UNIVERSITY OF TECHNOLOGY SYDNEY

Understanding how the public sector organises and controls the outsourcing of human services

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Certificate of original authorship

I, Shona Bates, declare that this thesis, is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Accounting Discipline Group of the UTS Business School at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Abbreviations

ABS	Australian Bureau of Statistics
ACOSS	Australian Council of Social Services
AIHW	Australian Institute of Health and Welfare (Australian Government)
AOD	Alcohol and Other Drugs (often in relation to treatment programs)
ASX	ASX Ltd operates the Australian Securities Exchange
CasePHN	The Case Organisation operating one of 31 Primary Health Networks
CMO	Community Managed Organisation
CoI	Conflict of Interest
CPI	Consumer Price Index (measure of household inflation)
Cth	Australian Commonwealth
Divisions	Divisions of General Practice (1992–2011)
DoH	Australian Government Department of Health
DHS	Australian Government Department of Human Services, now Services Australia
ED	Emergency Department (hospital)
Folio	CasePHN's online contract management system
GP	General Practitioner (Medical Doctor)
IT	Information technology
KPI	Key performance indicator
LHD	Local Health District (NSW)
LHN	Local Hospital Networks
MBS	Medicare Benefits Scheme
MDS	Minimum data set (for example, collected for AOD and mental health)
MH	Mental health
MSA	CasePHN Master Services Agreement
nd	Non-dated
NDIS	National Disability Insurance Scheme (Australia)
NGO	Non-government organisation
NPM	New public management
NSW	New South Wales, Australia
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PPP	Public private partnership
PSO	Public Sector Organisation
Provider	Primary health care service providers
Program	Primary Health Network Program
SFA	DoH Standard Funding Agreement
TCE	Transaction Cost Economics (theory)
WHO	World Health Organisation

Abstract

Public sector organisations (PSOs) outsource a range of activities, including human services such as health and social care. Transaction cost economic (TCE) theory suggests human services are difficult to contract over due to high asset specificity, uncertainty and frequency of transactions; the way human services are organised and controlled is also likely to be affected by probity requirements. The inter-organisational management control literature suggests relational control strategies — strategies that are nimble and adaptive — are best suited to activities of low contractibility; yet, where probity requirements are high, bureaucratic control strategies may be more appropriate. Given this tension, the objective of this thesis is to explain how the public sector can organise and control the outsourcing of low contractible human services. Using a qualitative case study of the outsourcing of primary health care services by the Australian Government, I use an abductive approach to explain how PSOs moderate the tension between low contractibility and probity when outsourcing human services. My findings contribute to the inter-organisational management control and TCE literatures, and practice.

First, I develop the conceptual specification of probity which has been largely ignored since its introduction to TCE in relation to sovereign transactions. I show probity arises from the nature of the party to the transaction and the context, and the nature of the service being contracted over including the value and nature of services (due to requirements outside of the contract). I also identify two types of probity: financial probity relates to the transparent, equitable, ethical and efficient use of public resources; social probity relates to the public sector's responsibility to ensure the safe and effective delivery of contracted services. Financial probity is likely to be constant and associated with transaction party/context, while social probity is likely to vary and is associated with both the party/context and the service.

Second, using the conceptual specification developed above, I extend our knowledge of how probity requirements are satisfied. Financial probity requirements are likely to be satisfied consistently and exclusively using bureaucratic controls. Further, relational controls are unlikely to satisfy probity requirements and are absent from this setting, irrespective of transaction characteristics present. Social probity requirements are also satisfied using bureaucratic controls, tailored to each arrangement in consultation with key stakeholders.

Third, I identify an intermediary 'triadic-by-design' model which is able to purposely change the contractibility of the outsourcing arrangement. The intermediary model changes the nature of what is contracted over by the PSO, and changes the boundary conditions where the low contractible services are organised, thus moderating the tension between low contractibility and probity in public sector settings. The findings help scholars better understand the transaction characteristic of probity and how the public sector can organise low contractible arrangements — both of which also have the potential to inform policy and improve practice.

Chapter 1 Introduction

1.1 Research objective

The objective of this thesis is to **explain how the public sector can organise and control the outsourcing of human services.** The public sector is a significant part of a country's economy (varying by level of income and institutional factors); in Australia, public sector spending accounts for 18.90% of GDP.[1] The public sector is often criticised for inefficiencies and systems failures, some specifically associated with outsourcing (Burns, 2019; Karp, 2019; Long, 2019; Sasse et al., 2019; Smee, 2019; Vujkovic, 2019). Despite repeated calls to examine how public sector inter-organisational arrangements are managed (Birnberg & Gandhi, 1976; Broadbent & Guthrie, 1992, 2008), and how different factors in the public sector impact on controls used (Barretta & Busco, 2011; Berry, Coad, Harris, Otley, & Stringer, 2009; Cristofoli, Ditillo, Liguori, Sicilia, & Steccolini, 2010), most scholarly knowledge about the management of outsourcing arrangements is based on empirical studies in the private sector (Caglio & Ditillo, 2020).

Public sector organisations (PSOs)[2] outsource a range of activities, including human services such as health and social care (Cristofoli et al., 2010; Johansson & Siverbo, 2011). Human services can be difficult to contract over for a number of reasons, including low measurability, poor knowledge of the transformation process, and high asset specificity; further, the way human services are organised and controlled is affected by institutional factors including the bureaucratic nature of PSOs and the expectations of integrity, accountability to both government and the public, and probity (Berry, Broadbent, & Otley, 1995b; Johansson & Siverbo, 2011; Speklé & Verbeeten, 2014; Williamson, 1999).

Public sector outsourcing is not new (Sturgess, Argyrous, & Rahman, 2016), but has grown in significance following the advent of new public management in the 1990s, reforms which sought to increase the efficiency and effectiveness of the public sector (Hood, 1995; Samuel, Covaleski, & Dirsmith, 2008; Verbeeten & Speklé, 2015). The way outsourced human services

[1] This is comparable to the UK (18.8%) and NZ (18.48%). Based on 2019 data accessed from https://www.theglobaleconomy.com/ (accessed 14 November 2020). The following countries demonstrate differences between low and high-income countries, and institutional differences: Indonesia, 8.75%; India, 11.77%, the US, 14.15%, China, 16.54%; Germany, 20.35%; Canada 21.17%; France, 23.10%; Norway, 24.42%; and Sweden 25.96%.

[2] Consistent with prior literature, I use the term public sector organisations (PSOs) (Bracci & Llewellyn, 2012; Broadbent & Guthrie, 1992, 2008; Carlsson-Wall et al., 2011; Cristofoli et al., 2010; Greer et al., 2017; Johansson & Siverbo, 2011; Johansson et al., 2016; Kominis & Dudau, 2012). PSOs include organisations, departments and agencies, established by government (the elected officials), responsible for providing utilities and services to society and advising government as required (Broadbent & Guthrie, 1992, 2008; Shergold, 2013b).

are organised and controlled can have both social and economic implications. Managed well, services are high quality, equitable and efficient, enable social and economic participation, and are accountable and responsive in terms of delivering program outcomes (Productivity Commission, 2016a, p. 11). Managed poorly, services can lead to significant failings (socially and economically) including short and long-term harm, even fatalities, and represent a failure by government to meet its fundamental obligations (Padovani & Young, 2006; Sasse et al., 2019). This makes human service outsourcing an important area to study (Kettner & Martin, 1990).

1.2 Practical motivation

Human services are financial supports and services provided by governments (delivered by PSOs) to enable and support economic and social participation, address inequality, and contribute to the wellbeing of individuals and the broader community (Productivity Commission, 2016a). Services are available throughout our life-course, address specific needs, and break complex cycles of disadvantage (ACOSS, 2014; DHS, 2015; Harvey, 1992; United Nations, 1948). Individual needs vary, from requiring single to multiple services, and from needing short to long-term supports; needs are best addressed individually and managed flexibly to encourage self-sufficiency (Productivity Commission, 2016a; Shergold, 2013a). Human services are of economic significance; not only do they enable economic participation, they are also a significant part of public expenditure. This study focuses on services (rather than financial supports), using Australia as the setting.

In Australia, human services are provided by multiple PSOs across different levels of government; for example, human services may be provided through health, 'welfare' (financial and social supports), justice/corrections, education, and housing. This makes the total expenditure on services difficult to identify (Eckersley & Ferry, 2020). For example, the Australian Institute for Health and Welfare (AIHW) reports, for the 2018–2019 period, expenditure of $185.4bn on health and $160.6bn on welfare. Welfare expenditure included $102.2bn (64%) in financial supports, $48.1bn (30%) in services (defined as services for family and children, aged population, and people with disability excluding the National Disability Insurance Scheme; NDIS), and $10.2bn (6%) in unemployment services.[3] This figure excludes private services and informal supports (Deloitte Access Economics, 2015).

The Australian public sector has increasingly sought efficiencies and greater effectiveness from the market, outsourcing a range of services including human services (Hood, 1995). The market for delivering face-to-face human services in Australia is significant and increasing (due to an

[3] Data source https://www.aihw.gov.au/reports/australias-welfare/welfare-expenditure (accessed 20 April 2020).

ageing population; Boomsma & O'Dwyer, 2019; PwC, 2016), with estimates of expenditure on outsourced human services upwards of $35bn per year (AIHW, 2015). Consequently, the role of the public sector has shifted to ensuring contracts (and therefore services) 'are effectively implemented' (Johansson, Siverbo, & Camén, 2016, p. 1027).

Human services are difficult to specify and measure, and therefore are difficult to organise and control (Birnberg & Gandhi, 1976; Cristofoli et al., 2010; Johansson & Siverbo, 2011; Johansson et al., 2016; Productivity Commission, 2016a; Sasse et al., 2019). In Australia, there have been significant examples of service failures by both PSOs and third-party providers, highlighted by a number of public inquiries: for example, the *Royal Commission into the Institutional Responses to Child Sexual Abuse*, the *Royal Commission into Aged Care Quality and Safety*, and the *Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability*.

Due to the nature of human services, even when outsourced, the public sector remains accountable for their effective (Bovaird, 2016; Bovaird & Loeffler, 2012; Butcher & Dalton, 2014; Cristofoli et al., 2010; Narayanan, Schoch, & Harrison, 2007; Productivity Commission, 2016b) and efficient delivery (Eckersley, Ferry, & Zakaria, 2014; Hagbjer, Kraus, Lind, & Sjögren, 2017; Ludowise, 2004). The public sector is required to operate transparently as it is accountable to stakeholders and constituents (Cristofoli et al., 2010; Johansson et al., 2016) — often referred to in the public sector as 'probity' (Shergold, 2013b). This presents challenges to the public sector in balancing the need for flexibility (in service delivery) and control (to ensure services are delivered that meet probity requirements), while ensuring the cost of managing services does not exceed the value of the services outsourced (Spurgeon & Hicks, 2003).

Human services are provided by governments around the world to enable social and economic participation, and form a significant part of public expenditure. Increasingly, PSOs outsource human services in pursuit of greater efficiency and effectiveness. The individualised nature of human services makes them difficult to contract over. Providing greater understanding of how the outsourcing of complex human services can be managed by the public sector, to ensure they are delivered effectively and efficiently, provides the practical motivation for this thesis.

1.3 Theoretical motivation

This section first provides the general theoretical location and motivation for this thesis. This is followed by three specific theoretical motivations that lead to the research question.

This study uses transaction cost economics (TCE) (Williamson, 1981b, 1981a, 1985, 2009b) as the theoretical lens. Developed by Oliver Williamson, TCE theory provides a mechanism inclusive of law, economics and organisation to examine the economics of organisation and in particular the cost of contracting (Williamson, 1979, 1985). TCE theory assumes there is a risk

of contracting hazards materialising (due to bounded rationality and opportunism), the extent of which is determined by the transaction attributes (asset specificity, uncertainty, and frequency, with probity added later). TCE is often used as a theoretical lens in management accounting inter-organisational outsourcing studies, including studies in public sector settings[4], to build understanding of transaction characteristics and how transactions are organised between firms to minimise transaction costs (Berry et al., 1995b). Scholars have used TCE theory to help explain the decision to outsource, how outsourcing is organised, and how outsourcing is controlled (Anderson & Dekker, 2010).

1.3.1 General location and motivation for this thesis

This study is located in the management accounting literature on inter-organisational management control (hereinafter the literature). This well-developed literature addresses a range of inter-organisational forms, from legal partnerships, to networks, to market exchanges, including outsourcing, in different institutional settings and jurisdictions (Anderson & Dekker, 2014; Caglio & Ditillo, 2008, 2020; Dekker, 2004; Grafton, Abernethy, & Lillis, 2011; Håkansson, Kraus, & Lind, 2010; Phua, Abernethy, & Lillis, 2011; van der Meer-Kooistra & Vosselman, 2006). The management control literature focusing on private sector outsourcing is well developed, with less attention being given to public sector settings. Theory derived from private sector studies does not necessarily hold in public sector settings due to different boundary conditions (Balakrishnan, Eldenburg, Krishnan, & Soderstrom, 2010; Brignall & Modell, 2000; Cristofoli et al., 2010; Narayanan et al., 2007).

This study focuses on public sector outsourcing of human services (Section 1.2). As identified in Chapter 3, human services have low contractibility as they are difficult to specify and measure, difficult to program, and subject to disturbances (uncertainty); are likely to require significant investment in human capital and systems (asset specificity), leading to potential hold up , and are likely to be difficult to contract over due to the frequency at which arrangements recur due to government funding cycles (frequency); how low contractible arrangements are managed are further complicated by probity (Cristofoli et al., 2010; Johansson & Siverbo, 2011; Johansson et al., 2016; Speklé & Verbeeten, 2014).

While reforms in the public sector have tried to introduce business concepts (Brignall & Modell, 2000), PSOs remain fundamentally different to private sector organisations due to party characteristics and their objective to maximise social welfare (as opposed to profit) while also protecting against opportunism (Cristofoli et al., 2010; Hood, 1995; Jensen & Stonecash, 2005; Johansson et al., 2016). The peculiarities of the public sector stem from the origins of PSOs;

[4] For example, Balakrishnan et al. (2010) and Johansson (2008).

they are owned by (funded by public money) and accountable to government (elected officials), often established by legislation to fulfill a specific objective or mission, including the delivery of public goods and services for citizens, implementing the government policy of the day (Johansson et al., 2016; Narayanan et al., 2007). PSOs are accountable in all operations — including those outsourced — to both the government and the public to provide effective, efficient, accountable, responsive, equitable and high quality services (Brown, Potoski, & Van Slyke, 2006). Such accountability may be heightened depending on the political visibility and social relevance and complexity of operations (Balakrishnan et al., 2010; Cristofoli et al., 2010). PSOs have specific requirements (and limitations) relating to governance, expenditure, procurement, remuneration and rewards, and are often providers of last resort (Balakrishnan et al., 2010; Barretta & Busco, 2011). One factor that clearly distinguishes public sector from private sector settings is the often-legislated governance requirement to demonstrate probity across all operations (IFAC & CIPFA, 2014; Williamson, 1999) — a characteristic also identified in TCE theory.

PSOs also have a long tradition of strong and bureaucratic cultures and control in optimising the public values underpinning public services (Balakrishnan et al., 2010; Brown et al., 2006; Cristofoli et al., 2010). Performance measurement may be driven by seeking legitimacy from stakeholders rather than seeking efficiency and effectiveness (Barretta & Busco, 2011; Johansson et al., 2016); given the extent, diversity and salience of stakeholders, performance management may be extensive to ensure the interests of different stakeholders are addressed (Ibid.). PSOs often rely on the strength of bureaucratic controls and the intrinsic motivation of staff to achieve their objectives while minimising opportunism.

While some scholars have explored the broader control archetypes evident in public sector settings in different jurisdictions (Johansson et al., 2016), few have considered what happens after the outsourcing decision is made and how low contractible arrangements may be organised and controlled. This thesis seeks to add to the limited knowledge of how the public sector organises and controls the outsourcing of services once the decision to outsource has been made. Given my practical motivation, I use TCE theory to examine the outsourcing of low contractible human services.

1.3.2 Adding to the conceptual specification of probity

In TCE theory, probity is a characteristic associated with the nature of the transaction, defined as the ‘loyalty and rectitude that something is carried out’ (Williamson, 1999, p. 322) requiring a ‘high standard of integrity’ (Williamson, 1999, p. 323). While probity is likely to be present across all forms of organisation (save criminal organisations), probity is an explicit governance requirement of the public sector, often legislated, and therefore is likely to be significant in public sector settings (Department of Finance, 2017; IFAC & CIPFA, 2014; Williamson, 1999).

The literature on public sector outsourcing (and the outsourcing literature more generally) appears to circumvent probity, despite probity being one of the clearest governance requirements evident and likely to impact all control choices made in this setting (IFAC & CIPFA, 2014). For example, some scholars highlight the importance of accountability and explore how it is (or is not) managed (Eckersley et al., 2014; Hagbjer et al., 2017; Kominis & Dudau, 2012), while others find that legitimacy seeking is the most important driver of controls requiring PSOs to 'implement visible, formal and bureaucratic controls' (Johansson et al., 2016, p. 1013). While scholars using TCE theory in public sector settings have the potential to address probity explicitly (as probity is more likely to occur), probity is often ignored (Balakrishnan et al., 2010; Johansson, 2008).

Probity is a late addition to TCE theory (introduced in 1999), vague by Williamsons' own admission (Williamson, 1999), unfamiliar (other TCE constructs being drawn from long-established theories), and is potentially misunderstood (demonstrated by scholars using other theoretical lenses to explore accountability and legitimacy seeking; e.g. Barton, 2006; Johansson & Siverbo, 2011; Johansson et al., 2016). Failing to understand the implications of probity, how it interacts with other transaction characteristics, and how this impacts on control choices, leaves the extant public sector outsourcing literature incomplete and potentially at risk of misinforming theory and practice (Anderson & Dekker, 2010; Caglio & Ditillo, 2008; Otley, 2016).

Williamson himself acknowledged probity needs to be further developed, yet scholars know little more about probity now than when it was first introduced into the TCE literature by Williamson more than 20 years ago. The lack of development of the conceptual specification has limited the use of Williamson's original specification of probity to the context in which it was developed, that is the outsourcing of sovereign transactions or transactions involving public authority (Da Veiga & Major, 2019; Fredland, 2004). The conceptual specification of probity needs to be developed further before it can be applied to public sector settings more broadly. The first theoretical motivation for this thesis is therefore to add to the conceptual specification of probity in order to broaden the application of TCE attribute of probity, and TCE more broadly given transaction characteristics do not always operate in isolation.

1.3.3 Understanding how probity requirements may be satisfied

In the original specification of probity, developed in a hypothetical setting of a sovereign transaction, Williamson (1999, p. 338) suggests probity, that is the integrity of the transaction, can be satisfied by the absence of incentives, extensive bureaucratic controls, the external appointment of leadership, and socially conditioned staff. While there is little evidence that probity has been dealt with specifically in the literature (Section 1.3.2), there is circumstantial evidence that supports Williamsons work. Scholars find high-powered incentives are sub-

optimal for public sector outsourcing as they replace intrinsic motivation and distort behaviour (Jensen & Stonecash, 2005; Speklé & Verbeeten, 2014). Other scholars highlight the public sectors' reliance on bureaucratic 'command and control' mechanisms to manage outsourcing arrangements irrespective of the nature of the transaction (Johansson & Siverbo, 2011; Johansson et al., 2016; Narayanan et al., 2007).

Williamson also suggests that the contractual hazards in his hypothetical setting 'favo[u]r cooperativeness (as against autonomy) in the design of the agency and its administration' and that 'a governance structure that supports a presumption of or predisposition toward cooperativeness will relieve the hazards of probity', implying a relational mechanism is more suited to what Williamson calls a 'probity transaction' (Williamson, 1999, p. 324). This ignores the fact that relational mechanisms may compromise probity (Carlsson-Wall, Kraus, & Lind, 2011; Ditillo, Liguori, Sicilia, & Steccolini, 2015; Narayanan et al., 2007), and may reflect more the contractibility of the sovereign transaction.

Given the lack of conceptual development of the transaction characteristic of probity beyond sovereign transactions (described in Section 1.3.2), it is unsurprising that scholars have largely failed to consider probity when applying TCE theory to inter-organisational management control studies. Despite being a clear governance requirement in public sector settings, how probity is satisfied has been mostly circumvented in the management control literature. Probity is not just relevant to all public sector operations (Williamson, 1999), but is likely to be an important consideration for management control strategies across all operations. Failing to understand how probity is satisfied leaves the explanation of the determinants of control in public sector settings incomplete. Therefore, the second theoretical motivation for this study is to explain how probity requirements are satisfied, and how this affects the organisation and control of low contractible arrangements.

1.3.4 Managing low contractible arrangements while also satisfying probity requirements

We know from the literature that outsourcing low contractible activities presents additional challenges in how arrangements are managed (Håkansson & Lind, 2004; Langfield-Smith & Smith, 2003; van der Meer-Kooistra & Vosselman, 2000; Vosselman, 2002) and specifically the level of collaboration and coordination required (Chua, 2011). Some scholars propose control models based on trust (Dekker, 2004; Langfield-Smith & Smith, 2003; van der Meer-Kooistra & Vosselman, 2000), while others propose relational controls and intensive ongoing communication and cooperation between parties (Anderson & Dekker, 2010; Håkansson & Lind, 2004; Speklé, 2001).

Public sector outsourcing of low contractible activities has received some attention in the literature, using different human services as their empirical settings (Balakrishnan et al., 2010;

Barton, 2006; Bracci & Llewellyn, 2012; Cristofoli et al., 2010; Eckersley et al., 2014; Hagbjer et al., 2017; Johansson, 2008; Johansson & Siverbo, 2011; Johansson et al., 2016; Kominis & Dudau, 2012; Kraus & Lindholm, 2010).[5] This literature does not appear to explain *how* the public sector organises and controls low contractible outsourcing arrangements (save for Cristofoli et al., 2010; Hagbjer et al., 2017), only the factors that influence control choices and potential control configurations (Cristofoli et al., 2010; Johansson & Siverbo, 2011; Johansson et al., 2016). Notably, Cristofoli et al. (2010) find archetypes of control developed for the private sector are not found in their public sector setting and identify party characteristics as being pivotal to this difference, along with the presence of a 'third voice' (clients) and political interference. However, they fail to explore party characteristics in detail or make the connection between party characteristics, this so-called third voice, and probity.

For low contractible arrangements, scholars find trust-based controls and relational controls — approaches that are flexible and agile — are best suited as they encourage sharing of information and understanding, and allow parties to resolve unknowns over time (Anderson & Dekker, 2010; Dekker, 2004; Håkansson & Lind, 2004; Langfield-Smith & Smith, 2003; Speklé, 2001; van der Meer-Kooistra & Vosselman, 2000). However, not only are bureaucratic controls preferred by PSOs as they provide transparency in the presence of probity (Johansson & Siverbo, 2011; Johansson et al., 2016; Williamson, 1999), the public administration literature highlights that relational controls potentially pose a threat to public accountability as they fail to satisfy probity requirements (Ditillo et al., 2015). The literature does not appear to explain how PSOs resolve this tension between managing low contractible arrangements while also satisfying probity requirements. PSOs continue to outsource low contractable services in settings where probity requirements are high; without understanding how this tension is managed, we are unable to understand how PSOs enable 'the cooperative ideal' (Barretta & Busco, 2011).

The objective of my thesis is therefore to explain how the public sector can organise and control the outsourcing of human services. Given low contractible arrangements may be best managed using relational controls, yet relational controls are unlikely to satisfy probity requirements in public sector settings, the central research question of this thesis is:

[5] Scholars use archival (Johansson, 2008; Zafra-Gómez, Pedauga, Plata-Díaz, & López-Hernández, 2014), survey (Johansson & Siverbo, 2011; Johansson et al., 2016), and case study data (Balakrishnan et al., 2010; Cristofoli et al., 2010), to explain the decision to outsource (Balakrishnan et al., 2010; Johansson, 2008; Zafra-Gómez et al., 2014), control archetypes and their antecedents (Cristofoli et al., 2010; Johansson & Siverbo, 2011; Johansson et al., 2016), and accountability in public sector settings (Barton, 2006; Bracci & Llewellyn, 2012; Eckersley et al., 2014; Hagbjer et al., 2017; Kraus & Lindholm, 2010).

How can the public sector organise and control the outsourcing of human services? In particular, how can public sector organisations resolve the tension between low contractibility and probity when outsourcing human services?

1.4 Research strategy

To understand how PSOs organise and control the outsourcing of human services, I study the outsourcing of primary health care services by the Australian Government's Department of Health (DoH). DoH outsources a program of services to 31 intermediary organisations, who then commission services on behalf of DoH in 31 independent regions across Australia. I study the whole outsourcing arrangement, comprising a contractual relation between DoH and one intermediary (the CasePHN), and contractual relations between the intermediary and service providers, to understand how the outsourcing arrangement is organised and controlled.

A qualitative case study method informs the study, drawing on 49 interviews, 29 observational days in the organisation, and an extensive document review conducted over an 18-month period. A within case design allows me to focus in detail on contractual relations that were considered by the organisation to be working well (answering calls to look at successful practice; Malmi & Granlund, 2009). An abductive approach allows me to iteratively develop findings and theory in a contextual setting (Dubois & Gadde, 2002), and identify how the public sector organises and controls the outsourcing of the primary health care services.

1.5 Theoretical contributions and implications

In this thesis I explain how the public sector manages the outsourcing of services of low contractibility, using a case study of the outsourcing of primary health care services in Australia through the Primary Health Network (PHN) Program. I explain how the PSO applies an intermediary model to resolve the tension between low contractibility and probity when outsourcing human services. In doing so, this thesis makes three contributions to the inter-organisational management control literature and the broader TCE literature relating to the conceptual specification of probity, how probity can be satisfied, and how the tension between low contractibility and probity can be resolved.

1.5.1 Developing our conceptual specification of probity by including source and type

My first contribution relates to the TCE attribute of probity and contributes to both the inter-organisational management control literature using TCE, as well as the broader TCE literature. While probity is not unique to the public sector (Butcher, 2018; Williamson, 1999) — as a society, we would hope that private sector organisations also behave honestly and decently — probity requirements in PSOs are often legislated, detailed and specific to the sector, making

probity highly relevant to public sector transactions. Exploring probity in a setting where it is likely to be highly relevant shows that probity is not a bland bureaucratic requirement, but is multi-dimensional.

First, I identify the sources of probity. This thesis demonstrates that probity arises from the nature of the party to the transaction and the context given the additional requirements specific to PSOs, validating prior studies that probity is related to the context or actors (Da Veiga & Major, 2019; Ruiter, 2005). In addition, probity arises from the nature of the service being contracted over, either transferring with the activity through contract requirements and/or program design, or arising from the value and nature of the service itself (due to requirements outside of the contract).

Second, I identify two types of probity: financial and social. Financial probity relates to the transparent, equitable, ethical (in relation to corruption; Gregory, 1999) and efficient use of public resources (Allen et al., 2016; Spurgeon & Hicks, 2003) across all operations. The financial dimension of probity is not new; scholars often only recognise the fiduciary aspect of probity (Allen et al., 2016; Butcher & Gilchrist, 2016; Da Veiga & Major, 2019; Gregory, 1999; Jensen & Meckling, 1976; Samuel et al., 2008; Tan & Egan, 2018). Financial probity requirements are consistent across activities, although there may be some variation depending on the value of the contract. Social probity relates to the public sector's responsibility to ensure the safe and effective delivery (quality and stewardship) of services contracted over (Almquist, Grossi, van Helden, & Reichard, 2013), and is likely to vary according to the nature of the service contracted over. While scholars have noted the relevance of both the financial and social context of transactions — particularly in the public sector (Almquist et al., 2013; Balakrishnan et al., 2010; Barretta & Busco, 2011; Reusen & Stouthuysen, 2017) — no links have been made to probity.

Third, financial probity is more likely to be associated with the nature of transaction party/context, although requirements may vary depending on the value of the services contracted over. Social probity arises from both the nature of the transaction party/context and the nature of the services. It is the nature of the services that make social probity requirements idiosyncratic. Different types of probity are accountable to stakeholders in different ways and are not necessarily valued or treated equally. By highlighting the different sources and types of probity, it becomes easier to recognise where and when probity arises in a transaction.

My first contribution is the development of the conceptual specification of probity. TCE theory is commonly used as a theoretical lens in the inter-organisational management control literature, albeit it less so in public sector settings (Anderson & Dekker, 2010; Ding, Dekker, & Groot, 2013). Developing our conceptual understanding of the TCE construct of probity beyond sovereign transactions (Williamson, 1999) extends the use of TCE in the public sector, ensuring

scholars account for a key governance requirement of public sector settings. This also encourages the application of TCE theory in its entirety in other settings. This enables greater consistency and comparison between private and public sector studies (Anderson, Christ, Dekker, & Sedatole, 2015), and provides an opportunity to build on and draw comparisons between studies (Otley, 2016). At a more practical level, providing a more detailed understanding of the different sources and types of probity and the relation between them provides more information to scholars and practitioners about what may drive control choices. Probity is not a single dimensional transaction characteristic, but more nuanced than previously assumed.

1.5.2 Explaining how probity requirements can be satisfied

My second contribution extends scholarly knowledge of how probity requirements are satisfied, and how probity affects the organisation and control of low contractible arrangements in the public sector.

First, consistent with prior studies, the empirical data show PSOs rely on bureaucratic controls to satisfy probity requirements. Using the conceptual specification of probity developed above, how probity requirements are satisfied varies across different types of probity. Financial probity appears to be the dominant from of probity, satisfied consistently and exclusively using bureaucratic controls, irrespective of the nature of services contracted over — neither relational controls or incentives satisfy financial probity requirements. This is consistent with prior studies and circumstantial evidence that highlight the public sectors reliance on bureaucratic controls and avoidance of incentives, irrespective of the nature of the transaction (Jensen & Stonecash, 2005; Johansson & Siverbo, 2011; Johansson et al., 2016; Narayanan et al., 2007; Speklé & Verbeeten, 2014; Williamson, 1999). Social probity is likely to be satisfied using bureaucratic controls tailored to each arrangement in order to also satisfy financial probity requirements; the bureaucratic controls are likely to be developed in consultation with or negotiated with key stakeholders — demonstrating some relational aspects to how social probity is satisfied. Relational controls may be used to supplement bureaucratic controls in other settings (in this case the intermediary setting) where social probity cannot be satisfied with bureaucratic controls alone; for example, in low contractible arrangements.

Second, consistent with prior studies I show that PSOs do not use relational controls as they fail to satisfy financial probity requirements (Ditillo et al., 2015; Narayanan et al., 2007). While trade-offs are common in determining control choices (Williamson, 1985), the findings show that probity is not traded-off in public sector settings — financial probity requirements must be satisfied across all operations. Financial probity not only determines what controls are required, but also what controls are not able to be used — irrespective of the transaction characteristics present.

While this may have no impact on outsourcing arrangements where contractibility is high (arrangements suited to bureaucratic controls), the dominance of probity is likely to lead to control misalignment where contractibility is low (arrangements suited to relational controls). In cases of low contractibility, PSOs either need to reconsider what probity is and how it is satisfied, increase the contractibility of arrangements, or find suitable alternatives when organising low contractible arrangements given the absence of relational controls in public sector settings. This extends Cristofoli et al.'s (2010) work by explaining why control archetypes developed for low contractible arrangements in for-profit settings may not be suited to public sector settings, and that this is driven by financial probity. I also reinforce their concerns that theory developed in other settings should be applied cautiously to PSOs and preferably re-examined.

Identifying how different types of probity can be satisfied across outsourcing arrangements offers opportunities to PSOs to target the use of arrangements to satisfy probity and minimise costs to both the PSO and partners. Further, this may also identify mechanisms to reduce risk to the PSO where probity requirements are not fully understood. Financial probity and how it may be satisfied appears to be well understood. However, standardised arrangements that satisfy financial probity do not necessarily suit social probity requirements; where standardised arrangements are applied, this could leave the PSO exposed.

The strength and consistency of the effect probity has on controls available to PSOs may vary in different jurisdictions depending on whether probity requirements are mandated (as they are in Australia). For example, in a survey of 290 municipalities in Sweden, Johansson and Siverbo (2011) show PSOs may deal with cooperation hazards differently across jurisdictions. Probity requirements may vary by jurisdiction, making public sector studies from different jurisdictions difficult to compare (Malmi et al., 2020).

The second contribution extends the work of earlier scholars (Williamson, 1999) and contributes to both the inter-organisational management control and TCE literatures by providing greater understanding of how different types of probity may be satisfied across an outsourcing arrangement and how financial probity is likely to dominate. Not only does financial probity determine control strategies used by PSOs, financial probity also determines controls strategies that cannot be used. Notably, financial probity leads to a reliance on bureaucratic controls and the exclusion of relational controls, even in environments of low contractibility. This helps explain why control archetypes developed for low contractible activities in for-profit settings are unlikely to be suited to public sector settings, extending the work of Cristofoli et al. (2010). While this is unlikely to affect arrangements of high contractibility, this creates tensions where the public sector is seeking to organise and control low contractible arrangements.

1.5.3 Explaining how the tension between low contractibility and probity can be resolved

My third contribution relates to the use of an intermediary model — where the PSO outsources to an intermediary organisation who then contracts with service providers — to enable the public sector to organise and control the outsourcing of human services. The intermediary model enables a PSO to organise and control outsourcing when there is both low contractibility and expectations of probity.

An intermediary model can be used to purposely change the contractibility of the outsourcing arrangement. First, the model changes the nature of what is contracted over by the PSO, moderating the tension between the low contractible activity and the bureaucratic context in which the outsourcing takes place. Second, the model changes the boundary conditions where the low contractible services are organised. Both steps allow greater control alignment, with the PSO relying on bureaucratic controls to manage PSO–Intermediary relation (Johansson & Siverbo, 2011), while the intermediary is able to use a mix of bureaucratic and relational controls to manage the low contractible Intermediary–Provider relation. This extends inter-organisational management control outsourcing literature by identifying an *ex-ante* model that moderates the contractibility of an activity (Barretta & Busco, 2011), and increases control alignment, by changing the context in which services of low contractibility are managed. Unlike prior studies, this mechanism increases contractibility without changing the nature of the services being delivered (Bracci & Llewellyn, 2012).

I extend theory developed in the economics literature and bring it into the management control literature by explaining how the intermediary model differs from supply chain arrangements (Gallet, O'Flynn, Dickinson, & O'Sullivan, 2015; Podemska-Mikluch & Wagner, 2013; Reusen & Stouthuysen, 2017). Compared to a supply chain based on dyadic arrangements (including the prime provider model; Gallet et al., 2015; Reusen & Stouthuysen, 2017), or increasing the contractibility of services provided (Bracci & Llewellyn, 2012), the intermediary model uses, by design, a third-party to facilitate the delivery of a program. This differs from the 'triadic-by-assertion' model where a party inserts itself into a dyadic relationship for its own benefit, and a 'triadic-by-invitation' model where the dyadic partners invite a third-party to facilitate a relationship — both of which occur *ex-post* (Podemska-Mikluch & Wagner, 2013). The facilitating role of the intermediary, and indeed the characteristics of the intermediary, are part of the program design (*ex-ante*) and hence is 'triadic-by-design' and is used by the PSO as a way to organise and control the outsourcing arrangement in what appears to be a way to address the tension presented by managing a low contractible activity in a highly bureaucratic environment (Johansson & Siverbo, 2011).

The third and final contribution extends the inter-organisational management control outsourcing literature by identifying a mechanism by which PSOs are able to organise and

control the outsourcing of low contractible activities in highly bureaucratic environments. While prior studies have examined the use of chains of dyadic relations used to outsource a service, or increasing the contractibility of services provided, this study demonstrates the use of a triadic-by-design intermediary model (extending Podemska-Mikluch & Wagner, 2013). The use of an intermediary changes the nature of what is contracted over directly by the PSO, and changes the context in which the low contractible services are contracted over to one not limited to bureaucratic controls. Changing the nature of what is contracted over directly by the PSO moderates the contractibility of the human services in the outsourcing arrangement. Importantly, in this context, this leaves the low contractible services unchanged (critical given the complex and individual needs of clients).

1.6 Practical contributions and implications

There are a number of contributions and implications arising from this thesis that may help inform practice. The insights from this thesis may help PSOs understand why some services are difficult to contract over, and help inform the design of arrangements to ensure low contractible activities are organised and controlled efficiently and effectively.

The thesis provides clarity around what probity is and how it can be managed. Understanding the different sources of probity (party/context and nature of service) and different types of probity (financial and social), and when they arise across the procurement process, will enable a more efficient targeting of probity arrangements by PSOs. Understanding what probity requires (bureaucratic controls) and prevents (relational controls), and the implications of probity on managing activities of low contractibility, will allow PSOs to make informed governance choices that meet probity requirements *and* address other transaction characteristics present.

Given the tension between probity and low contractibility, PSOs may benefit from intermediary models that moderate contractibility across the outsourcing arrangement. The intermediary model described in this thesis enables PSOs to increase the contractibility of the immediate relation. The model then allows low contractible services to be managed by an intermediary who is able to use a mix of bureaucratic and relational controls.

Finally, the intermediary model is likely to succeed in the case setting for a number of reasons. The success of this model is due to the design choices, particularly in the characteristics of the intermediary itself. The commissioning of services was not carried out in isolation; in the case setting, the intermediary had other roles and responsibilities in relation to improving primary health, thereby improving its knowledge-base and ability to promote and monitor services commissioned. Further, the culture and knowledge of intermediary staff were aligned with the program objectives, and were proactive in achieving results and solving problems. The model, however, is at risk from the way it is being implemented — primarily due to the level and

duration of resourcing, over specification of requirements, and also due to the complex landscape in which the model operates.

1.7 Thesis structure

The remainder of this thesis is structured as follows. The next chapter provides the context of this thesis, first by describing the construct of outsourcing and what differentiates outsourcing from other inter-organisational arrangements, and then by providing the context of human service outsourcing in Australia (Chapter 2). Drawing on the literature, TCE is then used to develop a conceptual framing of the transaction characteristics likely to affect public sector outsourcing of human services (Chapter 3) and the control strategies likely to be used in public sector settings (Chapter 4) once the decision to outsource has been made. This shows why human services are likely to be difficult to contract over and what control strategies we would expect to observe when they are outsourced. Chapter 5 then presents the research design, explaining the design choices made and how the design aligns with the objective of the study.

The next two chapters present the case description and the control strategies observed over the outsourcing arrangement. Chapter 6 presents the observations for the PSO–intermediary relation, and Chapter 7 presents the observations for intermediary–provider relations. Chapter 8 presents the analysis, focusing on how probity requirements and low contractibility, and the tension between them, are managed across the intermediary model in this setting. The implications of the analysis on theory and the contributions are described in Chapter 9. Finally, Chapter 10 provides the overall conclusions, implications, limitations, and opportunities for further research.

Chapter 2 Context of outsourcing human services

2.1 Introduction

This chapter defines the contextual setting for the thesis. First, I review the inter-organisational management control literature and identify what outsourcing is by explaining how it differs from other inter-organisational arrangements (Section 2.2). Second, I identify the context of public sector outsourcing of human services. I start by describing the trends in public sector outsourcing (Section 2.3), and then explain the scope of human services (Section 2.4), and how and why they are outsourced (Section 2.5). Together, this explains the location of this study and highlights why the public sector outsourcing of human services is an important empirical setting.

2.2 What is outsourcing?

Organisations are unlikely to be self-sufficient and do everything themselves (Demsetz, 1988; Tolbert & Hall, 2010). Organisations may enter into inter-organisational arrangements that may vary in their legal structure, the relationship between parties, and the level on ongoing control or oversight required. They range from easy to identify legal partnerships and joint ventures to simple market transactions. The purpose of this section is to identify the characteristics of outsourcing; specifically, what differentiates outsourcing from other types of inter-organisational arrangements.

2.2.1 Variation in the definition and treatment of outsourcing by scholars

The term outsourcing is commonly used in management accounting and other literatures, but is not always well defined (Bai, Coronado, & Krishnan, 2010; Balakrishnan et al., 2010; Donada & Nogatchewsky, 2006; Johansson et al., 2016; Lamminmaki, 2008; Minnaar, Vosselman, van Veen-Dirks, & Zahir-ul-Hassan, 2017; Sedatole, Vrettos, & Widener, 2012), perhaps relying on the literal definition ‘to obtain by contract from an outside supplier; to contract (work) out’ (Concise Oxford English Dictionary, 2011).

When outsourcing is defined, or when the literal definition to ‘contract out’ is relied upon, it is unclear what differentiates outsourcing from other forms of inter-organisational arrangements, and in particular from market arrangements (Christ, Mintchik, Chen, & Bierstaker, 2015; Gómez-Conde, 2015; Johansson, 2008; Langfield-Smith & Smith, 2003). For example, Christ et al. (2015, p. 80) define outsourcing as ‘the delegation, through contract, of resources and/or services to an external provider’, while Langfield-Smith and Smith (2003, p. 282) define outsourcing as ‘the contracting of any service or activity to a third-party’; however, this potentially describes a wide range of contractual relations. Both the literal definition of

outsourcing, and definitions used in the literature to date, have a basic premise that the activity was originally performed internally (i.e. controlled vertically within the organisation) — although Nicholson et al. (2006, p. 239) add, 'normally, but not always, performed in-house'.

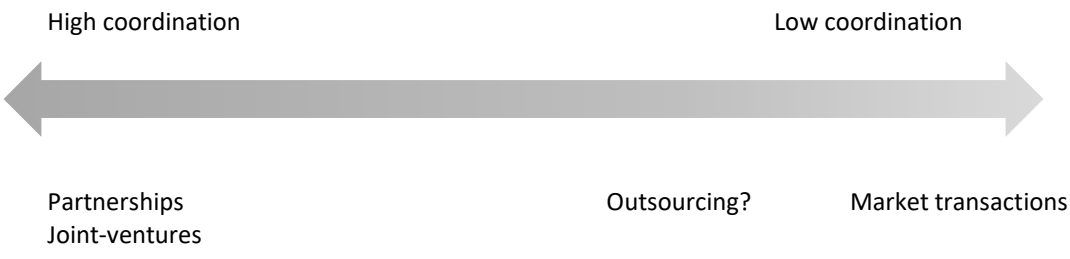
Scholars also treat outsourcing differently either focusing on the decision to outsource, how outsourcing is organised, or how the outsourcing arrangement is controlled (one of the few studies to consider all phases is Johansson & Siverbo, 2011). The lack of clarity in the definition and treatment of outsourcing is not unique to the management accounting literature (Eckersley & Ferry, 2020; Lankford & Parsa, 1999). The remainder of this section seeks to identify what outsourcing is for the purpose of this thesis.

2.2.2 Distinguishing outsourcing from other inter-organisational arrangements

In their simplest form, inter-organisational arrangements occur across the legal boundary of a firm (Hopwood, 1996; Otley, 1994), and include inter-dependencies between organisations at their 'strategic boundaries' (Mouritsen & Thrane, 2006, p. 244). Activities arranged beyond the boundary of an organisation need to be organised and controlled to ensure cooperation (to minimise opportunistic behaviour) and coordination (to manage inter-dependencies) between parties to achieve the desired outcomes (Anderson et al., 2015; Anderson, Glenn, & Sedatole, 2000; Coase, 1937; Dekker, 2004; Demsetz, 1988; van der Meer-Kooistra & Vosselman, 2006).

Different types of arrangements may be identified by the nature and extent of co-ordination required (DeHoog, 1990; Kettner & Martin, 1990; Williamson, 1985). Partnerships, hybrids and joint ventures require high levels of embedded coordination making them easy to distinguish (and are not discussed further); by comparison, market transactions generally require lower levels of coordination (Padovani & Young, 2006) (shown in Figure 1 below).

Figure 1 Inter-organisational arrangements based on different levels of coordination



The nature and extent of coordination required may help differentiate between inter-organisational arrangements at a high-level; however, where there are similarities between arrangements (such as market transactions and outsourcing) scholars require a more nuanced understanding of why the nature and extent of coordination varies.

The level of coordination (control) required is often driven by the strategic importance of the activity and the required continuity of association or control. Harold Demsetz, in *The Theory of the Firm Revisited*, differentiates between market transactions and managed coordination, by:

> …the **degree of conscious direction**… minimal in spot market transactions, but more important **in a context in which continuity of association is relied upon**. The direction of some by others catches the spirit of managed coordination… Specialization, continuity of association, and reliance on direction are characteristics of firm-like coordination. (emphasis added, Demsetz, 1988, pp. 155–156)

Specific to public sector outsourcing, Jensen and Stonecash (2005, p. 769) add, 'outsourcing enables the government to **retain control** over the specification of the service, the management of the contract and the evaluation of the service provider's performance' (emphasis added).

Roodhooft and Warlop (1999, p. 364) include the term 'vertical de-integration' in their definition of outsourcing (also considered by Gómez-Conde, 2015; Johansson, 2008) — highlighting a switch from internal to external vertical coordination (also identified by Tomkinson, 2016), suggesting an outsourced activity requires ongoing oversight. Other scholars highlight a 'specific embeddedness' is required to 'guarantee' delivery and retain the benefits of outsourcing (van der Meer-Kooistra & Vosselman, 2000, p. 51). They also suggest that close forms of cooperation are required when outsourcing essential components and services, such as activities key to the value chain[6], or where there is high uncertainty (van der Meer-Kooistra & Vosselman, 2000). This confirms the strategic nature of outsourcing and suggests more coordination is required, compared to other market transactions, to ensure the activity is delivered (Dekker, Ding, & Groot, 2016).

Consideration of whether an activity is a 'strategically relevant segment' (Shank & Govindarajan, 1992, p. 180) in a value chain also helps explain why there is such variance in what is considered to be outsourcing as opposed to a market transaction. An activity outsourced by one organisation may be a simple input or output in another organisation depending on the activity's strategic relevance. Aulich and Hein (2005) go further and differentiate between different types of outsourcing, including pragmatic outsourcing (driven by cost), tactical outsourcing (driven by short-medium term adjustments in the organisation), and systemic outsourcing (longer-term changes to power distribution).

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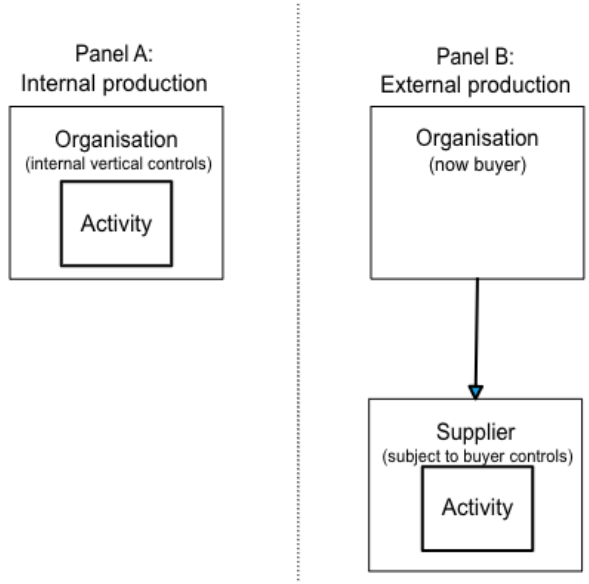
[6] van der Meer-Kooistra and Vosselman (2000) refer to the strategic cost management literature in relation to the value chain approach (also recognised by Dekker, 2003). A value chain is a 'linked set of value creating activities' (Shank, 1989, p. 50); an activity in a value chain is a distinct activity that will be influenced by other activities (and vice versa) in that chain (Shank & Govindarajan, 1992).

The strategic importance of an activity, and the subsequent need for ongoing coordination, may also explain why outsourced activities do not morph into market transactions over time — by their very nature they require *ongoing* managed coordination. Expressed differently, outsourcing is vertical in nature in that the buyer makes a strategic decision to engage another party (or parties) to undertake an activity, but the strategic importance of the activity requires the buyer to retain a level of control over the activity through the inter-organisational arrangement. While the activity is de-integrated (external to the organisation), it remains vertical, and coordinated by the outsourcing organisation, represented in Figure 2.

Figure 2 Vertical coordination following the switch from internal to external production



The strategic importance of an activity appears to be a clear driver of the level of control required, linked to both the value chain and whether the activity is easy to replace (related to the specificity of the activity). PSOs, like any organisation, have strategically relevant distinct activities that are part of a broader value chain, as well as a range of peripheral activities. Value chains of PSOs are likely to include activities that meet their strategic objectives (for example, improving socio-economic participation or improving health outcomes).

2.2.3 Summary

In this section I have identified what differentiates outsourcing from other market activities and how this may be demonstrated in PSOs. Outsourcing is an inter-organisational arrangement that forms a significant part of an organisation's value chain which, compared to other market transactions, requires ongoing managed coordination. The remainder of this chapter explores outsourcing by PSOs and specifically the outsourcing of human services.

2.3 Trends in public sector outsourcing

The public sector, over time, has changed significantly in size and responsibility. Two centuries ago, the public sector was small, provided minimal services, contracted commerce to deliver infrastructure and other services, and relied on charities and religious organisations to provide support to the poor (APSC, 2013). During the Twentieth Century the public sector grew substantially, providing logistics and intelligence during war time, and support for post-war recovery and growth through a 'monopoly of services and utilities' (Broadbent & Guthrie, 1992, p. 7).

In the 1990s, the public sector began to shrink (in terms of number of employees) and change the way it supported individuals. This can be attributed to micro-economic reform, the rise of new public management, the rise in costs and demand for services, the greater consideration of cost-efficiency and performance management, and a loss of confidence in the public sector (Barretta & Busco, 2011; Brinkerhoff, 2002; Butcher & Dalton, 2014; Gallet et al., 2015; Gregory, 1999; Hood, 1995; Kraus & Lindholm, 2010; Kurunmäki, 2009; Miller & Rose, 1990). New public management introduced economic rationality and efficiency to public sector activities (including performance measurement; Speklé & Verbeeten, 2014), bringing with it a separation of administrative and political control of services, a growth in organisational forms, a growth in services provided by third-parties, and increased competition (Broadbent & Guthrie, 1992, 2008; Christensen & Lægreid, 2015).

Governments around the world have increasingly sought other ways to deliver services (Hood, 1995). This includes establishing Public Private Partnerships (PPPs; often associated with long-term activities or large capital works), networks or internal markets (for example, health care in Australia and the UK), cooperation between PSOs (for example, co-procuring waste management or aged-care), and outsourcing (ranging from Human Resources and IT services, to social supports) (Kraus & Lindholm, 2010; Sasse et al., 2019). The public sector started by outsourcing services that were highly contractable (such as waste management), and with growing experience and increasing political pressure began to outsource moderately contractable activities (such as finance, IT and HR), and subsequently low contractable human services such as justice (prisons), disability, aged-care, and mental health services, delivered both by non-profit and for-profit organisations (Aulich & Hein, 2005; Johansson & Siverbo, 2011). Outsourcing is now 'so enshrined in public sector culture that neither its very existence nor effectiveness is ever questioned' (Spurgeon & Hicks, 2003, p. 188).

With this increase in outsourcing came new challenges of planning and managing services, and balancing accountability, performance and public confidence (Legislative Assembly of NSW, 2013). Outsourcing of services can and does fail. For example, the UK has witnessed a number of high-profile contract failures by G4S (London Olympics, electronic tagging of offenders,

young offenders facility, immigration centre, HMP Birmingham prison), Serco (electronic tagging), Capita (court translation, infrastructure management, army recruitment), and Atos (work capability assessments), that resulted in contracts being terminated or providers being fined (Sasse et al., 2019). In addition, two of the UKs largest providers — Carillion (construction and services) and Interserve (probation services and cleaning) — collapsed, and declining profitability deterred others from participating in the market (Ibid.). Outsourcing does not necessarily address the loss of confidence in the public sector, although government is able to attribute failures to other parties (Greer, Breidahl, Knuth, & Larsen, 2017).

Where outsourcing fails to deliver, services may be brought back in-house (Bawden, 2019; Marvel & Marvel, 2007; Petersen, Houlberg, & Christensen, 2015; Sasse et al., 2019), also termed insourcing, re-municipalising, renationalising and decommissioning (Bovaird, 2016), internal organisation or internalisation (Williamson, 1971), or vertical integration (Williamson, 1979). Williamson suggests integration when moral hazards and externalities are high, or where there is no market (or there is a monopoly), suggesting integration is a 'relatively extreme response' (1971, p. 119). This recognises that some services need to remain in or be brought back into the public sector to be efficient and effective (Jensen & Stonecash, 2005).

Australia is one of the strongest adopters of new public management in the OECD (Hood, 1995), although varying across the states and territories. For example:

> In addition to slashing expenditure and services, the Kennett Government [1992–1999 in Victoria, Australia] initiated an extensive contracting out (outsourcing) program. **So wide reaching was this program that it was said to be governed by the "Yellow Pages" principle**. That is, any activity carried out by a government entity which could be sourced from a supplier able to be located in the Yellow Pages telephone directory should be subject to competitively neutral market testing and contracting out. (emphasis added, Carlin, 2004, p. 270)

Failures in outsourcing in Australia are not uncommon. The transportation of convicts to Australia resulted in high mortality rates; this experience led to changes in the way contracts were specified (Sturgess et al., 2016). Where outsourcing fails, services have also been insourced; for example, the Queensland Crime and Corruption Commission's Taskforce (Taskforce Flaxton) recommended two underperforming privatised prisons be returned to public sector control (Queensland Government, 2018; Vujkovic, 2019).

Public sector outsourcing is far from new, although has grown substantially following the advent of new public management. Services can fail and may be brought back into the public sector to ensure their safe delivery. Failures in outsourcing continue to be observed, suggesting that public sector outsourcing would benefit from further study. As introduced in Chapter 1, the focus in this thesis is the outsourcing of human services because of their social and economic

significance. The remainder of this chapter provides the conceptual specification of human services and how they are outsourced by the public sector in Australia.

2.4 The scope of human services in Australia

Human services support economic and social participation, address inequality, and contribute to the wellbeing of individuals and the broader community (Productivity Commission, 2016a). The 1940s saw a rise of human services and social insurance provided by governments (Miller & Rose, 1990), who recognised the supports provided by charities and the church were unable to address inequality. In Britain, the rise of human services was attributed to William Beveridge's blueprint for a universal 'cradle to grave' system for social insurance and allied services (Beveridge, 1942)[7] — an approach that has been replicated to various extents around the world. Human services include social protection (financial supports) and person-to-person supports, both of which are designed to improve individual wellbeing as well as provide longer-term savings (Ritter et al., 2014). This thesis focuses on the public sector provision of person-to-person human services.

