Name: Sydney Policy Lab at the University of Sydney

Submission date: 5/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   Attribution: Sydney Policy Lab, The University of Sydney.

   1. Brendan McCormack, Academic Chair CARE program, Sydney Policy Lab
   2. Kate Harrison Brennan, Director, Sydney Policy Lab

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   All sectors; disability.; early childhood education and care; health; with a particular focus on aged care

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   To a great extent

2. What are the reasons for your answer?

   - Overly bureaucratic governance and regulatory systems.

   - Regulation systems not always focused on what is best for the consumer but are imbalanced towards system effectiveness and efficiency.

   - Over-emphasis on safety as an end-goal rather than safety that enables teams to make evidence-informed decisions about balancing safety with risk and innovation – ultimately how to provide a person-centred and person-responsive service.

   - Lack of community engagement in the design of regulatory systems – overly focused on professional regulation and assumed safety of the community and populations.

   - Measurement frameworks privilege ‘what can be measured’ and thus drives technocratic and technical aspects of care provision rather than the ‘more difficult to measure’ relational aspects of care.

   - Regulation and governance systems do not enforce person-centred approaches to care delivery, but instead reinforce the view that this is a ‘nice to have’ option. Consumers’ right to access person-centred care and services needs to be seen as a human right in the same way that other fundamental rights are enshrined in law. Until we

see movement on person-centredness as a core value of health systems and enshrined in law it will always be a 'project' by those committed to it and a 'nice to have' by policy makers.

- Whilst there is an emphasis on Aboriginal and Torres Strait Islander health (appropriately so) the multicultural diversity that is needed in health systems are not adequately addressed in regulatory mechanisms. Our work with various groups (such as Indian communities in Western Sydney) highlights the ways in which racism and cultural stereotyping are pervasive in health systems in NSW/Australia and as a consequence, diverse populations feel alienated and disenfranchised from the health services available.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   To a great extent

4. What are the reasons for your answer?

   Aged care facilities in particular are one of the most regulated services in all health and care systems. Whilst we use the rhetoric of 'home' as the philosophical basis of service provision, the regulatory system doesn't match this person-centred philosophy. Instead, we see regulation and accreditation systems in place that more align to acute (hospital) care provision. This undermines the potential of care workers to provide the kind of home-based service that can help older people to flourish and continue to live a meaningful life in an aged care system. This kind of thinking continues when we see the development of aged care at home services. Indeed, seeing these two services as different services also impacts on the perceptions of the role of residential aged care in society, i.e. not an integral and integrated part of community services, nor a part of community as a whole.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   The Sydney Policy Lab takes a community-led approach to embedding person-centred principles, values and practices in Australian public policy. Work undertaken across our portfolio over a number of years has direct implications for collaborative commissioning, particularly the principles required to have commissioning across the lifecycle, from identifying care needs through to designing solutions and the responsive procurement of services to operationalise those solutions and their evaluation.

2. What are the benefits of pursuing greater collaborative commissioning?

   Australia Cares, launched in 2022 out of dialogues with public policy experts, care recipients and practitioners, resulted in an ambitious project that builds on a deep desire for change in how we value care and recognise its intrinsic value to our lives and functioning of our society.

   Over 18 months, we brought together people from across Australia for online Care Labs and in-person for People's Assemblies in Broken Hill and Westmead. These two main strands of work have been supported by recorded stories of care, lived-experience research and relational economy research. They have resulted in policy development

suggestions that take account of the complexity of individual lives yet offer clear solutions across a range of areas, shaped by lived experience.

The first stage of the project formally concluded in early 2024 and has now grown into the CARE program. This two-year program provides a clear roadmap for collaborative commissioning by enshrining commissioning in a person-centred approach to care that:

- is holistic, binding together care, well-being and health, and therefore linked to other policy reform agendas

- listens to people throughout policymaking cycles

- builds a relational economy

- responds to community expectations

- is designed around the strengths and assets of specific cohorts and communities

- renews public institutions and invites partnerships

- spreads capital investment across the economy, especially to the forgotten parts.

Additionally, five years ago the Policy Lab explored commissioning models through a research project conducted in partnership with a range of community-based partners. This resulted in a set of fundamental principles for good commissioning to ensure people and communities are at the heart of human service design and delivery. (See attached report - All together: a new future for commissioning human services in New South Wales, 2020)

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

A range of barriers exist but should be seen as obstacles that can be overcome rather than blockers. These include:

- Cultural and operational shifts required in government agencies (ie way of working that centre relationships and build trust)

- Perception of communities not having the level of expertise or ability to identify workable solutions

- Lack of willingness or flexibility to experiment, including embracing risks and failures as learning opportunities

- Commissioning and procurement models that lead to unhelpful market fragmentation and competition

- Jargon-heavy or inaccessible language from government agencies

- Inflexible performance metrics that don’t allow for real-time evaluation and iteration as

needed

- Focus on narrow measures of productivity (eg based on inputs/outputs and direct economic outcomes) rather than broader direct and indirect relational economic and social benefits including those with longer time horizons and that serve to build social capital.

- Siloed nature of government portfolios and agencies, and tendency towards short termism.

- Lack of investment in R&D for new models of care (see attached report Supporting R&D in the Aged Care Sector, 2024)

Addressing each of these above will go a long way to more effective commissioning environment and better outcomes for people and communities.

Relatedly, principles identified by community members through the People's Assemblies on Care in Westmead and Broken Hill include:

1. Stop focusing on trying to fix broken systems

2. Reimagine care around specific cohorts and communities

3. Make care truly person centred

4. Ask people what they value and have reason to value in care, listen and find new solutions

5. Embrace community assets and social leadership

6. Resource and support small steps that create big changes

7. Invite partnerships around community-led initiatives.

We continue to turn this into action with our community partners through our CARE program of work.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

The participant did not respond to this question.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

The participant did not respond to this question.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

The participant did not respond to this question.

Cover sheet: Supporting document #1

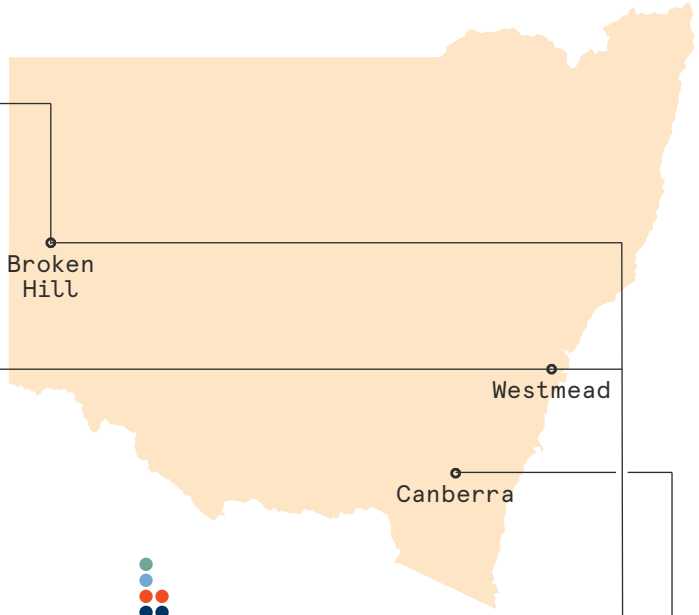
Australia Cares

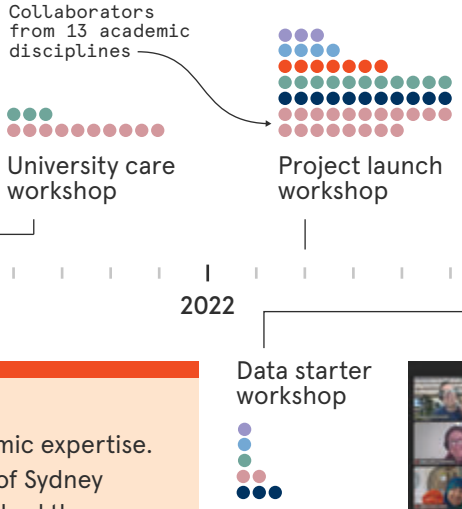
Sydney Policy Lab | The University of Sydney

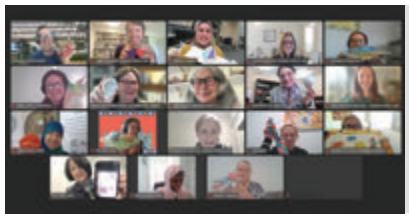
- **84** Community members
- **31** Policy & co-design experts
- **90** Academics
- **26** Government
- **37** Service providers
- **14** Philanthropy

People's Assemblies

Community deliberations in Broken Hill and Westmead where the University of Sydney has a presence. Assemblies set their own agenda and question for deliberation. At Westmead, the Assembly reconvened to develop policy solutions.







Care Labs

Online collaborative workshops with a diverse mix of participants to discern care principles and apply them in thematic policy areas.

About the project

Care is fundamental to who we are, as individuals and a society, but successive Royal Commissions have exposed long-running, systemic failures in policies related to care.

Finding solutions requires a new approach. Recognising diverse expertise makes for better policy, the Sydney Policy Lab's Australia Cares project was founded to enable community-led policy development shaped by lived experience, and community and academic expertise. Mark Scott, University of Sydney Vice-Chancellor, launched the project in April 2022 with support from the Paul Ramsay Foundation.

Over 18 months, the project has brought people from across Australia together for online Care Labs and People's Assemblies in Broken Hill and Westmead. These two main strands of work have been supported by recorded stories of care, lived-experience research and relational economy research.

> "Western societies have tended to put care on the bottom rung of what we value. We see that in the way caring roles are among the lowest paid. We need to challenge this way of thinking."

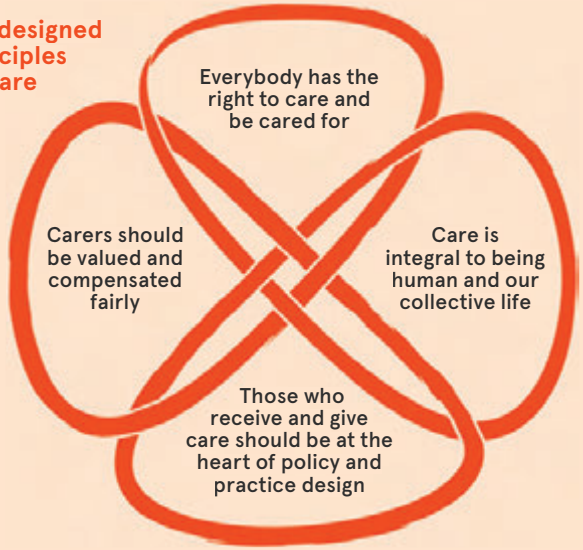
Professor Brendan McCormack

Dean, The Susan Wakil School of Nursing and Midwifery
Academic Chair, Australia Cares

Future publications →

- Stories of Care ethnographies
- Lived experience research
- Relational economy research
- Australia Cares major report

Co-designed Principles of Care



A cross-section of people collaborated in the Care Labs, including care givers and receivers, service providers and academics.

Their message was clear: We can do better.

Participants found Australia's current care system penalises and stigmatises people that are cared for and give care.

They felt care systems were often a burden that made these people invisible instead of helping them to flourish. Moreover, with the system focused on preserving itself, some people cannot find and afford quality care.

Together, participants co-designed four principles to address problems in the care system.

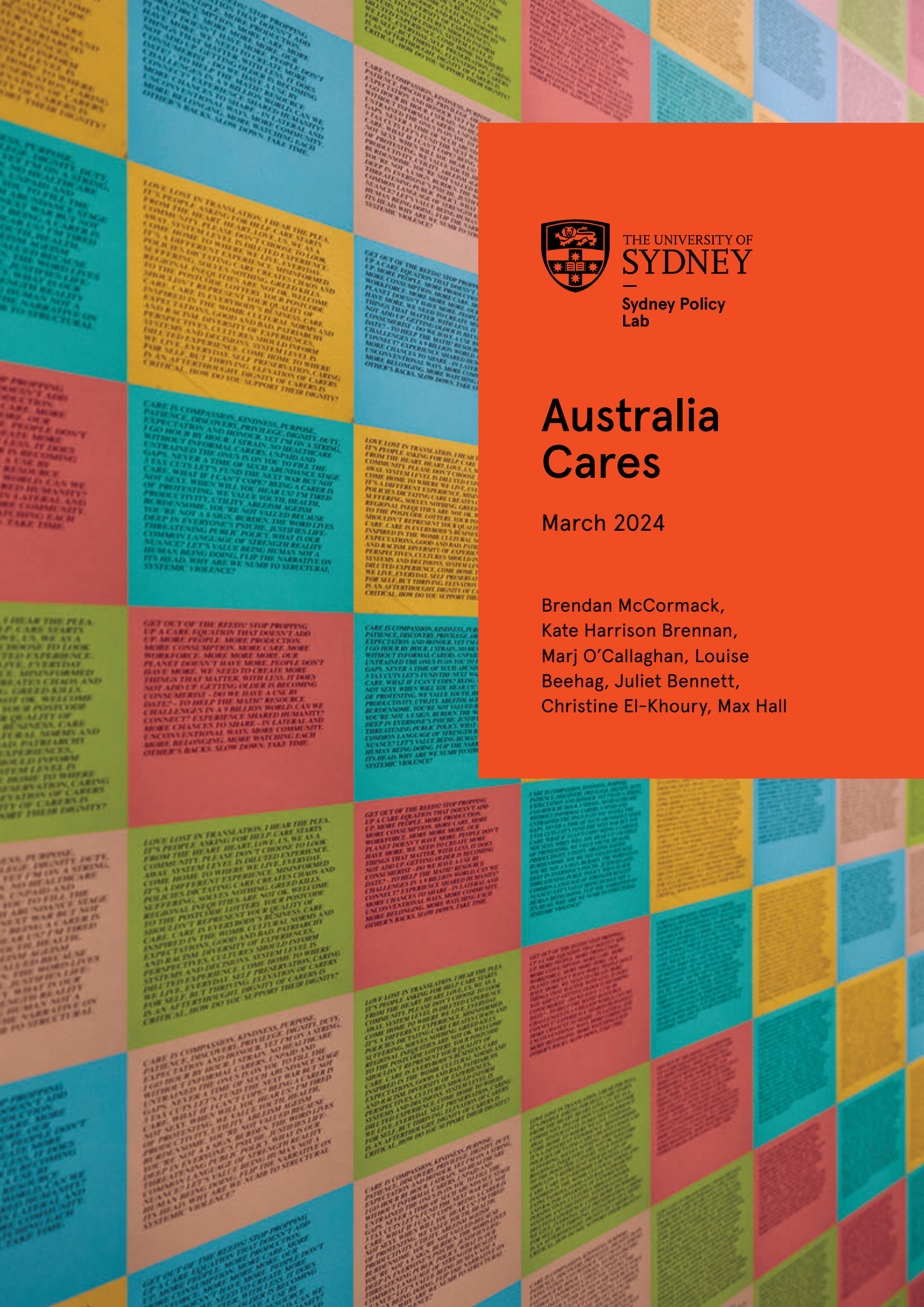
Findings from the People's Assemblies on Care

1. Stop focusing on trying to fix broken systems
2. Reimagine care around specific cohorts and communities
3. Make care truly person centred
4. Ask people what they value and have reason to value in care, listen and find new solutions
5. Embrace community assets and social leadership
6. Resource and support small steps that create big change
7. Invite partnerships around community-led initiatives

Policy Solutions
from the Westmead People's Assembly

	Problem	Solution
Universal health care for all in Australia, regardless of visa.	Access to urgent and emergency health care for those without Medicare is determined by the ability to pay for such care.	A humane approach to providing medical assistance and care that ensures a universal safety net for urgent and emergency care in Australia.
A new carer visa category.	Parent visas are not meeting the needs of community members. Families are waiting for visas that never come while experiencing acute care needs exacerbated by distance from loved ones with whom they share connections and culture.	A new carer visa with clear criteria to allow the holder to care for a family member in Australia who, for example, has a terminal illness or significant injuries, is pregnant or raising a young child.
Culturally-integrated services network to uplift and facilitate cultural and religious needs in care provision.	The cultural and religious needs of underserved populations are not well understood or engaged with by mainstream care services. This inhibits access to services and the spread of public health messages.	A network of care providers and volunteers to help facilitate specific community needs such as end-of-life care, funeral service support, local transport, pre- and post-natal care and health education.
One stop shop to assist with retirement and later life planning for care.	Ageing, for anyone, is like entering into another land. Ageing when you are a migrant compounds the sense of dislocation. Signposts are not available, so it's hard to plan for the journey.	Create a one stop shop to help the community understand what might be ahead as they age, the choices they can make and how they and their loved ones can plan well for the future.
Community health education program.	Carers of migrants who are migrants themselves often find it challenging to navigate care services efficiently and effectively. They miss out on support and services.	Provide better education and information for the community, with community and by community. Work with existing service providers to co-design education programs to improve care services and health carer literacy.
Families network forum for navigating and activating care.	Navigating and then accessing care is difficult. It's hard to know which information to trust and to find care relevant to needs. We know care services are available, but we're lost just trying to find them!	A digital resource through trusted public apps to help individuals and community navigate and access care relevant to them. Link the resource with various providers of care and the physical places people access care.

Cover sheet: Supporting document #2



THE UNIVERSITY OF SYDNEY

Sydney Policy Lab

Australia Cares

March 2024

Brendan McCormack, Kate Harrison Brennan, Marj O'Callaghan, Louise Beehag, Juliet Bennett, Christine El-Khoury, Max Hall

Cover image: Inflammatory Statements on Care by Australia Cares collaborators, inspired by Jenny Holzer's Inflammatory Essays.

Acknowledgment of Country

Ngyini ngalawangun mari budyari Gadinurada

We meet together on the very beautiful Gadi Country.

The Sydney Policy Lab acknowledges the generations upon generations of traditional custodians that have held responsibilities for Country, "custodian-ing" it from one generation to the next. We acknowledge the cultural protocols of protecting and holding knowledges that have sustained culture and Country for over 60,000 years.

Based in Sydney, we acknowledge the Gadigal Elders, past and present, and the beautiful Gadi Country where we work. We extend this acknowledgement to the Country, Elders and Ancestors of many other Aboriginal and Torres Strait Islander peoples across Australia. We honour and respect the sovereignty of the many Nations where we live and work.

We are committed to working respectfully and authentically with First Peoples across these beautiful lands, waters and skies.

Australia Cares

Appendices

Foreword

The COVID-19 pandemic highlighted the profound foundational role care and caring play in our society while exposing deep fissures in care policy that had developed over time.

Care services across all sectors experienced severe challenges to provide services that were person-centred. From early childhood education and care to disability care and aged care: the fact that most found ways to do so was remarkable, but there were often severe consequences for many involved. Alongside this, governments pulled policy levers that seemed unthinkable in the years prior.

With the acute phase of the pandemic behind us, we have the opportunity to learn from the way it tested Australian care policies and systems – in some cases breaking them, and in others showing new and better ways. We cannot miss the chance to embrace a holistic understanding of care and reimagine frameworks for how Australians wish to receive and provide care. This is the essential challenge taken on by the Sydney Policy Lab in the Australia Cares project.

Care is essential to much of our work at the University of Sydney. Students in our Faculty of Medicine and Health represent some 23 percent of the University's student population. They also account for one in five of the more than 66,000 students currently enrolled in 'Health' courses with NSW higher education providers – a generation who will provide care across the breadth of formal and informal settings. Our multidisciplinary research opens new possibilities for care in society. And when members of our academic community gather and connect with local communities across the state, they bring diverse strengths, needs, expertise and experiences in care.

What unites us is a desire to do work that has impact, creates social good and drives positive change. Convening with community in Broken Hill, Westmead and online, Australia Cares has brought together people with diverse expertise, including many of our scholars, colleagues at other universities and collaborators in civil society and government.

This is how striking breakthroughs come about – by gathering people with different disciplinary strengths, insights and research approaches to expand our ways of seeing, thinking and understanding. This is a vital contribution universities make to our country.

I commend all involved in this first phase of the Australia Cares project and welcome the publication of this compelling report. I look forward to the report having the policy influence the Australian people and the project's many and diverse collaborators deserve.

Professor Mark Scott AO
Vice-Chancellor and President
The University of Sydney

Australia Cares
Advisory Group

Dr Sheelagh Daniels-Mayes, Lecturer in Indigenous Studies and Deputy Associate Dean, Diversity and Inclusion – Disability, University of Melbourne

Emma Dawson, CEO, Per Capita

Robert Fitzgerald AM, Commissioner, Ageing and Disability Commission NSW

Tamika Herschausen, Disability Support Worker, United Workers Union

Emma Maiden, General Manager, Advocacy and External Relations, Uniting

Mark Peacock, General Manager Strategy, Transformation and Impact, HammondCare

Professor Kathryn Refshauge, Emeritus Professor, University of Sydney

Andrew Vodic, CEO, Community Disability Alliance Hunter

We wish to acknowledge Professor Marc Stears and Martin Stewart-Weeks who instigated the Australia Cares project. Marc was also Chief Investigator for the project while Director of the Sydney Policy Lab and during a period of transition following his departure and appointment as Director of the University College London Policy Lab in March 2022.

With thanks to Dr Benedict Coleridge for research.

Authors' note

Our care systems are in crisis and have been for decades. Multiple royal commissions and the pandemic have exposed Australia's failure to provide the kind of care that people want for themselves and those they love. Tinkering around the edges of our existing systems will not be enough. We need to respond with new thinking about policies and systems, developed in partnership with those who know how to provide care and those who receive it.

Care is fundamental to a good life and a fair society. We can all be certain we will give and receive care in different contexts and at different times of our lives. For many people, being a caregiver is a significant part of life. So too is receiving care for many others who are dependent on formal and informal carers. Yet so often our society has put care on the bottom rung of importance.

People want to challenge the status quo. They want our society to value care and recognise its intrinsic value to our lives and the functioning of our society.

At its best, care is about our dignity, interconnectedness and agency. At its worst, care done poorly or for the wrong reasons can strip people of their agency and entrench disadvantage.

These are the key hopes and concerns we heard in a series of dialogues with public policy experts, care recipients and practitioners that led us to launch Australia Cares in 2022.

In this report you will find an unfolding story of care experiences, issues, challenges and pathways to finding policy solutions. The results highlight the significance of community voice in shaping the economy of any care system. The findings reported here suggest complementary stories of care from those givers and receivers of care. Taken as a collective story, they direct us toward policy imperatives.

We are grateful for the many people who have given much to this project including community members and partners, university colleagues and the project's Advisory Group. Without the support of the Paul Ramsay Foundation for this exploratory phase of the project, such extensive community-led policy development would not have been possible.

Australians have stepped up to the challenge of thinking deeply about care and caring, with the intention that 'Australia Cares'. It's time to listen and act. Together, we can create new cultures, policies and systems of care.

Dr Kate Harrison Brennan
Director, Sydney Policy Lab
The University of Sydney

Professor Brendan McCormack
Academic Chair, Australia Cares
Head of School and Dean, The Susan Wakil School of Nursing and Midwifery
The University of Sydney

1. Reimagining care

Another project on care

Haven't we been looking at this for decades? And haven't we already held royal commissions, developed new strategies and technologies, and restructured services with new quality standards?

Haven't we already watched workers strike, read the academic reports and done the economic modelling?

Why another project when there is already so much happening?

There's a lot happening because care really matters. It's deeply personal, even intimate. It's a feature of our closest relationships, where vulnerability and dependence play out. We give and receive care across the course of life, from birth to death. When care goes right, it builds agency, dignity and connection through the reciprocal relationships between those giving and receiving care. When it goes wrong, it's a deep breaking of trust. At its worst, care can be exploitative and abusive.

We're making a mess of it

Every week we see and hear reports of people deeply shocked at the care received by their aged parents; colleagues, friends and family members with disabilities; and children. It happens across all types of care, leading to repeated tragedies, injustices and public scandals, as inquiry after review after royal commission continues to expose. We witness the ongoing social inequality experienced by First Nations people, often resulting directly from uncaring policies which shape the way care is provided at all levels across the country. We hear stories of exhaustion, understaffing and low morale told by nurses, early childhood educators, teachers, paramedics, aged care workers, disability carers and many others.

The many symptoms of our broken cultures, systems and practices of care are matched by a bewildering number of proposed remedies. It's as if a whole industry and infrastructure has grown up around plugging gaps and mending existing systems. Good people are doing good work and others are making a buck. But care in Australia remains deeply broken.

Why are we making such a mess? Why is too little changing for the better?

We're uncomfortable with care. Too often there's an undertone that characterises care as an unfortunate inconvenience, too private and too 'female' to be aired in public. Dependence and vulnerability are not words that come easy to us – we prefer to avoid thinking about them until we are forced to. 'God forbid it should be me. It's undignified.' We've painted those needing care as the unfortunate others, stripping them of their full personhood. So, we don't talk about it, even less celebrate it, and we've failed to understand and share the rich stories of beautiful care, respectful care, dignified care and care that shows what it is like to really help someone to flourish as a person.

We've normalised a society of not caring. We know people are struggling. We know people are lonely. We know they're not getting the care they need on a day-to-day basis. We leave people feeling helpless or hitting bureaucratic brick walls when they reach out for support. We're almost numb to it and we never take on the kinds of transformational political, financing and resourcing decisions of the quality and scale that need to be taken if we're to really fix care systems.

> "Why are we numb to structural systemic violence?"
>
> **Care Labs**
> **Inflammatory Essays**

We've also accepted the shocking disconnect present when we expect wonderful care, whether from paid or unpaid family and friend carers, but we completely undervalue carers. We set up systems with individualised care, designed to enable people needing care to identify their goals and seek services, then we expect that to be supported by people who are invisible, disrespected, unsupported or paid very poorly. It is a gap we're somehow not seeing.

The language we use and stories we tell hide inequality. Care is deeply racialised and stigmatised. We hear narratives suggesting there are people who are 'deserving' and 'undeserving' of care. Often, those who are 'undeserving' are also those who aren't from racial or ethnic majorities. Those who are 'undeserving' are often those who need care the most. And, ironically, those who are 'undeserving' are often those who step into caring roles that others don't want to do, allowing our society and economy to keep ticking.

Stigma works both ways. On one hand, those who need care are stigmatised and shamed for their 'dependency' in a world where we are meant to be productive and self-sufficient. On the other, because we are uncomfortable with our own need for care now or in the future, we devalue and stigmatise those who step up to make us less vulnerable by providing care.

> "Those who need care are subjected to shaming, ageism, ableism, and 'othering' in various guises. Those who give care absorb the compounding costs of loss of paid work, superannuation, access to paid parental leave, career progression and so on."
>
> **Care Labs collaborator**

> "Not caring results in human suffering, it results in real suffering. People who make the policies, who have the money to put a buffer between them, who were able to buy care and buy comfort – they will never understand that."
>
> **Care Labs collaborator**

Because we've failed to understand and value it, we've reduced care to a series of transactions, we deal with it in siloes and we think short term. Systematised policy responses to care have converted this deeply personal, unpredictable and relationship-based activity into units of labour and tools that can be standardised, measured and controlled. We look at it sector by sector, state by state, service by service, narrowing our field of vision and obscuring the interconnections between care as it plays out in different spheres.

In our current policymaking processes, we're advocating positions rather than opening hearts and minds. We're fighting it out within very tight parameters defined by current dysfunctional systems rather than demanding better from those who represent us.

At heart, what's broken is how we value care, the stories we tell ourselves about care, and the denial of our shared experience as people who give and receive care. And the ways we're trying to fix it aren't working.

So, in Australia Cares, we set out to do something different. We have set the bold ambition to reimagine care, and to do that drawing on sets of relationships and tools not usually deployed in policymaking.

Why Now?

During the height of the Covid pandemic we witnessed a wholesale shift in focus on care and the narrative of care. We saw care workers being clapped by politicians, decision-makers and the public. We witnessed the public call out failures in the care system that put those in need of care and care workers at risk. We experienced new charitable causes being established with the explicit focus of fundraising to support those in need of care but without the resources to acquire it.

This elevated focus on care and care work didn't last. Care became invisible again. Excitement that we had entered a new world of understanding of the importance of care disappeared as quickly as it arrived, and we returned to stories of broken systems, disrespected relationships and arguments about who should pay for care.

So, we want to write a new national story of care. A story that captures the value of care, its central place in communities and society, and is built on the rich mosaic of stories from those who give and receive care. We want to understand care deeply and make it visible in all its messy glory. Only when we tackle the policy challenges of care in this context will we have any hope at all.

We're up for that challenge, because we absolutely need to do something differently if we want change.

We know there are the ingredients for new ways to transform care, and we're ready to put those together. We want to put the voices of different communities at the centre of this story – the voices of those grappling with care every day. We want to test the powers of community-led policy development, shaped by lived experience, informed by distinctive contributions from people with diverse perspectives and supported by academic and community expertise.

We know there's a genuine appetite from people at all points in our care system to take this on. There is courage and ambition. There's a thirst that the current opportunities for policy development is not satisfying, and a call for courage and leadership.

So, we set out on this project with curiosity and determination, asking:

- What if we posed bigger questions about the place of care in the community and our economy?
- What if we inverted the policymaking model, enabling communities to set the agenda and give policy guidance?
- What if we brought people with diverse perspectives together to tackle those questions?
- What if we used the expertise and infrastructure of the University of Sydney to partner with communities?
- What if we stepped back from the short timeframes of political cycles?

In order to reimagine care, we have to reimagine policymaking. We asked: What if we dared to bring together the Sydney Policy Lab's core work of participatory policymaking with this most human and fraught issue of care? Could we co-create new policy insights that might just shift our cultures, systems and practices of care and develop new ways of making policy?

"It's a shame that we don't have leadership in this space. Politicians are not proactive: they're just always responding to crises. We don't have politicians with a vision generally valuing care, caring to see the importance, and so come to the public and say, look, his is so fundamental, and we need to fund it properly, and we need to bring about reforms."

