of adjacent services – given different services often share workforces.

Box 8 Emergency Housing vouchers (United States)

Vouchers were used as part of the United States emergency response during COVID-19. The *American Rescue Plan Act* of 2021 appropriated funding for 70,000 Emergency Housing Vouchers (EHVs) to subsidise housing for people experiencing or at risk of homelessness. The aim was to quickly house vulnerable populations who had not been assisted by other housing programs, and keep people safely housed. EHVs were tenant–based, going to individuals to use in the private rental market. They differed from other vouchers used in the US e.g. Housing Choice Vouchers in that they were targeted to people affected by homelessness, domestic violence, sexual assault, or human trafficking. While the voucher goes to the tenant, it comes with additional funding ($3500 per client) for the housing authority to provide supports (such as finding properties) and landlord incentives, such as bonuses or reimbursement to encourage directing supply to participants in the voucher program. Vouchers covered rent and utility expenses that were above 30% of their monthly income (adjusted to account for family composition, health and childcare expenses).

Challenges included identifying eligible participants, locating available housing, and recruiting landlords to participate. Many vouchers were not used, with significant barriers encountered in tight housing markets with low vacancy rates such as California, where it was difficult to find rental accommodation even with the support of vouchers. The additional resources provided to the housing authority to provide support were seen as crucial to ensuring the vouchers were utilised and effective in reducing homelessness.

Source : https://ternercenter.berkeley.edu/research-and-policy/emergency-housing-vouchers-lessons/

Box 9 National Disability Insurance Scheme

The NDIS was introduced in 2013 and offered a new way of allocating government funds to enable people with permanent and significant disabilities to access reasonable and necessary supports. The NDIS shifted from a system of block funding to individualised, person-directed supports. Eligible individuals are provided a budget with the amount of funding determined through a planning process. The person with disability or their agent can then engage service providers to deliver agreed upon services, using the funds. The model requires government to ensure a functional market (Carey et al., 2018)

Several problems are evident (Dickinson and Yates, 2023). The Scheme is difficult to navigate at the application stage and for those spending budgets. Administrative burden falls on people with disability, and those with education and administrative skills or support are able to best navigate the Scheme and utilise supports (Dickinson and Yates, 2023). In some areas, there are limited providers, resulting in thin markets. Associated, there is a socioeconomic gradient in spending (or 'plan utilisation'). People living in areas of higher socioeconomic advantage were more likely to utilise more of their approved NDIS budgets, reflecting how individualised funding can entrench social inequalities (Malbon et al., 2022). Although the Scheme came in under budget in its initial years (as participants were not fully utilising their budgets), rising scheme costs have since attracted media attention and political controversy. Mainstream, non-NDIS services have reduced provision of services to people with disability, causing increased demand for the Scheme.

4.7 Direct service provision or insourcing

While outsourcing is usually assumed, it is important to underline that the public sector (local, state and territory, and/or Australian Governments) can directly provide services. While there may be reasons to engage external services due to efficiency, practical, relational and strategic reasons (APSC, 2009), each model of contracting has associated risks as well as potential benefits and in some cases, it may be more efficient for governments to provide services directly. This may be the case, for example, where businesses or NGOs are not present or willing to operate in particular locations or to serve particular groups; where there are poor relationships between funders and external providers; where bureaucratic controls are ineffective; and where there are social or politically reasons to do so. Over time, reliance on markets may reduce the capacity of the public sector to deliver services directly.

Public provision may be warranted on its own or used as part of a mixed procurement strategy. Governments may draw on their own infrastructure and staff to deliver services, and bring services in-house when external markets fail. In systems where most services are outsourced, the public sector may be needed to play a role as the provider of last resort – making up for any gaps in the market and ensuring that clients with highly complex needs receive services. Further, local governments or government agencies operating in remote communities may provide services under contract to other agencies where there are no other service providers available. The need for significant infrastructure (such as buildings or other assets) may also be a reason for government to play a more central role in service delivery, such as when upfront investment is too high for non-government providers.

As Davidson (2022) points out, governments should also consider maintaining direct involvement to maintain their operational knowledge and capacity. Governments are unique in their capacity to effect change and operate in the public interest. They can ensure services are available on an equitable basis; prevent gaps and exclusions; reduce risks of opportunistic provider behaviour; help ensure stability; establish common infrastructure to ensure coordination and linkages between

providers and agencies; and operate in a transparent and accountable way. They can also be exemplary providers and set standards of quality, efficiency and cost; and can model good behaviour and exert a positive influence across the market. As a 'provider of last resort', government can support people and regions otherwise unable to obtain services – which is an issue when establishing new schemes and markets, such as the NDIS.