Human services are provided across the life-course; for example, early childhood, child protection, families, youth, domestic violence, primary health care (including mental health, alcohol and other drug treatment programs), disability support, aged-care, corrections/justice, (un)employment, housing, homelessness, employment, as well as programs targeting the wellbeing of specific populations. Access to and use of services will vary depending on the individual and may involve a multi-agency response (Kominis & Dudau, 2012).

> While some individuals and families (henceforth: clients) may need only a specific service over a short time-period to help them cope with a particular problem or situation, many clients face chronic problems. The fundamental causes of these problems are deeply rooted in childhood or family history and compounded by endemic poverty. They are the source of recurring and alternating dysfunctionalities in several related spheres of social functioning. (Harvey, 1992, p. 100)

Estimating service need is difficult. In Australia, in addition to rising inequality, disadvantage is particularly high for people with a mental health condition, people with disability, migrants and Aboriginal and Torres Strait Islander populations (ABS, 2015a; OECD, 2017). The Australian Government produces an annual *Report on Government Services* that reports expenditure on

[7] Beveridge originally identified five challenges: want, disease, ignorance, squalor and idleness. In 2017–2018, the London School of Economic reviewed Beveridge's work and reframed the challenges, under Beveridge 2.0, as poverty, health and social care, education and skills, housing and urbanisation, and the future of work — as well as the interrelationships between the themes. See http://sticerd.lse.ac.uk/_new/research/beveridge/ (accessed 18 November 2020).

services (Productivity Commission, 2020b, 2020a), indicating what the government is willing to spend. This figure is unreliable as it does not include unmet need (Henderson et al., 2018). [8] Neither does it include informal (unpaid) support provided by family and others to either substitute or supplement formal supports (ABS, 2015b); in 2015, Deloitte Access Economics (2015) estimated it would cost $60.3bn/year to replace the hours of care provided by unpaid carers in Australia.

In Australia, human services are provided by a combination of national, state/territory, and local government, as well as private providers (PwC, 2016). This creates a complex, often fragmented policy and service environment for individuals to navigate; this is further complicated by outsourcing service delivery to third-parties (discussed in Section 2.5 below). In Australia, services may be easier to access in metropolitan compared to rural/remote areas due to economies of scale; there is also evidence of higher rates of poverty in rural/remote communities (ACOSS & UNSW, 2018).

The way services are provided is also changing, from passively receiving services to services being self-directed or client[9] driven — something referred to as active rather than passive citizenship (Henderson, Freeman, Javanparast, Ziersch, & Baum, 2019; Miller & Rose, 1990). This makes each program and the way it is provided to individual clients idiosyncratic. Service delivery goes beyond the allocation of resources (Samuel et al., 2008), and more to the ideological nuance of how clients experience services, whether they are delivered in a culturally acceptable way, and how this impacts on their wellbeing (Petersen et al., 2015). The need to be more active in the use of services may also mean services are inequitable across society; individuals who have capacity, or are supported by an advocate, can navigate the system and are more likely to receive services needed. In human services, clients do not always know what they need, what is available, or what they are entitled to, and their use of services may or may not involve a financial transaction.

Understanding what services are available is not just a problem for the person needing services, but may also be an issue for their carer, primary care provider (such as their General Practitioner; GP), or other service provider (NZ Productivity Commission, 2015). Providers also need to know who else is supporting a client to coordinate care and improve outcomes. Within

[8] For example, the Alcohol and other Drug treatment (AOD) sector has also been historically underfunded (highlighted in 'Half a Million Steps' https://nswact.uca.org.au/social-justice/the-social-justice-forum/fair-treatment-campaign/, accessed 5 December 2020); many services are under-resourced — 'clients are falling through the gaps, services are not working together, or they just don't have the resources available to link in and work together' (*Interview 4*).

[9] The terms 'client' and 'consumer' are often used by PSOs to describe individuals and groups of individuals who access or potentially access human services. The terms are used interchangeably.

some service areas, coordinated client support programs[10] are provided to help clients navigate and engage with the appropriate services. Such programs address both service fragmentation and the bureaucracy associated with accessing services, while acknowledging integration may be a chimera (Leutz, 1999).

Human services include a wide range of financial and person-to-person supports that help individuals, throughout their life-course, participate in social and economic activities. The way human services are provided has changed to become more person-centred, focusing on individualised self-directed supports. Services are provided directly and indirectly by different PSOs across each level of government in Australia (Commonwealth, state/territory, and local), as well as by private providers, making the policy, funding and service context fragmented and difficult to navigate for both professionals and clients. This is further complicated when services are outsourced.

2.5 Public sector outsourcing of human services

Human services have not been immune to institutional reforms in countries around the world. Focusing on the Australian context, in 2008–2009, AIHW estimated 59% total expenditure on welfare services ($24.8bn) was administered by other parties (AIHW, 2015, p. 37). The Productivity Commission (2016a) later estimated expenditure on outsourced services at $35–45bn per annum, depending on what was included within the definition of human services.

PSOs outsource many different human services, often relatively small arrangements (compared to overall PSO service budgets), to predominantly non-profit but also for-profit providers (for an example, see the detailed expenditure reported by NSW FACS, 2015). This may spread risk and reduce the risk of hold-up (Brown & Potoski, 2005), particularly given non-profit providers are assumed to have similar values to PSOs and not be motivated by profit (Johansson & Siverbo, 2011).

Each PSO, responsible for the delivery of human services, may outsource multiple services to multiple organisations; therefore, human services become further fragmented, and difficult to navigate, access and monitor (Australian Government, 2017). This creates risk of both under-servicing and over-servicing.

> Examples of this fragmentation, duplication and inefficiency abound. The remote community of Jigalong in Western Australia received 90 different

[10] Examples can be observed in the Department of Veterans' Affairs http://www.dva.gov.au/i-am/ex-service-organisation/coordinated-client-support (accessed 27 January 2017), and Victorian Health https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination (accessed 27 January 2017).

> social and community services in 2013–14 for a population of less than 400 (WA DPC 2014). The Aboriginal Medical Services Alliance NT [Northern Territory, Australia] gave another example of a remote community in Central Australia where about 400 people receive social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis. (Productivity Commission, 2016a, p. 134)

Where clients require more than one service, there is a risk of poor coordination of care between services (Stafford & Stapleton, 2017), and difficulties attributing outcomes to one particular service or intervention (Kominis & Dudau, 2012). The distance between PSOs and services is increasing, with some programs being delivered through sub-contractors (Gallet et al., 2015); clients are unaware who is providing or funding the service they are receiving (Zmudzki, Griffiths, & Bates, 2017), creating difficulties when problems are encountered compared to when PSOs deliver services directly (Brown & Potoski, 2005).

2.5.1 Reasons to outsource human services

PSOs, like any organisation, outsource services for multiple reasons, not just in pursuit of efficiency (Petersen, Hjelmar, & Vrangbæk, 2018), but also for practical, relational and strategic (political) reasons (APSC, 2013).

Economic reasoning is a major but not necessarily the dominant consideration in public sector outsourcing (Domberger & Rimmer, 1994; Jensen & Stonecash, 2005; Petersen et al., 2018). Governments seek greater efficiency and believe this may be achieved through market competition (Butcher & Dalton, 2014). For example, PSOs may seek efficiencies by jointly procuring services with other agencies (Bovaird, 2016). There is nothing good or bad about markets; both good (virtuous) and bad (illicit) markets exist, determined by what the market delivers and how (e.g. health care vs illicit drugs; Braithwaite, 2018). This also assumes markets exist and efficiencies can be made, possible in Australian metropolitan areas but less likely in rural/remote Australia.

There are also practical considerations. PSOs are increasingly bureaucratic, restricting the nature and flexibility of services delivered to the extent they become ineffective (Raven, Bates, Kayess, Fisher, & Hill, 2014; Wilson, 1989). PSOs may also outsource services to take advantage of positive relationships between specific services and cohorts/clients (Aulich & Hein, 2005; Bovaird, 2016; Brinkerhoff, 2002; Brown & Potoski, 2005; Butcher, 2018; Hood, 1995). This may allow PSOs to deliver services through less intrusive, more responsive organisations that are able to offer greater choice to clients (Butcher & Dalton, 2014; Zmudzki, Griffiths, Bates, Katz, & Kayess, 2016; Zmudzki et al., 2015). This is particularly useful where people have complex or poor relationships with PSOs, institutions or authority.

Strategic (political) considerations will also influence whether to deliver services directly. There may be reasons for government to distance itself from services, such as asylum seeker detention centres; conversely, there may be reasons services are non-contestable (cannot be outsourced), including for security reasons, or where it is not socially acceptable to outsource (Aulich & Hein, 2005; Bovaird, 2016; Davidson, 2011; Dickinson et al., 2013; Durham & Bains, 2015). In Australia, despite repeated and significant failures, public inquiries continue to recommend the outsourcing of human services (Productivity Commission, 2010, 2011, 2016a, 2019) and suggest ways to overcome many of the problems encountered, including overseeing services and using broader commissioning processes to ensure client needs are identified and met (Productivity Commission, 2016a).

In summary, PSOs may outsource human services for a number of reasons — each of which could be potentially internalised as part of the economic decision to outsource. PSOs may be constrained in services they can deliver, be inefficient, and have poor relations with clients — impacting clients accessing and gaining benefits from services. In contrast, third-party providers may be able to respond flexibly, more efficiently, and have good relations with potential clients — making services easier to deliver and access, and therefore potentially more effective and efficient.

2.5.2 Different approaches to outsourcing human services

PSOs are often limited in how outsourced human services are organised, including the type and duration of inter-organisational arrangements they may enter into. Limitations may arise due to procurement rules, the nature of the activity, the market, and the funding (and duration of funding) available, and may vary by jurisdiction (Department of Finance, 2017). In addition, there have been a number of changes to how human services outsourcing is organised within these limitations.

PSOs are increasingly using contestability frameworks to determine whether services are contestable and therefore open to market competition, or non-contestable and performed internally (PwC, 2019). Contestability frameworks are developed in consultation with key stakeholders and consider factors such as whether or how a service aligns with other services, how critical the service is (and what is dependent on it), the level of risk (service continuity, sustainability, connectivity, uncertainty), whether there is capacity and interest to deliver services in the market, and whether outsourcing is acceptable to stakeholders (PwC, 2019). Once a service is deemed contestable, the PSO can go to the market and invite proposals (including from PSOs), and service offerings can be compared.

PSOs are changing the way outsourcing arrangements are organised, from contracting inputs and processes, to including performance or results, and placing the onus on providers to

demonstrate outcomes (Behn & Kant, 1999; Broadbent & Guthrie, 1992; Hood, 1995; Martin, 2005). This has been accompanied by a shift from outsourcing to commissioning, broadly defined as a continuous cycle of identifying and prioritising needs, purchasing and monitoring services, while engaging clients throughout the process (Dickinson, Gardner, & Moon, 2017; Harris et al., 2015). In theory, PSOs can commission services to meet specific outcomes, allowing flexibility in how outcomes are achieved.

PSOs are also experimenting with different forms of outsourcing. For example, PSOs may contract a 'prime provider' to organise and manage a *service* delivered by sub-contractors (akin to a supply chain) (Gallet et al., 2015). Prime provider models can vary in scope, size, partners, and governance (Ibid.). This approach has been criticised for increasing the distance between the PSO and the client, and therefore decreasing the accountability of government (Bovaird, 2016; Gallet et al., 2015). One such arrangement has been subject to a public inquiry following concerns of underperformance, lack of experienced staff, lack of clinical governance, high cost/poor value, and lack of accountability (Australian Government, 2017).

Finally, markets are also extending directly to clients through micro-commissioning (Bovaird, 2016). Rather than bulk buying services, PSOs allocate budgets (a 'package') based on a needs assessment; clients then choose what services to purchase from where within the terms of that package (used in disability services in Australia). Client driven services, while satisfying from a human rights perspective as the person has increased agency, assume: (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). In switching to this model, PSOs have a new problem of how to ensure choices exist and people have agency, while also protecting vulnerable people from opportunistic providers (from either over pricing, over selling, or under delivering services; for example, see ABC News, 2020).

Whatever form of outsourcing is used, the increased demand for outcome measures leaves funders, providers, researchers and evaluators wrestling with how to identify and attribute outcomes to any one program (including informal supports). There may be a considerable time lag between the program (intervention) and outcome — possibly even decades. Even where anticipated outcomes are observed, attribution to a program may be impossible (Banerjee & Duflo, 2012; Bewley, George, Rienzo, & Portes, 2016).

2.5.3 Summary

Public sector outsourcing of human services has a long history. Human services can and do fail, outsourced or not, the results of which can have long lasting impacts on service recipients, their families, and society as a whole (evidenced by a series of Royal Commissions examining the abuse of children, people with disability and older generations in different service settings).

Despite this, there remains many economic, practical, relational and strategic reasons to outsource human services. PSOs need to 'find modes of delivery (public, private or community) that are most likely to be effective, assessed not just on the basis of cost but on the public value that is created' (Shergold, 2017, p. 8). This is challenging given services are difficult to specify and measure, services are often tailored to address individual complex needs, and outcomes — if observed within the life of the program — are nearly impossible to attribute to a particular intervention.

2.6 Chapter summary

This chapter first reviewed the relevant inter-organisational management control literature and identified the key characteristics of outsourcing — and in particular, what differentiates outsourcing from other market-based activities. This provided a conceptual definition of outsourcing that underpins this thesis. The chapter then explained the empirical context of the thesis — the public sector outsourcing of human services. I explained that human services are a particularly complex area of service delivery; both the need for human services and the type of services available are diverse and often poorly understood. The scale of human services outsourcing, the complexity of services required, and the institutional characteristics associated with PSOs, mean that public sector outsourcing of human services provides a rich, interesting and socially important setting to explore the organisation and control of outsourcing arrangements further. The next chapter considers why human services are likely to be difficult to contract over.

Chapter 3 The low contractibility of human services

3.1 Introduction

This chapter identifies why the organisation and control of outsourced human services is likely to be challenging for PSOs. First, I introduce the theoretical lens used in this study — transaction cost economic (TCE) theory, how scholars have used TCE to problematise the control of inter-organisational arrangements (Section 3.2), and its relevance to public sector settings (Section 3.3). Second, I explain the underlying assumptions of TCE theory, each of the original transaction characteristics (asset specificity, uncertainty, frequency), and how each attribute is likely to manifest in the outsourcing of human services (Section 3.4). This explains why public sector outsourcing of human services are likely to be difficult to contract over, and therefore are likely to have low contractibility. Finally, given the late addition of the probity attribute to TCE, I identify the potential attributes of probity and how it may manifest in this setting, drawing on other literatures where relevant (Section 3.5).

3.2 TCE theory and its use in inter-organisational management control studies

Developed by Oliver Williamson, TCE theory provides a mechanism inclusive of law, economics and organisation to examine the economics (efficiency) of organisation and in particular the cost of contracting (Williamson, 1979, 1985). TCE theory assumes contracting hazards will occur due to bounded rationality and opportunism, the extent of which is determined by the transaction attributes.

TCE is often used as a theoretical lens in management accounting inter-organisational outsourcing studies to build understanding of transaction characteristics and how transactions are organised between firms to minimise transaction costs (Berry et al., 1995b).[11] Scholars have used TCE theory to help explain the decision to outsource, how outsourcing is organised, and how outsourcing is controlled (Anderson & Dekker, 2010).

Management control scholars use TCE to examine how particular transaction characteristics are managed (Covaleski, Dirsmith, & Samuel, 2003; Sartorius & Kirsten, 2005; Speklé, 2001; Vosselman, 2002; Williamson, 1991, 2005) and combinations thereof (for example, Langfield-

[11] For examples of inter-organisational studies, see Anderson, Christ, Dekker, & Sedatole, 2014; Anderson et al., 2000; Dekker, 2004, 2008; Ding, Dekker, & Groot, 2013; Krishnan, Miller, & Sedatole, 2011; Langfield-Smith, 2008; F. Miller & Drake, 2016; Reusen & Stouthuysen, 2017; van der Meer-Kooistra & Vosselman, 2006, 2000; Windolph & Moeller, 2012. For examples of outsourcing studies specifically, see Bai et al., 2010; Balakrishnan et al., 2010; Donada & Nogatchewsky, 2006; Johansson & Siverbo, 2011; Nicholson et al., 2006; Roodhooft & Warlop, 1999; Sartorius & Kirsten, 2005; Sedatole et al., 2012.

Smith & Smith, 2003; van der Meer-Kooistra & Vosselman, 2000), as well as individual arrangements (Langfield-Smith, 2008; Langfield-Smith & Smith, 2003; Minnaar et al., 2017; Nicholson et al., 2006; Nooteboom, 1993; Phua et al., 2011; Sartorius & Kirsten, 2005; van den Bogaard & Speklé, 2003; van der Meer-Kooistra & Vosselman, 2000).[12] TCE is also used in survey-based studies (Ding et al., 2013; Reusen & Stouthuysen, 2017) and to identify control archetypes, or patterns of control, suited to different types of inter-organisational arrangements based on the transaction attributes present.[13] Scholars suggest while multiple archetypes may be present, one archetype is likely to dominate (van der Meer-Kooistra & Vosselman, 2000, 2006). While archetypes ignore the individual nature and context of each transaction, and may oversimplify complex and nuanced dynamic processes (Caglio & Ditillo, 2008; Sartorius & Kirsten, 2005; van der Meer-Kooistra & Vosselman, 2000), they provide high-level insights about what we may expect to observe and offer scholars a framework for analysis. Combined, the inter-organisational management control literature using TCE provides a number of insights into transaction characteristics likely to be present and allows scholars to identify how they might be organised and controlled.

3.3 Relevance of TCE to public sector studies

While the majority of inter-organisational management control studies using TCE are located in for-profit settings, TCE is equally applicable to non-profit settings, including the public sector. Williamson highlights: 'transactions to which public sector governance is assigned pose added complications', where 'added complications' stem from the institutional context and/or the nature of public sector activities (Williamson, 1998, pp. 45–46).

Few scholars have applied TCE to public sector studies beyond the outsourcing decision (exceptions include Balakrishnan et al., 2010; Cristofoli et al., 2010; Roodhooft & Warlop, 1999).[14] While Johansson and colleagues have explored how outsourcing may be organised and controlled in public sector settings (Johansson & Siverbo, 2011; Johansson et al., 2016),

[12] This is often from the perspective of the buyer (Dekker, 2016). Few scholars examine the transaction from both perspectives (an exception beting Donada & Nogatchewsky, 2006) — a practice criticised by many, but potentially driven by the willingness of organisations to participate in studies rather than scholars' intention (Caglio & Ditillo, 2008; Dekker, 2016; Håkansson & Lind, 2004; Otley, 2016; Seal, Cullen, Dunlop, Berry, & Ahmed, 1999).

[13] For examples, see Caglio & Ditillo, 2008; Das & Teng, 2001; Dekker, 2004; Håkansson & Lind, 2004; Johansson & Siverbo, 2011; Langfield-Smith & Smith, 2003; Speklé, 2001; van der Meer-Kooistra & Scapens, 2008; van der Meer-Kooistra & Vosselman, 2000; Vosselman, 2002.

[14] Some accounting scholars are publishing in other literatures (for example, Ditillo et al. (2015) appears in *Public Administration*, and Johansson (2015) appears in *Public Management Review*). Given few public sector outsourcing studies are presented in the management accounting literature, this thesis also draws on other literatures.

neither studies use TCE (the first uses configuration and a systems approach, the second uses institutional theory).

Some scholars argue that decisions in the public sector are not economically rational; for example, there may be political explanations for public sector decisions (Johansson, 2015). As TCE ignores objectives that are not economising (Speklé, 2001), other theoretical lenses such as institutional theory may be seen as more relevant (Barretta & Busco, 2011). Economic theories have also been criticised for not considering the ethical dimension of public service (Gregory, 1999). I would argue that economic theory is as relevant to PSOs as it is to any other organisation on the basis that while not all choices appear to be economically rational, the cost of all choices can be internalised (see Section 2.5.1 above). I would also argue that specific attributes relating to the public sector context are explained through the TCE transaction characteristic of probity (Williamson, 1999), a characteristic that has been underutilised in empirical studies.

3.4 TCE theory and its application to public sector outsourcing of human services

TCE theory provides a mechanism to examine the economics (efficiency) of organisation based on the underlying assumption that, due to human nature, parties to the transaction are limited by bounded rationality and opportunism. Governance structures are used to economise on bounded rationality while safeguarding against possible opportunism (Williamson, 1985, p. xiii), the extent of which are determined by the transaction attributes present — identified in TCE theory as asset specificity, uncertainty, frequency and probity (the latter is discussed in Section 3.5). Understanding the transaction attributes provides an indication of how difficult an arrangement may be to contract over — the contractibility of the arrangement[15] — and can be used to inform the outsourcing decision in the first instance, while also identifying how outsourced transactions may be organised and controlled.

This section describes the underlying assumptions of TCE theory (bounded rationality and opportunism), the original transaction attributes discussed in the inter-organisational

[15] Speklé and Verbeeten (2014, p. 134) consider three cumulative conditions that relate to the contractibility of an arrangement: '(1) that goals can be specified unambiguously in advance; (2) that the organisation is able to select undistorted performance measures, i.e. metrics that provide incentives that are adequately aligned with the organisations ultimate objectives; and (3) that organisational actors know and control the production function that transforms efforts into results, and are able to predict the likely outcomes of alternative courses of action'. However, each of these conditions relate to uncertainty alone. In contrast, Johansson and Siverbo (2011) take a broader view where low contractibility of an arrangement is one that is difficult to govern, suggesting this may be driven by low measurability of outputs, poor knowledge of the transformation process, high asset specificity and probity. I take this broader view of contractibility, where transaction attributes make an arrangement difficult to contract over.

management control literature (asset specificity, uncertainty, and frequency) and how they are likely to manifest in the outsourcing of human services, and how together this contributes to the low contractibility of human services irrespective of the setting. In Section 3.5 below, drawing on other literatures, consideration is given to how the transaction characteristic of probity – the transaction attribute particularly relevant to public sector settings – is likely to further affect the contractibility of human services.

3.4.1 Underlying assumptions of bounded rationality and opportunism

People and organisations behave in a way that is intended to be rational; however, their behaviour is limited (bounded) by information available to them (Simon, 1997). If people are objectively rational, they identify alternatives, consider the impact of each alternative, and identify the best option from those alternatives. Herbert Simon (1997, pp. 94–96) identifies the limits of rationality as incomplete knowledge, difficulties of anticipation, and being able to conceive all possible patterns of behaviour.

TCE recognises that rationality is bounded; people and organisations, including public servants and PSOs, may be intendedly rational (therefore economising), but limitedly so, 'conceding that cognitive competence is limited' (Williamson, 1985, p. 45). Given bounded rationality, comprehensive contracting is unrealistic due to the cost of establishing governance structures where cognitive competence is limited.

Opportunism (self-interest seeking with guile) is a behaviour that maximises outcomes for an individual or an organisation (Simon, 1997; Williamson, 1979, 1985); examples include 'adverse selection, moral hazard, shirking, sub-goal pursuit, and other forms of strategic behaviour' (Williamson, 2000, p. 601). Opportunism may be minimised by ensuring parties have similar strategic objectives or values (Brown et al., 2006; Considine, 2003; Williamson, 2000); in outsourcing arrangements, parties may behave opportunistically, particularly where their strategic goals are misaligned.

Opportunism is not limited to organisations driven by profit. The public sector has historically outsourced most human services to non-profit organisations (PwC, 2016) with similar strategic objectives, values or purpose (Brown et al., 2006; Van Slyke & Alexander, 2006); this might be considered sufficient to minimise opportunism. However, non-profits may be just as susceptible to opportunism as for-profit organisations in delivering services on behalf of government. For example, they may target less complex clients who require less support ('creaming') or continue to provide services to clients who no longer need support ('parking') (Considine, Lewis, &

O'Sullivan, 2011; Considine & O'Sullivan, 2014; Dickinson, 2016; Eikenberry & Kluver, 2004; Hasenfeld & Garrow, 2012).[16]

As noted earlier, governance structures are used to economise on bounded rationality while safeguarding against possible opportunism (Williamson, 1985, p. xiii), recognising that '(1) all complex contracts are unavoidably incomplete (by reason of bounded rationality); and (2) contractual hazards sometimes await (by reason of opportunism)' (Williamson, 2009a, p. 151). Contracts therefore need to incorporate mechanisms that allow for residual transaction hazards to be managed *ex-post*. The extent of possible contracting hazards, and therefore the contractibility of an arrangement, is determined by the transaction attributes (Williamson, 1985).

3.4.2 Asset specificity

Asset specificity is the investment in specific assets (physical and human capital) that cannot be redeployed (Williamson, 1979, 1991, 1996, 2005). Asset specificity is claimed to have 'much of the explanatory power' of TCE (Williamson, 2008, p. 8), particularly in deciding whether to outsource (Roodhooft & Warlop, 1999), explaining governance structures (Langfield-Smith & Smith, 2003) along with transaction size (Johansson & Siverbo, 2011), and is often a determinant or characteristic of control archetypes (Speklé, 2001; van der Meer-Kooistra & Vosselman, 2000) including in public sector transactions (Williamson, 1999). Asset specificity may develop over the life of an arrangement as assets specific to the arrangement increase (Williamson, 1985).

In the context of human services provided by PSOs, asset specificity is likely to relate mostly to the investment in human capital needed to deliver services, as well as some investment in physical assets (Williamson, 1999). Investments may include hiring and training staff, developing systems and processes to deliver services (including clinical governance), providing mechanisms to capture data, establishing management and reporting mechanisms, and providing suitable property for staff to deliver services.

Asset specificity increases the risk of hold-up by the provider. Long-term contracts may further increase the risk of hold-up as investment in assets and organisational knowledge of the program increase. Asset specificity is also likely to be more problematic when matched by a decline in capacity of the buyer; this may manifest in a loss of in-house expertise to plan,

[16] In 2001, the Australian Productivity Commission was tasked by the Australian Government to investigate this issue in the job support sector (Considine et al., 2011). In response to the inquiry, under-servicing was addressed by increasing contract specification and internal controls.

organise and control the activity, or be the provider of last resort (Bovaird, 2016; Tomkinson, 2016).

The provider may also be at risk when required to invest in specific assets, especially for short-term contracts without assurance of continuation (Zmudzki et al., 2016). Specific assets, including staff, may be difficult for providers to maintain where contracts are short-term or renewed close to their expiration date (Griffiths et al., 2016). Short-term contracts may result in low investment in assets and possible under performance.

High asset specificity also has the potential to create bilateral dependency or mutual dependence (Johansson & Siverbo, 2011; Williamson, 1998). Over time, markets in activities associated with high asset specificity may be become smaller, limited to those with greater knowledge or bilateral dependency based on prior transactions — what Williamson (1985) calls 'fundamental transformation'.

3.4.3 Uncertainty

Williamson identifies two aspects of uncertainty: the ease at which something can be measured and disturbances to the transaction (Williamson, 1971, 1981a, 2008). Activities that are harder to specify and measure, subject to disturbances, and/or subject to information asymmetry, are likely to have greater uncertainty and require governance structures that are able to respond (Williamson, 1985). Given the multifaceted nature of uncertainty, Speklé (2001) rationalises uncertainty, differentiating between tasks that are programmable and those that are not.

Human services are inherently difficult to specify and measure; knowledge of the transformation process is often low, needs may change, tasks are complex, and outcomes are hard to measure and attribute (Bai et al., 2010; Barretta & Busco, 2011; Birnberg & Gandhi, 1976; Johansson & Siverbo, 2011; Speklé & Verbeeten, 2014). Flexibility of services is key to their success which makes human services difficult to translate into contracts and preplanning virtually impossible (Birnberg & Gandhi, 1976; Chapman, 1997). Outcomes may range from detectable changes (for example, a reduction in recidivism; Zmudzki, Griffiths, & Bates, 2017), to un-attributable changes (Bewley et al., 2016), to undetectable changes, to services being ineffective or causing harm[17], particularly when poorly specified and monitored (Jensen & Stonecash, 2005; Sasse et al., 2019). Identifying outcomes is further complicated as success

[17] For a recent example, see submissions to the public inquiry on 'Robodebt': https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Centrelinkcompliance (accessed 30 October 2020).

may be perceived differently by those who outsource, deliver or receive human services at different points in time (Shergold, 2004).

Human services are also delivered in unstable environments. Disturbances may arise from changes in policy, funding, organisations, and client need (see also Section 2.4; Anthony & Govindarajan, 2007; Otley, 2016; van der Meer-Kooistra & Vosselman, 2000). Arrangements therefore need to be monitored to determine whether adjustments are required. Not all disturbances are negative; while continuity of services is critical for the wellbeing of clients (DeHoog, 1990), social programs rarely remain static as they continually adapt to incorporate lessons learned, other evidence, as well as changes in needs (Birnberg & Gandhi, 1976).

A final consideration of uncertainty relates to information asymmetry between parties; this includes a lack of communication as well as strategic and sometimes opportunistic with-holding of information — referred to as behavioural uncertainty (Williamson, 1985). In human services, information generated through service delivery will remain with the provider and is unlikely to be shared with PSOs or other providers in its entirety, even where there is task interdependency (Johansson et al., 2016). Information asymmetry in human services may be exacerbated by differences in the type of organisation and its institutional environment (for example, law and policy; risk attitude; cultural and societal differences), as well as the cost of transferring information to others (Bellamy, 6, Raab, Warren, & Heeney, 2008; Nicholson et al., 2006).

Human services are likely to be difficult to specify and measure, and subject to both disturbances and information asymmetry, and consequently difficult to program (Speklé, 2001). By their idiosyncratic nature, human services are difficult to contract over — that is, uncertainty contributes to low contractibility. Uncertainty also interacts with asset specificity, making it ‘more imperative that the parties devise a machinery to “work things out”…’ (Williamson, 1985, p. 60).

3.4.4 Frequency

Frequency relates to the ‘frequency with which transactions recur’, where ‘frequency can be characterised as one-time, occasional, and recurrent’ (Williamson, 1979, p. 246). Costs associated with frequency are setup costs (related to asset specificity) and reputation effects (Williamson, 2008, p. 8). While frequency refers to the buyer, the setup costs relate to investments made by suppliers (Williamson, 1979, p. 247). As highlighted by Williamson, specialised structures come at a cost (Williamson, 1985, p. 60). Where transactions are recurrent, setup costs are shared across the recurring transactions and lead to better reputation effects (Williamson, 1999, p. 312). Costs associated with frequency arise when there is doubt that transactions are likely to recur. Frequency affects the form and cost of organising the transaction and may be both a hazard and a control mechanism for both parties.

In human services, frequency is likely to be driven by external factors such as political and funding cycles, and bound by complex procurement rules meaning that even a long-term program may be contracted on short-term basis (Cristofoli et al., 2010). For human service providers, short-term contracts (even when likely to be renewed) cause uncertainty for future income and consequently staffing, often leading to loss of staff prior to contract completion (McEntee, Roche, Kostadinov, Hodge, & Chapman, 2020). Providers may have little time to establish programs, resulting in the absence of infrastructure, control systems and reporting mechanisms to support service delivery (Zmudzki et al., 2016). For PSOs, short-term contracts allow buyers to make improvements to the arrangement prior to renewal or returning to the market (De Schepper, Haezendonck, & Dooms, 2015; Sturgess et al., 2016; UK Government, 2019). Short-term contracts also allow activities to be discontinued rather than terminated; termination may otherwise be both difficult and expensive unless mutually agreed. Short-term contracts may be used even when longer-term contracts may be more suited to complex activities, with regular renewal being a compromise (Anderson & Dekker, 2014).

The frequency at which a transaction recurs impacts the cost of governance structures and the therefore the contractibility of human services, assuming contractibility includes not just the difficulty of contracting but also the cost of contracting.

3.4.5 Summary

Examining each transaction attribute helps identify the ease at which a service can be contracted over. Human services are likely to have low contractibility for a number of reasons. Human services are likely to require significant investment in human capital, and systems that support the services provided. Hold up is possible; while this may be managed by short-term contracts, this can impact staff retention and investment in systems. Human services are often idiosyncratic, making them difficult to specify and measure, and difficult to program. Disturbances may lead to a change in service need and also impact service delivery. Information asymmetry may be exacerbated by legislative requirements, the fragmented nature of funders and services, and the culture of staff across different types of services (for example, health compared to social services). Human services are also likely to be difficult to contract over and deliver due to the frequency at which arrangements recur.

3.5 Implications of probity on public sector outsourcing of low contractible human services

Williamson (1999) added probity to the TCE transaction attributes, recognising while TCE is applicable to public sector organisations it failed to recognise the additional transaction costs incurred in this setting. Probity is a transaction cost particularly relevant to public sector settings and identifies costs associated with governance required to maintain the integrity of the

transaction. While probity was developed in relation to and is more likely to be a significant consideration in public sector settings, probity is not exclusive to the public sector and may occur in other settings.

While TCE theory is largely the consolidation of other works, probity is a relatively new attribute and has received little attention or application in the literature. As explained above, the outsourcing of human services is likely to have low contractibility due to a combination of asset specificity, uncertainty and frequency (Section 3.4). This section explores why the organisation and control of low contractible arrangements in public sector settings is likely to be further complicated by probity.

3.5.1 Probity as a TCE transaction attribute

Probity, a late addition to TCE theory, recognises while the integrity of a transaction is likely to be associated more with 'the nature of the sociology of organisation', it remains 'elementary' to the economics of organisation (Williamson, 1999, p. 322). In TCE theory, probity is defined as 'the loyalty and rectitude by which a transaction is discharged' requiring a 'high standard of integrity' (Williamson, 1999, p. 323). Probity is 'delivered through leadership and management attributes of governance that have hitherto been outside the ambit of comparative contractual analysis' (Williamson, 1999, p. 322). Probity contributes to the hazard of contracting directly and indirectly; probity creates additional governance requirements for managers to demonstrate integrity of processes, and limits the use of incentives considered to undermine probity, therefore limiting the way other transaction characteristics are potentially resolved (Williamson, 1999). Probity affects the efficiency of the transaction and the impact, like other transaction attributes, will vary based on the nature of the activity concerned.

There is a general absence of probity from the inter-organisational management control literature. Where TCE has been used in public sector outsourcing studies, where probity is likely to be significant, the construct of probity is not specifically examined (Balakrishnan et al., 2010; Johansson, 2008). One study notes the governance of low contractible human services is made more difficult by procurement legislation, and while making a cursory reference to probity fails to make the connection (Johansson & Siverbo, 2011).

The probity attribute was developed in relation to a hypothetical setting of sovereign tasks (foreign affairs) organised by government — a task that requires public authority[18] (Williamson, 1999). This is evident in the vertical, horizontal and internal discussion of public authority and

[18] Tasks that require public authority include foreign affairs, defence, intelligence, treasury and judiciary (Williamson, 1999).

responsibility, and about how probity affects whether an activity can be outsourced (Williamson, 1999). In this example, Williamson suggests that the highly complex task of foreign affairs should not be outsourced as it needs to be delivered by government to retain public authority. The introduction of probity using this example could imply that probity is only relevant to arrangements requiring public authority (Da Veiga & Major, 2019). However, this extreme hypothetical setting was simply a way to develop the construct of probity; Williamson (1999) highlights probity is also relevant to transactions in different organisational settings, acknowledging probity is more noticeable in PSOs as it is often an operational (and sometimes regulatory) requirement, and imposes additional costs on the organisation of the transaction (discussed in Section 3.5.2).

3.5.2 Probity as a governance requirement in public sector organisations

Probity is a specific and often legislated governance requirement affecting all public sector operations (IFAC & CIPFA, 2014). Probity, a characteristic of good governance (Department of Finance, 2017; IFAC & CIPFA, 2014; Stafford & Stapleton, 2017), is often demonstrated by bureaucratic controls that exhibit equitable, transparent and accountable behaviours. Probity comes from the Latin *probus*, meaning good, with the literal meaning of probity being 'the quality or condition of having strong moral principles, integrity, good character, honesty, decency' (Concise Oxford English Dictionary, 2011). The public sector aims to behave honestly and decently in its operations, demonstrated through high levels of bureaucracy and accountability (Department of Finance, 2017).

Where activities are delivered internally, PSOs are accountable for programs through internal governance mechanisms, policies and procedures, and risk averse, hierarchical bureaucratic controls, each of which has a cost (Stafford & Stapleton, 2017). Where activities are delivered externally, PSOs remain accountable for service delivery to ensure services remain accountable to government and the public (Stafford & Stapleton, 2017).

In public sector outsourcing, probity is most evident in procurement processes where government requires the 'proper use and management of public resources, [where] proper means efficient, effective, economical and ethical' (Department of Finance, 2017, p. 14). Probity must also be maintained through the fair management of outsourcing arrangements once established (Industry Commission, 1996). Probity thus extends to the ongoing stewardship of programs funded, suggesting the existence of 'more extensive forms of accountability … to providers of resources, users of services, higher levels of government and the wider community' (Hodges, Wright, & Keasey, 1996, p. 9; P. Smith, 1995).

In practice, transparent processes and outcomes, and accountability for conduct, (Vosselman, 2016) are key to demonstrating probity and represent business as usual for PSOs (Ritter et al.,

2014). In addition to transparent processes, probity is promoted actively through disclosure mechanisms, and reactively through independent scrutiny, inquiries, oversight and freedom of information processes (Horne, 2010; Industry Commission, 1996; NSW Government, 2010).

Disclosure may include the use of accounting mechanisms which by their very nature are 'concerned with the provisions of relevant information for decision-making, with the achievement of a **rational allocation of resources**, and with the **maintenance of institutional accountability and stewardship'** (emphasis added; Burchell, Clubb, Hopwood, Hughes, & Nahapiet, 1980, pp. 9–10). Accounting measures such as open book accounting, information exchange, and interactive control systems may be used to demonstrate probity and facilitate legitimacy seeking (Caglio & Ditillo, 2012; Covaleski et al., 2003; Kominis & Dudau, 2012; Windolph & Moeller, 2012). Some scholars are concerned that PSO adoption of private sector financial reporting (where probity is less of a consideration) downplays 'the traditional concepts of probity and stewardship' (Stafford & Stapleton, 2017, p. 378), while others suggest that their adoption bolsters their demonstration of accountability (Tan & Egan, 2018).

3.5.3 How probity has been dealt with in the literature to date

While prior empirical studies recognise the 'importance and problematic nature of accountability and management controls in public sector accountability' (Narayanan et al., 2007), scholars do not appear to have addressed probity explicitly. Despite the clear requirement to demonstrate probity in public sector settings, and its relevance to other settings, few management accounting studies have done anything more than acknowledge probity since Williamson's original work, except in relation to the outsourcing decision and overall governance choices (Johansson, 2008; Ruiter, 2005). Johansson (2008, pp. 248–249) suggests probity is probably the reason many public services in Sweden are still produced in-house, making a distinction that transactions where 'probity is essential are different from "ordinary" transactions' and 'the need for probity should not be that great in most transactions that are handled at the local level (infrastructure, education, elderly care, and so forth)'. This may reflect Williamson's definition of probity being specific to sovereign transactions rather than public sector operations more broadly. This may also reflect the style of government in Sweden; in contrast, the Australian Government is similar to the British Government which has an 'exceptional reputation for probity' (Levy & Spiller, 1994, p. 22). While not dealt with directly in the literature where it might be expected, scholars have considered aspects of probity, such as accountability and legitimacy seeking (Johansson & Siverbo, 2011; Johansson et al., 2016), reflecting the different theoretical lenses used.

Where probity is discussed in other literatures, it is often in terms of financial probity and public accountability (Allen et al., 2016; Samuel et al., 2008; Tan & Egan, 2018), ethical probity and the social capital of PSOs (preventing corruption for personal gain; Australian Government

Department of Finance, 2017; Da Veiga & Major, 2019; Gregory, 1999), loyalty (Fredland, 2004), or in relation to managing conflicts of interest (Butcher & Gilchrist, 2016), potentially limiting how probity is considered. The two studies using TCE to explore probity focus specifically on sovereign transactions (military and judiciary); they continue to explore what Williamson (1999) identifies as extreme transactions — those where public authority is deemed necessary (Da Veiga & Major, 2019; Fredland, 2004) — rather than consider how probity affects public services where public authority is not required. Da Veiga and Major (2019) test Williamson's work on probity in detail, mapping the internal (rather than inter-organisational) governance and audit processes of the United Nations, focusing on sovereign and judiciary transactions. They argue that probity is not 'attached to the transaction', but rather is attached to the 'actors' who have oversight of services and a role in fighting corruption (also recognised by Cristofoli et al. (2010)), and suggest an additional characteristic of independence of those actors (Da Veiga & Major, 2019, p. 83). This is consistent with the law and economics literature, where one scholar suggests that probity 'is not a primary attribute for choosing between modes of governance' rather is a secondary attribute 'deriving from the governance structure under which they take place' (Ruiter, 2005, p. 300). Fredland (2004) is one of the few scholars to consider probity alongside other transaction characteristics in inter-organisational arrangements, and highlights the importance of probity in considering the role of private military contractors. He highlights that probity hazard can vary depending on the nature of the activity and the loyalty required (comparing weapons supply, military training, and direct combat).

3.5.4 Summary

Probity contributes to the hazard (cost) of contracting by creating additional governance requirements to demonstrate integrity of processes, while also limiting the use of incentives (Williamson, 1999). While TCE theory is largely the consolidation of other works, probity is a relatively new construct and has received little attention or application in the literature. Looking at and beyond the inter-organisational management control literature provides some insights into how the transaction characteristic of probity has been dealt with both directly and indirectly to date. Probity is likely to be significant in all PSO operations, internal and external, particularly where probity is a regulated governance requirement as it is in Australia. Probity is better understood at the point financial decisions are made, such as during the contact-contract stage; however, little is understood about probity in the control phase of an arrangement.

3.6 Chapter summary

This chapter identified why the organisation and control of outsourced human services is likely to be challenging for PSOs. First, I introduced the theoretical lens used in this study, how scholars have used TCE to problematise the control of inter-organisational arrangements, and its relevance to public sector settings. Second, I explained the underlying assumptions of TCE

theory, each of the original transaction characteristic (asset specificity, uncertainty, frequency), and how each attribute is likely to manifest in the outsourcing of human services. This explains why public sector outsourcing of human services is likely to be difficult to contract over, and therefore has low contractibility. Finally, given the late addition of the probity attribute to TCE theory, and inter-organisational management control studies mostly circumvent probity, I referred to other literatures to help identify the attributes of probity and how it may manifest in this setting. Human services are likely to have low contractibility due to asset specificity, uncertainty, and frequency attributes of the transaction. The way human services are organised and controlled by PSOs is likely to be further complicated by probity. This provides the basis of the conceptual framing. In the next chapter, I identify control strategies that may be used to manage the attributes identified.

Chapter 4 Potential strategies to organise and control low contractible human services

4.1 Introduction

This chapter identifies the potential control strategies used to organise and control low contractible human services. First, I outline the function of management controls, and the control strategies across the outsourcing process (Section 4.2). Second, drawing on the relevant management control literature, I explain the control strategies relevant to each phase of the outsourcing process and how they may be suited to public sector outsourcing of human services (Sections 4.3 to 4.5). This allows me to identify the control choices that may be suited to this setting (Section 4.6).

4.2 Management control systems and strategies

Management controls systems help guide organisations to achieve their strategic objectives, operating as a package of interrelated controls across an organisation and its activities (Berry, Broadbent, & Otley, 1995d; Merchant & Van der Stede, 2017; Otley, 1980, 2016). Management controls allow the coordination of inter-organisational arrangements that may otherwise be hazardous (Anderson & Dekker, 2014; Das & Teng, 2001; Williamson, 1999). Given no contract is likely to be complete due to bounded rationality (Williamson, 1991), controls are used *ex-post* to reduce the cost of monitoring (and consequently increase the cost of opportunism), across the contact, contract and control phases (van der Meer-Kooistra & Vosselman, 2000), to ensure arrangements are a success (Anderson & Dekker, 2005, 2014; Reusen & Stouthuysen, 2017; Speklé, 2001).

Controls can be proactive, enabling the activity to occur; and/or reactive, responding to behaviours that may prevent desired outcomes from being achieved, or detecting undesirable behaviours or outcomes (Johansson & Siverbo, 2011; Merchant & Van der Stede, 2017). Controls can be bureaucratic (for example, outcomes and behavioural controls, often contractual or administrative in nature, that provide transparency and predictability) and relational (for example, partner selection and trust), and may operate in combination at strategic, managerial and operational levels (Anderson & Dekker, 2014; Anthony & Govindarajan, 2007; Dekker, 2004; Ouchi, 1979; van der Meer-Kooistra & Vosselman, 2006).

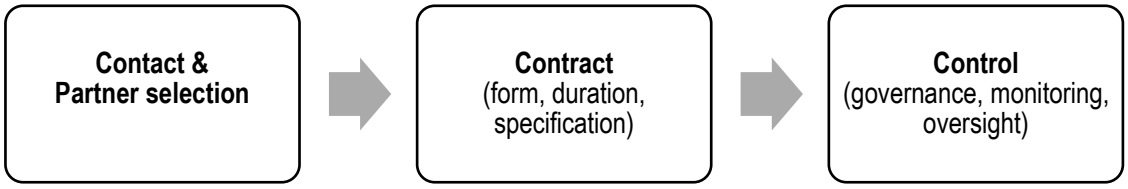
Controls do not guarantee outcomes; some may lead to ‘behavioural displacements’ or ‘perverse’ outcomes. Having more controls does not mean better control; not only can this approach be expensive, this can lead to worse outcomes (Merchant & Van der Stede, 2017).

There may be no such thing as an ideal package of controls (Otley, 1980) — two different approaches may lead to the same outcome within the same organisation (Sandelin, 2008).

In inter-organisational settings, management controls are necessary to minimise opportunistic behaviour, to coordinate information sharing between parties, and to achieve the desired outcomes (Anderson et al., 2015, 2000; Dekker, 2004), both within each organisation (Berry, Broadbent, & Otley, 1995c) and at the boundary (Dekker et al., 2016; van Meerkerk & Edelenbos, 2018). Control choices may be made in program design and at each phase of the contracting process (van der Meer-Kooistra & Vosselman, 2000). Inter-organisational controls need to be stable to provide transparency and predictability, yet be flexible and interactive to cope with changes in the arrangement and the context in which it takes place (Coad, 1995; Otley, 1994; van der Meer-Kooistra & Vosselman, 2000).

Consistent with both practice and prior literature (Donada & Nogatchewsky, 2006; Johansson & Siverbo, 2011; Nicholson et al., 2006), I consider what control strategies may be used across the outsourcing process *after* the decision to outsource has been made. The remainder of this chapter explains the control strategies relevant to each phase of the outsourcing process (Figure 3) and how they may be suited to public sector outsourcing of human services.

Figure 3 Phases of outsourcing after the decision to outsource has been made



Note: Based on the contact-contract-control phases used by van der Meer-Kooistra and Vosselman (2000).

4.3 Contact phase and partner selection

The contact phase announces to the market the services required, inviting qualified suppliers to respond with proposals outlining how those requirements will be met. Partners are selected based on their ability to provide the required services.

4.3.1 Contact phase

A buyer may engage with the market multiple times to develop requirements, identify realistic budgets (Anderson et al., 2000), and promote market development (Anderson & Dekker, 2005), prior to contacting the market with detailed requirements and the criteria on which proposals will be assessed (Ding et al., 2013). Engaging with the market may require a level of trust, particularly when sharing proprietary information (Sako & Helper, 1998). Buyers may find

different ways to promote market development and competition among suppliers, including contracting more than one party to deliver services (Williamson, 1981a).

In public sector outsourcing, procurement processes, while varying by jurisdiction/PSO, are likely to be very bureaucratic, implemented through detailed policies and procedures that identify actors and responsibilities, thresholds, and types of contracts to be used (IFAC & CIPFA, 2014). The procurement process ensures as many decisions as possible are made about the arrangement *before* contacting the market, including the contract (form, duration and detailed specification), funding, selection process and criteria, and monitoring and reporting requirements (Rubery, Grimshaw, & Hebson, 2013). Given human services are difficult to specify and measure, and PSOs may have less experience of direct service delivery, PSOs may need to consult others to develop detailed requirements (Butcher & Dalton, 2014).

The procurement process (form, timing, requirements, value) may affect who may be eligible to respond, as well as the skills and resources required to prepare proposals (De Schepper et al., 2015). Some providers may not have the capacity and resources to respond to requests for tender within the prescribed timeframe; this may lead to market rationalisation and reduce the market's ability to prevent opportunistic behaviours (Butcher, 2016; Butcher & Dalton, 2014; De Schepper et al., 2015). A two-stage procurement process, either using pre-selected panels (van der Meer-Kooistra & Vosselman, 2000) 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). Encouraging consortia to respond to requirements may help smaller organisations remain viable, some of which may provide niche services for specific cohorts (Bovaird, 2016; Gallet et al., 2015).

4.3.2 Partner selection

Following the contact phase, proposals from potential partners are evaluated to identify whether they have the appropriate characteristics to deliver the required services (Anderson & Dekker, 2014; Ouchi, 1979); this includes their capability and capacity, as well as the likelihood they will behave opportunistically. For example, experience in delivering similar services may reduce uncertainty (Anderson, Dekker, & Van den Abbeele, 2017), or may lead to hold-up (due to asset specificity). Partner selection can significantly impact the success of inter-organisational arrangements by managing performance risk of potential partners (Anderson, Christ, Dekker, & Sedatole, 2014).

The literature on partner selection includes the choice of selection criteria and effort spent selecting partners, recognising that this may vary depending on the nature of the contract (Dekker, 2008; Dekker, Sakaguchi, & Kawai, 2013; Dekker & Van den Abbeele, 2010; Ding et al., 2013). Prior experience with specific partners is likely to inform partner selection and also

the bargaining position of the supplier (Anderson et al., 2017; Donada & Nogatchewsky, 2006). Prior experience may also affect the intensity and type of controls required (Dekker et al., 2013; Ding et al., 2013; Nicholson et al., 2006; Sako & Helper, 1998; van der Meer-Kooistra & Vosselman, 2000). The buyer may also use information from third-parties or the buyer themselves (van der Meer-Kooistra & Vosselman, 2000). Another consideration is differences in the institutional context between the buyer and supplier organisations (Dekker, 2004; Johansson et al., 2016; Nicholson et al., 2006); for example, gaining cooperation between parties who have a very different purpose or culture may be difficult (Johansson et al., 2016).

In public sector outsourcing, the criteria for partner selection are likely to be detailed in the procurement documentation provided at the contact phase (Behn & Kant, 1999). Decisions are made based on the content of the proposal, although prior experience may be validated by seeking evidence from other parties such as referees (Behn & Kant, 1999). Providers may need to demonstrate their management controls ensure efficiency and effectiveness (Chenhall, Hall, & Smith, 2010), and demonstrate the cost-effectiveness of their proposed approach (Knapp, 2015; Merickova & Vozarova, 2012; Van Slyke, 2003). Given the low contractibility of human services, PSOs may also seek goal alignment when selecting partners to minimise the likelihood of opportunism (Brown et al., 2006; Considine, 2003; Johansson & Siverbo, 2011). The partner selection process in PSOs is likely to be bureaucratic and determined during the contact phase. This relies on establishing clear requirements and selection criteria during the contact phase — difficult when contractibility is low.

4.4 Contract phase

The contract establishes the relationship between parties and mechanisms to deter opportunism, specifying ‘the rules of the game’; this includes how performance will be measured, the rewards, and decision rights (Jensen, 1983, p. 326). The form, duration and specification of the contract may vary depending on the characteristics of the transaction, the transaction environment, the value of the contract, and the parties to the transaction (DeHoog, 1990; van der Meer-Kooistra & Vosselman, 2000; Williamson, 1981a).

4.4.1 Form

The form of the contract is likely to reflect the nature of the transaction, and in particular the level of uncertainty associated with the activity (Nicholson et al., 2006; Sartorius & Kirsten, 2005; van der Meer-Kooistra & Vosselman, 2000). Contracts may be transactional, regulatory or relational, aligning with the transaction attributes and setting.

Transactional contracting is used when requirements are straight forward, the market is well-established, and the contract is implemented at arms-length, something Williamson (1981a, p.

551) describes as ‘hard contracting’. A buyer contacts the market and partner selection is largely determined by price. The buyer can return periodically to the market and retender the services, encouraging improvements in quality and price; this provides market-based control due to the possibility of replacement. While transactional contracts are not necessarily suited to the outsourcing of complex human services due to the difficulty in specifying and measuring services (DeHoog, 1990), they have a long history in organising human services. Transactional contracts were used in the transportation of convicts to Australia (Sturgess et al., 2016) — contracts that were associated with high death rates on voyages. High death rates were not remedied through institutional learning by the supplier, but by the introduction of better controls (including penalties) and performance bonuses. As this example highlights, the form of contractual controls needs to follow function (Sturgess et al., 2016), and strict controls and penalties are needed to deter opportunists (DeHoog, 1990).

Regulatory contracting is a more traditional form of contracting in public sector settings which ‘specifies precisely how the vendor should do things’ (Behn & Kant, 1999, p. 471). This assumes the PSO is able to specify detailed requirements and is confident their specification will be effective in meeting client needs (Behn & Kant, 1999). While regulatory contracts have been used in human services outsourcing, they may not be ideal from the perspective of either party or service recipients; they are likely to be difficult to manage and be at risk of focusing managers attention on compliance rather than effectiveness (Considine et al., 2011; Padovani & Young, 2006).[19]

Relational contracting is used when requirements are not straight forward (Krishnan, Miller, & Sedatole, 2011), something Williamson (1981a, p. 552) refers to as ‘soft contracting’, providing a framework in which activities occur. Relational contracting is collaborative and relies on good relationships and trust between partners; it is particularly useful for managing longer-term contracts where flexibility over time is critical, therefore minimising the likelihood of hold-up between the buyer and supplier (Grafton & Mundy, 2017; Jensen & Stonecash, 2005). Relational contracting is often associated with collaborative, longer-term relationships, and relies on trust and shared interests, values and understanding between partners to self-regulate and safeguard exchanges (Dekker, 2004; Grafton & Mundy, 2017; Krishnan et al., 2011; Miller, Kurunmäki, & O’Leary, 2008; Ouchi, 1979). Relational contracting is likely to be able to accommodate the complexities of low contractible human services by establishing goals and allowing flexibility in how they are met (Almquist et al., 2013; Bovaird, 2016; Brown et al., 2006; Butcher & Dalton, 2014; Shergold, 2013a; Sturgess et al., 2016). However, relational contracts

[19] For example, a government commissioned evaluation reported that an 800-page contract was used for the governance of the outsourcing of immigration detention centres in Australia, which was found to focus attention on compliance rather than service delivery (Katz, Powell, Gendera, Deasy, & Okerstrom, 2013).

are not always suited to public sector settings as they are seen to by-pass formal control hierarchies common in bureaucratic organisations (Carlsson-Wall et al., 2011; Ditillo et al., 2015; Narayanan et al., 2007).