Associate Professor Luara Ferracioli
The University of Sydney

What is 'care'?

The word care is generally thought to be a positive term, implying love and kindness. However, it is not always straightforward. The word care can be triggering and jarring for people who have had traumatic experiences of care systems or those whose caring labour is undervalued or unacknowledged. People with disability often prefer the terms support worker and family member to care worker or carer, seeing the word care as paternalistic and patronising. Many early childhood educators have also rejected the word care, preferring to emphasise the educational role they play in children's development.

Although its meaning and usage are contested, there are good reasons the Australia Cares project still uses the word. Care is finally getting the attention of governments and citizens. We believe that, rather than replacing the word care, it's time to re-imagine care. Australia Cares seeks to transform care so relationships, agency and dignity are at the heart of how care systems, cultures and practices are funded, designed and delivered.

A starting definition of care comes from feminist theorists, Berenice Fisher and Joan C. Tronto:

"Care is a species activity that includes everything that we do to maintain, continue and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web."[1]

For Australia Cares, care is about 'healthfulness': cultivating 'environments of care that promote health', including 'healthful relationships' that support a person to flourish. Care is about person-centredness, relationships, professional care, nursing care, care theories, care and support economies, and support services. It includes care for older people, children, people with disability, people from racial or ethnic minorities, people when they are sick and self-care. Care for Country is central to this approach to care as we recognise, value and centre our connection to land and each other in the life-sustaining web of relationships of which we are a part. Care in all its guises is a vehicle for creating flourishing persons, communities and populations. Flourishing happens when we are 'held' through various experiences as we move through life. We flourish when we experience beneficial, positive growth that pushes us to be the best versions of ourselves. When we are helped to make the most of our naturally occurring potential to care by channelling it for good, we don't just flourish as persons, whole communities have the potential to become more resilient.

Reimagining care encourages us to reflect critically on our language so that how we speak about care itself is caring. This means choosing language that helps people, including ourselves, to feel supported to live our best lives.

2. Reimagining policymaking

Our work in this project has explored community-led policymaking through two initiatives, each exploring particular methodologies: Care Labs and People's Assemblies on Care.

We linked these initiatives with Stories of Care, lived experience research and an analysis of the care economy. These linked elements provide complementary perspectives to those obtained through the Care Labs and People's Assemblies, and are summarised in the appendices to this report.

Our reimagining of policymaking across the different initiatives was built on some core elements.

We know people, relationships, Country and places matter a great deal, and we took time to build relationships with the communities we planned to work with, university colleagues and people with diverse perspectives on care systems.

We brought together distinctive academic approaches to the work, spanning person-centred and creative methods, ethnography, deliberative democratic processes and design thinking approaches.

Academics from 13 disciplines were involved across the project activities, anchored by Professor Brendan McCormack as Academic Chair.

We value different forms of knowledge and invited diverse expertise from people with knowledge from personal experience, community knowledge, knowledge as a practitioner, organisational knowledge and academic knowledge. We convened activities bringing together people of diverse age, gender, socio-economic background and life experience.

We created spaces that would maximise the opportunity for collaborators to have a positive experience of being and working together. From the design of activities and preparation of materials to the details of how spaces were set up, we created safe and inclusive spaces for knowledge co-production. In all of our activities, we invited people to participate not only in their professional capacity, but by contributing their personal and lived experiences.

In this area of policy that is both highly intimate and social, we enabled opportunity for shared contemplation, attended to the inner worlds of collaborators and their social contexts, and enabled emotional engagement. We facilitated a dance between the use of creative individual and group methods – clay, poetry and metaphor, for example – matched with deep thinking, reflective discussions and systematic approaches through structured deliberative practices.

While we worked with structured plans, we were flexible with how these unfolded based on the flow of engagement with and between collaborators. We were able to stay focused on what was important in the moment and facilitate the emergence of new insights in a systematic and thoughtful way.

9
Care Labs

38
Care Lab collaborators

40+
People's Assembly on Care collaborators

20+
academic collaborators across 13 disciplines

Care Labs

Online collaboration to discern care principles and apply these in thematic policy areas

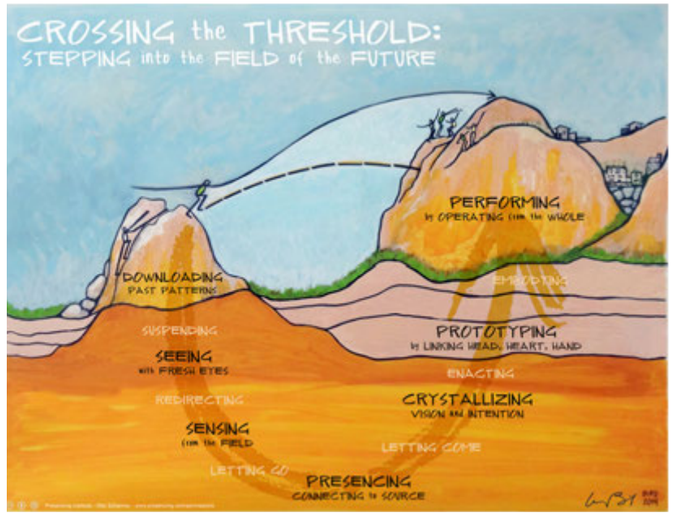
Following many conversations in 2022, we identified the opportunity to explore community-led policymaking in two thematic areas where there seemed to be great interest from our community coupled with opportunity to have policy influence: aged care in the home and community and disability support in early childhood education and care.

Professor Brendan McCormack led this initiative. We convened a series of online workshops between March and September 2023 and invited a diverse mix of collaborators. Across four core workshops and four shorter sessions, 38 people from different geographical locations collaborated in this policymaking. Many of these people joined us for a final Care Lab in November at Australian Parliament House in Canberra with politicians and decision makers.

We adapted the methodology of Theory U to inform the Care Labs and the focus on ensuring meaningful engagement from all collaborators. Theory U is an awareness-based methodology for changing systems which challenges us to connect with our internal world – our beliefs, values, experiences and assumptions – to engage fully with the external world.

"What about if we tried to make this not about us? What about if we tried to make this about the people in the communities that we exist for? What about if we did that – we flip flop our mental maps around? What would our governance look like? What would our management structures look like? What if we actually lived up to the rhetoric?"

Lin Hatfield Dodds
CEO of The Benevolent Society



In essence, Theory U combines principles derived from participatory action research, design thinking, mindfulness and civil society movements. These principles are consistent with the community and societal change underpinnings of Australia Cares and our collective intention of elevating care in society. We shaped the work of the Care Labs through the five collaborative commitments of Sharmer and colleagues, to provide us with a framework to guide our movement around `the U'.[2] Importantly, our intention was to use the labs to get to the bottom of `the U' – presencing – where we could all be content our collaborative explorations resulted in a shared understanding of care principles we could all `settle with'.

As we invited our collaborators into this process, we clearly signalled we were seeking to enable a way of being and working together that was different from the common experience of online workshops in which collaborators can be passive recipients of dense material presented by `experts'. For example, we sent a Care Lab pack ahead of the sessions with a guide, creative materials and a snack. The initial signalling continued in the style of facilitation and theoretically-informed modes of interaction. We used personal artefacts, clay modelling and poetry as stories of care were shared. We developed poetry and collaborative `inflammatory essays' to uncover care principles. Policy ideas were posited and tested using the Disney Creative Strategy method.

Top: Theory U illustration courtesy the Presencing Institute, licensed under Creative Commons BY-SA 3.0 Deed. Above: Care Labs pack. Below: Care Lab on Zoom; Canberra Care Lab in Australian Parliament House, November 2023.

Westmead and Broken Hill, where the University of Sydney has campuses

People's Assemblies on Care

Place-based, community-led policymaking

In 2023, we worked with two communities where the University of Sydney has a physical presence and campus: Westmead in western Sydney and Broken Hill in far-west New South Wales to hold People's Assemblies on Care.

These People's Assemblies were designed as a response to the weariness members of the Australian public felt at successive royal commissions doing post-mortems of policy failures in key policy areas related to care. Inspired by a wave of deliberative democratic exercises that have sprung up around the world, we selected a deliberative method to create a microcosm of a local community, a `mini public'.

Dr Kate Harrison Brennan led this initiative, and Professor Brendan McCormack and Mariah Goldsworthy co-facilitated the People's Assembly on Care at Broken Hill. Professor Brendan McCormack, Professor Bandana Saini and Dr Kate Harrison Brennan co-facilitated the People's Assembly on Care at Westmead.

In prioritising the experience of community members, we chose a more informal approach rather than the rigorous deliberative methods that have been explored elsewhere. As in the Care Labs, we designed activities that sought to enable a movement from precognitive to cognitive engagement with the topics and subject matter. We worked with world-leading design thinking agency Dust & Company to make use of design thinking methods, creating participatory and deliberative activities for the Assemblies.

For each Assembly, 20 community members were recruited. In Broken Hill, we worked with a broadly representative cross-section of the Broken Hill population, adjusted to ensure an equal representation of females and males as well as a higher proportion of Aboriginal and Torres Strait Island people than in the general Broken Hill community and people with experience of chronic illness. In Westmead, we focused selection on a cross-section of members of the community who have an Indian background. This was informed by insights from the first stages of the project in which those we spoke with in government and communities highlighted the need for policy development that reflected the values and expectations of culturally and linguistically diverse communities. We specifically sought families living in multigenerational households.

The Assemblies were designed to run in two phases in each location. Phase one, a three-hour evening workshop, was an exercise in consultation and agenda setting which set-up for phase two, an all-day workshop on a weekend to deliberate on policy solutions. In 2023, we completed both phases in Westmead and phase one in Broken Hill.

Phase two of the Broken Hill People's Assembly on Care was scheduled for October. At the request of Aboriginal and Torres Strait Islander members of the community and the Aboriginal Community Working Party following the referendum on The Voice, we postponed the Assembly to allow them time to grieve the outcome. We will confirm plans for the next phase with the guidance of community representatives and local University of Sydney colleagues.

Broken Hill People's Assembly on Care phase one.

The relational economy

Aged care research and development

The services that make up the care sector play a pivotal role in our everyday lives, communities and economy. As the care sector becomes a larger part of our economy, innovation in the sector is becoming increasingly important.

However, the care sector's value is greater than what is measured through GDP alone with traditional measures of economic progress not capturing many of the benefits of care work.

There is a moral or even a relational economy at work based on reciprocity.[3] The care sector extends the social ties and forms new relationships to provide care. Value, here, cannot simply be commodified and provided by the market and state.

In a stream of work on innovation in the aged care sector, we described the relational economy at work and analysed investment in the creation of new value in this economy through research & development (R&D).

We make the case for government intervention through public finance for R&D to support provision of aged care as a good and as an important part of the foundational economy – essential for wellbeing and human flourishing.

To achieve such ends, public finance cannot be for just big business and cities alone but should be invested across the whole economy. That is, across geographies, forms of infrastructure (physical, social and civic), organisational types, capabilities, jobs and skills. Without a holistic approach to investment in a relational economy, the current basis of value creation, including through the R&D that does take place, undermines what we value most as a society. At best, it provides benefit to only the top echelon, but without reciprocal relationships.

Improving the quality, effectiveness and efficiency of care services underpins human flourishing, improved wellbeing and better health outcomes in addition to higher economic growth. For example:

- Early childhood education and care workers influence long term health, educational and economic outcomes for children.
- Aged care workers improve life satisfaction, lower levels of loneliness and, through improving health outcomes, extend life and reduce health care use.
- Counsellors improve life satisfaction, economic participation and reduce health care use of their clients.
- Disability workers improve life satisfaction, increase economic participation and improve health outcomes of people with a disability.

Lived experience research

The lived experiences of people involved in care, from informal and formal care workers to the people they support, is foundational to the Australia Cares project. To learn from the ways people with lived experience are included in co-design and research, the Sydney Policy Lab initiated a reflective research program on lived experience methods. Through a series of interviews, dialogues and collaborative writing processes, we explored tensions between different approaches and core concepts underpinning lived experience methods, and shared examples of those methods in practice. Through our collaborative engagement, three core principles and values emerged as foundational to engaging people of diverse experiences.

1. Critical reflection and ongoing learning: Lived experience research requires researchers to question values and assumptions, be open to changing direction, and learn from the people and communities they work with.

2. Meaningful inclusion: We should consider how people with lived experience are being included throughout the design or research process. This means including people with lived experience as early as possible and being open to those people or communities changing the framing or research question. They are the closest to the topic of concern and their knowledge is to be privileged.

3. Evolving cultures and institutions: Including lived experience in research requires investing additional time and money in relationships with involved people and communities in authentic and reciprocal ways. Priority should go to ensuring people and communities benefit from their involvement in the research process and the outcomes.

Stories of care

What counts as care, and what agentive or dignified care means, differs for people across Australia based on a range of factors including their ethnicity, migration status, life experience, age, gender, sexuality and religion. In fact, for some communities and individuals, other values altogether might guide and structure care relations.

Through our Stories of Care, we have drawn on an anthropological approach and ethnographic methods. Anthropology has particular tools for understanding what care means within these different contexts, relations and lifeworlds because it is particularly sensitive to the relationships that build and sustain care. This element of the project is all about going to people in the everyday worlds they inhabit, following their care relationships and understanding their textured emotional experiences.

Through one-to-one ethnographic interviews with people who have collaborated in the Care Labs or People's Assemblies, we have yielded different kinds of insights, shedding light on the fundamental ethics of care people have, the realities of care they live, and the imaginations – utopian or otherwise – they have for how care should be organised in the future. This work compliments, but also questions, the other elements of the project, challenging researchers to reflect on whether the fundamental assumptions they have about the nature of care are universal.

3. Creating new knowledge

About care and caring

Across the project, people spoke about the gulf between their aspirations to live in a caring society and their lived experiences of care. Beyond the published reports on broken systems, which are numerous and compelling, we unearthed a sense of anger and frustration, and a deep sense of those being cared for and those doing the caring not being seen.

In sharing stories of care, we recognised that in caring and being cared for, we experience our shared personhood. Our collaborators shared rich personal experiences, beautiful stories of relationships and community shared between those being cared for and those caring. We were moved by stories of love, each intimate and individual but linking us with something shared and essentially human. We heard of the strong bonds within communities and families that enable care, and the personal and cultural significance of caring for family members. Care is central to identity and culture within many of the communities we worked with.

In contrast, stories were shared of the shocking lack of care and value given to those they love, whether it be as they age, seek disability support or come to Australia as migrants. We heard about a distressing level of 'othering' of people with disabilities, the invisibility of those outside of our major cities and the challenges of navigating more complex systems.

We heard that while caring is certainly difficult at times, it is not intrinsically burdensome. Our collaborators shared rich stories of the joys of caring – of enabling others to flourish. It is our cultures, systems and practices of care that impose a burden, placing pressure on the relationships between carers and those they care for. We heard stories of carers losing paid work to make phone calls and attend appointments, losing the capacity to build social connections; and facing poverty and lack of rest during retirement. We heard of the difficulties of navigating care in remote communities and the transcultural issues and challenges that get in the way of effective care and support for extended family systems in culturally diverse communities. There was a strong sense of these costs being invisible, to be covered privately and preferably quietly by individuals and households.

"I had to do a survey on wellbeing the other day and it wanted me to say I am happy a percentage of time and sad a percentage of time, and they had to add up to 100 percent. I'm like, emotions don't work like that. I can be 80 percent happy and 70 percent distressed."

Care Labs collaborator

We clearly heard the anger of carers. Anger at the load, invisibility and costs imposed by complex systems that are not working. Systems that don't make it easy for carers to access benefits and seem to serve the bureaucracy as an entity in itself rather than those who are navigating it. Family and friend carers shared stories of how they grieve the opportunities taken away by our systems, just as they celebrate the relationships and experiences gained through the human activity of caring.

"Who do they think is sitting around with all this free time to be everyone's power of attorney with the pain and the hardship of the hours on hold? I'm not even talking about providing the direct care – the indirect care carries an enormous cost where you have to take a day of unpaid leave to do your old mum's calls, but the rest of the economy doesn't respect that, and still, you have to work on their time. So, the gerontologist's office will not commit to calling you at a particular time. The hospital will not commit. Nobody will facilitate anyone else."

Care Labs collaborator

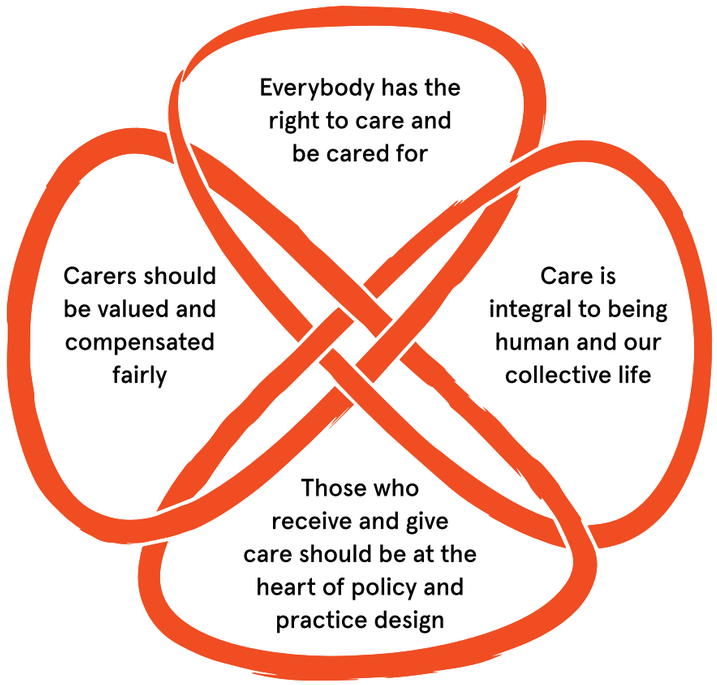
We heard the anger of those being cared for, of being 'othered' and made invisible. In our current systems and cultures, too often the rights of those caring are pitted against those they are caring for, as if we were playing a zero-sum game. Our collaborators have pushed back against that: rights to care and be cared for must be seen as complementary rather than being in opposition. My right to care with dignity and agency at its heart need not undermine your right to recognition and compensation. Your right to a voice and to build your skills as a carer must not be at the expense of my agency and dignity as I am cared for.

The failures of our care systems are experienced differently across communities. We heard stories of the failures in care provisioning and suitability for Aboriginal and Torres Strait Islander peoples, women, migrants and those living beyond metropolitan areas. We sensed a series of underlying questions: Are there those that deserve care and those that don't? Do those with money and assets after a lifetime of 'contributing' deserve more that those who have disability and will always require intensive support? Do we accept poorer quality care for some, just thankful that it's not us?

We heard the frustration and distress from underserved populations who are unable to access care for a range of reasons, from chronic shortages of care workers and care services to services that do not respond to cultural needs or are inaccessible because of policy imperatives. We heard of the domino effect when workforce shortages in one industry or sector of care have impacts across whole communities of care. We heard of the importance of trust in relationships of care and the sometimes-devastating impacts when this is absent. We discovered care cannot be considered without also taking account of housing, economic security, visa status and safety. In many of our conversations and in different contexts, the giving and receiving of care was linked to factors that might at first glance seem unrelated.

"The beauty of being a carer to someone we love, it's enormous … And when my father for example, said to me, oh, living here with you every day, it's a Sunday. Because he felt my love and care that made me feel tall and strong, no matter how exhausted I was."

Care Labs collaborator



The reality for so many is that these are inextricably linked and any meaningful consideration of care requires that we enable these connections to be acknowledged, described and analysed.

These stories are consistent with what we know to be many of the problems and challenges in care systems. For example, there is consistent evidence over many years of international research that shows the impact on relationships, physical health, mental health and financial security of informal carer roles and family carer roles when they are not recognised, acknowledged and properly supported. The stories we heard bring this evidence into sharp focus and to life through lived experience.

The lived experiences of our collaborators also show how poorly equipped our care systems are to address geographic and cultural diversity among the Australian population. Arising from deeply listening to these stories are some fundamental questions we need to address as a society, including: How do we overturn histories of neglect, marginalisation and discrimination from care systems among some populations and communities? How do we rebuild trust in decision-makers at all levels to engage in active inclusion strategies? How do we suggest decision-makers need to understand the whole picture to develop collaborative and inclusive policies on care?

Policy solutions from Care Labs

Our collaborators were clear: we must do better with care policy. It should be underpinned by an interconnected set of principles and lead to a fundamental redesign of our systems. We worked with the Care Lab collaborators to systematically analyse the data collected during the Labs to generate the above four principles of care that transcend people, contexts and specialties.

These principles are 'action guides' for shaping ongoing developments in care and future work of the Sydney Policy Lab. The rationale behind each of these principles is described in the right hand table.

Further, collaborators called for key actions that would help these principles come to fruition:

- Resources to enable the development of a diversity of images and stories in which we share the deeper experience of caring. It is time to get beyond soft focus, cleaned up images of caring that make invisible the gritty experiences such as those shared by our collaborators.
- The development of a rights-based framework for care policy. Our reimagination of care must place the rights to care and be cared for at the centre. Many of our collaborators were frustrated by their inability to make change at the level they desired without a rights-based framework on which to build.
- The development of quality standards and accountability at different levels, without the layers of bureaucracy and regulation that strip what is human out of caring. This should include deep consideration of how we can best measure the outcomes of quality care, of which the nature of the relationship between care recipients and care providers is a fundamental element.
- A deep examination of complex and often bureaucratic systems to understand how and where they impose unnecessary burdens on those being cared for and those giving care.
- The development of methods to enumerate the invisible costs imposed on carers by our care systems and borne disproportionately by women.
- Funding initiatives that incentivise and support young people to engage in care. Such initiatives could build positive experiences of those giving and receiving care, contribute to telling a new 'story' about care and be part of the response to workforce shortages.
- Co-designing and funding local care hubs to support appropriate care, relationships and connection in communities.

> "Those who need care are subjected to shaming, ageism, ableism and 'othering' in various guises. Those who give care absorb the compounding costs of loss of paid work, superannuation, access to paid parental leave, career progression etc."
>
> **Care Labs collaborator**

What we have	What we must build
A system which penalises and stigmatises those that are cared for and those that care	Care systems designed to support care and caring relationships
A system which makes invisible, and imposes a burden on, those who are cared for and those who care	Care systems that celebrate and value the place of care in all our lives
A system in which there are some who can access and afford quality care and some who can't	Care systems in which we have rights to be cared for and to care
A system built using a system-centred approach, with the perpetuation of the system at the centre	Care systems built using a person-centred approach with the perspectives of those with lived experience at the centre
A system in which the rights of those receiving care are pitted against the rights of those giving care	Care systems that recognise the complementary rights of those receiving care and those giving care

Policy solutions from People's Assemblies on Care

From the first phase of the People's Assemblies in Westmead and Broken Hill, driving questions for subsequent deliberation were developed. In Westmead, this focused on the care ecosystem and how transcultural issues and challenges get in the way of that ecosystem. While in Broken Hill, the driving question focused on care navigation and the complexities associated with finding one's way in, around and through the care system. While we are still to conduct the second round of deliberation with the Broken Hill community, we gleaned sufficient detail from our initial engagement to highlight a clear focus for action. Those gathered in the People's Assemblies on Care, supported by University of Sydney academics and professional staff, offered eight solutions to the challenges they identified.

	Problem	Solution
1. Universal health care for all in Australia, regardless of visa	It's not guaranteed that if you're in Australia and in urgent need of health care you will receive that care. In emergency departments across the country, signs make clear that unless you have a Medicare card, you will have to pay for medical care received.	A humane approach to provision of medical assistance and care that provides a universal safety net for urgent and emergency care within Australia.
2. A new carer visa category	Parent Visas – contributory or non-contributory – are not meeting the needs of community members. The federal government 2023 Review of the Migration System highlighted that families are waiting for parent visas that never come.[4] A growing migrant population has driven demand beyond places available. While recognising that family structures and distributions of care across cultural groups differ, members of the migrant population experience acute and timebound needs for care which are exacerbated when away from family members and others with whom they share long term connections, language and culture.	Create a new carer visa category that has clear categories for qualification. For example, to provide care to a family member who has been diagnosed with terminal cancer, has been significantly injured in an accident or has been told by their doctor to be on bed rest during pregnancy. This could also enable caring for a very young child.
3. Culturally integrated services network to uplift and facilitate cultural and religious needs in care provision	There are underserved populations whose various cultural and religious needs are not well understood by mainstream services. This means services are not accessed at all, services are accessed less than would otherwise be the case or public health messages are not received by members of the community because cultural and religious considerations and practices are not well understood or engaged with.	A network of care providers and volunteers who help uplift and facilitate specific community needs such as cultural meal delivery, end-of-life care, funeral service support, transport for community events, pre- and post-natal care, and health education on topics like the safety of co-sleeping with babies and infants.
4. One-stop shop to assist with retirement and later life planning for care	Ageing, for anyone, is like entering into another land. Ageing when you are a migrant compounds the sense of disorientation. Without signposts, it's hard to plan for the journey. In a world increasingly focused on digital solutions, this is no less the case when it comes to care services. However, so-called digital solutions bring layers of complexity and challenge that don't always result in meaningful outcomes for end users.	Create a one stop shop that would help migrants – the Australian community, too – understand what might be ahead on the journey, choices they can make and how they and their loved ones can plan well for the future.

	Problem	Solution
5. Community health education program	Carers of migrants who are also migrants themselves often find it challenging to navigate care services efficiently and effectively, and miss out on support and services.	Provide better education and information for the community, with the community and by the community. Work with existing community service providers to co-design education programs to improve care services and literacy of carers.
6. Families network forum for navigating and activating care	Navigating and then accessing care is difficult. It's hard to know which information to trust and to find care relevant to needs. We know care services are available, but we're lost trying to find them.	Create a digital resource curated and provided through trusted public apps to help individuals and the community navigate and access care relevant to them. Make it so that there is a seamless connection between the various actors who provide care and generate links with the physical places people go to access care.
7. Creative solutions to workforce shortages	The domino effect of workforce shortages in any one care sector generates a set of pressures on households and communities and contributes to workforce shortages not just in other care sectors, but across the local labour market.	Recognise that siloed thinking about interventions in one sector may exacerbate rather than solve broader workforce shortages. Learn from successes such as student placements that have led to ongoing work in community, and considered use of technology that enables care to be supported remotely. Developed solutions need to be holistic in nature, consider the whole care ecosystem and the relationships between individual components and embedded in established relationships with community organisations and service providers.
8. Care Navigators embedded in community	Shortage of services, as well as difficulties in navigating care systems, matched with long-standing fear and mistrust of formal systems, exacerbate barriers to accessing available care and support in a location.	Working in partnership with local communities, community leaders and people with lived experience, identify new ways to remove barriers to care through community asset mapping and co-creating solutions that draw on existing community assets and knowledges. Allocate resources to community developed care navigation systems that are fit-for-place and commit to the development of new services that enhance access to care and services.

A framework for action

This first phase of the Australia Cares project has demonstrated just what can be achieved when people are given the opportunity and support required to step back from systems and policy settings as they are and to imagine what could be.

The problem definitions and solutions in this report reflect what matters to a cross-section of people involved in care in Australia and two very different communities.

The policy recommendations contained in the report are not only highly desired by members of communities who have suffered from successive policy failures but have the potential to be highly effective if refined and implemented with this same community leadership and university partnership.

Governments at local, state and federal levels now have the opportunity – and need – to look beyond their near-term agendas in which they have sought to address the most urgent and pressing failures in current systems and policies related to care. These systems and policy settings have their origins in the 1950s, yet even measured by the values of decades past they have not succeeded.

Current harms, egregious policy and governance failures must, of course, be addressed, but it's time to transition to a new way of thinking about and doing care policy. It is time to move away from a dominance of neoliberal values that drive policymaking and delivery frameworks modelled on new public management to a greater emphasis on relationships and the relational economy that can drive innovative solutions for the future.

A coherent, forward-looking framework for action is urgently needed to enable a person-centred approach to care that:

1. is holistic, binding together care, wellbeing and health, and therefore linked to other policy reform agendas
2. listens to people throughout policymaking cycles
3. builds a relational economy
4. responds to community expectations
5. is designed around the strengths and assets of specific cohorts and communities
6. renews public institutions and invites partnerships
7. spreads capital investment across the economy, especially to the forgotten parts.

The Australia Cares project has demonstrated such a framework for action is desirable, feasible and viable. As a community-led, multidisciplinary project of the Sydney Policy Lab at the University of Sydney, enabled by philanthropic funding from the Paul Ramsay Foundation, we have also shown the potential for collaborations across sectors and between institutions to provide new solutions within such a framework.

In the project itself, we have piloted various forms of community-led policy development. Drawing on what we've learned, these could now provide the basis for the way forward for care policy in Australia: community-led policies developed and implemented on an iterative basis.

At the Sydney Policy Lab, we are committed to moving forward with communities across Australia on the Australia Cares project, and with this approach. Success will be when care policy enables communities across Australia to flourish in ways that are socially sustainable.

We invite governments and other partners to join us in this collaborative endeavour.

Phase one
Care framework development

A person-centred approach to care that:

- is holistic, binding together care, well-being and health, and therefore linked to other policy reform agendas
- listens to people throughout policymaking cycles
- builds a relational economy
- responds to community expectations
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- renews public institutions and invites partnerships
- spreads capital investment across the economy, especially to the forgotten parts.

Phase two
Community-led policy development and implementation

Postscript

An international perspective on care

Sir Andrew Dilnot
Warden of Nuffield College, Oxford. Chair, United Kingdom Commission on the Funding of Care and Support 2011

Care can be wonderful, a support to living a great life, delivered by individuals, structures and communities that are strengthened and enriched by caregivers and by those cared for. But in Australia, as in pretty much the whole world, the care system is struggling.

