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Alliance Contracting: How to progress in a world of uncertainty

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Introduction

Australian governments spend billions of public dollars every year tackling ‘wicked problems’. It is likely most of that money is put to good use. Unfortunately, we cannot say for sure if every dollar is used well or if it could have been used better. Despite having led the world in social services contracting, Australian governments have learned far too little about what money achieves once it leaves the balance sheet. Despite decades of discussion about inputs, outputs and outcomes, we have a poor evidence base with which to analyse what works and what does not and what might be done better.

This is consistently the advice of the Productivity Commission, the Australian National Audit Office (ANAO), various auditors-general and independent reviewers of public performance. Productivity Commission Chairman, Gary Banks (2009), summed up a substantial part of the problem in his introduction to the commission’s report *Challenges of Evidence-Based Policy-Making*, noting that ‘social policy is notoriously difficult to design and evaluate’. Discussing the *Overcoming Indigenous Disadvantage Report*, he noted that

identifying things that work 'has proven challenging, to say the least; not necessarily because there are few things that are "working", but because in most cases the information available to substantiate their effects is lacking' (Banks 2009).

The problem of our poor evidence base extends far beyond the Indigenous policy realm. Banks (2009) gave the following examples of counterintuitive evidence based on Productivity Commission reviews:

- immigration and higher birth rates have little impact on the ageing population
- the presumption that road use is subsidised relative to rail is not borne out by the facts
- the objective of zero solid waste is not only costly, but also environmentally unsound
- bidding wars for investment and major events by state governments generally constitute not only a negative sum game nationally, but also often a zero sum game for the winning state
- tax concessions for research and development (R&D) do not encourage new research
- binary views as to whether child care is good or bad are both wrong
- reducing class sizes has little empirical support, while the importance of teacher performance and the link to pecuniary incentives are neglected although backed by strong evidence.

Why this occurs is of course a matter of debate, but Australian Public Service Commissioner, Lynelle Briggs, also writing in *Challenges of Evidence-Based Policy-Making*, provided a thoughtful view:

In the real world, policy is developed in a fluid environment, is subject to competing vested and political interests, and can be driven by pressure to act quickly to solve headline-grabbing problems. Ideally, we need systems that are informed by evidence at each stage of policy development, from when an issue is first identified, to the development of the most appropriate response, and subsequent evaluation of its effectiveness. (Banks 2009)

Governments often announce funding in the language of results rather than effort. This has the effect of politically banking gains that are yet to achieved—for example, a claim that \$x made available to a program will deliver specific results for every client in the program over the

project period. One never hears, for instance, an announcement that \$x will likely have an effect on half a given treatment cohort with effects lasting an average of six months before program effects begin to degrade. Even more rarely are these claims evidenced by reference to high-quality trials; more often their credentials are borrowed from their provider. To the extent that reputable charities are the program deliverers, there is some comfort that expertise and effort will be brought to bear. But having spent time on the bidding side in these situations, I am aware of how often genuine best-evidence practice is not within the budget of the contract being sought.

This makes it very difficult for providers, public servants and their political masters to let the results speak for themselves over time. Programs that perform poorly may be quietly defunded, but even if this is possible (which it often is not) results cannot inform future spending if they are not reported transparently due to fear of contradicting previous announcements about expected results. Reporting is also not likely to be frank if parties cannot openly say that failure to achieve results will lead to changes over the program period. Providers are given a do-or-die responsibility with little room to innovate over the life of the contract. The lack of control added to unreasonable expectations leaves many providers seeing evaluation as a sword of Damocles.

A similar position is advanced by Kerry Schott in her final report for the NSW Commission of Audit (2012), which advised the government that it had not placed sufficient emphasis on evaluating the programs it funds. ‘To the degree that program evaluations occur at present, they are incorrectly viewed as a potential threat to the continuance of programs and funding’ (NSW Commission of Audit 2012). The report advised that evaluation was hampered by:

- a lack of performance information, cost, goals and objectives, linkages and program history
- evaluations being done by the agency and people involved in running the program
- insufficient resources being devoted to program evaluations
- the results of program evaluations being undermined by vested and sectoral interests that inevitably develop in support of programs.

All of these factors conspire against the development of an evidence base. This means that each time an additional dollar is made available to solve a given problem, we know less than we should about how to spend it.