The choice of contractual form is unlikely to be binary (van der Meer-Kooistra & Vosselman, 2006); for example, a relational contract may also have components that are transactional and vice versa (Grafton & Mundy, 2017). Contracts used by PSOs to outsource human services are likely to be mostly transactional in nature, suiting the bureaucratic environment, and may have elements of regulatory or relational contracting, managed by medium to long-term transaction specific contracts and safeguards to ensure compliance (Kettner & Martin, 1990; Speklé, 2001).

4.4.2 Duration

Short and long-term contracts each present advantages and disadvantages to the buyer and supplier (Williamson, 1985). Short-term contracts are useful when uncertainty is high; for example, where confidence in the service model (transformation process), supplier, or availability of funding are low. Short-term contracts offer market-based controls where markets are thick, assuming that markets reduce the need for controls (Johansson et al. (2016) and Dekker et al. (2013) find evidence to the contrary). However, where the buyer subsequently returns to the market, the supplier has an advantage as they have access to more information about both the supplier and the services required.

The cost of establishing and managing short-term contracts is high for both parties; further, both parties may be disinclined to invest in systems and infrastructure to support each other over the contract period — in human services this may affect the quality of services provided (Williamson, 1985). Williamson (1985, p. 339) highlights the advantages of recurrent short-term contracting (over long-term contracting) as it 'facilitates adaptive, sequential decision making'. While benefitting the buyer, this is unlikely to be attractive to the supplier without a clear commitment. In human services outsourcing, this lack of commitment may affect staff retention and the relationship between staff and clients (McEntee et al., 2020).

In contrast, long-term contracts provide a commitment to both the provider and potential clients of the ongoing nature of the service, encouraging investment in staff and systems to support service delivery. Long-term contracts suit relational contracts (Bovaird, 2016) which recognise that not every element of the transaction can be specified up front and allow adjustments to be made throughout the duration of the contract.

4.4.3 Specification

Specification within the contract provides transparency to both parties as to what is required and how the arrangement will be managed (Narayanan et al., 2007); what Bentham identified as

hope (of reward) and fear (of punishment) (Sturgess et al., 2016). All contracts are likely to be incomplete due to the prohibitive cost of anticipating every eventuality (Barnard, 1938; Myrdal & von Hayek, 1974; Williamson, 1985, 2000) and must therefore include mechanisms to identify and manage residual transaction hazards (Anderson et al., 2014; Anderson & Dekker, 2005; Ding et al., 2013; Jensen & Meckling, 1992).

In public sector outsourcing, contract specification must be balanced in order to ensure that the supplier has enough flexibility to deliver the program while the PSO has enough control to ensure services are delivered (Addicott, 2014). Over specification may lead to service delivery becoming inflexible, while too little control may result in opportunism by providers and failures in service delivery (Birnberg & Gandhi, 1976; Brown & Potoski, 2003; Considine et al., 2011). Key areas of contract specification include obligations on parties, monitoring/reporting and incentives, and governance across and within parties. The level of contract specification is determined by the form of the contract (Section 4.4.1), the level of (un)certainty and task programmability (Nicholson et al., 2006; Speklé, 2001), and by partner selection and associated risks (Ding et al., 2013). There may be some negotiation between parties which may involve compromise (Butcher & Dalton, 2014; Jensen & Stonecash, 2005; Oliver, 1991). Contract specification may increase over a contract period as uncertainties are resolved (van der Meer-Kooistra & Vosselman, 2000).

Obligations on parties

The contract may include obligations on either party to carry out an action to enable the contract to be delivered; the buyer may be required to provide detailed product/service specifications, and the supplier may be asked to provide evidence of required permits or compliance with standards. Information exchange is likely to be higher in close inter-organisational arrangements and is likely to increase the efficiency of the arrangement (Baiman & Rajan, 2002; Dekker, 2003). In human service outsourcing, the PSO may be required to provide information about the program and potential clients, and the supplier may be asked to provide evidence of required permits, staffing or clinical governance. The contract may specify what information is provided, how, when and in what form.

Monitoring, reporting and incentives

Contracts specify what is required to be delivered and how, and provide mechanisms to monitor and report progress, and drive performance — each of which will vary depending on the nature of the arrangement (Berry et al., 1995d; Burns & Stalker, 1961; Cohen, Loeb, & Stark, 1992; Dekker, 2004; Merchant & Van der Stede, 2017). Payments, a form of results (outcome) control, may be used to incentivise performance in line with the direction, duration and intensity of effort required (Dekker, 2004). Payments may be triggered by achieving key inputs, processes,

outputs or outcomes, depending on the measurability of activities (Alchian & Demsetz, 1972; Speklé & Verbeeten, 2014). Where services are easy to specify, milestone payments may be attached to outputs or outcomes. Where services are difficult to specify and information about outputs or outcomes are incomplete — as is the case for human services — buyers (PSOs) may attach incentives/payments to a combination of inputs, processes or behaviours (Dekker & Van den Abbeele, 2010).

In public sector contracting, payments are often attached to key deliverables, with a final payment to be paid on (and leverage) completion (Martin, 2005; Sturgess et al., 2016; Tomkinson, 2016). Other forms of incentive may include contract renewal but are likely to exclude incentive payments found in for-profit settings (Jensen & Stonecash, 2005; Speklé & Verbeeten, 2014; Williamson, 1999).

In human services, performance indicators may relate to the quantum of services provided, safeguards required, as well as the acquittal of funds (Tomkinson, 2016). The use of indicators allows different arrangements to be compared and promotes accountability of both the buyer and supplier to stakeholders (Smith, 1993, 1995). Performance indicators may need to change over time as understanding of the transformation process increases (Addicott, 2014; Chenhall, Hall, & Smith, 2017). Meaningful performance indicators are not easy to establish in human services (Berry et al., 1995b; Seal, 1995). In some settings, it may be difficult for services to claim an outcome is attributable to a specific service, another service, or would have occurred anyway, even if a control or comparable population exists (Kominis & Dudau, 2012). There is also a risk of indicators leading to perverse behaviour, including providers 'parking' or 'creaming' of clients to demonstrate efficiency (Considine, 2003; Martin, 2005). PSOs may therefore include a suite of measures informed by theories of change developed and implemented in consultation with key stakeholders (Addicott, 2014; Brignall & Modell, 2000; Martin, 2005; Smith, 1995; Tomkinson, 2016). As a consequence, performance reporting is likely to be costly (Marvel & Marvel, 2007; Tomkinson, 2016).

Governance requirements

Governance strategies include lines of authority and accountability, and systems of coordination, from board structure and composition, down to individual employees (Abernethy & Chua, 1996). Inter-organisational arrangements also require governance mechanisms to ensure their success (Caglio & Ditillo, 2008; Dekker, 2004). Governance requirements may be specified in the contract to facilitate ongoing coordination and adaptation between parties; this may include identifying desirable/undesirable behaviours, cybernetic controls, clan controls, and building values into performance management systems (Anderson & Dekker, 2014; Ding et al., 2013; Langfield-Smith, 1995). Key personnel or boundary spanners (Dekker, 2016; Dekker et al., 2016) identified in the contract provide the point of liaison between the two organisations

and may take an active role in facilitating the implementation of the contract. Inter-organisational controls may influence internal controls of both parties to the transaction, and vice versa (Dekker, 2016).

Governance strategies are also suited to facilitating public sector outsourcing of human services. The inclusion of an organisational model or governance structure in a contract clarifies responsibilities, lines of accountability, and facilitates the flow of information and funds across parties (Addicott, 2014; Shergold, 1997). Boundary spanners may also be formally identified (van Meerkerk & Edelenbos, 2018).

Over time, PSOs have increased the controls specified in outsourcing contracts to minimise risk (Considine et al., 2011). PSOs are likely to rely on formal controls (outcome and behavioural controls) established in the contract, including specific instructions, behavioural requirements and performance targets, supported by formal monitoring and reporting processes (Speklé & Verbeeten, 2014; Verbeeten & Speklé, 2015).

4.5 Control phase

Contracts 'are not self-administering, self-correcting, or self-improving' (Behn & Kant, 1999, p. 471); oversight of outsourcing arrangements is required until all obligations under the contract have been met. Oversight may be proactive or reactive, and formal (bureaucratic) or informal (relational) (Caglio & Ditillo, 2008; Johansson & Siverbo, 2011; Narayanan et al., 2007; Phua et al., 2011; Speklé, 2001; van der Meer-Kooistra & Vosselman, 2000). The control phase includes ongoing governance of the contract, as well as ongoing monitoring, each reflecting the level of risk in the provider meeting their obligations under the contract.

4.5.1 Ongoing governance

Formal governance arrangements may be established both between and within organisations as a condition of the contract (discussed in Section 4.4.3) and may evolve as required. Once a contract is executed, governance may be provided by the buyer or a third-party.

PSOs are likely to use more extensive governance arrangements due to the bureaucratic culture of the organisation and their accountability to a broader range of stakeholders, including service users (Awio et al., 2007). In public sector settings, additional governance may be provided by independent evaluators, audit offices, ombudsmen, commissions, parliament, representative groups and the public (see Chapter 2).

4.5.2 Ongoing monitoring

Contracts must be monitored to be effective and to reduce the risk of opportunistic behaviour by the provider (Alchian & Demsetz, 1972). Monitoring requirements are specified during the contracting phase (Speklé, 2001) and may be added to *ex-post* (Behn & Kant, 1999). Extensive monitoring requirements may lead to measurement fatigue, with both parties ignoring or overlooking other aspects of performance (Merchant & Van der Stede, 2017). Monitoring is not without costs and therefore must be proportionate to the activity (Rasheli, 2016).

In public sector outsourcing, monitoring is critical for contracts to be effective (Narayanan et al., 2007) and to become more effective (Cohen et al., 1992), not only to ensure services are delivered but also to ensure contracts remain fit for purpose. Buyers and suppliers should 'be prepared to learn, change, improve, and learn some more' (Behn & Kant, 1999, p. 481). Monitoring is critical when residual transaction hazards are high, as is likely to be the case for low contractible human services; this requires the capacity, skills, knowledge and understanding of the expected transformation process, as well as the ability to interpret data to undertake monitoring effectively (O'Flynn & Alford, 2008; Stafford & Stapleton, 2017). Monitoring costs can be high as a consequence; however, effective monitoring may lead to overall cost savings. Performance measures must be continually reviewed and updated to ensure they remain fit for purpose (Behn & Kant, 1999).

The management control literature suggests the use of relational controls where transactions have low contractibility; however, relational controls may not suit the bureaucratic environment of PSOs (Ditillo et al., 2015; Narayanan et al., 2007; Vosselman, 2016). Relational controls could supplement bureaucratic controls in some contexts (Johansson & Siverbo, 2011).

4.6 Control strategies suited to public sector outsourcing of low contractible arrangements

As highlighted in the literature, multiple control archetypes may be used to manage an inter-organisational arrangement; however, one archetype is likely to dominate (van der Meer-Kooistra & Vosselman, 2000, 2006). The inter-organisational management control literature suggests relational controls are more suited to the management of low contractible arrangements (Dekker, 2004; van der Meer-Kooistra & Vosselman, 2000). However, for the most part, relational controls are not suited to the bureaucratic environment of public sector settings (Ditillo et al., 2015; Narayanan et al., 2007; van der Meer-Kooistra & Vosselman, 2006).

A summary of the relational styles of control suited to low contractible arrangements, and bureaucratic styles of control suited to public sector settings, presented in Table 1 below, highlight how different the two styles of control are.

Table 1 Summary of relational and bureaucratic styles of control

Phase	Relational styles of control suited to low contractible arrangements	Bureaucratic styles of control suited to public sector settings
Contact and partner selection	• May work with providers and other stakeholders to develop requirements and identify realistic budgets • Open to different ways of achieving the objectives	• High specification of the requirements — the way of achieving the objectives is likely to be specified • Transparent partner selection process and selection criteria
Contract (form, duration, specification)	• Form of contract likely to be dominated by relational characteristics, providing a framework in which activities occur and flexibility in how goals are met • Form of contract is likely to be collaborative — this includes negotiating terms • Likely to have lower levels of specification than bureaucratic styles of control, and likely to be of longer duration; changes may be made to the contract during the contract period • Payments may include rewards for innovation	• Form of contract likely to be dominated by transactional and regulatory characteristics, including detailed specifications of how things should be done • Strict requirements, controls and penalties • Likely to be of shorter duration to provide opportunity to go back to market (allows market form of control); any changes to the contract are likely to be made when recontracting • Payments linked to clear inputs and outcomes • Clear lines of accountability and reporting
Control	• Likely to be collaborative, balancing oversight to manage residual transaction hazards while avoiding measurement fatigue to ensure objectives of the contract are met	• Formal oversight with clear governance, reporting and measures of success

As discussed in the literature (Ditillo et al., 2015; Narayanan et al., 2007; van der Meer-Kooistra & Vosselman, 2006), not only are the styles of control different — they may also be conflicting, raising the question *how can the public sector organise and control the outsourcing of low contractible services*?

To date, this appears to have been inadequately addressed in the inter-organisational management control literature. For example, Narayanan et al. (2007) consider how to demonstrate accountability when contracts are incomplete, suggesting that bureaucratic controls are suited to transparency and accountability when tasks are easy to specify. However, the setting (a university) and the activity outsourced (mail and cleaning services) are unable to provide insights into how low contractible activities can be managed in public sector settings (Ibid.). Others use survey data to explore the impact of legitimacy concerns and stakeholder pressure (over and above efficiency and effectiveness of service delivery) on the choice and intensity of controls used, highlighting the need for PSOs to use visible controls (Johansson et al., 2016). Similar to Dekker et al. (2013) they find control intensity increases with competition, whereas TCE theory argues that competition is a form of control and therefore control intensity should decrease. They highlight opportunism cannot be ignored and that coordination is critical to achieving outcomes. In horizontal arrangements, there is some evidence of informal or social

controls in supporting collaboration across a mandated hospital network while balancing efficiency and legitimacy (Grafton et al., 2011).

While prior literature provides useful insights into the control strategies likely to be used by PSOs, the literature does not appear to provide definitive expectations guiding *how public sector organisations can organise and control the outsourcing of human services, and in particular, how PSOs can resolve the tension between low contractibility and probity when outsourcing human services.*

4.7 Chapter summary

This chapter identified the control strategies that might be used by PSOs to manage inter-organisational arrangements after the decision to outsource has been made. Public sector outsourcing has not received much attention in the management control literature; therefore it was only possible to identify what *might* be observed in this setting drawing on the broader inter-organisational management control literature and other literatures where relevant. There is a clear tension between how PSOs manage outsourcing arrangements of low contractibility while also satisfying probity requirements. PSOs are likely to rely on more bureaucratic, formal controls; however, low contractible human services are likely to benefit from relational contracting, contracting that is nimble and adaptive. This tension requires further study. The next chapter describes the research design that will be used to answer the research question.

Chapter 5 Research design

5.1 Introduction

This chapter presents the research design. First, I explain the sequential choices made in developing the design, to answer the research question: *How can the public sector organise and control the outsourcing of human services?* The research methodology explains the philosophical assumptions that determine the inquiry paradigm (Section 5.2). The research strategy then sets out the overall approach or logic of inquiry (Section 5.3), the single case study method (Section 5.4), and the ethical considerations (Section 5.5). Second, I describe the data collection procedures; how data were collected and analysed (Sections 5.6 and 5.7). Third, I explain the validity of this approach (Section 5.8). This chapter describes the strategies used to reduce bias and subjectivity; each stage of the design is presented with the rationale for this choice and how it was implemented (Blaikie, 2000; Bryman, 2012; Creswell, 2003; Crotty, 1998; Kumar, 1996; Patton, 2015).

5.2 Research methodology

This thesis adopts a post-positivist research methodology. This section describes the characteristics of post-positivist research and why it is suited to this study.

The objective of this thesis is to explain how the public sector can organise and control the outsourcing of human services. The literature is extensive in how outsourcing is arranged in private sector settings, and more so with arrangements that have high contractibility; however, little is known or understood about how the public sector organises and controls outsourcing, particularly for arrangements with low contractibility, once the decision to outsource has been made. The nature of the research question and the theoretical setting determines the inquiry paradigm or methodology used in this study (Abernethy, Chua, Luckett, & Selto, 1999; Ahrens & Chapman, 2006; Creswell, 2003).

This thesis builds on prior studies and seeks to provide explanation between established constructs — aligning the study with a post-positivist stance. Positivism is a philosophical paradigm (arising from Comte's early work) based on a concept of 'real scientific knowledge … limited to what can be logically deduced from theory, operationally measured, and empirically validated' (Patton, 2015, p. 105). Post-positivism is more 'modest', and was developed in response to criticism about the 'narrow tenets' of positivism, acknowledging that reality may never be truly known (Patton, 2015, pp. 105–106).

Post-positivism has critical realist assumptions, recognising there is a reality but it will only be imperfectly understood (Lincoln & Guba, 2000) as 'no causal argument is ever definitive' (Lukka, 2014, p. 560). Adopting this stance allows linkages to be built between constructs and scientific rigour to be applied (Section 5.8). The role of the researcher in this form of inquiry is to remain value free as much as possible, and transform what is observed in an empirical setting to provide greater clarity or extension to existing theory (Lincoln & Guba, 2000).

5.3 An abductive approach

This section describes why abductive reasoning is suited to this study, and how it is used. Abductive reasoning is used to describe and understand social phenomena and convert this into technical accounts; this infers the best explanation which is able to contribute to theory that can be tested elsewhere (Blaikie, 2000; Bryman, 2012; Dubois & Gadde, 2002). By comparison, inductive strategies look for patterns in data to create generalisations, deductive strategies test hypotheses of relations between constructs (absent in this setting), while retroductive strategies are used to observe regularity and explain what is responsible for this (forming a hypothesis) (Blaikie, 2000).

Abductive reasoning follows the hermeneutic tradition where the researcher starts by describing social phenomenon in the everyday language of informants (participants in the study) — not in the language of the discipline. Abductive reasoning generates first order constructs by abstracting the motives and actions of a 'typical actor' within the organisation from multiple individual accounts, recognising that accounts have shared intersubjective meaning (Blaikie, 2000). Inter-subjectivity can be achieved by using multiple sources of data about the same phenomenon — not just from different informants, but also drawing on documentary evidence and observations (see Section 5.6). Such an approach is objective (not relying on one source of data) and seeks to find truth in the phenomenon being studied (Denzin & Lincoln, 2000). The researcher then 'redescribes' the first order constructs using technical language (used in the literature) to create second order constructs (Blaikie, 2000). This generates the understanding, or a theoretical model, of the activities that can be explored further leading to theoretical contributions (Blaikie, 2000). Abductive reasoning is the logical choice for this thesis, congruent with a post-positivist approach, as data are presented from the perspective of informants (rather than the researcher) providing the most plausible conclusion (Bryman, 2012).

Abductive processes often start from 'a striking empirical observation that begs an explanation' (Lukka, 2014, p. 563). For this thesis, the striking empirical observation was how PSOs continue to outsource human services given they are difficult to contract over — evidenced by a number of inquiries into service failings. Drawing on the literature, a conceptual framing was developed to identify likely transaction attributes (Chapter 3) and how they might be organised and controlled (Chapter 4); this allowed me to focus data collection on understanding the tension

between how PSOs manage the outsourcing of low contractible services while also satisfying probity requirements (Eisenhardt, 1989; Lukka, 2014; Taylor, 2018). Using abductive reasoning, the conceptual framing was then used to focus the collection of empirical data, identify what assumptions hold, and identify what cannot be explained or what goes against theoretical assumptions (Taylor, 2018). This approach provides insights into the motivations behind the actions within organisations, providing an understanding of not just what control strategies are used, but why (Blaikie, 2000).

5.4 A single case study method

An abductive strategy requires a rich source of data to provide an understanding of the actions and motivations of those involved in organising and managing the outsourcing arrangement (the phenomena), to shed light on the theoretical constructs (transaction characteristics and control strategies used to manage them) and the relation between them. This section describes why a qualitative single case study method is suited to the abductive strategy and how the case organisation was identified.

5.4.1 An exploratory single case study

This thesis is exploratory in nature, and requires a deep rather than broad understanding of the phenomenon of interest (Patton, 2015). Understanding *how* PSOs organise and control the outsourcing of human services requires detail about how the arrangement is managed and the context in which that arrangement takes place (Lillis, 2008, p. 242). The research question, as well as the post-positivist abductive approach, are best addressed using a qualitative single case study method. This is able to generate insights into controls used, informed by multiple types and sources of qualitative data, studied and validated in its national environment (Blaikie, 2000; Creswell, 2003; Dekker, 2016; Dubois & Gadde, 2002; Lincoln & Guba, 2000; Otley, 1994; Yin, 2014). This allows ongoing interaction between data and theory, and the corroboration or triangulation of evidence; case studies allow researchers to generate thick descriptions of the phenomenon of inquiry and refine theoretical constructs for further investigation (Blaikie, 2000; Bouma & Ling, 2004; Creswell, 2003; Denzin & Lincoln, 2000; Lukka & Modell, 2010).

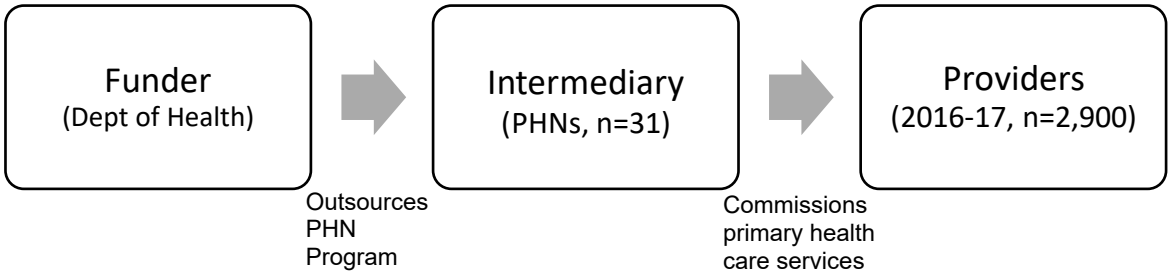
5.4.2 Selecting the case setting

The case was selected using theoretical and purposive sampling (Bryman, 2012; Eisenhardt, 1989). First, the main PSOs responsible for delivering face-to-face human services in New

South Wales (NSW) Australia[20] known to outsource services were identified (Patton, 2015); this produced five Commonwealth and 14 NSW Government PSOs. Service areas were excluded where they had been subject to structural transformation (such as disability), organisational transformation (NSW Department of Communities and Justice), or targeted specific demographics (such as Aboriginal and Torres Strait Islander communities) due to additional cultural considerations and not being representative of the wider population. PSOs were also excluded where they were unlikely to share the research findings once available (such as services provided to members of the Australian Defence Force). This left PSOs responsible for health at both the Commonwealth and State level. I then looked for an outsourcing arrangement of sufficient size (to ensure sufficient informants and data) and duration (to ensure the PSO had time to develop ways to organise and control the arrangement). I also looked for a setting where the outsourcing arrangement appeared to be working well, given my objective is to explain *how* the public sector can organise and control the outsourcing of human services.

The outsourcing arrangement that provides the context for this study is the Primary Health Network (PHN) Program, funded by the Australian Department of Health (DoH). The program was established on 1 July 2015, and funds 31 PHNs to, among other things, commission primary health care services on behalf of DoH for unique geographic areas (UNSW, Monash University, & EY, 2018) (see Figure 4 below).

Figure 4 Overview of PHN Program outsourced by Department of Health



The PHN Program was subject to an independent evaluation which reported positive progress in implementing the model (UNSW et al., 2018); the PHN Program has also been expanded to fund additional services, suggesting confidence in the model (Section 6.4.3). When selected, the PHN Program had been running for 3 years.

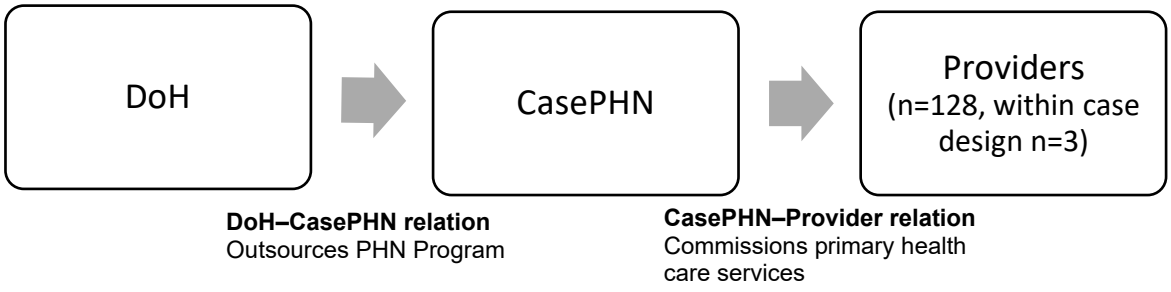
[20]The location of the researcher.

5.4.3 Defining the case setting

Case studies need to be 'bounded by time and activity' (Creswell, 2003, p. 15) to focus on the phenomenon of interest. The single case for this study is defined by the outsourcing of the delivery of the PHN program by the Department of Health (DoH), as delivered by a single Primary Health Network — the CasePHN.[21] The single case is bound by the DoH–CasePHN relation only as it relates to the commissioning activities[22] required under the contract.

Given the extent of the commissioning activities undertaken by the CasePHN, I used a within case design (Eisenhardt, 1989) to bound the case further — focusing on three CasePHN–Provider relations that were considered by the CasePHN to be 'working well', not just in terms of achieving key performance indicators (KPIs), but across the procurement and contracting process (*Interview 13*). The three CasePHN–Provider relations were selected from each of the main funding streams — mental health (severe illness), alcohol and other drug treatment (AOD; post-custodial), and population health (early childhood screening) — to ensure what enabled the service to work well was not contingent on the funding stream or staff involved. An overview of the outsourcing arrangement that bounds the case study is provided in Figure 5. Each CasePHN–Provider relation had been in the control phase for more than 2 years to enable informants to provide insights about how controls were used and how they had changed over time. To ensure confidentiality of participants and the CasePHN, the results from the within case design are not disaggregated.

Figure 5 Overview of the outsourcing arrangement that bounds the case study



The CasePHN is the focal organisation of the study as it is key to both relations. In addition, the operations of the CasePHN are almost exclusively driven by the contract with DoH, providing a unique setting as the CasePHN is not influenced by other hybrid relations (Anderson & Dekker, 2014; Speklé, 2001). Focusing on the CasePHN allowed me to examine both the DoH–

[21] The CasePHN is the pseudonym given to the case study organisation that provides the setting for this study. The organisation asked to remain anonymous.

[22] Commissioning is one component of the PHN Program (*PHN Guidelines*).

CasePHN and CasePHN–Provider relations that make up the outsourcing arrangement. This may not have been possible if DoH was the focal organisation.

Establishing the boundary of the case provided the inclusion criteria for informants in the study. Inclusion criteria for participation were individuals directly involved in either the DoH–CasePHN or the CasePHN–Provider relation, including DoH, the CasePHN and providers. Within the CasePHN, informants did not fall within defined business units; staff were located in planning, clinical streams, and the contracts and finance teams. The unit of data collection was the individual involved in the management of each relation that makes up the outsourcing arrangement; the unit of analysis is the management of activities related to the DoH–CasePHN and CasePHN–Provider relations. In order to provide an understanding of the broader context of the PHN Program, informants also included other stakeholders who had working knowledge of the PHN Program, such as those involved in designing or evaluating the PHN Program, as well those involved in broader commissioning processes such as peak bodies. Other informants were identified in consultation with the CasePHN.

For abductive reasoning to be effective, the organisation must be an active participant in the research, providing access to staff and documents related to the DoH–CasePHN and CasePHN–Provider relations, as well as verifying the first order constructs. The PHN Executive Team (the Executive) and Chair of the CasePHN Board, as well as staff across the organisation, provided full support and were actively engaged throughout the study.

The case setting was also bound by time, both in terms of the maturity of the outsourcing arrangement observed (discussed in Section 5.4.2 above) as well as the time spent in the field (discussed in Sections 5.5–5.6). A 12-month onsite fieldwork period (September 2019–August 2020), negotiated and agreed with the Case Organisation, ensured enough time was available to collect, analyse and validate observations with key informants. On-site fieldwork stopped in March 2020 and switched to remote fieldwork due to COVID-19.

5.5 Ethical design and conduct of the study

Any research involving human participants must comply with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research*; this requires the ethical design, review and conduct of research with human participants (NHMRC, 2018). The research was approved by UTS Human Research Ethics Committee (ref: UTS19-3481 HREC).

Informed consent was required from the CasePHN to participate in the study. Initial consent was provided by the CEO and General Manager Corporate Services[23] and a formal application was made to the organisations' Research Committee. Once approved, a contract was established between the researcher, the university and the CasePHN to establish the boundaries of the study (time and activities) and provide insurance while conducting fieldwork. During this phase, the Executive were invited to provide feedback on the research protocol.

All data was collected, analysed and reported in accordance with the approved ethics protocol. All data (audio files, transcripts, observations, documents) were deidentified and stored on a secure drive (hereinafter referred to as the 'datafile'), and are reported in a de-identified and anonymised form unless agreed otherwise.

The CasePHN CEO asked that the organisation be deidentified to the extent this was possible in this thesis and future publications, acknowledging that the characteristics of the CasePHN may lead to assumptions about its identify being made. This was to prevent the misuse of data by third-parties, while enabling enough data to be reported to improve understanding. For this reason, informants are identified in this thesis by Interview number unless the role is important to or provides specific context to the quote. The Executive asked to review any publications arising from this thesis prior to publication.

5.6 Data collection

Consistent with a post-positivist methodology, evidence was gathered as objectively as possible about both the context and the phenomenon, allowing evidence to be corroborated from multiple sources (Yin, 2014). Sample size was naturally bounded by the organisation and the units of analysis — the relations making up the outsourcing arrangement. Data collection commenced in February 2019 and finished in November 2020 and was divided into six distinct phases, presented in Table 2 below.

[23] The latter being gatekeeper of both staff and data (Creswell, 2003).

Table 2 Data collection phases for the study

Period	Phase	Activities
Feb-April 2019	Preparation	Familiarisation with publicly available documentation to inform research protocol. Applied for ethics approval.
July 2019		Interviewed team who evaluated the PHN Program (to inform case study design).
April 2019–July 2019	Establishment	Met with CasePHN Executives to discuss research proposal and invite them to participate in the study. Applied to CasePHN Research Committee and established Research Contract.
May 2019–end	Familiarisation	Analysed documents to become familiar with the CasePHN and business processes.
August 2019	Planning	Met senior staff to identify CasePHN's priorities and reporting requirements, refine research instruments, identify CasePHN-Provider relations to explore in detail, and discuss potential data sources including key informants and the logistics of data collection.
September 2019–February 2020	Data collection	Interviewed informants involved in the DoH–CasePHN relation. During interviews, a number of documents were provided for analysis.
November 2019–March 2020		Interviewed and observed staff involved in establishing and managing CasePHN–Provider relations to understand how contracts are managed. Interviewed other stakeholders to gain insights into the relations. As above, during interviews, further documents were identified and provided for analysis.
July 2019–March 2020	Analysis and validation	Analysis was ongoing throughout the fieldwork period. Initial analysis identified gaps in data and informed additional data collection. During this period, there was an opportunity to validate initial findings with senior staff. This included validating the characteristics of successful contracts and what enabled a good contract.
March 2020–November 2020		As the analysis developed, and theoretical implications became refined, there was further opportunity to return to key stakeholders to validate findings (including DoH). This was useful to shape not just the findings, but also the language used to ensure it reflected contemporary practice and thinking.

Data sources included documents (policies and process, as well as documents related to specific relations), interviews with informants and observations. Table 3 below provides an overview of different data sources related to the context and phenomenon of interest.

Table 3 Overview of different data sources relating to context and phenomenon

Data source	Context	Phenomenon
Program documentation	Policy, procedures, annual reports, organisational structures, webpages, media articles, previous evaluations and research reports.	Records identifying need, request for tender, meetings, decision-making, contracts, progress reports, evaluations and other internal reports.
Archival records	Includes Australian Bureau of Statistics (ABS) or AIHW data to provide additional contextual information about service setting and need.	Includes organisational records such as financial statements and expenditure on services.
Interviews	Guided conversations with key informants (CasePHN staff and other stakeholders).	Guided conversations with key informants (practitioners and program leaders, senior staff and providers)
Direct observations	Observe how meetings and decision-making processes function, environment, IT, etc.	Attend meetings and observe decision-making processes where feasible.

5.6.1 Document analysis

Document analysis was used to understand the history, politics and context prior to the fieldwork period, in order to commence fieldwork well-informed. Document analysis reduces participant burden and allows the researcher to look for corroborating evidence rather than explanation (Creswell, 2003). Documents are written for a specific purpose and were considered in the context in which they were generated (Bryman, 2012; Creswell, 2003).

Document analysis continued throughout the study period, incorporating new documents referred to and provided by informants. Document analysis covered the breadth of the two relations that made up the outsourcing arrangement; for the CasePHN–Provider relations, a much deeper analysis was conducted for three specific relations included in the within case design (described in Section 5.4.3).

Documents fall into a number of different categories, grouped as publicly available documents and controlled documents (some of which may be commercial or confidential in nature and may be difficult to access).

Publicly available documents

Western Governments are highly transparent in their activities; PSOs and their agents often adopt a proactive policy of disclosure or 'open data'.[24] For this reason, there are many publicly available documents concerning policies, procedures, procurement activities, reviews, inquiries, strategies and financial accounts, as well as laws and statistical information about public sector

[24] For the Australian Government see https://www.pmc.gov.au/public-data/open-data (accessed 8 March 2019); for the NSW Government see https://data.nsw.gov.au/nsw-government-open-data-policy (accessed 24 October 2020).

activities (Bryman, 2012) — this transparency also extends to contracted parties as a condition of their engagement. Information not currently available may be subject to 'freedom of information' requests.[25] PSOs also report raw (deidentified) and analysed statistical data about the population; for example, socio-economic data are available from the ABS, and health data are available from AIHW.

Publicly available documents and data were downloaded from websites and stored in the datafile. Characteristics of the documents were recorded in an index created in an Excel file, including type of data (public), source, date of publication, date downloaded, and version number. During interviews, the researcher explored how familiar informants were with the documentation and whether practice aligned with policy and guidance.

Controlled documents

A number of controlled documents were provided to the researcher during the study. This included confidential documents (for example, documents relating to the commissioning of services) and internal documents (for example, procedures, minutes of meetings, organisational charts, and other non-sensitive information). Documents provided by the organisation that were not available publicly were identified as confidential in the datafile; these documents informed but are not quoted in this thesis.

Documents collected and analysed

Due to the extent of the document review, and the confidential nature of some of the documents included, only the scope and type of documents collected are described in Table 4 below. A list of documents referred to in the following chapters are provided in Appendix C, including the abbreviation used (in italics) in this thesis.

[25] In Australia, this is provided under the *Freedom of Information Act 1982 (Cth)* and managed by the Office of the Australian Information Commissioner https://www.oaic.gov.au/freedom-of-information/ (accessed 28 June 2020).

Table 4 Scope of archival documents collected and analysed

Scope	**Type of document** (including scope)
Primary healthcare	**Public documents** include reviews of Australian primary health care, AOD and mental health.
PHN Program	**Public documents** about the contact and contract phase (program requirements, legal agreement); control phase (guidelines on commissioning, Needs Assessments, Activity Work Plans, change management, market development, and performance reporting); other reports and evaluations (literature review and first evaluation); information for providers; and topic specific guidance (including AOD and mental health). **Controlled documents** include discussion papers and other guidance specific to CasePHN operations.
CasePHN organisational context	**Public documents** about the organisation, scope, governance, and services provided; this includes annual reports and strategic plans.
CasePHN's commissioning process	**Public and controlled documents** concerning the commissioning process, including Needs Assessments, Activity Work Plans, and policies, procedures and processes, and training material, and outputs relating to the design and procurement of services.
DoH–CasePHN relationship	**Public documents** include program guidelines and contract templates. **Controlled documents** include guidance and training material.
CasePHN–Provider relationship	**Public documents** concerning the commissioning process, from co-designing models of care to procurement and evaluation of services. **Controlled documents** concerning the procurement and management of three identified services, including contracts and performance reporting.

5.6.2 Interviews

Interviews provide a way to understand what happens in practice and why, in the context in which it happens (Yin, 2014). As noted in Section 5.4.3, the case study is bounded by the outsourcing of the PHN Program and specifically the DoH–CasePHN and CasePHN–Provider relations. Recruitment for interviews was purposeful and targeted the complete population (Creswell, 2003; Patton, 2015); all staff directly involved in establishing, monitoring or reviewing the relations identified were invited to participate in an interview (including DoH, CasePHN and providers). Given the size of the CasePHN, and to ensure anonymity, the invitation to participate was extended to all officers, managers and the Executive at the CasePHN involved in managing relations with providers — not just those relations identified for detailed analysis using within case design.

In addition, a number of external stakeholders were invited to participate in the study who had intimate knowledge of the outsourcing arrangement and the DoH–CasePHN and CasePHN–Provider relations. This included scholars, consultants, and representative organisations.

In compliance with ethics protocols, individuals were invited to participate in the study by the Executive and their direct reports. Participation in the study required informed, voluntary consent which could be withdrawn at any time. Where individuals agreed to participate, a time and place were organised that minimised inconvenience. Prior to the interview, the participant information statement and consent form were explained again, and permission was sought to audio record the interview. Audio recordings were transcribed by a professional transcription company under a confidentiality agreement (n=23), or by myself (n=26). Forty-nine interviews were conducted between July 2019 and August 2020 (Table 5).

Table 5 List of interviews

#	Date	Organisation	Position	Method	Minutes
1	Jul-19	Other	Stakeholder 1	face-to-face	45
2	Aug-19	Other	Stakeholder 2	skype	26
3	Sep-19	CasePHN	Manager 1	face-to-face	55
4			Officer 1	face-to-face	54
5	Oct-19	CasePHN	Manager 2	face-to-face	68
6			Officer 2	face-to-face	16
7			Manager 3, Officer 3	face-to-face	55
8			Executive 1	face-to-face	59
9			Manager 4	face-to-face	68
10			Manager 5	face-to-face	68
11	Nov-19	CasePHN	Executive 2	face-to-face	58
12			Executive 3	face-to-face	82
13			Executive 4	phone	55
14			Executive 4	phone	32
15		Other	Stakeholder 3	face-to-face	39
16		CasePHN	Manager 6	face-to-face	52
17			Executive 4	face-to-face	73
18	Dec-19	CasePHN	Officer 4	face-to-face	60
19			Manager 7	face-to-face	58
20			Executive 3	face-to-face	47
21		Provider	Provider 1	phone	40
22		CasePHN	Officer 5	face-to-face	37
23			Officer 3	phone	47
24			Officer 6	phone	68
25		Provider	Provider 2	phone	33
26		CasePHN	Manager 8	face-to-face	73
27			Manager 3	face-to-face	61
28			Officer 7	face-to-face	54
29			Officer 8	face-to-face	59
30			Officer 9	face-to-face	71
31			Manager 4	face-to-face	53
32			Executive 1	face-to-face	31
33			Officer 10	face-to-face	58
34			Manager 3	face-to-face	56
35		Provider	Provider 3	face-to-face	47

#	Date	Organisation	Position	Method	Minutes
36		CasePHN	Manager 9	phone	55
37	Jan-20	CasePHN	Officer 11	face-to-face	45
38			Executive 2	face-to-face	26
39			Executive 5	face-to-face	89
40		Other	Stakeholder 1	face-to-face	69
41		CasePHN	Manager 9	phone	78
42			Executive 5	face-to-face	119
43	Feb-20	Provider	Provider 4	phone	53
44			Provider 5	phone	50
45		Other	Stakeholder 4	phone	45
46			Stakeholder 5	phone	56
47	Mar-20	Other	Stakeholder 6	phone	44
48			Stakeholder 7	phone	56
49	Aug-20		Stakeholder 8	phone	58

Given the focus of inquiry, most informants were from within the CasePHN (Table 6). There was representation across the depth (from CEO to program officers) and breadth of the organisation (clinical, population health, corporate services, planning and other; Table 6 and Table 7). Some interviews were conducted with more than one informant (either due to availability or preference, or for specific purpose; Patton, 2015) and more than once either due to availability or due to the stage of the study.

Table 6 Interviews by organisation

	Interviews (n)	Interviewees (n)*
CasePHN		
Executives	11	5
Managers	13	9
Officers	12	11
Providers	5	5
Other stakeholders		
Researchers	2	1
Consultants	3	3
Non-government organisations (NGOs) /Peak representative organisation	2	2
Multiple organisations	1	1
Total	**49**	**37**

* Variations due to joint interviews and multiple interviews.

Table 7 Interviews by organisational stream

Stream (includes CasePHN and others)	Interviews (n)

Clinical	22*
Population health	9
Corporate services	8
Planning	4
Other	6
Total	**49**

* 11 mental health stream, 7 AOD stream, 1 Aboriginal health stream, 1 multiple

Interviews were open-ended, following the discussion guide presented in Appendix A; the scope included demographics and context, followed by questions related to the DoH–CasePHN and CasePHN–Provider relations. The discussion guide was checked by the Executive to increase the validity of the research instrument (Bouma & Ling, 2004). Every interview was recorded, transcribed, and supported by notes. As with every source of data, there may be issues of bias, recall, or inaccurate articulation (Yin, 2014). Evidence was verified wherever possible using other data sources (interviews, observations and documentation). This also increased the anonymity of informants.

Larger meetings with two or more participants at the initial stage of the study and when seeking validation of constructs were recorded as observations as they were not conducted under a discussion guide or audio recorded.

5.6.3 Observations

Observations allow researchers to collect naturally occurring data to understand the phenomenon in its setting; observations may be direct (attending meetings and observing the phenomenon in situ), indirect (about people, their behaviour, the environment, computer systems and technology), and include observations during the interview process (discussed above) (Bryman, 2012; Patton, 2015; Silverman, 2018). Observations are an opportunity to observe whether people do what they say they do, and observe activities in greater detail. Organisational and individual consent was provided to observe staff in the workplace.

Observations allow the researcher, among other things, to generate rich descriptions, be sensitive to the research context, be open (not limited by interview questions), ‘see the unseen’ (what is obvious to informants that is not mentioned in interviews), generate new insights and lines of inquiry, delve into sensitive issues, and overcome social desirability bias (Patton, 2015, p. 335). Like any method, it is not without issues. Staff may act differently with someone observing them in their workplace; however, over time, and as relationships build with the organisation, informants are likely to behave as they would if the researcher was not present.

Workplace observations commenced in September 2019 and continued through to March 2020. During this time I spent 29 days at the case organisation where I was able to observe and make

fieldnotes (Creswell, 2003). I was also able to observe a number of on-site and off-site meetings (n=15) relating to the organisation and how it managed each phase of the commissioning process. A summary of observations is provided in Table 8 below.

Table 8 Summary of observations

Location	Nature of observations
CasePHN (29 days)	Observations in the workplace (between September 2019 and March 2020).
Meetings (n=15)	Onsite meetings related to service procurement and moderation, 'Procurement Hub', organisational 'stand-up' briefings, research meetings with managers and executives, and T demonstrations (including Folio and SharePoint). Off-site meetings related to contract management, interviewing providers, advisory group, and attending an AOD film screening (networking with key health staff).

Detailed summaries of observations were made (Bryman, 2012); where the observations were part of formal meetings, these notes were cross-checked with records of meetings. Observations were verified using other data sources, and vice versa.

5.7 Data coding and analysis

Data were collected, stored, labelled, coded and analysed to answer the research question. This section describes the techniques used to manage and analyse the data.

5.7.1 Managing data

Case studies have the potential to generate a large amount of data. A process was established to store data in accordance with ethics protocols and ensure a chain of evidence was maintained. In line with ethics protocols, data will be stored in a de-identified form and destroyed after 7 years.

All documents, interview transcripts and observations were first saved in the datafile, using unique codes to label each piece of evidence identifying key attributes (Saldana, 2016); for example, type of data (document, interview, observation), the nature of the material (public, confidential), and other identifiers (organisational, demographic). An index was created in an Excel file that listed the name, source, link to, and any conditions attached to the use of the data, with a separate sheet for each type of data. A fieldwork diary was also maintained to organise data collection and note any follow-up actions.

5.7.2 Making sense of the data

NVivo software[26] was used to attach codes to data and organise the data for further analysis, allowing sense to be made of the data while identifying themes arising. The use of software is beneficial when analysing unstructured data from different sources; it provides a chain of evidence between the data, analysis and reporting, and allows gaps in data to be identified and resolved (Patton, 2015).

Data was coded using an incremental design, in four stages. The first cycle of coding was based on high-level descriptive codes — the type of data and source, and the relation it was associated with (DoH–CasePHN, CasePHN–Provider). The second and third cycle of coding then classified and sorted data according to the phase of the commissioning process – this was particularly important in capturing the dynamics of the DoH–CasePHN and CasePHN–Provider relations over time as processes matured. I used a pre-determined set of codes generated from the PHN Program documentation relating to the commissioning cycle, enabling the coding to remain in a language familiar to informants. Codes related to the organisation (context, governance, operating framework), program requirements (different codes for each relationship based on program requirements), contact and contract phase (procurement process, approaching the market, selecting the supplier, negotiating the award, executing the contract), contract management (implementing the contract, managing the contract, reviewing and renewing the contract and how this changed over time), and the review process (by individual relations, across different relations, program review, process review). While pre-determined codes can restrict analysis to pre-determined themes (Saldana, 2016), a category of 'other' was added to capture data that did not fit neatly into the commissioning model. Finally, a fourth cycle of coding was conducted using thematic coding *in vivo* where data in the third cycle of coding needed to be explored further, again maintaining the language of informants (Saldana, 2016). In some cases, third order codes were added or adjusted in response. The coding process enabled me to identify specific areas of interest in the case setting. The final coding frame is presented in Appendix B.

5.7.3 Analysis, interpretation, validation and reporting

The depth of case study data enabled me to examine different phases of the contracting relations (contact, contract and control) to understand variations across the phases and across different relations over time as controls matured. After initial analysis, and in accordance with the abductive approach (see Section 5.3), first order constructs were presented back to

[26] NVivo Version 11.4.3, provided by QRS International.

informants for verification during follow up interviews with the Executive (Blaikie, 2000; Bouma & Ling, 2004; Cristofoli et al., 2010).

The constructs were then redescribed in the language used in the literature for further analysis. For example, while some informants and data specifically included the term ‘probity’ and the requirement to meet probity obligations, probity was also identified in other ways such as evidence of the extent probity was managed through transparent governance processes (policies, procedures, delegations). In comparison, the term ‘low contractibility’ was not used by research participants but was identified in terms of difficulty in determining and measuring services required.

Once coded, categories (Saldana, 2016), patterns and the relationship between codes can start to be understood. Data analysis is about finding patterns, including similarities, differences, frequencies, sequences, correspondence (to other activities), and causation, as well as inconsistencies (anomalies and deviations), and understanding why they occur (Bryman, 2012; Saldana, 2016). As this occurs, the amount of data is reduced to the areas of interest, making it possible to interpret.

The conceptual framing, identifying the transaction characteristics likely to be present (Chapter 3) and the control strategies likely to be used in this setting (Chapter 4), was used to organise the data and then find similarities and differences between the conceptual framing and the data. The data from the case study was analysed to confirm the transaction characteristics present and then used to identify how different relational and bureaucratic control strategies were used across each phase of both contract relations that make up the outsourcing arrangements. The results of this stage of analysis are presented in Chapter 6 and Chapter 7.

Further analysis was then undertaken to identify how low contractibility and probity, and the tension between them, were managed across the outsourcing process – including how this differed across the relations. This analysis was used to confirm and extend the conceptual framing. The analysis is presented in Chapter 8 and the theoretical and practical implications are presented in Chapter 9.

The use of an evolving analytical framework, enabled by an abductive approach and supported by theory, allows a systematic approach to be used; this is in keeping with the post-positivist inquiry paradigm, while also increasing validity (Dubois & Gadde, 2002; Miles, Huberman, & Saldana, 2014).

5.8 Validity of approach

To ensure the accurate reflection of the phenomenon (Ritchie & Lewis, 2003), the design must demonstrate reliability (same data and conclusions, or internal subjectivity) and validity (whether a statement corresponds to reality) (Nørreklit, Nørreklit, & Israelsen, 2006). Validity is required in terms of both the choice of method and how it is applied — given this study is qualitative in nature, how rigorously data is collected and interpreted (Lincoln & Guba, 2000).[27]

Given the choice of method, I consider four common tests applied to social science case study research about the validity and reliability of this approach: construct validity, internal validity, external validity, and reliability (Yin, 2014). While each is considered throughout the research design, it is reported separately here to clearly demonstrate how the design choices increase the validity and reliability of the findings (Creswell, 2003).

5.8.1 Construct validity

Construct validity concerns 'identifying the correct operational measures for the concepts being studied' (Yin, 2014), that is, 'the extent to which the constructs of theoretical interest are successfully operationalised in the research' (Abernethy et al., 1999, p. 8). Construct validity can be demonstrated by triangulating multiple sources of evidence (i.e. constructs are stable across multiple sources; Bryman, 2012), establishing a chain of evidence, and asking key informants to review draft findings to ensure the correct measures are used (Yin, 2014). This is particularly important to ensure the results stay true to the original data (Ritchie & Lewis, 2003).

In this study, in addition to using constructs already evident in the literature, the abductive strategy provided a 'communal test of validity' to the research (Lincoln & Guba, 2000, p. 177) and contributed to construct validity (Bryman, 2012). First order constructs were generated from detailed accounts and observations, validated with key informants, to ensure operational measures for concepts being studied reflected practice. Second order constructs, while more technical in nature, were again validated with informants and experts, providing a second test of construct validity.[28] Abductive reasoning, and the stepped approach to generate and validate constructs, allows me to generate plausible explanations (Lukka, 2014). The empirical chapters

[27] Creswell (2003, pp. 196–197) identifies eight strategies for qualitative researchers to check the accuracy of their findings: triangulating different sources of data; parallel coding by another researcher; using rich descriptions; being honest about researcher bias; including information counter to themes (not just material supporting); spending sufficient time in the field to understand phenomenon being studied; validating findings with the organisation; and the use of an external auditor.

[28] This was achieved by follow up interviews with key informants to validate preliminary findings, the drafting of a Board paper summarising the analysis, and providing a summary of the research to informants who were invited to provide feedback.

of this thesis were also provided to a member of the Executive to ensure the results remained true to the original data.

5.8.2 Internal validity

Internal validity concerns the strength of the causal relation (and absence of other causes) (Yin, 2014), that is the 'extent to which the research design permits us to reach causal conclusions' (Abernethy et al., 1999, p. 8) and the confidence of any relationship found (Bryman, 2012). The causal relation is informed by prior literature and uses evidence from informants to validate or question the conceptual framing (Bryman, 2012). A number of steps were taken to strengthen internal validity, including the use of a suitable sample of data to capture the phenomenon, accurately identifying and labelling the data (coding), constantly comparing the data (intersubjectivity; Blaikie, 2000) and checking accuracy of fit during the analysis, and testing findings from one aspect of the data (for example, interviews) with another (for example, documentation). The use of a case study method, focusing on events directly related to specific contractual relations in the context they occurred, drawing on multiple sources of evidence, enabled me to corroborate findings and build explanation (Lukka & Modell, 2010). This allowed me to generate rich descriptions from the data, adding to the authenticity and plausibility of the findings (Lukka & Modell, 2010).

Important here is not disregarding outlier or deviant cases (Ritchie & Lewis, 2003). Where data were contrary or missing, alternative or rival explanations were explored. The abductive method contributes to internal validity as 'contrastive thinking is crucial' to this method (Lukka, 2014, p. 564).

5.8.3 External validity

External validity relates to whether and how the findings are applicable to other 'populations, settings or times' (Abernethy et al., 1999, p. 8). The use of prior theory and replication logic (Yin, 2014) contributes to identifying the criteria used to select and define the case; this enables the study to be replicated in similar settings such that the findings should be equally plausible. Choosing a case study that is representative of an extreme context offers opportunities to externally validate the findings more so than if an extreme case was selected (in this study, the CasePHN is one of 31 PHNs operating across Australia). Despite this, given the idiosyncratic nature of the CasePHN (geographic and socio-economic context) and the study period, it is unlikely that direct replication is realistic.

Some scholars are sceptical about whether case studies can demonstrate external validity given settings are likely to continually change, referring to the inability to 'freeze' a social context (Bryman, 2012, p. 390); while PSOs and the services they provide could be criticised for being

overly bureaucratic and slow to transform or adapt, they are nonetheless subject to change and therefore these concerns are also likely to apply here. I therefore accept that the research is unlikely to be directly generalisable with a single unit of analysis; however, the depth of this case study means that it is still able to generate theory out of the findings (Bryman, 2012, p. 17).

Given the abductive logic of inquiry, I was able to validate findings with respondents and explore external validity, given this was not the only outsourcing or contracting relation informants have been or were involved with. The thick descriptions generated by the case study method and the abductive approach (Lukka & Modell, 2010) contribute to external validity in that the *relatability* of the research could be tested instead (Blaikie, 2000, p. 222). Relatability was tested beyond the case organisation; for example, asking providers, other researchers and practitioners whether they could relate to the findings of the research. Given the exploratory nature of this study, exploring the credibility, transferability or plausibility of the findings is considered to be appropriate (Lincoln & Guba, 2000).

5.8.4 Reliability

Reliability relates to whether data collection procedures, if repeated, would give the same results (Yin, 2014). A scientific procedure in the form of a site-specific research protocol was developed with the case organisation prior to data collection; this was updated during the fieldwork period to ensure that it accurately described how data was collected and analysed. Careful records of evidence gathered also created a chain of evidence that can be audited by other researchers. This approach both minimises the likelihood of error or bias, and if used to replicate the study in the same setting with the same participants over the same time period, should provide results close to those presented here (Bryman, 2012).