Where the public sector directly provides services which were formerly outsourced, it is referred to as insourcing, or sometimes, as remunicipalising, renationalising, decommissioning and internalising (Bovaird, 2016). This is a response to failed models of outsourcing. For example, in Queensland, the *Crime and Corruption Commission Taskforce* (Taskforce Flaxton) recommended two underperforming privatised prisons be returned to public sector control (Queensland Government, 2018). In Europe, social movements have sought to remunicipalise publicly funded services, where direct government provision has been a preferred alternative (Weghmann, 2020; Voorn, 2021).

The strengths and weaknesses of public provision for government for service providers and clients are summarised in Table 7.

Table 7 Public provision: strengths and weaknesses

	Government as service providers	Clients
+	• Direct accountability and control, establishing standards and focusing on public interest • Less overheads and transaction costs • Potential to offer greater stability	• Potential for greater stability • Potential for better access (access where no services existed, equitable access, and less opportunistic behaviour)
–	• Less flexibility in how to meet user needs • Requires technical capacity	• Less flexible service delivery (see Raven et al., 2014)

4.8 Summary of models of contracting

The typologies outlined above are not exhaustive but indicate the main configurations of contracting relevant to human services. Importantly, these are not necessarily exclusive and may be used in combination. To work well, all require adequate resourcing, accountability, specialisation and expertise, trust and positive relationships. The cost of and time to engage in different models of contracting must be recognised. The appropriateness of different models depends on many factors, including the types of services required and the need for flexibility; the potential for the market to deliver to different places and cohorts; policy overlap among funders; the client cohort which is targeted, and the nature of their relationship with government and potential providers; the funding available and the nature of the relationships funds will support and whether other models can leverage additional funds; funding duration and lead time; and capacity of government and providers to deliver, procure and oversee services. These configurations provide broad relationships and set foundations for the ways services are procured and contracted (Addicott, 2014) – discussed next.

5 Procurement

The ways in which services are procured can have a significant impact on the outcomes achieved, as well as sector and provider sustainability, staff satisfaction and retention, and client outcomes. This section describes some of the key considerations when procuring services and how they may be overcome, relating to procurement processes (including rules, and methods) (Section 5.1); the contracting process (Section 5.2), and how performance is managed (Section 5.3).

5.1 Procuring services

5.1.1 Procurement rules

Broadly, procurement refers to the ways external providers are contracted and selected (Australian Department of Finance, 2023, p.6; Sturgess, 2015, p.13). It relates to the process of acquiring services – from the 'make or buy' decision, spanning the 'whole life' of the purchaser-provider contract relation, to evaluation and review of the activity.

After identifying and defining needs, procurement involves specifying services required, market analysis, determining how to go to market, inviting the market to respond, evaluating proposals, appointing a preferred supplier, designing and implementing contracts, overseeing the contract and supplier performance, and reviewing outcomes to assess the effectiveness of arrangements (NSW Government, 2022, p.119). As government agencies, funders must procure services or 'approach' the market in accordance with strict rules to ensure fair tender processes, and to demonstrate accountability and probity (Department of Finance, 2017; IFAC & CIPFA, 2014; Stafford & Stapleton, 2017). Bound by probity and accountability, procurement processes should demonstrate value for money, ensure fair competition, procure in ethical and effective ways, and use accountable and transparent processes (Australian Department of Finance, 2023).

5.1.2 Procurement methods

Common methods of procurement are open tender, select tender, and direct negotiation – their use is bound by procurement rules. The **procurement method may limit who responds** to the tender, for example if significant skills and resources are required, which can thin the market (J. R. Butcher, 2016; J. R. Butcher & Dalton, 2014; De Schepper et al., 2015). This may be for good reasons, such as to implement Closing the Gap and ensure services for First Nations communities are developed and provided by Aboriginal Controlled Community Organisations. However, new providers who do not have experience of delivering similar services, or experience of delivering a similar scale of services, may be restricted from entering the market.

The procurement process can be costly to both the public sector and potential providers (Spurgeon & Hicks, 2003). Using a **two-stage, or multi-stage procurement process**, either using pre-selected panels (or shortlists of pre-approved suppliers) or by seeking expressions of interest and inviting successful parties to prepare full proposals, may reduce costs in responding to tenders (at least in the first round). Inviting consortia to respond to requests for tenders may also help smaller, locally-based organisations remain viable, which is important as these types of services often provide niche services for specific cohorts but may lack the management infrastructure to tender

on their own (Bovaird, 2016; Gallet et al., 2015) – see also Sections 4.3 (prime provider models) and Section 4.4 (alliance models). In any case, the form of procurement, such as whether an open or select tender is used and the eligibility to respond to tenders, should be inclusive of the range of service providers in the current market. Selection criteria for assessing proposals should also be carefully designed to include the requisite expertise and representation from clients and people with lived experience.