Struggling to give care that is desperately needed, struggling to recruit and value those who provide formal care, struggling to support those who care informally and, above all, struggling for the political and public support that is essential if the system is to deliver the human flourishing that should be at its heart.

So, it is a delight to see the Australia Cares report coming to fruition and we should all hope that this marks a period of intense discussion, but above all action. For too long, care has been a neglected sector, and that is long overdue for change.

For us all to get this right, we will need the courage and honesty to face what is plain, but somehow hidden. The need for care has been growing rapidly across the world, both care for younger and working-aged people and care for older adults. This growing need follows directly from massive increases in life expectancy in older adults and great steps forward in enhanced life expectancy for people whose care needs begin early in life. These trends are things to celebrate, but as we celebrate we must also be honest about what some of the consequences are.

It is a commonplace for politicians and commentators, and members of the public, to assert the amounts of money involved are huge and so nothing can be done. Both parts of such statements seem at least questionable to me. In most countries expenditure on adult care is significantly less than one percent of national income. This will go on rising as populations age, but the idea that this is a large amount of money when compared to, say, the wider health system or the education system is simply wrong. And to the assertion that nothing can be done, we should say that is both wrong, because as this report shows, things can be done, and unacceptable.

One of the central questions is how to balance the responsibility of individuals and the wider community. It is vital to recognise that this is in part a political judgement, so people will take different views of how to balance these two. But there are still things to be said.

Central to care is uncertainty. None of us can know before we are born whether we will be born with a care need. And even as we approach retirement age, few of us can know whether we will have a care need as we age, and almost none of us can know how long such a care need will last. Most people will not have a long or intense period of care in their later lives, but some will. Saving is not an appropriate response – most people could never save enough to cover a long and intense period of care, and most people won't need such provision. So, care is an area, like health, where we want to pool risks. In some nations, health care risks are pooled through private insurance as well as through state provision, and the balance between state and private risk pooling varies a lot across countries. But in no country is there a thriving private insurance market for care, because the commercial risks associated with offering such insurance for many years into the future are too great. If we are to make this system work, I believe the state has to be involved in providing risk pooling for at least the very high costs that might affect any of us, although will in practice only affect a small minority. With that in place there is scope for individuals, communities and both charitable and commercial bodies to help make a system that works.

We must stop hiding from the need for care, which is why I am so pleased to see this new report. But reports are not enough. Reports need to be followed by discussion, and discussion by action. Being a country that gets care right could not only deliver huge benefits for that country and its people, but for the rest of the world, as a model of the way in which human flourishing can be achieved alongside other economic goals, and that we can see great care given, by outstanding and properly valued staff in an industry that thrives and innovates, in a country that celebrates all of its population.

Notes

1. Bernice Fisher and Joan C. Tronto, "Toward a Feminist Theory of Care" in Circles of Care: Work and Identity in Women's Lives, edited by Emily K. Abel and Margaret K. Nelson. (Albany, NY: State University of New York Press, 1990).
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Appendices

Reimagining Care

How might citizen-led policy development improve ideas and policy to address the crisis in care in Australia?

People's Assemblies on Care: Bringing people to the forefront of policy development

"Not another royal commission!" is now a common lament. In Australia and around the world, the COVID-19 pandemic made clear that we face a crisis of care. At the same time, Australians, like many others around the world, are losing faith in democracy. They are calling for greater engagement with policymakers to address a perceived failure to tackle the serious global and domestic challenges we face as a nation.[1]

To rise to the challenge presented by the dual crises of care and democracy, the Sydney Policy Lab, based at the University of Sydney, seeks to strengthen how care policy is conceived. We seek to do that by inverting the royal commission model of looking at what went wrong, and instead support forward-looking, collaborative policy development that is led by the communities and the people whose lives and livelihoods are most at stake.

Taking inspiration from consumer health movements and person-centred models of care, the Sydney Policy Lab, will convene People's Assemblies on Care to give citizens the opportunity to deliberate on the care policy matters most important to them and come up with new ideas to address the pressing problems within Australia's broken care sector with the support of expertise from the University of Sydney.

The Sydney Policy Lab believes care-giving and care-receiving are fundamental functions of society. Policy to support these functions cuts across our most intimate and social bonds and determines the extent to which we can all live well and with dignity. The development of care policy therefore demands sustained engagement with affected communities and individuals. When there is an active role for communities in policymaking, a rich diversity of lived expertise is brought to bear on policy design, outcomes and evaluation.

By exploring the potential of deliberative democratic methods, which have been applied with increasing frequency in key OECD countries including, experimentally, in Australia, we hope to develop new means of addressing the dual crises in care and democracy.

With the support of the Paul Ramsay Foundation, the Sydney Policy Lab will initially trial two pilot People's Assemblies on Care in locations where the University of Sydney is part of the community landscape. We look forward to working with communities in Broken Hill and Westmead in New South Wales. Our aspiration is for the People's Assemblies on Care to enable members of the public to write their own agenda for care, deliberate over relevant evidence, and determine key priorities for the future of care policy, thereby improving outcomes and, in turn, strengthening our democracy.[2]

What is deliberative democracy, and what can it achieve?

In Australian representative democracy, citizens elect their representatives to form a parliamentary body. Those elected representatives then deliberate on matters in parliament, including on policy made through legislation. Parliamentary democracy allows for representation and deliberation, subject to party discipline, but limits the ongoing direct participation of citizens.

Deliberative democratic methods complement and strengthen representative parliamentary democracy by creating additional opportunities for members of the public to directly and carefully weigh and discuss important public questions. What has been described as a "deliberative wave" prioritises discussion among members of the public, learning and collaborating with the support of trained facilitators and experts to form collective recommendations for policymakers.[3] Possible formats include citizens' assemblies, citizens' juries and citizens' panels. Each of these provide opportunities to arrive at better solutions to policy problems because they tap into a diverse range of community perspectives that are tested through social interactions with others.

Careful determination of who participates in deliberative activities ensures that those who are normally excluded from policymaking are included. Deliberative processes can also strengthen support for policy outcomes in the broader community because people are more likely to trust, and consider legitimate, a decision that has been informed by their fellow citizens, as opposed to decisions made by government at a distance from community needs.

Piloting the People's Assemblies

The pilot People's Assemblies will be held in two locations. The first pilot takes place in the regional town of Broken Hill in far-western NSW, the home of our colleagues and research partners at the University of Sydney Broken Hill University Department of Rural Health.

The second pilot takes place in Westmead in western Sydney, where the Sydney Policy Lab collaborates with University of Sydney colleagues based at the Westmead Health Precinct.

The two phases of the People's Assemblies

Phase 1: Community agenda setting

On a mid-week evening, the Assembly members in each location will be invited to reflect upon what care means to them. The groups will then discuss the challenges in care in the communities represented.

Pilot 1: Broken Hill

Broken Hill is within the Far West Local Health District which covers almost 200,000 square kilometres of remote NSW. The District is the most sparsely populated in New South Wales, with 62 percent of its estimated 30,000 residents living in Broken Hill. The remainder of the population live in agricultural towns along the Murray River, in small remote communities of between 80 and 800 people or on stations. It also has the highest proportion of Aboriginal residents at 12 percent. The District reports that "population is decreasing, ageing and experiencing significant morbidity related to lifestyle factors and chronic illness."[4]

"Responding to the demand for greater democratic input from communities, each of the two pilot People's Assemblies will occur in two phases. In each phase, approximately 20 members of the public will come together to reflect on the most pressing public questions related to care in their everyday lives and communities. By exploring the issues relevant to participating individuals and their broader communities, we seek to uncover obstacles to the effective delivery of care, chart the social and material resources available to the communities in question, and identify new avenues for community-led reform of the care sector."

Dr Kate Harrison Brennan
Director, The Sydney Policy Lab

This appendix was originally published in July 2023 as a report exploring directions for People's Assemblies on Care.

By the end of this session the groups will be able to identify a care issue that matters most to them and their local community upon which they will deliberate in the second phase of the Assembly.

Phase 2: Deliberation and recommendations

On a weekend day, the Assembly members from the first phase will be reunited and provided with resources, including insights from diverse experts, to enable their development of new policy ideas and recommendations. Stipends, meals and all necessary materials for participation will be provided to participants in the People's Assemblies.

The Sydney Policy Lab is excited to put this democratic innovation into practice. We will make every effort to ensure that participants have an engaging experience, and perhaps even some fun, as we experiment with this venture in deliberative democracy.

What happens after the People's Assemblies on Care?

We are working to ensure that there are multiple paths to impact for the policy recommendations developed in these People's Assemblies on Care. Our priority is that these deliberations inform and engage policymaking processes in Australia.

We envision working with more communities who wish to hold a People's Assembly on Care and establishing a People's Commission on Care, housed at the Sydney Policy Lab. The Commission would act as an anchor, a resource and an innovator for the forward-looking, community-led approach to care policy development in the People's Assemblies, supporting Australia's communities to play an active role in care policy development and reform.

Pilot 2: Westmead and surrounds

Located approximately 28 kilometres from the Sydney central business district, Westmead is a suburb in the demographically diverse urban domain of western Sydney. The suburb is home to the Westmead Health Precinct, one of the largest health, education, research and training precincts in Australia. Westmead and surrounds are home to a large community of Indian-born residents. Neighbouring Harris Park, a suburb where almost half of residents were born in India, has recently been renamed Little India in honour of its diaspora communities.

Notes

1. Gerry Stoker, Mark Evans and Max Halupka, Trust and Democracy in Australia: Democratic Decline and Renewal (Democracy 2025, 2018), apo.org.au/node/208536. See also: "2023 Edelman Trust Barometer: Australia Report," Edelman, 2023, edelman.com.au/trust-barometer-2022-australia.
2. See: Claudia Chwalisz, "Good practice principles for deliberative processes for public decision making" in Innovative Citizen Participation and New Democratic Institutions: Catching the Deliberative Wave (OECD, 2020), doi.org/10.1787/339306da-en.
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4. "Far West," NSW Health, health.nsw.gov.au/lhd/Pages/fwlhd.aspx.

Project Methodology

Guiding principles

For the Australia Cares project, we designed and developed the two streams of community-led policy development around a small number of shared principles.

See the University as a key public institution

Universities are critically important public institutions that are central to our society and democracy. As self-governing communities of scholars, members of universities are united in the shared purpose of pursuit of knowledge and teaching. Ideally, a university is able to be a community of communities, inviting and supporting plurality, deliberation and formation of citizens.

Value people, relationships, Country and places

Across the Care Labs and People's Assemblies, we held the principle that people, relationships, Country and places matter a great deal. We worked for more than a year in the establishment phase of the project to build relationships and attend to the specific experiences, needs and interests of those in the communities with which we planned to work. We integrated that commitment into our project governance with the composition and membership of the Australia Cares Advisory Group.

We convened the Care Labs with people from different geographies, roles and life experiences, doing so online to ensure greater access to the Sydney Policy Lab. We were aware of the need to prioritise opportunities to acknowledge the specific contexts in which Care Labs collaborators live and work. We invited them to collaborate in the Care Lab not only in their professional capacity, but contributing their personal and lived experiences. Part of this process involved ethnographic follow-up interviews, where we reflected with Care Labs collaborators on the aspects of their experience and life histories that they felt unable to share in a collective space, but saw as important.

For the People's Assemblies, we built relationships with University of Sydney colleagues at Westmead and the Broken Hill University Department of Rural Health (BHUDRH), as well as those who work at Camperdown and other campuses with related responsibilities. We then built relationships with people and organisations beyond the University in those two locations, travelling to Broken Hill and Westmead on a number of occasions.

We sought the support of the Broken Hill Aboriginal Community Working Party for the project and the involvement of members of the Working Party and Maari Ma Aboriginal Health Corporation at the Assembly. We then co-facilitated the Assembly with our colleague, Mariah Goldsworthy, who is the First Nations Project Officer at the BHUDRH. Both Assemblies began with a Welcome to Country and we look forward to integrating the spiritual connection to and commitment to care for Country in our conversation at the second phase of the Assembly at Broken Hill.

Seek plurality, invite diverse expertise and distinctive contributions

The Sydney Policy Lab was founded on the belief diverse expertise makes for better policy. This project builds on those foundations. As a multi-disciplinary initiative of the University of Sydney, we are tasked with fostering and supporting collaborations to address some of society's biggest challenges. This was reflected in the project design as a whole and the academics, disciplines and methods involved in the two streams of work.

The project's academic leads, united by participatory methods, brought distinctive approaches to the work: Professor Brendan McCormack, head of The Susan Wakil School of Nursing and Midwifery, is experienced in person-centred and creative methods, while Dr Kate Harrison Brennan uses deliberative democratic and design thinking approaches. Academics from 13 disciplines were involved across the two streams.

Both the Care Labs and the People's Assemblies invited diverse expertise and distinctive contributions. The Care Labs involved 38 people.

This included people with knowledge from personal experience, community knowledge, knowledge as a practitioner, organisational knowledge and academic knowledge. Those who took part in the People's Assemblies were randomly selected against criteria to ensure diversity of age, gender, socio-economic background and life experience.

Leaders of community groups with an interest in care policy development participated to lend their expertise as practitioners and community-based service providers. A range of interdisciplinary academics were invited to contribute, facilitate and tailor specific methodological approaches, as well as to interpret findings, so we ensured a plural process of knowledge production.

Create a positive civic experience of being and working together

Opportunities to come together and work for a common, civic purpose are increasingly rare. We identified the importance of creating spaces, whether a Care Lab or People's Assembly, which would maximise the opportunity for collaborators to have a positive experience of being and working together. Part of this process involved paying attention to the detail in how spaces were set up, and how people were invited into them. Processes such as offering food, ensuring an accessible location and time, and sharing creative materials were essential to generating an atmosphere of belonging and openness, and to creating safe spaces for knowledge production.

In the Care Labs, we sought to do so by clearly marking for collaborators that we were seeking to enable a way of being and working together that was different from the common experience of online workshops in which collaborators can be passive recipients of dense material presented by 'experts'. For example, we sent a Care Lab pack ahead of the sessions with a guide, creative materials and a snack. The initial signalling continued in the style of facilitation and theoretically-informed modes of interaction.

For the People's Assemblies, we began with welcome refreshments and shared meals sourced from local catering popular among the community we were working with. At Westmead, we found an Indian violin player to play during the refreshments and dinner time. We drew on design thinking while designing the deliberative sessions to maximise the experience of those who took part.

For example, our InTensions activity involved us marking out a continuum on the floor in the room, sharing pre-determined propositions about care and asking collaborators to move themselves across the room to take a place on the continuum. We then engaged collaborators to share the reasons they took their position and facilitated the conversation to broaden understanding in the room.

Enable opportunity for shared contemplation

Care is foundational to who we are as persons and as a society. Australia Cares deals in the intimacy of a person's humanity – it asks what a flourishing life is. The project then draws communities together to contemplate what is needed for flourishing. In an area of policy that is so personal but also communal, and that has been dominated by the need to do retrospective top-down analyses of policy failures, we hope this is a contribution to the life of these communities as well as an opportunity to amplify their voices

Attend to the inner worlds of collaborators and their social contexts

Because the nature of care is highly intimate and social, we wanted to be attentive to the inner worlds of collaborators and their social contexts. In the Care Labs we did so primarily by using Theory U. In the People's Assemblies, we used design thinking methods to enable collaborators to create Care Maps, use silhouettes of people as prompts to speak about people and care in their own lives, and played a guessing game – Whose Life? – to empathise with others and develop profiles of care users. We linked both streams of work to our Stories of Care stream which uses an ethnographic

method. An ethnographic approach is aimed at understanding the values, morals and expectations that shape experiences of care, and the relationships through which care is practiced. Dr Nikita Simpson, an anthropologist in the project team, attended a Care Lab and the first phase of the People's Assembly at Broken Hill. We invited collaborators in the People's Assembly and Care Labs to share their stories of care, reflecting on topics and experiences that informed their contribution to shared spaces.

Hold the space and opportunity for embodied expression of different, dearly-held values and views

While the methods and emphasis of the Care Labs, although held online, were more weighted towards embodied participation, the People's Assemblies were also guided by this principle, which was fulfilled through the use design thinking and participatory methods, alongside the more orthodox use of deliberative methods for a People's Assembly.

In the Care Labs, this looked like a dance between the use of creative individual and group methods – clay, poetry, metaphor and inflammatory essays, for example – matched with deep thinking and reflective discussions. In the People's Assemblies, this looked like systematic approaches to engaging in group dialogue through structured deliberative practices, alongside creative methods that allowed people to pen up and share intimate details of their lives without feeling exposed.

Enable emotional engagement with policy issues

Through the design of opportunities to engage, active facilitation, support and examples given, we sought to enable emotional engagement with the subject of care and the policy issues. This often required modelling emotional engagement through mini-stories told by facilitators or examples shared. When collaborators engaged emotionally with the subject, topics for discussion or policy issues we sought to ensure spaces were able to hold emotion, and we allowed collaborators to follow up on particularly sensitive issues through one-on-one 'stories of care' interviews.

Working with flow

Through our focus on engaging with our inner world of embodied knowing about care and externalising this world through creative and cognitive processes, we enabled a flow of energy to emerge between collaborators. While we worked with structured plans for the Care Labs and People's Assemblies, we were flexible with how these unfolded based on the flow of engagement with and between collaborators. This flexible approach to engagement meant we were able to stay focused on what was important in the moment and facilitate the emergence of new insights in a systematic and thoughtful way.

Care Labs

We adapted the methodology of Theory U to inform the working of the Care Labs and the focus on ensuring meaningful engagement from all collaborators. Theory U is an awareness-based methodology for changing systems that challenges us to connect with our internal world – our beliefs, values, experiences and assumptions – to engage fully with the external world. This means we need to be aware of our own beliefs, values, biases, prejudices and assumptions before we can start to understand how best to bring about change in the world. The methodology is informed by transformative principles of 'being before doing' and recognising we all have blind spots when it comes to changing ourselves and others.[1]

Blind spots such as lacking awareness of the influence of our values on how we behave and act or how our unconscious prejudices shape the decisions we make. Theory U contends that to act effectively we need to know the source from which we operate when we act, communicate, interpret or think. It is easy to see what we do – results – and how we do it – process – but we are usually not aware of the 'why' in our doing. That is, what has really influenced us in the process or the source of our influences.

It is easy to advocate for being explicit about the sources that influence us as persons but less easy to access those sources. We are often unaware of them – they can be unconscious – or, if we become aware, we can 'shut down' because we are unable to cognitively process them. Working with Theory U challenges us to use different methods of engagement that take us through a process of becoming aware over time in a systematic way by using practical methods and tools for change makers to build collective capacity. Doing this creates a new narrative for evolutionary societal change.

March Hunch Hours

Short workshops to test thematic areas and generate early ideas

STREAM ONE

May workshop

Convening and listening.
Sharing stories and capturing core themes and principles.

August workshop

Observing and discerning.
Writing inflammatory statements on care.

STREAM TWO

July workshop

Conditions for human flourishing.
Reflection and sharing of stories.

August workshop

Synthesis and application.
Using Disney Creative Strategy tool.

August–November

Mini Care Labs

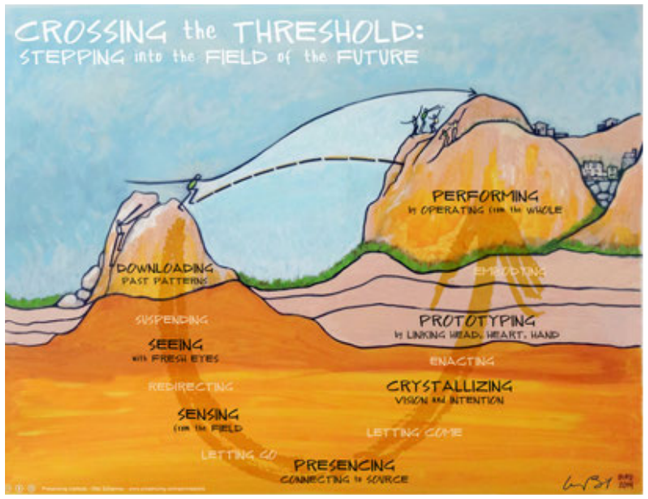
Further exploration of policy priorities in preparation for Canberra

November

Care Labs in Canberra

A representative group from across all activities shared stories and collaborated on action for better policymaking

Left: Timeline of 2023 Care Labs.
Right: Theory U illustration courtesy of the Presencing Institute, licensed under Creative Commons BY-SA 3.0 Deed.



Because of this deep emotional engagement with change processes, bringing about transformation is not a linear process but is instead a U-shaped movement.

In essence, Theory U combines principles derived from participatory action research, design thinking, mindfulness and civil society movements. These principles are consistent with the community and societal change underpinnings of Australia Cares and our collective intention of elevating care in society. We shaped the work of the Care Labs through the five collaborative commitments of Sharmer and colleagues, to provide us with a framework to guide our movement around 'the U.'[2] Importantly, our intention was to use the labs to get to the bottom of the U – presencing – where we could all be content our collaborative explorations resulted in a shared understanding of care principles we could all 'settle with'.

The design of each Lab was influenced by the practices that underpin Theory U and systematically take us to a point of presencing.

Co-creating: Facilitating practice processes that engage with a range of resources and forms of knowing. Our practices had a clear purpose that were continually evaluated to enable evolution and progress. We encouraged prototyping that enabled all collaborators to be inspired and creative.

Co-evolving: Continuous development of self, the team, the internal environment and the external environment. We recognised persons are in a state of becoming and will experience and voice this development in different ways. Engagement with the wider context of community and care services is fundamental.

Co-initiating: We adopted a deliberate intention to act and move forward, informed by attentive listening to others, to ourselves and to what emerged from the Labs that helped bring together individual and shared commitment for action.

Co-presencing: We committed to 'being present' to help us connect with our deepest sources of inspiration and stillness to learn from the past, make sense of the present and move to the future. We engaged in collective reflexive learning.

People's Assemblies on Care

In 2023, the Sydney Policy Lab worked with two communities where the University of Sydney has a physical presence and campus: Westmead in western Sydney and Broken Hill in far-west New South Wales to hold People's Assemblies on Care. These People's Assemblies formed a distinctive stream of community-led policymaking and were designed as a response to the sentiment that members of the Australian public were tired of successive royal commissions doing post-mortems of policy failures in key policy areas related to care.

Throughout the first year of the Australia Cares project we had heard there was deep interest in inverting the model of a top-down, retrospective analysis of systems and policies that had failed to deliver on community expectations. Given the failures in areas of policy related to care had been so long-running and systemic, there was also a sense it would be important to enable community-led conversations to express what they value and have reason to value, setting the agenda that would enable subsequent policy development.

Since providing and receiving care is so intimate, and also social,

we looked for methods that would allow for greater representation of groups normally more peripheral in national conversations and greater deliberation of the issues important to them.

We selected a deliberative method to create a microcosm of a local community or a 'mini public'. Inspired by a wave of deliberative democratic exercises that have sprung up around the world, we sought to design the People's Assemblies on Care to:

- maximise the experience for citizens to engage with one another and care policy
- support those gathered to decide what is important for them to deliberate upon
- bring together academic and community expertise in service of the community's agenda for deliberation
- enable those gathered to develop new policy ideas and recommendations
- enable academics taking part to learn with community members.

In prioritising the experience of community members, we purposefully chose to deprioritise rigor in the deliberative method itself. Practically this meant we chose a more informal approach without formal testimonies, designed activities that sought to enable a movement from precognitive to cognitive engagement with the topics and subject matter and did not conduct polling of collaborators before or after the Assembly. We worked with Fred Dust, former Global Managing Director of IDEO, now Founder of Dust & Co., and Rob Healy, also from Dust & Co.to use design thinking methods to create participatory and deliberative activities for the Assemblies.

To select community members to take part in the Assemblies, we worked with Rebecca Huntley from 89 Degrees East to design the sample. In turn, she worked with a subcontractor to recruit 20 community members for each Assembly. In Broken Hill, the recruitment protocol was for a broadly representative cross-section of the Broken Hill population, using Australian Bureau of Statistics data as the reference point. We then adjusted those quotas to seek an equal representation of females and males, a higher proportion of Aboriginal and Torres Strait Islander people than in the general Broken Hill community, and people with experience of chronic illness.

In the final group recruited in Broken Hill, there were eight people identifying as Aboriginal and Torres Strait Islander – Indigenous Australians make up approximately 10 percent of the Broken Hill community – and approximately eight people known to be experiencing chronic illness. In Westmead, we focused selection on members of the community who have an Indian background. This was informed by insights from the first stages of the Australia Cares project in which those we spoke with in government and communities highlighted the need for policy development that reflected the values and expectations of culturally and linguistically diverse communities. In Westmead and the surrounding suburbs of Wentworthville, Parramatta, Harris Park, Rosehill, Girraween, Pendle Hill and Toongabbie up to 45 percent of the community are of Indian descent. For the Westmead Assembly, we recruited 20 people from the Indian diaspora from these suburbs. The protocol was set so collaborators could be born in India or Australia and be citizens or non-citizens. We also sought an equal representation of females and males and a cross-section of this community by age. In recognition of the dominant cultural practice of living in multigenerational households, we specifically sought families living in such settings and defined this as more than one generation of adults living together.

The Assemblies were designed to run in two phases in each location. Phase one, a three-hour evening workshop, was an exercise in consultation and agenda setting which set-up for phase two, an all-day workshop on a weekend to deliberate on policy solutions.

In Broken Hill, Professor Brendan McCormack, Dean of the Susan Wakil School of Nursing and Midwifery facilitated the three-hour session with First Nations Lead at the BHUDRH, Mariah Goldsworthy. The Assembly was supported by Richard Weston and Nola Whyman from the Maari Ma Aboriginal Health Corporation and Corina Kemp, a representative of the Far West Local Health District and member of the Broken Hill Aboriginal Community Working Party. Richard Weston, Nola Whyman and Corina Kemp assisted with the facilitation of small group discussions and supported our lead facilitators as community observers, providing reflection and clarification throughout the session.

The Assembly benefited greatly from their deep understanding of community needs and of care systems. Dr Nikita Simpson, an anthropologist, joined the Sydney Policy Lab team in facilitating deliberations in smaller groups. Dr Simpson was also available to document the care stories of those who gathered and wished to share their stories in greater depth.

From this first phase of the People's Assembly in Broken Hill, a key question was discerned: How do we capitalise on community resources and forms of knowing to co-create solutions that enable effective navigation of care systems in Broken Hill?

Phase two of the Broken Hill People's Assembly on Care was scheduled for October. At the request of Aboriginal and Torres Strait Islander members of the community and the Aboriginal Community Working Party following the referendum on The Voice, we postponed the Assembly to allow them time to grieve the outcome.

In Westmead, we held the Assembly on Care at the University of Sydney's Westmead Clinical School which is inside Westmead Hospital. Professor Brendan McCormack facilitated the three-hour session with Professor of Pharmacy Practice Bandana Saini. Phase one in Westmead was supported by Mereline Murimwa-Rarami from SydWest Multicultural Services and by Sapna Lazarus from SEVA International, a not-for-profit focused on serving the South Asian community. The Assembly was enriched by their understanding of care systems and perspective on community needs. Associate Professor Myra Hamilton joined the Sydney Policy Lab team in facilitating deliberations in smaller groups.

From this first phase of the People's Assembly in Westmead, the driving question for subsequent deliberation was developed: What transcultural issues and challenges get in the way of an effective eco-system of care and support that enables extended family systems to flourish?

The People's Assembly reconvened in early November and was opened by Professor Kathy Belov, University of Sydney Pro-Vice-Chancellor, Global & Research Engagement. The Assembly was supported by the community organisations and lead facilitators from phase one as well as by University of Sydney staff: Chandana Guha, consumer representative and research assistant, Centre for Kidney Research, School of Public Health; Dr Vaibhav Tyagi, Senior Research Fellow, School of Nursing and Midwifery; Associate Professor Murray Fisher, School of Nursing and Midwifery; and Dr Anita Van Zwieten, School of Public Health.

Notes

1. Tara Brach, Radical Compassion: Learning to Love Yourself and Your World with the practice of RAIN (London: Rider Books, 2020); Paul Gilbert, The Compassionate Mind (London: Robinson, 2010); Jon Kabat-Zinn, Coming to Our Senses: Healing Ourselves and the World Through Mindfulness (London: Hachette Books, 2006).
2. Otto Scharmer et al., The Essentials of Theory U: Core Principles and Application (Oakland CA: Berrett-Koehler Publishers, 2018).

Illuminating Lived Experience

Exploring researcher perspectives on co-design through participatory methods

The lived experiences of people involved in care – from informal and formal care workers to the people they support – is foundational to the Australia Cares project. To learn from the ways people with lived experience are included in co-design and research methods, the Sydney Policy Lab initiated a reflective research program on lived experience methods.

Through a series of interviews, dialogues and collaborative writing processes, co-authors of a forthcoming report explored tensions between different approaches and core concepts underpinning lived experience methods and shared examples of those methods in practice.

This summary shares key insights that emerged from that discussion. It poses questions that may help guide researchers and policymakers seeking to engage people with lived experience and three core principles we believe are required for such engagements.

Defining lived experience research

The concepts of co-design and lived experience research are often confused or used interchangeably. Through our dialogue we explored their overlap and what makes them different.

Co-design, and other methods like co-production, seek to co-create. Co-design is a type of research method that seeks to privilege or centre the voice of community participants with lived experience by ensuring they are equal collaborators and full partners throughout the full research process, from identifying research priorities, designing methods and data collection, interpretation and analysis, all the way to shared authorship and implementing impact strategies.

Lived experience research is a broader category in which researchers seek to privilege the voices of people with lived experience but not necessarily to co-create. For example, people with lived experience may only be involved at specific stages of a research process, perhaps as members of an advisory group, participants in workshops or subjects for data collection. Different 'levels of participation' in research exist and depending on how people with lived experience are involved in the research they may have limited power to exercise influence over the project and its outcomes.