With public sector reform increasingly focused on commissioning and other forms of active purchasing, this lack of an evidence base means there is too little to purchase 'off the shelf'. As policymakers shift to a preference for integrated social services, there is a growing requirement to identify multidimensional models of care and new kinds of contracts with which to purchase them. Given the need to innovate, these contracting models will need to support co-design through experimentation, review and adaptation. In the United Kingdom (ACEVO 2015) and New Zealand (New Zealand Treasury 2014), one model being used to develop new social service products is alliance contracting.

How can alliances solve the evidence deficit?

The social sector cannot easily provide better programs than they currently do because too often the cost per client they are allocated through government tenders is insufficient to apply best practice. It is almost always insufficient to undertake evaluation, review and reflection either during or after program delivery. The current approach of sporadically reviewing results post hoc means that funders do not know until all of the money is spent whether the money was spent well. More importantly, clients who underwent the program cannot benefit from insights delivered after the program has ended.

The private sector can scale up and deploy models with a strong evidence base under social benefit bonds (SBBs) or similar reward-based payments where they assume a delivery risk. The private sector is unlikely to take on the additional risk of product R&D without an obvious pipeline of profitable work to be won at a scale sufficient to pay back their investment. This may change, but probably not soon. If the private sector was capable and incentivised to develop effective intervention methodologies, there would be important questions as to intellectual property rights. While there are legitimate foreseeable arguments that creating property rights could spur innovation in the field, the prudent path, at least in the short term, favours creating

a public domain evidence base with open-source policy prescriptions. In the testing phase, the high transaction costs, including lawyers and financial advisers, associated with SBB-style products are unlikely to represent good value for small experimental projects with a high risk profile.

Academics and consultants have a role to play but they are essentially evaluation service providers who are not in a position to change the total number of opportunities to perform evaluations. They are also disconnected from the service delivery, which means their insights are unlikely to support methodological improvement over the life of the project.

Traditional contracting cannot deliver this outcome because the product and therefore the price may need to change over time as results inform adaptations. Contracting specifications often have the perverse outcome of reducing service quality by acting as a barrier to innovation. When governments spend large sums quickly under input or even output-based contracts they are sentencing future service users and providers to nothing better than the best thinking available when the contract was signed. It would be better for payers and providers to be frank about the limits of current evidence and agree to contracts that allow them to work in collaboration to test, refine and redeploy continuously improving service methodologies.

What is needed is an approach to spending money on social programs that procures R&D in a scientific manner that can be shared as public domain knowledge to improve social policy through better evidence. Contracting must balance effort and reward, but, more importantly, must support an agile approach to program deployment based on open collaboration between purchaser, provider and client.

Happily, such a model has been used in the infrastructure sector for many years and is being adapted for use in the social sector. Alliance contracting is an arrangement in which parties work cooperatively, sharing risk and reward. The payer and the provider work as a single governance team to deliver the results the purchaser wants and which merit the provider being paid an agreed rate of return.

How do alliances differ from standard contracts?

Fundamentally, alliances are built to resolve uncertainty. They are a model designed for situations where neither the payer nor the provider can be sure what problems they will have to address to reach their goal. What they do know are the skills required, what kind of experience will help and what a fair rate of return should be if the private partner does a good job.

The Commonwealth Department of Infrastructure and Regional Development's *National Alliance Contracting Guidelines: Policy Principles* sets out the following rules for alliance contracts:

- The project has risks that cannot be adequately defined or measured in the business case or prior to tendering.
- The cost of transferring project risks to the contractor is prohibitive.
- The project needs to start as early as possible before the risks can be fully identified and/or project scope can be finalised, and the project client (as well as the project investor) is prepared to take the commercial risk of a sub-optimal price outcome.
- The client has superior knowledge, skills, preference and capacity to influence or participate in the development and delivery of the project, including for example, in the development of the design solution and construction method.
- Where taking a collective approach to assessing and managing project risks will produce, in special and rare circumstances, a better outcome than contracted allocation risk. (DIRD 2015)

The social policy sector has many challenges that meet the above criteria of requiring immediate action to be taken in an area where the risks cannot be fully identified and where people outside government have superior knowledge, skills and capacity. There are always too many clients who need immediate help to allow services to stop delivery while we define more perfect treatments. Purchasers cannot wait for perfect models to be available for purchase off the shelf. A collaborative contract is needed to learn while doing and share the risks associated with innovation.