5.1.3 Factors determining procurement method

NSW Government guidelines identify different factors that determine what procurement method to use. They relate to the nature of the services required; the diversity of clients and needs; market capacity, capability and interest in providing services in locations required; the value of the contract; and the duration of the contract.[7]

Procurement methods underpin relationships between government funders and service providers, and impact on trust and system confidence, service delivery and outcomes. Most decisions about contracting, including conditions, specifications, payment, and reporting will be made by government funding agencies early on in the procurement process.

Funders should also be mindful of the impact of procurement methods, specifically the **timeline of procurement** and any factors **including/excluding organisations from responding to requests**, on outcomes. Funders should ensure potential providers have sufficient time to respond to requests for tender (Bates et al., 2022; Mental Health Australia, 2015; Spurgeon & Hicks, 2003). Further, adequate time is required between issuing the contracts and services being required, to allow time to purchase property if required, recruit staff, establish control systems and reporting mechanisms, and establish referral pathways (Bates et al., 2022; Zmudzki et al., 2016).

Other considerations include the duration of contracts and processes for when contracts end (discussed in Section 5.2.3).

5.1.4 Key considerations in procuring services

Key considerations in procuring services include:

- Whether tender processes are open or select, and use single or multi-stage processes
- Eligibility and selection criteria
- Timelines of the procurement process, and
- Duration of contracts.

Consideration should be given to the costs of procurement, whether arrangements deter possible providers and thin the market, and whether processes contribute to disruption for clients.

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[7] See https://www.facs.nsw.gov.au/providers/working-with-us/working-with-you/pricing-procuring-and-contracting-human-services/chapters/how-we-procure-services (accessed 6 September 2023).

5.2 The contracting process

There are many risks associated with procuring services from third parties, which are managed through the contracting process.

Contracts must **balance the need for control and accountability of services delivered** (ensuring delivery while avoiding opportunistic behaviour), **while not being so rigid as to stifle innovation** (Addicott, 2014; Birnberg & Gandhi, 1976; Brown & Potoski, 2003; Considine et al., 2011).[8] Having more controls does not mean better control – this can be both expensive and lead to poorer outcomes (Merchant & Van der Stede, 2017). Further, 'elaborate contracts are sometimes seen as reflecting poor relationships, inviting performance "only to the letter" of the formal agreement' (Mental Health Australia, 2015, p.10). Often, the specification of the contract is determined prior to going to market (Rubery et al., 2013); however, there is some benefit in reviewing the specifications with the individual provider – particularly when they have extensive experience in delivering similar services, or over the life of the contract as understanding of the cohort, services and implementation issues grows.

5.2.1 Obligations on parties, payments and reporting requirements

Contracts will **specify controls** relating to obligations on parties, payments and reporting requirements. Obligations may include governance arrangements, expenditure (what funds can and cannot be spent on), staffing (such as working with children checks or qualifications), accreditation, monitoring requirements, key performance indicators (target cohort, occasions of service, outcomes), and reporting requirements (including reporting the acquittal of funds).

Standard contracts are usually used to procure services that are often very detailed ('visible, formal and bureaucratic' (Johansson et al., 2016, p.1013) to meet probity and accountability requirements. In other jurisdictions, such as in New Zealand, '"**high trust contracts**" aim to simplify agreements and to reduce the reporting and other paperwork requirements on service providers … [and] aim to facilitate flexibility in service delivery' (Mental Health Australia, 2015, p.10). However, to be eligible for a high trust contract, providers must have a proven relationship and performance record with government, the community and other agencies.

5.2.2 Program specifications

In terms of contracting services, contracts may contain highly **detailed specifications for how services must be delivered** leaving little room for flexibility or innovation. Specifying services in contracts, including their nature, scope and quantity, can be particularly difficult in human services. Requirements need to be specified in ways that ensure services have flexibility to respond to changes in population need, and that they will meet the needs of different client groups, which may be difficult to anticipate. The wide range of client needs and circumstances, and the different outcomes sought, can make specifying services and designing appropriate performance measures particularly challenging. As such, contracts are likely to be 'incomplete' due to the cost of anticipating every eventuality (Barnard, 1938; Myrdal & von Hayek, 1974; Williamson, 1985, 2000).

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[8] As observed during the COVID 19 pandemic, a relaxation of controls was required to enable services to innovate to enable them to continue during the pandemic.

For homelessness services, the services needed, and nature of demand, depends on what happens in adjacent systems, including the income support system and other services, such as justice and health, where release processes may lead to particular demands from homelessness services, and referral pathways in and out of other contracted services.