In our report we argue lived experience research methods are not always co-design, yet co-design should always include lived experience people and communities deeply and creatively throughout the research process.

Many of us are concerned the language of co-design can be used for other consultative practices. When engagement with lived experience participants is a tick box exercise, rather than a meaningful process that emancipates communities, it is not co-design.

There is no formula for lived experience research. To realise the emancipatory potential of recognising and building knowledge centred on people's lived experience, methods will look different for different people. Our aim is to encourage researchers to be creative in the ways co-design and lived experience are approached while being true to the critical roots of participatory methodologies.

Rather than being prescriptive, the principles and practices developed in our research are offered as a guide – a starting point for play.

Guiding questions for engaging lived experience

Through our dialogue we distilled three questions that can guide research design and elicit reflection and action from researchers and policymakers engaging lived experience, including ourselves:

1. How are we ensuring our relationship practices with persons and communities are reciprocal and not extractive?
2. How are we including people from diverse communities, at their discretion, as active and equal members of our research teams in ways that allow them to exercise agency and autonomy?
3. How are we collaboratively identifying and evaluating tangible evidence our collaborators benefit from their involvement and the research outcomes?

Three core principles

Through our dialogue, three core principles and values emerged as foundational to engaging people of diverse experiences.

1. **Critical reflection and ongoing learning**

Commit to critical reflection and ongoing learning at personal and institutional levels.

Lived experience research requires researchers to question values and assumptions, be open to changing direction, and learn from the people and communities they are working with. Here we mean researchers to include researchers with lived experience of the topic under investigation, with and without qualifications. Lived experience methodologies start with a process of critical reflection on the position of those who are initiating the policymaking or research. This means being aware of:

- our own power and social position as well as the historical and cultural context from which our privilege derives as, for example, researchers at the University of Sydney

- people who have not benefited from historical circumstances
- types of skills and knowledges that have been cultivated and privileged in a western capitalist society
- ongoing impacts of racism, colonialism and imperialism.

Moreover, it means recognising the:

- ableism and stigma that overlooks the abilities of people with lived experience of disability
- ongoing injustices Aboriginal and Torres Strait Islander peoples face, the horrific impacts of white Australian policies that have denied Indigenous people their culture, languages and ways of knowing
- Country on which we work and the ways our lives are entangled in the wellbeing of the ecosystems of which we are a part
- destruction patriarchy has caused and its ongoing impact on our hidden values and assumptions.

This is the context that we live and research in. We participate in the continuing evolution of this culture and context. The first principle of lived experience research is a call for continuous critical self-reflection, learning and improvement.

2. Meaningful inclusion

Commit to sharing power and ensuring people with lived experience and communities are involved and in the lead throughout the research lifecycle. Involve people in inclusive and generative ways, wherever possible on terms they decide.

We should consider how people with lived experience are being included throughout the design or research process. This means including people with lived experience as early as possible and being open to those people or communities changing the framing or research question.

They are the closest to the topic of concern and their knowledge is to be privileged. There are many ways to do this. Our full report showcases some of these methods, drawing on our own experience with co-researchers, co-designers, lived experience-led research, power analysis and consulting lived experience advisors.

3. Evolving cultures and institutions

Commit to involving the cultures and institutions engaged in this work to properly and ethically value, respect and benefit people and communities of diverse lived experiences in long-lasting ways.

Including lived experience in research requires investing additional time and money in relationships with involved people and communities in authentic and reciprocal ways. Approaches that are tokenistic, extractive and exclusive must be avoided. Priority should go to ensuring people and communities benefit from their involvement in the research process and the outcomes.

Research culture and our institutions have not historically valued people with lived experience. This final core principle articulates the need to continually evolve cultures and institutions to ensure they value, respect and benefit people and communities of diverse lived experiences in long-lasting ways. This includes a focus on challenging systems and structures that perpetuate injustice.

The Language of Care

A strengths-based, person-centred guide to changing terrain

Dr Juliet Bennett

The language we use reflects hidden attitudes and values. Language can make people feel good or bad, powerful or powerless. Transforming care requires us to reflect on the words we use and learn how we can use words to make people, including ourselves, feel supported to live our best lives.

This top-level exploration of the language of care draws on and points to language guides specific to different areas including First Nations peoples, disability, mental health, and recovery from alcohol and other drug addiction. We highlight a few commonalities across these areas, focusing on three principles: (1) start with the person, (2) focus on strengths not deficits and (3) reflect critically on contexts as an ongoing learning process. We recognise a map is not the terrain, all language guides are incomplete and the language of care will continue to change in our changing world.

1. Start with the person

People are more than their diagnosis, age, job or disability. These are just one aspect of a person and their identity. When making language choices we should consider not only how we describe a person receiving care or support, but all the people they are in relationships with, including family, friends and support workers. It is important to respect the rights and dignity of each person.[1]

Language that reflects an orientation to people and their agency starts with the person, and descriptive labels can follow. One might talk about:

- 'a person with disability' not 'the disabled'
- 'an older person' not 'the elderly' or 'the aged'
- 'a person experiencing homelessness' not 'the homeless'
- 'a transgender person' or 'transgender people' not 'a trans'
- 'people who are vision impaired' not 'the blind'
- 'a person who has schizophrenia' not 'a schizophrenic'
- 'a person with paraplegia' not 'a paraplegic'
- 'a person with a dependence on ...' not 'an addict' or 'an alcoholic'
- 'a child with learning disability' not 'a slow learner'

The point of this principle is to avoid words, narratives and assumptions that reduce a person to one aspect of their personhood. Instead, draw attention to the many dimensions that make each of us who we are.

2. Focus on strengths not deficits

No one wants to be thought of as a 'problem' that someone else is supposedly going to 'fix'. A 'deficit' view of a person or community focuses on negative experiences and depicts people as in need of others to provide solutions or care. This is linked to low societal expectations of capabilities and can lead to people losing independence, choice and control in their lives.[2]

In contrast, a strengths-based approach focuses on a person or community's positive experiences, such as what a person likes about their lives or when relationships are at their best. This directs attention to the many existing strengths a person or community has and their agency to solve problems that impact them.

Strengths-based approaches have been applied in many areas including recovering from sickness, drug rehabilitation, government services, international aid, people with disability and survivors of family abuse. Here are some examples of the language shifts a strengths-based approach could entail:

- only referring to a person's disability or illness when it is relevant
- 'person or people with disability' not 'person with a disability' or 'people with disabilities'[3]
- 'a person with AIDS' not 'AIDS victim' or 'a person suffering from AIDS'
- 'a child with disability' not 'a child crippled by ...'

- 'person who survived …' not 'a victim of …'
- 'person who has multiple sclerosis' not 'person afflicted by …' or 'person suffering from …'
- 'person with an intellectual disability' not 'intellectually challenged' or 'mentally handicapped'
- 'person with a conviction' or 'incarcerated person' not 'ex-offender' or 'the incarcerated'
- 'person seeking citizenship' not 'illegal immigrant'
- 'providing meaningful opportunities' rather than 'helping disadvantaged'
- 'priority population' not 'at risk' or 'vulnerable'
- 'lower income' or 'higher income' countries not 'third world' or 'first world'

Language guides on disability recommend avoiding language that suggests pity, perpetuates stereotypes or implies people with disability have a lower quality of life or want to be 'normal.'

Equally, describing people with disability or people who support them as 'inspiring' and often implying that others should be grateful that they don't have a disability, or that a person with disability achieved something 'despite their disability' assumes a low expectation to begin with. Use neutral language instead and avoid made-up terms like 'differently-abled' and 'special needs' which are ableist and patronising.[4]

This principle emphasises that the questions we ask, their framing and the assumptions made by our word choices have a real impact on people. Focusing on a person's strengths provides a starting point for building on those strengths in creating the life that person wants to live.

3. Reflect critically on contexts

All our experiences take place in social, economic and environmental contexts. Reflecting on the context of language invites a reflection on power and the public dimensions of personal challenges. An example is shifts in language around gender resulting from feminist's critical reflection on context and power over the past century.

In disability, there has been a shift away from a 'medical model' that defines disability in terms of individual 'deficits' in relation to a medically-determined spectrum and assumes experts need to look after people with disability. The contrasting "social model of disability" defines disability in relation to specific physical, social and cultural infrastructures that inhibit – dis-able – a person's abilities.[5]

Critically reflecting on language across cultures and history reveals that the concept of disability emerged from and was defined in the context of industrialisation. This is illustrated by the fact there is no word for disability in Aboriginal languages.[6]

Another example is the public dimensions of mental health. The media, economic pressures and even climate change can trigger mental illnesses such as anxiety, depression and bipolar. Reflection on the language we use to refer to mental health can help institutions like schools and workplaces evolve to better support neurodiversity and everyone's mental health.[7]

Critical reflection may inspire language changes, including:

- 'person without disability' not 'able-bodied'
- 'a child without disability' or 'non-disabled person' not 'able-bodied' or 'normal'
- 'brain difference' or 'neurodiversity' not 'mentally-ill'
- 'people' or 'citizens' not 'consumers'
- 'police officer' not 'policeman'
- 'human' rather than 'man' as a collective noun for humans
- 'Aboriginal person' or 'Aboriginal people', Torres Strait Islander people, or a specific language group not 'Native,' the acronym 'ATSI,' 'Aborigine,' 'Aboriginal(s),' or 'Islanders'
- adopting gender-neutral language such as 'invite your spouse or partner' rather than 'invite your husband or boyfriend'
- acknowledging diversity through use of plurals such as describing Aboriginal and Torres Strait Islander 'histories,' 'perspectives,' and 'ways of being'
- capitalising words for respect, including 'First Nations,' 'Country,' 'Land,' and 'Traditional Owners'

The principle emerging here is that gender, disability and brain differences are part of human diversity. Our social, economic and environmental contexts and practices can help or hinder that diversity and a person's ability to thrive. The ongoing process of critical reflection about language involves building relationships and listening to people who are being described.There are exceptions to every rule and principle, including these examples. Some people choose to put identity first and say 'disabled person'. Some groups of people have reclaimed words that were previously derogatory, such as 'queer' and the 'mad movement'. However, these are in-group terms and one wouldn't refer to a person as queer or mad unless they have told you that's how they identify. Some words, such as Aunty and Uncle for First Nations people, should only be used when invited to. Relationships and communication are key to adapting our language to each other's preferences.

Transforming how we care

Language is intertwined with power dynamics and social norms. There's value in reflecting on the words we use, what we mean by them and how others receive them. Person-centred, strengths-based language helps to challenge and transform power dynamics for greater equality and justice. The language we use about care is always changing. Critical reflection may ask us to reconsider whether to use the word 'care' itself! Reimagining care requires a commitment to reflecting like this as an ongoing learning process.

Language guides that informed this piece

- Mental Health Coordinating Council. Recovery Oriented Language Guide. 3rd ed. 2022. https://mhcc.org.au/recovery-oriented-language-guide-3rd-edition/.
- Network of Alcohol and Other Drug Agencies. Language Matters. 2021 https://nada.org.au/resources/language-matters/.
- People with Disability Australia. PWDA Language Guide: A guide to language about disability. 2021. https://pwd.org.au/resources/language-guide/.
- Reconciliation Australia. Demonstrating inclusive and respectful language. 2021. https://www.reconciliation.org.au/wp-content/uploads/2021/10/inclusive-and-respectful-language.pdf.
- Sum of Us. A Progressive's Style Guide. 2016. https://interactioninstitute.org/wp-content/uploads/2016/06/Sum-Of-Us-Progressive-Style-Guide.pdf.

Notes

1. Brendan McCormack and Tanya McCance, Person-Centred Practice in Nursing and Health Care: Theory and Practice (United Kingdom: Wiley Blackwell, 2016).
2. Marno Retief and Rantoa Letšosa, "Models of disability: a brief overview," Theological Studies 74, no. 1 (March 2018).
3. This is because disability is an uncountable noun like tea, knowledge or beauty, not a specific condition.
4. People with Disability Australia, PWDA Language Guide: A guide to language about disability (2021), https://pwd.org.au/resources/language-guide/.
5. Theresia Degener, "Disability in a Human Rights Context," Laws 5, no. 3 (August 2016); Colin Barnes, "Understanding the social model of disability: Past, present and future," in Routledge Handbook of Disability Studies, ed. Nick Watson and Simo Vehmas (New York: Routledge, 2020).
6. While there are "factual references to a person's functioning capacity within a community," such as deaf or blind, these terms are not pejoratives. Instead, they reflect "an acceptance of diversity and difference." Scott Avery, Culture is inclusion: a narrative of Aboriginal and Torres Strait Islander people with disability (Sydney: First Peoples Disability Network, 2018), 2, 4.
7. Amanda Tattersall, "Our collective mental health is stuffed, and it's more than just a medical problem," The Shot, August 10 2022, https://theshot.net.au/opinion-news/our-collective-mental-health-is-stuffed-and-its-more-than-just-a-medical-problem/.

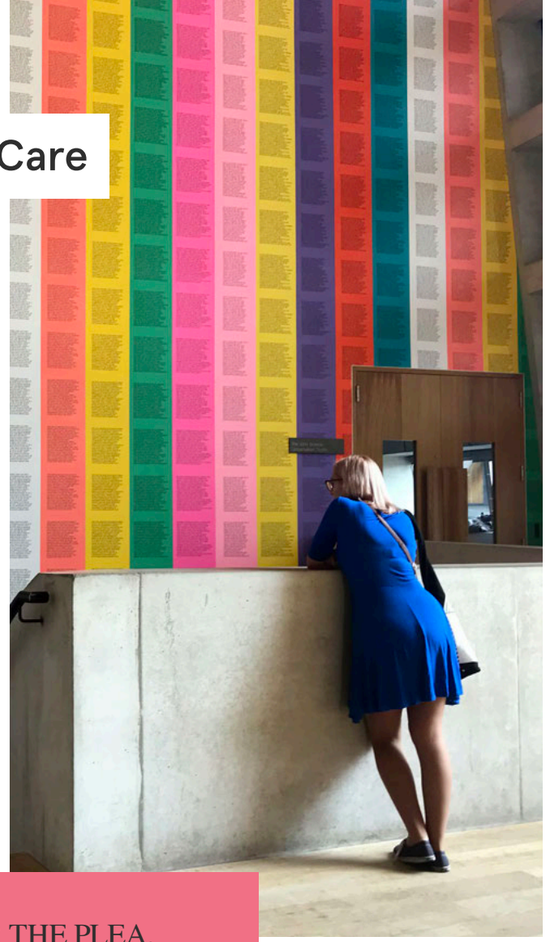
Inflammatory Statements on Care

Inspired by Jenny Holzer's Inflammatory Essays

Co-authored by
Australia Cares collaborators

15 August 2023

As she commenced a series of posters for pasting directly onto gallery walls by the hundred, artist Jenny Holzer sought out topics "that were unmentionable or that were the burning question of the day." Inspired by Holzer's work, Australia Cares collaborators working on the burning questions of care co-authored the three inflammatory statements on these pages. Like their namesakes, these statements aim to provoke, bursting with the immediacy of emotions around care and capturing the personal intensity of care experiences often elided policy documents.



Photograph of Jenny Holzer's Inflammatory Essays on display at the Tate gallery courtesy of C-Monster, licensed under Creative Commons BY-NC 2.0

LOVE LOST IN TRANSLATION. I HEAR THE PLEA. IT'S PEOPLE ASKING FOR HELP. CARE STARTS FROM THE HEART. HEART, LOVE, US, WE AS A COMMUNITY. PLEASE DON'T CHOOSE TO LOOK AWAY. SYSTEM LEVEL IS DILUTED EXPERIENCE. COME HOME TO WHERE WE LIVE, EVERYDAY. IT'S A DIFFERENT EXPERIENCE. MISINFORMED POLICIES DICTATING CARE CREATES CHAOS AND SUFFERING, SOLVES NOTHING. GREED KILLS. REGIONAL INEQUITIES ARE NOT OK. WELCOME TO THE POSTCODE LOTTERY. YOUR POSTCODE SHOULDN'T REPRESENT YOUR QUALITY OF CARE. CARE IS EVERYBODY'S BUSINESS. CARE INSPIRED IN THE WOMB. CULTURAL NORMS AND EXPECTATIONS, GOOD AND BAD. PATRIARCHY AND RACISM. DIVERSITY OF EXPERIENCES, PERSPECTIVES, CULTURES SHOULD INFORM SYSTEMS AND DECISIONS. SYSTEM LEVEL IS DILUTED EXPERIENCE. COME HOME TO WHERE WE LIVE, EVERYDAY. SELF PRESERVATION, CARING FOR SELF, BUT THRIVING. ELEVATION OF CARERS IS AN AFTERTHOUGHT. DIGNITY OF CARERS IS CRITICAL, HOW DO YOU SUPPORT THEIR DIGNITY?

GET OUT OF THE REEDS! STOP PROPPING UP A CARE EQUATION THAT DOESN'T ADD UP. MORE PEOPLE. MORE PRODUCTION. MORE CONSUMPTION. MORE CARE. MORE WORKFORCE. MORE MORE MORE. OUR PLANET DOESN'T HAVE MORE. PEOPLE DON'T HAVE MORE. WE NEED TO CREATE MORE THINGS THAT MATTER, WITH LESS. IT DOES NOT ADD UP. GETTING OLDER IS BECOMING CONSUMERIST - DO WE HAVE A USE BY DATE? - TO HELP THE MATH? RESOURCE CHALLENGES IN A 9 BILLION WORLD. CAN WE CONNECT? EXPERIENCE SHARED HUMANITY? MORE CHANCES TO SHARE - IN LATERAL AND UNCONVENTIONAL WAYS. MORE COMMUNITY. MORE BELONGING. MORE WATCHING EACH OTHER'S BACKS. SLOW DOWN. TAKE TIME.

CARE IS COMPASSION, KINDNESS, PURPOSE, PATIENCE, DISCOVERY, PRIVILEGE. DIGNITY. DUTY, EXPECTATION AND HONOUR. YET I'M ON A STRING, I GO HOUR BY HOUR. I STRAIN. NO HEALTHCARE WITHOUT INFORMAL CARERS. UNPAID AND UNTRAINED THE ONUS IS ON YOU TO FILL THE GAPS. NEVER A TIME OF SUCH ABUNDANCE STAGE 3 TAX CUTS LET'S FUND THE NEXT WAR BUT NOT CARE. WHAT IF I CAN'T COPE? BEING A CARER IS NOT SEXY. WHEN WILL YOU HEAR US? I'M TIRED OF PROTESTING. WE VALUE YOUTH, HEALTH, PRODUCTIVITY, UTILITY. ABLEISM AGEISM BURDENSOME. YOU'RE NOT VALUED BECAUSE YOU'RE NOT A $ SIGN. BURDEN. THE WORD LIVES DEEP IN EVERYONE'S PSYCHE. JUSTIFIES LIFE-THREATENING PUBLIC POLICY. WHAT IS OUR COMMON LANGUAGE OF STRENGTH REALITY NUANCE? LET'S VALUE BEING HUMAN NOT A HUMAN BEING DOING. FLIP THE NARRATIVE ON ITS HEAD. WHY ARE WE NUMB TO STRUCTURAL SYSTEMIC VIOLENCE?

Photographs: Shuaib Yeung for
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March 2024

Supporting R&D in the Aged Care Sector

Impact Economics and Policy | Sydney Policy Lab

IMPACT ECONOMICS AND POLICY

THE UNIVERSITY OF SYDNEY
Sydney Policy Lab

Impact Economics and Policy

Impact Economics and Policy brings together a group of expert economists and policy specialists with experience working for government, not-for-profits and big four consulting. Established at the start of 2022, our mission is to partner with clients for impact through providing robust evidence, fresh analysis and strategic communication to tackle Australia's biggest public policy challenges.

Dr Angela Jackson, Lead Economist

Angela is a health economist and has published a number of high-profile reports on health, aged care, disability, housing and gender policy.

Angela holds a PhD on the Economics of Disability in Australia from Monash University, a Masters in International Health Policy (Health Economics) with Distinction from the London School of Economics and Political Science, a Bachelor of Commerce (Hons) from the University of Melbourne and a Bachelor of Economics from the University of Tasmania.

Nathan Blane, Manager, Economics

Nathan is an economist and public policy expert that has worked for the Commonwealth Treasury, the Grattan Institute and most recently UnitingCare Australia as a Senior Adviser, Economic Policy. In this role he advised on community services and economic inclusion policies.

Sydney Policy Lab

The Sydney Policy Lab is a non-partisan space created by the University of Sydney where communities and the academy come together to investigate and solve complex policy issues that face our world. As innovators of a new public policy R&D system, our work builds relationships between people from diverse backgrounds to encourage greater empathy and drive the creation and implementation of community-led policies.

Dr Kate Harrison Brennan, Director

Kate has worked as Head of Policy & Design at the Paul Ramsay Foundation, CEO of an Anglican not-for-profit, adviser to an Australian Prime Minister and in the public service. Her publications focus on public policy and international organisations.

Professor Brendan McCormack, Academic Chair, Australia Cares

An internationally-renowned nursing leader, Brendan has spent his career enabling person-centred practices in nursing and healthcare through participatory action research. He is now Head of School and Dean, Susan Wakil School of Nursing and Midwifery at the Faculty of Medicine and Health. Brendan has a deep commitment to cultures and practices of relational care.

We acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Owners of Australia and their continuing connection to both their lands and seas. We also pay our respects to Elders – past and present – and generations of Aboriginal and Torres Strait Islander peoples now and into the future.

Supporting R&D in the Aged Care Sector

Executive summary

Care has always been at the centre of our society, with the relationships it creates and deepens foundational to our collective wellbeing.

Likewise, the care sector plays a pivotal role in our everyday lives, in our communities and in our economy. And as the care sector becomes a larger part of our economy, innovation in the sector is becoming increasingly important.

The benefits of care services are wider than those that can be captured through market mechanisms and include:

- The existence and strength of relationships between carers and care recipients
- The wellbeing and quality of life of carers and care recipients
- The productivity of informal carers and care recipients
- Longer length of life for care recipients
- Reduced health system costs.

Research and development (R&D) is essential for innovation and driving improvements in care outcomes. However, investment in R&D is not occurring and in this research we take a deep dive into aged care to better understand the nature of the problem and the potential solutions.

Aged care

As with the entire care sector, R&D in the aged care sector is essential to improve the quality and cost effectiveness of services and address the evolving needs of care recipients. The benefits of investing in aged care R&D are varied but they all have a potentially profound impact on outcomes and the overall performance of the aged care system.

R&D in the aged care sector leads to the development of innovative treatments, therapies and practices. By conducting research, the sector can find new ways to diagnose, treat, prevent and manage diseases. Similarly, innovations can be made to improve wellbeing by providing new understandings of the broader lifestyle services on offer through sector. Innovative breakthroughs can save lives and improve quality of life.

On average, Australian firms spend 0.4 percent of expenditure on R&D. In 2020–21 just $464,953 of the $3 billion in total expenditure on residential aged care was invested in R&D, or 0.016 percent. By way of comparison, if the aged care sector spent as much on R&D as bee keeping it would equate to an additional $150 million per year on R&D.

There are international examples of R&D in the aged care sector that have realigned or reimagined services to maximise the outcomes including the autonomy of care recipients and efficiency of delivery. However, changes are needed in Australia in how we value care and support R&D so the potential of such innovations can be harnessed.

A number of reasons can explain the lacklustre performance of R&D in the care sector including the nature of aged care as a good, and difficulties in capturing the true benefits and value of innovation.

In this report we make recommendations to support R&D in the aged care sector going forward:

1. Establishing a coordination organisation for aged care R&D within government.
2. Developing a joint statement to provide a clear and transparent overview of the shared research and development objectives between the government, care recipients and the aged care sector.
3. Increasing government funding to reflect the relational nature of care services and support R&D across different organisational types and locations.

Why does innovation in the care sector matter?

Innovation is one of the cornerstones of economic policy because it underpins higher productivity and increased prosperity.[1] The investment that firms make in R&D is a major contributor to innovation, and governments work hard to ensure the environment is conducive to such investment.[2]

The CSIRO has estimated every dollar of investment in R&D in Australia generates $3.50 in direct economic benefits, excluding societal and environment gains.[3]

The services that make up the care sector play a pivotal role in our everyday lives, in our communities and in our economy. And as the care sector becomes a larger part of our economy, innovation in the sector is becoming increasingly important.

However, the care sector's value is greater than what is measured through GDP alone with traditional measures of economic progress not capturing many of the benefits of care work.

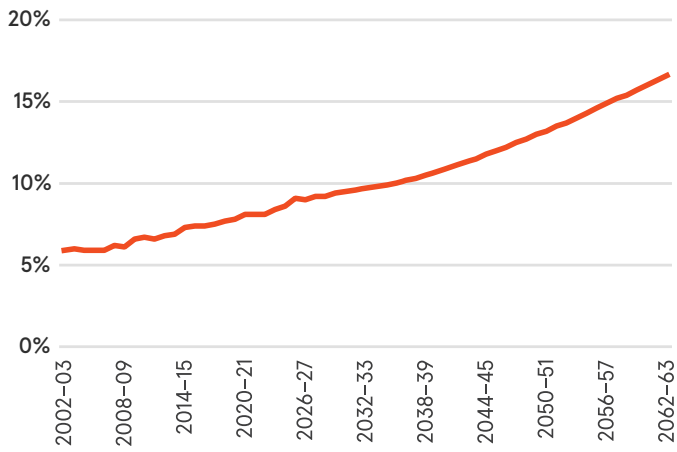
Care work is relational and involves a degree of reciprocity, and the nature of the relationship between care recipients and care providers is a fundamental element of the quality of care provided. The very act of providing care generates value through the extension of social ties and forming new relationships, which are not captured or capable of being captured by the market.[4]

Improving the quality, effectiveness and efficiency of care services underpins human flourishing, improved wellbeing and better health outcomes in addition to higher economic growth:

- Child care workers influence long term health, educational and economic outcomes for children.
- Aged care workers improve life satisfaction, lower levels of loneliness and through improving health outcomes extend life and reduce health care use.
- Counsellors improve life satisfaction, economic participation and reduce health care use of their clients.
- Disability workers improve life satisfaction, increase economic participation and improve health outcomes of people with a disability.

While the quality, effectiveness and efficiency of care services is heavily influenced by the individuals directly providing care, innovations in models of service delivery and the use of technology can have large impacts.

Figure 1: Care sector's share of GDP



Source: Treasury (2023). 2023 Intergenerational Report.

1. Kennedy, S (2023). Opening statement to the Economics Legislation Committee.
2. Department of Industry, Science and Resources (2023). Encouraging Australian businesses to invest in R&D.
3. CSIRO (2021). Returns to Innovation Working Paper.
4. Pabst A. (2021). Postliberal Politics: The Coming Era of Renewal.

There are international examples of how services can be realigned or reimagined to maximise the outcomes we want to promote, like the autonomy of care recipients and efficiency of delivery. However, changes are needed in the way that we value care so the potential of such innovations can be harnessed.

Across the care sector there is a lack of investment in the R&D needed to deliver the innovations in services that could deliver these better outcomes.

This is partly explained by the nature of care services. Providers are unable to fully capture the benefits of innovations. The benefits of care services are wider than those that can be captured through market mechanisms and include:

- The wellbeing and quality of life of carers and care recipients
- The productivity of informal carers and care recipients
- Longer length of life for care recipients
- Reduced health system costs.

In this research we seek to explore in detail what the benefits of such investment could be, why investment is lacking and how governments can ensure policy settings are conducive to investment. We focus on aged care services as an example to highlight the nature of economic and policy issues that will need to be addressed. We conclude there is a need for greater government stewardship of the R&D ecosystem in the care sector to realise the potential gains.

International innovations in care

"**The Buurtzorg model** (Dutch for 'neighbourhood care') is a nurse-led model of holistic home care that supports independent living in a community setting and is driven by a belief in 'humanity over bureaucracy'."[5] Operated by a self-managed team with minimal bureaucracy, the Buurtzorg model privileges the evaluation of 'person-centred outcomes' balanced against efficiency and cost effectiveness.

A review of programs that implemented the Buurtzorg model highlights success in achieving a person-centred care approach, improved communication with patients and family caregivers and the potential for establishing new networks with other services. "The main challenges were related to the self-managed working culture, the organizational framework, or national healthcare policies, which hindered the implementation process."[6]

Apps have improved the connection between care recipients and care providers. Evaluations of these apps show improvements in quality of life, care experiences and carer stress.

The use of **Virtual Reality** (VR) to enhance individual wellbeing, for example with patients receiving hospice care. A 2021 study found VR use "holds possibilities for relieving symptoms such as pain and anxiety frequently experienced by people in hospices," as well as "creating the capacity to reconnect with a previous sense of self and to allow respite through the capacity to transcend current reality and connect with another meaningful reality."[7]

Social prescribing describes methods of enabling health professionals, such as GPs or community nurses, to refer people to non-clinical services or sources of support in their local community. The prescribers, often known as "community connectors" or "community coordinators," link patients to these services and supports rather than prescribing, for example, a pharmacological treatment. The Global Social Prescribing Alliance showcases best practice in this area and key learnings.[8]

5. The Institute for Research and Innovation in Social Services (2020). The Buurtzorg Model.
6. Hegedüs, A; Schürch A; & Bischofburger, I (2022). Implementing Buurtzorg-derived models in the home care setting: a Scoping Review.
7. Lloyd, A & Haraldsdottir, E (2021). Virtual reality in hospice: improved patient well-being.
8. Global Social Prescribing Alliance (2021). Global Social Prescribing Alliance Playbook.

Drivers of R&D investment

Firms will undertake R&D when they perceive the expected benefits to outweigh the expected costs.[9] The most common benefits that drive commercial decisions around investment in R&D include:

- Greater market share through offering unique or superior products
- Charging a higher price for a product that is perceived as higher quality or offering more value to consumers
- Increased profit through improved productivity and reduced costs
- Fostering a culture of adaptation and innovation that can keep firms relevant.