5.9 Limitations to the research design

While I have been as transparent and logical as possible in designing this study, I cannot claim it is the 'royal road to ultimate knowledge' (Lincoln & Guba, 2000, p. 178). First, a case study using abductive reasoning relies on the ongoing engagement of the case organisation. The CasePHN was highly engaged throughout the study; this approach required an extensive fieldwork period to enable staff to participate in the research outside of peaks in their workload. This approach may be difficult to replicate in other organisational settings or when the researcher has less time to complete the study. The level of engagement by other parties varied. Providers were active participants in the study, participating in interviews and observations, while DoH participated by written correspondence only — often taking weeks or months to respond. Given the documentation available publicly, and the engagement of other stakeholders, this did not compromise the study.

Second, while the validity of case study research is increased where there are multiple cases, given the exploratory nature of this thesis it was premature to consider multiple case design. The single case method is akin to a pilot study that could be refined for further testing, adding to the validity of future results. Using a within case design provided an opportunity to look at multiple relations between the CasePHN (the constant) and different providers in more depth.

Third, qualitative case study research faces many criticisms related to objectivity and demonstrating validity (among other things; Bryman, 2012). Such criticisms have been identified and addressed in this chapter.

Finally, during data collection the context was affected by a number of significant external health-related events which required the CasePHN's full attention (bushfires, measles outbreak, COVID-19). Data collection was minimised during each event to ensure responses were unobstructed and burden was minimised. Observations continued for as long as possible, providing opportunities to witness how disturbances were managed.

5.10 Chapter summary

This chapter presented the research design for the empirical study. First, I explained the sequential design choices, including the epistemological and ontological considerations that provided the philosophical foundation for the methodology and approach. Given the exploratory nature of this study, I used a post-positivist methodology, with abductive reasoning, to describe and infer the best explanation from a social phenomenon. Theoretical criteria were used to select a case study that provided a representative outsourcing arrangement within an extreme context (human service outsourcing). I then described data collection and analysis procedures, and key data sources. Finally, I described the validity of and limitations to the research design. The next two chapters provide a rich description of the case study, organised by the two relations that make up the outsourcing arrangement.

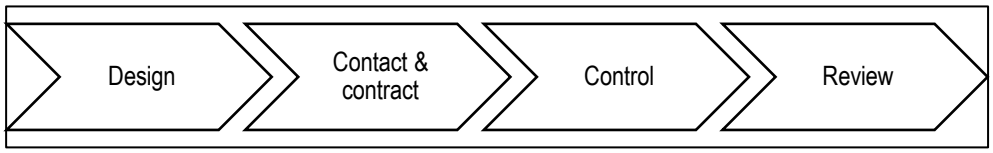
Chapter 6 The DoH–CasePHN relation

6.1 Introduction

The public sector outsourcing of primary health care services through the PHN Program involves two sets of contracting relations: the PSO–Intermediary relation established to implement the program, and the Intermediary–Provider relations established to provide commissioned services. Examining both relations, and how one affects the other, provides insights into how PSOs organise and control the outsourcing of human services.

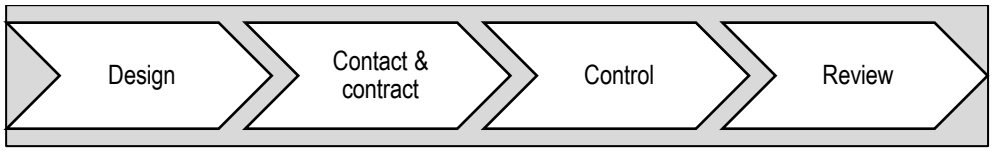
This chapter presents the detailed case description of the first part of the outsourcing arrangement — the relation between the PSO (Department of Health; DoH) and one intermediary (the CasePHN). The chapter starts by describing the context of the outsourcing arrangement (Section 6.2) and the program design (Section 6.3). The contact, partner selection and contract phase, contract management (control) phase, and review phase are then described in turn (Sections 6.4–6.6), represented in Figure 6 below (the outer box being context).

Figure 6 Chapter structure



The program documentation referenced in the next three chapters are listed in Appendix C, including the abbreviation used presented in italics.

6.2 About the PHN Program



This section explains the context of the program being outsourced. This includes a definition of primary health care, the history of primary health care in Australia, and why and how the PHN Program was introduced. The section also includes a brief overview of the CasePHN and the context in which it operates.

6.2.1 Definition of primary health care

The *Alma-Ata Declaration* (WHO, 1978) identifies health as a fundamental human right, comprising physical, mental and social wellbeing, and defines primary health as:

> Essential health care … made **universally accessible** to individuals and families in the community… . It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the **first level of contact** of individuals, the family and community with the national health system bringing **health care as close as possible to where people live and work,** and constitutes the **first element of a continuing health care process.** (emphasis added, Paragraph VI)

The Declaration highlights people not only have the right to health care, but also the 'right and duty to participate individually and collectively in the planning and implementation of their health care' (paragraph IV).

In Australia, DoH defines primary health care as:

> …**generally** the first contact a person has with Australia's health system. It relates to the treatment of patients **who are not admitted to hospital**. (emphasis added, *PHN FAQ*, p.1)

Primary health care may be better identified by activities, as presented in the shaded boxes in Figure 7 below, although the boundary between primary health and acute residential care is not always clear (*Interview 49*).

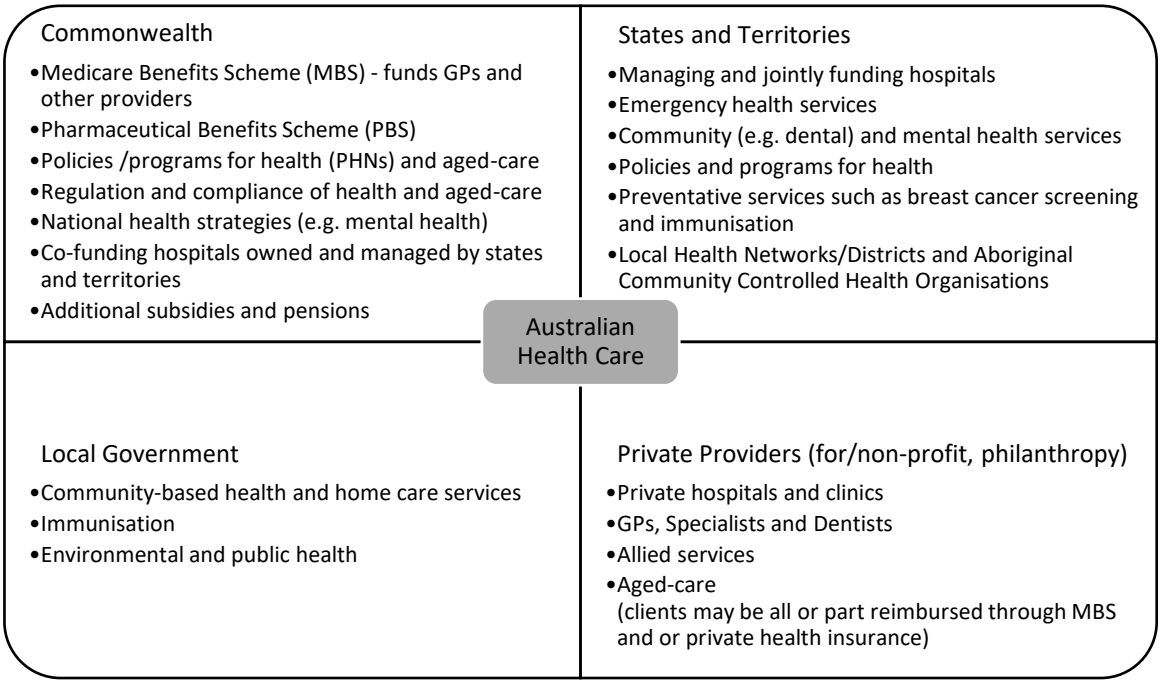
Figure 7 Identifying primary health care by activities

Source: Content drawn from DoH website https://www.health.gov.au/sites/default/files/australia-s-health-landscape_1.jpg (accessed 8 Jan 2020). Shading denotes primary health care activities.

6.2.2 Primary health care in Australia

An overview of the health landscape in Australia is presented in Figure 8 below, identifying the key responsibilities of each tier of government and private health providers.

Figure 8 Overview of the health landscape in Australia (stakeholder responsibilities)



Sources: health.gov.au/about-us/the-australian-health-system (accessed 4 July 2020), Henderson et al. (Henderson et al., 2018), and PWC (2011)

Figure 8 highlights how fragmented the health care landscape is in Australia. This affects how different parts of the system communicate with each other, with communication not being 'the default' (*Interview 49*), and how people access services.

> I've never seen more service fragmentation than I've ever seen. Now, we're having to have these care navigators and I think what a failure, what a failure. We're having to introduce these specialised roles to cope with the fact we've now got this service fragmentation. …. I think the language of integration is the language of failure in some respects. … It's saying that our services are so disconnected that we need to integrate them. (*Interview 12*)

Service providers need to engage and negotiate with different policy and funding stakeholders (Butcher & Gilchrist, 2016; Henderson et al., 2018), while service users may need skills or assistance in navigating the service landscape. One stakeholder suggested that the fragmentation is so engrained that a 'black swan event' (triggered by financial, workforce, and another driver) would be needed to drive the substantial changes required to resolve the complexity and fragmentation in the operating context (*Interview 1*).[29]

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

The split in funding and delivery of primary and acute health care has implications for the overall functioning of the health system, with adjustments to one often impacting (positively or negatively) on another. Prevention and early intervention programs can significantly reduce costs of acute care (*Interview 42*), while decisions to close public outpatient clinics may lead to additional costs to GPs and limit care to those who can afford private specialists (*Interview 42*). One informant said:

> We are, at the end of the day, also consumers of the system … I want, when I need a service, to know what is out there, to be able to access it in a timely way, that it isn't going to impact financially on me in a way that I can't afford, and that I get a good quality service, I'm treated respectfully, and that whatever I've gone there for has actually been addressed. … The biggest challenge is the fragmentation. (*Interview 11*)

Fragmentation is not the only problem. With improved health outcomes leading to an ageing population, and with changes in lifestyles, services need to address more chronic and complex conditions — conditions that, in the existing landscape, require coordination across a range of health care providers (Horvath, 2014).

In strengthening primary health care, there are opportunities to improve population health, reduce health inequalities, reduce the cost of healthcare (reducing the need for more intensive care), and increase patient satisfaction (*PHN Evaluation*, p.9). Improving coordination in primary care is particularly important given the independence of general practice from the broader Australian health system (J. A. Smith & Sibthorpe, 2007). Notable changes to the coordination of primary health care occurred with the introduction of 119 Divisions of General Practice (1992); their subsequent consolidation into 61 Medicare Locals (2011); and their further consolidation into 31 PHNs (2015) (Horvath, 2014). The size of PHNs provide economies of scale while providing opportunities to connect with local communities to identify and meet their needs (Booth & Boxall, 2016). The impact of each change was felt by staff working in both primary health coordination and service provision (*Interview 40, Interview 42*); some stakeholders perceived this change to widen the gap between coordination and services (*Interview 40*, *Interview 49*). Over this time, the scope changed from coordinating, to coordinating and providing services, to coordinating and commissioning services, increasingly leveraging the market to achieve efficiencies in meeting national health priorities (Henderson et al., 2018; Horvath, 2014).

6.2.3 Introduction and governance of the PHN Program

The PHN Program was established under legislation 'to integrate the care of patients across the health system and improve health outcomes for communities…' (*Financial Framework (Supplementary Powers) Regulations 1997,* Schedule 1AB, Part 4, Section 57). The PHN Program has two key objectives:

> To improve the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.
>
> To improve the coordination of care to ensure patients receive the right care, in the right place, at the right time. (*PHN FAQ*, p.1)

To achieve these objectives, PHNs are required to: identify primary healthcare needs in their region and commission services to address those needs; support GPs and other health practitioners, and build capacity and quality of care; and collaborate and integrate services locally and eliminate service duplication (*PHN FAQ*). This case study focuses on the commissioning of services, defined as 'a continual and iterative cycle involving the development and implementation of services based on Needs Assessment, planning, co-design, procurement, monitoring and evaluation', discussed in Section 6.3.2 (*PHN Commissioning*). DoH established seven national priority areas to guide the commissioning of services — mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged-care, and AOD — supported by specific funding streams.

The ongoing administration and oversight of the PHN Program rests with the DoH PHN Branch (*PHN Guidelines*). The structure and location of the PHN Branch has changed over the duration of the program, from state-based to centralised arrangements (*Interview 38*). While the PHN Branch has overall responsibility for the program, other branches (such as Mental Health Services and AOD) fund and provide oversight for specific activities (*Interview 38; PHN Evaluation*), making the management of the program complex for all stakeholders concerned (*PHN Evaluation*). The PHN Branch is often a 'conduit' rather than 'decision makers in their own rights' (*Interview 38*).

6.2.4 The CasePHN and the operating context

Each PHN has a unique organisational legacy[30] which impacted on the speed they matured and their relationships with key stakeholders (*Interview 39, Interview 44, PHN Evaluation*). This section describes the operating context, legacy and governance of the CasePHN.

[30] Of 31 PHNs, 12 PHNs were formed by a direct a one-to-one transition from Medicare Locals, three were a direct transition from Medicare Locals with a boundary change, seven comprised a consortium of Medicare Locals with other organisations (including providers, NGOs, university, PSOs, peak bodies), six comprised a consortium of Medicare Locals only, and three were new organisations; i.e. they lost all corporate knowledge of primary health coordination in the region in the transition (*PHN Evaluation*, p.12). 'Medicare Locals that had the same boundaries [one-for-one] as LHDs … had a certain status because, they were valued, almost embedded partners with those LHDs' (Interview 39).

Operating context

The CasePHN serves a diverse population in a metropolitan area in NSW; the boundary is defined by two Local Health Districts (LHDs), with two additional local hospital networks (LHNs) within the region. To give a sense of operational scale, in 2019–2020, the CasePHN was supported by 88.8 FTE and received $47.6m from DoH to deliver the PHN Program (up from $35.3m in 2016–2017) with 70% going directly to commissioned services (*Annual Report*). The CasePHN also receives funding from other organisations for research, early intervention and screening programs (*Interview 5, Interview 12, Interview 19*), as well as additional funding from DoH to trial programs as a 'lead site' (*Interview 30*).

Legacy

The CasePHN was formed by three Medicare Locals. While this allowed the PHN to retain intellectual property (*Interview 39*), the legacy organisations worked quite differently (procuring or delivering services directly; *Interview 10, Interview 42*), and had varying relationships and reputations with key stakeholders (*Interview 1, Interview 42*). The CasePHN went through a bigger change than most PHNs (*Interview 1*), and took time to consolidate operations and organisational cultures (*Interview 3, Interview 42*).

Program officers had clinical or population health backgrounds (*Interview 3*) and different levels of experience in primary health care coordination (*Interview 39*). Of the staff interviewed, four had transitioned from Divisions to Medicare Locals to PHNs, while an additional four had worked for a Medicare Local. CasePHN Staff turnover was initially high (29% in 2015, dropping to 14% in 2019; *Board Paper: HR Metrics*), reflecting changes to the organisation, roles, office location, and funding which created insecurity for staff (*Interview 13, Interview 26*). Particular roles suffered from high staff turnover (*Interview 1*), while other roles were difficult to fill due to the remuneration available not reflecting the skills required (*Interview 8, Interview 9*). Staff changes led to a loss in momentum (*Interview 3, Interview 10*) and it took 'quite a while for people to realise their place and also to realise there might not be a place and move on' (*Interview 13*). There was also instability outside the organisation with changes in NSW Health.

> LHDs, don't forget, have gone through heaps of amalgamations and dis-amalgamations over their time as well. So, they'd have the same sort of one step forward, two steps back type of thing as well, because it's not long ago that they were, you know, amalgamated to be bigger and they've only just come back to be smaller. … Change is just the norm. (*Interview 3*)

The commissioning role was new for the organisation and most staff, and had to be developed from the ground up. The CasePHN went through a period of rapid development — establishing policies and procedures, developing skills and systems to deliver its core functions. Operations consequently took a step backwards, taking 1–2 years to consolidate (*Interview 3*), and up to 3-

years to recover from 'having the infrastructure bulldozed flat and having to rebuild' (*Interview 39*).

Governance

The CasePHN is operated by an independent incorporated entity established to promote 'health, and control and prevention of disease in human beings… under a funding agreement with [DoH]' (*Constitution*). The legal entity comprises 'seven member networks, including five general practice companies, one allied health network and a community network' (*Strategic Plan*). The CasePHN publishes an Annual Report, including audited financial statements, reporting on the operations of the PHN in the financial period.

The Board is the key decision-making body of the organisation, supported by a Community Council, Clinical Council, Clinical Leaders Network and Advisory Groups (see Table 9 below).

Table 9 Governance mechanisms within the CasePHN

Group	Membership	Role	Source
Board	8 elected, 3 appointed members (content experts, law and commerce)	Approves strategic plan, provides direction, approves funding allocations, and reviews strategic risks Supported by committees on finance, audit and risk, governance and nominations	*Constitution* *Strategic Plan* *Risk Policy* *Annual Report*
Clinical Council	21 members (primary health care professionals)	Advises Board and staff on clinical matters, including quality of care, practice issues, health planning and commissioning GP-led	*Strategic Plan* *Annual Report* *PHN Guidelines*
Community Council	18 members	Advises Board on regional issues and person-led care Provides input to commissioning activities	*Annual Report* *Strategic Plan* *PHN Contracting*
Clinical Leaders Network	Purely clinicians (new group, <12 months)	Advises on health care reform; health care delivery rather than population health Identifies clinical champions	*Interview 49*
11 Advisory Groups[31]	Terms of reference and membership vary for each group	Support regional planning and service integration Provide forums to share knowledge and practice, develop relationships, promote services, provide support/advocacy Support commissioning (program design, partner selection, evaluation)	*Annual Report*

[31] Aboriginal and Torres Strait Islander Health and Wellbeing; Health Pathways; Continuing Professional Development; AOD; Antenatal Shared Care; Mental Health and Suicide Prevention; 'Can Get Health Canterbury'; After-Hours; Disability; Person-Centred Medical Neighbourhood (*Strategic Plan*).

Group	Membership	Role	Source
		Include lived experience, cultural diversity, and different stakeholders Meetings supplemented with newsletters (*Interview 7, Interview 34*)	

The Clinical Council, Community Council and Advisory Groups are considered integral to the functioning of the CasePHN.

> We certainly have a culture of pragmatism that, you know, we acknowledge that we're not the experts on everything and that… there are plenty of people who know more… So why wouldn't you involve them and get advice from them on running the stuff that we do? (*Interview 39*).

Board members include senior staff from key stakeholder organisations (LHDs, LHNs) who 'bring a perspective' but 'do not represent' the organisations they work for (*Interview 42*). The skills of the Board are reviewed annually; current deficits include audit, finance, marketing, and IT, while the membership also lacks diversity (cultural and age) (*Interview 12, Interview 13, Interview 42, Interview 46*).

The functioning of the Board is evaluated regularly, and has demonstrated 'improved collegiality, information sharing, and communication among board members and between the board and the Exec[utive]' (*Interview 49*). The Chairs of the Board, Clinical and Community Councils meet regularly (*Annual Report*) and ensure 'there's clear two-way communication' between them (*Interview 49*). While there may be some perceived conflicts of interest in the membership of governance groups and the operations of the CasePHN, one stakeholder perceived this as 'a lot of aligned interests' (Interview 49). Potential conflicts of interest are actively identified and managed through conflict of interest *(CoI) Policy, CoI Procedure* and *CoI Declarations*.

As the CasePHN matured, the Board reporting requirements changed: 'their expectation in 2016 is different to what their expectation is now' (*Interview 10*), with trust in the Executive growing (*Interview 12*). This in part is due to the Executive improving information going to the Board, particularly financial information (underspend, commitment and forecasts) and how it is presented (dashboards), and in part due to improvements in systems, operations and performance; for example, reducing underspend from $8m to $4m to $400k over a 3-year period, and committing 98.3% funds in the last period (*Interview 13, Interview 16*, *Pipeline Report, Monthly Management Financial Report*). The Board is pushing the CasePHN towards outcomes-based commissioning and to make 'better use of data, better use of e-communication, better use of electronic means of improving care, better use of practice nurses

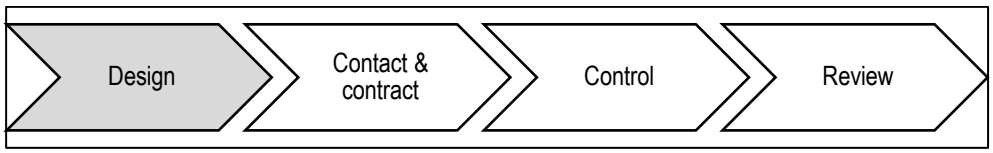
in general practice', and is working with a group of clinicians (Clinical Leaders Network) who are interested in driving change (*Interview 42*).

The CasePHN has evolved rapidly, consolidating the three legacy organisations and developing relationships with key stakeholders in the region. After a period of instability, the operations and governance have stabilised, and staff turnover has reduced.

6.2.5 Summary

Primary health care is a critical part of the Australian health care landscape and supports the overall socio-economic development of the community. The coordination and delivery of primary health care in Australia has undergone significant change, with the most recent resulting in the introduction of PHN Program. The CasePHN implements the PHN Program in a metropolitan region in NSW. The CasePHN was formed from three Medicare Locals and has taken time to consolidate and develop business practices around commissioning. The operations of the CasePHN have now settled, evidenced by a reduction in staff turnover and greater confidence by the Board in the Executive. The remainder of the chapter describes the PHN Program and the DoH–CasePHN relation — the first part of the outsourcing arrangement.

6.3 PHN Program requirements



The PHN Program was not entirely new, rather a variation of what existed under Medicare Locals delivered at a different scale. This enabled DoH to engage with existing stakeholders — state and territory governments, Medicare Locals and peak bodies — when developing the PHN Program requirements. The requirements, established prior to contact phase, include governance and operational requirements (Sections 6.3.1 and 6.3.2) and the structure of the contract (Section 6.3.3); additional requirements (including performance measurement) were developed *ex-post*. The Program documentation provided by DoH to augment delivery of the PHN Program and support both the DoH–PHN and the PHN–Provider relationships are referred to in italics (see Appendix C, Table 20 for a comprehensive list).

6.3.1 Governance requirements

DoH recognises that good governance can have a positive influence on performance and enables public scrutiny (*PHN Evaluation, PHN Literature Review*).

> The stronger that an organisation's internal governance arrangements are, the less likely central government will feel the need to intervene. (*PHN Literature Review, p.26*)

The *PHN Guidelines* specify the type of organisation that can operate a PHN, as well as the governance structures required to deliver the program. To be eligible to operate a PHN, the organisation must be an incorporated body or public sector entity (not specifying whether it should be non-profit; *PHN Guidelines*). As legal entities, PHNs are required under the *Corporations Act 2001 (Cth)* to maintain and audit accounts for their members, allowing financial scrutiny of the organisations (*PHN Literature Review*).

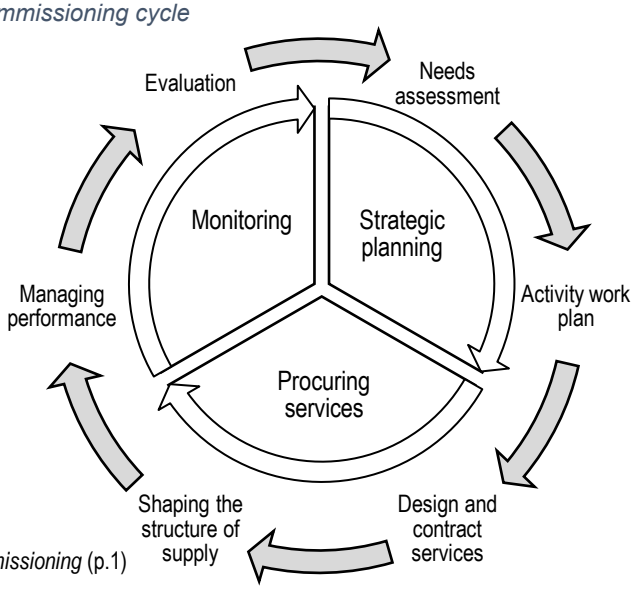
The *PHN Guidelines* require PHNs to establish a skills-based Board, reflecting the Corporate Governance Principles described by the Australian Stock Exchange (ASX). The Board is accountable for 'the performance of the PHN in relation to outcomes, as well as clinical, financial, risk, planning, legal and business management systems' (*PHN Guidelines*), and must actively manage and avoid conflicts of interest. Subsequent guidelines (*PHN Change Management*) also encourage shared leadership to reduce the risk of relying on individuals who may move on. Governance structures must address cross-boundary issues and enable collaboration and partnerships with other PHNs.

The *PHN Guidelines* also require PHNs to involve communities in governance through GP-led Clinical Councils, Community Advisory Committees, and work with LHNs/LHDs and other key stakeholders, to ensure the needs of the community are identified and met (*PHN Change Management*). This increases consumer participation in health service planning (*PHN Contracting*), reflecting the *Alma-Ata Declaration*.

6.3.2 Operational requirements

PHNs are required to commission services through a cycle of planning, procuring, and monitoring services, presented in Figure 9 (*PHN Commissioning,* p.1).

Figure 9 The commissioning cycle



Source: *PHN Commissioning* (p.1)

The commissioning cycle establishes the key mechanisms used to manage the DoH–CasePHN relation and deliver the PHN Program. First, PHNs are required to conduct a Needs Assessment for each funding schedule using data to identifying health needs and service needs within the PHN region, and public consultations to confirm needs and identify priorities and how they might be addressed (*PHN Guidelines*). Second, PHNs are required to develop an Activity Work Plan for each Needs Assessment/funding schedule, providing a list of activities it plans to commission (or de-commission) over a 12-month period that meet the priorities identified in the Needs Assessment — based on funding provided (including any conditions on use) and capacity of the market to deliver (*PHN Contracting, PHN Needs Assessment*). The PHN then reports on progress against the Activity Work Plan.

The *PHN Guidelines* require PHNs to engage in market development to encourage competition and therefore choice (for PHNs and consumers) and efficiency (value for money and innovation; *PHN Designing and Contracting Services*). The *PHN Guidelines* and *PHN Framework* also encourage collaboration with DoH, with each other (through knowledge exchange and co-commissioning/co-procurement), and with state and territory governments, LHNs/LHDs, providers and the community, recognising the complex operating context. Collaboration is integral to the commissioning cycle across the development of the Needs Assessment and Activity Workplans, and in terms of market development, procurement, monitoring and evaluation.

DoH identifies a mix of financial and non-financial incentives to encourage PHNs to meet their objectives:

> High performing PHNs will be identified through performance measurement processes, including benchmarking and through PHNs contribution to system development and the sharing of innovations and best practice. High performance may attract various financial and non-financial rewards such as: incentive funding; increased contract length; the opportunity to take over contracts for those regions with poor performers; and/or public recognition of performance. (*PHN Guidelines*)

This is discussed further in Section 6.5.2.

6.3.3 Structure of the contract

The legal agreement used to establish PHNs comprises a Standard Funding Agreement (*SFA*) used across all DoH activities which specifies the general terms and conditions. The SFA is supported by a Core Funding Schedule, and a series of Activity Funding Schedules that specify funding, operational requirements, milestones and related payments, and any documents incorporated into those terms and conditions (for example, the *PHN Guidelines*). The SFA and Core Funding Schedule were issued for 3-years, while the duration of Activity Funding Schedules varies.

Standard Funding Agreement

The terms and conditions of the *SFA* cannot be changed, only added to (*PHN Guidelines*). They are largely administrative, relating to record keeping and accounts, reporting, personal information (§2); use of funds, payments (§3); personnel controls (§4); assets (§5); access to premises and information (§6); intellectual property (§7); confidentiality (§8); and risk management (§9).

The *SFA* establishes provisions for cybernetic controls, with specifics contained in the Schedules (budgets, financial accounts, records and reports for each activity). The *SFA* requires expenditure of funds prior to the activity end date (§3.3.3) specified in the Activity Funding Schedule. There are provisions for carry over of committed funds due to unforeseen delays (§3.3.4), pending delivery of final reports (§3.3.5), or where an expense has been incurred but not invoiced (*Board Paper $*).

Core Funding Schedule

The *SFA* is accompanied by a Core Funding Schedule; this specifies and resources core PHN activities. Funding allocation 'takes into account a number of factors, including population, rurality and socioeconomic factors' (*PHN Guidelines*) and is allocated in three streams:

> **Operational funding** for the administrative, governance and core functions of PHNs.

> **Flexible funding** to enable PHNs to respond to identified national priorities.
>
> **Program funding** to commission program specific services, having completed the regional Needs Assessment … (*PHN Guidelines*)

Innovation and incentive funding may also be provided. Innovation funding may be provided to develop innovative models that, where successful, could be implemented more broadly (*PHN Guidelines*). This is evidenced through DoH funding 'lead sites' (*Interview 30*) to trial different programs. There is no evidence of incentive funding to date.

The Core Funding Schedule specifies reporting requirements. PHNs are required to demonstrate their governance structure is in place; prepare a Needs Assessment and Activity Work Plans; report on the implementation of Activity Work Plans at 6 and 12-month intervals; and report on financials. Guidelines describing how performance would be assessed were issued 9 months after the program was implemented (focusing on program implementation) and updated more than 3 years after the program was implemented (focusing on whether the program is meeting its objectives), with regular reviews planned.

Activity Funding Schedules

The *SFA* and *PHN Guidelines* allow DoH to add Activity Funding Schedules to the contract to deliver national health priorities without returning to the market (*PHN Guidelines*).[32] Schedules vary in duration from 6-months to 3-years (see Section 6.4.3) and specify: policy objectives; program objectives and deliverables, what is in/out of scope, and relevant guidance (acknowledging that this may be in development); requirements for data collection, clinical governance and service quality requirements; specific program related requirements (may include models of care) and transition requirements to minimise impact on clients; performance domains (including access, efficiency, appropriateness, and effectiveness); service delivery targets (such as the proportion of low intensity services); priority populations; and reporting and approval requirements (Needs Assessment, Activity Work Plan, budgets, 6 and 12-month reports) (*Interview 32*).

Analysis of CasePHN–Provider relations show the relations can be grouped into five categories, presented in Table 10 below, ranging in specificity from existing contracts that were transferred from DoH to PHNs, to flexible funding where PHNs are able to address local needs.

[32] National priorities do not always align with local priorities. For example, the CasePHN has identified that alcohol and its relation to domestic violence, violence, and mental health, are higher priorities than the drug Ice in the region (*Interview 7*).

Table 10 Categories of activities commissioned (based on level of specificity)

Category	Example
Contracts that have transferred from DoH to PHNs	headspace and AOD Treatment Grants Program contracts (*Interview 28, Interview 27)*
Activities previously managed by Medicare Locals that remained in scope of PHNs	Aboriginal Health (*Interview 10*)
New activities that are highly specified	*The Way Back* model of post-suicide support (*Interview 11*)
New activities required to meet national policy objectives	Specific domains and objectives for mental health funding (*Interview 24, Interview 26*)
Flexible funding that enables the PHNs to address local needs	Early intervention speech pathology screening and services (*Interview 12, Interview 20*)

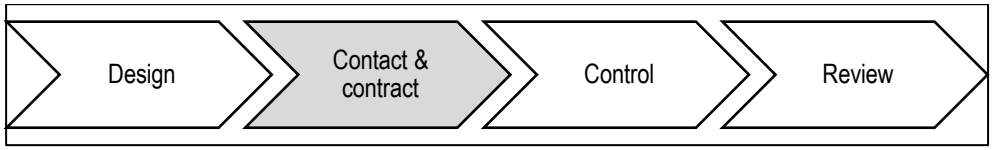
Source: Analysis of CasePHN–Provider relations

The categories identified above were validated by informants (*Interview 3, Interview 8, Interview 11*). For mental health funding, it is estimated that 40% of funding is for nationally prescribed commitments, with the remaining 60% being flexible within the activity priority areas (*PHN 5-year MH Horizon*, p.8).

6.3.4 Summary

The initial program design, developed in consultation with Medicare Locals, specified governance requirements, the commissioning cycle, and controls around funding (specified in the contract Activity Funding Schedules) and were developed *ex-ante.* The design incorporated provisions to add Activity Funding Schedules that enable DoH to introduce, renew or withdraw specific programs of funding without returning to the market. The program documentation that supports the implementation of the program was largely developed *ex-post*.

6.4 Contact, partner selection and contract phase



This section describes how DoH approached the market, selected the supplier, and negotiated and executed the contract.

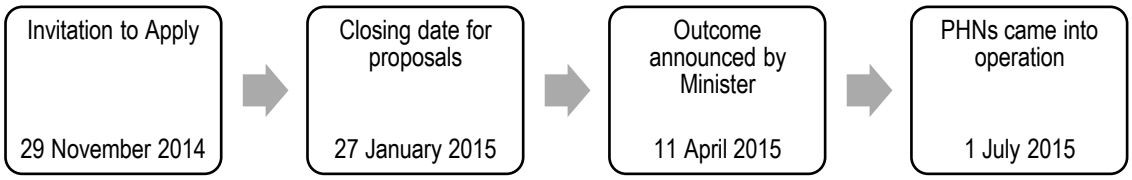
6.4.1 Approaching the market

Compliant with Treasury rules, DoH established an open competitive funding process using an Invitation to Apply issued in the financial year 2014–2015:

> Applications were encouraged from a wide range of entities including for-profit and not-for-profit, private organisations and state and territory governments [including partnerships or consortia]. (*PHN Guidelines*, p.18)

The approach to market included the *PHN Guidelines* and *SFA*.[33] The procurement timeline is presented in Figure 10 below.

Figure 10 Contact to contract timelines



Source: Correspondence with PHN Strategy Branch, Primary Care Division, DoH (15 January 2020)

Interested parties had a relatively short timeframe to respond to the invitation to apply (given the Christmas/summer shutdown period in Australia) and a relatively short period to establish the entity once notified they were successful (given the changes required).

6.4.2 Selecting the supplier

The process for partner selection was established in the *PHN Guidelines* and specified how proposals would be assessed and by who. The initial assessment by DoH ensured applications met the eligibility and selection criteria. Proposals were then assessed by the PHN Assessment Committee in terms of organisational form and structure, as well as evidence of capacity and capability to deliver the operational requirements (including governance). The applicants were also subject to a risk assessment to inform contract negotiations (*PHN Guidelines*), although there was no evidence of negotiation with the CasePHN. This approach ensured financial probity and transparency throughout the partner selection process.

> [DoH] wanted you to prove that you had experience in doing things, and they were also wanting new players. And the questions that they were asking new players looked like it would disadvantage them because they might not necessarily have experience in doing the things that they wanted them to do, because they were fairly technical. … we had to set out a transition plan, how we would move the staff from the existing Medicare Locals. Because one thing the Commonwealth wanted to avoid was … they wanted to avoid redundancy as far as possible. … They positively encouraged PHNs to transfer the employment of Medicare Local staff across to the new organisations …. (*Interview 39*)

[33] It is unclear whether additional requirements were specified in the approach to market; this was not available to the researcher (requests were made to DoH).

The process to establish the PHNs was one-off, establishing 31 PHNs across Australia initially for a 3-year period, although DoH did not rule out returning to the market at any time (*PHN Guidelines*). Potential conflicts of interest were managed through both the procurement process and contract. To the CasePHN's knowledge, there was no competition from other parties to operate the PHN in this region (*Interview 8, Interview 13*). Successful proponents were notified on 11 April 2015 and were required to be operational on 1 July 2015.

6.4.3 Negotiating and executing the award

While there was no negotiation of the original contract, which was 'pretty much presented as a *fait accompli*' (*Interview 39*), there were minor errors in the original agreement; DoH promised to resolve the errors after execution — a 'trust us on this' approach (*Interview 39*). These errors were attributed to the 'break-neck speed' (*Interview 39*) at which the program was implemented. The only aspect PHNs were able to negotiate was the timing of payments, originally misaligned with expenses the PHNs would incur (*Interview 39*).

Additional funding is provided through Activity Funding Schedules. New activity funding is often announced in the May budget, but not necessarily translated immediately into Schedules (often 6-months later; *Interview 39*). Again, while there is little room for negotiation, there have been instances where the timing of the first deliverables have been renegotiated; in one example, there were originally 6-weeks between the date the schedule was executed and the date the service had to be up and running, ignoring the time needed to commission and establish the service (*Interview 33*). PHNs regularly identify the implications of timing to DoH (*Interview 39*), an issue that was also raised by other stakeholders (*Interview 46, Interview 47*).

DoH also invites PHNs to apply to test new programs. For example, the CasePHN was successful in applying to trial a new DoH mental health intake process (*Interview 32*). Some programs rely on co-funding activities with states and territories (e.g., *The Way Back*; *Interview 37, Interview 38*), while other requirements have no funding attached (for example, the development and implementation of a *Regional Mental Health Plan; Interview 36, Interview 38*).

Funding schedules

Table 11 provides a timeline of the issue and renewal of the *SFA* and associated schedules.

Table 11 Timeline of the duration of the SFA and associated funding schedules

SFA and associated funding schedules by duration	2015/16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22
SFA/Core Funding Schedule							
Primary Mental Health Care (including suicide prevention)							
Drug and Alcohol Treatment Services (AOD core funding)							
National Ice Action Strategy							
Integrated Team Care (Aboriginal Health)							
After-Hours							
National Psychosocial Support Measure							
National Psychosocial Support Transition (Continuity of Support)							
Community Health and Hospitals grant (Cancer)							

Note: Each alternate block of shading denotes a new schedule and its duration. For example, core funding has been provided in two 3-year schedules.

The **Core Funding Schedule** was issued with the SFA and includes governance requirements, key deliverables associated with the commissioning cycle, and the provision of flexible funding for local priorities and activities not funded in other schedules. Operational funding was reduced in the second iteration assuming efficiencies could be made post-establishment (*PHN Evaluation*). The schedule has been renewed for a second 3-year period and will be rolling thereafter (each year will start a new 3-year funding period).

The **Primary Mental Health Care Schedule** identified six priority areas[34] for different levels of need (stepped-care), for priority populations, and to address needs across the life-course. Existing programs were transferred to the PHN under this schedule, including headspace and the Mental Health Nurse Incentive Program. Part of the funding is quarantined for headspace and Aboriginal mental health; other funding is flexible (*Interview 3*). This Schedule is now a 3-year rolling schedule.

The **AOD Core Funding Schedule** was issued in the third year of the PHN Program. DoH transferred existing AOD Treatment Grants Program contracts (managed by DoH) to PHNs in 2018; the contracts could not be varied until 2020/21 (the updated AOD Needs Assessment will inform this process (*Interview 11, Interview 13*); see Section 7.3.1, Figure 13). The last renewal of the schedule did not include cost increases (calculated based on the consumer price index; CPI) or other award costs, reduced operational funding, and released 30% quarantined funds from Indigenous programs (*Observation 6*). Funding from the National Ice Taskforce is provided

[34] Low intensity, child/youth, psychological support, care coordination (severe mental illness), suicide prevention, and Aboriginal mental health (*Interview 3*). Aging population was added in 2017 (*Interview 32*).

separately in the **National Ice Action Strategy Schedule.** The Taskforce recommended additional services (including services targeting Indigenous communities) to help reduce the demand for and impact of Ice (*PHN Circular 1*). A 2019 ministerial release suggested this will be reissued for 2-years to align with the AOD Core Funding (*Interview 27*).

Services for Aboriginal patients with chronic disease, or who need to improve access to primary health services, are provided under the **Integrated Team Care Schedule**. Many of the services provided were carried forward from services previously provided by Medicare Locals (*Interview 10*).

Services provided under **After-hours Schedule** aim to reduce emergency department (ED) presentations, and include GP services, pharmacies, dentists, allied health, and telephone helplines. Services funded include homelessness and geriatric services who account for a large number of ED presentations. The after-hours program is currently being evaluated nationally; suggestions have been made to incorporate after-hours funding into the Core Funding Schedule (*Interview 8*).

In addition to the mental health schedule, DoH issued two other schedules related to mental health. A **National Psycho-social Support Measure Schedule** provides support for people with severe mental illness and reduced psychosocial capacity who are not eligible for the NDIS and are not accessing existing programs. Despite committing $80m nationally over 4-years[35], the schedule was issued for 3-years. A **Continuity of Support Schedule** was funded for 12-months ($121.29m nationally; Ibid.) to support clients of a discontinued program transition to the NDIS or other supports.

Finally, the CasePHN applied through a tender process to become a lead site under the **Community Health and Hospitals Grant** (Cancer) (*Interview 30*). The program is designed to enhance primary care or general practices' capacity to manage patients already diagnosed with cancer to reduce ED presentations and provide access to healthcare closer to home.

The introduction of rolling Activity Funding Schedules is considered to have improved the power dynamic; this has also improved relationships with providers by increasing stability in the program (*Interview 20*).

[35] See https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-n-national-psychosocial-support-measure (accessed 8/1/2020).

Frequency and announcement of funding

As shown in Table 11, there are many different schedules to the contract, each of which are renewed frequently and inconsistently. Using the Primary Mental Health Care Schedule as an example, a 1-year schedule was provided in 2015/2016 for funding headspace services previously provided by Medicare Locals directly; on 15 June 2016 (15 days before the end of the financial year), a 2-year schedule was issued for mental health services, including the remaining headspace sites which initially involved transferring contracts from headspace-National to the PHNs. A 1-year extension was provided on 27 June 2017 (3 days before the end of financial year) and included an aged-care package for primary mental health care. On 9 April 2019, the CasePHN received a 3-year funding extension until 30 June 2022, which was varied on 8 November 2019 to include the *Way Back* support service (*Interview 32*). As can be seen by this example, the lead-time has varied, along with changes to the duration, scope and value of the schedule. This is not unique to mental health (*Interview 4*).[36] Notably, no schedule exceeds 3-years in duration, even when funding commitments are longer (as is the case for the National Psychological Support Measure Schedule).

Short funding cycles place stress on both the CasePHN and providers, with implications on workforce retention, operations, relationships, and outcomes being achieved. Short lead-times for new activities have caused 'chaos' (Interview 39) for both PHNs and providers who need to commission and deliver multiple services (respectively) at short notice.

> So in terms of commissioning, the main issue for us was that there was new money. … [Activity Funding Schedules] used to come along fairly precipitously, and they didn't come along with much warning. (*Interview 39*)

There was evidence that DoH often renewed contracts close to expiry (*Interview 32*), requiring PHNs and providers to trust DoH would do the right thing, while also creating bottlenecks of workflow for both DoH and PHNs when contracts are renewed. However, trust can only go so far — all contract renewals are subject to confirmation of funding from DoH.

> The worse thing they can do is to promise to extend the funding and then not give you the Deed of Variation. You can't tell the contractors to pack up and go home, but you can't give them a contract to extend ... (*Interview 42*)

[36] 'Drug and alcohol funding has historically always been [short-term]' (*Interview 4*); 'it's a big issue…it's very damaging to the sector' (*Interview 27*). For Ice and AOD activity schedules, funding was confirmed on 8 March for implementation on 1 July (*Interview 34*). Other schedules had a shorter period between confirmation to implementation, as little as 6 weeks (*Interview 24*).

Without confirmation, PHNs and providers haemorrhage staff as the renewal date approaches. This places pressure on services where staff are difficult to recruit, reduces the efficiency and effectiveness of the program, and interrupts service delivery.

> We had organisations that didn't know if their funding was going to be extended or not. … [They] had to let go of staff because they had to give them 3-months' notice … it's really hard to recruit staff in this area anyway, organisations had to let good people go, and then find out they were getting money and then have to go back out and recruit. (*Interview 45*)

> When there's less than 6-months left [on the contract] … staff start to leave. And so, what that means is those organizations ability to deliver the occasions of service that we want and that you're paying for start to decrease. The longer you leave it, the more they start leaving, the bigger the dip is. And then as soon as you re-fund them, then it takes probably an equal time plus about 50% to get back up to where you were before they started losing staff. … So by delaying [renewal], what you're doing is you're reducing the impact of this program on the health of Australian people. (*Interview 39*)

The use of short-term contracts, often issued or renewed at short notice, has had a negative impact on both the CasePHN and providers, impacting financial and operational stability, and the services provided to clients.

Level of specification

The PHN Program requires PHNs to identify the need for services, and then design and commission services to meet those needs. In reality, the activity schedules predetermine many services commissioned, down to specific models of care and even specific branding (for example, *headspace* and *The Way Back*), providing some consistency in services provided. Other schedules require services to be commissioned to meet national objectives (irrespective of local priorities) and vary in levels of specificity, leaving little funding to address local priorities.

> [The funding is] fairly much ring-fenced. So [national] priorities need to become the PHNs priorities. (*Interview 49*).

The pitfalls of over specifying (Considine et al., 2011) or predetermining types of services purchased are well-known, often leading to services focusing on compliance rather than innovation. For example, a review of Australian AOD treatment services conducted prior to the introduction of the PHN Program highlighted:

> To **decide *a priori* undermines strategic and technical planning**, creates a level of inflexibility in decision-making, **constrains the possibility of leverage** with the states/territories**, fails to engage the sector** and current and prospective clients, and conflicts with the Commonwealth's responsibilities in relation to national priorities, equity and service quality. (emphasis added, Ritter et al., 2014)

Rather, the authors suggest conducting a needs assessment, consulting the community about priorities, and engaging with states and territories to plan future service delivery — similar to the PHN commissioning cycle. The highly prescriptive nature of activity schedules is a significant diversion from the intention of the model and has the potential to mislead stakeholders.

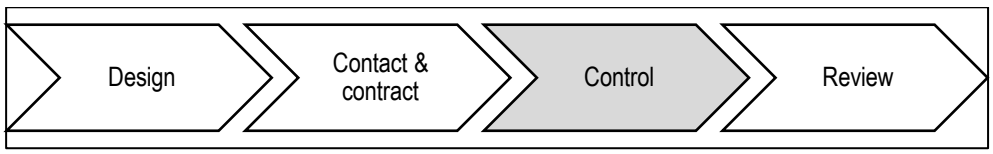
> I think often our stakeholders don't realise how little of our funding is actually funding that we are able to use flexibly. (*Interview 49*)

The frequency and duration of new funding schedules highlights the flexibility of the PHN Program (from DoH's perspective) in terms of meeting health priorities, and the chaotic nature of the program for PHNs and providers. The level of specificity in the schedules to the agreement is inconsistent with the commissioning cycle, but enables DoH to respond to national health priorities making funding available through the PHN Program.

6.4.4 Summary

The contact and contract phases between DoH and the market were highly bureaucratic, with many aspects of the program predetermined prior to contact. This enabled a high level of transparency in the process and probity in partner selection. There was little to no negotiation in the terms of the agreements, and little program documentation was available *ex-ante*. The requirements of the contract, by virtue of changes to program documentation and schedules, changed the nature of the program significantly *ex-post*. The mechanism to expand the program with the addition of schedules without returning to the market allowed DoH to respond quickly to emerging health needs.

6.5 Contract management



Controls for oversight and reporting were established in *PHN Guidelines* prior to market contact, with additional requirements introduced through program documentation and schedules to the agreement. This section describes how the contract was being managed from implementation to review/renew.

6.5.1 Implementing the contract

The implementation of the program was challenging due to the timing of the announcement and the start date (Figure 10), the timing of Activity Funding Schedules (Table 11), and the

expectations of DoH — particularly in the start-up period where the CasePHN was still developing systems and processes.

> We had to organise on the run, all the co-design processes. We had to do a whole lot of liaison with other different organisations. And then we had to run a whole lot of procurement processes and, and these things take time. … all PHNs were slow to push the money out. And the reason was because they were all taking the concept of commissioning very seriously. They were all doing a Needs Assessment. They were all doing co-design. They were all doing a rational procurement process. And these things don't happen in days, you know, they happen over months. And so … it took months to get the first contracts signed and get things rolling because we had to do it properly. We had you know, guidance that we had to comply with. And the kind of, informal communication we were getting from the Commonwealth at the time was, don't worry about that — just get the money out. (*Interview 39*)

Procurement of services by the CasePHN could not commence until Schedules were issued by DoH; this could vary between 6 to 12 weeks prior to program commencement (*Interview 3, Interview 6, Interview 8, Interview 9*). This has been resolved in part with the introduction of 3-year rolling funding (*Interview 5*); however, the release of funding remains contingent upon DoH's timely annual approval of Activity Work Plans which are sometimes not approved until close to the end of the financial year (*Interview 9, Interview 13, Interview 38*).

DoH provides 50% of funds for each Schedule at the commencement of the financial year (*Interview 5*) with other payments made throughout the year. Funds cannot be moved between schedules; each schedule comprises operational and commissioning funds, with commissioning funds quarantined (*Interview 5*), some for specific programs (*Interview 3*). The operational component of Activity Funding Schedules (for both PHNs and providers) varies from 0% to 8.8%**,** compared to an average of 26% for comparable organisations (*Funding Model Presentation*).

> [There needs to be] a lot more resources in the PHNs to do the job of being a PHN rather than them having such a minute on-cost percentage on everything they do. (*Interview 46*)

Capping overhead costs based on a percentage of contract value does not reflect fixed costs, meaning that operational overheads for small contracts are under resourced and large contracts are potentially over resourced. This is also translated across to services commissioned, as one provider noted:

> When you're dealing with fairly small amounts of money, it's inadequate to actually run a program properly. And I think all my fellow CMOs [community managed organisations] would say that we're really struggling with such tight restrictions on the admin component… I mean it's almost impossible to run something on that level of margin. (*Interview 43*)

Limitations to funding, including cuts to operational and activity funding (AOD, *Observation 6*), will impact the viability of services and the way they are commissioned by the CasePHN. Inadequate funding prevents PHNs and providers investing in systems and processes that could lead to efficiencies now and in the longer-term (*Interview 35*).

6.5.2 Managing the contract

DoH provides regular briefings to PHNs about any changes to the program or how it is managed. Progress is monitored based on key program deliverables, and performance is assessed based on a small suite of indicators (for each PHN and across the Program). Performance will determine future contract negotiations (*PHN Guidelines*).

Meetings between DoH and PHNs

A PHN Branch Grants Officer (within DoH) is responsible for the management of the contract. [37] This position was initially located in each DoH state/territory office and then moved to a central location.

> We went from a state-based program officer … where we met with them face-to-face, quite frequently, lots of phone conversations, and it was more of a personal sort of relationship, to the officers being based in Canberra, less local content and more just administrative type function. (*Interview 38*)

Four different people have worked in this role in the three and a half years the PHN Program has been running (*Interview 32*).

> [DoH] have a high turnover of staff. And so sometimes live issues get lost. So sometimes issues arise that they raise that they want us to address, if we just don't say anything for a while, they'll disappear ... So it actually comes back to us to do the right thing. (*Interview 39*)

The PHN Branch holds teleconferences with all PHN CEOs together every month (*Interview 39*). Originally, staff from different DoH branches would provide 'short verbal updates and then follow up with some written information' (*Interview 38*). More recently, information has been distributed in advance to provide an opportunity to ask questions (*Interview 38*). Despite the briefing being scripted, with the script distributed prior to the meeting (*Interview 39*), the CasePHN found the meetings useful — particularly in terms of finding out about new initiatives (*Interview 39*). The meetings also provide an opportunity to raise issues with DoH (*Interview 32, Interview 38*), although there was some cynicism about what could be resolved (*Interview 39*).

[37] One informant suggested that each Grants Officer may be responsible for 2 or 3 PHNs (*Interview 8*).

> CEOs will kind of raise issues for the record so that it's on the record, but don't have much faith that the Department will be able to address issues … (*Interview 39*).

For example, each month the PHNs remind DoH about the implications of short lead-times to funding activities:

> And so we say that every month [when we meet with DoH] because you know, there are always new people and yet they kind of go, "Oh, what can we do?" And so this thing just, it just repeats over and over again. But … maybe we are starting to make an impact because I think they are starting to get a bit twitchy when 6-months comes up. Whereas previously they didn't get twitchy until about 3-months, by which time, you know, the contractors were starting to lay off staff. You know, that's what we'd say, 6-months staff to start leave; 3-months to substantial numbers; 6-weeks before the end of the contract, the contractors give their staff notice; 2-weeks before the end of the contract, the staff have mostly gone. (*Interview 39*)

This monthly meeting is supplemented with a number of other meetings and fora (summarised in Table 12) where PHNs are able to communicate with DoH (and each other).

Table 12 Fora for communication between DoH and the PHNs

Forum	Scope	Frequency
DoH–PHN CEO teleconference	• DoH briefs 31 CEOs • PHNs can ask questions (often taken on notice)	Monthly
2-day PHN Conference	• Hosted by DoH, attended by 4-5 staff from each PHN • DoH provides updates on funding, strategies and initiatives • PHNs showcase their work	Annual
Mental health forum	• As above, specific to mental health	6–12 months
NSW/ACT PHN Network	• DoH attends part of meeting to provide updates, identify priorities and answer questions	Monthly
Ad hoc meetings	• DoH briefs PHNs on new initiatives or responses to national emergencies	As required
PHN SharePoint	• DoH disseminates information • Allows PHNs to share examples of best practice • Weekly newsletter about key dates and activities	Ongoing
Public website	• DoH publishes PHN Program policy, guidance, fact sheets and data	Ongoing[38]

Source: *Interview 31, Interview 32, Interview 38*.

[38] See https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home (accessed 24 Jan 2020). Despite significant activity in health in response to bush fires and pandemic, this website has not been updated substantially since January 2019 (confirmed in correspondence with DoH PHN Branch).

The relationship with DoH was identified as a potential risk to the CasePHN's operations; the DoH Grants Officer may not have content knowledge across the different PHN Program areas or organisational experience in program delivery (a factor identified as a risk; *Interview 20*). DoH relied wherever possible on written communication, supplemented with scripted verbal briefings. The CasePHN established a monthly teleconference between the DoH Grants Officer and the Executive to manage this risk, to build the relationship between DoH and the CasePHN, while also ensuring all communication with DoH occurred through a central point (*Interview 8, Interview 20, Interview 32, Interview 39*). The meetings provided an opportunity for the Executive to update DoH on key events and raise any issues (often related to the timing of schedules, and the risks and consequences of delays), and provided DoH an opportunity to ask questions (*Interview 8, Interview 20, Interview 38*).

> It's an avenue for us to follow up on things we put in writing, or to ask about things that we're wanting to know where they're up to. Their responses are very formal and very, "we'll come back to you", it's not like our questions are answered then and there. (*Interview 38*)

The monthly teleconference enabled the CasePHN to reduce risks associated with the DoH–CasePHN relation, enabling DoH to 'do a better management of that contract' (*Interview 20*).