Services should be designed with consideration of service gaps and potential overlaps and should include clients' and communities' input into appropriate solutions. The supply chains created by government funding should be responsible and ethical, meeting environmental, modern slavery and other standards, recognising the value of involving clients and people with lived experience in service design and delivery.

5.2.3 Contract length

A further important design aspect is the **duration of contracts**. Short-term contracts may be driven by funding availability or be a conscious choice by funders when the program *or* provider is new, thereby allowing improvements to be made when contracts are renewed or allowing contracts to be easily terminated (De Schepper et al., 2015; Sturgess et al., 2016; UK Government, 2019). However, short-term contracts (even when renewed) are very costly and a source of frustration and disruption to funders and providers, and can also disrupt service delivery for clients. For service providers, they cause uncertainty about funding security and staffing, as employment contracts may be linked to funding cycles. Often, services experience loss of staff prior to contract completion, creating gaps in teams which are hard to resolve in the short-term, which can undermine relationships between services and clients, and reduce service quality (Bates et al., 2022; McEntee et al., 2020).

Additionally, short contracts are problematic as they may not incentivise or provide sufficient time or resources for either funders or provider organisations to make necessary investments in systems and controls to support the delivery of contracts with a short duration. In contrast, long-term contracts send signals to both services and clients of the ongoing nature of services, encouraging investment in staff and systems. Long-term contracts can include review mechanisms recognising that not everything can be specified up front and there need to be opportunities to adjust the services as required. While one-, two- and three-year contracts are commonly used, alternatives include 2+2+2 arrangements. This design, which provides 6-year contracts with two yearly review points, has been adopted in South Australian Homelessness Alliances. Rolling contracts have also been introduced in the Department of Health-Primary Health Network contracting arrangement where contracts are extended in rolling cycles (Bates et al., 2022). Findings from the *Australian Community Sector Survey 2022* indicate that nationally, while contract duration is better in housing and homelessness services compared with other parts of the community sector, only 55% of organisations have at least one contract in place of at least 5-years duration (Cortis and Blaxland, 2023, p.24-25).

When contract periods end, funders must decide whether to continue to fund existing services by renewing contracts, for example, or whether and how to commence new procurement processes, or bring services in-house. At this point, design considerations include ensuring appropriate measures of success are considered, and ensuring decisions are made well in advance of expiration dates (Bates et al., 2022; Griffiths et al., 2016; Mental Health Australia, 2015).

5.2.4 Payment

Specification also includes **payments** – which may incentivise or reward behaviours around key milestones, thresholds or targets. Where outcomes are difficult to identify, measure and attribute, contracts may reward a combination of inputs, processes and behaviours – and on final completion of the contract which is often demonstrated by providing financial acquittals (Martin, 2005; Sturgess et al., 2016; Tomkinson, 2016). Importantly, funding must be adequate for services required; inadequate funding will deter provider engagement, reduce quality and capacity, and increase the difficulties of recruiting and retaining staff (Cortis and Blaxland, 2023). Financial arrangements need to be structured in ways that ensure providers are not incentivised or able to behave opportunistically. Risks of opportunism include targeting less complex clients who require less support ('creaming') or 'parking' clients who are perceived to be difficult to support (Bates, 2022; Considine et al., 2011; Considine & O'Sullivan, 2014; Dickinson, 2016; Eikenberry & Kluver, 2004; Hasenfeld & Garrow, 2012).

Payments are a key means of managing contracts, such as through contract milestone payments. Payment structures will vary depending on the type of activity contracted and whether it requires high upfront investment. Contracts often include some form of establishment payment (to support set up costs), activity funding payments (volume of services delivered), and outcomes-based payments (in terms of achieving targets and desired outcomes) (Koff et al., 2021; NSW Health, 2020). However, payment by results risks that opportunistic providers will overly narrow their focus to the activities or metrics which attract payments. It should be noted that in community services, payment arrangements should recognise that although many not-for-profit organisations are in a strong financial position, not all have adequate buffers in place to manage financial risk. Cortis and Lee (2019) found only 32% of social service charities in receipt of public funding had at least three months of spending in reserve. This suggests it is unrealistic to expect providers to have financial capacity to cover payment delays and funding lags, and to cover risk. Indeed, risks of contracting with government to deliver services can be substantial; contracts may, for example, include clauses allowing them to terminate services or change requirements at short notice.

One novel example of payments for outcomes is the use of social impact bonds or social impact investment models. One such example was piloted in the Home and Healthy Program (see Box 10) which highlighted the risk to providers of payments being tied to poorly defined outcomes.

Box 10 Pilot of the Home and Healthy program

Home and Healthy was piloted from June 2020-July 2022. Funds were allocated for a social impact investment, as part of the *NSW Homelessness Strategy 2023*. The intention was to test whether compared with 'business as usual' grant-based SHS funding in which payments were not linked to specific results, outcomes would be improved under an impact investment model which linked payments to performance indicators.