The extent to which these benefits are realised will depend on the characteristics of the market a firm operates in and how well it can protect any intellectual property it generates from R&D activity.

Most R&D investment is funded by firms directly. However, governments also play a role in funding due to the wider economic benefits such investment can bring. Government intervention is warranted because firms may invest too little in R&D when they cannot capture all of the benefits or the benefits are highly uncertain.

Almost all OECD countries have policies or programs designed to incentivise business R&D. Most countries have a tax incentive included in this policy mix. Unlike other countries, Australia, alongside Canada and the Netherlands, relies almost entirely on a tax incentive to encourage R&D. Other countries offer more support to business R&D through direct measures like competitive grants.[10]

Australian government support for R&D

Research and Development Tax Incentive

The Research and Development Tax Incentive gives Australian businesses an incentive to invest in R&D by offsetting the costs associated with research and development against the tax a company owes. The objective of the program is to:

> encourage industry to conduct research and development activities that might otherwise not be conducted because of an uncertain return from the activities, in cases where the knowledge gained is likely to benefit the wider Australian economy.[11]

Direct government support

The Commonwealth, state and territory governments also provide direct support for R&D through funding universities, and awarding competitive and specific grants. These sources of support are important and ensure R&D is occurring in sectors where the potential benefits of R&D due to increased market share or reduced costs are unlikely to be realised.

The National Health and Medical Research Council and the Australian Research Council are the two primary sources of research funding in Australia. More recently, more focused funding mechanisms have been introduced to target particular areas of research. For example, $34 million has been provided to establish Aged Care Research Industry Innovation Australia.[12]

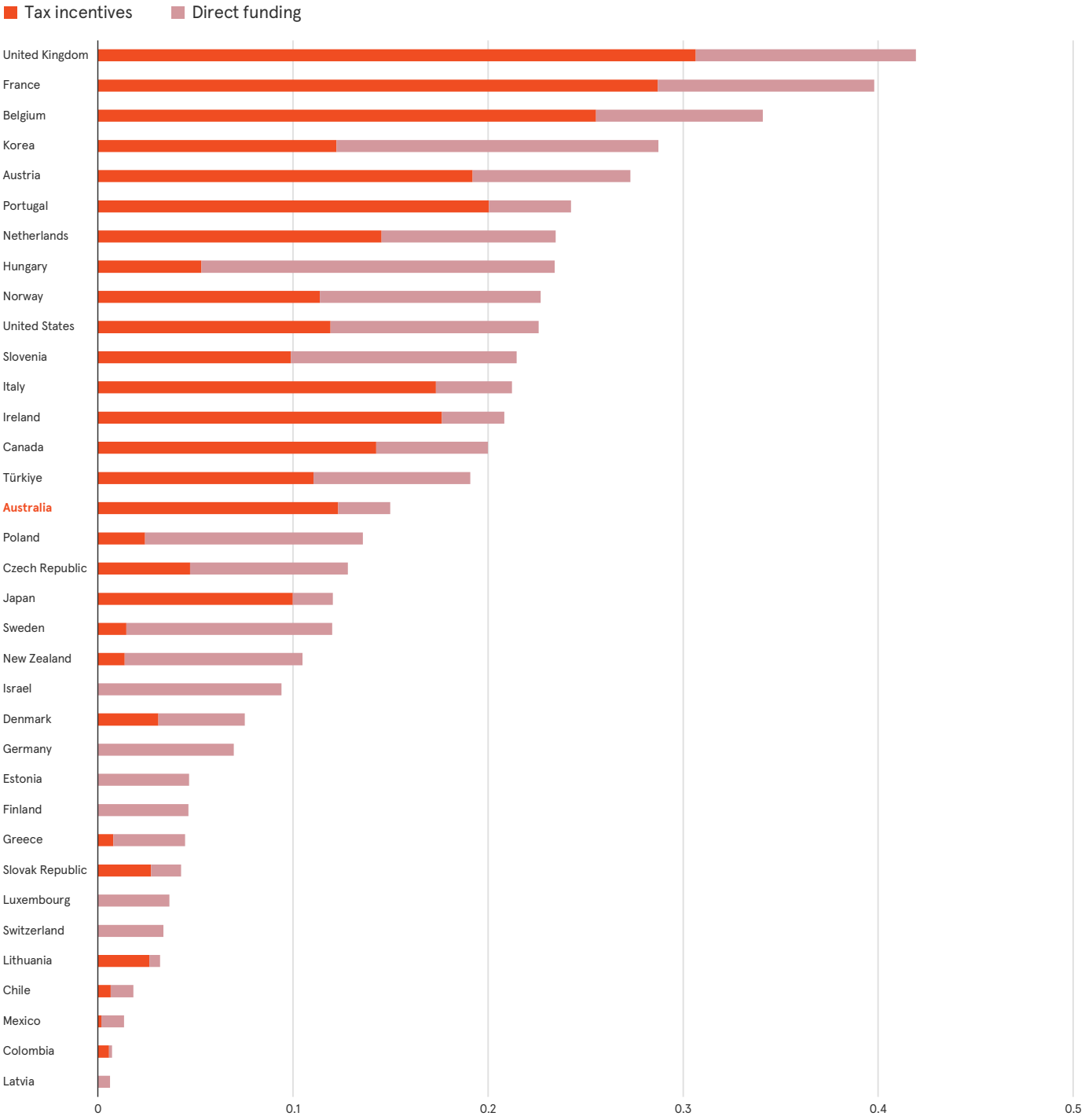
9. Romer, P (1990). Endogenous technological change.

10. Ferris, B; Finkel, A; & Fraser, J (2016). Review of the R&D Tax Incentive.

11. Australian Parliament. Division 355 of the Income Tax Assessment Act 1997.

12. Flinders University (2022). Aged Care Research & Industry Innovation Australia (ARIIA).

Figure 2: Tax incentives and direct funding for business R&D, 2019, percent of GDP



Source: OECD (2023). OECD R&D Tax Incentives database.

Current levels of R&D in aged care

The Australian aged care sector is lagging in its R&D performance when compared to other areas of the economy.

While there have been important and noteworthy pockets of innovation, the sector is not undertaking the same level of R&D seen elsewhere.

Private investment

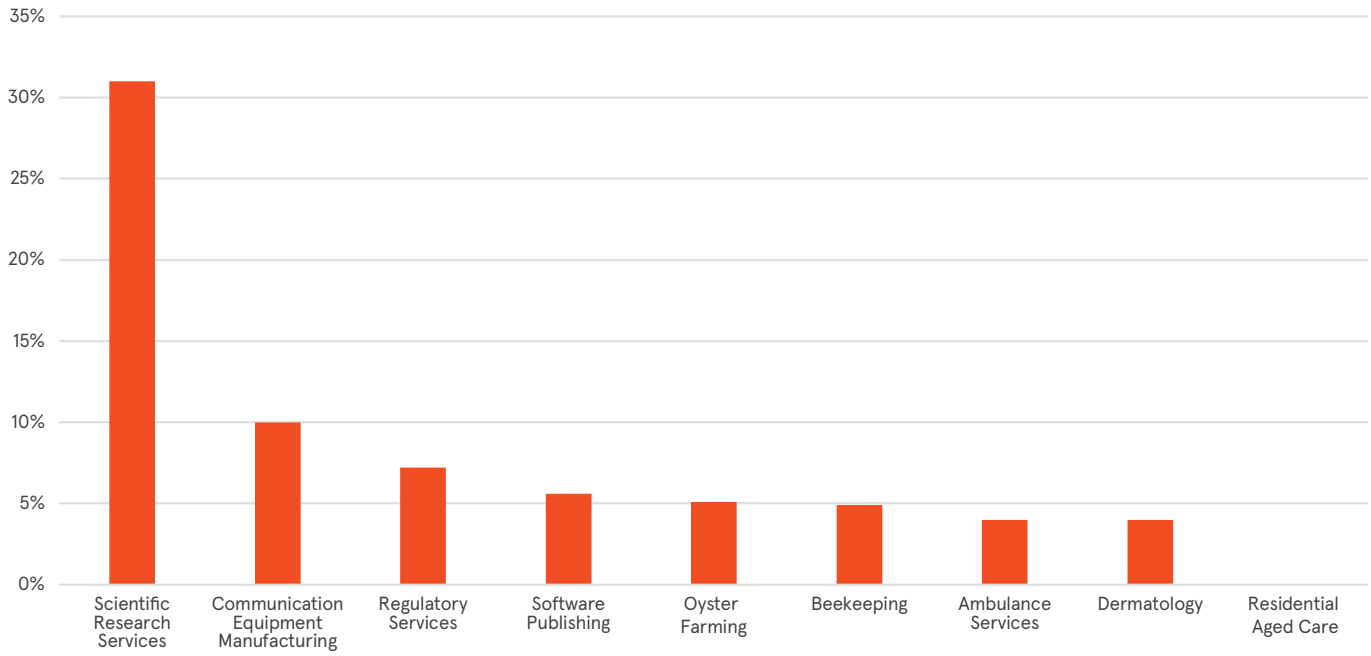
On average, Australian firms spend 0.4 percent of expenditure on R&D. In 2020–21 just $464,953 of the $3 billion in total expenditure on residential aged care was invested in R&D, or 0.016 percent.

This is much lower than other sectors such as regulatory services, beekeeping, software publishing and oyster farming, which spend about 5 percent of total expenditure on R&D. In percentage terms, these sectors spend over 300 times more on R&D than the aged care sector, highlighting the lack lustre performance of the aged care sector when it comes to privately funded R&D.[13]

By way of comparison, if the aged care sector spent as much on R&D as beekeeping it would equate to an additional $150 million per year on R&D.

13. ATO (2023). Taxation Statistics 2020-21.

Figure 3: R&D share of total expenses for select business categories, 2020-21, percent



Source: ATO (2023). Taxation Statistics 2020-21.

Public investment

Following the Royal Commission into Aged Care Quality and Safety, there has been a renewed focus on public funding of aged care R&D.[14] Two funds have been established to exclusively fund aged care R&D:

- $34 million establishing Aged Care Research Industry Innovation Australia to 2024.[15]
- $330 million for the Dementia and Aged Care Services Fund focused on existing and emerging dementia challenges in aged care.

In addition, funding for aged care R&D can be accessed from the Medical Research Fund, the National Health and Medical Research Council and the Australian Research Council Grants. However, very little funding has been awarded to aged care projects:

- $40 million of the $2.6 billion Medical Research Fund, less than 1.5 percent, has been directed to aged care since 2017.[16]
- $19 million of the $2.8 billion National Health and Medical Research Council, less than 0.7 per cent, has been directed to aged care since 2021.[17]
- $31 million of $15 billion from the Australian Research Council (ARC), 0.2 percent, has targeted aged care research since 2002.[18]

14. Royal Commission into Aged Care Quality and Safety (2021). Final Report.
15. Flinders University (2022). Aged Care Research & Industry Innovation Australia (ARIIA).
16. Department of Health and Aged Care (2023). Medical Research Future Fund grant recipients.
17. National Health and Medical Research Council (2023). Outcomes of funding rounds.
18. Australian Research Council (2023). ARC public datasets.

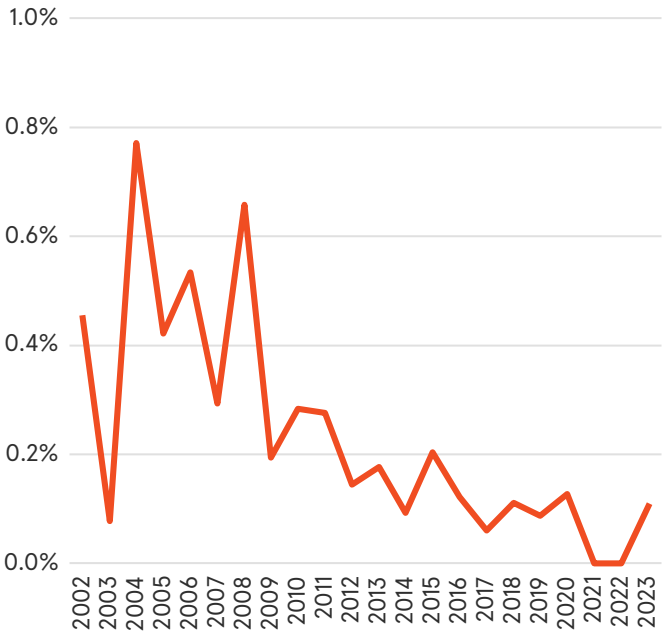
ARC funding for aged care-related research has fallen as a share of total funding over the past twenty years. Between 2002 and 2011, 0.4 percent of the total was directed to aged care, from 2012 to 2023 the proportion was 0.1 percent.[19]

Total investment

The result is that funding for R&D focused on aged care services is very limited. Across private and public sources around $100 million per year or 3.6 percent of total expenditure in aged care is spent on R&D.

19. Australian Research Council (2023). ARC public datasets.

Figure 4: Australian Research Council funding directed to aged care, percent



Source: Australian Research Council (2023). ARC public datasets.

Aged care R&D funding

Funding source	Coverage	Total funding	Aged care funding
Private R&D	Aged care only	Over $13 billion in 2020-21	0.004% - $0.5 million in 2020-21
Aged Care Research Industry Innovation Australia	Aged care only	$34 million over two years to 2024	100.00% - $34 million over two years to 2024
Dementia and Aged Care Services Fund	Existing and emerging dementia challenges in aged care	$330 million over four years to 2023	100.00% - $330 million over four years to 2023
Medical Research Future Fund	All health	$2.6 billion since 2017	1.44% - $40.2 million since 2017
Australian Research Council	All research	Over $15 billion since 2002	0.21% - $31.1 million since 2002
National Health and Medical Research Council	All research	$2.8 billion since 2021	0.67% - $18.6 million since 2021

Why does innovation in aged care matter?

Under current arrangements there is a lack of investment in aged care R&D that is undermining the development of innovative technologies and practices needed to drive improved care outcomes across the sector. As observed in the Royal Commission Interim Report:

> Australia prides itself on being a clever, innovative and caring country. Why, then, has the Royal Commission found these qualities so signally lacking in our aged care system? We have uncovered an aged care system that is characterised by an absence of innovation and by rigid conformity. The system lacks transparency in communication, reporting and accountability.[20]

R&D in the aged care sector is essential to improve the quality and cost-effectiveness of services and address the evolving needs of care recipients. The benefits of investing in R&D aged care are varied but they all have a potentially profound impact on outcomes and the overall performance of the aged care system.

Key benefits of stronger aged care research and development capacity include:

1. Services that better meet the individual needs of care recipients
2. Improved cost effectiveness
3. Improved capacity to do more R&D in the future
4. Improved capacity to adopt and diffuse new ideas and regulations
5. Positive spillover impacts.

R&D in the aged care sector leads to the development of innovative treatments, therapies and practices. By conducting research, the sector can find new ways to diagnose, treat, prevent and manage diseases. Similarly, innovations can be made to improve wellbeing by providing new understandings of the broader lifestyle services on offer through sector. Innovative breakthroughs can save lives and improve quality of life:

> Investment in innovation, science and research provides the foundation for groundbreaking technologies as well as new and significantly improved processes, products, marketing and organisational practices.[21]

Simultaneously, R&D in aged care can enhance the efficiency and cost-effectiveness of service delivery. Through R&D efforts, the government and providers can identify better practices and implement new processes to streamline operations. This can reduce administrative burdens, shorten wait times and lower costs.[22]

Strengthening research and development capacity over time builds the human capital required to grow and expand research programs in the sector. The discoveries made through research not only benefit current practices but also lay the groundwork for future innovation. Individuals and institutions develop skills and processes that drive and encourage R&D. As a result, R&D done well today leads to even better R&D tomorrow.

Innovation has been defined as invention plus adoption plus diffusion.[23] Performing research and development well fosters collaboration and knowledge sharing among individuals and institutions across the sector. A robust invention network strengthens adoption and diffusion capabilities across the sector. The practice of implementing locally developed R&D makes the sector more agile and responsive to international developments and mitigates the expense of implementing government policy changes.

Given the interconnected nature of the care sector, and other areas of the economy, there are also positive spillovers beyond aged care. For this reason, innovations intended to improve the aged care sector will also have broader benefits in other sectors.[24]

20. Royal Commission in Aged Care Quality and Safety (2019). Interim Report.

21. Industry, Innovation and Science Australia (2021). Driving effective Government investment in innovation, science and research.

22. Business Queensland (2023). Research and Development.

23. Kelly C, Young A. (2013). Promoting innovation in healthcare.

24. Bakhtiari, S (2016). The Role of Spillovers in Research and Development Expenditure in Australian Industries.

Why is there a lack of investment in aged care R&D?

As with all firms, aged care providers will undertake R&D when they perceive the expected benefits to outweigh the expected costs.[25] The most common benefits that drive decisions around providers' investment in R&D include:

- Greater market share through offering unique or superior products
- Higher price for a product that is perceived as higher quality or offering more value
- Increased profit through improvement in productivity and reduced costs
- Fostering a culture of adaptation and innovation that can keep firms relevant.

While providers should be able to capture the benefits of reduced costs from R&D, the nature of the market for aged care services means the benefits of providing a superior product or higher quality may not be fully captured by providers.[26]

In particular, the relational nature of aged care work is based on reciprocity. In order to provide aged care, social ties are extended and new relationships are formed. The value of these relationships cannot be captured within a market framework, creating a market failure and a lower level of quality and provision.

The market for aged care services

The Australian aged care sector functions as a quasi-market, where government funding to providers is determined by the number and care needs of residents,

25. Romer, P (1990). Endogenous technological change.

26. Harris, R & Trainor, M (2009). Why do some firms undertake R&D whereas others do not?

Market characteristics	Impact on R&D investment
The provision of aged care services requires a degree of reciprocity, and a key value of its provision is through its extension of social ties and new relationships the value of which cannot be captured in traditional markets.	Because the value cannot be captured, there is lower level of R&D investment than would be socially and economically optimal.
Measuring outcomes and success of R&D is difficult because the impact of provider effort on care outcomes is hard to determine due to differences between residents that are unobservable and the long timeframes over which outcomes occur.	Providers may not benefit from increased market share as a result of R&D if it is not possible to measure outcomes accurately.
Quality of care has many dimensions and assessment of quality is subjective and heavily influenced by the relationship between carers and users.	Any improvement in quality may not be reflected in available quality data, increasing the risk that there will not be benefits from R&D.
Residents with high care needs often must rely on others to make decisions about care.	There may be an improvement in the wellbeing and quality of life of residents, but decision makers may undervalue this improvement meaning providers do not benefit.
There is asymmetry of information with providers possessing more information about service quality and how it impacts on residents leading to adverse selection and moral hazard.	Providers may be able to overstate the quality improvement.
The absence of private insurance markets to cover the costs of social care means that governments dominate the financing of the sector. Similarly, many consumers are unable to afford top-up contributions beyond government funding.	Providers may not be able to charge a higher price when they provide higher quality care or deliver better outcomes due to government pricing structures.
Aged care is an experience good, meaning that before moving into aged care judging quality is difficult, so is comparing facilities. The reliance on services for day-to-day needs increases the consequences of making a poor decision. This is especially true given very high costs to switching providers.	Decisions are made with limited information and will not track quality as well as other markets.

and residents have the freedom to select their aged care provider. The Government simultaneously regulates provider performance, staffing ratios and consumer charges.

Economists consider that markets represent the most effective mechanism for achieving optimal quantity and quality, with increased competition leading to more efficient resource allocation. However, for this ideal scenario to materialise, the aged care market must align with the characteristics of a perfect market.

The market for aged care has a range of characteristics which make it difficult for individual providers to benefit from R&D, and therefore reduces their incentive to invest in R&D.

These imperfections in the market for aged care services mean providers may not be rewarded for improving quality and better meeting the needs of residents in the same way as with other markets, reducing the benefits of investing in R&D. This strengthens the need for appropriate government regulation and funding of aged care services, as well as the need for government support for R&D in the sector.

The Government could also look towards reforms of the aged care market that would ensure providers are more likely to capture some of these benefits, including:

- Improved use of quality indicators to ensure providers are rewarded through higher market share for improving quality and better meeting the needs of residents
- Limiting price competition to ensure quality is the main source of differentiation between providers
- Use of average pricing so that where providers are more efficient than the market average they are rewarded, and where providers are less efficient than average they have strong commercial incentive to improve their efficiency.

Nature of aged care as good

Even in a well-functioning market the nature of potential benefits from providing aged care services means they do not accrue to providers in aged care. These benefits can be thought of as positive externalities and, because they are not captured by providers, they do not factor into

	Beneficiaries				
Benefits	**Informal carers**	**Care recipient**	**Provider**	**Government**	**Care workforce**
Improved health outcomes	Increased ability to participate in work and improved wellbeing	Improved health	Reduced care costs in residential aged care setting	Reduced expenditure on health care	Improved employment conditions
Improved wellbeing	Increased ability to participate in work and improved wellbeing	Improved wellbeing	No	No	Improved employment conditions
Reduced care costs	Reduced cost of services	Reduced cost of services	Increased profits	Reduced government expenditure	No
Increased demand for services	Not fully realised	Increase in number of relationships	Increased demand for services	Increase in expenditure	Increase in number of relationships

their decision making about the optimal level of R&D.

- Both care recipients and care providers benefit from the provision of care services through the extension and deepening of social ties and relationships.
- While providers benefit from improved health care outcomes through reduced care costs, there are broader benefits including for governments through reduced health expenditure, workers through lower care needs of residents and informal carers through increasing ability to participate in paid work.
- Improved health outcomes and improved wellbeing of care recipients arising from R&D make care recipients a key ultimate beneficiary of R&D done well.
- Increased wellbeing of care recipients can benefit informal carers' and workers' wellbeing, as well as increase the ability of informal carers to engage in paid work.
- Reduced costs of delivering care benefit providers through higher profits but also workers through potentially underpinning higher wages across the sector.
- Increased demand for aged care services not only benefits providers through increased market share, but also can benefit aged care workers through improved employment conditions.

Consequences of market imperfections and failings

Decisions on what and how much R&D to undertake in the aged care sector should reflect the range of potential benefits and beneficiaries. But there is strong evidence that community priorities are not being appropriately weighted in the current system. In particular, financial outcomes have been prioritised at the expense of care and wellbeing outcomes.

Reflecting the relational nature of care, investment is required across geographies, forms of infrastructure (physical, social and civic), organisational types, capabilities, jobs and skills. Without a holistic approach to investment in a relational economy, the current basis of value creation – including through the limited R&D that does take place – risks a lack of focus on what we value most as a society.

Evidence heard at the Royal Commission indicated regular, if not common, deviation from community care expectations. Financial outcomes were prioritised above care outcomes when physical and chemical restraints were used with terrible results. Similarly, care priorities suffered when young people were placed in residential aged care because there was nowhere else for them to go.[27] In these and a range of other instances, we see evidence of a tendency to overapply financial consideration and underapply care consideration.[28]

Reversing the underapplication of wellbeing considerations is at the centre of the Government's recently released wellbeing budget, the Measuring What Matters Statement. That statement calls for a more deliberate appreciation of non-financial value and opens:

> Traditional economic indicators have long been the focus of public debate and remain a vital part of measuring progress, but they are far from the whole story.[29]

Wellbeing outcomes are at the centre of why we have an aged care system. While measurement of outcomes can make assessing the benefits hard in aged care, care outcomes lend themselves well to R&D projects.

27. Royal Commission into Aged Care Quality and Safety (2021). Final Report. And Royal Commission into Aged Care Quality and Safety (2019). Interim Report.

28. Related research shows the more prevailing a profit motive within an aged care provider, the worse the care outcomes are. Cf. National Ageing Research Institute (2020). Inside the system: aged care residents' perspectives, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 13.

29. Treasury (2022). Measuring What Matters Statement.

How to support R&D in the aged care sector

Robust and developed R&D approaches are ubiquitous in high-performing industries. Sectors like agriculture, pharmaceuticals and financial services all have sustained track records of improving productivity to drive better outcomes for consumers. Understanding the drivers in these industries offers the prospect of unleashing the potential for greater R&D in the care sector.

Different sectors draw on different strengths and opportunities to drive effective R&D practice, but there are five important drivers of R&D across all sectors:

- Clear R&D objectives
- Importance
- Sector capability
- Funding
- Risk tolerance.

Clear R&D objectives

Clear metrics are an important part of R&D as they provide a way to measure and evaluate performance, impact and effectiveness. McKinsey and Co. identify the absence of accountability metrics as one of the four key causes of commercial R&D failure, noting that "R&D groups in most sectors lack effective mechanisms to measure and communicate progress."[30]

Some of the most successful R&D processes have very simple input and outcome metrics. Often there is just one: make a profit while working within the organisation's legal and moral obligations. The pharmaceutical industry is renowned for its standardised pipeline of clear progress metrics and valuation implications.[31]

In aged care there are not these simple input-output relationships, with the enduring value of care services coming from the impact they have on the individual care recipient's quality of life. These impacts are often difficult to measure and can be different across different cohorts, location and individuals. This all contributes to the outcomes from R&D in aged care being difficult to ascertain and capture.

Quality of life measures which can attest to the broad benefits of aged care services are by design subjective, multidimensional and individualised, making them challenging to quantify and assess. Other outcome measure such as clinical performance or safety records can be more objective. However, they do not capture the relational nature of aged care services.

The Royal Commission noted the limitation on quality of care research that results from issues with measurement:

> ... if you are researching for quality of care or quality of life outcomes, these matters are not capable of being flawlessly measured, as compared to blood pressure, for example, which is capable of objective measurement.[32]

However, there is scope for improvement. A comprehensive evidence review undertaken by Flinders University assessed 46 international measurement tools of quality of life, consumer satisfaction and consumer experience.

The quality of life tools reviewed were able to develop understanding of the subject's physical health, alongside their mental health, emotional state, social connection, environment and personhood. Consumer satisfaction tools develop understanding of the care recipients' views

30. McKinsey & Co. (2020). Building an R&D strategy for modern times.
31. Light (2012). Pharmaceutical Research and Development: What Do We Get for All that Money? SSRN Electronic Journal
32. Royal Commission into Aged Care Quality and Safety (2021). Final Report.

of their own experience around issues such as respect, being supported to make their own decisions and staff skill.[33]

Using tools like these, practice and policy decisions can be made with a fuller understanding of care outcomes. Obtaining this outcome will require the active promotion of wellbeing as a research priority. It will also require more funding into the sector and a more balanced approach to which projects are funded.

Perceived importance of R&D

In industries with a strong focus on R&D, firms and funders recognise the need to prioritise the research and development topics with the greatest potential benefit.[34] Organisations and individuals are motivated by the scale of the potential benefit of a task or project.

Aged care providers have also experienced a consistent cycle of review and incubation paired with very limited success of rolling out new innovations at scale.[35] Pioneer gaps such as this have created fatigue and a sense that R&D isn't as worthwhile because, even if it is productive, it might not be implemented.

Changes in government policy can also produce uncertainty of strategic objectives. Where one government may prioritise quality, a later government may favour alternate R&D objectives such as cost control. This risk led the Australian Centre for Social Innovation to call for new R&D institutions with intergenerational stewardship responsibilities that would provide the sector with consistent objectives.[36]

Ultimately lifting the perceived importance of R&D requires support and guidance by the government and from within the sector. Additionally, the outcomes of R&D need to be promoted and visible.

33. Ratcliffe, J. et al. (2021). Measurement tools for assessing quality of life, consumer satisfaction and consumer experience across residential and in-home aged care: Summary Report

34. Cf. Aged Care Research and Industry Innovation (2022). Grants.

35. Royal Commission into Aged Care Quality and Safety (2020). Research Paper 3 – Review of Innovative Models of Aged Care.

36. Australian Centre for Social Innovation (2021). Social R&D White Paper.

Sector capability

Sector capability is essential as "the ability to exploit novel ideas to deliver economically viable innovation is dependent on the strength and availability of scientific cadres and talents."[37]

Aged care R&D is inadequate in part because expert talent is insufficiently attracted to work in the space. Professor Briony Dow, Director of the National Ageing Research Institute, told the Royal Commission that research into the delivery of aged care is not viewed to be particularly important:

> the problem is circular: societal attitudes filter down, aged care research is not seen as a particularly attractive area by educators and researchers, and this is reinforced by a lack of funding.[38]

As with all capability enhancement, R&D capability requires time to develop and strengthen over successive wins and improvements. Again, the aged care sector suffers for having seen too few innovations developed and implemented to full effect.

Once engaged in aged care-related work, skilled researchers will only be motivated to stay if they can see the real world impact of their work being implemented and where the impact of that implementation is transparent.

37. Sarpong, D (2023). The three pointers of research and development (R&D) for growth-boosting sustainable innovation system.

38. Royal Commission into Aged Care Quality and Safety (2021). Final Report.

Funding

There is a case for government intervention through public finance for R&D to support provision of aged care as a good and as an important part of the foundational economy essential for wellbeing and human flourishing.

Making new discoveries requires exploration. This needs expertise, equipment and facilities, regulatory compliance, and market research. Even through these investments, the uncertainty of discovery means failure is common. Each of these R&D components introduces new and often significant costs.

As previously outlined, funding for R&D is lacking in the aged care sector:

> Such R&D is typically undertaken by market participants to obtain competitive advantages, but providers in the aged care sector lack the resources to invest in risky R&D.[39]

While government funding can deliver R&D outcomes, direct funding into aged care R&D has been limited with an average of $1 million a year from the Australian Research Council, $6 million a year from the National Health and Medical Research Council and $7 million a year from the Medical Research Future Fund. Ultimately lifting R&D performance in the sector will require additional funding from government.

Risk tolerance

Innovators need to be willing to fail. Research shows that in corporate innovation failure tolerance is critical.[40] In the absence of a willingness to fail, the necessary exploration and testing can't be undertaken.