There are currently too many knowledge gaps to write effective contracts for many kinds of social service provision. While an increasing number of analysts and advocates are excellent at benefit analysis, costs present a far trickier problem. This is because while we have a good understanding of the impacts of disadvantage, exclusion and other ills on clients and the community, we have less clarity about the costs of effective solutions. This is usually because we do not know enough about the therapeutic models that work effectively.

For instance, we may know that a homeless person needs case management, housing services, health care and a brokerage budget; we cannot say as easily how many hours of which practitioner's time are required in what balance between the various services.

We may know that a homeless teenager needs housing, physiotherapy, health services and re-engagement with school and family; we do not know how many hours of caseworker time are needed, what qualifications the caseworker needs to be most effective and therefore their hourly rate, which of the school re-entry programs represents value for money within our teen's case management budget or how many hours a week of visits to their emergency housing are required.

This may sound too hard to fix but some programs do go into this level of detail. Defined methodologies such as 'multidimensional treatment foster care' are specific about the level of training for staff, the composition of multispecialty teams, the duration of treatment and other elements. There is a range of treatment methodologies that have rigorously defined delivery systems and which are licensed by their developers to ensure fidelity to their treatment model. Interestingly, a common feature of such refined treatments is that they are substantially more expensive than more commonly contracted services.

What government gets in return for the extra cash is a greater certainty of likely success rates. The Washington State Institute for Public Policy's cost-benefit comparator tables suggest that these defined methods regularly outperform generic service contracts (WSIPP 2015).

Without knowing which unit cost achieves which likely success rate, the purchaser cannot enter into a contract with genuine confidence. Thinking about this from a market design point of view, we can see that for some services there is not enough information in the marketplace to allow best-value contracts to be struck.

One way of thinking about this is to start with the different types of problem definition, which fall broadly into three groups.

1. **Preventing future expense:** For example, integrated health management for sufferers of chronic illness prevents avoidable hospital admissions. Effective family therapy prevents foster care costs. Housing for the homeless can avoid substantial justice system and health costs. There is information available about direct costs to public agencies such as health and justice, as well as plenty of good estimates by the Productivity Commission, among others, regarding lifetime costs of income losses, welfare transfers, tax losses and gross domestic product (GDP) losses due to lower participation and productivity.
2. **Preventing unconscionable harms:** In some cases, solving a problem is not cost effective but we have a moral duty to do it anyway. For example, prison is in some cases a relatively less expensive 'service' cost for some people with chronic comorbidity and disadvantage challenges compared with the cost of social housing, mental health services, drug treatment, employment assistance and casework, that might be required to successfully re-engage the person with the community. Nonetheless, most people would agree that society cannot simply imprison the mentally ill and chronic reoffenders for fiscal reasons. We act in this case to reduce social harm.
3. **Preventing social exclusion:** There is a range of programs addressing challenges at the less acute end of the spectrum for which a clear cost-benefit case cannot easily be made, but which we nonetheless seek to deliver at good value to the taxpayer. These may include sports, arts and community grants that are generally desired by the population as contributors to social cohesion. The case for funding a free public opening night party for the Sydney Festival is not likely to stack up fiscally or economically, but it certainly makes a lot of people happy and adds to a sense of community and social well-being for those who attend. There are some economic benefits ascribed to arts events associated with tourism and recreational spending, but the returns on this 'investment' are not generally to taxpayers. It may never be possible to accurately assess the costs of social and cultural exclusion, but society has a strong moral view that a community should encourage social and cultural integration and exchange.

In each case, we have to determine a good-value price for the ‘treatment’ based on a slightly different approach to our analysis.

- **Treatments to prevent expense** can be assessed with traditional cost–benefit analysis (CBA). The ‘treatment’ should ideally work for a large enough number of the treated group and the ‘cure’ should persist long enough to cover the period in which costs would have been incurred. If this happens, any price less than the prevented expense represents value for money. Transaction costs come in to play but can be incorporated into the efficient price.
- **Treatments to prevent harm**, such as prisoner rehabilitation programs, can also be assessed using CBA, to compare relative value *with each other* rather than to determine a net positive CBA. It bears repeating that a positive or negative CBA should not determine whether something is funded. It merely serves to inform choices about which approach will deliver better value. Much effort can be wasted pursuing strategies to get to the magic number greater than one when all we really need to know is the relative performance of different programs solving a similar problem.
- **Treatments to prevent exclusion** have increasingly been the subject of efforts to design value assessment tools. There are plenty but they are largely sets of qualitative measures. Similar to the above argument about net value, too much time is spent trying to value expenditure on things such as art to reach a magic number that unlocks formal economic permission to proceed. It would be simpler to focus on getting a good unit price for whatever activities are desired.