Home and Healthy was delivered by Mission Australia, after a tender process. The key program aim was to reduce the prevalence and impacts of homelessness for highly disadvantaged people, who were exiting health facilities in NSW. The target cohort of the initiative were people aged 18-65 exiting or engaged with a hospital or community health service, including mental health and drug and alcohol treatment facilities, who were at risk of or experiencing homelessness.

The model intended to generate financial as well as social returns. Services were provided with both a base payment and payments linked to achieving certain outcomes, based on KPIs specified in service delivery contracts. Outcomes were assessed according to goals being reached for set periods. The Service Delivery Agreement specified base payments plus payments per result for specified outcomes (for example, a client maintaining a tenancy for 3 months). KPIs and linked payments were specified in the service agreement.

Most participants did not achieve a program outcome during the 24-month pilot. The program did not meet stated objectives based on performance metrics, in part as it stopped taking referrals and closed early. Although the program was delivered as planned, the goals being met were not adequate to meet thresholds for payments. The administrative load on both staff and clients to evidence outcome achievement was very onerous and needed to be adjusted. The pilot ended early and was not rolled out.

Source: Blunden et al., 2023

5.2.5 Key considerations in procurement processes

Key considerations include:

- Level of detail in specifications for service delivery, and opportunities for flexibility and innovation
- Balance of bureaucratic and relational controls to ensure services and contracts are responsive to new information about the target cohort and what works, and
- How payments are structured to cover costs and incentivise or reward performance whilst preventing opportunistic behaviour.

5.3 Managing performance

Contracts are not self-administering and must include mechanisms that allow for the management of any residual hazards (Behn & Kant, 1999). Managing contracts can incur costs on both buyers and suppliers. Public funders often include extensive administrative or bureaucratic controls to provide oversight to ensure services are being delivered as specified. While bureaucratic controls suit the accountability and probity requirements of government, these may lead to reporting fatigue and high administrative overheads for both parties (Bates, 2022). Strict requirements may reduce opportunities to innovate and make improvements to how services are delivered.

5.3.1 Monitoring

Monitoring contracts requires that governments have capacity, skills, knowledge and understanding of the expected transformation process, and the ability to interpret data to undertake monitoring effectively (O'Flynn & Alford, 2008; Stafford & Stapleton, 2017). Monitoring is critical given well-designed programs that work in one area may work differently in different contexts. Relational controls, such as early, and ongoing conversations between funders and providers, or mutual involvement in interagency forums, can supplement bureaucratic controls, to help identify risks and how they may be overcome, and identify opportunities for improvement (Addicott, 2014; Bates et al., 2022). Where the use of relational controls is not possible, such as when funders lack content knowledge to identify or respond to risk or change, or where probity requirements are too high, services may be better managed by a specialist (external) third party – for example, through an intermediary model (see Section 4.4).

5.3.2 Reporting

Reporting is important to ensuring effective service delivery. Usually, public agencies rely on bureaucratic controls such as written reports on progress and KPIs, as these easily demonstrate accountability and probity. However, complex services often also benefit from the use of informal or relational controls, such as talking to people or participating in interagency or other advisory groups, to help identify and respond to risk in changing and challenging environments (Bates et al., 2023).

Measures of success, or key performance indicators, articulate areas of focus and performance standards, and may be based on evidence-based program logics. Historically, measurement has tended to focus on inputs and processes, on the assumption that particular inputs and processes would lead to the desired outcomes; developing relevant measures requires knowledge of service delivery and what outcomes may be achieved (O'Flynn & Alford, 2008). While the ethos of contracting has shifted towards including outcomes measures, contracting often relies on a mix of input, process, outputs and outcome measures (short- and medium-term), with measures frequently focusing on what is easier to measure (Almquist et al., 2013; Gregory, 1999).

Focus on accountability for outcomes has increased (Behn & Kant, 1999; Broadbent & Guthrie, 1992; Hood, 1995; Martin, 2005); however, outcomes from human services may not be achieved within the life of a program, and it can be difficult to attribute one outcome (even where it is recorded) to single services or interventions (Banerjee & Duflo, 2012; Bewley et al., 2016). This is especially the case for people with complex needs, who may require services and supports from multiple sources. Outcomes may range from detectable changes (Zmudzki et al., 2017), to un-attributable changes (Bewley et al., 2016), to undetectable changes, to services being ineffective or causing harm, particularly when poorly specified and monitored (Sasse et al., 2019). Further, given human services often require a multi-agency response, how are outcomes attributed to one agency's intervention over another's (Kominis & Dudau, 2012)?