The social license to operate has become an increasingly pressing issue in aged care over the past 20 years with considerable negative media attention relating to the profit focus of providers and common substandard care being offered to recipients.[41] Within this low trust context, provider willingness to undertake trial or experimentation involving care recipients can be muted.

Additional protocols are required for ethical experimentation with people and communities so that social R&D can thrive. This was highlighted when the Royal Commission into Aged Care and Safety and the Royal Commission into Victoria's Mental Health System both recommend participatory research and design activities into deliberative processes.[42]

A coordinator that advises on and supports appropriate risk in aged care R&D will better facilitate the right level of engagement and a greater research output. Transparency of research practice and research outcomes, where appropriate, will also spread the mindset necessary to undertake productive research.

39. Royal Commission into Aged Care Quality and Safety (2021). Final Report.

40. Tian, X (2014). Tolerance for Failure and Corporate Innovation. The Review of Financial Studies.

41. Cf. Sammut, J (2008). The aged care industry is desperate for more of accommodation bonds and Royal Commission into Aged Care Quality and Safety (2021). Final Report.

42. Royal Commission into Victoria's Mental Health System (2021). Final Report and Royal Commission into Aged Care Quality and Safety (2021). Final Report.

Jumping aged care R&D barriers

The barriers to greater aged care R&D are considerable. Overcoming them will require comparable and sustained effort.

The following recommendations are necessary to get aged care R&D back on track, including through government funding.

Recommendation 1

A coordinator

A coordinating organisation should be established for aged care R&D within government. This coordinating organisation should have the following objectives:

- Support a joint statement on aged care R&D: The organisation should provide secretariat support to develop the joint statement on aged care R&D, see recommendation two.
- Balance funding distribution: Ensuring government funding support for R&D in aged care is distributed in a manner that appropriately balances clinical, financial and quality of care objectives, across the economy. This will deliver research efforts that are well rounded and consider all aspects of aged care, leading to comprehensive improvements.
- Promote quality of care: Promote the significance of quality of care objectives within the aged care sector. By emphasising the importance of delivering high-quality care to older individuals, the coordinating organisation can drive a culture of excellence and improvement.
- Ensure integration with care workforce reforms: Ensure investment in aged care R&D keeps the care workforce central, valuing the everyday economy and workers' jobs, supporting vocational education and training, building social relations and trust, and creating meaningful jobs with opportunities for career progression.
- Support and guidance for researchers: Provide support and guidance to researchers in designing and conducting R&D projects in aged care settings. This support should include information on acceptable types of failure, empowering researchers to take calculated risks without fear of detrimental consequences. If necessary, regulations for the provision of aged care should be amended to accommodate support for safe and appropriate R&D.
- Strategic implementation: Improve the implementation process for successful R&D projects. Streamlining the process will ensure that, when effective research is conducted, the resulting improvements can be efficiently integrated into aged care practices.
- Drive transparency: Provide advice to government and the sector on policy settings necessary to strengthen the relationship between quality and market share. Publicly report on the priorities, progress and outcomes of R&D in the aged care sector.

Recommendation 2

A joint statement on aged care R&D

A joint statement should be pursued to provide a clear and transparent overview of the shared research and development objectives between the government, care recipients and the aged care sector. This clarity ensures everyone involved understands the goals and can work collectively towards achieving them.

Highlighting the importance of quality care as a central research objective should be a focus of the statement. This focus will ensure research efforts are not solely driven by clinical and financial considerations but also by a genuine concern for the wellbeing of aged care recipients.

A statement will also convey that aged care offers promising opportunities for research careers. This can attract talented individuals to this sector, ultimately leading to innovation and improvement in aged care practices.

A clear and well-communicated joint statement will provide confidence within the aged care sector that their efforts in development and improvement will be implemented. This, in turn, can stimulate further innovation and investment in research.

By acknowledging the acceptable types of failure in research, the joint statement will encourage a culture of learning and growth. This fosters an environment where researchers and care providers can experiment, make improvements and collectively advance the quality of care in aged care settings.

Recommendation 3

More funding

An immediate increase in direct government funding is essential.

Aged care R&D needs more funding. The amount of funding to be delivered into the sector for R&D should be a consideration of the joint statement on R&D, and should ensure that approaches reflect the relational nature of care services including the importance of place.

Short term allowances should be made for the financial crisis currently unfolding in aged care with a long-term view to return to a more even balance between provider and government contributions.

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All Together

A new future for commissioning human services in New South Wales

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Sydney Policy Lab

Acknowledgement of Country

We acknowledge the tradition of custodianship and law of the Country on which the University of Sydney campuses stand. We pay our respects to those who have cared and continue to care for Country.

About the Sydney Policy Lab

The Sydney Policy Lab is a multidisciplinary research institute at the University of Sydney and a nonpartisan space where people from all walks of life can meet and develop plans collectively for the future.

We exist to forge collaborative relationships between researchers, civil society, industry, politicians and policymakers that are capable of creating new knowledge and driving change that would shape an Australia which is more equal, where power is in the hands of everyday people and where more people feel a secure sense of belonging in their own society.

The Lab develops original and far-reaching research projects which unite the grounded wisdom that comes from everyday experience and the perspectives gained from rigorous scholarship. We work in partnership with institutions who seek to put new ideas into practice.

Our unique way of working strengthens the ability of our researchers and partners to collaboratively generate new ideas, transform the ways they work and effect change.

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Table of Contents

A note about the Community Sector in New South Wales

The people and communities of New South Wales (NSW) are similar in many ways to others around the world. Everyone wants to live in safe, strong and resilient communities, living full lives with friends, families and loved ones. Sadly though, not everyone has shared in the decades of prosperity. Inequality is growing. There are still too many people in NSW who are being left behind, who are doing it tough or who live in fear of danger.

The community sector has played an essential role in NSW for over a century, providing crucial services that build community strength and cohesion. They are the housing, youth and domestic violence services that provide relief and support in times of crisis and accommodation in times of need. They also include services supporting families and children to create and maintain safe and nurturing environments. And local community centres where people come together to share, learn and connect with each other.

The independent community-based organisations at the heart of these services, often propelled by passionate volunteers, are most closely connected with communities, be they urban, rural or remote. They can also be a guiding light to governments when it comes to identifying what people need and designing innovative responses.

Community sector peak bodies in NSW support these independent organisations. Peaks convene forums for information sharing and learning, develop individual and organisational skills and capacity, and advocate for sector funding or policy changes that will take pressure off the system.

A leader of one of the peak organisations explains:

A key role of community sector peaks in NSW is working to ensure that government funded organisations are equipped to respond to changes in government policy direction. Sometimes, this requires working independently with specific stakeholders. Other times, the peaks work closely together respond to systemic issues.

The change by the NSW Government from its historical contracting to a commissioning model is one such moment where 10 community sector peaks saw the opportunity to bring together their collective wisdom and experience to drive a different discussion.

Regardless of service delivery, client group, or geography, the peaks recognised early that discussions with elected government and departments about transitioning to commissioning would have powerful influence if had with one voice.

We invited Sydney Policy Lab to help our voice gain clarity.

Participating NSW peak organisations:
The Centre for Volunteering, Churches Housing, Domestic Violence NSW, Fams, Homelessness NSW, Local Community Services Association (LCSA), NSW Council of Social Services (NCOSS), Shelter NSW, Y Foundations and Youth Action.

Foreword

The provision of key services to communities, and especially to communities experiencing disadvantage, is one of the fundamental tasks of any government.

But getting it right is extraordinarily difficult.

It is difficult right now, of course, because of COVID-19 and the terrible disruption that follows in its wake.

But it was already difficult before that.

For far too long, many service recipients have reported being dissatisfied with the experience they receive, whether it is because they feel they are looked down upon by those who occupy decision-making positions or because the complexity of their situation and their interlocking needs is not properly understood.

Service providers and their representatives also report feeling undervalued. Sometimes they complain of being pitted against each other as competitors for ever more restrictive public funding. At other times, they insist that their wisdom and expertise is not treated seriously enough by those who are more distant from the frontline.

Expectations of government and the public service are sometimes complex too. They know that citizens more broadly demand high quality, but also value-for-money services and they are rightly anxious that any error or failure to call out inadequate service provision will likely reflect badly on them.

It is in this context that a new idea has emerged that promises to draw all of these different groups together, sharing power and responsibility and developing a more collaborative approach for the future.

It is an idea that places human beings' capacity for relationship building at the heart of its analysis. It emphasises that connection, dialogue and shared goals often stand a greater chance of transforming lives than competition, hands-on management and conflict.

In practical terms, that big idea goes by the prosaic name of "commissioning."

This report investigates what commissioning can be, what it currently is and how we might seek radically to improve it for the future.

The argument that it sets out is that successful commissioning depends on a courageous and creative spirit––a willingness to experiment––and on the depth of the connections between all the different partners in the service delivery ecosystem. Only where trust is built and real relationships are crafted can this new approach hope to succeed where previous ones have failed.

All of this will require us to be driven by people rather than focused on process, and to take decisions which require professional judgement and empathy, while creating a genuinely community-led response to the challenges we face.

That is not an easy path.

This approach will raise profound challenges for those of us who assess risk and demonstrate accountability. It will require us to recalibrate our thinking for a complex 21st-century world. But the opportunities are enormous nonetheless, and I hope very much that this report encourages more people to try.

Professor Marc Stears
Director, Sydney Policy Lab

Summary

60 second summary

Since the late 1990s, the term commissioning as a concept and practice has steadily gained ground in characterising the procurement, funding, design, delivery and evaluation of human services for individuals and communities.

In its ideal form, commissioning promises to deliver service redesign through a collaborative approach across government, service providers and communities that puts people at the heart of their care as active participants.

It has been framed as a panacea to address the complicated task of delivering services to meet citizen needs in today's increasingly complex world. However, translating it into policy and embedding it into practice has proven to be a complicated task.

The process to date in New South Wales (NSW) has been challenging for the NSW Government and community sector peak organisations that represent community service providers across the state. Despite a shift in rhetoric, commissioning human services in NSW has largely mirrored New Public Management (NPM) style contracting and procurement, characterised by competitive and transactional ways of working.

This report seeks to reshape the understanding of commissioning, away from a search for policy blueprints to be transplanted from other places or experiments, towards a realisation that good commissioning is *a way of working* that sees government agencies, service providers and other stakeholders working together and requires a commitment to community involvement, flexibility, learning and relationships.

To move towards good commissioning, the research coins the tool of a commissioning jigsaw—six core questions that commissioners must engage with to shape any experiment. It also distils four fundamental principles which, when taken together, form a lens through which the government and community sector ought to approach the design of commissioning initiatives in NSW.

Executive summary

What can good commissioning look like in NSW? And what can government agencies, service providers and peak bodies do to bring this to life? These are the key questions this report seeks to answer.

As citizens lead increasingly demanding lives and their needs become increasingly complex, ensuring people receive the support they need has become an equally complicated task.

Since the late 1990s, the term *commissioning* as a concept and practice has steadily gained ground to characterise the procurement, funding, design, delivery and evaluation of human services for individuals and communities. Commissioning has been done in different ways in different jurisdictions, and so definitions of commissioning vary.

When it comes to the NSW Government engaging family and community sector organisations to deliver services relating to housing security, child wellbeing, domestic violence and community development, commissioning has emerged with the promise of a new way of working. A new approach that encourages government agencies, service providers and other stakeholders to collaboratively design and deliver services whilst putting people and communities at the heart of their care as active participants.

In its ideal form, commissioning shifts systems away from a focus on narrow problem solving towards fostering wellbeing, from managing need towards developing agency and capability, from transactions towards relationships, and from containing risk towards creating possibility.

While there is much excitement for this more integrated and inclusive approach, translating it into policy and embedding it into practice is a challenging task and, as this report explains, necessarily so.

As multiple government agencies grapple with the cultural and operational shifts required, initial shifts in language have not yet translated into perceivable changes in procurement practices. This has exacerbated historically strained relationships between government and the NSW community sector, as well as within the sector.

Nevertheless, the Sydney Policy Lab's research has found that the current state of play is characterised by both challenges and hope. There is considerable agreement on the underpinnings of what is understood to be *good commissioning,* and crucially, people in the sector as well as government agencies are demonstrating significant goodwill and leadership in efforts to work together to support safe and strong communities across NSW.

This report seeks to support this important process. It is the result of an ambitious collaboration in 2019 between the Sydney Policy Lab and ten peak organisations in the NSW family and community care sector. By bringing together leading academic knowledge, international best-practice expertise and deep local experience it combines the voices and evidence of academics and practitioners in NSW and Australia more broadly, as well as New Zealand and the UK.

The report explores three core questions on commissioning:

1. Commissioning: What is it and what is it not?

2. What has been the experience in NSW?

3. How can commissioning be done well and what might a way forward look like in NSW?

Commissioning: What is it and what is it not?

While there is no one fixed definition, commissioning is widely and increasingly understood as a strategic, collaborative and *way of working* that centers relationships, is highly context-specific and encompasses all stages of the policy cycle.

In this context it is particularly important to distinguish between the potential of commissioning when practiced in a collaborative environment across government, service providers and communities, and New Public Management (NPM) style contracting, which is transactional and tends to operate in an oppositional and competitive environment. This research found that while the two approaches are based on wholly different value systems, contracting has in the past been implemented under the guise and rhetoric of commissioning.

This report seeks to dispel the myth that a single transplantable commissioning policy blueprint exists, and instead coins the concept of a commissioning jigsaw containing six core questions which funders, service providers and communities ought to collaboratively engage with in order to shape relational commissioning experiments in their jurisdiction that meet the needs of their communities and context.

What has been the experience in NSW?

NPM-style practices such as public service outsourcing, competitive tendering, contracting and other procurement along market-led and efficiency-seeking principles remain commonplace in NSW. This research found that these precedents have shaped experiences with commissioning to date, eroding relationships between the NSW Government and the family and community services sector and creating barriers to effective long-term collaboration.

How can commissioning be done well?

This report distils four fundamental principles that underpin good commissioning, centering on the need to build relationships and trust; elevating the role of communities in planning and delivery; embedding learning and flexibility to allow for experimentation, reflection and evolution; and rethinking funding models to invest in people and communities.

Taken together, these four principles of good commissioning form a lens through which the government and community sector ought to approach collaboration on the design of commissioning experiments in NSW—in particular the core questioned outlined in the commissioning jigsaw that are the foundation of any experiment. The paper also offers concrete examples of the types of activity that either enhance or hinder progress.

What might a way forward look like in NSW?

The report concludes with a closer examination of how this approach might inform experiments in NSW, presenting a set of recommendations intended to help the NSW Government and community and family peaks move forward.

No magic bullet exists for getting commissioning right and any framework is only as strong as its participants' commitment to learn, adapt and evolve. In this spirit, the report emphasises the need to build genuine partnerships that include establishing an independent commissioning agency, or agencies, to support and develop commissioning experiments across the state.

Introduction

Introduction

How do we ensure that people have access to the foundations of a fair and prosperous society – personal security, housing, health, education and transport?

How can people going through tough times get the support they need to get back on their feet?

How can governments deliver services in ways that meets the legitimate desire of citizens to control their own lives and make their own decisions?

These questions have always been difficult and answering them now is as hard as it has ever been. Citizens lead increasingly complex and demanding lives. They have little time or patience for navigating often rigid and complicated systems that struggle to respond to all the different and often interconnected types of problems or disadvantage they face.

A single mother with a disability might need support finding accommodation to escape a violent relationship and provide a safe and stable home for her young child. In a traditional service delivery landscape, this mother might need help from multiple people and community service providers, many of whom may not interact effectively with each other.

In the last five years, a new approach called "commissioning" has been suggested as the solution to challenges like these.

In its ideal form, commissioning promises to deliver service redesign through a collaborative approach that puts people and communities at the heart of their care as active participants.

It is an approach that intends to shift systems away from a focus on narrow problem solving towards fostering wellbeing, from managing need towards developing agency and capability, from transactions towards relationships, and from containing risk towards creating possibility.[1]

In the words of award-winning and influential social entrepreneur Hilary Cottam:

> Modern welfare must create capability rather than manage dependence; it must be open, because all of us need help at some stage and when we are thriving many of us have help to offer; it must create possibility rather than seek only to manage risk; and it must include everyone, thereby fostering the connections and relationships that make good lives possible.[2]

Much practised in the UK and New Zealand, commissioning has more recently made its debut in Australia.

Working out how to bring commissioning to life in NSW has become a conundrum for a number of government agencies. More than 15 reports on commissioning and outcomes-based funding have been published by different agencies, signalling a desire to work in a different way.

However so far, the initial shift in language has not yet translated in significant change on the ground. As such, some peak organisations and service providers report having grown increasingly exasperated with ongoing funding practices which they believe prompt short-term transactional interventions and foster cultures of competition, alongside cycles of review, and jargon-heavy reform programs.

All of this, at its worst, has resulted in mistrust and fragmentation in a sector that is meant to look after people, forge resilient relationships and deliver care. Ultimately, it is the people and communities that commissioning is intended to serve who lose out.

Fortunately, there is a common desire across government and peak bodies to drive towards successful change.

The leadership of NSW peak bodies—organisations which represent, resource and advocate for hundreds of independent, community-based service providers across NSW—have committed to a shared ambition to collaborate on areas of common interest and collective concern. They intend to lead big conversations about the future of the sector, the evolution of the role and performance of peak bodies, and the relationship between new policy frameworks—all drawing from their experience and relationships on the ground and a resolve to involve people and communities more directly and effectively in their work.

This report is one result of that intention.

We begin from the assumption that good commissioning is no easy task. In the pages that follow we shall demonstrate that each instance of commissioning is unique. Getting it right requires a whole-of-system approach to service design. It needs governments, peaks and community groups to forge real relationships and practical collaborations rather than simply adhere to a pre-designed policy blueprint. It demands a culture of experimentation, iteration and flexibility to find the sweet spots of success that can go on to inspire future experiments.

While this may seem daunting it offers unique opportunities. This is a big opportunity that comes at a crucial moment that should not be wasted.

So, where to next?

How do we get from where we currently are to good commissioning?

That is what this report will explore.

A note about the research

This report is the result of an ambitious collaboration between the Sydney Policy Lab and ten peak organisations in the NSW family and community sector. The Lab was commissioned by these organisations in 2019 to examine commissioning as a concept and a practice internationally, across Australia and in NSW, and to propose recommendations for the peaks and other interested stakeholders.

The resulting research brought together analysis of state-of-the-art academic knowledge, international best-practice expertise and deep local experience. It drew on evidence from desk research encompassing key academic and grey literature[3] and from qualitative interview research on case studies, including interviews with international practitioners in New Zealand and the UK and local experience in NSW and Australia more broadly.

Initial insights were tested and enhanced through a series of participatory workshops and one-to-one interviews with over 30 people across the NSW community sector and the NSW Government.

The research was conducted by a multidisciplinary team led by Professor Susan Goodwin at the University of Sydney and Professor Marc Stears, Director of the Sydney Policy Lab, and comprised of Mark Riboldi, Dr Elaine Fishwick and Lisa Fennis, from the Sydney Policy Lab. All interviews and analyses were conducted with the approval of the Ethics Committee at the University of Sydney according to the highest academic standards.

This detailed research was then synthesised into this report which aims to provides insight to four core questions around commissioning, each of which is now discussed in a separate chapter below:

1. **Commissioning: What is it and what is it not?**
2. **What has been the experience in NSW?**
3. **How can commissioning be done well?**
4. **What might a way forward look like in NSW?**

Commissioning: What is it? What is it not?

Commissioning is a way of working that is just starting to emerge in NSW following experiences overseas. Every commissioning experiment is unique to the jurisdiction in which it is practised. It is shaped by local and contextual factors as well as choices commissioners make around the role of the community, service providers and government.

These choices determine whether commissioning merely changes the name of current contracting practices and looks like "old wine in new bottles", or if it enables a bolder shift towards achieving broad social outcomes.

Strategic commissioning involves clearly identifying and prioritising service outcomes and clarifying the resources necessary to achieve those results. It may include the development and redesign of the systems and structures through which these services will be delivered. It requires a mature engagement with delivery agents, particularly in commissioning the function or service upfront.

O'Flynn & Sturgess, 2019[4]

Commissioning in theory

While definitions of commissioning in practice tend to vary, it is increasingly understood as a strategic endeavour that involves working relationally across government, service providers and communities and that encompasses all stages of the policy cycle.

> For me, commissioning is about thinking through what outcomes we're seeking to achieve as a group of people—government, non-government, communities themselves—then how do we work together as a system to achieve those outcomes?
>
> *NSW Government interviewee*

Since the late 1990s, the term commissioning as a concept and practice has steadily gained ground in the area of designing and delivering human services for individuals and communities, first in the United Kingdom, then in New Zealand and more recently in Australia. As a term, commissioning is used to describe different practices in different contexts.

In the United Kingdom (UK), commissioning has for many years been synonymous with public sector procurement and purchasing of non-government services. Responding to a number of perceived problems with the more transactional aspects of procurement process, organisations such as the New Local Government Network (NLGN) have begun to talk about 'community commissioning' in order to reorient services around relationships which start with citizens and their needs.[5]

In NSW, commissioning of community-based organisations is being framed as a different approach to purchasing services that the NSW Government has funded for many years, if not decades.

This report conceives of commissioning as a practice, a new *way of working* for human service design and delivery, as opposed to a catchall for all public sector procurement.

Australian experts describe commissioning as being "poorly or ambiguously defined" and "not a science; there is no one model or way of doing this."[6] Nonetheless, there is general agreement around the ideals of commissioning, particularly in its holistic or strategic approach.[7]

The following definition from the NSW Department of Family and Community Services (FACS)[8] in 2017 is consistent with broad definitions from the community sector, academics and other state and federal government agencies, commissioning is:

> a collaborative process to assess individual and community needs and assets, agree on outcomes, and design and evaluate the most efficient response to achieve outcomes over the short and long term.[9]

Similarly, a recent Australia New Zealand School of Government (ANZSOG) report for the Australian Public Service broadly defined commissioning as:

> concerned with how government goes about assessing needs, planning, designing and prioritising services (and other activities), authorising and funding, and evaluation.[10]

Multiple evaluations of experiments in commissioning have emphasised that a collaborative approach that centres relationships is crucial to successful commissioning, assigning government agencies with a more dynamic role in today's complex and multi-actor service delivery landscape.

In this sense, commissioning as a strategic and relational practice is somewhat of an evolution from the way governments have organised themselves to deliver services and meet community need in the past.

Broadly, from the 1930s to 1970s the underlying governing principle in social democracies like Australia, New Zealand and the UK was that public services were best coordinated and delivered centrally through government bureaucracies. This is the approach known in the literature as "Traditional Public Administration".

This was followed by the era of "New Public Management" (NPM), commencing from the late 1970s and early 1980s, characterised by the belief that bureaucracies left to their own devices rarely serve the interests of the least advantaged effectively. In seeking to enhance service quality, and sometimes also to reduce costs, NPM brought practices from the business sector into government. These included outsourcing existing services, competitive tendering, market creation and strict contract management.

Crucially however, NPM recognised that public service provision could never be the same as a commercial market and should therefore not be treated as such. Even in the heyday of NPM government agencies retained primary responsibility and accountability over care for its citizens, regardless of who delivered human services or the precise mechanisms they deployed.[11]

The resulting mixed environment—where governments provide some services directly, purchase other services from private or charitable providers and create markets to fund other services—is the starting point for any change today.

Dissatisfaction has grown with this approach in recent years, for many reasons.

Gary Sturgess,[12] former Director General of the NSW Cabinet Officer and currently the NSW Premier's ANZSOG Chair of Public Service Delivery, highlights that NPM approaches have been unable to satisfactorily address issues around the integration and coordination of services, performance management and quality control, and strategic engagement with service providers.

Others, including the British social entrepreneur, Hilary Cottam, have also observed the failure of NPM models to tackle entrenched disadvantage systemically. These critiques tend to emphasise the prevalence and shortcomings of often short-term and transactional nature of the relationships between government agencies, service providers and community groups.

Cottam traces this back to an underlying assumption in NPM that presumes partners cannot work together collaboratively or creatively but need instead to be treated as competitors with narrow areas of interest and expertise. She argues these beliefs prevent deeper and more sustainable responses to social problems from emerging.[13]

It is in light of criticisms such as these that commissioning has emerged as an alternative to NPM approaches. Commissioning is intended to allow partners to work strategically and

collaboratively across the broad spectrum of needs analysis, service design, delivery and evaluation to ensure that systemic issues as well as instances of one-off disadvantage are addressed, while ensuring that deeper and more sustainable relationships are created between the funders of services, service providers and the recipients of services.

Table 1 sets out the differences in principles and practice between the NPM approach and what is expected of commissioning as it is emerging in the literature internationally. It is an adaptation of a table by Dr Jennifer Mason, also used in an Association of Children's Welfare Agencies (ACWA) discussion paper on commissioning in NSW and utilised in a discussion paper by the Community Services Directorate.[14]

As the table on the following page demonstrates, the core differences between NPM Contracting and Commissioning exist at both the level of concrete practice and underlying assumptions.

NPM approaches tend to assume that everyone acts in their own interest, necessitating a vertical culture where government retains primary control over service design, procurement, performance setting, monitoring and contract management. NPM contracting is therefore in many ways a bureaucratised top-down exercise.

Commissioning, in comparison, starts with the assumption that all participants in the system—funders, service providers and service beneficiaries—have the potential to align around a common interest. This creates space for a horizontal culture which focuses on collaboration and developing trust. As Cottam puts it, commissioning is a relational exercise lending itself to genuine co-production.

For jurisdictions wishing to engage in commissioning, the big challenge is clearly how to move most successfully from a transactional top-down contracting approach to a whole-of-system commissioning approach based on strong cross-sector relationships.

There has been remarkably little objection to this change in theory, yet practice often tells a different story. As is detailed below, there are a plethora of experiments in commissioning taking place globally. Notably, research on these various jurisdictions suggests that a shift in language to commissioning has not always translated to a shift in practice from the NPM orthodoxy.

For example, J. Gordon Murray found that more than half of public servants who lead procurement in the UK stated that they thought that procurement and commissioning were the same thing.[15] Similarly, Janine O'Flynn and Gary Sturgess pointed to "considerable evidence that in Australia, the language of commissioning is being used as a substitute for procurement or outsourcing, rather than the more strategic integration of purpose and action."[16] Even closer to home, 90 percent of non-government organisation (NGO) practitioners in NSW interviewed by ACWA agreed that "it isn't clear how commissioning is different from past contracting and funding models."[17]

Not all experiments have seen such disappointment. This research identified a number of commissioning approaches that have been well-received locally and by expert analysis. Before we consider the possibilities of commissioning in NSW, therefore, this report presents some of these stories of commissioning in practice.

Table 1. **The difference between NPM contracting and commissioning**

	NPM Contracting	Commissioning
Underlying assumption	Each party pursues its own self-interest, to the exclusion of others; for the public good, government must thus create structures of incentive, control and discipline.	Different parties are able to come together to achieve common goals, and therefore governments must create trusting environments where collaboration can take place.
Ethos	Market / Efficiency / Transactional	Community / Effectiveness / Relational
Needs assessment and service design		
How are services defined?	The funder—typically a government agency—decides what services are needed and then goes to market.	The funder participates in collaborative processes with external providers and users to determine required services
Who provides the service?	Decided by competitive tendering or other competitive selection process.	Preferably decided by selected tender, interactive tendering, joint ventures, lead agency or consortia models, for example.
What do the contracts look like?	Contracts are transactional, detailed and over a short time frame, seeking to anticipate as many eventualities as possible to prevent gaming behaviour.	Contracts are relational, longer-term and set a broad framework to report against, relying on negotiation between trusted partners to resolve disputes.
What will ensure performance?	Financial and extrinsic rewards and sanctions are set out in contracts; use of litigation and cancellation of contract for non-performance.	Reliance on altruistic intrinsic motivation, collective accountability and periodic course correction through deep relationships and ongoing collaboration.
Monitoring and evaluation		
How is performance measured?	Activity is mandated by funder in contracts, often with an emphasis on easily quantified processes, inputs and output measures.	Joint process between funder and provider to agree on desired outcomes; development of relational strategies to achieve shared objectives.
How is performance monitored?	Contracts require frequent reports from provider to funder; random audits; external audit and investigation.	Generally self-regulation by providers through codes of conduct, professional accreditation and peer review; minimal use of coercive reporting requirements.
How is performance improved?	Activity measured against contracted targets from year to year, with improvements sought in cost per client transaction.	Ongoing networked coordination provides opportunities for learning, skills development and understanding of impact for individuals and organisations.
How are the interests of service users protected?	Random audits and checks by the funding agency or outside regulators; tracking of outcome measures; funding of customer complaint and advocacy mechanisms; use of market mechanisms such as individual funding packages and pay by performance schemes.	Client-centred mission of NFP providers; intrinsic motivations including ethical codes of client-facing workers, community consultation mechanisms embedded in governance structures; consultation with service users on outcome measures—wellbeing and client satisfaction.

Commissioning in practice

As discussed, commissioning has been practised in various contexts in various ways for many years. Rather than provide an extensive list of every instance of commissioning, this report examines four commissioning stories that characterise a specific level of interaction between governments, service providers and community members.

> If commissioning is to be more than just a fad or passing fashion, then we need to think critically about this concept and the most appropriate way to operationalise it in our localities.
>
> *Helen Dickinson, 2015*[18]

Government-led commissioning: The Wigan Deal

As part of the UK government's program of decentralisation and austerity, funding to Wigan Council in northwest England is being cut by £160 million over ten years from 2011, amounting to almost 40 percent of their funding.[19] In response, Council has taken a radical approach through The Wigan Deal ("The Deal")—an informal agreement between the public sector, community groups and businesses to pursue a preventative approach to meeting community needs, where residents are actively involved in the future of services and community health in the area. So far, The Deal has involved:

- Council freezing community tax—a core source of service delivery revenue.
- Encouraging residents to get more involved in the local community—by recycling, volunteering, using local parks and buying local.
- Breaking down silos and pursuing integrated service delivery, including through weekly huddles and other regular points of cross-sector contact.
- Training all council staff in ethnographic and people-centred conversations.
- Investing £10 million in community organisations over five years while drastically reducing the amount of reporting required.