> The Australian Government are very averse to risks. They see that it's our job to manage the risks … My job is to provide some reassurance to them… My job is to support them … (*Interview 20*)

Communication between DoH and the CasePHN is highly bureaucratic, but is supplemented, as evidenced above, by relational controls from the CasePHN up to DoH. This highlights the DoH–CasePHN relation is managed by both parties, not just DoH; the CasePHN is actively managing the risk created by the way DoH manages the DoH–CasePHN relation.

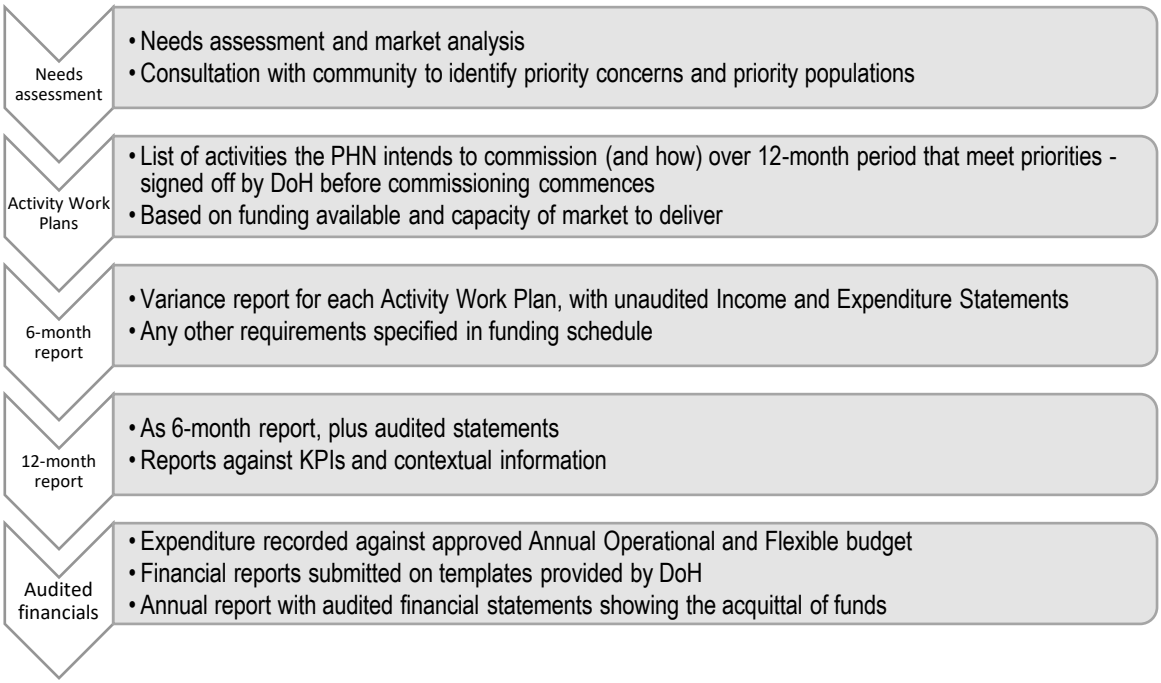
Monitoring progress

The management of the contract is based on the assessment of key program deliverables (Needs Assessment, Activity Work Plans, progress reports against Activity Work Plans, Annual Report and audited accounts; see Figure 11), a series of national headline performance indicators (equity, effectiveness and efficiency; Productivity Commission, 2020a), local indicators (based on Needs Assessment), and organisational performance measures (relating to governance structures, Needs Assessments and Activity Work Plans, budgets and audited financial statements). The content of each is specified in the contract, schedules and program documentation.

DoH reviews and approves deliverables and monitors the implementation of the overall PHN Program, in particular under/overspends, ensuring the commissioned activities are consistent

with the funding agreement (*Interview 32*). DoH often provides feedback or seeks clarification on aspects of reporting (*Interview 8*). The PHN Branch relies on content experts, both internal and external, to assess key deliverables.[39]

Figure 11 Key deliverables used to manage the contract



Source: PHN Guidelines, PHN Framework, *Interview 16*

Not all reporting requirements were clear. Some were perceived to be 'vague' (*Interview 32*), such as asking for examples of best practice.

> [How can] you possibly assess the performance of the whole PHN Program on everyone's vague three top things they've achieved? (*Interview 32*)

The amount of reporting created significant workloads for both the CasePHN and DoH.

> [DoH] have excessive and significant reporting requirements from us, but they don't have the team to do the analysis and to respond in a meaningful timeline. At the same time, they're constantly changing the formats of the reports or the way they want things reported. (*Interview 13*)

Delays in approving deliverables, and carryover of underspend, impacted on operations and meeting KPIs.

[39] For example, the PHN Advisory Panel on Mental Health. See https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-health-advisory-panel (accessed 3 August 2020).

> So, for example, we submitted the 6-month report back in March. And it's never been approved, and I think they've just written it off now and we submitted our 12-month report at the end of September. It hasn't been approved yet [end of November]. Usually they come back to us with some questions, clarifying stuff. So, you can't be guaranteed…. And that has contributed to some challenges, particularly from a financial perspective, underspend and things like that. And it's like, you're putting in a proposal that you want to continue on, and you're waiting, and waiting, and waiting… They won't approve any carryover until they've seen your audited financial statements. (*Interview 32*)

One informant suggested delays in approving carryover of underspend may lead to PHNs moving to block funding services (which reduces the risk of underspend) rather than activity-based funding; however, this may not be the most efficient and effective use of public funds (*Interview 13*). Some informants were optimistic that the lack of response showed DoH trusted the model and the CasePHN (*Interview 8, Interview 13*).

> I think the fact that they haven't looked at our 6-month reports is a sign that they thought there were bigger priorities, and they trust that we're doing what we said we would. (*Interview 13*)

Another saw this lack of response as 'disrespectful' (*Interview 34*). To manage delays, DoH has brought forward the due date for Activity Work Plans from May to February — allowing Grants Officers longer to review them (*Interview 8*). The bureaucratic and slow processes have not gone unnoticed by DoH; according to one informant, a third-party is now conducting an internal review of how DoH manages the PHN Program (*Interview 32*). Pending the results of this review, DoH placed the requirement to deliver 6-month reports on hold (except for mental health; *Interview 32*).

Reporting requirements have also changed over time (*Interview 9, Interview 13*) which caused frustration (*Interview 32*).

> So, we used to report about successes, barriers and outcomes. That category [outcomes] has gone now. You don't report on that at all. Its more about your activities …. And whether they are on track or not, and if they're not on track, explain why. (*Interview 10*).

Reporting requirements also varied across schedules, with some schedules requiring monthly reports reflecting the profile of the activity (*Interview 32*).

The mechanism for reporting has also changed, most recently to an online reporting portal (PHN Electronic Performance Reporting System or 'PEPRS'; *Interview 31, Interview 32, Observation 4, Observation 5*). This offers the potential to provide 'greater consistency' across PHN reports and perhaps an opportunity to 'draw some trends out' — something that had not been reported back to PHNs or made public by DoH to date (*Interview 32*).

Assessing performance

Performance assessment is guided by the *PHN Program Performance and Quality Framework* (*PHN Framework*).[40] The *PHN Framework* identifies performance indicators (recognising the impact of external factors on outcomes), including key program objectives, priority areas and organisational performance (governance, operational management, people management, commissioning, financial management and stakeholder relationships), and provides guidance on reporting and how performance will be assessed. The document is supported by a series of program logics to reflect the outcomes expected in each of the priority areas (recognising that there may be a delay observing outcomes) and specifies each indicator and performance criteria in detail.

The principles underlying the *PHN Framework* include minimising burden on PHNs, providing transparency, focusing on outcomes and quality, taking a holistic approach to the PHN while aligning to PHN Program objectives, and being flexible to accommodate the different priorities of each PHN. The *PHN Framework* also refers to and identifies the relationship between this and two other health Frameworks: the *Australian Health Performance Framework*[41] and the *Quadruple Aim* used to measure health system performance (this aims to improve patient experience, reduce healthcare costs, improve the health of the population, and improve provider experience; RACGP, 2019).

The *PHN Framework* specifies DoH will assess the performance of each PHN as well as the PHN Program as a whole. In the financial year 2019/2020, DoH provided each PHN with a report on their performance relative to other PHNs using a small subset of indicators — providing a ranking with no context (*Interview 8*). The CasePHN saw this as positive, identifying opportunities for improvement (*Interview 8*); however, ranking alone had limited value.

> We are ranked somewhere in the bottom quadrant of PHNs in relation to immunisation, but we're only one and a half points behind [the top]. (*Interview 20*)

PHNs were invited to comment on the report; DoH will then provide a more detailed performance report to measure progress against PHN Program objectives (*Interview 8*). To manage expectations, PHNs were provided with a 'Mock Report' for a fictional PHN (*Interview*

[40] Version 1 related to activities from March 2016 to June 2018, focusing on the establishment of the PHNs governance and planning tasks. Version 2 applies to PHN activities from 1 July 2018 onwards (discussed here, unless otherwise specified). The requirements in Version 1 were considered too onerous and did not provide clear expectations or real time feedback to support continuous improvement (*PHN Evaluation*).

[41] See https://www.aihw.gov.au/reports-data/australias-health-performance/australias-health-performance-framework (accessed 2 August 2020).

8). In addition to rating performance as 'on track, progressing, and initial' (based on all organisational KPIs and 24 KPIs where the PHN should be able effect change; *PHN Framework*, p.33), DoH will comment on areas of success, identify areas for improvement in the next period, identify stretch goals, and provide a summary of how many PHNs met each performance indicator (*Interview 8, PHN Framework*). The report will be provided to the PHN but not shared publicly and will inform future contract negotiations (*Interview 8*).

DoH released its first PHN Program Performance report for the period 2018–2019 (relating to $1.3bn expenditure) in October 2020 (*PHN Performance*). The report provides a high-level overview of the performance of the program with some references to the number of PHNs demonstrating outcomes, including areas for improvement such as improving provider reporting of minimum data sets (MDS) for AOD and mental health. Many outcome areas relied on older datasets (for example, 2015/2016 cervical cancer screening rates, 2016/2017 breast screening rates and GP health assessments for over 75s; *PHN Performance*). The report also identified a number of outcome measures used to establish 'baselines' for future performance reports — many of which were identified as needing work, or needing more information (*PHN Performance*).

Managing performance

The *PHN Framework* indicates that after issuing the PHNs with performance reports:

> The Department will work closely with any PHNs which rate as 'Initial' for an outcome theme with the intention to improve their assessment in following years. It is expected over time that PHNs will rate as On Track for all outcome themes. (*PHN Framework*, p34)

To date, there is no evidence of performance management of the CasePHN (*Interview 38, Interview 39*). Given the history of primary health care coordination (see Section 6.2.2), one informant suggested DoH may be 'more likely to change the model' rather than performance manage individual providers (*Interview 42*). Although as another noted, 'you're always going to have high-performers and those doing what they need to, and those that are underperforming — you can't scrub a whole entire system to address it' (*Interview 38*).

Contract negotiations/variations

Variations to program requirements are implemented by adding Schedules or changing requirements when Schedules are renewed (discussed in Section 6.4.3 and Table 11 above). Changes to the overall program may be notified through CEO briefings, notices on the PHN

SharePoint site[42], ministerial announcements, or by direct communication to the PHN. Other changes may be implemented through changes to program documentation. Given this is a single case study, there is no evidence to identify whether the CasePHN's performance has affected contract negotiations (relative to other PHNs).

Summary

The oversight and performance management of PHNs by DoH appears to be passive in that DoH requires PHNs to self-assess performance (*PHN Evaluation*) and report KPIs using a self-assessment tool. Feedback on deliverables is often delayed, if provided at all. The process of contract management is highly bureaucratic, and the majority of communication is formal — often in writing or confirmed in writing. The first performance report for the program was published in November 2020 and created a baseline rather than reported on performance.

6.5.3 Renewing the contract

At the end of the initial 3-year funding period, DoH renewed the contract (and Core Funding Schedule) for a further 3-years (*Interview 8*).

> The Commonwealth don't make helpful noises all the time … Like it's not 3-years with an intention to continue. … Their [in]ability to contract beyond 3-years is really frustrating. Is really, really frustrating… So it's really difficult to do business with them. (*Interview 1*)

DoH reduced operational funding on the basis that efficiencies could be achieved now the program was established (*PHN Evaluation*) and increased the specification about how funding could be used (*Interview 8*). The CasePHN was able to negotiate the carryover of funds from the previous agreement to make up the shortfall — the funding model and the process of carrying over funds were both recognised as unsustainable (*Interview 8, Interview 13*). One informant added:

> On a per capita basis, [PHNs] are probably a bit underfunded, and [the original funding] doesn't recognise the historical basket case sort of factor. (*Interview 1*).

Schedule renewals had implications on CasePHN staffing as individual staff contracts could only be renewed for the period their activity was funded; as a consequence, the CasePHN was 'unable to offer everyone contracts of the same length' (*Interview 8*). Further, many of the

[42] This provided information that was not otherwise funnelled down through the organisation, including reporting dates and extensions, and national evaluations (After Hours) (*Interview 31*).

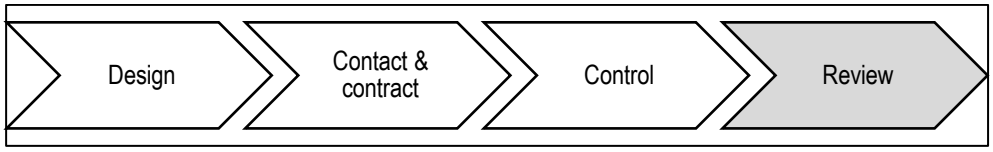
Schedules were renewed/issued with little notice, creating problems for the CasePHN and providers in forward planning and recruiting/retaining staff (*Interview 14*).

The updated performance management process will inform future PHN contract renewals (*PHN Framework*). This should make the renewal process more transparent, assuming it is implemented as intended.

6.5.4 Summary

The implementation of the contract was considered by the CasePHN to be chaotic, reflecting the short implementation time which seemed to be counterintuitive to the program design (*Interview 39*). Contract management relied on bureaucratic controls to passively manage the DoH–CasePHN relation, focusing on planning, exceptions reporting, correct acquittal of funds, and governance. There were minimal market controls, evidenced by the lack of competition during the original contact/contract phase. There also appeared to be no relational controls from DoH to PHNs, although there is some evidence of attempts to reduce information asymmetry (while managing probity) by sharing information on the PHN SharePoint site, producing additional guidelines and information notes, and briefing CEOs. There was also evidence of the CasePHN managing up — building relations and reducing information asymmetry and therefore risk.

6.6 PHN Program review



The relatively short-term funding of the PHN Program makes contracting cyclical rather than linear. The PHN Program and associated documentation is subject to ongoing review to ensure that the model is working and continually improving. Individual PHN performance assessments enable comparison of performance across PHNs and may identify broader areas for improvement (see Section 6.5.2).

The PHN Program is also subject to formal review processes, including external evaluation, to provide independent insights into the overall efficacy of the program (Section 6.6.1). Other evaluations and reviews may be carried out by DoH, PHNs, or others, relating to specific programs or locations (Section 6.6.2).

6.6.1 PHN Program evaluation

DoH commissioned an independent evaluation, from July 2015 to December 2017, to assess how the PHN Program was implemented in different contexts, to understand whether the PHN Program had achieved its objectives, and to inform the ongoing implementation of the program (*PHN Evaluation*). The evaluation found that while in its infancy, the program was making progress towards its objectives and 'maturing at an appropriate rate' (*PHN Evaluation*, p.1); was fit for purpose in different contexts; and enabled greater agility in the delivery of primary health care services (compared to direct commissioning) (*PHN Evaluation*, p.1). Not all PHNs had progressed equally, often reflecting the legacy of the organisation and alignment with state/territory health organisations (*PHN Evaluation*, p.22). The way PHNs matured over their first 3-years depended on whether they had made a direct transition from a Medicare Local to PHN (where boundaries and organisation remained the same) and the number of LHN/LHDs within their region (*PHN Evaluation, Interview 40, Interview 42, Interview 46*):

> It comes down to really simple things like, they have policies and procedures that have been around for 10 years, whereas we've got new policies and procedures that we've been developing … which is a distraction. (*Interview 42*).

The evaluation highlighted 'the very "lean" nature of most PHN's operating models, particularly for PHNs in rural and remote areas', recommending long-term funding cycles that would allow PHNs to 'better plan and align funding arrangements with LHNs [LHDs]' (*PHN Evaluation*, p.2), as well as securing and investing in employees long-term. In the absence of significant operational and program funding, the *PHN Evaluation* highlighted that program delivery is reliant on building relationships with and leveraging other funders; however, further work was required to actively engage LHNs/LHDs in planning and service delivery locally. Funding for new activities (and expansion of activities) increased substantially over the first 3-years. The remit and associated funding of PHNs could increase further as confidence in the PHN Program grows, new health priorities are identified and reforms are introduced, and greater collaboration is achieved with state/territory services.

Overall, the evaluation found program goals to be ambitious and 'it may take many years to see the benefits' (*PHN Evaluation*, p.59). The program also needed stability to overcome 'change fatigue and disengagement' given the change from Divisions to Medicare Locals to PHNs (*PHN Evaluation*, p.54). The long-term strategic direction of the PHN Program — or for that matter other primary health priorities, how it relates to other government reforms, and how it will be supported — is unclear: 'without this, there is potential for siloing, inefficiency and mismanagement' (*PHN Evaluation*).

DoH updated and issued a number of guidelines addressing deficits that were identified in both the interim and final evaluation reports.

6.6.2 Other evaluations and reviews

A number of evaluations have been conducted on specific areas of the PHN Program, commissioned nationally by DoH or locally by PHNs, each contributing to the evidence-base for the PHN Program. This includes national evaluations of service models (for example, headspace), site specific evaluations (for example, the Melton headspace site; Deloitte Risk Advisory, 2018), and broader program evaluations (for example, the After-Hours program; Jackson, 2014). Other evaluations have been conducted; however, few have been made publicly available.

The PHN Program has also been subject to direct and indirect independent review, including by the Senate and the Productivity Commission.[43] The PHN Program is also subject to academic inquiry looking at different aspects of the commissioning model, including the change to commissioning, the role of governance and community panels, and ensuring equity in primary health care (Booth & Boxall, 2016; Cheverton & Janamian, 2016; Henderson et al., 2019, 2018; McClean & Trigger, 2017).

The operations of PHNs are also reviewed within and across PHNs, to share best practice and also to develop common practice (*Interview 13, Interview 46*). To date, the way PHNs operate is fractured. PHNs are 'still a bit challenged to be consistent and transparent in their approach' (*Interview 45*); in contrast, contracts managed by NSW Ministry of Health on behalf of the LHDs, ensure 'the tendering process stays the same across all of the LHDs' for state-wide programs (*Interview 45*). Consistency between PHNs could reduce burden of providers responding to different processes and timelines 'while not losing some of the benefits that a regional entity can provide' (*Interview 45*).

6.6.3 Summary

There are a number of mechanisms that exist to review and improve the PHN Program, from mechanisms built into design (ongoing, either DoH or individual PHNs; or intermittent, such as periodic evaluations), to external review mechanisms conducted as required. While continual review is critical to ensure the program is fit for purpose and meets the clinical governance

[43] An example of an indirect review is the recent Productivity Commission Inquiry into Mental Health (Productivity Commission, 2019) which recommended a single, alternative Regional Commissioning Agency to commission all mental health services across a larger region.

requirement for continuous improvement, there is justification for stability in the program to embed relationships and core functions (*PHN Evaluation*).

6.7 Chapter summary

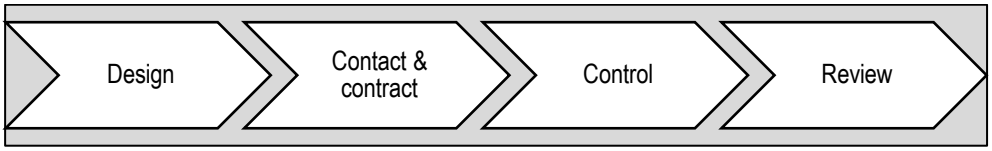
This chapter first presented the contextual background for the outsourcing arrangement including the complex funding and service landscape, the history of primary health case coordination, the CasePHN and the program requirements. The chapter included a detailed case description of the DoH–CasePHN relation and how this was managed from contact to review. The controls used by DoH are striking; DoH relied on bureaucratic controls to manage the relation with the intermediary and avoided relational controls. In response, the intermediary used relational controls to manage up to reduce information asymmetry and risk. This is explored in the analysis presented in Chapter 8. The next chapter examines the second part of the outsourcing arrangement — the commissioning of services by the PHN.

Chapter 7 The CasePHN–Provider relation

7.1 Introduction

This chapter presents the detailed case description of the second part of the outsourcing arrangement, the Intermediary–Provider relation. Consistent with the previous chapter, I describe the operational context of the CasePHN's commissioning activities (Section 7.2) and the planning processes related to the design of the commissioning activities (Section 7.3). The contact, partner selection and contract phase, contract management (control) phase, and review phase are then described in turn (Sections7.4–7.6). As before, program documentation referenced in this chapter are listed in Appendix C.

7.2 Operational context of the CasePHN's commissioning activities



Each PHN is set up differently; 'you're not going to find two PHNs structured the same' (*Interview 11*). The broader operational context of the CasePHN is described in Section 6.2.4; this section describes the context of the CasePHN's commissioning activities, first in terms of the organisational strategies, then by the way operations are organised.

The CasePHN is guided by a series of strategic plans and frameworks, developed with key stakeholders, that draw on best practice and research in primary health care (*Interview 31*). Each contain specific objectives related to the CasePHN's commissioning activities (identified in Table 13 below), all of which rely on collaboration with a range of stakeholders.

Table 13 Summary of key strategic plans and operating frameworks

Plan/framework	Objective	Objectives related to commissioning
Strategic Plan (2019–2021)	• Improve practice • Integrate systems • Commission services	• Commissioning informed by local needs, identifying priority populations and outcomes (p.17) • Joint/co-commission services where possible (p.20) • Recognises the value of co-design[44] and collaboration across commissioning activities[45]
Mental Health and Suicide Prevention Regional Plan 2019–2022 (*Regional MH Plan*)[46]	• Promote mental and physical health and wellbeing • Prevent mental ill-health and distress, and provide timely early intervention • Detect mental illness and distress early and enable recovery • Provide effective, appropriate, timely and integrated treatment and support	• Address fragmentation, inefficiencies, and lack of person-centred care in mental health services • Seven priority areas: access and equity, priority populations, physical health, Aboriginal health, suicide prevention, integrated services, and workforce • Engage clients and carers to ensure services appropriately designed, delivered and evaluated
Clinical Governance Framework *(Clinical Framework)*	• Hold services accountable for continuous improvement • Ensure services are patient-centred, safe and effective	Seven pillars of clinical governance: • Consumer and community participation (to meet needs) • Seamless experience accessing/delivering services • Service evaluation, improvement and innovation • Clinical risk management • Information management and technology • Workforce development and credentialing • Clinical accountability
Commissioning Framework (2019–2022)[47]	• Defines commissioning cycle and governance • Identifies national and local priorities	• Strategic approach to meet service needs, with indicative annual commissioning timeline • Eight principles: understand diverse needs, address needs, collaborate to reduce fragmentation, co-design meaningfully, shape market, promote probity through procurement, and continue to learn • Commits to quadruple aim (population health, consumer experience, value for money and provider

[44] Co-design is the 'difference between delivering services for people and doing so with them' (*Strategic Plan*, p.24).

[45] The CasePHN holds a strategic planning day with stakeholders to report on progress, and prioritise future work (*Observation 2, Interview 8*).

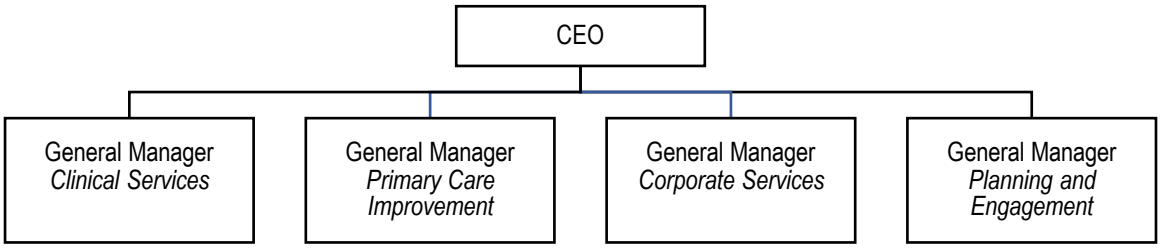
[46] Developed with two LHDs, two LHNs, peak bodies and providers, with extensive consultation, in accordance with national guidelines. The process helped develop relationships with LHDs (*Interview 45*).

[47] Authored by PwC (*Interview 13*).

Plan/framework	Objective	Objectives related to commissioning
		experience) and evaluating program effectiveness, efficiency and appropriateness
Evaluation Framework	• Principles for evaluation of commissioned services	• Planning: identify theory of change and measurable outcomes; identify resources; plan evaluation to ensure data available • Scope: determine scale (proportionate to risk, novelty and scale) and outcomes of evaluation • Governance: ensure independent ethical evaluation; involve stakeholders in evaluation planning and oversight; communicate findings

The CasePHN CEO is supported by four General Managers (together they comprise the Executive), each responsible for different aspects of commissioning (see Figure 12 below).

Figure 12 CasePHN Executive and organisational structure



A breakdown of funding and contracts are provided, by Funding Schedule, in Table 14 below. Many of the contracts are now well-established, meaning that the organisation is spending more time monitoring and renewing contracts compared to the first two years of operation which focused on establishing new services (*Interview 39, Interview 42*).

Table 14 Summary of commissioning activity (2019–2020) by Schedule

Funding Schedule	Number of Contracts	Value ($m)
Core funding schedule (flexible)	33	3.5
Primary Mental Health Care (including suicide prevention)	43	16.5
Drug and Alcohol Treatment Services (including Ice)	20	4.9
Integrated Team Care (Aboriginal Health)	4	1.5
After-Hours	16	2.2
Psychosocial Support Services	12	7.2
Total	128	35.8

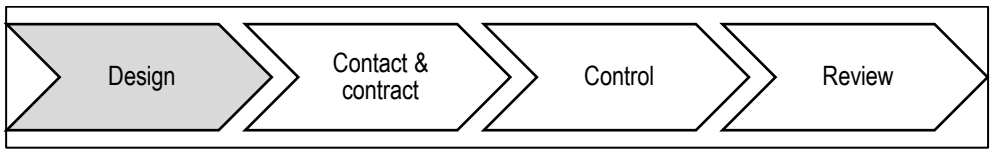
Source: *Annual Report*
Note: Does not include additional funding for lead sites or external funding. For example, $6.9m is provided for Cancer Management in Primary Care, funded by the Australian Government Community Health and Hospitals program (*Annual Report*).

Commissioning is conducted in accordance with organisational policies and procedures, and supported by seven unintegrated IT platforms to facilitate contract management, workflow and reporting (*Interview 5*).[48] Continuous improvement is enabled through internal forums such as the 'Procurement Hub' where staff get together to resolve issues or share examples of best practice (*Interview 5, Observation 10*), as well as the NSW PHN Network groups (*Interview 27*).

Collaboration with stakeholders is recognised as critical by the Executive (Interview 42). In addition to two LHDs, the CasePHN identifies other important partners in the region as '[two hospital networks], Justice Health, local GPs, allied health professionals, nurses, secondary care providers, non-government organisations, community managed organisations and other organisations across the health and human services sector' (*Strategic Plan*).

This section provides the operating context of the CasePHN's commissioning activity, recognising each PHN organises itself differently. The remainder of this chapter describes each step of the commissioning process.

7.3 Identifying health priorities



The commissioning process is initiated by strategic planning activities which identify the commissioning requirements for the region. Needs Assessments identify local health needs and priorities in line with national performance indicators (Section 7.3.1), while Activity Work Plans prioritise how funds will be allocated (Section 7.3.2). The Needs Assessments and Activity Work Plans are contract deliverables under the DoH–CasePHN relation.

7.3.1 Needs Assessment

Individual need is often associated with social determinants of health (housing, education, employment, infrastructure, transport, family, community) and demographic factors (background, age, location) (*PHN FAQ*, *Strategic Plan*). Where funding is limited, services may target priority populations, identified by social determinants of health, to reduce health

[48] Salesforce (stakeholder information), SharePoint (policies, procedures and templates), TenderLink (tender process), DocuSign (secure electronic signature), Folio (or HealthShare for contracts with LHDs; contract management and storage system, manages PHN and provider workflows; Folio*, Observation 12*), NAV (invoicing, changing to Microsoft Business Central), and Power BI (business reporting, the only software that interacts other software) (*Observation 12*). The CasePHN also provides a client information management system 'RediCase' to some providers (*Interview 33*).

inequalities. A Needs Assessment is a systematic method to identify unmet health care needs, drawing on 'predominantly national datasets' (*Interview 9*) to benchmark the region's population and identify potential health priorities; priorities are refined through stakeholder consultation (including providers, consumers, and governance groups identified in Table 9; *PHN NeedsAssess*).

The availability, scale and currency of data affect planning. For example, anecdotal evidence suggested aged-care was a priority; yet, without data, this could not be identified as a priority (*Interview* 9). Some aspects of the Needs Assessment, such as cancer screening rates, are simple to identify due to the way screening is recorded. Other needs, such as mental health and AOD, are harder to identify and the CasePHN has used external consultants to assist (*Interview 9*). To date, Needs Assessments have not included comprehensive service mapping (identifying services available to meet health needs) due to the lack of existing data (*Interview 9*) and the resources required to map services properly (*Needs Assessment Nov2016*, p.4). The CasePHN has 'one of the highest numbers of providers of general practice and … so many hospitals, two networks, two LHDs', each of which also provide and commission services (*Interview 9, Interview 44*). Each Needs Assessment is approved by the Board prior to submitting to DoH for approval.

DoH initially required the Needs Assessments to be updated annually (Figure 13), using new data available, taking substantial time and resources to complete (reported to DoH in *Needs Assessment Dec2017*).

Figure 13 Needs Assessment timeline for CasePHN

March 2016	Baseline Needs Assessment
Nov 2016	Updated Needs Assessment
Nov 2017	AOD Needs Assessment (Ice Strategy)
Nov 2017	Mental Health and Suicide Prevention Needs Assessment[49]
Dec 2017	Updated Needs Assessment
Dec 2018	Updated Needs Assessment
Dec 2019	Updated Needs Assessment
Feb 2020	Updated AOD Needs Assessment

From 2019, updates to both Needs Assessments and Activity Work Plans were required every 3-years or as substantial changes were made (*Interview 9*). The CasePHN was in the process

[49] This aligns to the six key objectives and priority areas for mental health and suicide prevention; i.e. driven by (rather than informing) the Activity Funding Schedule and contractual obligations related to mental health.

of simplifying both to minimise changes and approvals required in the future (*Interview 9*). While the availability of health data has increased and become more granular (for example, in 2018 ABS population data became available at Statistical Level Area 3[50]; *Interview 9*), data is still limited in some areas, dated, does not reflect changes in health status, and is not available at consistent geographic scales, limiting the observation of trends over time.

The Needs Assessments have identified ongoing disparities in health in the region, specifically in certain populations and locations (*Interview 22*), often linked with lower socio-economic status and cultural and linguistic diversity (*Interview 12, Interview 35*, *Needs Assessment 2019*). While the underlying health priorities are unlikely to change significantly over time, they may be affected by external shocks (*Interview 40*), including changes to acute care (*Interview 42*), infrastructure and changes to population density and populations (*Interview 12*), and shifts in policy or funding (*Interview 26, Interview 34*).

Needs assessments, once approved by DoH, are published on the CasePHN's website, signalling to stakeholders the priorities in the region. The CasePHN is not the only party responsible for meeting those needs; for example, while the AOD Needs Assessment identifies a large unmet need in the region, the CasePHN manages only 10% of current AOD sector funding (*Interview 27*). Needs Assessments however present a snapshot in time using historical data and do not model or predict future needs (*Interview 12*).

7.3.2 Activity work plans

Activity Work Plans are developed for each Funding Schedule, showing how funds will meet priorities identified in the Needs Assessment, including programs specified by DoH. Short lead-times or delays in renewing schedules (see Section 6.4.3) impacts on the preparation of Activity Work Plans (*Interview 34*).

Activity Work Plans include the aim and description of each activity; whether it is existing, modified or new; the priorities addressed; the target population (and whether Indigenous); coverage (all or part of region); consultation processes used; milestones and duration of the activity; and the most likely procurement method, including whether co-designed or co-commissioned. Activity Work Plans are written to ensure the CasePHN does not restrict itself to one service offering, allowing flexibility should new funds become available (*Interview 11*). Many

[50] Spatial unit used by the ABS. See https://www.abs.gov.au/ausstats/abs@.nsf/0/4BF2827AC128BF62CA256AD4007F680C?opendocument accessed 6 January 2021.

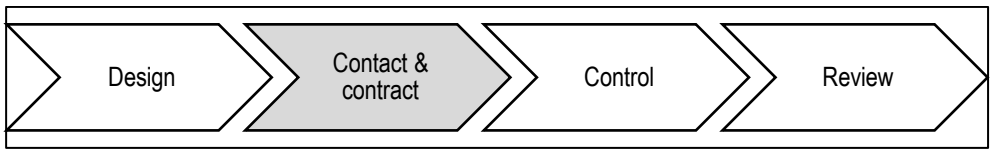
of the activities in the plans are now ‘repeat business’, although ‘the detail is morphing as time goes on’ (*Interview 11*).

Once approved by DoH, Activity Work Plans are available on the CasePHN website, providing a clear signal to the market, and form the basis of future performance reporting. The CasePHN cannot contact the market until the plans are approved. Frequent delays in approving plans have impacted procurement of new services, as well as the continuity and renewal of existing services (*Interview 9, Interview 34*). This has in part been resolved by DoH approving components of plans related to existing services, allowing renewals to occur. However, new activities were still subject to approval and consequently delayed. This placed pressure on both the CasePHN and providers to deliver services within the funding period (*Interview 9*).

7.3.3 Summary

The Needs Assessments identify priorities for the region, while Activity Work Plans indicate how available funds will be spent relative to priorities identified and requirements of the funding schedules. Both documents have changed over time as experience has grown. The Needs Assessment is contingent on data being available that is meaningful to the region, and on resources being available (including time) to analyse data and consult stakeholders. The development of Activity Work Plans is contingent on timely confirmation (reissue of contract/schedules) from DoH about funding available; procurement of services is contingent on the timely approval of Activity Work Plans — both confirmation and approvals are often delayed.

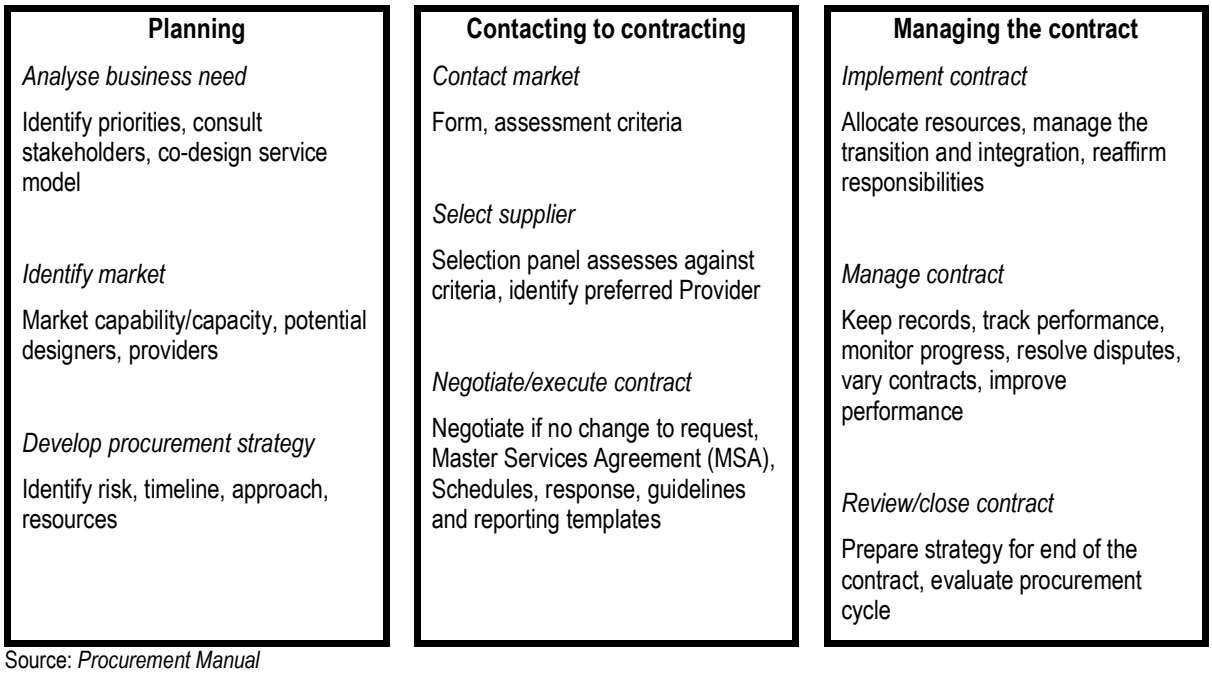
7.4 Contact, partner selection and contract phase



Once Activity Work Plans are approved, the CasePHN initiates the procurement process for each activity — a process that has developed considerably since the CasePHN was established (*Interview 3*). The *Procurement Policy* prescribes the processes and tools used for procurement (summarised in Figure 14), and establishes a transparent process with a high degree of probity (transparent, fair and defensible).[51]

[51] Probity is also managed through policy and processes related to conflicts of interest, financial delegation, and risk management.

Figure 14 Overview of Procurement and Contracting process



Source: *Procurement Manual*

A program officer leads the procurement process, supported by their direct team and manager; contracts are reviewed by Corporate Services (*Interview 26, Interview 30*). Staff draw on the knowledge and experience of other staff (including other PHNs and other stakeholders), as well as prior research and evaluations (*Interview 23, Interview 24, Interview 27*), to manage the contact and contract stage. This section explains each step in the process, from planning the procurement (Section 7.4.1), to contacting the market and contracting the provider (Sections 7.4.2–7.4.5).

7.4.1 Planning the procurement activity

A procurement plan is prepared for each new activity identified in the Activity Work Plan (*Training: Procurement; PHN Commissioning Guide*). The detail varies depending on contract value, novelty, whether a program already exists (and requires reorienting), and the level of specifications provided by DoH (*Interview 19, Interview 41*) — in effect, this results in the 'same ending, but starts differently' (*Interview 26*). The plan is developed by analysing the business need, identifying and engaging the market, and developing a procurement strategy under which the procurement is carried out (*Training: Procurement*).

Analysing business need

A concept for the service is developed, showing how it relates to regional priorities, other services and organisations, the availability and maturity of the workforce, and the evidence-base it draws on to achieve the outcomes required (*Interview 19, Interview 28, Interview 30,*

Interview 41). Alternatively, the concept may be prescribed to a greater or lesser extent by DoH (*Interview 41*). Depending on the activity, resources and time constraints, the CasePHN may contract a third-party to review literature and best practice (*Interview 41*). A program logic is then developed (*Interview 19*) to identify inputs, processes or activities, outputs and outcomes the program is designed to achieve; this also informs how the program will be measured and evaluated (*Evaluation Framework*).

Depending on the service required, the CasePHN may co-design the model of care with key stakeholders, and in particular consumers, to ensure the 'people who have knowledge of that area, and know what works best, are part of the co-design' (*Interview 29*). Co-design requires resources and time (*Interview 41*).

> We brought in the people [clients] in the community, peer workers, clinicians, … people from ED departments, care teams, from the PHN of course, and psychologists in the area, and I think we might have had our clinical council members involved … we saw there was a greater need, and evidence as well, that supported having peers involved, so adding that lived experience aspect to an already kind of a clinical program. … [clients] needed more [support] on how to navigate the mental health system, rather than provide a therapy sort of service. … then we moved towards, how can we achieve this? (*Interview 29*)

In line with the *Clinical Framework*, stakeholders are consulted about the proposed service model (*Interview 24*), including potential service delivery partners and providers (*PHN Info-Markets*), and consumers and community members, about the objectives of the program and what outcomes the service is targeting (*Training: Contracting for outcomes).*

> We start to work up a model specification and then it's often put to our internal advisory committees at the PHN. (*Interview 41*)

This includes other agencies that may fund, co-commission or support the program (to avoid duplication, address gaps in services, and increase integration). The CasePHN is 'mindful [they] are funding only for short time-frames' (Interview 30), and identifies what happens to clients if the funding ends.

Both co-design and consultation enables services to integrate with existing supports (*Interview 30*), recognising staff are not able to be 'across everything' (*Interview 41*), to generate a draft model of service (*Commissioning Framework*), the viability of which is tested through market engagement.

Identifying and engaging the market

The CasePHN consults the market, through existing governance mechanisms (Table 9) and stakeholder networks, about their capability and capacity to deliver the proposed services

(*Interview 7*). Open or two-stepped approaches are used to contact the market. Direct tenders are only used when open approaches are unsuitable, the market is limited, health needs are urgent, or services require competitive dialogue (*Procurement Manual*). Direct tenders were observed where a unique provider was required (*Interview 26*), and when well-performing services were extended to reach an additional cohort within a limited timeframe (*Interview 30*).

Developing the procurement strategy

When the requirements are finalised, and the potential market is known, a procurement strategy is developed that identifies and justifies the procurement approach, the key steps and timeline, resources required (including the selection panel and selection criteria; *Procurement Manual*), and identifies potential risks and the reporting/monitoring requirements.

> When you're thinking about those things [terms of the contract], you don't know who the service provider is going to be, so you've got to look at all of the options, and make a choice based on all the information you have at hand. (*Interview 24*)

Selection criteria are developed based on program and contractual requirements (*Procurement Manual*). Criteria may include 'fitness for purpose, timeliness, reliability, safety, market competition, benefits and risk — incorporating the levels of risk commensurate with scope and scale of the procurement' (*Procurement Policy*, p.2).

> This is the type of model of care we're looking at. Tell us how are you going to do it? Who are you going to work with to do it? How much it's all going to cost? Tell us how you're going to meet industry standards. Tell us how it's recovery oriented. (*Interview 41*)

The value of the contract will inform the type of contract used[52], the financial delegation required to approve the procurement process, and the eventual authority for contract award. In practical terms, only the Master Services Agreement (*MSA*; comprising fixed terms and a schedule that is completed to reflect the specific requirements) is used for commissioning services.

Many procurement activities are tightly bound by requirements (objectives, outcomes, value and timing) established by DoH (*PHN Evaluation*), with little flexibility available to PHNs. Further, the timing of new schedules and renewals often leaves little time to approach the market or collaborate (Section 6.4.3). Due to the timing of funding schedules, most contracts are subject

[52] The Master Services Agreement is used for contracts >$50k, Professional Services Agreement for contracts <$50k (*Procurement Manual*).

to review and renewal at the end of the financial year; this impacts on workloads and creates uncertainty for both PHNs and providers at year-end.

Summary

A detailed procurement plan is developed prior to contacting the market. This includes the service requirements, selection criteria, form of contract, and how proposals will be assessed. The requirements may be predetermined by DoH, or may be developed locally in consultation with key stakeholders and clients.

7.4.2 Contacting the market

Market contact is managed using *TenderLink*[53] — an online portal for procurement (*Interview 11*). Tender documents include program requirements and selection criteria (including any weighting), the draft *MSA*, a financial template, and the timeline for the tender process (deadline and notification of outcome) (*Procurement Manual*). Any modifications or responses to questions are provided via TenderLink (*Procurement Manual*).

Due to operating constraints associated with DoH funding, there is not much flexibility about the time given to respond to a request for a proposal. Market interest can vary significantly, from one to 25 responses (*Interview 39, Interview 26*). All proposals are treated as confidential to maintain the intellectual property held within them.

7.4.3 Selecting the supplier

Proposals are checked by the program officer to ensure they meet the requirements of the tender, and then assessed by the selection panel (identified when planning the procurement; Section 7.4.1). Panel members are required to declare any conflicts of interests (*CoI Declaration*) to maintain probity and independence (*Observation 1, CoI Procedure*). Probity is defined in the *Procurement Manual* (p.16) as 'the evidence of ethical behaviour … defined as complete and confirmed integrity, uprightness and honesty in a particular process'.

The selection panel may include an external party and a consumer representative (*Observation 1*).

> I think it was really important to have the consumers and clients of the service at the heart of the decision making and for them not to feel that we

[53] See https://illion.tenderlink.com/ (accessed 25 October 2020).

> made the decision on their behalf. We gave a number of opportunities for people to have input into the process. (*Interview 10*)

While external panel members do not have the same history with potential providers as CasePHN panel members (*Interview 26, Observation 1*), their involvement adds to the transparency and independence of the process and provides community insights that may not be available internally (*Observation 1*).

The CasePHN must be confident that the Provider(s)[54] can complete activities on time, meeting the terms of the DoH–CasePHN contract (§3.3.3 *SFA*; *Board Paper: Underspend*). Governance and clinical governance are considered to be a major risk in proposals, and close scrutiny is given to clinical governance frameworks and timelines — particularly when the contract is for a new service and requires new staff to be recruited (*Interview 30*). Each panel member scores the proposal against the evaluation criteria determined prior to tender (*Observation 1*), including value for money defined as 'a function of cost, risk and quality' (*Procurement Manual, p.*15). The panel then convenes a moderation meeting to discuss scores for criteria that vary by more than one point between highest/lowest score (*Procurement Manual*, p.17, *Observation 1*). A probity officer oversees and documents the process (*Interview 6, Observation 1*). The panel may conduct checks with referees or seek further information to validate claims in the response. The panel then makes a recommendation to the CEO who then makes a recommendation to the Board (*Observation 1*).

The CasePHN informs the preferred provider of the outcome, noting that the contract will not be awarded until the clarification and negotiation phase (see Section 7.4.4) is complete and documented (*Procurement Manual*).

7.4.4 Negotiating/re-negotiating the contract

The schedule to the *MSA* specifies the objectives of the program, key dates, services to be delivered, governance and clinical governance arrangements, funding and budgeting, key reports and payments, key personnel, as well as insurance and contacts for notices. The level of detail reflects the scale of services commissioned (*Interview 42*), and can be more complex if they relate to more than one DoH activity funding schedule (reflecting their respective reporting requirements; *Interview 7*).

Providers may (re)negotiate the contract if 'it does not require materially changing the terms of the invitation to tender, nor providing a supplier with a chance to materially change their tender

[54] Acknowledging that multiple suppliers, either independently or as a consortium, may provide optimal service delivery (*Procurement Manual*).

response' (*Procurement Manual*, p.12). While the main requirements of the contract are established prior to contact (terms, requirements and value), aspects of the schedule may be negotiated such as refining the model of care, KPIs (definitions and targets) and other reporting requirements to ensure they reflect the final service model and risk assessment (*Procurement Manual*).

KPIs

KPIs are used to manage performance. They differ from other deliverables and activities as they identify whether the program is contributing to outcomes for the individual/population, allowing both parties to identify potential quality improvements (*Interview 22*). They include process KPIs, such as number of clients, 'occasions of service', and outcome indicators (*Interview 42*).

> On one hand, it's really important to be able to measure whether a service is really delivering good work or not. On the other side, it can be hard to measure. (*Interview 4*)

KPIs are developed in line with the Australian Government's national performance indicator framework (Productivity Commission, 2020b) in terms of equity, effectiveness and efficiency, and are reported to DoH (*Interview 10, Interview 31*). KPIs are also influenced by the *Clinical Framework*, the Activity Funding Schedule, the *Strategic Plan*, national MDS requirements[55], and requirements for cultural safety (*Interview 43*).

KPIs are identified through the program logic for the service — 'whatever you've said your goal is, that's how you choose your KPIs' (*Interview 31*) — recognising the importance of associated measures of physical health that are often ignored, particularly in mental health (*Interview 36*). There is a balance between not being 'too bureaucratic, but bureaucratic enough that things are safe, and things are accountable' (*Interview 36*).

The development and implementation of KPIs must be cognisant of their impact on clients, and be meaningful for the client and the service being provided (*Interview 4, Interview 30*). One informant was concerned KPIs were a 'tick box' exercise for services to receive funding, and that this would transfer through to young clients, with counsellors 'teaching [young people] to tick the box to get the money' (*Interview 4*).

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[55] National minimum datasets exist for mental health programs (see https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-infopri2-toc~mental-pubs-n-infopri2-pt2~mental-pubs-n-infopri2-pt2-3, accessed 23 October 2020) and AOD programs (see https://www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services, accessed 23 October 2020). However, additional indicators may be required specific to the purpose of the program outsourced.

Importantly, collecting data to report the KPI should not cause harm or obstruct the delivery of the service (*Interview 43*).

> [Clients had] been asked weekly while they're in hospital. They come out and we're asking them. If they're referred to a psychologist in the community, it's been gathered there. Their doctor may ask them, they might be in another program. So, they can have five or six people asking them the same K-10 survey[56] … and that's without any of the other measures. … So we've actually got seven measures every three months and that's an awful lot of instruments for clients to be filling out. I don't think it's very recovery oriented. And I think it will mean that almost half the sessions would just be trying to get clients to fill out another instrument. … [A better measure would be] have they had a hospital admission, have they been presented at emergency suicidal, have they taken an overdose, or self-harmed in some way … but that data is held with the LHD. (*Interview 43*)

While the provider will have committed to a level of service in their proposal (*Interview 26*), there is negotiation about how outcomes are achieved and finding meaningful ways to measure them (*Interview 29*).

> It's super collaborative. We sit down together and have a conversation about it. (*Interview 27*)

Ultimately, KPIs should be about whether a client is achieving an improvement; however, the outcome itself may be determined by the objectives of the program funding (*Interview 15*).

> Trying to strike that balance between what is a true measure of impact or reflective of outcomes that matter to consumers and communities versus something that can be measured and ties to the work a contract or provider that they can reasonably influence, and shape. I think making that translation of kind of very high-level, long-term population level, system level outcomes to appropriate performance measures and KPIs in contracts is a really tough thing. (*Interview 47*)

The CasePHN considered it had improved the way it defines and measures KPIs (*Interview 27, Interview 37*). For new programs, and with inexperienced providers, targets are negotiated and then refined over time as experience grows (*Interview 35*). The CasePHN recognises further changes will be required when moving to outcomes contracting.

> It's become much more of an ongoing conversation around what does success really mean, at the client level, for this program, and working back from the outcome for the client, and using the program logic to work back to the service model ... That's led to more meaningful KPIs. We still have the

[56] The Kessler-10 (K-10) is a standard instrument used to determine psychological distress at a point in time. Required by DoH as part of the MDS, it is not the best measure for every cohort; for example, it is unsuitable for geriatric patients (due to likelihood of dementia) or Aboriginal and Torres Strait Islander communities (not culturally acceptable) but must be used regardless (*Interview 30*).

> volume-based stuff there [occasions of service], and our Board insists on some standard measurements across all our contracts. (*Interview 27*)

While there are efforts to standardise KPIs (Stirling, Ritter, Rawstorne, & Nathan, 2020) — within the PHN, by peak bodies and other funders[57] — KPIs are dependent on program funding objectives and are not always client centred (*Interview 4, Interview 15*) or aligned with other services provided for the PHN or other funders (*Interview 28*). For example, one AOD service received funding from five different agencies (two PHNs, Homelessness Services, Corrective Services, NSW Health, Department of Prime Minister and Cabinet), each with different reporting requirements (*Interview 38*).

> It would make sense to have one contract that all the different [funders] put into. (*Interview 21*).

Frequency of client data recorded varies depending on the nature of the program. Where clients receive services for a fixed-term, capturing data at entry and exit show outcomes from the service; for ongoing services, data needs to be captured at intervals (without burdening clients) to be able to track progress and ensure clients are not retained ('parked') indefinitely and allow others to access the service (*Interview 21, Interview 29*). For some services, a good outcome may be 'no further deterioration' in condition or improvements to overall quality of life rather than clinical improvements (*Interview 42, Interview 43*). Well-designed KPIs ensure services do not 'park' or 'cream' clients (Considine, O'Sullivan, McGann, & Nguyen, 2020); however, there is a risk that the reporting of KPIs becomes excessive as a result (*Interview 43*) and leads to a focus on reporting rather than improving service delivery (*Interview 21*). One provider said:

> [We have] something like 50 KPIs or measures to report on per program, and a lot of them are output type measures that are not that useful. And some [programs] have more, some would have 100. The quarterly reporting is quite extensive. (Interview 43).

There is a risk that reducing service performance to numbers will provide few insights into how the program is working, especially if no immediate outcome is expected (for 10+ years) (*Interview 17, Interview 30*), but this may be overcome by supporting the KPIs with other information.

> If there is a space where you can elaborate or, and that's where you'll find the services who are really doing the good work. They will elaborate. They will want to get those stories out there. (*Interview 4*)

[57] NSW Network of Alcohol and other Drugs Agencies and NSW Health (*Interview 4, Interview 15*).

In contrast, many providers see the benefit of using KPI data to help advocate for their service and improve the service (*Interview 41*). Notably, not all activities neatly fit the KPIs required by DoH or the CasePHN. For example, the provision of mental health screening tools in general practice may be more aligned to practice improvement function than individual services (*Interview 44*).

Targets

Targets (service levels established for KPIs) are proposed by the CasePHN based on experience with other services and refined in discussion with the provider (*Interview 18, Interview 24*). Some targets may be non-negotiable, but the way they are captured or reported may be negotiated (*Interview 36*). One provider said:

> It's a learning process for both of us really. It's not something that we're going to get right straight away; it takes a bit of work, but I feel like after a couple of years, we're getting pretty close now. (*Interview 21*).

For new services, it may be difficult to estimate the number of occasions of service that can be achieved. Different targets may be needed for different populations; in one relation, lower targets were required for harder to find groups to prevent 'creaming' of easier to reach clients (*Interview 35*). Different targets may also be required in the establishment phase as referral pathways and trust in services develop; supported by monthly rather than quarterly targets (*Interview 41*). In some cases, KPIs and targets are best refined when the service becomes established and the client group becomes better understood (*Interview 24*).

There is significant variation in providers meeting their targets (from struggling to exceeding) suggesting that targets could be further improved (*Interview 19*) or performance management is required (see Section 7.5.2). While KPIs and targets can be adjusted during the contract period if they are not working, one informant recognised 'it is not a good look' and needs to be justified (*Interview 19*).