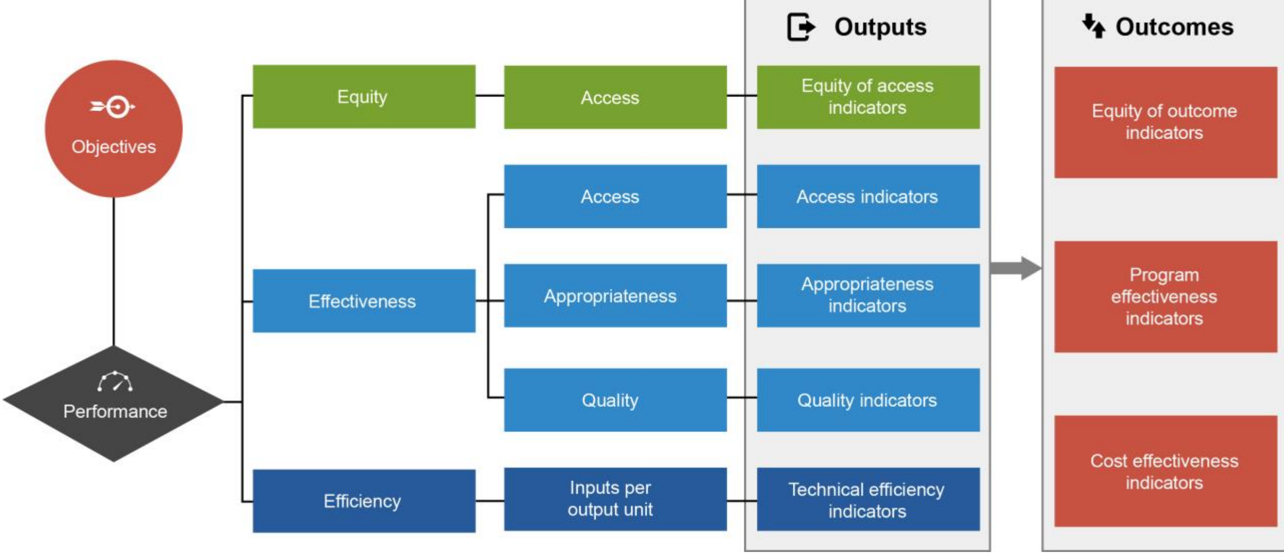
Often, performance measures are specified at a high level for service systems, to be consistent with national minimum datasets. Procurement may reinforce these conceptualisations, specifying measures that correspond with high level frameworks. The Productivity Commission's Report on Government Services (2023) for example outlines a conceptual approach to performance

measurement – replicated in Figure 3 below. This recognises the objectives of service delivery (equity, effectiveness and efficiency) and the transformation process from inputs to outputs and outcomes over time. The efficiency of this transformation process is gaining interest, including from NSW Treasury, who have developed frameworks to compare the efficiency of investment between programs to ensure investment is targeted to the most cost-effective program.[9]

Ultimately, performance measures need to meet multiple objectives. As well as enabling funders to track whether services are being delivered and meeting objectives, measures need to be relevant and meaningful to clients and providers, minimise burden, and not detract time from clients receiving services. They should be helpful for monitoring clients' progress and support providers to identify areas where services may not be working and lead to improvement. User friendly mechanisms to capture and report indicators, tailored to the service requirements, should be provided by government such that smaller organisations are able to report on outcomes without additional investment in data and client management systems. It is also important to recognise that providers may have multiple contracts, and associated with this, must report against multiple measures. Measures are often inconsistent between funders (see Bates et al., 2023). In other service areas, peak bodies have worked with services and funders to develop a standard set of measures (see NADA). Consistency of measures across programs may also be addressed, to some extent, by establishing national minimum datasets. However, such datasets may not necessarily capture the specific objectives and outcomes of specific funding packages therefore leading to even more measures being introduced (Bates et al., 2023).

Finally, performance measures should be continually reviewed to ensure they remain fit for purpose (Behn & Kant, 1999). Given success may be perceived differently by funders, service providers and clients, and at different points in time (Shergold, 2004), performance measures should be reviewed with the service provider and clients.

Figure 3 The Productivity Commission's performance indicator framework



Source: Replication of Figure 1.2 from The Report on Government Services: Approach to performance management (Productivity Commission, 2023)

[9] https://www.treasury.nsw.gov.au/four-pillars/outcome-budgeting (accessed 6 December 2023).

5.3.3 Evaluation

Evaluations contribute to the evidence base for future service procurement and a model of continual improvement.