The Deal has saved Wigan Council £141.5m while improving social care, health and wellbeing outcomes. Residents have been found to be some of the happiest in northwest UK.

Despite this success, the area continues "to experience higher levels of deprivation and inequality" compared to the rest of the UK. Council's service innovations have not been able to counteract the far-reaching impacts of removing money from human services.

Joint First Nations commissioning: Whānau Ora

In response to a 2015 New Zealand (NZ) Productivity Report recommending increased opportunities for Maori governance and devolved commissioning and delivery of social services, the NZ Government established the Whānau Ora partnership to work with Maori, Pasifika (from the Pacific Islands), and Pakeha (settler) families.[20]

The partnership set up three commissioning agencies which see themselves as equal partners with whānau—extended family groups—and have autonomy within a high-level outcomes framework based on Maori values, beliefs and principles.

The agencies decide how they want to operate and which services to fund, with the broad aim of putting whanau at the heart of decision-making.

A core stream of funding is for local people to set up and operate services and businesses that contribute to the health and wellbeing of the local community—including safety from violence projects, locally sourced produce cafés and work-based literacy programs.

Another stream of funding is for navigators employed by commissioning agencies to act as case managers and advocates, facilitating access to health, education, welfare and housing services for those who need them.[21]

A 2018 review of Whānau Ora found that that this way of working "results in positive change for whānau creates the conditions for the change to be sustainable."[22] The broad shift has been towards a more holistic view of health and care, from top-down funding of services for individuals to wrapping services around whānau.

Localised commissioning: Integrated Social Services in Europe

In 2013 the European Commission introduced the Social Investment Package, an integrated policy framework designed to develop social protection in member states, rather than service responses that react to discrete challenge as they occur. Funds were made available for member states to integrate care and support services with other public services including education, health and employment.[23]

The main impetus for integration was to prioritise prevention in response to the increasing numbers of service users. Integration across sectors has included resources transfer, policy and legislation reform to enhance coordination or to promote full structural integration.[24]

Key features of integrated services include: case management, investment in coordination and relationship building, multidisciplinary teams that include service users, shared management across agencies, streamlined communication and information channels, joint and pooled budgets, one-stop-shop services, and allowing for space and time to test new ways of working together.

An indicative program within the framework is Open Dialogue, convened and part-funded by Denmark's National Board of Social Services. It provides services for people with severe mental health problems across five Danish municipalities.

The program has a dual approach of regularly bringing cross-sector professionals together to network and share information and a training program for service users that focuses on personal empowerment and individual decision-making.[25]

Network-based commissioning: The Plymouth Complex Needs Alliance

Facing a funding crisis due to austerity and wanting to engage in "a more collaborative way of commissioning," Plymouth City Council sat down with organisations and service users to rethink how services in the local area could answer the question, "How do we help vulnerable adults in Plymouth live the lives they want to live?"[26]

It motivated eight organisations, including the Council, to form an Alliance around a variety of complex needs like homelessness, drug and alcohol misuse, mental health and offending. The procurement and negotiating period began in June 2018, and the Alliance began formally operating in April 2019 with an initial five-year contract and an option to extend to ten.

The organisations collectively decide who will do what. The principles of the Alliance include:

- A "no wrong door" approach, where someone can present at multiple points into the system and still receive the same high quality and consistent offer of care.
- A system of complex needs workers who deliver support wrapped around the person.
- A reduction in duplication and inefficiency.
- Systemic decisions being made collectively about resources using a "best for people using services" principle and the ability to respond flexibly to need.

Not a blueprint, but a six-piece jigsaw

The aforementioned commissioning stories demonstrate the variety of factors that must be considered when commissioning human services. Given its success, prospective commissioners may be tempted to look to Wigan Council and attempt to transplant Wigan's model onto their jurisdiction. This would be a mistake, as it ignores the contextual factors unique to Wigan, as well as the iterative process of the Wigan Deal over time.

As former Wigan CEO Donna Hall says:

> After years of hard work, service redesign, culture change and great community ideas and activity, it is an approach that is delivering better outcomes with fewer resources.[27]

The number of choices available for commissioners is one of the main reasons it is difficult to come to a singular definition of how to do commissioning. Nonetheless, based on the research it is possible to settle on six core questions with which commissioners always need to engage:

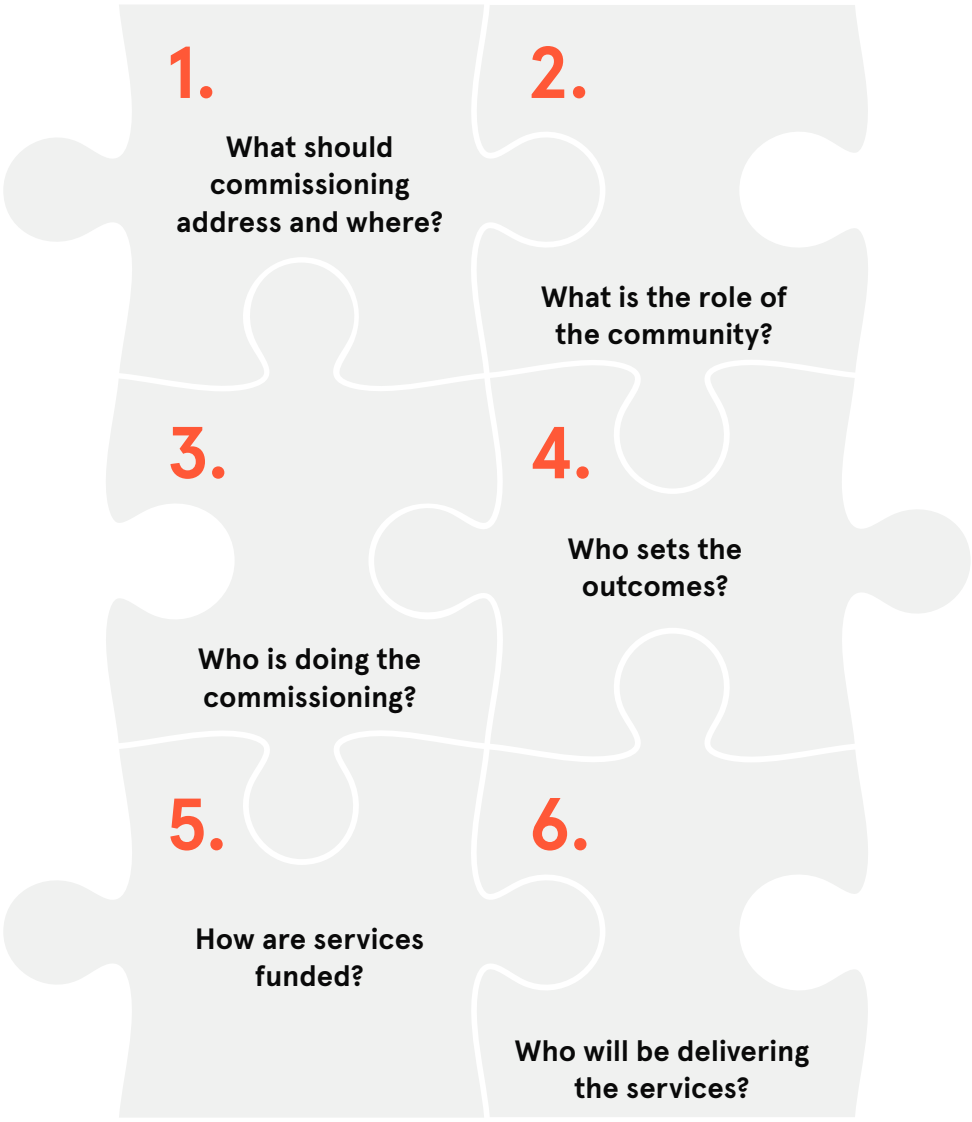


Figure 1. The Commissioning Jigsaw

Each question will be considered in more detail below, along with examples of international best practice.

1. What should commissioning address and where?

The starting point for conversations around commissioning will depend on the local circumstances and where the drive to commission comes from.

For example, an active and organised community that is concerned about the lack of opportunities for young people in a particular area, might encourage various levels of government to work together on the issue; or a government wanting to address the levels of sexual abuse and domestic violence might want to try a new approach to working with communities, experts and service providers.

The starting point for both these conversations is an identified policy problem that needs to be addressed for the overall wellbeing of the communities involved.

Seen this way, good commissioning is a strategic process, taking a wide and long-term view of how to tackle a particular problem. Taken to one extreme, commissioning could be a whole-of-system exercise; however, the logistics involved in planning and delivering services on this scale likely need to be developed over time.

A more strategic approach appears to be commissioning on a smaller scale, using lessons from the process to inform future experiments. Two factors of consideration here are the geographic area in which commissioning occurs and the particular issues or policy problems that the commissioning initiative is designed to address.

The Logan Together collective impact project in Queensland, for example, operates within the Logan City Council area with a focus on children.[28] The Maranguka Justice Reinvestment Initiative operates within the town of Bourke, focusing on the local Aboriginal community.[29] Commissioning in relation to health usually occurs within Local Health Districts and focuses on primary health care and prevention.

2. What is the role of the community?

For governments traditionally used to managing and controlling all aspects of the process—either through direct provision or performance management of non-government organisations—the question might more accurately be: *how much power are you willing to devolve and share?*

The same question applies to community service providers. Although many community-owned services began operating independently, over the years these organisations have attracted government funding. This creates pressure over time for community organisations to become more responsive to the demands of funders than the communities they represent, forcing them to ask: *whose needs is your organisation serving?*

The commissioning curve on the next page presents the different options for the community's involvement in the commissioning process.

Towards the community-led end of the curve, success involves people feeling like they have agency in the process. Communities make decisions about desired outcomes and also funding allocations.

Closer towards the government and or technical expert-led end, people are not driving change, but they feel represented and listened to. Success involves intermediary organisations—community service peaks or joint commissioning agencies, for example—being attuned to community perspectives and playing a mediation and translation role.

Commissioning Curve

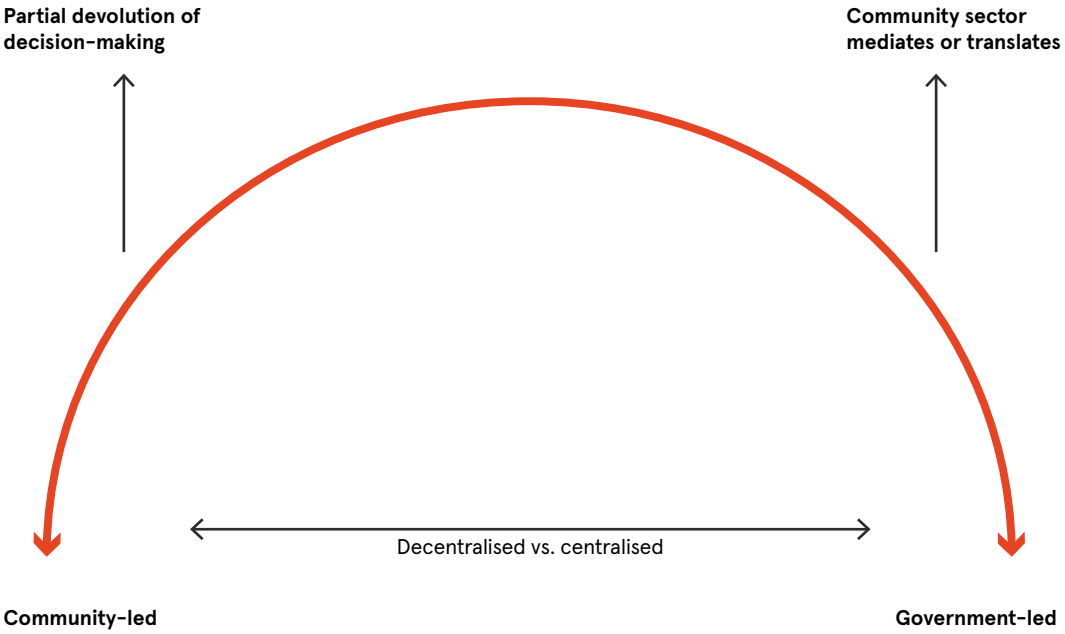


Figure 2: **The commissioning curve.**

3. Who does the commissioning?

In available practice, there are essentially three types of commissioner: governments, communities and intermediary organisations.

Government-led commissioning covers the majority of commissioning experiments that have been the subject of review and evaluation in the broader literature. Here, governments are simultaneously funder and purchaser. Successful government-led commissioning likely invests in relationships and ensures funding security, flexibility and capacity building for service providers.

Community or individual-led commissioning involves greater autonomy and agency for the people closest to the problems at hand, even when government remains the primary funder. This applies to determining how outcomes are set, how services are coordinated and how funds are allocated. For community-led commissioning to work, ongoing investment in skills, knowledge and capacity is required to build capability and avoid entrenching social inequities.[30]

Intermediary options between total government control and complete devolution tend to involve governments or other funders entering into partnerships with communities and service providers, or establishing independent joint-commissioning authorities. Governance structures with accountability mechanisms can ensure communities have a voice while maintaining professional standards. Strong emphasis is placed on convening networks and building relationships across government, service providers and communities.

4. Who sets the outcomes?

Outcomes reflect the broad and long-term goals of a system, such as higher life expectancy, reduced prison population or increased housing security. As such genuine outcomes for individuals or communities are typically the result of multiple service interventions across an extended period of time. They are rarely, if ever, attributable to a single interaction between a person and a service provider.

Outcomes need to be broad enough to reflect this reality, but narrow and specific enough to be meaningful. Well-designed activity measures can mark progress towards broader system

goals and allow service providers to demonstrate how their work contributes to broader collective outcomes.

Traditionally governments make all the core decisions about what a system ought to achieve, oversee how it is implemented and monitor progress. However, when government and service providers collaboratively set and agree on target outcomes and activity measures all parties can benefit. It can ensure that government gains input from practitioners working directly with people and that service providers understand how they contribute to system-wide outcomes. Further legitimacy for service delivery can be added by ensuring communities believe the target outcomes are appropriate and services are designed flexibly to meet them.[31]

Overall, target outcomes should be determined collectively. As one expert interviewee put it, "where commissioning really doesn't work is where outcomes are added on at the end of the process by commissioners."

5. How is funding provided?

The way funders allocate money and other resources to human service providers has an impact on the relationship between those organisations and the way that services are delivered.

Due to the influence of NPM, funding mechanisms in countries like Australia have typically seen a drift towards competitive tendering, strict output measurement conditions, and incentive-based pay-for-performance models. Unfortunately, research consistently finds that these practices are regarded as undermining the trust, relationships and flexibility required to do commissioning well.[32]

Joint or alliance-based commissioning presents a solution to this impasse by creating a more productive, collaborative and integrated environment. With more trust in the system, funding can be provided in untied blocks or grants, supplemented with due diligence around the professional standards of funded services.

When designing a system from scratch, a perfect process will require waiting until the broad outcomes have been set before deciding whether to make or buy required services. However, the reality is that any redesign process will be an evolution rather than a completely new start.

6. Who is delivering the services?

The service delivery landscape in countries like Australia is made up of a mixture of government agencies and non-government organisations—including large charities, private business, social enterprises and small, community-owned service providers. It is likely to continue this way.

The starting point for commissioning in any particular area should involve thorough assessment of the services that currently operate. One of the most important questions that follows is how these providers can work more collaboratively. In collective impact projects this is typically achieved through backbone teams and community hubs.

The final consideration is to identify any service gaps within the ecology of service provision and to examine whether these can be met by existing government or non-government providers, or whether new agencies need to be established.

Commissioning in New South Wales

As has been the case in other jurisdictions around the world, the particular nature of the shift to commissioning human services in New South Wales is unique to NSW.

Based on interviews with around 30 key participants across the NSW Government and community sector organisations, the chapter settles on a current state of play that presents challenges and hope. While the relationships between the two sectors have in the past been strained, sufficient goodwill exists to experiment with commissioning and try working together in new ways.

2

We've been funded to do the same kind of things for a long time. Commissioning is an opportunity to let go of what we've been doing and start from the point of what we are trying to achieve.

Community sector interviewee

Context

The transition to commissioning in NSW has followed a period of public service outsourcing, contracting and procurement along market-led and efficiency-seeking principles. Such NPM-style practices are still commonplace.

A number of factors have influenced the NSW Government's approach to funding and delivering human services. These include key reports in 1992 and 2008, commissioned in response to public concerns about child welfare, which recommended transferring out-of-home care for vulnerable children from the public to the not-for-profit sector.

The recommendations, and the responses of government, were influenced by a general trend towards market-led approaches to public policy. They included practices characteristic of New Public Management like a clean purchaser-provider split, individualised contracts, funding conditional on performance targets and competitive tendering.[33]

NSW Government outsourcing accelerated following the 2011 election of the O'Farrell Coalition Government, accompanied by a focus on public sector cost-cutting, including through the application of an annual three percent efficiency dividend on all government agencies.

From 2012 to 2014, the "Going Home Staying Home" reforms were designed to address funding and delivery of specialist homelessness services. Contracts for specialist homelessness, youth and domestic violence services were awarded through a competitive tendering process.[34]

Since 2016, the "Their Futures Matter" reforms have been a multi-agency attempt at systemic change "to enable all children, young people and families to reach their potential" by prioritising "investment to solutions that achieve measurable and meaningful outcomes that transcend agency silos".[35]

The arrival of commissioning in NSW led to a flurry of government reports and proposals, with various NSW Government agencies producing at least 15 reports on commissioning and outcomes-based funding between 2014 and 2019.

The general starting point in these reports is that commissioning is a flexible way to rethink what is possible in terms of identifying community needs and service delivery,[36] with an emphasis on stakeholder engagement and systemic, outcomes-based funding replacing narrow and performance-based funding and oversight focused on activities.[37]

At the same time, reports on contracting non-government organisations continue to emphasise opening up services to market competition, competitive procurement processes and proposals for increasing involvement of enterprise funding initiatives such as social impact bonds.[38]

In recent years, various NSW Government agencies have experimented with commissioning, including NSW Health, Corrective Services NSW, and the NSW Department of Family and Community Services (FACS).

The NSW Government shifted to outcomes budgeting in the 2017-18 State Budget and in 2019 created the Stronger Communities Cluster, under the Department of Communities and Justice (DCJ)—which now incorporates FACS—presenting an opportunity to align and coordinate a commissioning approach across various agencies.

With, as one project interviewee noted, upwards of $4.5 billion being spent in funding NGOs to deliver human services, there is clearly vested interest from government and non-government organisations to deliver effective services that build stronger communities.

The past in New South Wales

This section presents some of the key themes that emerged from the research.

In addition to three workshops with leaders from NSW family and community sector peak organisations, around 30 interviews were conducted with representatives from NSW peak bodies funded through the NSW FACS Sector Development Plan, other leading NSW community sector organisations, and representatives from the NSW Government Departments of Premier and Cabinet, Treasury, FACS and Communities & Justice.

The interviews were semi-structured and covered the interviewees' understanding and experiences of commissioning, the impact of NSW Government policies on their work practices, and the types of principles they feel underpin good service design and delivery.

These include reflections on competitive tendering, innovation, FACS-led processes, funding constraints, the power dynamics between the sector and government, as well as the potential future for commissioning in NSW.

Competitive tendering

Both government and non-government interviewees reflected that the practice of competitive tendering for awarding contracts had eroded trust between service providers, and between the sector and government.

For community sector interviewees this manifested particularly around the rollout of the Going Home Staying Home reforms. "The reforms had a profoundly negative impact on relationships and trust," one interviewee said. "The sector is traumatised, and they don't trust the government at all."

Another interviewee, reflecting on the impact on collaboration said, "Some organisations still refuse to be in the room with each other."

One sector interviewee noted that competitive tendering of human services has left NSW with "a mishmash," a "matrix of mess about who's doing what." Another noted the impact "on the way that we share information and the way we trust or don't trust other workers in the sector."

A number of interviewees observed that when they are in competition against someone else, they feel like they are fighting for survival and have the need to "protect their patch" and back away from others. This affects the ability of community sector workers and organisations to focus on their core priority of delivering high quality and effective services.

Innovation

Most interviewees believed that the NSW Government needed to change the way that it thought about innovation.

For some interviewees, the government approach to innovation was just to look for quick technical solutions to systemic problems. "You don't solve domestic violence with an app," one respondent said.

Another interviewee noted, "Sometimes I think by innovation government means efficiencies, finding new ways of doing things so that they cost less. If government was genuinely interested in innovation there would be some more flexibility," so services could actually innovate.

Another opinion about government pursuit of innovation was that there was a constant drive to be able to announce something new which "redirected funding away from core or crisis services. The system is interdependent and has to respond to both short- and long-term needs."

Hierarchy

All community sector interviewees reflected that despite the positive language around commissioning and collaboration in reports, there are stark differences in power when it comes to practice. This has a created a type of us and them environment.

"There's no shared vision around client outcomes or how we measure outcomes," one respondent said. Another said that government mandated outcomes frameworks "never give people the bridge to get to where they need to be to see their own work in it."

Other interviewees reflected on hierarchies in policy development: "Government prepare policies, strategies, tenders, initiatives in secret behind closed doors and then roll them out," to the non-government sector to implement.

One NSW Government interviewee saw a similar pattern inside government, where central agencies have tended to design strategies and policies internally and then "lob them over the wall" for another agency to implement. "It doesn't work," they reflected.

Funding constraints

Most community sector interviewees reflected on the challenges of operating in a resource-scarce environment with complicated funding mechanisms and variable funding sources.

One interviewee noted the problems caused by program-based funding and inconsistent commissioning processes. "We've got about 18 different government funding streams," they said. "It's a very inefficient, expensive and resource intensive way of running. The bulk of that funding is funding almost exactly the same thing but with slightly different emphasis."

A number of NSW human service sector peaks noted that they would like to move away from getting "caught up in everyone else's circus." The overwhelming preference among those peak organisations was to take their lead more from the people and communities that service providers work with on a day to day basis, rather than spend time responding to government.

One interviewee highlighted "the really unthinkable financial pressure" that small community organisations put themselves under, including "really not sensible financial management because they're desperate to run the services and not lose their place in the sector."

Government-led processes

A number of interviewees expressed frustration at the way FACS and the NSW Government had in the past approached working with the community sector.

This included decisions being imposed on the sector which went against recommended best practice, a lack of genuine consultation and information sharing, strict and onerous funding contracts and reporting requirements, and a general lack of appreciation for the long-standing expertise in the sector.

One interviewee criticised the government's "constant outsourcing to the actuarial firms" who are "being paid a lot of money to harvest expertise from our sector, repackage it and then provide it to government under commercial-in-confidence, which government then uses to make their funding decisions without passing that knowledge back to the sector."

One practitioner with established international expertise in commissioning felt the government's approach lacked clarity and relied overly on jargon. "Sometimes I don't even know what's being said," they stated. "It all sounds very clever but none of it makes sense to me."

The future of commissioning

Government and community sector interviewees talked optimistically about the potential for commissioning in NSW to break from past practices and move towards a new way of working.

One government interviewee noted that one potential area for change was in relation to collaboration. Commissioning, they said "is something that you need to do together. You have to work in partnership with providers, with the NGO sector, not doing it to them." The interviewee noted the in the UK, while NGOs would criticise government, "they would also work a bit more closely together."

Other government interviewees noted that the Government needed to think more about its role as steward. This included how to steward effectively and integrate relational approaches within government, not just in how government relates to external service providers.

Community sector interviewees expressed a desire for better recognition from government of the work they do. "A bit more demonstration of respect for the sector and what we do, and a lot less demonising of the people that we serve," one interviewee said.

Many expressed the desire to focus more squarely on the needs of community and demonstrate that the community sector is "committed to working together collaboratively."

Government and community sector interviewees identified that the NSW Human Services Outcomes Framework could be a good starting point for developing broad community outcomes everyone could work towards. As one interviewee stated, "It doesn't have the level of detail that would suit every commissioning instance, but it can be used for the basis for where you want to drill down."

The Future in New South Wales

Discussions about the recent past presented a simple yet important story about the experience of commissioning human services in NSW. Despite the intent and language in key documents, most interviewees felt that the reality of commissioning of community services by FACS in NSW has to date not been markedly different from previous contracting practices.

At the same time, due to pre-existing hierarchies and barriers to open information sharing, the relationships between the government and community sectors have become strained and oppositional. There is a lack of trust and goodwill, which undermines potential for collaboration and partnership.

Nonetheless, there are huge opportunities and a willingness to collaborate. Members of both sectors share a broad vision for how strategic commissioning could work in NSW, along with the desire to move beyond the status quo and work together collaboratively for the benefit of people and communities across NSW.

This leads to three key findings:

1. NSW commissioning in practice has not varied significantly from NPM contracting

As in a number of other jurisdictions, commissioning in NSW has been perceived as a continuation of old ways of working rather than a shift to something new.

According to the community and human service sector workers interviewed for this report, despite the shift in rhetoric in government to "commissioning for outcomes," actual practice has not changed in any meaningful way, particularly in terms of outputs and Key Performance Indicators narrowly defining service provision—commissioning in NSW is old wine in new bottles.

This view is consistent with an ACWA/Centre for Community Welfare Training report which collected views of community sector leaders working in out-of-home-care. The overwhelming majority of respondents stated that "it isn't clear how commissioning is different from past contracting and funding models."[39]

The finding is also supported by the senior NSW public sector representatives interviewed for this report. They identified a number of ways in which the ideals of commissioning had not been put into practice. This included the community sector and government agencies operating in a resource-constrained environment, the hierarchical approach of government impeding strong relationships, and at times a poor flow of information between government and the community sector.

This suggests that the NSW Government's approach to commissioning, and thus how it has developed in practice, has been more akin to NPM contracting than commissioning, as outlined in Chapter One of this report.

2. The NSW Government and community sector have a strained relationship

The relationship between government agencies and community-service providers can be characterised as oppositional and strained by a variety of historic factors which collectively impede collaboration.

Both government and community sector interviewees highlighted a lack of trust between

the community sector and government that impedes the ability to work together. Contributing factors identified by the community sector include recent practices of competitive tendering, information hoarding, funding constraints and a general command and control approach. As one community sector interviewee said, "some relationships have been really severely damaged. We're all a little bit scared of losing everything."

One government interviewee observed the negative impact of poor communication from government about changes in policy. Another identified that responsibility for relationships runs both ways: "They've been asleep at the wheel, a lot of the peaks."

Another contributing factor to this relationship is the historical context of the community sector. Community organisations have traditionally formed voluntarily to provide services in places and to people when the broader system is regarded as failing.

These "origin stories", as one interviewee put it, can place community organisations and their employees in an oppositional stance to government in both attitudes and practice.

3. There is nonetheless long-term alignment between the NSW Government and community sector

The interviews revealed broad agreement between government and community sector representatives in two areas: the purpose of commissioning as a strategic and relational exercise—outlined in Chapter One—as well as on the broad principles for good commissioning that will be examined in depth in Chapter Three.

This alignment, along with the willingness to work together, presents a real opportunity for successful commissioning in NSW.

A number of non-government respondents expressed the need to "backtrack and return to basics like joint planning and implementation. One community sector interviewee noted that the key component missing is "partnerships and relationships." A government sector interviewee agreed, noting that "we have this traditional dynamic between purchaser and provider, which is a transactional relationship. We know we don't want that anymore. We know we want to be partners in service delivery, but we haven't articulated how that works yet."

Another government respondent flagged a preference for "commissioning for contribution, rather than attribution," aligning with the views of the community sector that the system should reflect that meaningful outcomes for individuals and communities can be the result of multiple service interventions.

Community sector interviewees all expressed a willingness to work more collaboratively with each other in order to present a more unified voice to government. This aligns with the view of government sector interviewees that a more cohesive community sector voice would make forming partnerships and relationships more viable.

Both government and community sector interviewees pointed towards the Commissioning Co-governance Group, established in 2019, as an important step. "It's a great starting point," one government interviewee said, "because we're around the table."

A community sector interviewee noted that the group allowed the sector to reach clarity about the government's approach to commissioning, while providing opportunity for respectful feedback, ideas and potential alternative approaches.

This alignment and goodwill present the opportunity for the government and community sector to collectively move from an oppositional and transactional competitive environment towards a collaborative environment that fosters good relationships to address community need.

Good commissioning: How do we do it?

This research distils four fundamental principles that underpin good commissioning. Taken together, these four principles of good commissioning form a lens through which the government and community sector ought to approach collaboration on the design of commissioning experiments in NSW.

This chapter also offers concrete examples of the types of activity that can either enhance or hinder progress towards the realisation of these principles.

3

For us to continue to function, everything had to change. A new policy or programme would not be enough. It needed a radical rethink about how we could put people and connections at the heart of public services.

Donna Hall, former CEO of Wigan Council[40]

Good commissioning focuses on collaboration and relationships and it prioritises strategic conversations about people's needs and preferences. It involves targeted experiments in community engagement and service delivery, as well as sophisticated data-analysis and information sharing.

This chapter presents four key principles which the research has found to underpin successful commissioning initiatives.

1. **Putting relationships first;**
2. **Letting communities lead;**
3. **Embedding learning;**
4. **Investing in people.**

When taken together, they form a lens through which the government and community sector ought to approach this transition towards commissioning in NSW – in particular the core questioned outlined in the commissioning jigsaw that are the foundation of any experiment.

Shifting to good commissioning will require government agencies and community sector organisations to undertake new roles and work together in new ways.