Payments

The schedule to the *MSA* identifies whether the funding is activity-based (based on occasions of service), block-funded (to meet objectives), or outcomes-funded (allowing flexibility in how outcomes are achieved) — or a combination (*Interview 14*). The distribution of payments depends on whether the service has upfront establishment costs; ongoing costs will then be met across the financial year (at 6-months, 9-months; *Interview 5*). Final payments are made on receipt of the final report and audited financial statements to ensure funds have been acquitted as specified (*Interview 5*). Contracts generally limit overheads to 8% of the contract value,

mirroring the agreement with DoH, but can be implemented variably by the CasePHN depending on the value of the contract (*Interview 17*).

Progress reports

The schedule to the *MSA* specifies the reporting requirements. They include performance reports (progress of activities, KPIs, output and outcome information, variations/challenges, and opportunities for improvement), financial reports (periodic financial reports of income, expenditure), and final report and audited financial statements showing the acquittal of funds (*Interview 6, Procurement and Contracting Manual*, p.22).

Reporting requirements are negotiated for each contract (*Interview 17*); the reporting template is not standard, is usually developed by the provider (*Interview 18*), and includes KPIs and qualitative information. The scope includes clinical governance (any complaints/incidents, quality improvements, audits), management and communication, and information about the team delivering the service (*Interview 11*).

Summary

While many aspects of the contract are determined prior to market contact, there is some degree of flexibility when developing and implementing KPIs and targets, recognising that both parties will go through a period of learning as the service becomes established. Likewise, the way providers report on progress varies, aside from KPI and financial templates, depending on the Activity Funding Schedule that provides the funds as well as the services required.

7.4.5 Executing the contract

The contract comprises the *MSA* (which establishes the legal arrangement between the two), the schedule, the tender response, relevant guidelines, and any reporting templates (*Procurement Manual*). Due diligence is undertaken prior to contract execution, checking providers prior financials (*Interview 16*) and insurance (*Procurement Manual*). A 'pre-start meeting' is held to confirm responsibilities of each party under the contract (*Procurement Manual*, p.18).

The contract is executed by the appropriate financial delegation using *DocuSign* (a software used to manage agreements that includes eSignatures; *Interview 6*); although some providers insist on hard copies which can cause delays in contract execution (*Interview 18*). The unsuccessful respondents are then notified. The CasePHN may also issue a media release for

the contract awarded and inform local Members of Parliament of any 'announceables'[58] (*Interview 8*).

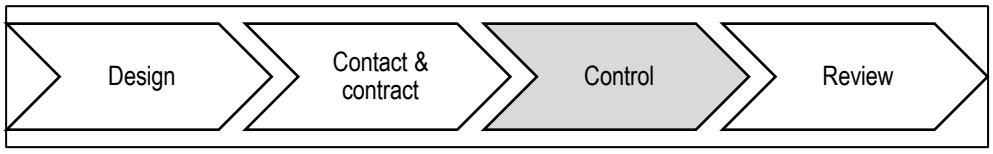
The executed contract is uploaded into Folio, the contract management system accessible to both staff and providers. Key information is transposed into checklists in Folio and assigned to staff and providers to complete, with automated reminders issued 2-weeks prior (*Interview 6*). Providers upload reports directly and receive support as required (*Interview 10*, *Interview 26*).

7.4.6 Summary

The contact and contract phase follows a detailed procurement policy and process, supported by templates developed by the CasePHN.

While probity in the contact and contract process is clearly demonstrated, uncertainty remains about how to best define and measure success. This is managed by negotiating KPIs, targets and reporting requirements with providers, and refining them at contract renewal or earlier if required.

7.5 Contract management



The contract is managed in accordance with the Contract Management Plan, developed as part of the Procurement Plan; this ensures all parties 'fully meet their respective obligations as efficiently and effectively as possible' (*Procurement Manual,* p.20). The contract management plan includes communication requirements, risk management, dispute resolution, performance management, payment and reporting. All aspects of the contracts are currently managed by program officers (content experts), at an intensity that reflects their value and risk, with support from the corporate services contracts team as needed (*Interview 13*). The contract is managed in three phases — implementation, management and review. All aspects of contract management are recorded in Folio by both staff and providers (*Observation 12*).

[58] Announceables is a term often used in Australian politics (and possibly elsewhere) relating to positive sounding news items or soundbites used by publicly elected figures. Any new contract must have a communication plan and identify the local Federal Minister of Parliament (*Procurement Manual)*. The CasePHN is required to notify DoH monthly of any announceables; DoH then notifies the local Member (*Interview 32*).

7.5.1 Implementing the contract

Once the contract is executed the provider is required to develop an implementation plan to show how the service will be established, how clients will be transitioned/recruited, and how it will be integrated with other services. The key risks for new services relate to recruiting staff, recruiting clients, and achieving the desired client outcomes (*Interview 19, Interview 41, Interview 42*). The speed at which staff are recruited varies, with non-profit organisations being more nimble (recruiting within 8 weeks; *Interview 43*) than LHDs (*Interview 42*). Depending on the size of the service and Provider, an implementation manager may be employed by the provider to get the program up and running (*Interview 43*). Meetings between the CasePHN and provider are often more frequent during the start-up phase of the contract, allowing the CasePHN to become aware of any issues in staff or client recruitment.

Establishing services

A meeting between the CasePHN and provider is used to reaffirm responsibilities to ensure both parties are clear on what will be done, by who and when, to avoid delays in establishing the service and promoting referral pathways (*Interview 17*). The first deliverable is an activity work plan (referred to as the Work Plan to avoid confusion with DoH deliverable) where the Service 'sets out what they're going to do over that year or period of the contract' (*Interview 24*), including how the program will be implemented, promoted and managed over the duration of the agreement (*Interview 43*).

> [A good Provider] is somebody who gets the service on the ground relatively quickly, and gets it up and running, and sorts out client recruitment early on. (*Interview 42*)

For many services, particularly complex services, the CasePHN takes a collaborative and supportive approach (*Interview 19*) and this is well received by providers — particularly when this also includes flexibility (*Interview 43*). As one provider noted:

> Sometimes recognising that having some flexibility to change some of the parameters over the life of the contract in a collaborative way, that if there are elements that are not working for a program, that it's seen as being a co-design or a re-codesign to make it more effective, rather than a failure of the provider to deliver what was in the contract. (*Interview 43*)

Programs that have been extensively co-designed can be unsuitable in practice as clients may require different forms of support (for example, one-to-one rather than group support; *Interview 43, Observation 1*).

Recruiting clients

One of the biggest challenges for services is recruiting clients into the program. While needs are high, referral pathways need to be established due to service fragmentation. Services need to be promoted to ensure there are not significant delays in meeting service levels funded (*Interview 33*). Word of mouth can 'make or break' a service (*Interview 4*); experience of a service, including whether it is inclusive and culturally appropriate, is often shared by clinicians and clients (*Interview 4, Interview 10*).

The CasePHN promotes services through its networks (members, committees, advisory groups), newsletters, meetings with other providers, HealthPathways[59], and may refer clients directly through its own referral line (*Interview 11, Interview 23, Interview 27, Interview 37*). Expectations of what services can deliver in the short-term are often ambitious (*Interview 1*), often originating from requirements established in the Activity Funding Schedules to the DoH–CasePHN contract. Realistically, service use will increase as referral pathways become established and trust grows (*Interview 10*). This can take up to 6-months, with 'often no recognition that in the first year those targets should perhaps be 50%, not 100%' (*Interview 43*).

Where services providing ongoing rather than capped services to clients reach capacity, the CasePHN works with providers to refine priorities and identify how to transition clients to other programs who may no longer meet the criteria (*Interview 29*).

7.5.2 Managing the contract

Once the service is established, the process of contract management becomes more standardised (*Interview 24*), facilitated by the Folio contract management system (*Observation 12*). Bureaucratic controls provide structure and are open and transparent about what is required of the provider and what will be delivered (*Interview 41, Interview 42*).

> We're not commissioning widgets, we're commissioning human services, but this is government money and there are people who are vulnerable and need support. So you have to show us how you're doing that too. (*Interview 41*)

Bureaucratic elements of contract management 'create safety and security in that relationship, so it's a necessary part of it… if you don't have a good process, then how do you go back and

[59] HealthPathways are online clinical decision support frameworks that help GPs refer patients to local services. See https://www.healthpathwayscommunity.org/About (accessed 25 October 2020).

determine if it worked or not' (*Interview 27*). However, 'the more top down or "just do it" you get … the more pushback and avoidance you get' from providers (*Interview 41*).

Providers are required to keep records and report on performance against the contractual requirements and their Work Plan. Ultimately, the CasePHN wants to know:

> (1) Did you see the number of patients you're supposed to? (2) Did you deliver the number of occasions of services that you were supposed to? (3) Did they get better? If you saw more patients than we asked you to and you provided less occasions of service than we asked you to, and they got better, then we're really happy with you and we'll have a chat about how we can further improve and support your model of service. (*Interview 42*)

The CasePHN monitors progress and makes adjustments to the program if required, with a view to improving performance over time.

An open and ongoing dialogue with providers enables the CasePHN to have a greater understanding 'when a provider is really engaged and committed, and proactive in looking at their data and improving their services … but also saying when things did not go so well' (*Interview 36*). This approach also supports service integration and improving access and quality (*Interview 41*). This creates a relationship where the provider is 'coming to you, reporting risks, working collaboratively to resolve issues, staying within the funding, being innovative' (*Interview 36*).

Maintaining records and reporting

In accordance with the providers' Clinical Governance requirements (*Interview 18*), clinicians maintain detailed records (casefiles) of services provided. Data is extracted from case files to report KPIs and MDS items. Some providers (not related to size) may have sophisticated systems to manage individual records and generate reports; however, for many, data must be extracted manually, often from more than one system (for example, referral and client management systems; *Interview 35*) and each clinician potentially records and extracts data differently (*Interview 35*).[60]

Record keeping and reporting is more challenging when working across organisational boundaries. Some models of care may require different services to work together — for example, clinicians and peer workers — who may not have access to the same systems (or any systems; *Interview 29*), or where clients are transferred from hospital settings to other services

[60] Investment in data management systems is not supported by short-term service funding, particularly where overhead expenditure is capped (*Interview 21, Interview 43*).

(*Interview 33*). For some programs, the CasePHN provides a client information management system (RediCase) which it can access directly to draw data and reports from (*Interview 29, Interview 33*) [61]; however, this may need to be supplemented with local systems where RediCase does not meet Provider's needs.[62]

Monitoring performance

Monitoring is a joint responsibility (Providers monitor and report performance, CasePHN tracks progress) that facilitates continuous improvement and triggers milestone payments (managed through Folio). In addition to reporting KPIs, providers are required to provide quarterly reports against their Work Plan, explaining performance, challenges and successes, and quality improvement (*Interview 11*).

The intensity of reporting and monitoring is identified in the procurement plan, based on value, risk and any additional requirements specified in the DoH Activity Funding Schedule (*Procurement Manual*).[63] Performance is evaluated based on KPIs, clinical governance, integration, how challenges are identified and resolved, how staff are supported, and whether the provider demonstrates continuous improvement (*Commissioning Framework, p.18*). While performance against KPIs is often the key indicator of whether a service is delivering what is required, contract managers also identified other 'red flags' such as changes in staffing, communication, and willingness to engage (*Interview 39*).

The quality of reporting varies: 'sometimes it's amazing and it's, you know, a piece of art almost, and other times it can just be a jumbled, hard to interpret, mess' (*Interview 19*). In some cases, program officers provided templates to help providers report on progress, recognising that small services are often managed by clinicians inexperienced in contract management (*Interview 18*). The timeliness of reports (and data entry into RediCase; *Interview 33*) was also identified as an issue, despite Folio sending automated reminders: 'with LHDs, it's very common for them to be super late' (*Interview 22*), suggesting some types of organisation required earlier reminders due internal processes taking longer.

A month after reports are received, the CasePHN meets with the provider to discuss progress, risks and next steps, carrying out onsite inspections where relevant (*Procurement Manual*).

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[61] The software has been jointly purchased by 9 PHNs. Data is manually extracted from the backend into Excel (requiring expertise) to be analysed (software does not have analysis functionality) (*Interview 33*).

[62] 'Some KPIs aren't able to be captured in RediCase', meaning the provider needs to record, extract and report them separately (*Interview 33*).

[63] Too much monitoring can harm relationships and detract providers from core activities (*Interview 21, Interview 43*).

Each meeting is documented (both agenda and outcomes/actions) and is usually face-to-face — at the CasePHN or Provider's office. Program officers invite case workers/clinicians to alternate meetings to gain insights into how the program is working, either within the service or within the system more broadly (*Interview 10*). The meetings provide the CasePHN with an understanding of how services are managed and clients are engaged, how services are developing and staff trained, and whether partnerships are being made (*Interview 23*). Some CasePHN staff only meet providers at their sites:

> I used to alternate and have people come here. But I get much more out of going out to the sites, seeing additional staff, … clients, the frontline team members, you get a lot more richness about what's going on. You pick up a vibe in the organisation, you see the physical building and if there are any issues with that ... it acknowledges, you're running a service, we already burden you with so much reporting, we don't want the meeting to be another burden. So I try and minimise the impact for them. Like, you wouldn't get [two additional managers] coming out, like that's hours of their time. So that's why I do that. (*Interview 34*)

The meetings allow the CasePHN to build strong relationships with the providers — something that has been well received (*Interview 21*). New risks may be identified during contract meetings — they are entered into the procurement plan and risk tables; mitigation strategies are discussed, including who is responsible for risks, how risks will be minimised and when. Risks are followed up at subsequent contract meetings and earlier if necessary (*Interview 30*).

> I think for the most part the [CasePHN] team are quite good at identifying the risks and working with providers to, you know, set up strategies to reduce likelihood. But that said, you can't always control for everything. (*Interview 19*)

Risk management is considered a key component of contract management. The CasePHN takes a collaborative approach to risk management and it is embedded in every aspect of contract management and the procurement process.

> The only way to manage risk is to shout it from the rooftops because there's nothing to be ashamed of about risk. We mitigate as best we can and the best way to mitigate is to make sure everybody's aware and that they call out what they see as the risks and whether or not those are adequate mitigations. (*Interview 17*)

Some staff acknowledged that they didn't necessarily update the risk register as much as they should — as they were 'probably too busy trying to solve the problem' (*Interview 41*). There was also the question raised about who owns the risk table once the contract is executed (*Interview 17*). The CasePHN is currently working to incorporate the risk table into Folio such that both the CasePHN and provider can access a 'live' risk schedule and manage risks through Folio (*Observation 10*).

Conversations between the CasePHN and provider are not limited to progress meetings and occur as required by either party; this allows any issues (and opportunities) to be identified and managed as early as possible. This approach is recognised and valued by providers, particularly when the CasePHN program officer is 'very engaged' (*Interview 44*).

Improving performance

Improving performance relates to continuous improvement. There were examples of KPIs being changed when not met — a reflection of the original KPI not being fit for purpose (*Interview 33*), unachievable (in one case, the CasePHN modified the contract, 'paying [the Provider] more to do less'; *Interview 41*), or failing to provide evidence of outcomes (*Interview 41*).

> Even though a target may not be met, it goes a long way towards us understanding what's really involved. (*Interview 19*)

In most cases, KPIs were adjusted at contract renewal (*Interview 19*). However, they were also renegotiated during the contract period — to varying success. In one case, after a period of co-design and negotiations of new KPIs, the provider considered, taken together, the new KPIs were not recovery-oriented and detracted from service provision (*Interview 43*). CasePHN staff reflected that this process was ultimately 'too collaborative', and they may now lack authority to performance manage the provider (*Interview 41*).

The use of detailed contracts and performance measures risks providers only meeting the requirements; whereas simplified agreements, drawing on relationships and trust, may lead to continual improvement and innovation within the contractual parameters (Mental Health Australia, 2015). Given the detailed nature of the contracts, and PHN commissioning being relatively new, the CasePHN needs to actively work with providers to seek continuous improvement (*Clinical Framework*). Continuous improvement may come from providers themselves, often in response to challenges meeting KPIs.

> So [one Provider] was quite innovative when they realised that despite their focus on trying to not add to the current wait list [the waitlist was increasing] ... And so they established [another service], which is a waitlist intervention, looking at more group education for parents and caregivers. (*Interview 18*)

Continuous improvement was likely to be driven by individual service managers or the ethos of the organisation (*Interview 18*).

Managing underperformance

The CasePHN performance manages providers who continually fail to do what they say they will do, or fail to respond (*Interview 18*).

> The first alarm bell is when a provider just doesn't respond … or puts in a report or [a Work Plan] that's substandard and doesn't seem to think that it's an issue. (*Interview 19*)

Performance management is not something the CasePHN has much experience in (*Interview 22*). This may reflect that all parties are learning — but as the CasePHN gains experience, and programs stabilise, this would be expected to change. There were concerns that underperformance was not being escalated early enough internally due to the vested interests of staff in the service and the relationship (*Interview 42*). For this reason, independent 'red flagging' of KPIs may be introduced to identify performance issues earlier (*Interview 42*); however, this does not necessarily identify the underlying cause of underperformance (*Interview 26*). Similarly, early signs of underperformance are not always reflected in KPIs; for example, staffing issues are often identified through ongoing dialogue with the Provider.

There was some evidence of hold-up, by niche providers (*Interview 4*) and certain workforces which were 'political' and were 'used to kicking up a stink' (*Interview 41*). One example highlighted the need to clearly specify service models to ensure there was no ambiguity about what was in and out of scope, also highlighting that the provider was responsible for ensuring any sub-contractors remained in scope (*Interview 41*).

There was no evidence in this study of the CasePHN penalising services who had underperformed (*Interview 43*).

> The only discussion that we are having with people at the moment is we might not continue your contract because you're not providing the services that you said you would. And we do have those conversations… If they were collecting outcomes data, and they could show that they were actually a success and people that they were seeing, they were making a huge difference to them, it might be a different conversation. (*Interview 42*)

There was an instance of services never becoming established — due to organisational or workforce issues — and effectively being decommissioned (*Interview 5*).

A summary of access KPIs is presented to the Board on a monthly basis, identifying contracts that are on target (90% KPIs met), partially achieving target (75–90% met), and significantly below target (< 75% met) (*Board Report Commissioned Services*). For contracts performing significantly below target, the Board requires reasons for variance (predetermined categories of problems relating to: referral pathways, promotion of service, staff recruitment/retention, underestimated intensity of service delivery, novelty of model, or underperforming) and what is being done to manage performance (postpone/withhold milestone payment, review staff resources and management, review referral pathways, extension of time, review KPIs, review program design, consider decommissioning) (Ibid). Providers who do not meet the terms of the

contract may be managed through either a variation to the contract, a mutually agreed cancellation, or termination due to breach (*Procurement Manual*, p.33).

Contract variation

In some cases, an extension of time may be required to complete the terms of the contract — particularly if there were delays awarding the contract or establishing the service (*Interview 23*). When there is no change to the funding or service requirements, providers may formally request to extend the contract time (*Procurement Manual*). Payments are withheld until the milestones are complete (*Interview 23*).

Due to high levels of uncertainty (in clients and model of care), the CasePHN is open to refining 'the service model in response to learnings, unexpected issues and emerging opportunities' (*Commissioning Framework*, p.18). Variations may also be sought to change the services required or change the value of the contract, for example when 'provisional items are now more clearly understood and costed' (*Procurement Manual*, p.32); this is managed through a deed of variation.

Summary

In summary, bureaucratic controls provide the scaffolding of contract management processes in the CasePHN–Provider relation. In addition, the CasePHN works with providers in a collaborative way, using relational controls to supplement and support bureaucratic processes.

7.5.3 Reviewing the contract

Each contract is under continual review throughout the duration of the relation. This includes the strategic and operational review of services, clinical audits, promotion of evidence-based interventions, providing feedback to providers, collecting outcomes data, collecting data from service users, and reviewing programs annually to ensure they remain targeted and effective (*Clinical Framework*).

At the end of the contract period, the CasePHN determines whether all services have been delivered and reviews audited financial accounts to check that funds have been acquitted in accordance with the agreement (*Procurement Manual*). The procurement is evaluated in terms of the performance of all stakeholders involved in the process, including the CasePHN, and the 'appropriateness, efficiency and effectiveness of service delivered' (*Procurement Manual*). The program may be subject to a formal evaluation (*Evaluation Framework*), examining the impact of the activity commissioned, either during (to improve service models and KPIs; *Interview 29, Interview 41*) or at the end of the contract period. This information is used to improve the evidence-base and the commissioning cycle.

Renewal

When Activity Funding Schedules are reissued by DoH, many commissioned services are renewed. The timing and duration of renewals is contingent on confirmation of funding from DoH.

The CasePHN explains any changes to the *MSA* and the schedule (service model, KPIs, reporting and budget) to the provider (*Interview 23*). This process starts early for some clinical streams (December/January) who anticipate a 'bottleneck' of contract renewals at the end of the financial year (*Interview 23, Interview 28*), and recognise the time it takes to review complex programs (*Interview 28*).

> There was so much recommissioning going on in the organisation, the contracts team was really stretched. I don't remember when we ended up getting our funding, but it was not as early as it could have been. We were able to give assurances to the headspace centres, give them letters of comfort, which turns out is a thing … [for] some of them, that was sufficient for them to renew contracts for their staff. (*Interview 28*)

The renewal process provides an opportunity to improve contracts (and reduce uncertainty) drawing on experience across the CasePHN in the prior period (*Interview 18, Interview 41*). This provides an opportunity to reduce ambiguity, simplify and improve consistency — particularly in schedules within clinical streams (*Interview 18*). This will continue to be important as the organisation and the commissioning activity continues to mature (*Interview 42*), as the CasePHN manages its own risks delivering its contract with DoH (*Interview 41*), and as the CasePHN moves towards outcomes commissioning (*Interview 42*).

Decommissioning/transitioning

Services may be short-term due to changes in priorities, funding or policy (Interview 41); clinical guidance (for example, frequency of women's health screening; *Interview 19, Interview 37*); level of use and/or other services becoming available (*Interview* 24); and underperformance (*Interview 41*). However, client needs are likely to continue. Services (and therefore contracts) are not something that can simply come to an end; the CasePHN and providers need to identify how to decommission services and transition clients to other services.

Decommissioning may present a reputational risk to the organisation (*Interview 37*) and is not a common process. Early decommissioning processes were experimental in nature, and were developed in consultation with providers. The CasePHN has subsequently developed and updated policies and processes, identifying principles of decommissioning while recognising every activity is unique (*Interview 19, Interview 27*), managing relational risks through a form of exit agreement (Anderson et al., 2014).

How clients are transitioned into and out of programs is identified as early as the request for proposal (*Interview 26*). The *MSA* now contains a transition clause placing an obligation on providers to transition clients to alternative services should the agreement come to an end (*Interview 42*). This has the potential to reduce hold-up given and make it easier for the CasePHN to switch service providers (Phua et al., 2011).

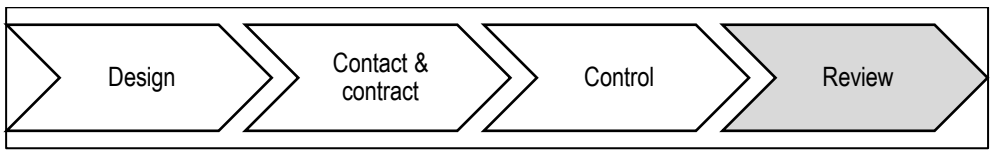
Once the decision to decommission is made, the CasePHN works with the provider to develop a decommissioning plan. Services are gradually wound down and a communication plan is implemented that updates referral pathways and notifies clients, pointing them towards other services in the area (*Interview 19, Interview 37*). Careful transitioning aims to 'minimis[e] disruption and maximis[e] support' (*Interview 24*). When active clients are transferred to different services, the transition process must be incorporated into the contracts of both providers (*Interview 24*).

7.5.4 Summary

Contract management ensures all parties meet their obligations under the contract. Data show that the CasePHN and providers are still learning how to specify performance measures that lead to effective service delivery. The way services are contracted and managed varies depending on the contract and the risks present, the team managing the program, and is constrained by the DoH–CasePHN relation, as well as other policy and structural factors.

Contract management in this setting is not a 'set and forget' approach. In response to high levels of uncertainty, a mix of bureaucratic and relational controls are key to knowing whether a contract is working well. It relies on *active* engagement with the provider to track KPIs, to ensure what is measured is meaningful, to ensure targets are reasonable, to check whether the service model meets the needs of clients, and to push for continual improvement.

7.6 Review process



The CasePHN seeks continual improvement in its own activities (*Clinical Framework*), as well as services commissioned. This process is a key part of the commissioning process and enables the CasePHN to reduce uncertainty over time. Rather than contracting being linear, the commissioning process highlights the cyclical nature of contracting — even if this involves a change in supplier. The review process includes the review of individual contracts (discussed in

Section 7.5.3 above), programs of services, internal policies and processes, and staff capacity and development.

7.6.1 Reviewing programs

In addition to reviewing individual contracts, some clinical teams at the CasePHN proactively review KPIs and targets across contracts to improve consistency and remove superfluous measures (*Interview 22*). A broader review, instigated by the move to incorporate KPI reporting into Folio, has led to the development of organisational, program and contract level KPIs; this will improve consistency and consequently improve organisational-wide reporting, overcoming differences across the organisation (*Observation 10*).

Broader national program evaluations also contribute to the evidence-base for commissioning. National evaluations of services commissioned locally, however, may fail to use appropriate methodologies or disaggregate findings for local target populations (*Interview 36*).

7.6.2 Reviewing internal processes

The CasePHN continually reviews and improves commissioning processes, within the constraints of the PHN Program (*Interview 11*). Informants also highlighted the need for changes to the broader operating and funding context to reduce levels of uncertainty and fragmentation (*Interview 11, Interview 12, Interview 40, Interview 42*).

The commissioning process had undergone significant change in the previous 18-months (*Interview 12*).

> Our processes, and our tools and structures for contract management, continue to become more formalised and transparent and more supportive. (*Interview 41*)

Improvements had been made to planning, contracting, and performance management. The case setting was evolving rapidly (*Interview 47*). One informant said, ‘if you did [the] research in 2-years’ time, once some of that's settled down, I think people would feel a bit differently’ (*Interview 45*). This section describes the key internal review processes that contributed to the ongoing improvement of commissioning.

Reviewing planning processes

While the Needs Assessment and Activity Work Plan requirements are specified by DoH, there is flexibility in how they are presented. The CasePHN recognises both need to be simplified (‘bundled up’) to show objectives rather than the detail of what activities will be implemented;

this will in theory allow greater flexibility and hence less changes (which then require approval from DoH, often delayed) to be made in the future (*Interview 31*).

Activity Funding Schedules and Activity Work Plans created siloes at the CasePHN and in commissioning activities. Staff identified the need to do more 'joined up' commissioning, recognising the link between mental and physical health, and mental health and AOD (*Interview 11, Interview 12*). However, commissioning services from different Activity Funding Schedules requires compliance with both funding schedules (for example, providing two MDS) — as one informant said, 'I don't think I could do it to [the Provider]' (*Interview 27*).

Reviewing contract management processes and systems

An independent audit of contract management processes was conducted (for the 2017–2018 period) to examine the effectiveness of and compliance with contract management processes (*Internal audit*). The audit identified a number of strengths, as well as areas for improvement including the governance of procurement (strategy, risk assessment, training, management, and performance management), delegations of authority, skills, record keeping, and support for providers using Folio – most of which appear to have been addressed.

The *MSA*, introduced in 2017, has been under continual review to address gaps and ensure consistency with the *SFA* (*Interview 17*). The way risks are managed is also being reviewed, with the risk schedule likely to be incorporated in Folio, owned by the Provider, and monitored by the CasePHN (*Interview 11, Observation 10*). The CasePHN is also improving the escalation/de-escalation processes as contracts are renewed; this ensures matters are dealt with by both parties at the right level (*Interview 17*).

> We're really working on [this] at the moment and it's really paying dividends. Our project officers are speaking to their peers at the provider organisations, and actually getting the truth. And then, if one of them is not getting the answer they want, they escalate it. Either they do or we do, and it's much better. And then it deescalates. (*Interview 17*)

Many changes had been administrative, which staff see as making 'everything a lot clearer, and organised, and easier to keep track of' (*Interview 24*), although this approach 'wasn't for everyone' (*Interview 17*). Aligning changes with Folio was likely to lead in greater accuracy, consistency and efficiency; however, revisiting KPIs and targets across all contracts was going to require significant resources (*Observation 10*).

Further improvements will be made to make efficiencies in light of operational funding cuts and the requirement to move towards outcomes-based commissioning (*Interview 34, Interview 42*), bringing a shift in how PHNs do business (*Interview 47*). Efficiencies may be achieved in the longer-term by collaborating with other PHNs in data management and contracting processes

(*Interview 42, Interview 45*). This is likely to be instigated by PHNs rather than DoH, but the limited resources available would mean any changes would be slow (*Interview 42*).

Reviewing how contracts are managed

There is a push within the CasePHN, driven by data gathered from staff exit interviews, to remove administrative aspects of contract management from content experts (*Interview 11, Interview 19*); however, this is not possible within the current staffing structure (*Interview 34*). While separating the administrative tasks could lead to increased efficiency (on the basis that administrative staff are cheaper; *Interview 13*), and allow clinical staff to focus on content matters and 'being a partner in health reform' (*Interview 11*) while potentially improving job satisfaction (*Interview 17*), many saw this as potentially watering down the CasePHN–Provider relationship and potentially undermining relational controls (*Interview 11, Interview 19*).

> [The CEO] wants to know the detail, for example, how many people is the program benefiting? Are they getting good outcomes? Are we worried about their performance? What are they doing about it? … And if you don't have that intimate knowledge of that service and that relationship, I don't think you can provide those answers. (*Interview 11*)

One team, due to the large number of contracts it manages, has considered the different skills required to manage contracts (administrative, stakeholder engagement, content expertise) and recruited an administrator, leaving engagement to staff with relationships with providers and knowledge of the sector (*Interview 34*). This provides stability for providers in terms of contacts, something that has been highlighted as important in the sector and to the team, while increasing efficiency of administration within the team (*Interview 34*). The team recognised the importance of the Provider's relationship with the content expert.

> So what it means is that they will be much more willing to talk to you if things start to go not to plan. And genuinely, they ask for advice on stuff; I wouldn't imagine those sorts of conversations would happen if say [a contract administrator] were the contact person. (*Interview 34*)

In effect, this is a small trial of the separation of roles. It is not clear how long this structure will last, however, as DoH has since cut back the operational funding for this program of work (reducing the FTE for this team by one-third, but not changing commissioning requirements; *Interview 34*).

Continuing professional development

Individual staff appear to take responsibility for maintaining their content knowledge. Across the organisation, staff have opportunities to continue their professional development through internal and CasePHN-wide communications (*Interview 23*), training in contract management

(*Interview 17*; *Training: Contracting for outcomes*), sharing experiences with colleagues (*Interview 5, Interview 33, Observation 10*), and one-to-one supervision.

The CasePHN is working to continually improve business processes and the capabilities of staff responsible for commissioning. To date, this has brought greater consistency and formality to commissioning activities.

7.6.3 Summary

In line with the *Clinical Framework* and *PHN Guidelines*, services, programs and processes, and staff, are subject to continual improvement, supported by the culture of the organisation and the stakeholders it works with to achieve the best outcomes it can in public health. This process is also driven by reductions in operational funding. Review processes to date have been largely focused on establishing processes and procedures and improving templates and systems, rather than innovation. Innovation is likely to require more significant investment and is not necessarily achievable when operational overheads are being reduced.

7.7 Chapter summary

This chapter first presented the contextual setting for the intermediary; the legacy of the organisation, the current operating framework, and the strategic planning processes as they relate to the commissioning role. The chapter then provided a detailed case description of the second part of the outsourcing arrangement — the CasePHN–Provider relation — and how this was managed from contact to review. While the relation appeared to be highly bureaucratic, reflective of the relation with DoH, there was also flexibility in how the process was managed (related to scale, novelty and therefore risk). Importantly, the intermediary used relational controls to supplement bureaucratic controls to manage uncertainty. The CasePHN has very collaborative relationships with providers and other stakeholders, driven by strong cultures driven to improve public health. The next chapter analyses the case description provided in this and the previous chapter, and compares the observations with the conceptual framing.

Chapter 8 How DoH manages the outsourcing of the PHN Program

8.1 Introduction

This chapter presents the analysis of the empirical data and answers the research question: *How can the public sector organise and control the outsourcing of human services?* Outsourcing requires ongoing managed coordination (Chapter 2). TCE theory suggests human service outsourcing has low contractibility due to asset specificity, uncertainty and frequency, which is likely to be further complicated by probity (Chapter 3). While the literature suggests relational control strategies suit activities of low contractibility, relational controls may be less suited to bureaucratic environments such as public sector settings where probity requirements must be satisfied (Chapter 4).

In this chapter, drawing on the empirical data (Chapter 6 and Chapter 7), I identify how the tension between probity and low contractibility is managed across the outsourcing process. First, I describe the key sources of probity and low contractibility and the key control strategies used across the contracting process (Sections 8.2 and 8.3). Second, I explain how the tension between probity and low contractibility is managed in this empirical setting (Section 8.4). This develops our understanding of how the public sector manages the outsourcing of low contractible services where probity requirements must be satisfied.

8.2 Satisfying requirements for probity

The aim of this section is to explain the different sources of probity in this empirical setting and how probity requirements are satisfied across the outsourcing arrangement. The requirement to demonstrate probity in public sector settings makes probity a significant transaction hazard in public sector settings.

8.2.1 Sources of probity

As described in Section 3.5, probity is a specific and often legislated governance requirement that requires PSOs to behave honestly and decently, demonstrating integrity, across all operations (IFAC & CIPFA, 2014; Williamson, 1999). In outsourcing arrangements, probity is most evident in procurement where the PSO seeks the ‘proper use and management of public resources [where] proper means efficient, effective, economical and ethical’ (Department of Finance, 2017, p. 14). While probity is particularly important around key decision points, probity is relevant across the outsourcing arrangement, from design to review.

While not subject to legislated probity requirements directly, probity arrangements are transferred to the CasePHN through the DoH–PHN relation. There is also an expectation of probity from key stakeholders in the CasePHN's region, who may in turn have their own probity requirements. Multiple stakeholders in the empirical setting are subject to legislated and sometimes different governance requirements, including DoH (Department of Finance, 2017), the LHDs and LHNs (NSW Government, 2020). This made co-commissioning services with different organisations challenging as each had different governance requirements that had to be met (*Interview 48*).

8.2.2 Satisfying probity through design

The design of the outsourcing arrangement satisfies probity requirements in a number of ways. First, the process of design for the PHN Program was open and transparent; a review conducted by Horvath (2014) examined previous models of primary health care coordination and recommended changes to the existing Medicare Local model. The PHN Program was developed in consultation with stakeholders openly and transparently (*PHN Guidelines*). There was evidence that Medicare Locals and the precursor to the PHN Network were able to advocate for small amendments to the design, including increasing the number of PHNs established and aligning PHN boundaries with those of key stakeholders (*Interview 46*).

Second, the outsourcing arrangement establishes a transparent process — the commissioning cycle — under which the program is delivered. The commissioning cycle is a highly transparent process, and gains legitimacy by engaging stakeholders including consumers in the process, resolving historic issues of consumers being excluded from the design of services (Shergold, 2013a). Outputs of the commissioning process, including the Needs Assessment and Activity Work Plans, are made public.

Third, the CasePHN, one step removed from the public sector, is able to co-design models of care/service requirements with service users, providers and other experts (internal governance groups as well as experienced staff). This builds legitimacy in the CasePHN's operations and the program.

Fourth, unlike Medicare Locals who could commission or provide services directly, the PHN Program prohibits direct service provision. This removes any potential conflicts of interest between PHN operations and providers (Horvath, 2014).

Finally, the contracting process used in both the DoH–CasePHN and the CasePHN–Provider relations is open, equitable, transparent and accountable, and subject to review by the Government Minister and other parties.

The design of the outsourcing arrangement satisfies probity requirements across decisions relating to the expenditure of public monies, and demonstrates stewardship of services through the transparent and inclusive planning processes that build legitimacy in the outsourcing arrangement.

8.2.3 Satisfying probity through contact, partner selection and contract

Probity requirements are satisfied by both DoH and the CasePHN through the contact and control phases of procurement. Both use highly documented processes, described and disclosed in full during the contact phase. This includes the PHN Program/service requirements, the selection criteria, the selection process and timeframe, the contractual terms, and how performance will be managed.

This bureaucratic approach ensures the selection of partners is equitable and transparent, and documented against predetermined selection criteria, demonstrating the relevance of probity to both parties. While probity in procurement decisions is a priority, the contact and contract processes across both relations also ensure organisations have the capability and capacity to provide services required. This is managed through safeguards embedded in the contract and guidelines, including clinical governance, qualifications and experience of staff, and prior organisational experience.

One informant at the CasePHN suggested that probity requirements in the CasePHN–Provider relation may be too strict. For example, limited feedback is provided to unsuccessful parties in procurement processes.

> Probably [goes] too far, because sometimes [unsuccessful parties] need to know some things and we'd like to be able to tell them a bit more to help them improve the next one. But probity reasons or restrictions limit what you say. (*Interview 26*)

This is counter to market development and demonstrates that probity is not straight forward; on the one hand, parties may satisfy probity requirements by being transparent and sharing information with stakeholders, while on the other, probity may require parties to protect information on the basis of commercial confidentiality or conflict of interest.

8.2.4 Satisfying probity requirements through ongoing control

In the DoH–CasePHN relation, DoH satisfied probity requirements through highly bureaucratic control processes and reliance on written/scripted communication (with scripts circulated in

advance).[64] Scripted briefings were provided to the group of 31 PHN CEOs of any updates to the program, ensuring transparency and fairness between PHNs *ex-post*; questions were taken on notice and responded to in writing (Interview 42). This was provided at the PHN Program level as opposed to the DoH–CasePHN relation, suggesting the way probity requirements were satisfied ignored risk.

DoH manages individual relations by reviewing key outputs from the commissioning cycle — Needs Assessment and Activity Work Plans — and progress reports including audited financial statements. Key deliverables must be approved prior to the PHN acting on their content. While DoH places emphasis on financial acquittal (financial aspect of probity), many of the deliverables relate to the stewardship of the PHN Program and services (social aspects of probity). DoH requires PHNs to publish their Needs Assessments and Activity Work Plans to maintain transparency in the process. In terms of the DoH–CasePHN relation, if there is any one-to-one communication, this was very formal:

> …it's all done by email. Sometimes we would get a phone conversation before the email to say, we need to clarify this, or I'm seeking further information on this. And then follow it up by email. (*Interview 38*)

Consistent with TCE theory, DoH demonstrated probity through the notable absence of relational controls which could potentially undermine probity arrangements (Ditillo et al., 2015; Narayanan et al., 2007), and the absence of performance incentives (Williamson, 1999). DoH used budgetary controls to seek efficiencies, reducing operating costs and activity funding across a number of Activity Funding Schedules (discussed in Section 6.5.3 above). While the *PHN Guidelines* suggest incentives are available, the only incentive appeared to be contract renewal (Krishnan et al., 2011), albeit with a reduction in funding (Section 6.5.3). Likewise, there was no evidence of financial penalties for underperformance.

Until late 2020, while DoH had been transparent about the *process* of performance monitoring, DoH had not been transparent about the *outcomes* of performance monitoring for both the PHN Program or individual PHNs. The long-anticipated performance report published in October 2020 (5 years after the program commenced) was high-level and provided little detail about performance issues, instead creating a baseline for future reporting (*PHN Performance*). While the *process* of control is transparent, in this setting the *outcomes* of control have been less transparent. However, outcomes are subject to Freedom of Information requests and other forms of public scrutiny, including formal review by government.

[64] Even for this current study, DoH preferred to answer questions in writing rather than participate in an interview.

In the CasePHN–Provider relation, the CasePHN uses similar procurement processes and contracts to those used by DoH, mirroring controls used around the decision points of procurement, and formal planning and reporting processes. One informant made clear the CasePHN was managing the risk of meeting its own obligations under the DoH–CasePHN relation (*Interview 17*), satisfying probity requirements around financial decisions and providing ongoing stewardship of the program.

8.2.5 Satisfying probity requirements through review

The review process is a key step in the commissioning cycle and, like all other public sector operations, is subject to probity requirements. To date, reviews have included the evaluation of the implementation of the PHN Program, the evaluation of specific services, as well as the review of program documentation. The formality of review processes as well as the publication of findings satisfy probity requirements.

The first evaluation of the PHN Program was made public demonstrating transparency and accountability in the evaluation process and outcomes. However, not all evaluations (terms of reference, or findings) have been made public since (see Section 6.6.2). This could be intentional by DoH to keep underperformance (or poor outcomes) quiet (*Interview 48*).

While probity has been mentioned in the program documentation, the way probity requirements are satisfied across the program has not been subject to review. Some stakeholders argue that PSOs do not fully understand probity (*Interview 47, Interview 48*) and therefore perhaps probity itself should be subject to review.

> I think the first point is I think **probity is misunderstood hugely**. I think what I see often is, particularly by government is, a need to better understand what probity is and what it's there for. … what we often see occur is that you get very excessive probity situations which aren't reflective of that risk and are completely inappropriate. … **people often default to an exceptional level of probity** that is inappropriate without understanding the impact that it has on what they're trying to achieve. So, this isn't me saying that probity isn't right. It's just saying, **you've got to have proportional probity that reflects the risk of the issue that you're trying to manage in the first place**. As part of that, what we often see is people use probity arrangements that have been designed from something previous and apply it to current situations. (emphasis added, *Interview 48*)

The nature of the PHN Program, and in particular the commissioning process, may also mean generic organisation-wide probity arrangements are not suitable.

> In a commissioning environment, you've got a far more open, iterative interactive process that gathers the views and perspectives of providers and considers that in the design of what procurement looks like. So, by default

> you need a completely different application of probity in those sorts of environments because there's a different sort of risk. (*Interview 48*)

The CasePHN demonstrates transparency in the review process across both relations. In addition to demonstrating probity in strategic planning processes, the CasePHN is continually reviewing, improving and publishing updated policies and guidelines, including probity arrangements for governance and the procurement process.

8.2.6 Summary

Probity is a specific, legislated governance requirement of PSOs and thus a significant transaction hazard in public sector settings. In both the DoH–CasePHN and CasePHN–Provider relations, probity requirements are satisfied using highly specified governance mechanisms and bureaucratic processes, ensuring the outsourcing arrangement is transparent and gains legitimacy from key stakeholders. Both parties use open, equitable, transparent and accountable contracting processes, all of which are subject to review by the Government Minister and other parties, particularly in relation to financial oversight and equity in the allocation of resources. There is evidence that probity is higher in the DoH–CasePHN relation compared to the CasePHN–Provider. DoH places greater emphasis on the transparency of processes than the implementation or outcomes of those processes, especially in relation to performance. DoH seeks legitimacy from stakeholders by satisfying probity requirements through clear and transparent processes.

8.3 Managing low contractibility

The aim of this section is to explain the different sources of low contractibility in this empirical setting, and how low contractibility is managed across the outsourcing arrangement.

8.3.1 Sources of low contractibility

There are multiple sources of low contractibility associated with the outsourcing arrangement, relating to asset specificity, uncertainty and frequency.

Asset specificity

Asset specificity arises from the investment in human capital by both the CasePHN and providers. This is evidenced by the impact of the funding flow and staff turn-over (due to delays renewing the outsourcing arrangement) on sustaining service delivery (Sections 6.5.3 and 7.3.2). There is also evidence of hold-up by some providers (Section 7.5.2). While there is evidence of investment in policies and procedures, there has been limited investment in IT systems due to capped operational funding.

Uncertainty

There are multiple sources of uncertainty. First, uncertainty arises from the general nature of primary health care services; services are difficult to program due to individual needs and circumstances. Outcomes are difficult to measure due to the complex transformation process, the array of formal and informal supports available (making attribution difficult), and the time lag between interventions and outcomes. When observing the commissioning process (CasePHN–Provider), it was clear that services remain difficult to specify and measure with specifications and performance measures being continually revised (See Sections 7.4.4 and 7.5.2). The uncertainty in specifying and measuring services makes performance difficult to determine (Krishnan et al., 2011).

Second, uncertainty is associated with the novelty of the PHN Program and the incomplete/changing specification (*PHN Evaluation*). DoH approached the market with high-level requirements, including governance requirements (Board, Clinical and Community governance groups), key tasks (commissioning cycle), and objectives (practice improvement). Additional guidance was developed *ex-post* (evidenced in Appendix C), which could be perceived as reducing uncertainty by providing additional clarity, or be perceived as increasing uncertainty by changing the requirements. DOH also uses the PHN Program to respond to new health priorities through the issue of new activity schedules, and trialling new service models in selected PHNs (Section 6.4.3).

Third, the primary health care setting is susceptible to disturbances (shocks), affecting DoH, PHNs, providers and clients. This was evidenced during the fieldwork period which included a severe bushfire season[65] and a pandemic, both of which affected the need for and delivery of services. DoH is able to mobilise the Australian Government's response to health priorities through PHNs, distributing information and resources, providing training, identifying infrastructure to support broader response initiatives, and making contingency plans with providers. During disturbances, the CasePHN was also observed managing the impact on commissioned services and its own operations (*Observation 9, 13*).

Fourth, uncertainty also arises from the service context, in particular the division between primary and secondary care (Section 6.2.2), and the respective policy makers, funders and providers (Australian Government, state/territory governments, LHNs/LHDs, private providers; *PHN Evaluation*). Each funder has different contracting requirements; one program may receive

[65] In December 2019 and January 2020, DoH used PHNs to distribute $45m nationally to support frontline primary care (*Observation 5*).

funding from multiple sources, and one provider may provide multiple programs for different funders. Both lead to service fragmentation for clients, and inefficiencies in service delivery.[66]

Frequency

Frequency is driven by the DoH–CasePHN relation, the frequency at which the contract and Activity Funding Schedules are issued and renewed, and the expenses incurred in arranging new activities. While the contract and Activity Funding Schedules are renewed, i.e. they recur, are relatively short in duration, and often have little lead time (evidenced in Section 6.4.3).

As described in Chapter 3, different attributes of a transaction contribute to the low contractibility of an arrangement and their interaction can compound low contractibility.

8.3.2 Managing low contractibility through design

This section explains key control strategies used to mitigate and manage low contractibility through program design. This includes the commissioning model, the flexibility in the contract allowing DoH to respond to new health needs, and mechanisms to encourage collaboration with a view to increase efficiency and reduce fragmentation in primary health care services.

Collaborating with experts

PHN Program design, specifically the commissioning framework, allows aspects of low contractibility to be mitigated and managed in the outsourcing arrangement. DoH identifies high-level priorities in schedules to the contract. The CasePHN then, through the commissioning process, identifies and prioritises local health and service needs in collaboration with key stakeholders (including other funders and services, clinicians and clients) in relation to the high-level priorities, including how they will be addressed and how they will be integrated within the existing service context. The process provides the foundations to start integrating and coordinating health care across the commissioning cycle — from identifying priorities, to sharing expertise and knowledge, to potentially co-funding/co-commissioning services as the model becomes established (PwC and Commissioning NSW, 2020) — acknowledging such deep collaboration requires both time and resources to achieve (Cheverton & Janamian, 2016).

[66] This has not gone unnoticed by the Australian Government. A recent Productivity Commission report suggests the consolidation of mental health service commissioning at a regional level (Productivity Commission, 2019); however, this ignores comorbidity of conditions, 'treating that part of the person in isolation' rather than looking 'at their wellbeing in general' which ultimately would lead to different types of service fragmentation (*Interview 38*).

In the CasePHN–Provider relation, CasePHN content experts work with local stakeholders (clinicians and consumers) to co-design models of care to increase the likelihood of services meeting client needs. Staff are also able to draw on experience and a growing evidence-base of evaluations of services commissioned. Many CasePHN contract managers have clinical experience and understand the challenges and opportunities in delivering services (*Interview 11*).

> I appreciate the experience of the Provider, because I was one, and I bring that into how I build a relationship, and it's great, thinking about outcomes-based commissioning, and starting to talk to people about how we can get better at, I guess, carving a service around what we ultimately want to achieve for someone, and then how can we quantify that in a contract, in a way that's going to meet the requirements of those above, but still is really motivating and relevant for those delivering. (*Interview 27*)

Procurement is not carried out in isolation (*Interview 42, Interview 46*). Each PHN has Clinical and Community Advisory Councils, a Board, as well as an improvement function, to 'support and improve the quality of general practice and to organise primary healthcare into a system' (*Interview 46*). This supports the commissioning process by providing opportunities to engage with stakeholders to gain insights about health needs, services available, models of care, and how they may be integrated into the service context, as well as monitor services and service needs, and promote new clinical pathways (*Interview 44*).

> The other part of my time is looking into getting out and doing service visits, to services outside what we commission, to try and get some hands-on information about what's happening on the ground for people, as well as kind of promoting what services we do commission. (*Interview 23*)

Recognising the inherent uncertainty in specifying and measuring primary health care services, the design of the PHN Program and how the PHN Program is operationalised by the CasePHN appears to mitigate and manage aspects of low contractibility of primary health care services delivered under the outsourcing arrangement.

Incorporating flexibility

An element of flexibility is incorporated into the outsourcing arrangement to manage uncertainty. DoH is able to issue additional Activity Funding Schedules to the DoH–CasePHN relation without returning to the market; Activity Funding Schedules have varied between 6-months and 3-years in duration (see Section 6.4.3). The provision to add schedules has given DoH the flexibility (and agility) to respond to disturbances in the form of emerging health priorities — saving time and costs associated with returning to the market and establishing new contracts. During the fieldwork period, DoH also demonstrated greater flexibility in reporting and funding processes when responding to health emergencies.

> We just hope that in the long-term [DoH] recognise that flexibility and that responsiveness, and actually allow us to do that on a regular basis, [rather] than require a pandemic to provide us with additional reporting and funding flexibility. (*Interview 49*).

The design of the PHN Program, specifically the commissioning framework, allows the CasePHN to identify and respond to changing priorities and commission or decommission services in response. The fixed and short duration of Activity Funding Schedules provides DoH with the flexibility to stop funding programs as priorities change.

The Schedules to the DoH–CasePHN contract also contain provisions for DoH to incorporate greater specification and guidance *ex-post.* This reflects the 'rushed' roll-out of the PHN Program (*Interview 42*) and the initial documentation being high-level, and allows DoH to increase the contractibility of the arrangement over time (see Appendix C, Table 20).

Summary

Several aspects of low contractibility are mitigated to some extent through program design. This is achieved by planning and designing services and models of care with stakeholders and clients, and incorporating flexibility in the outsourcing arrangement to respond to changing health needs.

8.3.3 Managing low contractibility through contact, partner selection and contract

This section explains key control strategies used to mitigate and manage low contractibility through the contact, partner selection and contract phases for both the DoH–CasePHN and CasePHN–Provider relations. The phases formalise many of the design choices (Section 8.3.2); the market is provided with the program/service requirements (the design), partner selection criteria and selection process, the terms of contract (specifying funding and duration), and how performance will be managed, all of which signal the use of very bureaucratic control choices (van der Meer-Kooistra & Vosselman, 2000).

Establishing criteria for partner selection

Partner selection is identified in the inter-organisational management control literature as a key mechanism to reduce uncertainty (Dekker, 2008; Dekker et al., 2013; Dekker & Van den Abbeele, 2010; Ding et al., 2013). Both DoH and the CasePHN use bureaucratic processes to control partner selection. The selection criteria are able to mitigate low contractibility in different ways. Given partners are selected based only on their responses to requests for tender (due to probity requirements; see Section 8.2.3), it is critical to include specifications that will draw out information from potential partners on which their suitability can be assessed.

In the DoH–CasePHN relation, DoH established specific governance requirements in the *PHN Guidelines* to attract partners with strong content knowledge (not necessarily available within PSOs; Farrow et al., 2015; O'Flynn & Alford, 2008) and social purpose. The design of the PHN Program is based on the premise that 'the stronger that an organisation's internal governance arrangements are, the less likely central government will feel the need to intervene' (*PHN LitReview,* p.26). At the time of going to market, the focus was on governance and the organisational capacity to establish systems (*Interview 42*).

In the CasePHN–Provider relations, the CasePHN established a range of selection criteria, including the capability and capacity of the potential provider, the cost effectiveness of the service, and the suitability of their proposed approach. Proposals were evaluated and scored by a panel comprising CasePHN staff, content experts and clients (*Observation 1*).

Incorporating flexibility in contracts

The contracting process is highly bureaucratic across the outsourcing arrangement. Standardised contracts were used by both parties across both relations; this minimised uncertainty (and cost) for both funders but left little room for negotiation. In the DoH–CasePHN relation, there was no negotiation of the terms of the contract leading to a power imbalance and the possibility only of DoH being satisfied. The CasePHN highlighted errors in the initial contract; however, these were not resolved until later — the PHNs were asked to 'trust' that DoH would rectify errors *ex-post* (*Interview 42*). The contract also included an option to add guidance *ex-post* allowing DoH to reduce uncertainty over time, and add Activity Funding Schedules to allow DoH to respond to new health priorities.

The contract (the *MSA*) used in the CasePHN–DoH relation evolved to mirror the DoH *SFA* (*Interview 17*); however, the schedules used to specify requirements and how they would be measured were open to some negotiation as long as they continued to meet the requirements of the original approach to market. The CasePHN–Provider relation is more likely to be mutually acceptable, leading to greater cooperation.

Using short commissioning cycles

The annual funding/commissioning cycle helps manage low contractibility by limiting relations to short-term contracts. While contracts of a short duration can be used to manage uncertainty associated with new programs, new providers and new models of care, and reduce the risk of hold-up[67] caused by asset specificity (Speklé, 2001; van der Meer-Kooistra & Vosselman,

[67] There was evidence of hold-up by providers who knew they were the only provider able to deliver services required to a specific population (*Interview 27*).

2000), it was unclear whether the short duration was intentional or related to the public sector context. In the DoH–CasePHN relation, DoH issued the initial contracts to PHNs for 3-years — longer than the life of Medicare Locals, but short-term given the structural change required. Funding schedules varied from 6-months to 3-years, despite in some instances policy/funding commitments being 4-years in duration, demonstrating the reliance on contract duration to manage uncertainty and the cyclical nature of contracting (Section 6.4.3). In 2019, DoH began introducing 3-year rolling schedules, renewed each year, reflecting a reduction in uncertainty and/or a growing confidence in the model. This provides some stability to both PHNs and providers; however, this is not ideal.[68] Contracts of short duration created uncertainty for providers across the outsourcing arrangement and inefficiencies in the set-up and governance costs of each relation.