Programs should also be evaluated to ensure they are achieving the desired outcomes. Evaluations are usually conducted by third parties and involve analysing data, including linked data, to understand whether the program is achieving its outcomes. Given the complexity of individuals' needs, and the complexity of providing supports, evaluations often involve qualitative components to understand whether there have been issues implementing the program (process evaluation), whether the program has achieved its goals (outcomes evaluation), and whether the program is cost-effective (economic evaluation).[10] The findings are used to inform funding decisions, service improvement, and whether for example pilot programs should be expanded. Evaluations also offer an opportunity to compare different service models for different target populations. Evaluations can also identify ways to not only improve the service, but also improve the way the service is contracted – improving design, KPIs and other governance arrangements. Evaluations can inform whether to continue or discontinue to the services, whether to change the service design, and whether to expand the service.

Contracts themselves need to remain fit for purpose, and facilitate improvement, and therefore should be reviewed periodically (Behn & Kant, 1999). Reviews should ensure contracts and services are working well and meeting needs in the community. However, continually changing monitoring and reporting requirements can create instability, inconsistency across reporting periods, and additional costs (Bates et al., 2022).

5.3.4 Key considerations in managing performance

Key considerations include:

- Using relational controls to enable success
- Recognising costs of monitoring and reporting, and ensuring monitoring and reporting is meaningful to clients and providers (to track outcomes and enable service improvements) and demonstrates accountability to government, and
- Ensuring data enables the evaluation of both the contract and whether it is enabling service delivery and evaluation of the program design and whether it is achieving the desired outcomes.

[10] See for example https://www.treasury.nsw.gov.au/finance-resource/evaluation-policy-and-guidelines (accessed 6 December 2023).

Box 11 Homelessness Investment – Logan Demonstration Project to improve contract management

The Community Services Industry Alliance worked in partnership with the QLD Department of Housing and Public Works and Specialist Homelessness Services to identify ways to strengthen the flow of investment to support better outcomes for people experiencing homelessness. The project proposed a roadmap which would focus the system on learning, continuous improvement, and use co-production and contracting to strengthen partnerships and capability, and bring elements of the system together in support of place-based strategies.

The project recognised that contract managers are critical to the Specialist Homelessness Services investment system, and influence the way services deliver programs and share information. A demonstration project was developed in Logan, focused on the role contract management might play in enhancing outcomes.

The project identified that while contract management in QLD housing and homelessness services was focusing on value for money and risk management, it needed to strengthen the focus on end-user outcomes. It sought to determine what Industry and Government can do to improve contract management, and ensure contracting supports outcomes.

The project recommended developing contract managers' capabilities across multiple areas, including finance, negotiation, collaboration, governance, and decision making. It underlined the need to co-produce meaningful data, develop place-based snapshots, and use relational approaches to reinforce contractual relationships and more effectively impact on homelessness. This would improve feedback loops and enable better conversation and negotiation within contracts. It also suggested providing opportunities for contract officers to experience first-hand other parts of the system. No evidence is available about how this has been acted upon or its impacts.

Source: https://csialtd.com.au/2020/09/14/logandemonstrationprojecthomelessnessinvestment/
https://csialtd.com.au/wp-content/uploads/2020/09/Current-and-Future-State-Report-Summary-FINAL.pdf

6 Conclusions

Commissioning is a cyclical process through which government funders identify needs in the community; prioritise how those needs might be met; plan, design and engage services to meet those needs; and manage performance and evaluate outcomes. Ideally, this process will lead to continual improvement. Procurement, which involves government tendering, and contracting, which establishes legal agreements to bind parties, are parts of the broader commissioning process.

This report has drawn on Australian and international literature, and provides examples of different approaches to commissioning and issues to consider across the commissioning process, to empower the homelessness sector to advocate for better ways to commission homelessness services in NSW. The findings of this report have been substantiated by feedback provided during consultations and the SHS Network meeting in November (see Appendix A).

The report has discussed approaches and identified the strengths and limitations of different contracting models, including direct contracting, co-commissioning, alliance models, prime provider models, intermediaries, individualised funding, and direct government provision. While commissioning is often assessed from the perspective of government, here we have also specifically identified the strengths and weaknesses of each model for clients and service providers.

No configuration of contracting is perfect. However, an understanding of each, and their strengths and weaknesses, can help funders consider options and identify opportunities. Direct contracting and prime provider models are familiar to NSW homelessness services, where governments are the main funding body, and providers often work together via joint working agreements. The appropriateness of these and other models requires further consideration by funders – and this should incorporate the perspectives of service providers and clients, as well as overall market sustainability given the reliance on markets to meet needs. A robust commissioning approach is likely to incorporate a range of models to meet the needs of varied local populations and reflect the local market characteristics.