Principle 1: Putting relationships first

> Care is a not a product that can be bought or sold, care is a human relationship.
>
> *Project interviewee*

The core challenge for NSW Government agencies and the community sector in the shift to commissioning is changing from transactional governance and models of operating to ones that are relational. This requires shifting the focus to building relationships based on trust and reciprocity.

The Australian Public Service (APS) was posed the same challenge in a key 2019 report by ANZSOG, which recommended that:

> The APS leadership, individually and collectively should drive a shift in mindset across the public service, taking it from transactional to relational, procurement to contracting, and from transfers, grants and outsourcing to commissioning.[41]

This report notes that trust can be strengthened through the devolution of decision-making to service providers and communities, while implementing a strong "integrity framework" that ensures accountability and legitimacy for the system. It suggests that working in this way can help commissioning be "agile, innovative and efficient".[42]

For governments and commissioners more used to engaging with non-government organisations through transactional NPM contracting rather than more collaborative commissioning approaches— see Table 1 for a comparison—developing these relationships and devolving power may be challenging.

This is because NPM contract management is a transactional exercise that starts from the assumption that everyone is acting in their own self-interest. This creates an oppositional and competitive environment that encourages information hoarding.

In contrast, a relational approach to commissioning and contract management starts with the assumption that actors have a shared interest in the wellbeing of communities. This creates potential for a collaborative competitive environment that uses agreed service delivery targets as part of a process of learning and adaptation.

When difficulties or crises emerge, strong relationships encourage persistence and resilience through a sense of cohesion, collective endeavour and work fulfilment. It also opens opportunities for creativity and the sharing of skills and information.

The role of commissioners here, as laid out by Toby Lowe and Dawn Plimmer in their 2019 report "Exploring the new world: Practical insights for funding, commissioning and managing in complexity" is to nurture local healthy ecosystems and build relationships of trust between themselves and the organisations they commission, and between those organisations and the users of services.[43]

In her 2015 review of commissioning in the UK, Dickinson notes that community service providers are naturally well-positioned to have trusting relationships with "marginalised and minority groups."[44]

This suggests that within a NSW commissioning framework a role may exist for peak organisations to act as conduits between government and communities, leveraging their relationships and connections with communities in a coordinated way and facilitating genuine conversations with people around the support they need to live to live healthy lives.

Working relationally with government will require a shift in working for many community organisations, especially for those with origin stories that involve filling gaps created by the system and tend to see government as an opponent.[45]

The upcoming Sector Development Review and recently formed Commissioning Co-Governance Group are clear opportunities for the NSW Government and community sector peak organisations to reset their strategic relationship, or as one interviewee put it "put our weapons down."

In her 2018 paper, Jennifer Mason identified a number of initiatives that could improve relationships and trust between government and the human services sector in NSW. These included: less of a "command and control" environment, mutual acceptance of the need for change and a stable funding environment.[46]

The way forward to building these trusting relationships—working towards a service delivery landscape that learns and evolves with people at the centre—will take time. It is a process in itself: a journey towards community-led outcomes that will require new partnerships and collective agreements.

Table 2. **Activities that build and undermine trusting relationships**

Activities that build trusting relationships	Activities that undermine trusting relationships
✓ **Empowerment:** Devolution of control and responsibility from government to service providers and communities exhibits trust. This can occur through various collaborative and co-design processes, such as facilitating community-led planning and practising relational contract management.	× **Top-down policy development:** As one government interviewee put it, traditional practice is for experts—within government, universities, think tanks or service providers—to centrally design policies and then "throw it over the wall and expect people to implement it. It doesn't work," and it fosters resentment.
✓ **Relational contract management:** Contract management doesn't need to be a tick-box exercise. Ensuring that organisations develop new capabilities, collaborate effectively and stay focused on collective objectives is beneficial to the system as a whole. Working in a support capacity, relational contract managers can identify early warning signs of potential crises and address them proactively.	× **Transactional contract management:** Detailed contracts requiring strict activity reporting can foster mistrust between governments and service providers, as can funding contingent on meeting particular targets. As one interviewee put it, "it would be nice to have some agreed outcomes to meet, but not be so explicit or micromanaging around the service models and the way outputs are put together."
✓ **Creating partnerships:** Strong relationships can be built by working on a more equal footing through collective projects that get beyond one party consulting with another. Project interviewees highlighted the potential for partnerships around training, outcome measurement frameworks, or commissioning agencies with multi-party governance.	× **Competitive tendering:** Sharing information and skills is made more difficult when organisations have to compete with each other. Many interviewees noted the erosion of trust between service providers due to competitive tendering. This can be countered through models like select and joint tendering over longer timeframes.
✓ **Consistency:** Strong relationships develop over time through regular contact points between government, the community sector, service providers and the community. Interviewees from the NSW community law sector attributed strong relationships to quarterly meetings for networking, information sharing and training.	× **Shifting language and approaches:** Multiple community-sector interviewees for this report expressed skepticism about the government's sincerity around the shift to commissioning. Frequent changes in approach were seen to lead to reform fatigue, as was the adoption of new terminology without a perceived change in practice.

Principle 2: Letting communities lead

In NSW, the initial move to commissioning has been almost entirely led by government. Yet continuing in this vein is unlikely to lead to the broad social outcomes the NSW Government is trying to achieve.

Ensuring that communities are in the driving seat is an essential component of successful commissioning, and the research revealed the NSW Government and community sector peak organisations want to involve people and communities more directly in the design and delivery of human services.

In their 2019 report for ANZSOG on the Australian Public Service, O'Flynn and Sturgess note:

> Commissioning should be anchored to community needs and aspirations, not decisions made by government for communities, and may well be a catalyst for more local solutions rather than central decisions; partnership rather than paternalism.[47]

Involving communities in the design and delivery of services has been a growing trend internationally and in Australia. The spectrum of involvement ranges from user experience of transactional services, through to deep engagement in redesign of policy or services, sometimes referred to as design-led policy intervention, human centred design, place-based design and similar.

Experiments with participatory decision-making and deliberative democracy worldwide, including in Australia, have demonstrated a variety of results, including increased community cohesion, improved funding allocation and financial planning, and ensuring "a broader range of expertise which helped officials develop effective solutions and uncovered blind spots".[48]

Involving service users and local communities in the commissioning process helps ensure frameworks that are developed align with their needs. To develop a genuine and effective human services outcomes framework, commissioners will need to involve a broader range of organisations, including government agencies beyond the Department of Communities and Justice, small and large NGO service providers, the legal assistance sector and organisations representing groups of people such as Aboriginal and Torres Strait Islander people, people with disability and culturally and linguistically diverse communities.

Innovative forms of on- and off-line community engagement can allow service users to engage as individuals in the design, development and prototyping stages of services, and also collectively in determining local goals, outcomes and service pathways.

Dickinson's 2015 reflections on UK experiences in commissioning for Australian jurisdictions highlighted the need to embed engagement in governance structures to overcome the public perception that "decisions have been made before consultation takes place."[49]

When people have a say over their lives and they feel that government and service providers are acting for the benefit of the community, they are more likely to work toward collective goals. Hilary Cottam, who inspired the community-centred approach of the Wigan Deal, talks about this shift in terms of focusing on creating possibility as opposed to solving problems.[50] It increases community capacity and the integrity of the human services system as a whole.

The Australian Centre for Social Innovation and Community Services Industry Alliance noted in a 2018 report that this is required in the design of services, as well as in the ongoing service evaluation and adaptation.[51] Similarly, a 2019 New Local Government Network report

on community commissioning in the UK recommended legislative measures such as "public sector bodies to engage communities in their commissioning and procurement processes."[52]

Embedded in and run independently by communities, community service providers are a natural partner for government wanting to work more closely with service users. At the same time, interviewees emphasised that when community organisations engage in this process while receiving government funding in a market-based system, their activities may respond more strongly to government preference rather than what communities need.

As such the community sector may need to consider how they safeguard their independence, in terms of the programs they run and how they are funded. A comparator organisation to consider is Locality in the UK, which has a diversified funding base and represents a network of community organisations in a variety of ways akin to NSW peak bodies.[53]

The challenge for the NSW Government and community sector is how to involve community in a way that avoids token consultation and puts communities in the driving seat.

Table 3. **Activities that strengthen and impede community leadership**

Activities that strengthen community leadership	Activities that impede community leadership
✓ **Ethnographic listening:** Rather than trying to quickly diagnose problems and then refer people off to appropriate services, an ethnographic approach aims to really listen to and engage with people on a deep level, in order to create real change.	× **Centralised decision-making:** The closer that decisions are made to impacted people and communities the better. Decisions made at a distance and then imposed on service providers and communities lack the crucial buy-in required to make change work.[54]
✓ **Community-level planning:** Governments, service providers and other allied organisations can facilitate community access to information about what's happening in their local area, support the development of community outcomes, and then trial strategies to achieve them. This requires devolving decision-making and creating standardised open datasets.	× **Scaled services:** The closer a service is to a community, particularly around ownership and governance, the more people relate to it. The potential collapse of large-scale providers, for example, ABC Learning in Australia and Carillion in the UK, presents extra risk to governments from large NGO service providers.
✓ **Participatory democracy:** Direct decision-making by community members can boost local engagement, facilitate capacity building and create a sense of collective ownership. With the right accountability and deliberation mechanisms, the community can make powerful and informed decisions about outcomes and budget allocations.	× **Assuming authority:** Governments, peak organisations and services providers all need to guard against claiming the authority to speak on behalf of the communities they represent and work with. Governance structures within commissioning agencies and community organisations need to embed genuine participation and representation.
✓ **Community service hubs:** Centrally designed and funded services and programs are not enough to ensure people get the help they need, particularly in rural, regional and remote areas. Community run service hubs can provide opportunities for service collaboration, coordination and connect people to help when they need it.	× **Lack of capacity and coordination:** Because effective community engagement is complex, time consuming and resource intensive, service providers, community members and government employees need ongoing development in the skills needed to collaborate effectively. A lack of community level service coordination leads to waste and disillusionment.

Principle 3: Embedding learning

Traditionally, governments and other funders have searched for silver bullet service models and delivery programs that will address policy problems. Experience and evidence however—including from NSW Government and community sector interviewees for this report—suggest that the services people and communities need inevitably change over time, and that an effective service delivery landscape must have the flexibility required to learn and evolve.

Various studies into the future of human services note the importance of governments taking on such evolving and iterative ways of working. This includes, as a UK report co-produced by the Northumbria University, the Community Fund and Tudor Trust explains "experimentation, reflection and redesign" and "putting learning at the heart of governance."[55]

As Lowe and Plimmer note in their 2019 report on community commissioning in the UK:

> What worked for one person may not work for another. What worked in one place in one time may not work in other places. What worked at one time may stop working as the context changes.[56]

The importance of embedding learning and flexibility in large part stems from the imperative to address community need as efficiently and effectively as possible. Rigid hierarchical systems can be too slow to respond, while competitive market environments can erode the relationships needed for effective communication and collaboration.

O'Flynn and Sturgess note that "this necessitates governments having a more flexible and adaptive approach both within government and in how government relates to non-government service providers."[57]

Systems will always need to adapt to emerging needs, and a mature system needs to strike a balance between holistic service provision at scale and local innovation that can respond effectively to emerging need, gather information and trial new practice that informs changes to the broader system.

As noted by Sturgess in a paper on the origins, influences and characteristics of public service commissioning, working effectively will therefore require "an increase in experimentation with new service models and the development of better approaches to delivery" through increased delegation and parallel innovation.[58]

This creates an imperative for data transparency and multidirectional digital engagement throughout the system. The Barcelona Digital City initiative, for example, acknowledges data as a 'prime asset' that through collective ownership and open-source software can empower 'efficiency, transparency and social innovation.'[59]

Service providers also need to be able to genuinely listen to the communities that they are trying to help, so that they are able to respond to need and know whether their service interventions are working.

This has implications for funding, both in terms of the types of activities that funders expect service providers to perform and the conditions that are attached when funding is provided. Strict performance monitoring contracts were heavily criticised by community sector interviewees, as these do not provide service providers with the flexibility they require to innovate and respond to emerging community need.

The development and management of outcomes frameworks is another challenge for commissioners. Goals and target outcomes need to be broad enough to be meaningful within a complex system, yet tight enough so organisations can demonstrate impact. At the same time, these targets cannot be so tight that they impede effective service delivery.

The focus of the shift then becomes systematising ways of working that ensure the system is both accountable—rigorous enough that progress can be monitored and evaluated—while ensuring space for genuine innovation and course correction.

Perhaps the most significant challenge for the NSW Government and community sector when it comes to operationalising a flexible and evolving system is the shift from oppositional to cooperative ways of working.

The potential is certainly there. Interviewees across government and the community sector welcomed the idea of a shift in approach to one that's more vulnerable, and where people leave their agendas at the door to engage without preconceived ideas about what people and communities are experiencing and need.

Responsibilities for the NSW Government within a learning system might include the cooperative development of digital platforms for sharing and analysing data, while community sector peaks are well placed to enable collaboration and capacity building.

With connections across government and the sector, peaks can facilitate environments across the state where service providers connect and share. In similar spaces, people and communities could have genuine conversations about their priorities and goals, understand how to better access services, and learn how to self-advocate more effectively within the system.

Table 4. **Activities that enhance and inhibit learning and flexibility**

Activities that enhance learning and flexibility	Activities that inhibit learning and flexibility
✓ **Feedback loops:** Systems that enable constant and consistent listening and learning—from service users, broader communities and practitioners—assist in understanding what is working, what is not and where to trial new evolutions in service delivery.	× **Rigid performance contacts:** Performance contracts that tie services into particular service models and link funding to outputs stifle the ability of service providers to innovate and respond to emerging need. As former Wigan Council CEO Donna Hall says, "we need to be tight on outcomes and loose on delivery."
✓ **Open and coterminous data sets:** Rather than relying on corporate intellectual property across multiple platforms, open source data and software can enhance the ability of public agencies, local community groups and service providers to innovate and share. Consistent data standards make information gathering and analysis easier, particularly when aligned to outcomes frameworks.	× **Information hoarding:** Practices such as competitive tendering, command and control hierarchies and siloed departments restrict the flow of information in the system and impede learning. Communities and service providers need access to information to make informed decisions, as well as common data collection measures.
✓ **Co-owned structures and processes:** Collaboration across sectors and jurisdictions is key for creating a learning environment. Long-term partnerships can erode traditional barriers, foster relationships and create structures in which learning can take place.	× **Operating on short cycles:** The ability of service providers, government agencies and communities to work in an effective, evolving system requires commitment beyond regular political cycles. Medium- to long-term funding security gives service providers the space to innovate. As one interviewee said: "If you want great outcomes and great people to be doing the work, you have to give them security."
✓ **Developing standards over time:** Rather than narrowly measuring and managing all the activities of service providers, commissioners can instead require all service providers to meet organisational standards through a relational accreditation scheme that focuses on organisational strengthening development.	× **Only funding service delivery:** Measuring the impact of fostering relationships, data analysis, network-building and skills development is less easily quantifiable but no less important to the success of commissioning. This is particularly important when trying to move away from and take pressure off the crisis end of the system.

Principle 4: Investing in people

Interviewees from across the NSW Government and the community sector acknowledged the difficulties of planning and delivering effective human services in a funding constrained environment.

This is consistent with evidence from the literature, which particularly points to the need to respond by shifting away from transactional methods of funding and contract management. A 2018 study in the UK, for example, indicated there was no positive evidence to recommend an outcomes-based commissioning model that uses incentives and short-term performance measures.[60]

Dickinson's 2015 evidence review of commissioning public services highlighted that key areas requiring investment include developing relational and technical skills in government and service providers, ensuring "high quality, timely and appropriate data" and engaging with and "understanding the individuals and communities that will access services."[61]

The New Local Government Network recommends that community-centred commissioning bodies need to have "the space, support and funding to experiment with new forms of community power and commissioning that at the same time ensure that funding is subject to community scrutiny."[62]

Similarly, a report by Ten20, Social Ventures Australia and the Australian Centre for Social Innovation, focusing on funding community-led place-based practice, highlighted the need to fund backbone organisations that facilitate relationships and service collaboration in communities. Whether funding for community commissioning is private or public, pooled funds "enable more efficient flows of funding" and "reduce duplication and inefficiencies."[63]

In sum, the evidence demonstrates that commissioners would be amiss to approach commissioning as a cost savings exercise. This will likely require different ways of working for the NSW Government as well as service providers and peak organisations. One project interviewee compared the current structuring of funding of the human service system in NSW to road cycling:

> We spend most of our funding at the back end, helping cyclists that fall over or crash. Or looking at who is out in front. But the real action is in the peloton – teams of people working within a larger mass, all heading in the same direction, looking for the right time to launch a lead rider off in the right direction. It doesn't matter how good your lead rider is if your peloton riders aren't strong.

The move to a new way of working that focuses on building community strength and capacity will naturally have social and economic impacts on other parts of the system, as people may be diverted away from the crisis end of the system.

Equally important is that the new way of working will also require both government agencies and the community sector to reconsider their roles.

Systemically, the primary function for government agencies is to design, steward and facilitate effective networks and systems that meet the needs of people and communities.

In other words, if the government approach to human service delivery were a rowboat, under the model of centralised and bureaucratic public service delivery—the Welfare State—the government would both steer and row the boat. With the introduction of market-led and

corporate principles—New Public Management—the government kept responsibility of steering, but supervised someone else doing the rowing.

The current environment is yet again radically different, as government agencies must respond to a multi-faceted service delivery landscape and ever more demand from people and communities for autonomy and choice. In this context the government may largely steer the ship, but they do so having asked the passengers where they want to go. And they take into account who is doing the rowing and how.

In turn, peak bodies may need to consider coordinating joint bids and tenders, acting either as bid facilitator or lead contractor in integrated service delivery. Such a role a could present a potential antidote for the negative aspects of competitive tendering. Instead, collective tendering could occur across various jurisdictions, such as the whole state or within a particular local health district or local council area.

In moving forward, while it is vital that government agencies and peak organisations each discuss these potential shifts internally, early collective discussions about how the whole system could fit together will help build relationships and avoid misunderstanding or duplication.

As O'Flynn and Sturgess recommend in their report for ANZSOG, the Australian Government needs to ensure the public service develops inhouse commissioning expertise and establish an "independent Centre for Public Service Commissioning, in conjunction with state governments and private and not-for-profit providers."[64]

Table 5. **Activities that enhance and inhibit investing in communities**

Activities that enhance investing in communities	Activities that inhibit investing in communities
✓ **Backbone organisations:** It can be beneficial to have organisations whose role it is to support the operations of service delivery—networking and relationship building, information gathering and analysis, community engagement and communications. These hubs can be hosted in local community centres, local councils or in newly created organisations.	× **A transactional funding environment:** The investment required to make commissioning work is as much human as it is financial, requiring a change in the way government agencies relate to service providers and communities. This may require retraining for some staff, as well as bringing in people with different skill sets.
✓ **Mixed funding models:** Funding models, processes and agreements should support continuity in service delivery and allow for innovation. This will help develop strong relationships, capacity across the system, allow service providers to respond swiftly to emerging community need.	× **Too much hierarchy:** Successful commissioning requires attention to both horizontal and vertical concerns.[65] Too much focus on centralising processes and accountability mechanisms, for example, can impede the important tasks of developing trusting networks and ensuring service providers and communities have decision-making roles.
✓ **Stability:** Frequent changes in aspects of the system like service delivery models, funding mechanisms and reporting requirements can disrupt the activities of service providers and their ability to focus on direct service delivery. Instead, commit to five- to ten-year experiments before reviewing collectively.	× **Too much focus on crisis services:** Focusing on early support services can relieve pressure on the crisis end of the system. As one interviewee noted about homelessness, "ultimately we should have very few crisis services, and we should all be providing support to people to help them maintain their housing."
✓ **Skills development:** Effective commissioning requires ongoing attention to skills development for government agencies, commissioners, service providers and communities. Regular contact and sufficient resourcing can assist in keeping people in roles longer as well as ensuring skills transfer over time.	× **Overcomplicated funding mechanisms:** The fewer funding applications that service providers need to make, the more time they spend meeting community need. Interviewees described applying for funding programs such as social impact bonds as "complicated", "convoluted", "unwieldy", "rigid" and "inaccessible for some organisations".

Conclusion and recommendations

At the heart of commissioning is experimentation. A commissioning framework is only as strong as its participants'commitment to learn, adapt and evolve.

This report therefore recommends that the best way to move forward is by doing—the NSW Government and community sector peaks should commit to a series of experiments in commissioning, using the four key principles for good commissioning as a lens to guide decision-making.

There (are) opportunities for a constructive reset of the commissioning relationship between the NSW Government and the NGO sector, based on some agreed principles and proposals for shared work.

Dr Jennifer Mason, 2018[66]

Beyond the status quo

> What if... we came together and actually put all our differences aside. And said, for the greater good, we're going to put aside our egos and say, yeah, we want a plan, we want a voice, we want a vision that we can all agree on?
>
> *Project interviewee*

Despite the alignment around the four broad principles outlined in chapter three and the willingness to try working collaboratively, commissioning experiments in NSW remain a challenging task for the government and community sector.

The NSW Government and community sector will need to grapple with their individual roles in the system and make changes to update traditional ways of working, engaging with key pieces of the commissioning jigsaw through the lens of the four key principles.

Changes will need to be made not only concerning the relationship between the government agencies and the community sector, but also how government agencies interrelate and how peak bodies work with each other and their members.

The conversation will need to broaden beyond the peak organisations funded through the NSW Sector Development Program. This has begun through the recently created Commissioning Co-Governance Group but will need to extend further in order to conduct genuine commissioning experiments.

A natural starting point will be areas where collaboration already occurs between community organisations, other non-government service providers and government agencies, potentially focused around responding to a complex issue such as homelessness or domestic and family violence.

An important aspect moving forward will be the interaction with Aboriginal and Torres Strait Islander communities and organisations. The right to self-determination for Australia's First Nations peoples connects closely with the principle of *ensuring communities lead*. Commissioning experiments in any part of NSW need to take into account and be led by the views and aspirations of the local Indigenous communities and Traditional Custodians.

It is worth noting that the Aboriginal Child and Family Commission, proposed by AbSec—the NSW Child, Family and Community Peak Aboriginal Corporation—in their paper "Delivering Better Outcomes for Aboriginal Children and Families in NSW" has a number of close similarities to the Whānau Ora commissioning experiment discussed earlier in the report.

The NSW Commissioning Jigsaw

This report recommends that NSW Government agencies and NSW family and community sector organisations embark on a genuine partnership. One that collaboratively designs a new approach to commissioning, that commits to overarching principles for good human service design and delivery, and conducts a series of commissioning experiments considered through the lens of the four principles for good commissioning.

This final section returns to the commissioning jigsaw introduced in Chapter One, offering some insights to guide the Government and community sector as they—through an evolving series of collective commissioning experiments—learn how to best support people's needs and build resilient, safe and strong communities.

What should commissioning address and where?

Do not try and commission the entirety of human services across NSW within a single framework. A large scale logistical exercise like this would likely swiftly bureaucratise and become lost in the policy development hallways of government agencies and peak organisations. This would undermine the ability for the system to be flexible and enable community leadership.

Ideally, run commissioning experiments in smaller geographic areas—at a town, local council or Local Health District level—focusing on particular policy problems. Working in this way will provide opportunities to test varying approaches to governance, performance management and accountability, as well as open opportunities for partnering with different local government and non-government organisations.

What should be the community's role?

NSW should experiment with multiple forms of community engagement, including the broad methods outlined in Chapter One, exploring how communities can have agency through decision-making, data-sovereignty, and how commissioning processes can ensure people feel represented and listened to. This should include avenues to participate and engage on- and off-line in the design and development of services.

Where there are communities ready to lead and wanting to embrace decision-making—Aboriginal communities exploring justice reinvestment or other collective impact approaches, for example—governance structures can be facilitated that embed community leadership. In other communities experiencing high levels of need, a more natural starting point may to devise structures and mechanisms that elevate community voices and support capacity building and community advocacy, with the medium-term aim of supporting the emergence of local community leadership structures.

Who should do the commissioning?

NSW should move away from government-led commissioning. An independent commissioning agency—or agencies—should be created, with a governance structure combining government, community service providers, First Nations leadership and people with lived experience of disadvantage and discrimination. Any agencies created should enable and support the creation of commissioning alliances and community-led commissioning. Various models can be found as an appendix to a 2019 ANZSOG report on commissioning for the Australian Public Service.[67] Such independent agencies can also act as intermediaries between the NSW

Government and community sector in providing the quality assurance and performance management necessary for high quality service delivery.

Who should set the outcomes?

Broad outcomes for commissioning across NSW should be established collectively, ideally by an independent commissioning agency. The Whānau Ora outcomes framework is a good model that places well-being and community development at the forefront. In the interim, the current NSW Human Services Framework could serve as a starting point.

At a more local level, service providers and communities should be involved in determining and agreeing on the outcomes they want to focus on within the broader framework. Community sector peak bodies will have an important role in connecting local communities and service providers to the broader outcomes framework, while government can assist with data provision and enabling community participation and decision making.

How should funding be provided?

Governments and community sector peak bodies have an important role to play in sourcing and distributing funds in a way that removes undue burden from community service providers. Ideally, community service providers should not be required to make complex funding applications, report against multiple agreements with varying datasets, or competitively tender against each other.

Any tendering processes should ideally occur collectively. Consideration should be given to providing pooled funding for local commissioning experiments and commissioning alliances to distribute as decided collectively, including to establish community hubs that coordinate local service delivery and facilitate community governance.

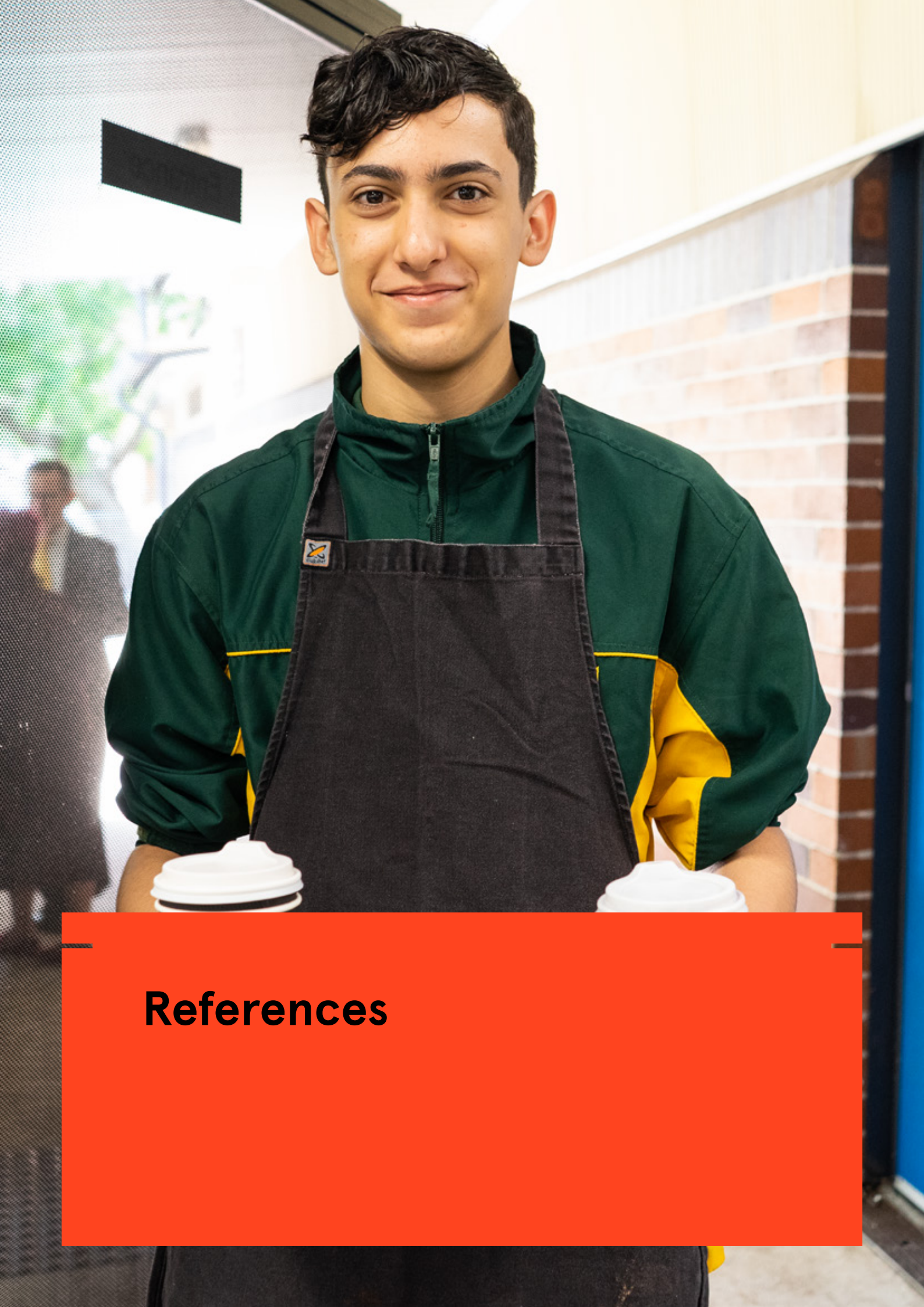
Ideally, funding contracts should be for a minimum of five years, with performance contracts that do not prescribe service types, outcomes or activities. Activities and service types should be measured in order to facilitate learning and establish contribution to the broader outcome frameworks.

Quality assurance and performance management of funding agreements should be relational and independent, prioritising building individual and organisational capacity and resilience over efficiencies and metrics.

How should services be delivered?

Preference should be given to community-based service providers and social enterprises where they currently exist, complemented by and working in collaboration with NSW public service agencies.

The NSW Government and community sector peak organisations should collectively facilitate state-wide learning and information sharing. This will assist service providers to reorient activities around community priorities and develop better, less competitive relationships with each other and the wider community.



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