The right contract model for a program depends on which kind of prevention we are doing and what kind of treatment is involved.

The kinds of treatment fall roughly into three groups.

1. **Treatments:** These are the most robust methods with clear program logic and defined delivery methodologies. Examples include functional family therapy, drug courts and parent–child interaction therapy. Treatments:
 - can be compared with a control
 - outputs and outcomes are predictable
 - unit costs are clear
 - can be purchased competitively
 - can be funded on pay by results
 - can be funded through social bonds.

2. **Services:** These include community food services, job placement, respite care, social and community housing, arts and sports services. The advantage of assessing services is that unit costs such as wages, capital, administration overheads and brokerage fees are relatively constant and transparent.
3. **Approaches:** These are evidence-based professional practices such as case management and mediation, which can be purchased but with less certainty about the 'dosage' strength and duration required to gain a desired result. However:
 - results cannot be predicted with certainty
 - scalability is unknown
 - replicability in new jurisdictions is unknown
 - metrics are often qualitative
 - efficient price is not known
 - effective price could be higher than funded.

Many of our social services are more like approaches than treatments. That is often not the fault of the providers. As discussed above, purchasers are not going to market with opportunities that allow for the use, testing or development of these more intensive service models. In the case of approaches, purchasers have a strong interest in helping the provider perfect their method and better understand their costs. An alliance model allows the parties to operationalise evidence-based approaches within a shared risk framework to test and refine therapeutic interventions. Once refined, both will better understand and predict likely outcomes and reasonable prices.

How it might work

The alliance model entails three phases of activity, described below:

Hypothesis testing phase

- Consult on proposed method with payer, provider, clients and stakeholders.
- Roll out as agreed.
- Monitor inputs, outputs, outcomes and impacts.
- Review and refine treatment method as often as required to meet client needs within budget.
- Assess whether current budget envelopes are reasonable.

Definition phase

- Document the cohort, their needs and reasonable service commitments.
- Agree on unit costs and measurement approach.
- Document the treatment methodology.
- Revise contracts to reflect revised costs and outcomes.

Performance management phase

- Service provider managed for results by funder.
- Robustness-tested regarding unit costs, results and reporting.
- Value-for-money testing becomes possible.
- Pay for results becomes possible.
- Reports and evaluations can be shared to add to the stock of evidence.

Importantly in this context, changes made due to initial approaches falling short of expectations can be shared without putting the parties into an adversarial contract-remedy scenario. The adversarial nature of standard contracting undermines honesty between the parties and with the wider community of practice. In a project where both parties are learning and will make mistakes, it is vital that a positive attitude to change is a shared legal responsibility.

How it has worked: The Sea Cliff Bridge

The beautiful Sea Cliff Bridge connects Coalcliff and Clifton, just north of Wollongong in New South Wales. It replaced an old road that ran along the cliff and was increasingly subject to rockfall. The road replacement was urgent and the task complex. Instead of competitively tendering, the Roads and Traffic Authority entered into an alliance with multiple partners including Laing O'Rourke.

The geography is challenging: there are five distinct geotechnical domains along the cliff line. The area was subject to multiple environmental, community and Indigenous heritage complexities. Twenty-six different options were considered with the final construction requiring two bridges: the first composed of five spans requiring four piers and a second multiple-span bridge built on

a continuous curve to bypass the middle headland. The bridge contains an electric current to prevent sea spray deterioration. The bridge was completed for \$52 million instead of the forecast \$48 million but was delivered on time, giving the community back their connections with the least possible disruptions.

All parties praised the alliance model as contributing to the pace and professionalism but also the ingenuity of the project, which delivered innovations in health and safety, project management, community engagement and technical and construction challenges. The project won a slew of awards, including the 2006 Austroads Bridge Conference Award for large structures, the 2006 Case Earth Awards NSW, the International Quality & Productivity Centre (IQPC) Alliance Contracting Excellence (ACE) Awards and the 2006 Engineers Australia Engineering Sydney Division Award.