In the CasePHN–Provider relation, the CasePHN could not contract for a period exceeding the duration of the relevant DoH–CasePHN Activity Funding Schedule. The CasePHN mostly replicated the duration of the DoH–CasePHN Activity Funding Schedules to maximise stability for providers, recognising it takes time for services to become established and know whether they are working (*Interview 38*). Occasionally contracts of shorter durations were used when commissioning new providers and/or new models of care. This control mechanism may be used more as the duration of DoH schedules increases. The contract renewal process (through reissue rather than extension) provides an opportunity to resolve contracting issues with providers (such as specification of requirements and performance measures), and review and improve the terms of the contract as business processes are refined. In retrospect, this has many similarities with recurrent short-term contracting, which facilitates adaptive, sequential decision-making (allowing changes to controls) and is suited to complex activities (Anderson & Dekker, 2014; Williamson, 1985). However, neither the CasePHN nor the providers knew this would be the case initially.

Summary

The contact and contract phase implement design choices to manage low contractibility. The contact and contract processes across both the DoH–CasePHN and CasePHN–Provider relations were highly bureaucratic, relying on standardised contracts and processes. Flexibility was built into the DoH–CasePHN contract to allow DoH to respond to new health priorities. While there was no negotiation between DoH–CasePHN, the CasePHN was willing and able to

[68] Other organisations recommend introducing 5-year funding contracts as a minimum (*Interview 45*; Productivity Commission, 2019).

negotiate the content of schedules with providers and improved specification when contracts were reissued in subsequent funding periods.

8.3.4 Managing low contractibility through ongoing control

The way low contractibility is managed across the control phase of the outsourcing arrangement is the key point of difference between the DoH–CasePHN and the CasePHN–Provider relations. The differences were highlighted by providers where services previously contracted over by DoH (including AOD services; *Interview 21*) had been transferred to the CasePHN to contract over as part of the PHN Program.

Using relational controls to 'manage up'

In the DoH–CasePHN relation, low contractibility is managed through program design — requiring the intermediary to implement a commissioning cycle, the implementation of which is able to manage low contractibility of the arrangement. The implementation of the PHN Program is managed through bureaucratic controls associated with key outcomes of the commissioning cycle, specifically reviewing and approving the Needs Assessments and Activity Work Plans associated with each funding schedule, and reporting on the progress of implementing the Activity Work Plans *ex-post*. This is supplemented with scripted briefings to the 31 PHN CEOs as a group to provide new information and for any issues to be raised (discussed in Section 8.2.4 above). The CasePHN identified the way DoH was managing the DoH–CasePHN relation as a potential risk, and organised a monthly meeting (by telephone) between the two parties to provide unsolicited information to DoH to reduce this risk — in effect, the CasePHN managed up. The CasePHN briefed DoH about its work, key successes and challenges, providing additional information to DoH that it perceived important to reduce the risk in the relation (Section 6.5.2). This was not a contractual requirement and was instigated by the CasePHN to reduce uncertainty and manage risk.

Enabling success using relational controls

In the CasePHN–Provider relation, the CasePHN used relational controls to support bureaucratic controls, particularly to manage the low contractible aspects of the services. Program officers worked in a supportive and collaborative capacity with providers to ensure services were delivered (van Meerkerk & Edelenbos, 2018). This enabling (relational) approach was particularly critical in the first 3-years of the program when uncertainty was high (*Interview 11*). Ultimately, the CasePHN 'want[s] the provider to succeed' (*Interview 19, Interview 24*).

CasePHN staff and providers believe an open dialogue leads to better collaboration and better contract management over the long-term (*Interview 24, Interview 25*). The level of collaboration

is often driven by the provider (*Interview 24*) and, as noted above, may vary by contract as well as over the life of the contract.

> I think the more complex service delivery, a more collaborative approach would be perhaps more appropriate, particularly in the early days of the contract when it's, you know, what are the issues in getting it set up. (*Interview 43*)

One provider highlighted that 'because [the CasePHN are] not delivering, they're only contract managing, they don't actually problem solve at that level for you', making comparisons to LHD funders who 'tend to be a bit more engaged with the local services and a bit more collaborative... because they are actually delivering services' (*Interview 43*). This insight highlights the importance of content knowledge when using relational controls.

Managing the contract using relational controls

Program officers benefited from having content expertise, service delivery experience, and connections within the sector when managing the contract (*Interview 4, Interview 11*).

> If you've got people here who have worked on the ground, you know when a service is saying they're doing what they are supposed to be doing, and when they're probably not. (*Interview 4*)

Program officers were able to 'build trust and rapport' and have an open dialogue with providers to manage the incomplete contract (*Interview 11*). In addition to face-to-face quarterly meetings with providers, Program officers maintained an open dialogue enabling issues to be raised immediately rather than waiting for formal contract meetings (*Interview 30, Interview 34, Interview 37*). The approach varied by clinical stream, program manager and service, suggesting this was a factor of both leadership style and risk. For example, some teams preferred on-site progress meetings 'out of respect' to the Provider, which also encouraged other staff to participate (including clinicians and clients) (*Interview 27*). This was valued by providers.

> We've [had face-to-face meetings] from the beginning with the CasePHN and we've never really done that with any regularity with any of the other funders that we work with. … I have no clue who was managing [the Commonwealth] contract. Wouldn't even know who the person was. ... And then [another PHN], I don't have the kind of individual meetings like we [have with the CasePHN]. There's a bit of contact there, but it's not as regular. (*Interview 21*)

They added:

> Out of the five contracts that I manage, [the CasePHN] are the best people to work with. And really the reason for that is because of the relationship we

> have with them … it genuinely feels like a partnership. … [the CasePHN Program Manager] has been in that job since the beginning … I guess we trust each other, and we know how each other works and we can have discussions about things there. If they're not working, we can have a conversation about what we need to do to change it. So that relationship really is the key thing. (*Interview 21*)

Other providers concurred:

> I think it is very much relationship driven as well. I think something that strengthens that is that if there is an issue, we can, we do lots of risk management within our project and we can kind of see the risks as they're coming up and I am always very open with [the CasePHN] about that. I see it as very much a collaboration and have done from the start. I've tried not to see [the CasePHN] as just being a funding body. (*Interview 25*)

The open dialogue between parties provides additional contextual information which in turn has led to the renegotiation of KPIs. Changes to KPIs reflect experience of program delivery, difficulties in recruiting or retaining clinicians and clients, and fluctuations in occasions of service as the service matures (*Interview 4*). Open dialogue has also alerted the CasePHN to performance issues, identified by changes in staffing, changes in level or quality of communication, operational problems, and changes in the service context — highlighting the risk of relying on bureaucratic controls alone (*Interview 29, Interview 37*). For example:

> I've heard from former staff [at the Provider], from one of the centres, that the culture is really bad, the staff are not feeling supported, there's a lot of turnover. (*Interview 28*)

Collaboration also provides a mechanism to seek continual improvement.

> I think the value add that we provide is the relational stuff. I think again, the continuous quality improvement is something I think all PHNs have in common. And the other thing is the importance of relationships. (*Interview 42*)

Limitations to funding may mean that this approach is not sustainable across all relations in the future (*Interview 13*).

Managing anxiety and building trust using relational controls

Open dialogue also plays a role in managing anxieties around future funding. CasePHN staff are open with providers and are quick to communicate updates from DoH about contract renewal. This is appreciated by providers and this transparency helps build trust between parties and strengthen collaboration (Interview 21; consistent with Chua & Mahama, 2007).

> I think that in some ways, probably the PHNs are going to be held a little bit responsible for some of the fall out of those changes [in funding]. But it's not really, from what I can see, not really their fault. (*Interview 45*)

It was acknowledged that in addition to content knowledge and service experience, continuity of staff is critical to relational controls and building trust (*Interview 45*), along with showing an interest in the service (*Interview 4*), and having regular (*Interview 24, Interview 37*) and open communication (*Interview 18*).

> Relationships are often person-centred. So, if the person who was strong with those relationships left, then it takes time to rebuild a relationship. (*Interview 3*)

CasePHN staff are conscious of the boundaries of relationships with providers and holding the provider accountable for delivery (*Interview 37*), the importance of being 'bipartisan' (*Interview* 26), and allowing providers to 'do the work' (*Interview 44*) rather than manage the service themselves (*Interview 22*). CasePHN staff also recognise the fine balance between maintaining relationships with a provider and 'annoying them' (*Interview 33*), being 'intrusive' (*Interview 24*), 'overloading providers with information' or having too many meetings (*Interview 21*), or introducing new barriers (*Interview 44*).

> [Providers are] busy and they have a job to do as well. So, even though it's a mutually beneficial relationship to have on both sides, it can be difficult at times depending on everyone's priorities because they've got different priorities to us. So much of it boils down to who the person is that you're in contact with... (*Interview 30*)

The relationship between the CasePHN and providers had changed over time, with one provider suggesting that as the relationship had become more formalised under the contract it no longer felt like a partnership. This was in part attributed to the increased monitoring requirements (*Interview 41*).

Summary

There is a stark difference between how relational controls are used in the DoH–CasePHN and CasePHN–Provider relations, with the CasePHN driving the use of relational controls in both relations. This supports prior studies that demonstrate the dominance of bureaucratic controls in public sector settings irrespective of the contractibility of the activity.

8.3.5 Managing low contractibility through review

Review processes add to the evidence-base and have the potential to improve contractibility over time for both the DoH–CasePHN and CasePHN–Provider relations, as well as contribute to the broader evidence-base for primary health care delivery. The review process is critical given

the contracting process is not a one-off linear process, but rather an ongoing cyclical process using contracts with short durations. The ability of the review process to increase the contractibility of the PHN Program over time is contingent on the scope of the review (including resourcing, timing and methodology) and the dissemination of and response to results.

The DoH–CasePHN relation has been subject to an independent evaluation which identified gaps or issues with existing guidance that have since been resolved (*PHN Evaluation*; Section 6.6.1). DoH has committed to reviewing policy and guidance related to the PHN Program (for example, the *PHN Framework*). DoH has also commissioned evaluations of services delivered under the CasePHN–Provider relation where the requirements were specified in detail by DoH (for example, headspace). Only two evaluation reports are publicly available; while others may be shared with PHNs, this does little to reduce uncertainty more broadly across the sector.

In addition to evaluations of specific services, the CasePHN has sought continuous improvement in processes across its operations which impact both the DoH–CasePHN and CasePHN–Provider relations. Continuous improvement is sought across the commissioning process in line with the *Clinical Framework*.

> [The CasePHN is now] a rapidly maturing organisation … I actually hope we never mature quite frankly; I always want there to be a spark of learning and a spark of innovation that is driving us forward, so the curve doesn't flatten. (*Interview 12*).

While commissioning processes took time to establish and stabilise, processes are now well established (*Interview 12*), and CasePHN staff felt like they were 'in a good place' (*Interview 11*). The process is under continual review to incorporate lessons learned (*Interview 10, Interview 13, Interview 37*), as well as reflect changing requirements from the DoH–CasePHN relation, to improve the governance of low contractible activities.

> Commissioning is kind of like an existential thing for us. … we don't get money to do other things — we have to do it well. And so consequently, I think that kind of existential threat means that we take it very seriously and we do it well and we're doing it increasingly better. (*Interview 42*)

There are informal and formal mechanisms to raise and discuss issues, and highlight good practice for others to learn from; this includes within teams, within funding streams, and at an organisational level through the Procurement Hub (*Observation 10, Interview 23*, *Hub Minutes*). The CasePHN is seeking to improve the evidence-base across different work streams, consolidating and improving KPIs, and exploring innovative ways to do research (*Interview 12*).

Some CasePHN reviews are driven by reductions in funding from DoH (see Section 6.5.3) and the need to demonstrate the value of their work.

> One of the things that we feel the PHN needs to do is prove the value of the work it is doing. And for us to show that more clearly, we need to show the impact of the commissioned services. (*Interview 49*)

Both DoH and the CasePHN are continuing to increase the evidence-base in primary health care services and seek improvements in the way the outsourcing arrangement is organised and managed. DoH by adding guidance to address issues as they arise, and the CasePHN by proactively seeking to improve the commissioning process in part driven by the reduction in operational funding.

8.3.6 Summary

This section explains sources of low contractibility and how they are managed across the outsourcing arrangement. Low contractibility arises due to specialised human capital (asset specificity), the difficulty in specifying and measuring services and disturbances to the health care sector (uncertainty), and the short duration of contracts affecting set up and management costs (frequency). Low contractibility is likely to remain due to the inherent nature of primary health care services, but can be minimised and managed in the way the outsourcing arrangement is organised and controlled. Across this outsourcing arrangement, different types of flexibility are included in the design, contracting and control of the program, while relational controls are used by the CasePHN to ensure its overall success. The outsourcing arrangement is still relatively new; given the cyclical nature of commissioning and the low contractibility of the arrangement, the review process allows all parties to potentially increase the contractibility of the arrangement over time.

8.4 Managing the tension between probity and low contractibility

The aim of this section is to explain how the tension between probity and low contractibility is managed in this setting.

8.4.1 Managing the tension through design

Design is the primary mechanism used to satisfy probity requirements and manage low contractibility in this setting (Anderson & Dekker, 2014), as well as manage the tension between them. Control choices made during the design phase are then formalised across the procurement process, from contact to review.

The design of the outsourcing arrangement creates two relations with differing contractibility. The DoH–CasePHN relation, where probity is regulated, is the organisation and management of a program — an activity that is easier to specify and control. The CasePHN–Provider relation concerns the organisation and management of low contractible services. This design choice transfers the low contractible services to an intermediary (the CasePHN) to manage; an

intermediary less constrained by probity and able to use a range of controls to manage the different transaction attributes present (evidenced in Section 7.5.2 above).

The design of the PHN Program also incorporates mechanisms to manage the tension between probity and low contractibility through the commissioning process. Stakeholders are engaged to help identify and prioritise health needs in the region, and then identify how they might be addressed, with the outcomes of this process published. This provides transparency, accountability and legitimacy across the process, and reduces uncertainty by involving experts, including potential clients, in the design of services. The design of the PHN Program also has inbuilt flexibility to manage disturbances to the sector or health care needs. Additional Activity Funding Schedules allow DoH to respond quickly to emerging health needs; this process was established in the contact stage (*PHN Guidelines*, p.9) providing transparency and equity to the process while anticipating disturbances. The design also provides mechanisms to incorporate additional guidance *ex-post*, recognising the incomplete specification of the program. Most guidance is publicly available, except for internal discussion papers and documents/tools supporting the performance management process.

The combination of the intermediary model, mechanisms to respond to changing needs, and transparent bureaucratic processes, provide the basis to manage many of the tensions between probity and low contractibility in the outsourcing arrangement.

8.4.2 Managing the tension through contact, partner selection and contract

In the **contact and partner selection** phases both parties use open market procurement and very formal bureaucratic controls — DoH went to market once to establish the 31 PHNs, whereas the CasePHN often returns to the market to contract new services. Both parties provide extensive documentation about requirements, how proposals will be assessed, and the contract, during the contact phase; uncertainty is managed through program/service design (Section 8.4.1). Given the lower contractibility of the CasePHN–Provider relations, the CasePHN works with a range of experts to identify and prioritise needs and develop models of care to reduce uncertainty in the relations. This process is in part bureaucratic as it follows a documented process, and is in part relational by the nature in which stakeholders are engaged.

In the **contract phase** there is an inherent tension between low contractibility and probity in contract specification; specifically, the use of bureaucratic controls to demonstrate probity while providing flexibility to manage low contractibility. This tension is somewhat mitigated by design and (1) the use of this intermediary model, and (2) the commissioning process where key stakeholders are involved in program design. In the DoH–CasePHN relation, DoH specifies requirements in detail leaving the intermediary and providers with little room to respond to local needs or innovate (Anderson et al., 2000). Further, contracts become DoH-centric — or having

sequential interdependence (Dekker, 2004) — and consequently both the DoH–CasePHN and the CasePHN–Provider relation are dominated by bureaucratic controls originating from DoH. The tension is also managed by short-term contracting. The controls within the contract (planning and reporting processes), and the contract renewal process, are highly bureaucratic satisfying probity requirements, while the regular renewal of contracts provides a mechanism to review and update mechanisms to manage low contractibility.

8.4.3 Managing the tension through ongoing control

In the DoH–CasePHN relation, DoH relies on bureaucratic controls to the exclusion of relational controls. While this might be considered appropriate for the nature of the services contracted (program rather than services), and satisfies probity requirements, it is not without problems; there is still uncertainty due to the nature of primary health care services and the infancy of the PHN Program. DoH relies on numerous bureaucratic checks to ensure activities are planned and delivered. The extensive reporting requirements used to satisfy probity cause bottlenecks and delays, and potentially pose risks to the ongoing monitoring of the program. While conceptually the tension between probity and low contractibility is managed in the design of the arrangement, it is unclear whether this tension is being managed by DoH during the control phase. For example, residual uncertainty has been identified by the CasePHN as a risk to the relation and is being proactively managed by the CasePHN — effectively managing up.

In contrast, in the CasePHN–Provider relation the CasePHN supplements bureaucratic controls (that satisfy probity) with relational controls (to manage low contractibility). This mix of controls reflects the lower contractibility of the CasePHN–Provider relation, and demonstrates how low contractibility can be managed while also satisfying probity in a different organisational setting. This approach is potentially more expensive than routinised bureaucratic controls and is under threat from reductions in funding, as well as over specification of services and extensive reporting requirements by DoH (*PHN Evaluation*, Section 7.6). As one informant highlighted:

> There's so much potential for what we could do, if we were given half a minute to stop and think, and do that properly. (*Interview 27*)

As described in Section 8.3.4, the use of bureaucratic and relational controls in combination is required to satisfy probity requirements while managing the low contractibility of the arrangement, but is not always straight forward. The empirics reflect the literature which identifies the relation between bureaucratic and relational controls as both complementary (Donada & Nogatchewsky, 2006) and as a potential source of conflict by sending mixed messages to parties (Johansson & Siverbo, 2011). Care must be used when combining bureaucratic and relational controls to ensure the benefits of both are realised (Dekker, 2004),

particularly when they are seen to by-pass formal hierarchies of control (Carlsson-Wall et al., 2011).

8.4.4 Managing the tension through review

The review processes across the outsourcing arrangement help manage and potentially increase the contractibility of the outsourcing arrangement while also satisfying probity requirements. The review process is relevant given the cyclical (rather than linear) contracting process, the novelty of the model, as well as the low contractibility of primary health care services. Review processes also contribute to the legitimacy of both the PHN Program and the operation of parties in each relation, and may help justify the change made to primary health care coordination.

While there is no inherent tension between probity and low contractibility in the review process itself, the review process does not help increase the contractibility of the activity if the results from reviews are not shared. Despite a number of reviews occurring in relation to planning and services during the fieldwork period (reported in Chapter 6), the PHN public website showed no evidence of these developments.[69]

8.4.5 Summary

The tension between probity and low contractibility in this outsourcing arrangement is managed by creating two relations with differing contractibility. The DoH–CasePHN relation, in a setting where probity is regulated, concerns the organisation and management of a program — an activity that is easier to specify and control. The CasePHN–Provider relation, located in a non-government setting, concerns the organisation and management of low contractible services. This outsourcing arrangement transfers the low contractible services to an intermediary (the CasePHN) to manage — an intermediary not constrained by probity that is able to use a range of controls to manage the different transaction attributes present. This intermediary model is supported by further design choices incorporating flexibility, stakeholder expertise, and short commissioning cycles to manage low contractibility while also satisfying probity requirements.

8.5 Chapter summary

This chapter presented the analysis of the empirical data. I identified the key sources of probity and low contractibility and how they were satisfied and managed across each phase of the

[69] As of October 2020 (correspondence with DoH), the website was last updated in May 2019 (in relation to health statistics available) while the last new policy documents relate to the complaint policy and conflicts and related party policy documents that provide guidance to accompany the *SFA* (*PHN CoI, PHN Complaints*, January 2019).

outsourcing arrangement, identifying similarities and differences across the two relations. I showed that the outsourcing arrangement used in this case setting was able to manage the low contractibility of the services required and moderate the tension between low contractibility and probity in this setting. This was achieved by reducing uncertainty in the DoH–CasePHN relation, and reducing the impact of probity in the CasePHN–Provider relation by changing the control context; the CasePHN was able to supplement bureaucratic controls with relational controls to manage the low contractibility while also satisfying probity requirements that were still evident. The next chapter extracts what this means for management control theory and TCE theory in relation to managing inter-organisational arrangements.

Chapter 9 Implications of the study

9.1 Introduction

This chapter explains the broader theoretical contributions and implications of the empirical study identified when answering the research question: *How can the public sector organise and control the outsourcing of human services?* The contributions and implications are shaped by the theoretical lens (TCE) used to collect and analyse empirical data from the case setting, and address the theoretical motivations of this thesis described in Chapter 1. The empirical data and analysis (Chapter 6–Chapter 8) describe an intermediary model of outsourcing, provide rich descriptions about how this model operates, and explain how this model manages the tension between probity and low contractibility in public sector outsourcing arrangements.

In this chapter I explain the abstracted theoretical contributions[70], how this extends our knowledge about public sector outsourcing in low contractible environments, and why this is important. Using insights from the empirical study, I develop the conceptual specification of probity by explaining the sources and dimensions of probity and how they vary across the outsourcing process (Section 9.2). I then explain how different dimensions of probity are satisfied across the arrangement, how probity affects how low contractible arrangements are organised and controlled in this setting, and how this contributes to our understanding of control choices in public sector settings (Section 9.3). Finally, I explain how an intermediary model enables the public sector to organise and control the outsourcing of human services in this setting by moderating the tension between probity and low contractibility (Section 9.4).

9.2 Developing our conceptual specification of probity

The aim of this section is to develop our understanding of the TCE attribute of probity, contributing to both the inter-organisational management control literature using TCE as well as the broader TCE literature. In TCE theory, probity is a characteristic associated with the nature of the transaction, defined as the 'loyalty and rectitude that something is carried out' (Williamson, 1999, p. 322) requiring a 'high standard of integrity' (Williamson, 1999, p. 323). While probity is likely to be present across all forms of organisation, probity is an explicit governance requirement of the public sector, often legislated, and therefore is likely to be significant in public sector settings (Department of Finance, 2017; IFAC & CIPFA, 2014; Williamson, 1999). Our understanding of probity is less developed than other TCE transaction

[70] As such, the terminology changes from DoH–CasePHN–Provider relations to PSO–Intermediary–Provider relations.

characteristics (Section 3.5); a better understanding of probity will allow for a more thorough application of TCE theory, particularly in public sector settings where probity is likely to be more significant.

Williamson (1999) introduces the construct of probity to TCE theory using a hypothetical sovereign transaction of foreign affairs. The transaction is characterised by high uncertainty, high asset specificity in the form of human capital, and high probity, which he defines as 'the loyalty and rectitude with which the foreign affairs transaction is discharged' (Williamson, 1999, p. 322). While providing some insights into how probity might be recognised and dealt with, Williamson also highlights that the concept of probity remained 'vague' and lacked 'operationality' (1999, p. 338).

Despite being identified within TCE theory, and being a clear governance requirement in public sector settings (Da Veiga & Major, 2019; Fredland, 2004), the management accounting literature on public sector outsourcing appears to circumvent probity. Some scholars highlight the importance of accountability and explore how it is (or is not) managed (Eckersley et al., 2014; Hagbjer et al., 2017; Kominis & Dudau, 2012), while others find that legitimacy seeking is the most important driver of controls requiring PSOs to 'implement visible, formal and bureaucratic controls' (Johansson et al., 2016, p. 1013). Scholars using TCE theory in public sector settings have the potential to address probity explicitly (as probity is more likely to occur) — yet probity is often ignored (Balakrishnan et al., 2010; Johansson, 2008). Where probity is considered, scholars highlight the financial nature of probity (Allen et al., 2016; Samuel et al., 2008; Tan & Egan, 2018), and the need to reduce the likelihood of corruption or conflicts of interest (Butcher & Gilchrist, 2016; Da Veiga & Major, 2019; Gregory, 1999).

The transaction attribute of probity has largely been overlooked in public sector outsourcing studies, despite being an explicit governance requirement in this setting. Williamson himself acknowledged probity needs to be further developed, yet scholars know little more about probity now than when it was first introduced into the TCE literature by Williamson more than 20 years ago. The lack of development of the conceptual specification has limited the use of Williamson's original specification of probity to the context in which it was developed, that is the outsourcing of sovereign transactions or transactions involving public authority (Da Veiga & Major, 2019; Fredland, 2004). The conceptual specification of probity needs to be developed further before it can be applied to public sector settings more broadly.

This section explains the different sources and types of probity that emerged from the empirical setting and how probity varies across contracting relations. This develops the conceptual specification of the TCE construct probity.

9.2.1 Recognising different dimensions of probity

By examining probity across the outsourcing arrangement in the case setting, different dimensions of probity were identified in terms of both source (i.e. where probity requirements arise) and type (i.e. the nature of probity requirements).

Sources of probity

Probity requirements may arise from the **nature of the contracting party and organisational context.** There is a general expectation that all organisations act lawfully, ethically and responsibly, and are accountable (ASX, 2019). Individual organisations may have specific or additional probity requirements as part of their organisational strategy that affect how they contract over other parties; this was evidenced in the intermediary organisation in my case setting. Specific probity requirements are also likely to be associated with the organisational context of PSOs (Balakrishnan et al., 2010; Horne, 2010; Levy & Spiller, 1994; Williamson, 1999); probity requirements are likely to be higher in PSOs where probity is an often a legislated governance requirement (IFAC & CIPFA, 2014). This association between probity and the nature of the contracting party and organisational context is consistent with prior studies (Cristofoli et al., 2010; Da Veiga & Major, 2019; Ruiter, 2005; Williamson, 1999); however, does not explain the variation in probity requirements within an organisational setting as is evident in the case setting.

Some probity requirements are likely to remain relatively constant either across the entire arrangement, such as the requirement for transparency in processes and decisions, or within certain phases of the arrangement, such as requirements for equity during the contact phase. Other requirements may *vary* with the **value and nature of the services contracted over**. In the case setting, probity requirements varied according to the value of the contract in the contact and contract phase.[71] Probity requirements also varied in the contract and control phase due to the nature of the services contracted over, stemming from the requirements specified by DoH in the activity funding schedules. This included requirements imposed by the contracting party about specific governance arrangements of the program, additional reporting requirements (such as increased frequency of reporting for some activities), and requirements arising from outside of the contract in relation to clinical governance. This association between

[71] In Australia, Commonwealth procurement rules have thresholds based on the value of contracts at $80,000, $400,000 and $7.5 million based on the nature of the government entity (corporate/non-corporate) and activity (construction and other) affecting the level of procurement rules and tender processes that apply (Department of Finance, 2020). In the intermediary organisation, the threshold for simplified contracts and procurement process was set at $50,000 (*Procurement Manual*). Note that in both cases, the higher level of contracting and procurement processes applied reflecting the value of the activities.

probity and the value and nature of services contracted over does not appear to have been explained in the literature.

The two sources of probity requirements are related. The primary, but not exclusive, source of probity arises from the nature of the contracting party and the organisational context. In the case setting, many of the probity requirements transferred with the activity contracted over, from the PSO to the intermediary and onto providers, through contract requirements (including disclosure requirements, and use of funds) and program design. The variation in probity requirements is explained by the value and nature of the services contracted over, some of which may arise from outside of the contracting relation. In this setting, variations in probity requirements can be attributed to both the nature of the contracting party (PSO compared to non-profit organisation) and the nature of the services contracted over (a program compared to primary health care services, as well as value of the services contracted over). It appears some probity requirements are constant, while other probity requirements vary across and within arrangements.

Types of probity

The empirics show there are two types of probity — financial and social. **Financial probity** relates to the transparent, equitable, ethical (in relation to corruption; Gregory, 1999) and efficient use of public resources across all operations (Allen et al., 2016; Department of Finance, 2017; Spurgeon & Hicks, 2003). The financial dimension of probity is not new; scholars who refer to probity only appear to recognise this fiduciary aspect (Allen et al., 2016; Butcher & Gilchrist, 2016; Da Veiga & Major, 2019; Gregory, 1999; Jensen & Meckling, 1976; Samuel et al., 2008; Tan & Egan, 2018). Financial probity is unlikely to vary due to the services contracted over, except for variations based on procurement thresholds; financial probity appears to arise from the context of where the funds originated, and transfers with the activity funded.

Social probity relates to the public sector's responsibility to ensure the safe and effective delivery (quality and stewardship) of services contracted over (Almquist et al., 2013). Social probity is likely to vary according to the nature of the service contracted over. Social probity is likely to be higher when contracting over services for particular health needs (for example, severe mental ill-health) and particular populations (for example, children, the elderly, and people with disability), and consequently may vary in terms of the nature of the transaction and the transaction context.

While scholars recognise the relevance of both the financial and social context to transactions — particularly in the public sector (Almquist et al., 2013; Balakrishnan et al., 2010; Barretta & Busco, 2011; Butcher, 2018; Reusen & Stouthuysen, 2017) — no links have been made to

probity. Butcher (2018, p. 3) suggests importing the concept of a 'social licence to operate' to human services. He highlights that non-profits operate with high levels of 'social legitimacy, credibility and trust' (Ibid.). A social licence to operate involves identifying stakeholders, identifying what is important to stakeholders, engaging stakeholders in decision-making, and evaluation (Butcher, 2018, p. 6). I would argue that this is already a component of probity, one that needs to be clearly articulated. Stafford and Stapleton (2017) make the connection between probity and stewardship, criticising governments for being accountable for errors rather than results. Clearly articulating different types of probity — financial which is likely to be constant, and social probity which is likely to vary — would provide clarity and increase trust in government that it was doing the right thing.

Relation between source and type of probity

Financial probity requirements mostly arise from the nature of the transaction party/context and in this setting. Requirements were detailed in legislation and policy documents (Department of Finance, 2017), translated into program requirements for the outsourcing arrangement (*PHN Guidelines*), and remained relatively constant across different funding activities with minor variations depending on the financial value of the service contracted over.

In contrast, social probity requirements arise from both the nature of the transaction party/context, given PSOs have a responsibility to ensure the safe and effective delivery (quality and stewardship) of services contracted over, as well as the nature of the specific service contracted over. This was documented at a program level and through specific funding schedules that identify requirements to deliver the program safely, effectively and equitably (see Table 15).

Table 15 Relation between type and source of probity

Type/Source	Nature of transaction party/context	Nature of service contracted over
Financial probity	Requires the transparent, equitable, ethical and efficient use of public resources across all operations and therefore is likely to remain relatively constant.	Ignores the nature of the service contracted over. But may vary based on the value of the service.
Social probity	PSOs have a responsibility to ensure the safe and effective delivery (quality and stewardship) of services contracted over.	Likely to vary based on the nature of the service (and vulnerability of clients).

Both dimensions of probity observed are accountable to stakeholders in different ways (Cristofoli et al., 2010), and not necessarily valued or treated equally. There may be a tension between the financial and social dimensions of probity, particularly as stakeholders may be affected differently; for example, consumers (referred to as a 'third offstage voice'; Cristofoli et

al., 2010, p. 367) may have different priorities and expectations compared to funders and providers (Barretta & Busco, 2011; Smith, 1995; Stafford & Stapleton, 2017).

9.2.2 Extending our knowledge of probity

My first contribution relates to the TCE attribute of probity and contributes to both the inter-organisational management control literature using TCE, as well as the broader TCE literature. Probity is not unique to the public sector (Butcher, 2018; Williamson, 1999) — as a society, we would hope that private sector organisations also behave honestly and decently. Probity requirements in PSOs are often legislated, detailed and specific to the sector making probity highly relevant to public sector transactions. Exploring probity in a setting where it is likely to be highly relevant allows scholars to develop the construct of probity. This study shows that probity is not a bland bureaucratic requirement, but comprises different dimensions.

First, I identify the sources of probity. This thesis demonstrates that probity arises from the nature of the party to the transaction and the context given the additional requirements specific to PSOs, validating prior studies that relate probity to the context or actors (Da Veiga & Major, 2019; Ruiter, 2005). In addition, probity arises from the nature of the service being contracted over, either transferring with the activity through contract requirements and/or program design, or arising from the value and nature of the service itself (due to requirements outside of the contract).

Second, I identify two types of probity: financial and social. Financial probity relates to the transparent, equitable, ethical (in relation to corruption; Gregory, 1999) and efficient use of public resources (Allen et al., 2016; Spurgeon & Hicks, 2003) across all operations. The financial dimension of probity is not new; scholars often only recognise the fiduciary aspect of probity (Allen et al., 2016; Butcher & Gilchrist, 2016; Da Veiga & Major, 2019; Gregory, 1999; Jensen & Meckling, 1976; Samuel et al., 2008; Tan & Egan, 2018). Financial probity requirements are consistent across activities, although there may be some variation depending on the value of the contract. Social probity relates to the public sector's responsibility to ensure the safe and effective delivery (quality and stewardship) of services contracted over (Almquist et al., 2013), and is likely to vary according to the nature of the service contracted. While scholars have noted the relevance of both the financial and social context of transactions — particularly in the public sector (Almquist et al., 2013; Balakrishnan et al., 2010; Barretta & Busco, 2011; Reusen & Stouthuysen, 2017) — no links have been made to probity.

Third, financial probity is more likely to be associated with the nature of transaction party/context, although requirements may vary depending on the value of the services contracted over. Social probity arises from both the nature of the transaction party/context and the nature of the services. It is the nature of the services that makes social probity idiosyncratic.

Different types of probity are accountable to stakeholders in different ways and are not necessarily valued or treated equally. By highlighting the different sources and types of probity, it becomes easier to recognise where and when probity arises in a transaction.

9.2.3 Summary

My first contribution is the development of the conceptual specification of probity. TCE theory is commonly used as a theoretical lens in the inter-organisational management control literature, albeit it less so in public sector settings (Anderson & Dekker, 2010; Ding et al., 2013). Developing our conceptual understanding of the TCE construct of probity beyond sovereign transactions (Williamson, 1999) extends the use of TCE in the public sector, ensuring scholars are able to include a key governance requirement of public sector settings. This also encourages the application of TCE theory in its entirety in other settings. This enables greater consistency and comparison between private and public sector studies (Anderson et al., 2015), and provides an opportunity to build on and draw comparisons between studies (Otley, 2016). At a more practical level, providing a more detailed understanding of the different sources and types of probity and the relation between them provides more information to scholars and practitioners about what may drive control choices. Probity is not a single dimensional transaction characteristic but more nuanced than previously assumed.

9.3 Explaining how probity requirements may be satisfied

In the original specification of probity, developed in a hypothetical setting of a sovereign transaction, Williamson (1999, p. 338) suggests probity can be managed by the absence of incentives, extensive bureaucratic controls, the external appointment of leadership, and socially conditioned staff. While there is little evidence that probity has been dealt with specifically in the literature (Section 9.2), there is circumstantial evidence that supports Williamsons work. Scholars find high-powered incentives are sub-optimal for public sector outsourcing as they replace intrinsic motivation and distort behaviour (Jensen & Stonecash, 2005; Speklé & Verbeeten, 2014). Other scholars highlight the public sectors' reliance on bureaucratic 'command and control' mechanisms to manage outsourcing arrangements — irrespective of the nature of the transaction (Johansson & Siverbo, 2011; Johansson et al., 2016; Narayanan et al., 2007).

Williamson also suggests that the contractual hazards in his hypothetical setting 'favo[u]r cooperativeness (as against autonomy) in the design of the agency and its administration' and that 'a governance structure that supports a presumption of or predisposition toward cooperativeness will relieve the hazards of probity', implying a relational mechanism is more suited to what Williamson calls a 'probity transaction' (Williamson, 1999, p. 324). This ignores the fact that relational mechanisms may compromise probity (Carlsson-Wall et al., 2011; Ditillo

et al., 2015; Narayanan et al., 2007), and may reflect more the contractibility of the hypothetical sovereign transaction (Williamson, 1999).

Given the lack of conceptual development of the transaction characteristic of probity beyond sovereign transactions (described in Section 9.2), it is unsurprising that scholars have largely failed to consider probity when applying TCE theory to inter-organisational management control studies. Despite being a clear governance requirement in public sector settings, how probity is satisfied has been mostly circumvented in the management control literature. Probity is not just relevant to all public sector operations (Williamson, 1999), but is likely to be an important consideration for management control strategies across all operations. Failing to understand how probity is satisfied leaves the explanation of the determinants of control in public sector settings incomplete.

This section identifies the control strategies used to satisfy probity requirements in public sector arrangements, and then explains how this affects the organisation and control of low contractible arrangements in this setting.

9.3.1 Understanding how different types of probity are satisfied

In the case setting, probity can be observed in both the PSO–Intermediary relation and to a lesser extent in the Intermediary–Provider relations (Section 8.2). Using the conceptual development of probity explained in Section 9.2 above, and empirical data, the control strategies used to satisfy different types of probity can be identified across the outsourcing arrangement.

Financial probity (Table 16) is satisfied consistently across both relations in the outsourcing arrangement using bureaucratic controls, irrespective of the nature of services contracted over. This supports the literature which shows probity is best satisfied using bureaucratic controls (Stafford & Stapleton, 2017), established in the contact and contract phases within allocative processes, and then monitored in the control phase (Narayanan et al., 2007; Spurgeon & Hicks, 2003).

Table 16 How financial probity may be satisfied across both relations

Relation	Design	Contact, partner selection	Contract	Control	Review
PSO–Intermediary	Designed in consultation with key parties, therefore providing information to the market. Transparent policy and guidelines around procurement and ongoing performance reporting.	Bureaucratic (transparent and equitable) procurement process, adjusted to scale of transaction.	Transparent, equitable selection process. Standardised agreement. Clear financial monitoring and control, including budget allocations and reporting requirements. Small variations by schedule such as reporting and KPIs	Intermediary required to submit plans of how funds will be spent and report against plans. End of financial year, required to submit audited financial statements showing acquittal of funds.	Review process resulted in provision of templates for financial reporting, and online portal to submit plans and progress reports. Clear review process.
Intermediary–Provider	Not permitted to deliver services directly to avoid conflict of interest. Transparent and inclusive commissioning cycle. Activity Work Plans published providing clear signal to market.	As above. Partner selection includes independent panel members.	As above, with some negotiation of contract schedules.	As above, with the addition of relational controls to support monitoring. Content of reports varies by relation. Move towards standardised KPIs and reporting.	Policies and procedures continually reviewed. Clear review process and reporting (both financial and non-financial outcomes).

Source: Summarised from data presented in Chapter 8.

Social probity (Table 17) is also satisfied largely through bureaucratic controls; however, the controls are more nuanced, tailored to each transaction often in consultation with key stakeholders — signalling a relational aspect to the development of controls. Across each phase of the relation (from design to review), social probity may be satisfied by engagement and consultation with key stakeholders to identify and prioritise needs, design service models, identify how success may be measured, and evaluate proposals and services, creating bureaucratic controls through relational processes. During the control phase, bureaucratic controls (for example, clinical governance and service models) may be further supported by relational controls when bureaucratic controls are insufficient, for example when contractibility is low. The development of bureaucratic controls in consultation with stakeholders may be used to satisfy social probity and build legitimacy and confidence with stakeholders that services are achieving their goals. Note that in the case setting, social probity is specified in the PSO–Intermediary relation (through the commissioning cycle) and satisfied in the Intermediary–Provider relation and reported back to the PSO.

Table 17 How social probity may be satisfied across both relations

Relation	Design	Contact, partner selection	Contract	Control	Review
PSO–Intermediary	Establishes commissioning cycle.		Bureaucratic controls establish requirements of the commissioning cycle.	Rely on independent experts to evaluate programs and deliverables.	Independent evaluation of the program and services.
Intermediary–Provider	Strategic planning at a regional scale with stakeholders. Co-design at service level with broad range of stakeholders.	Market engagement to increase participation and collaboration. Include independent experts (clients, clinicians) in awarding contract to ensure client needs met.	Agree on measures, targets and reporting, and how relation will be managed.	Bureaucratic (boundary controls). Relational controls may be used to support bureaucratic controls where contractibility is low and bureaucratic controls are insufficient.	Evaluation of services. Evaluation of commissioning processes. Continual improvement of commissioning cycle.

Source: Summarised from data presented in Chapter 8.

Identifying and understanding how different types of probity are satisfied across the contracting process may help organisations tailor controls and avoid unnecessary costs arising from excessive ('blanket') probity arrangements, as well as avoid unnecessary risks from not managing different types of probity.

9.3.2 Understanding the impact of probity on low contractible arrangements

While trade-offs are common in balancing the costs and benefits of control choices (Williamson, 1985), the empirical data suggests financial probity, predominantly arising from the contracting party and organisational context, has greater influence over control strategies than other transaction attributes in public sector settings, determining the context for which all other control choices are made (Table 18). Focusing on the overall design of the outsourcing arrangement and the PSO–Intermediary relation, the PSO makes control choices in advance of going to market about the form, duration and value of the contract. Partner selection is a highly bureaucratic process, subject to extensive procedures and audits providing transparency and predictability to all stakeholders involved (Anderson & Dekker, 2014; Dekker, 2004). There is no negotiation during the contract phase, or evidence of trust despite expecting or needing to be trusted by others (transparency, a key component of probity, promotes trust; Horne, 2010; Spurgeon & Hicks, 2003). The control and review phases both appear to be exclusively bureaucratic.

Table 18 Summary of control strategies observed in public sector outsourcing

Phase	Control strategies used by PSO and how they satisfy financial probity and *social probity*
Design	• **Program specifications** developed openly and transparently with stakeholders to reduce uncertainty. Process of design demonstrates probity. Outcome of design process is made public. Design includes governance and monitoring requirements.
Contact and partner selection	• **Procurement strategy** (including procurement process, partner selection, contract form/duration, control, performance monitoring) established prior to contact, based on value not activity. Contact process is open, transparent and equitable. • **Partner selection** is formal, dictated by procurement strategy (panel memberships, selection criteria and process). *Governance, capability and capacity dominate selection criteria (includes prior experience, e.g. contractual and competence trust).*
Contract	• **Contract form and duration** predetermined, standardised and transactional, even when contractibility is low. Duration is contingent on funding cycle rather than activity. Often short-term (12-months or less) to manage risks — up to 3 years (even when funding commitment is longer). No negotiation of terms. **Flexibility** incorporated into the contract for PSOs to add/remove services to meet changes in need or funding available, and add guidance recognising the program is evolving. • **Incentives** are absent**.** Payments may vary and include a mix of upfront, process or outcomes payments. Regulatory or transactional approach to contracting.
Control	• **All controls are bureaucratic irrespective of contractibility**, requiring significant resources by both parties to manage. • **Contracts remain the same**, any variation to program managed by adding/removing schedules.
Review	• **Transparent independent review process** of policy, program and individual services. *Also subject to inspection or validation of services by third-parties (inspector, independent evaluators).*

While social probity is also important in this setting, social probity requirements are satisfied by the PSO while also satisfying financial probity requirements. Notably the use of relational controls to supplement bureaucratic controls in the control phase of the arrangement (see Table 17) occurs in the Intermediary–Provider relation.

Financial probity appears to impact the public sector's organisation and control of low contractible arrangements in two ways. First, the PSO satisfies financial probity requirements exclusively through the use of bureaucratic controls. Bureaucratic controls ensure services are delivered consistently and equitably, while safeguarding clients (Williamson, 1999, p. 325), but are not necessarily tailored to or proportionate to risk (Balakrishnan et al., 2010). High levels of bureaucracy are resource intensive. In the case setting, this was evident in the time required for the intermediary to prepare detailed plans and reports, and the time taken for the PSO to assess whether the deliverables met requirements. This supports studies in the inter-organisational management control and other literatures that highlight the public sectors' reliance on bureaucratic 'command and control' mechanisms to manage outsourcing arrangements, irrespective of the transaction characteristics present (Balakrishnan et al., 2010; Johansson & Siverbo, 2011; Johansson et al., 2016; Miller & Rose, 1990; Narayanan et al., 2007; van der Meer-Kooistra & Vosselman, 2000; Williamson, 1999). The PSO also satisfied social probity using bureaucratic controls in order to also satisfy financial probity requirements.

Second, consistent with prior studies, the PSO does not directly use relational controls, despite contractibility still being a concern (due to novelty of arrangement and type of services contracted over), as they fail to satisfy financial probity requirements (Ditillo et al., 2015; Horne, 2010; Narayanan et al., 2007). The PSO tailored the bureaucratic controls used to satisfy social probity in consultation with key stakeholders, suggesting a relational aspect to the development of bureaucratic controls. The use of relational controls was not prohibited in the intermediary setting, but were used to supplement rather than substitute bureaucratic controls.

Given the impact of probity, and in particular financial probity, on how public sector outsourcing is managed, PSOs either need to reconsider what probity is and how it is satisfied (Section 8.2.5), increase the contractibility of arrangements, or find suitable alternatives when organising low contractible arrangements given the absence of relational controls in public sector settings. In this setting, the low contractibility of the arrangement was managed by an intermediary which was not constrained in its control choices (discussed in Section 9.4).

9.3.3 Extending our knowledge of how probity requirements are satisfied and implications on other control choices

My second contribution extends our knowledge of how probity requirements are satisfied, and how probity affects the organisation and control of low contractible arrangements in the public sector.

First, consistent with prior studies, the empirical data show PSOs rely on bureaucratic controls to satisfy probity requirements. Using the conceptual specification of probity developed in Section 9.2, how probity requirements are satisfied varies across different types of probity. Financial probity appears to be the dominant form of probity, satisfied consistently and exclusively using bureaucratic controls irrespective of the nature of services contracted over — neither relational controls or incentives satisfy financial probity requirements. This is consistent with prior studies and circumstantial evidence that highlight the public sectors reliance on bureaucratic controls and avoidance of incentives, irrespective of the nature of the transaction (Jensen & Stonecash, 2005; Johansson & Siverbo, 2011; Johansson et al., 2016; Narayanan et al., 2007; Speklé & Verbeeten, 2014; Williamson, 1999). Social probity is likely to be satisfied using bureaucratic controls tailored to each arrangement in order to also satisfy financial probity requirements; the bureaucratic controls are likely to be developed in consultation with or negotiated with key stakeholders, demonstrating some relational aspects to social probity. Relational controls may be used to supplement bureaucratic controls in other settings (in this case the intermediary setting) where social probity cannot be satisfied with bureaucratic controls alone; for example, in low contractible arrangements.

Second, consistent with prior studies I show that PSOs do not use relational controls as they fail to satisfy financial probity requirements (Ditillo et al., 2015; Narayanan et al., 2007). While trade-offs are common in determining control choices (Williamson, 1985), the findings show that probity is not traded-off in public sector settings — financial probity requirements must be satisfied across all operations. Financial probity not only determines what controls are required, but also what controls are not able to be used irrespective of the transaction characteristics present (Section 9.2.2).

While this may have no impact on outsourcing arrangements where contractibility is high (arrangements suited to bureaucratic controls), the dominance of probity is likely to lead to control misalignment where contractibility is low (arrangements suited to relational controls). In cases of low contractibility, PSOs either need to reconsider what probity is and how it is satisfied (Section 8.2.5), increase the contractibility of arrangements, or find suitable alternatives when organising low contractible arrangements given the absence of relational controls in public sector settings. This extends Cristofoli et al.'s (2010) work by explaining why control archetypes developed for low contractible arrangements in for-profit settings may not be suited to public sector settings, and that this is driven by financial probity. I also reinforce their concerns that theory developed in other settings should be applied cautiously to PSOs and preferably re-examined.

Identifying how different types of probity can be satisfied across outsourcing arrangements offers opportunities to PSOs to target the use of arrangements to satisfy probity and minimise costs to both the PSO and partners. Further, this may also identify mechanisms to reduce risk to the PSO where probity requirements are not fully understood. Financial probity and how it may be satisfied appears to be well understood. However, standardised arrangements that satisfy financial probity do not necessarily suit social probity requirements; where standardised arrangements are applied, this could leave the PSO exposed.

The strength and consistency of the effect probity has on controls available to PSOs may vary in different jurisdictions depending on whether probity requirements are mandated (as they are in Australia). For example, in a survey of 290 municipalities in Sweden, Johansson and Siverbo (2011) show PSOs may deal with cooperation hazards differently across jurisdictions. Probity requirements may vary by jurisdiction, making public sector studies from different jurisdictions difficult to compare (Malmi et al., 2020).

9.3.4 Summary

The second contribution extends the work of earlier scholars (Williamson, 1999) and contributes to both the inter-organisational management control and TCE literatures by providing greater understanding of how different types of probity may be satisfied across an outsourcing

arrangement and how financial probity is likely to dominate. Not only does financial probity determine control strategies used by PSOs, financial probity also determines controls strategies that cannot be used. Notably, financial probity leads to a reliance on bureaucratic controls and the exclusion of relational controls, even in environments of low contractibility. This helps explain why control archetypes developed for low contractible activities in for-profit settings are unlikely to be suited to public sector settings, extending the work of Cristofoli et al. (2010). While this is unlikely to affect arrangements of high contractibility, this creates tensions where the public sector is seeking to organise and control low contractible arrangements.

9.4 Explaining how the tension between low contractibility and probity can be resolved

The aim of this section is to explain how an intermediary model enables PSOs to organise and control the outsourcing of human services, managing the tension between probity and low contractibility. This contributes to the inter-organisational management control literature more generally, and in particular the subset examining outsourcing in public sector settings.

As outlined in Chapter 2, outsourcing requires a higher degree of managed coordination across organisational boundaries, compared to market transactions, reflecting the nature of the services being contracted over and the significance of the service in their value chain (Demsetz, 1988; Langfield-Smith & Smith, 2003; van der Meer-Kooistra & Vosselman, 2000, 2006; Williamson, 1985). Given all contracts are incomplete, management controls are used to address residual hazards and increase the likelihood the arrangements are a success (Anderson & Dekker, 2014; Das & Teng, 2001; Williamson, 1999). Low contractible arrangements present additional challenges in how they are managed (Chua, 2011; Håkansson & Lind, 2004; Langfield-Smith & Smith, 2003; van der Meer-Kooistra & Vosselman, 2000; Vosselman, 2002).

PSOs operate in a highly bureaucratic environment; this can make the direct provision of complex services ineffective and inefficient (Section 2.5.1). PSOs have increasingly looked to the market to provide complex services on their behalf. However, the public sector's reliance on bureaucratic controls has made the organisation and control of outsourced low contractible services difficult and subject to a number of high profile failures (Sasse et al., 2019), ranging from 'parking' or 'creaming' of clients (Considine et al., 2020), to underservicing, to causing harm and fatalities (evidenced in many recent Royal Commissions; Section 1.2).

Much attention has been given to inter-organisational arrangements in private sector settings, where parties have clear incentives to deliver. Scholars provide insights into control strategies suited to different types of transaction characteristics in different organisational contexts. Where scholars have considered public sector outsourcing of low contractible activities, they

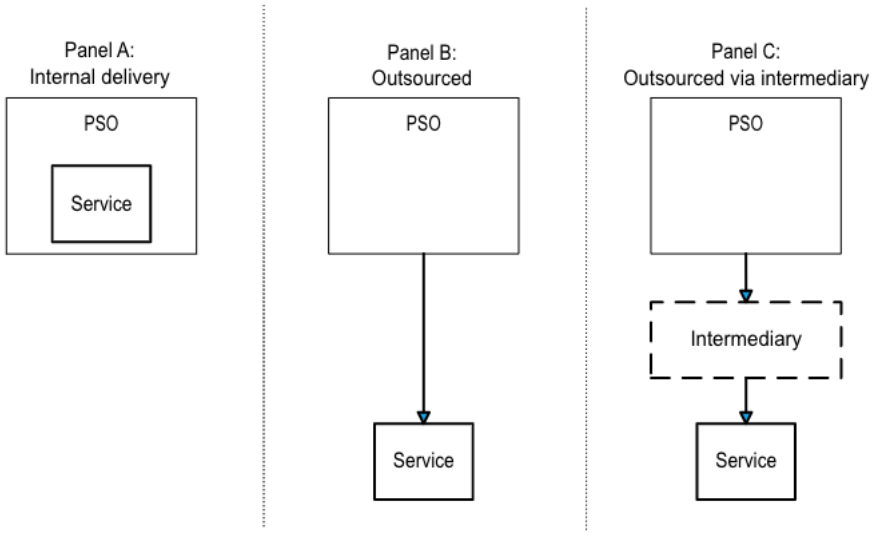
demonstrate that control strategies developed in private sector settings do not transfer neatly to the different contextual characteristics evident in the public sector (Cristofoli et al., 2010). Scholars suggest relational controls are best suited to low contractible arrangements as they encourage information sharing and understanding (Almquist et al., 2013); however, relational controls may be at odds with and even threaten probity in public sector settings (Ditillo et al., 2015; Johansson & Siverbo, 2011; Johansson et al., 2016; Narayanan et al., 2007; Williamson, 1999). The literature does not appear to explain how PSOs resolve this tension between managing low contractible arrangements while also satisfying probity requirements. PSOs continue to outsource low contractable services in settings where probity requirements are high, and without understanding how this tension is managed, we are unable to understand how PSOs enable 'the cooperative ideal' (Barretta & Busco, 2011).

This section explains how an intermediary model enables PSOs to organise and control activities of low contractibility in a bureaucratic environment, and in doing so resolve the tension between probity and low contractibility when outsourcing human services.

9.4.1 Understanding the 'intermediary model' and how this differs from supply chains

In environments of low contractibility, PSOs have a number of choices. First, they can deliver services directly (Figure 15, Panel A). As described in Section 2.5.1 above, this is not necessarily the optimal arrangement. Second, they can outsource services to a third-party provider (Figure 15, Panel B). With this comes other challenges about how to organise and control services. Third, as observed in the case setting, the PSO may outsource to an intermediary organisation who then contracts with service providers — labelled here as the 'intermediary model' (Figure 15, Panel C).