There is a growing understanding and recognition of the impact of commissioning, and growing interest in trying different models of commissioning for different purposes. Direct contracting can address urgent needs, or may be appropriate for shorter, smaller, or pilot projects. Co-commissioning may work well where service users have highly complex needs that cross policy siloes, while alliance models may be suited to place-based models where good working relationships are already in place, and prime provider models can provide funders with expertise in commissioning services to meet local needs and align with existing services provided.

Regardless of the model used, commissioning should ensure the full costs of service delivery are met, including the fixed costs for overheads such as capturing data, providing clinical supervision, and establishing community advisory groups. Addressing contract duration and the lead times for procurement processes, implementation of services and contract renewals, is critical to ensure outcomes are delivered and are sustained. Further, funders' requirements for control and accountability should be managed in ways that do not stifle innovation and improvement, and should be supplemented by open dialogue between funders and providers to identify and solve any

issues arising. Evaluations should include specific questions around how the commissioning and contracting process has affected implementation and outcomes to inform future commissioning cycles. Ultimately, the common objectives shared by funders and services in meeting clients' needs should provide the central focal point for system design. Good relationships between the sector and government, and within the sector, are valuable foundations for building a better commissioning approach.

Finally, consideration should be given to how commissioning homelessness services fits in and around other areas of government reform. There has been growing interest in place-based initiatives in NSW, as well as collaborative governments arrangements (see for example, the Waterloo Human Services Collaborative Group).[11] These initiatives may also be relevant to how services are commissioned. The *NSW Homeless Strategy* and the *National Housing and Homelessness Plan* also set the policy framework; broader consultation processes about national and state policies offer an opportunity to influence early stages in the commissioning cycle. Finally, other operational elements that support the commissioning of services should also be considered in future advocacy work – such as around national minimum datasets.

[11] See for example, work commissioned by ANZSOG: https://anzsog.edu.au/news/adapting-place-based-initiatives-hybrid-world/ and https://anzsog.edu.au/app/uploads/2023/05/ANZSOG_CoGov_Scoping-study_Final-RI.pdf

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Appendix A

Responses from participants of the NSW Specialist Homelessness Services Network Meeting: 23/11/2023

Question 1: What is working well for you in the commissioning process?

‘Open dialogue with commissioning departments.’

‘We haven’t had communique from our contract manager as yet on recommissioning for 2024’

‘Our organisation doesn’t have current funding but absolutely do homelessness work. I feel like we are locked out at the moment and don’t have any opportunity to gain funding.’

‘Our contract manager is really great and understands the current climate which makes a huge difference.’

‘Our contract managers and the dialogue’

‘Flexibility to deliver services differently’

‘The regular meetings are helpful & opportunities to communicate openly’

‘Contract manager and open communication.’

‘Listening to clients needs and being bold about changing service delivery.’

Question 2: What has helped you get better outcomes from commissioning – for the service, for clients?

‘If your services work well together then consortiums can work. It does take a long time and takes willingness from each organisation’

‘A realistic focus on resources and what is actually possible’

‘Regular meetings, strong sense of purpose - the right partners’

‘Proper process and real listening’

‘Where funding body respects the expertise and local knowledge of the service provider

Lack of funding has forced us to collaborate with other services which sometimes leads to great outcomes.’

‘Client support – collaboration’

‘Partners with the same focus and values’

‘Local collaborations, understanding, local knowledge.’

‘Respect for the work we do and the validation of the issues we face daily. Then collectively working on strategies that would reduce it eliminate issues.’

‘Funding body respecting expertise and local knowledge of service providers’

‘Sharing of resources’

‘In the past this has been having great relationships with funding contact and who is open to really accept flexibility driven by client needs’

‘Local knowledge of communities’

‘Contracts that are developed on clearly defined outcomes based on transparent and accurate data

‘Having a funder that truly listens to what will actually achieve positive outcomes instead of what just looks good’

‘When there has been a long lead in time, a clear co-design process with accountability on decisions that are informed from lived experience panel, service providers and government.’

‘Clearly defined definitions and expectations for a commissioning process is critical for ensuring people can engage with the process appropriately’

‘Review and refection on evolution of clients types and assess how to best support them according to their situation. The programs creation from 10-years back, increase of complexity taken into account’

‘Agreed a program logic should be developed as part of re-commissioning process. Challenge is many service providers still don’t have staff with skill set to ‘develop & embed this.’

Question: What would help you get better outcomes from the contracting process?

‘Not all outcomes are measurable!’

‘Understanding of what both services and funders can do.’

‘Clear information and timeframes.’

‘Better negotiations around needs and the costs associated around these needs‘
‘Understanding of the issues around employment and retention of staff and the cost associated with retaining good staff.’

‘Brokerage. The last presentation on brokerage was not given enough time for services to provide feedback and did not reflect cost associated with need. Perhaps this needs to be reviewed.’