The project was complex, involved multiple constraints and stakeholders and was time critical and highly politically sensitive because the original road was closed in the lead-up to an election in a marginal seat. The alliance model gave the parties a contractual structure to be innovative, collaborative and responsive to the community. These features are common in social services and the alliance model can bring similar benefits to addressing them.

Certainly some alliances fail to deliver on expectations. The Commonwealth Department of Defence received poor assessments, including from its own minister, regarding the performance of its Air Warfare Destroyer alliance with Raytheon. Notwithstanding this persistently cited example of failure, the total value of alliance projects in the road, rail and water sectors in Australia from 2004 to 2009 was \$32 billion (Department of Treasury and Finance 2009), which suggests many infrastructure purchasers are happier than the Defence Department with the model.

It is worth noting in this context that a joint guidance paper authored by representatives of the treasury departments of Western Australia, Queensland, New South Wales, Victoria and the federal government suggests there are pitfalls to be avoided in alliances including the temptation to cede thought leadership to the non-governmental partner (Department of Treasury and Finance 2014). A previous study, by Melbourne University and Evans and Peck and commissioned by

the Victorian Treasury, found that 'there is a possible imbalance in the value proposition for alliancing' (Department of Treasury and Finance 2009: 9). While the model is theoretically sound, active management for value on the part of government is clearly required.

This is arguably a further benefit of the model. While competitive tendering allows government to notionally pass its responsibility to a third party, alliances require ongoing engagement and assertive pursuit of value and results by the government payer.

Maintaining the benefits of competition under alliance contracting

A common concern with alliance contracts is that they provide less certainty about funding requirements. Alliances arguably destroy the key advantage of contracts: risk transfer. Because the contracts are signed before unit costs are understood, it is difficult for finance departments to budget with certainty. However, the certainty of expenditure under any contract that is poorly understood can only be an illusion. If government contracts service X to provide Y clients with employment support at \$Z per client, but it really costs Z+\$10, the program will simply underperform.

This is arguably what happens much of the time. Having consulted for the non-governmental organisation (NGO) sector, this author is aware of many large NGOs that bid to win despite knowing the per capita costs are insufficient to undertake best-practice work. Their position is understandable; the work is only available at the inadequate price so they do the best they can. However, no one benefits from maintaining the illusion that inadequate funds can achieve an agreed outcome with certainty. In these cases, the public purchaser is buying activity and best efforts but is not really transferring risk because, ultimately, if the social problem persists, government will remain the party responsible for trying once again to fix it.

Having said that, it is important to maintain where possible the healthy disciplines associated with competitive tendering. This can be achieved within an alliance framework. Tendering can be used for determining alliance partners, and contract review rights can be used to determine whether to proceed after milestones such

as determination of unit costs. Staying within budget is possible if non-price variables are well understood and not ruled out too early as factors that can change. In particular, the number of clients who can be assisted should not be fixed before unit costs, effect sizes and persistence rates are understood. If the number of clients to be assisted must remain fixed then the nature of the service has to be open to change. Differential treatment intensity is already effectively a feature of current contracts management as resources are balanced across a cohort rather than equally divided.

The need for such learning systems is growing

The need for contracting models that support innovation and risk sharing will likely grow. The Commonwealth Government's primary health reforms are focused on integrated care services, which Australia's health market does not currently offer at scale. In mental health, it is increasingly clear that integrated housing, employment, health and social services will need to be developed. Government will need to collaborate with providers to get these new services for clients.

The transition from volume-based contracting to value-based contracting and commissioning will require adaptive models that allow all parties to innovate services. If government is to develop 'choice-based markets', as recommended by the National Commission of Audit (NCOA 2014), or social purpose capital markets and social enterprises, as recommended by the McClure report, *A New System for Better Employment and Social Outcomes* (DSS 2015), government will need to work with its partners to innovate current models of care contracting. The present system is too opaque for either customers or investors to drive change.

Alliances offer an opportunity to develop the new treatments we need in an open-book partnership that supports transparency and grows the knowledge base for policymakers and providers. Most importantly, alliance models provide a mechanism to build better services for clients with their active collaboration.

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This text is taken from *The Three Sector Solution: Delivering public policy in collaboration with not-for-profits and business*, edited by John Butcher and David Gilchrist, published 2016 by ANU Press, The Australian National University, Canberra, Australia.