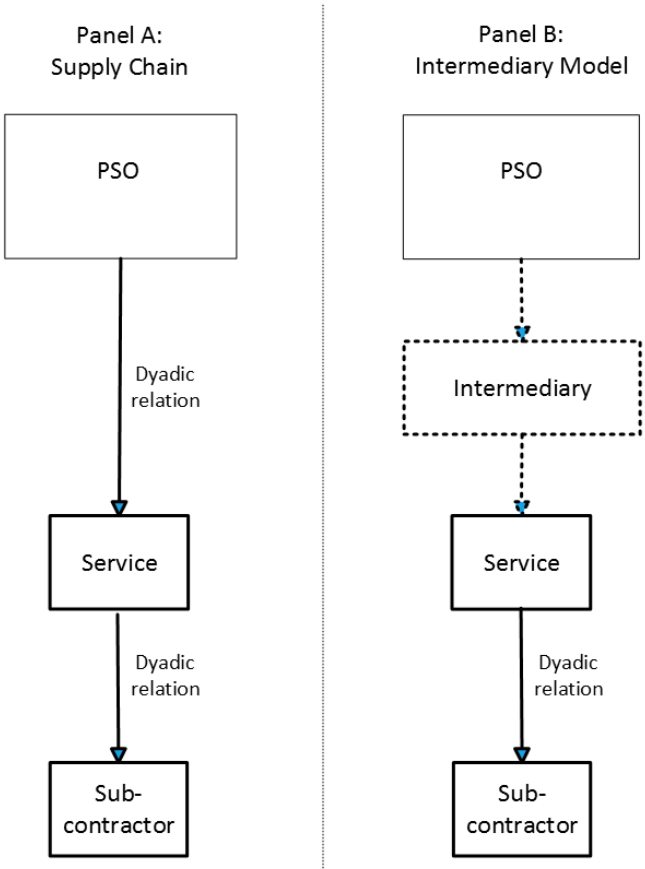
Figure 15 Delivery choices: internal, outsourced or outsourced via an intermediary



At first glance, the intermediary model could be mistaken for a supply chain, comprising a string of dyadic relations (Reusen & Stouthuysen, 2017). Yet there are differences between the intermediary model and a supply chain, and it is these differences that help moderate the tension between probity and low contractibility.

Dyadic relations — where two parties come together voluntarily — are the simplest form of contractual arrangement (Podemska-Mikluch & Wagner, 2013). Supply chains comprise of multiple dyadic relations, often in networks but discussed here as linear for simplicity (Figure 16, Panel A). As the number of dyads in an arrangement increases, so too does the distance between the original buyer and final supplier (Podemska-Mikluch & Wagner, 2013). Increasing the distance between the buyer and supplier can have negative effects, and may lead to anxiety about whether the services are delivered (Håkansson & Lind, 2004; Shaw, Smith, Porter, Rosen, & Mays, 2013). Anxiety may be particularly high in the public sector; PSOs have a duty to provide services but do not necessarily have a feedback loop confirming services have been delivered. The level of anxiety may also be affected by the scale the PSO operates at (national, regional, local) and the scale and location of services provided.

Figure 16 Simplified model comparing supply chain and intermediary model



Note: Dotted lines denote key differences between the models. A sub-contractor is included in Panel B as this is often the reality of health service delivery where services sub-contract clinicians (Interview 36, Interview 43).

The intermediary model (Figure 16, Panel B) differs from dyadic supply chains (Figure 16, Panel A) in a number of ways. First, the intermediary is a *triadic* participant in the exchange, established to commission services from providers on behalf of the PSO, the intermediary is prohibited from delivering services directly. In supply chain relations, the second party can either deliver services themselves and/or sub-contract any part of the transaction to a third-party (identified in Figure 16, Panel A as the sub-contractor). Second, the use of an intermediary purposely changes the nature of what the PSO contracts over (a program rather than services), while also changing the organisational context where the service is contracted from. In a supply chain relation, the PSO would contract over services and allow the other party to decide whether or not to deliver them directly or sub-contract (similar to the Prime Provider Model; Gallet et al., 2015). In this arrangement, the PSO controls what services are delivered by the service provider, but recognises the intermediary is better placed to manage that contract relation. While the PSO is not in day-to-day direct contact with service providers, contracts enable the PSO to access the service provider at any time; further, the service provider is in some cases required to report minimum datasets directly to the PSO. Third, by contracting to intermediaries, the PSO is able to significantly reduce the number of parties it contracts over compared to if it were to contract over services directly as it would in a supply chain model. Finally, the PSO is able to specify the characteristics required of the intermediary (the triadic party) — including the form and governance of the organisation, location and scale of the operations, expertise of staff, and specific requirements of the program it contracts over — to reduce uncertainties and anxieties associated with outsourcing, while maximising the efficiency and effectiveness of the services delivered. The intermediary model is therefore a triadic rather than supply chain relation.

Triadic exchanges arise where sponsors seek ‘to change the pattern created through dyadic exchanges’ (Podemska-Mikluch & Wagner, 2013, p. 182). As described above, the intermediary model described in this setting changes the pattern by changing the nature of what the PSO contracts over (from service to program) and changing the boundary conditions where human services are contracted over (from PSO to non-government organisation). The intermediary model also significantly reduces the number of arrangements the PSO contracts over compared to if it were to contract over services directly.

The economics literature differentiates between two forms of triadic relations: ‘triadic-by-assertion’, where a third-party *inserts* themselves into a dyadic relationship for its own benefit (common in market environments, sometimes resulting in conflict); and ‘triadic-by-invitation’ where a third-party is *invited* into a dyadic relationship by one or more party to help facilitate a relationship (Podemska-Mikluch & Wagner, 2013). In other literatures, scholars distinguish between a relational triadic participant driven by profit, and another who ‘acts as a match-maker linking two disconnected entities’ (Howard, Wu, Caldwell, Jia, & König, 2016, p. 65). Both

suggest the original dyadic relationships are pre-existing and the triadic relation is established *ex-post* to facilitate the relationship between the two original parties. While showing some similarities with the 'triadic-by-invitation' or 'match-maker' model as the intermediary was invited to participate in the relationship by the PSO (and no similarities with triadic-by-assertion), the use of an intermediary was by design, i.e. *ex-ante*, to facilitate the delivery of the program. No dyadic relations existed between parties before the program commenced. Further, the form of the intermediary was also by design. Therefore, rather than being 'triadic-by-invitation', the intermediary model in this setting is 'triadic-by-design'.

This model is not without risks, particularly to the Intermediary. There is evidence of sequential interdependence of resources (funding), where the intermediary is almost wholly reliant on the contract with the PSO for funding; this results in PSO–Intermediary relation being PSO-centric as the intermediary is beholden to the funder (PSO) to sustain operations. There is also evidence of reciprocal interdependence between the intermediary and Provider; the intermediary can only meet its contractual obligations when the provider delivers services — in this case setting, the intermediary is not permitted to deliver services itself (Dekker, 2004). The intermediary must ensure providers deliver to minimise its own risk of failure (Dekker, 2004), which strengthens the model from the perspective of the PSO and reduces the risk of hold-up. Sequential and reciprocal interdependence are unlikely to affect other parties in the intermediary the model. The Provider, due to market fragmentation has access to other sources of funding, resulting in asymmetric dependence and a power advantage (Donada & Nogatchewsky, 2006); the PSO, due to the ability to return to the market or deliver services directly (see Figure 15 above).

9.4.2 Understanding how the intermediary model manages the tension

The intermediary model enables the public sector to organise and control low contractible arrangements, managing the tension between probity and low contractibility, in two ways.

First, the use of an intermediary changes what the PSO contracts over, thereby increasing the contractibility of the PSO–Intermediary relation. The PSO contracts the intermediary to facilitate the delivery of a program (and the procurement of services as part of the program). The PSO uses a combination of planning, budgeting and financial results controls to manage the PSO–Intermediary relation which allows comparisons to be made across the 31 intermediaries delivering the PHN Program (Merchant & Van der Stede, 2017). This allows the PSO to rely on bureaucratic controls to manage the outsourced program (Johansson & Siverbo, 2011).

Second, the intermediary model changes the boundary conditions in which the low contractibility services are contracted over to a context less constrained by probity *without* changing the

services delivered. The intermediary is not a PSO and is able to use a mix of control strategies to contract over the providers. This is particularly important when establishing new services.

The model works because of the design choices made; the PSO specifies the characteristics required of the intermediary including the form and governance of the organisation, location and scale of the operations, expertise of staff, and specific requirements of the program it contracts over, to reduce uncertainties and anxieties associated with outsourcing, while maximising the efficiency and effectiveness of the services delivered. The intermediary model also works because of sequential interdependence of resources, and reciprocal interdependence between the intermediary and provider, meaning that the only way the intermediary can sustain operations and meet its contractual obligations is to ensure providers deliver services. This mitigates risk of hold-up.

This study is not the first to consider increasing the contractibility of an outsourcing arrangement. Contractibility may increase naturally over time, as information asymmetry declines or tasks become more routinised (Considine, Lewis, & O'Sullivan, 2011). Contractibility may also be increased artificially. Bracci and Llewellyn (2012) investigate increasing the accountability (and therefore contractibility) of human services by moving from 'people changing' to 'people processing' in the provision of social supports. They find a people processing approach results in narrowing 'the scope of accountability to cost-efficiency measures' and ignores service effectiveness (Bracci & Llewellyn, 2012, p. 827).[72] I would argue that significant changes would be required to increase contractibility of the activity enough to improve control alignment — changes that would likely compromise service effectiveness.

The intermediary model works as it reduces uncertainty in the PSO–Intermediary relation, and probity in the Intermediary–Provider relation, resulting in greater control alignment in each relation. Therefore, the intermediary model is able to moderate the tension between probity and low contractibility when outsourcing low contractible human services.

9.4.3 Extending scholarly knowledge about public sector outsourcing

My third contribution relates to the use of an intermediary model to enable the public sector to organise and control the outsourcing of human services. The intermediary model enables a

[72] The routinisation of human services has also been subject to an inquiry by the Australian Senate Standing Committees on Community Affairs (CentreLink's Compliance Program, 'Robodebt'). See https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Centrelinkcompliance (accessed 30 October 2020).

PSO to organise and control outsourcing when there is both low contractibility and expectations of probity.

An intermediary model can be used to purposely change the contractibility of the outsourcing arrangement. First, the model changes the nature of what is contracted over by the PSO, moderating the tension between the low contractible activity and the bureaucratic context in which the outsourcing takes place. Second, the model changes the boundary conditions where the low contractible services are organised. Both steps allow greater control alignment, with the PSO relying on bureaucratic controls to manage PSO–Intermediary relation (Johansson & Siverbo, 2011), while the intermediary is able to use a mix of bureaucratic and relational controls to manage the low contractible Intermediary–Provider relation. This extends inter-organisational management control outsourcing literature by identifying an *ex-ante* model that moderates the contractibility of an activity (Barretta & Busco, 2011), and increases control alignment, by changing the context in which services of low contractibility are managed. Unlike prior studies, this mechanism increases contractibility without changing the nature of the services being delivered (Bracci & Llewellyn, 2012).

I extend theory developed in the economics literature and bring it into the management control literature by explaining how the intermediary model differs from supply chain arrangements (Gallet et al., 2015; Podemska-Mikluch & Wagner, 2013; Reusen & Stouthuysen, 2017). Compared to a supply chain based on dyadic arrangements (including the prime provider model; Gallet et al., 2015; Reusen & Stouthuysen, 2017), or increasing the contractibility of services provided (Bracci & Llewellyn, 2012), the intermediary model uses, by design, a third-party to facilitate the delivery of a program. This differs from the 'triadic-by-assertion' model where a party inserts itself into a dyadic relationship for its own benefit, and a 'triadic-by-invitation' model where the dyadic partners invite a third-party to facilitate a relationship — both of which occur *ex-post* (Podemska-Mikluch & Wagner, 2013). The facilitating role of the intermediary, and indeed the characteristics of the intermediary, are part of the program design (*ex-ante*) and hence is 'triadic-by-design' and is used by the PSO as a way to organise and control the outsourcing arrangement in what appears to be a way to address the tension presented by managing a low contractible activity in a highly bureaucratic environment (Johansson & Siverbo, 2011).

9.4.4 Summary

The third and final contribution extends the inter-organisational management control outsourcing literature by identifying a mechanism by which PSOs are able to organise and control the outsourcing of low contractible activities in highly bureaucratic environments. While prior studies have examined the use of chains of dyadic relations used to outsource a service, or increasing the contractibility of services provided, this study demonstrates the use of a

triadic-by-design intermediary model (extending Podemska-Mikluch & Wagner, 2013). The use of an intermediary changes the nature of what is contracted over directly by the PSO, and changes the context in which the low contractible services are contracted over to one not limited to bureaucratic controls. Changing the nature of what is contracted over directly by the PSO moderates the contractibility of the human services in the outsourcing arrangement. Importantly, in this context, this leaves the low contractible services unchanged (critical given the complex and individual needs of clients).

9.5 Chapter summary

This chapter explained the broader theoretical and practical implications of the empirical study. First, I developed the conceptual specification of the TCE attribute of probity and explained the different sources and types of probity, and how they can be managed across the outsourcing process. Probity is associated with the nature of the party and the organisational context, and the nature of the service contracted over. I also distinguished between financial and social probity and explained how they vary over different phases of inter-organisational arrangements. Second, I explained how different probity requirements may be satisfied and how financial probity requirements influence the control choices in public sector arrangements. Third, I explained how an intermediary triadic-by-design model of outsourcing moderates the tension between low contractibility and probity in public sector settings. Rather than change the contractibility of the final activity, this model used an intermediary to facilitate service delivery, changing the nature of what is contracted over directly by the PSO, and changing the context in which the low contractible services are contracted over to one not limited to bureaucratic controls. This thesis contributes to our understanding of probity which may help PSOs improve the efficiency and effectiveness of how outsourcing is organised (presented in Section 10.4). The limitations of this thesis are presented in the next and final chapter.

Chapter 10 Conclusions

10.1 Introduction

The objective of this thesis was to explain how the public sector can organise and control the outsourcing of low contractible human services. Informed by a case study of public sector outsourcing of primary health care services in Australia, I explained how one PSO organised and controlled the delivery of services using an intermediary triadic-by-design model. In this concluding chapter I explain how this thesis answers the research question. First, I present a summary of this thesis (Section 10.2) and explain the theoretical and practical contributions and implications of this study (Sections 10.3 and 10.4). I then explain the methodological, empirical and theoretical limitations (Sections 10.5) and identify opportunities for further research (Section 10.6). My final observations and concluding remarks are presented in Section 10.7.

10.2 Thesis summary

Most accounting scholarly knowledge about the management control of outsourcing arrangements is informed by empirical studies in the private sector, knowledge that is not necessarily transferable to PSOs given their very different institutional environments (Caglio & Ditillo, 2020; Cristofoli et al., 2010). While some scholars have explored the broader control archetypes evident in public sector settings (Balakrishnan et al., 2010; Johansson & Siverbo, 2011; Johansson et al., 2016), few have considered in detail how PSOs control outsourcing arrangements, and in particular how low contractible activities are organised and controlled in environments where probity — a specific and often regulated governance requirement — is high (Cristofoli et al., 2010; Kominis & Dudau, 2012). The objective of this thesis was therefore to explain how the public sector can organise and control the outsourcing of human services, and in particular, how PSOs can resolve the tension between low contractibility and probity when outsourcing human services.

In Chapter 1, I explained the location of this thesis — the well-developed inter-organisational management control literature, and the subset of literature examining outsourcing. Outsourcing is an interesting form of inter-organisational arrangement as it requires a higher degree of managed coordination across organisational boundaries (compared to market transactions) reflecting the nature of the activity (Demsetz, 1988; van der Meer-Kooistra & Vosselman, 2000, 2006). The theoretical lens used in the study, Transaction Cost Economics (Williamson, 1981b, 1981a, 1985, 2009a), is often used by scholars in this literature to identify transaction hazards (antecedents of control).

Drawing on prior literature and TCE theory, I then introduced the three theoretical motivations. First, the transaction attribute of probity has largely been overlooked in public sector outsourcing studies, despite being an explicit governance requirement in this setting. Scholars know little more about probity now than when it was first introduced into the TCE literature by Williamson more than 20 years ago. The lack of development of the conceptual specification has limited the use of Williamson's original specification of probity to the context in which it was developed — the outsourcing of sovereign transactions or transactions involving public authority (Da Veiga & Major, 2019; Fredland, 2004). The conceptual specification of probity needs to be developed further before it can be applied to public sector settings more broadly. The first theoretical motivation for this thesis is therefore to add to the conceptual specification of probity in order to broaden the application of TCE attribute of probity, and TCE more broadly given transaction characteristics do not always operate in isolation.

Second, given the lack of conceptual development of the transaction characteristic of probity, it is understandable that scholarly knowledge of how probity requirements may be satisfied is also lacking. Despite being a clear governance requirement in public sector settings, how probity is satisfied has been mostly circumvented in the management control literature. Probity is not just relevant to all public sector operations (Williamson, 1999), but is likely to be an important consideration for management control strategies across all operations. Failing to understand how probity is satisfied leaves the explanation of the determinants of control in public sector settings incomplete. Therefore, the second theoretical motivation for this study is to explain how probity requirements are satisfied, and how this affects the organisation and control of low contractible arrangements.

Third, scholars find trust-based controls and relational controls — approaches that are flexible and agile — are best suited to low contractible arrangements as they encourage sharing of information and understanding, and allow parties to resolve unknowns over time (Anderson & Dekker, 2010; Dekker, 2004; Håkansson & Lind, 2004; Langfield-Smith & Smith, 2003; Speklé, 2001; van der Meer-Kooistra & Vosselman, 2000). However, bureaucratic controls are preferred by PSOs as they provide transparency in the presence of probity (Johansson & Siverbo, 2011; Johansson et al., 2016; Williamson, 1999); the public administration literature highlights that relational controls potentially pose a threat to public accountability as they fail to satisfy probity requirements (Ditillo et al., 2015). The literature does not appear to explain how PSOs resolve this tension between managing low contractible arrangements while also satisfying probity requirements. This tension in the literature provided the final motivation and the research question: *How can the public sector organise and control the outsourcing of human services? In particular, how can public sector organisations can resolve the tension between low contractibility and probity when outsourcing human services?*

In Chapter 2, I identified the characteristics of outsourcing and what differentiates outsourcing from other inter-organisational arrangements. I then described the research setting, including an overview of trends in public sector outsourcing, the scope of human services, reasons to outsource, and different approaches to outsourcing human services. This identified the social and economic importance of developing a better understanding of how human services outsourcing can be organised and controlled.

In Chapter 3, using TCE theory, I explained why the outsourcing of human services is likely to be problematic. In Chapter 4, drawing on the extant literature, I identified control strategies we might expect across the outsourcing process in public sector settings. This provided the conceptual framing for this study which, along with my theoretical motivation and research question, informed my research design (presented in Chapter 5).

I then presented how the outsourcing arrangement — the delivery of the PHN Program in one region in Australia — was managed using an intermediary model. Chapter 6 described the relation between the DoH (the PSO) and one of the 31 PHNs (the CasePHN; intermediary); Chapter 7 described the relation between the CasePHN and providers. In the analysis presented in Chapter 8, I identified how probity and low contractibility were managed in both the PSO–Intermediary and Intermediary–Provider relations, and how the tension between them was resolved.

In Chapter 9, I presented the theoretical implications of this study, specifically the conceptual development of probity, how probity may be satisfied, and how PSOs can manage the tension between probity and low contractibility.

Next, I explain the implications of each these findings and identify the contributions made by this study to the literature.

10.3 Theoretical contributions and implications

In this thesis I explain how the public sector manages the outsourcing of services of low contractibility by using a case study of the Australian PHN Program. I explain how the PSO applies an intermediary model to resolve the tension between low contractibility and probity when outsourcing human services. I make three contributions to the inter-organisational management control literature and the broader TCE literature, summarised in this section.

10.3.1 Developing our conceptual specification of probity

My first contribution relates to the TCE attribute of probity and contributes to both the inter-organisational management control literature using TCE, as well as the broader TCE literature. Probity is not unique to the public sector (Butcher, 2018; Williamson, 1999) — as a society, we

would hope that private sector organisations also behave honestly and decently. Probity requirements in PSOs are often legislated, detailed and specific to the sector making probity highly relevant to public sector transactions. Exploring probity in a setting where it is likely to be highly relevant allows scholars to develop the construct of probity. This study shows that probity is not a bland bureaucratic requirement, but comprises different dimensions.

First, I identify the sources of probity. This thesis demonstrates that probity arises from the nature of the party to the transaction and the context given the additional requirements specific to PSOs, validating prior studies that relate probity to the context or actors (Da Veiga & Major, 2019; Ruiter, 2005). In addition, probity arises from the nature of the service being contracted over, either transferring with the activity through contract requirements and/or program design, or arising from the value and nature of the service itself (due to requirements outside of the contract).

Second, I identify two types of probity: financial and social. Financial probity relates to the transparent, equitable, ethical (in relation to corruption; Gregory, 1999) and efficient use of public resources (Allen et al., 2016; Spurgeon & Hicks, 2003) across all operations. The financial dimension of probity is not new; scholars often only recognise the fiduciary aspect of probity (Allen et al., 2016; Butcher & Gilchrist, 2016; Da Veiga & Major, 2019; Gregory, 1999; Jensen & Meckling, 1976; Samuel et al., 2008; Tan & Egan, 2018). Financial probity requirements are consistent across activities, although there may be some variation depending on the value of the contract. Social probity relates to the public sector's responsibility to ensure the safe and effective delivery (quality and stewardship) of services contracted over (Almquist et al., 2013), and is likely to vary according to the nature of the service contracted. While scholars have noted the relevance of both the financial and social context of transactions — particularly in the public sector (Almquist et al., 2013; Balakrishnan et al., 2010; Barretta & Busco, 2011; Reusen & Stouthuysen, 2017) — no links have been made to probity.

Third, financial probity is more likely to be associated with the nature of transaction party/context, although requirements may vary depending on the value of the services contracted over. Social probity arises from both the nature of the transaction party/context and the nature of the services. It is the nature of the service that make social probity requirements idiosyncratic. Different types of probity are accountable to stakeholders in different ways and are not necessarily valued or treated equally. By highlighting the different sources and types of probity, it becomes easier to recognise where and when probity arises in a transaction.

My first contribution is the development of the conceptual specification of probity. TCE theory is commonly used as a theoretical lens in the inter-organisational management control literature, albeit it less so in public sector settings (Anderson & Dekker, 2010; Ding et al., 2013). Developing our conceptual understanding of the TCE construct of probity beyond sovereign

transactions (Williamson, 1999) extends the use of TCE in the public sector, ensuring scholars include a key governance requirement of public sector settings. This also encourages the application of TCE theory in its entirety in other settings. This enables greater consistency and comparison between private and public sector studies (Anderson et al., 2015), and provides an opportunity to build on and draw comparisons between studies (Otley, 2016). At a more practical level, providing a more detailed understanding of the different sources and types of probity and the relation between them provides more information to scholars and practitioners about what may drive control choices. Probity is not a single dimensional transaction characteristic but more nuanced than previously assumed.

10.3.2 Explaining how probity requirements are satisfied in low contractible environments

My second contribution extends our knowledge of how probity requirements are satisfied, and how probity affects the organisation and control of low contractible arrangements in the public sector.

First, consistent with prior studies, the empirical data show PSOs rely on bureaucratic controls to satisfy probity requirements. Using the conceptual specification of probity developed in Section 9.2, how probity requirements are satisfied varies across different types of probity. Financial probity appears to be the dominant form of probity, satisfied consistently and exclusively using bureaucratic controls irrespective of the nature of services contracted over — neither relational controls or incentives satisfy financial probity requirements. This is consistent with prior studies and circumstantial evidence that highlight the public sectors reliance on bureaucratic controls and avoidance of incentives, irrespective of the nature of the transaction (Jensen & Stonecash, 2005; Johansson & Siverbo, 2011; Johansson et al., 2016; Narayanan et al., 2007; Speklé & Verbeeten, 2014; Williamson, 1999). Social probity is likely to be satisfied using bureaucratic controls tailored to each arrangement in order to also satisfy financial probity requirements; the bureaucratic controls are likely to be developed in consultation with or negotiated with key stakeholders — demonstrating some relational aspects to social probity. Relational controls may be used to supplement bureaucratic controls in other settings (in this case the intermediary setting) where social probity cannot be satisfied with bureaucratic controls alone; for example, in low contractible arrangements.

Second, consistent with prior studies I show that PSOs do not use relational controls as they fail to satisfy financial probity requirements (Ditillo et al., 2015; Narayanan et al., 2007). While trade-offs are common in determining control choices (Williamson, 1985), the findings show that probity is not traded-off in public sector settings — financial probity requirements must be satisfied across all operations. Financial probity not only determines what controls are required, but also what controls are not able to be used irrespective of the transaction characteristics present (Section 9.2.2).

While this may have no impact on outsourcing arrangements where contractibility is high (arrangements suited to bureaucratic controls), the dominance of probity is likely to lead to control misalignment where contractibility is low (arrangements suited to relational controls). In cases of low contractibility, PSOs either need to reconsider what probity is and how it is satisfied (Section 8.2.5), increase the contractibility of arrangements, or find suitable alternatives when organising low contractible arrangements given the absence of relational controls in public sector settings. This extends Cristofoli et al.'s (2010) work by explaining why control archetypes developed for low contractible arrangements in for-profit settings may not be suited to public sector settings, and that this is driven by financial probity. I also reinforce their concerns that theory developed in other settings should be applied cautiously to PSOs and preferably re-examined.

Identifying how different types of probity can be satisfied across outsourcing arrangements offers opportunities to PSOs to target the use of arrangements to satisfy probity and minimise costs to both the PSO and partners. Further, this may also identify mechanisms to reduce risk to the PSO where probity requirements are not fully understood. Financial probity and how it may be satisfied appears to be well understood. However, standardised arrangements that satisfy financial probity do not necessarily suit social probity requirements; where standardised arrangements are applied, this could leave the PSO exposed.

The strength and consistency of the effect probity has on controls available to PSOs may vary in different jurisdictions depending on whether probity requirements are mandated (as they are in Australia). For example, in a survey of 290 municipalities in Sweden, Johansson and Siverbo (2011) show PSOs may deal with cooperation hazards differently across jurisdictions. While scholars should be mindful probity requirements may vary by jurisdiction in terms of how they are specified, 'accountability, transparency, efficiency, effectiveness, responsiveness and rule of law' are essential elements of good public governance and therefore probity is likely to be evident in some form in all OECD countries, as well as many others (OECD, 2011).

The second contribution extends the work of earlier scholars (Williamson, 1999) and contributes to both the inter-organisational management control and TCE literatures by providing greater understanding of how different types of probity may be satisfied across an outsourcing arrangement and how financial probity is likely to dominate. Not only does financial probity determine control strategies used by PSOs, financial probity also determines controls strategies that cannot be used. Notably, financial probity leads to a reliance on bureaucratic controls and the exclusion of relational controls, even in environments of low contractibility. This helps explain why control archetypes developed for low contractible activities in for-profit settings are unlikely to be suited to public sector settings, extending the work of Cristofoli et al. (2010).

10.3.3 Explaining how the tension between low contractibility and probity can be resolved

My third contribution relates to the use of an intermediary model to enable the public sector to organise and control the outsourcing of human services. The intermediary model enables a PSO to organise and control outsourcing when there is both low contractibility and expectations of probity.

An intermediary model can be used to purposely change the contractibility of the outsourcing arrangement. First, the model changes the nature of what is contracted over by the PSO, moderating the tension between the low contractible activity and the bureaucratic context in which the outsourcing takes place. Second, the model changes the boundary conditions where the low contractible services are organised. Both steps allow greater control alignment, with the PSO relying on bureaucratic controls to manage PSO–Intermediary relation (Johansson & Siverbo, 2011), while the intermediary is able to use a mix of bureaucratic and relational controls to manage the low contractible Intermediary–Provider relation. This extends inter-organisational management control outsourcing literature by identifying an *ex-ante* model that moderates the contractibility of an activity (Barretta & Busco, 2011), and increases control alignment, by changing the context in which services of low contractibility are managed. Unlike prior studies, this mechanism increases contractibility without changing the nature of the services being delivered (Bracci & Llewellyn, 2012).

I extend theory developed in the economics literature and bring it into the management control literature by explaining how the intermediary model differs from supply chain arrangements (Gallet et al., 2015; Podemska-Mikluch & Wagner, 2013; Reusen & Stouthuysen, 2017). Compared to a supply chain based on dyadic arrangements (including the prime provider model; Gallet et al., 2015; Reusen & Stouthuysen, 2017), or increasing the contractibility of services provided (Bracci & Llewellyn, 2012), the intermediary model uses, by design, a third-party to facilitate the delivery of a program. This differs from the 'triadic-by-assertion' model where a party inserts itself into a dyadic relationship for its own benefit, and a 'triadic-by-invitation' model where the dyadic partners invite a third-party to facilitate a relationship — both of which occur *ex-post* (Podemska-Mikluch & Wagner, 2013). The facilitating role of the intermediary, and indeed the characteristics of the intermediary, are part of the program design (*ex-ante*) and hence is 'triadic-by-design' and is used by the PSO as a way to organise and control the outsourcing arrangement in what appears to be a way to address the tension presented by managing a low contractible activity in a highly bureaucratic environment (Johansson & Siverbo, 2011).

The third and final contribution extends the inter-organisational management control outsourcing literature by identifying a mechanism by which PSOs are able to organise and control the outsourcing of low contractible activities in highly bureaucratic environments. While

prior studies have examined the use of chains of dyadic relations used to outsource a service, or increasing the contractibility of services provided, this study demonstrates the use of a triadic-by-design intermediary model (extending Podemska-Mikluch & Wagner, 2013). The use of an intermediary changes the nature of what is contracted over directly by the PSO, and changes the context in which the low contractible services are contracted over to one not limited to bureaucratic controls. Changing the nature of what is contracted over directly by the PSO moderates the contractibility of the human services in the outsourcing arrangement. Importantly, in this context, this leaves the low contractible services unchanged (critical given the complex and individual needs of clients).

10.4 Practical contributions and implications

The case study in this thesis provides insights and contextual understanding that are able to contribute to practice (Lillis, 2008). The insights may help PSOs understand and overcome the difficulties associated with managing low contractible activities while also satisfying probity requirements.

First, probity is an operational requirement of PSOs. Probity appears to be treated liberally and homogenously across all activities by the PSO in the case setting, at great cost to all parties. Understanding the different sources of probity (party/context and nature of service), and different types of probity (financial and social), and where they arise across the commissioning cycle (contact, contract and control), will enable a more efficient targeting of probity arrangements by PSOs, potentially reducing the cost of managing financial probity while ensuring social probity is understood and managed — noting this may vary by jurisdiction. Understanding what probity requires (bureaucratic controls) and prevents (relational controls), and the implications of probity on managing activities of different contractibility, will allow PSOs to make informed governance choices that meet probity requirements *and* address other transaction characteristics present.

Second, relational controls enable contracting parties to work together to mitigate and manage low contractibility. As evidenced in the case setting, where relational controls are used, they require time (and consequently resources) to implement more so than bureaucratic controls alone (evidenced by exploring a switch away from relational controls in order to reduce operational overheads); where relied upon should be resourced appropriately.

Third, the intermediary model described in this thesis enables the PSO to increase the contractibility of the relation it contracts over. The model then allows the low contractible services to be managed by an intermediary able to supplement bureaucratic controls with relational controls. The model reduces the number of relations contracted over, but increases the size (in terms of resources) of those relations. This is unlikely to be the only model used by

PSOs to outsource activities of low contractibility. The insights provided in this thesis may help identify other models, or be used to develop new models, that are able to resolve the tension between low contractibility and probity.

Finally, the intermediary model is likely to succeed in the case setting for a number of reasons. First, the success of this model is due to the design choices, particularly in the characteristics of the intermediary itself. Second, the commissioning of services was not carried out in isolation; in the case setting, the intermediary had other roles and responsibilities in relation to improving primary health thereby improving its knowledge-base and ability to promote and monitor services commissioned. Third, the culture and knowledge of intermediary staff were aligned with the program objectives, and were proactive in achieving results and solving problems. The model however is at risk from the way it is being implemented — primarily due to the level and duration of resourcing, over specification of requirements, and also due to the complex landscape in which it operates.

It is important that research contributes to and supports practice (Meer-kooistra & Vosselman, 2012). Much can be learned from examining the way services are organised, learning from the strengths and weaknesses of how programs are designed and contracted. This has the potential to complement the more traditional service evaluations of models of care.

10.5 Study limitations

No study is without limitations (Lincoln & Guba, 2000). The use of a different lens or paradigm will affect what a researcher sees and the relevance of what she sees in her analysis (Anderson et al., 2015; Tolbert & Hall, 2010). The choices made in the research design are presented in Chapter 5; the purpose of this section is to acknowledge the methodological, empirical and theoretical limitations that affect the interpretation of the findings.

10.5.1 Methodological limitations

This study adopted a single qualitative case method using a within case design (Yin, 2014). This was an appropriate choice given the exploratory nature of this study and allowed me to explore the two different levels of contractual relations within the intermediary model from different perspectives — from the funder, intermediary, providers and other stakeholder perspectives. This approach also allowed me to generate rich data about how the outsourcing arrangement was managed, from the perspectives of different parties, and how the tension between low contractibility and probity was resolved. This highlights the importance of considering how *all* parties in contracting relations manage and behave in the relationship, particularly as it can impact on the viability of the arrangement, risk of hold-up, and cost. This substantiates prior criticisms in the literature that empirical studies are often one-sided and fail

to capture both sides of relations (Caglio & Ditillo, 2008; Johansson & Siverbo, 2011). [73] There is great value in understanding inter-organisational arrangements from different perspectives, as well as considering whole value chains to understand what this means for consumers — admittedly easier in short value chains such as the one described in this thesis. This study also provides insights into how inter-organisational controls work across different sectors (Stafford & Stapleton, 2017). However, this approach was not without limitations.

First, a case study using abductive reasoning relies on the ongoing engagement of the case organisation. My presence in the Case Organisation allowed me to build trust with staff and identify opportunities to observe how the outsourcing arrangement was managed on a day-to-day basis. The insights and descriptions by informants were particularly rich and my presence in the organisation and attendance of key meetings provided greater insights than document review and interviews alone. While the CasePHN was highly engaged throughout the study, this approach required an extensive fieldwork period to enable staff to participate outside of peaks in their workload. This approach may be difficult to replicate when the research is bounded by time and resources, or when the case organisation is less engaged.

Second, while the validity of case study research is increased where there are multiple cases, given the exploratory nature of this thesis it was premature to consider multiple case design. I identified a representative case to enable external validity to be tested in future research. The findings of this case study are relevant to the 30 other organisations operating as Primary Health Networks in Australia, to other funders and providers of primary health care at both state/territory and commonwealth levels, and to other stakeholders involved in primary health care. The findings are also likely to be relevant more broadly to other human service outsourcing arrangements, in other jurisdictions, defined by high levels of probity and low contractibility.

While the case organisation was small, it manages a large number of contracts with providers. This allowed me to explore the way different services were commissioned by different parts of the organisation. Given the number of services commissioned, not all contracts could be explored in great detail; I therefore used a within case design to explore three services in detail (one from each clinical stream) that were considered by the CasePHN to be ‘working well’ or had made substantial improvements to the way they were being managed. This involved a more in-depth document review of the entire commissioning process for each service, and included the perspectives of different parties to the contracting relation (Johansson & Siverbo, 2011; van

[73] For example, some scholars examine inter-organisational relationships from a buyer perspective (Johansson & Siverbo, 2011), others from a supply perspective (Johansson et al., 2016; Nicholson et al., 2006), few scholars consider inter-organisational arrangement from both perspectives (an exception being Minnaar et al., 2017).

der Meer-Kooistra & Vosselman, 2006). This provided insights about consistency and variation in the way contracts were managed across the organisation. In addition, all contract managers were included in the study to understand how contracts were managed across the organisation. To ensure confidentiality of participants and the CasePHN, the results from the within case design are not disaggregated.

Third, qualitative case study research faces many criticisms related to objectivity and validity (among other things; Bryman, 2012); this was acknowledged and managed in this thesis (Meer-kooistra & Vosselman, 2012). The research design tried to maximise the validity of the study, in particular construct validity, internal and external validity, and reliability. I used multiple sources of evidence (documents, interviews, observations) to corroborate findings and build explanations (Creswell, 2003; Lukka & Modell, 2010), and used an abductive strategy to provide a communal test of validity (Lincoln & Guba, 2000). Findings were validated with informants and external experts, providing 'member checking' of the accuracy of the findings and reducing risk of researcher bias (Creswell, 2003, p. 196). While many informants were from within the CasePHN, informants also included DoH, providers, other stakeholders (including academics and peak bodies), and experts working in this field.

10.5.2 Empirical limitations

There are a number of empirical limitations to this study that should be considered if this study is replicated or extended in the future. First, the analysis is relevant to when the study was conducted (Dubois & Gadde, 2002). While this is true for any case study, this is particularly important here given the PHN Program is relatively new and is still developing, and the intermediary is rapidly maturing.

Second, the analysis is also relevant to the context of this study, which is highly complex. In Australia, primary health care is the responsibility of Commonwealth, state/territory and local governments, and private providers. Given the findings of any study are limited by the boundary conditions, the findings may have limited application to other settings. That said, the same complexities also apply to other human services in Australia and fragmentation is likely to occur in other jurisdictions.

Third, the analysis is also relevant to the nature of the transaction. As described in Chapter 6, primary health care is a complex activity — difficult to specify and measure, with outcomes difficult to attribute to one intervention alone. Primary health care is a subset of human services and many types of human services hold similar traits. In some cases, the only difference between the services provided in the case setting and services provided in other settings is the funder of the program.

Fourth, participation by the DoH in this study was limited to document analysis and correspondence with DoH. The Department opted to answer queries and questions in writing rather than participate in an interview — the way DoH participated in the study was consistent with the way they managed the PHN Program. Each communication took more than a month to resolve, something that should be borne in mind when designing future studies.

Finally, the analysis also reflects the data available to me as a researcher. The CasePHN was generous with their time and provided me with access to documents through a gate keeper. DoH was less engaged in the study and I largely relied on public information, supplemented by queries and written questions that were resolved over time.

My findings are bound to the time, context, activity and stakeholders involved. While there may be many similar settings, the transfer or comparison of the findings to other settings should be mindful of the boundary conditions of this study.

10.5.3 Theoretical limitations

TCE is often used in inter-organisational management control studies to examine the decision to organise an activity beyond the organisation's boundary, how to organise it, and how to manage residual transaction costs given no contract can be complete. TCE provides a useful framework to understand and organise observations, to identify characteristics of the transaction, but does not identify costs associated with those characteristics or how to manage them.

In this study I use TCE to develop a conceptual framing that helped guide data collection (Eisenhardt, 1989). This allowed me to understand how TCE theory applies in this setting and make refinements as necessary, allowing me to make a potential incremental contribution to substantial theories in an area that has been previously under-explored in the literature (Eisenhardt, 1989; Kuhn, 1970). The use of TCE as the theoretical lens affects what I as a researcher see and the relevance of what I see in the analysis (Tolbert & Hall, 2010). TCE theory allowed me to 'illuminate' the phenomenon of interest and in doing so develop the theoretical construct within the theory (Keating, 1995, p. 70). Given the limited number of studies in the inter-organisational management control literature dealing with outsourcing of human services, I drew from a number of other literatures to help frame this study and interpret the findings, including public administration and management, economics and organisational science.

There also limitations to TCE depending on how it is used. First, one criticism of TCE theory is that contextual effects are not explicitly identified. Williamson distinguishes between parties to the transaction and characteristics of the transaction, but fails to differentiate between

characteristics of the transaction and the context (or social context) in which the transaction occurs — a point of difference that is addressed in the management control literature and is also addressed in this thesis (Balakrishnan et al., 2010; Berry, Broadbent, & Otley, 1995a; Caglio & Ditillo, 2008, 2020; Cristofoli et al., 2010; Håkansson & Lind, 2004; Johansson & Siverbo, 2011; Johansson et al., 2016; Langfield-Smith & Smith, 2003; Sartorius & Kirsten, 2005; Speklé, 2001; van der Meer-Kooistra & Vosselman, 2000; Vosselman, 2002). I would argue contextual effects are incorporated into many of the transaction characteristics — specifically uncertainty (disturbances) and probity (which I identify is associated with both the transaction and the context/parties). However, scholars using TCE must be cognisant of contextual factors and purposely identify and include them as I have done here.

Second, TCE is often used to identify the transaction costs to the buyer. Yet TCE theory can, as in this study, highlight transaction costs related to both parties; in particular, the impact of control choices on other parties to the transaction and how other parties may respond (in this case, by managing up). This highlights the importance of understanding inter-organisational arrangements from the perspectives of both parties to the transaction (Caglio & Ditillo, 2008; Dekker, 2016). Further, TCE is often used as a deficit model to identify hazards/costs that need to be controlled. However, TCE can also be used to identify ways to enable cooperation and to avoid or mitigate costs.

Third, some may question the application of TCE to public sector settings given public sectors are not driven by profit. TCE is more broadly interested in efficiency rather than profit and, as Williamson (1999) recognises, is as relevant to public sector organisations and the outsourcing of human services as it is to the outsourcing of manufacturing component parts or accounting services. Both look to the market to deliver services — both may do so for both economic and strategic reasons. TCE is as relevant to PSOs as other organisations; the application of TCE to public sector settings may enable scholars to develop TCE further given the added hazards arising in public sector transactions due to probity (Williamson, 1999).

Finally, TCE may be applied to the decision to outsource, governance choices and ongoing management. This study focuses on how an activity is organised and controlled once the decision to outsource has been made. The decision to outsource primary health services has been incremental over time and this most recent incarnation builds on Medicare Locals and Divisions before this. Therefore, the decision to establish the PHN Program was not a decision of make or buy, rather a change to how services were currently organised.

10.6 Future research

This study is exploratory in nature and therefore opens up many prospects for further research. There are obvious opportunities to increase confidence in the validity of the findings and their

explanatory power through replication (Eisenhardt, 1989). The CasePHN is one of 31 organisations delivering the PHN Program; each PHN varies in terms of legacy (new or existing organisation) and type of organisation (university, NGO, local government and LHN/LHD peak bodies; UNSW et al., 2018, p. 12). Examining how the intermediary model works where the PHN has different organisational characteristics would test whether the tension between low contractibility and probity can also be resolved in different organisational settings (Caglio & Ditillo, 2020; Marques, Ribeiro, & Scapens, 2011). It is also important to consider whether this intermediary model is tolerant to further reductions in operational overheads.

Each contribution from this thesis should be further explored by becoming the focus of future inquiries in their own right. Probity requires further attention, both in terms of how it manifests and how probity is satisfied — particularly given it is likely to have significant explanatory power for control choices in public sector settings. Scholars may wish to consider whether financial and social probity manifest in the same way in internal and external arrangements; and whether probity is limited to financial and social probity (internally or externally) or whether there are other dimensions. Probity must also be considered in other organisational settings, including non-profit and for-profit organisations, to understand the extent to which probity manifests and how it is satisfied.

The intermediary 'triadic-by-design' model described in this thesis is interesting from a management control perspective; unlike other triadic models discussed in the economics literature, the triadic-by-design model was a pre-emptive choice made by the buyer. PSOs have been long grappling with how to organise and control complex outsourcing arrangements, making many mistakes along the way; it is important to compare the characteristics of this intermediary model with alternatives to understand the antecedents for their use — in effect developing archetypes of organisation that are precursors to archetypes of control. Factors to consider may also include the scale and diversity of services managed, and the level of control required to satisfy financial and social probity requirements. Given governments seek to improve both the effectiveness and efficiency of services, consideration must also be given to the cost effectiveness of different models and how to resource them to ensure they function as intended.

PSOs are still largely overlooked by management accounting scholars. Given their social and economic significance, PSO operations — both internal and external — warrant further attention. TCE is often used in other empirical settings to identify transaction characteristics; greater application of TCE theory in its entirety to public sector, private and non-profit organisations would allow for greater comparison between organisational settings and identify the similarities and differences between them. Adding to the conceptual specification of probity should allow scholars to do this.

10.7 Concluding remarks

Human services are economically and socially important, critical to the wellbeing of the most vulnerable people in our community, yet difficult to specify, deliver and manage. The provision of safe, effective and efficient services, getting the best outcome from limited resources, is no easy task. The public sector recognises it is not always best placed to provide services directly and is increasingly outsourcing the provision of services to third-parties; further, PSOs recognise their governance requirements when outsourcing are not ideal. As demonstrated in this thesis, PSOs need to be and can be creative in how they manage low contractible outsourced human services in an environment where probity requirements dominate.

The motivations for conducting this study were driven by observations from evaluating human services in Australia; I started to notice the way services were being contracted was impacting on service outcomes, yet this was rarely in scope of evaluations. Unconstrained by the terms of reference set by funders, I have had the luxury through the PhD candidature of being able to explore the transaction characteristics of human services and, using a strengths-based approach, have gained insights into how human services can be organised and controlled. In addition to the theoretical contributions to the inter-organisational management control literature, I hope to use the study described in this thesis to highlight why the way services are organised and controlled matters. Importantly, it is not sufficient to take a one-size fits all approach to satisfy probity when outsourcing — particularly when this approach is largely focused on financial probity; PSOs must also ensure social probity requirements are satisfied. Outsourcing does not absolve government of responsibility for the safe and effective delivery of human services.

The next step is to encourage PSOs to consider how they organise and control the outsourcing of human services — from providing more time to respond to requests for tenders, to making better ‘noises’ about or increasing the duration of programs or timeliness of contract renewals, through to using different models of outsourcing such as this triadic-by-design approach — and see what impact this has on services and outcomes. How human services outsourcing is organised has the potential to affect the very fabric and functioning of our society. Improving the organisation of services could lead to greater efficiencies and better outcomes for individuals and society as a whole. Improving the organisation and control of outsourced human services will contribute to the safe, high quality, equitable and efficient provision of services to those who need them. Importantly, improving the organisation of and control of services may help avoid short and long-term harm, and fatalities, experienced by too many individuals who have either not been able to access services, or who have received poor or inadequate services over their life-course. Given the social importance of this topic I would encourage other scholars to join me in progressing this research area further.

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Appendix A Interview discussion guide

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

What is your role in the organisation and how long have you been in that role?

What is the governance structure of the [organisation/CasePHN]?

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

What is the commissioning [procurement] process?

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

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

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

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

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

Appendix B Coding frame

Table 19 Coding frame

First wave	Second wave	Third wave	Fourth wave
DoH–CasePHN	About the program	Definition of primary health care	
		Primary health care in Australia	
		Introduction of program	
		Governance of program	Oversight by DoH Oversight by others
		CasePHN and operating context	
	Requirements	Governance	
		Operational	
		Other requirements related to commissioning	
		Legal agreement	Standard funding agreement Core funding schedule Activity funding Incentives
		Program documentation	
		Market engagement	
	Contact and contract phase	Approaching market	
		Selecting supplier	
		Negotiating award	
		Executing contract	
	Contract management	Implementing the contract	
		Managing the contract	Record keeping, performance tracking Monitoring progress Contract variation Improving performance
		Reviewing/renewing the contract	
		Other aspects of contract management	
	Program review process	Individual contracts	
		Comparison with other PHNs	
		Program review and evaluation	
		Other forms of review	
CasePHN–Provider	Organisation	History of the CasePHN	
		Governance	Board Clinical Council Community Council Advisory Groups Other groups or networks

First wave	Second wave	Third wave	Fourth wave
		Operating framework	Strategic Plan Mental Health Regional Plan Clinical Governance Commissioning Framework Evaluation Framework Annual reports
		Operations	Structure Funding Policies, procedures, systems Staff capability Staff turnover Culture Stakeholder relationships Responses to local, national and international emergencies
		Three case studies	Case study 1 (pop health) Case study 2 (AOD) Case study 3 (mental health)
		Operational challenges	
	Identifying primary health care needs in the region	Needs assessment	
		Activity work plan	
		Exceptions	
		Co-commissioning	
	Contact and contract phase	Planning what services will be procured and how	Analysing business need and specifying requirements Market engagement Procurement strategy
		Approaching the market	
		Selecting the supplier	
		Negotiating the award	Negotiating KPIs Establishing targets Funding parameters Reporting requirements
		Executing the contract	
		Exceptions	
	Contract management	Implementing the contract	Allocation of resources Transition and integration
		Managing the contract	Record keeping Performance tracking Monitoring progress Contract Variation Improving performance (continuous improvement, performance management)
		Reviewing and closing/renewing the contract	Are services complete Assessment

First wave	Second wave	Third wave	Fourth wave
			Renewal
			Variation
			Transition
		Decommissioning	
		Other aspects of contract management	Content knowledge
			Oversight by other parties
			Incentives
			Competition
			Risk management
			Building good relationships
			Other activities supporting contract management
		Exceptions	
	Review process	Review individual contracts	
		Review programs of funding	
		Review internal processes	Review planning process
			Review contract management processes and systems
			Review how contracts are managed
			Continuing professional development

Appendix C Document analysis

Table 20 PHN Program documentation (DoH)

Date	Full name of document*	Abbreviation where cited	Author	Notes
Nov-14	PHN Grant Program Guidelines (V1)		DoH	1
Dec-15	PHN Needs Assessment Guide	*PHN Needs Assessment*	DoH	2
Feb-16	PHN Grant Program Guidelines (V2)	*PHN Guidelines*	DoH	
Feb-16	Drug and Alcohol Treatment Services PHN Circular 1	*PHN Circular 1*	DoH	
Mar-16	PHN Literature and Evidence Review	*PHN Literature Review*	PWC/KingsFund/ UoM	
Mar-16	PHN Performance Framework (v1)		DoH	
Jun-16	PHN Planning in a Commissioning Environment – Guide & Resources	*PHN Commissioning*	DoH/PWC	3,4
Jun-16	PHN Designing & Contracting Services Guidance	*PHN Contracting*	DoH/PWC	3
Jul-18	PHN Change Management & Commissioning Competencies Guidance		DoH/PWC	5
Jul-18	PHN Market Making & Development Guidance	*PHN MarketDev*	DoH/PWC	5
Jul-18	PHN Evaluation Report	*PHN Evaluation*	EY/UNSW/Monash	
Sep-18	PHN Program Performance & Quality Framework (v2)	*PHN Framework*	DoH	
Sep-18	Reform and System Transformation: A Five-Year Horizon for PHNs	*PHN 5-year MH Horizon*	PHN Panel	6
2018	PHN Provider Info Sheets (various)	*PHN Info-*	DoH/PWC	5
2018	PHN Provider Info Sheet - Commissioning overview	*PHN Info-Commissioning*	DoH/PWC	5
nd	PHN FAQ	*PHN FAQ*	DoH	
Jan-19	PHN Complaints Policy	*PHN Complaints*	DoH	
Jan-19	PHN Conflicts and Related Party Policy	*PHN CoI*	DoH	
2020	PHN Performance Report 2018–2019	*PHN Performance*	DoH	

Notes:

* Documents available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home (accessed 8 January 2021)

1 Developed in consultation with Medicare Locals, state and territory governments and other stakeholders

2 Acknowledges input from PHNs in development

3 Informed by literature review

4 Acknowledges input from PHN Commissioning Working Group

5 Co-designed with PHNs through the PHN Commissioning Working Group and relevant sub-group

6 PHN Advisory Panel on Mental Health, with EY, DoH and other partners

Table 21 CasePHN documentation

Full title of document reviewed	Abbreviation where cited
Strategic documents	
CasePHN Constitution	*Constitution*
Strategic Plan 2019–2021	*Strategic Plan*
Annual Report 2019–2020	*Annual Report*
Clinical Governance Framework	*Clinical Framework*
Commissioning Framework 2019–2022 (PwC)	*Commissioning Framework*
Evaluation Framework	*Evaluation Framework*
Mental Health and Suicide Prevention Regional Plan 2019–2022	*Regional MH Plan*
Key deliverables	
Needs Assessments: March 2016; Nov 2016; specific locations (Integrated Team Care, Mental Health, Suicide Prevention, AOD) Aug 2016; AOD Dec 2017; Mental Health and Suicide Prevention Dec 2017; Dec 2017; Dec 2018; Dec 2019.	*Needs Assessment*
Activity Work Plans: After Hours, 2019–2021; Core Funding, 2019–2022; AOD 2019–2022; National Psychosocial Support, 2019–2021; Primary Mental Health Care, 2019–2022.	*Activity Work Plan*
Policies, processes, templates for procurement	
Code of Conduct	
Project planning template	
Procurement and contracting policy	
Procurement and contract manual	*Procurement Manual*
Professional Services Agreement (and guidelines for use)	
Master Services Agreement (and guidelines for use)	*MSA*
Procedure for dispute resolution A&R approved	
Conflict of interest policy	*CoI Policy*
Conflict of interest procedure	*CoI Procedure*
Conflict of interest declaration	*CoI Declaration*
Delegations policy	
Risk management policy	*Risk Policy*
Risk management procedure	
Financial reporting template	
Training material	
Training – Procurement	*Training: Procurement*
Training – Contract management	
Training for PHN Commissioners May 2019 (PwC)	*Training: Commissioners*
Training Program Logic Workshop 9 April 2019 (PwC)	*Training: Program logic*
Professional development training: Contracting for outcomes (PwC)	*Training: Contracting for outcomes*
CasePHN web pages, flyers and newsletters	

Full title of document reviewed	Abbreviation where cited
The Commissioning Cycle (accessed 16 October 2019)	
Drug and alcohol support (accessed 16 October 2019)	
AOD Community Services Guide, AOD eNews (May 2019, August 2019)	
Mental Health (accessed 16 October 2019)	
Mental Health and Suicide Prevention: service flyer; services (stepped-care)	
Monitoring and evaluation (accessed 16 October 2019)	
Procuring services (accessed 16 October 2019)	
Internal reports and other documents	
Board paper: HR Metrics (September 2019)	*Board Paper – HR Metrics*
Board paper: Underspend, committed & accruals (March 2019)	*Board Paper – Underspend*
Board Charter	*Board Charter*
Commissioned Services Summary Report (September 2019)	*Board Report – Commissioned Services*
Commissioning Pipeline report (October 2019)	*Pipeline Report*
Monthly Management Financial Report (October 2019)	*Monthly Management Financial Report*
AOD Advisory group Terms of Reference	*TOR AOD Advisory Group*
AOD Advisory group membership	
Procurement Hub minutes (18 November 2019)	*Hub Minutes*
Briefing Paper (19 August 2019): SACS Component AOD Schedule	*Briefing paper SACS component*
NSW ACT Mental Health Network, Stepped-Care Model and Principles	
NSW PHN Network Presentation on funding model	*Funding Model Presentation*