

---

# Fair and just or just fair? Examining models of government—not-for-profit engagement under the Australian Social Inclusion Agenda

Gemma Carey\* and Therese Riley

Centre for Health and Society, School of Population Health, University of Melbourne, Melbourne 8344 0661, Australia.

\*Correspondence to: G. Carey. E-mail: [gcarey@unimelb.edu.au](mailto:gcarey@unimelb.edu.au)

Received on February 6, 2011; accepted on October 1, 2011

---

## Abstract

**This paper explores the interrelationship between two contemporary policy debates: one focused on the social determinants of health and the other on social (inclusion) policy within contemporary welfare regimes. In both debates, academics and policy makers alike are grappling with the balance between universal and targeted policy initiatives and the role of local ‘delivery’ organizations in promoting health and social equality. In this paper, we discuss these debates in the context of a recent social policy initiative in Australia: the Social Inclusion Agenda. We examine two proposed models of engagement between the government and the not-for-profit welfare sector for the delivery of social services. We conclude that the two models of engagement currently under consideration by the Australian government have substantially different outcomes for the health of disadvantaged communities and the creation of a more socially inclusive Australia.**

---

## Introduction

We now know that many of the social determinants of health lie outside the healthcare sector and across diverse policy areas, such as housing and education [1–3]. Despite this, the politics of health is often taken to mean the politics of healthcare [4]. Emerg-

ing research in Canada and the United States has shown that we need to ask ‘what are the political and economic determinants of the social determinants of health?’ [5]. This question draws attention to the relationship between political ideology, welfare regimes and policy decisions regarding which initiatives government will invest in and how.

Recent trends in health inequalities research demonstrate that welfare states (and the values and ideas that underpin them) and social policy are significant determinants of health. Coburn [6, 7] and Navarro [8, 9] have found that key health indicators, such as child and infant mortality rates, differ significantly between different welfare state regime and political ideologies that underpin them (i.e. neoliberalism). Conceptually, we can envisage a number of reasons why this might be so; the welfare state intervenes in communities at a number of different levels and for a range of purposes, which impact health. For example, to differing degrees welfare states endeavor to: address poverty and disadvantage through intervening in the structure of society; provide goods and services to meet the needs of citizens and promote less tangible ‘goods’ associated with communities such as social capital, which are important for well-being. In contrasting the impact of different approaches to the welfare state on health, Coburn and Navarro build a case for the overall importance of the ‘interrelationship’ between the welfare state and social policy for the health of populations.

In recent times, there have also been a number of major global and national reports urging governments to act on health inequalities [1, 10]. The underlying

premise is that '[h]ealth inequalities result from social inequalities' [1]. Therefore, the scale of health inequalities within and across populations could act as a marker for how fair a society is [1]. To move closer to a fairer and hence healthier, society both the Marmot Review in the UK and the WHO Commission on the Social Determinants of Health urged policy makers to take a social gradient approach to action. This approach is based on considerable empirical evidence that demonstrates that a person's social position is directly linked to their health status [2]; the higher a person is on the social gradient the better a person's health. For policy, a social gradient approach behooves policy makers to steer away from focusing 'only' on the most disadvantaged populations. The Marmot Review argues that '[i]f the focus were on the very bottom and social action were successful in improving the plight of the worst-off, what would happen to those just above the bottom or at the median, who have worse health than those above them? All must be included in actions to create a fairer society' [1]. Hence, a social gradient approach advocates for 'proportionate universalism', whereby investments in initiatives are proportionate to the needs of particular populations within a universal initiative [1]. Acting on the social determinants of health therefore requires a 'whole of system' approach. As Margaret Whitehead *et al.* argued in their Task Group report to the Marmot Review that ...

[s]trategies that rely just on local interventions will be insufficient to make a lasting and profound difference to the patterns of inequality across the country. Action at all levels of government and active engagement with civil society and the business sector is required over a sustained period of time (probably a decade or longer) [11].

For Australia, current debates regarding welfare regimes, social policy and the social determinants of health are extremely pertinent: in 2007, the newly elected Labor Government announced its social policy agenda for welfare state restructuring—the Social Inclusion Agenda (SIA). At the heart of the Agenda is the development of a new relationship between government and civil society organizations. The

same organizations described above as key players in addressing health inequalities. These organizations act as important intermediaries between national agendas and local community needs, delivering welfare and social services to citizens. Consequently, much of the success of the SIA pivots on the ability of the Australian government to reform its partnerships with these key policy actors.

This paper begins with a critical discussion of welfare state regimes (i.e. the ideas and values that underpin and drive welfare states) and health inequalities (see Table. 1 for a glossary of terms). We go on to describe the Australian SIA in detail, particularly the government's efforts to forge 'new and productive relationships' with civil society organizations (otherwise known as not-for-profit organizations) [12]. In doing so, we examine two models for engagement with the not-for-profit sector currently under consideration by the Australian government [13]. These are a 'choice and competition' model and a 'trust' model. In critiquing these two models, we ask 'which would best serve the interests of both the SIA and the social determinants of health?'

---

## Welfare regimes and health inequalities

---

Factors that influence health, such as income inequality, lack of housing, social services and access to education, do not occur in a vacuum [5]. They are decided upstream, in debates about social services and welfare. In recognition of this, a number of scholars are now urging us to examine the political determinants of health [6–9, 14]. To illustrate the importance of considering the political and economic context of health inequalities, recent work has focused on demonstrating a link between different types of welfare regimes and the health status of populations.

Coburn and Navarro demonstrate that key population health indicators are linked to welfare regime structure [6–9]. That is, whether a nation identifies with a liberal, conservative or social democratic ideology (this research uses Epsing-Anderson's [15] welfare typology to distinguish between styles of welfare state. Under Epsing-Anderson's typology,

**Table I.** *Glossary*

Civil society	Civil society is seen as the public sphere that mediates between the individual and the state. It is said to include social movements, not-for-profit organizations, political parties, institutions such as schools, and the free market [67]
Individualism	Principles of individualism stress the rights, freedom and importance of the individual in relation to other entities, especially the state. Discourses of individualism are embedded in neoliberal ideologies: market-logic requires people to be understood as autonomous and enterprising economic agents who can compete in the free-market [68].
Neoliberalism	also known also as the 'New Right' or 'economic rationalism' [68–70], neoliberalism is grounded in the belief that if left to operate freely, markets will provide the greatest good to society. Neoliberal ideologies came to dominate national and global politics over the last two-three decades.
Mixed economy of welfare	In a mixed economy of welfare, the state works with non-state actors, such as private or voluntary agencies, provide welfare. This arrangement is sometimes referred to as welfare pluralism [71].
Public policy	Refers to the policies, actions, inaction and laws undertaken by governments (for a more comprehensive discussion see [72])
Social democracy	Social democracy views markets as a fundamental source of inequality. The state is understood to have an obligation to provide goods that markets cannot deliver, or that markets deliver in an unequal way. A social democratic state is characterized by a strong government presence in economy and society [31].
Social policy	Public policy concerned with social issues and human welfare (see [73]).
Third Way	Third Way politics is a framework for policy making which seeks to adapt social democracy to the current political, economic and social environment. The Third Way makes an appeal to community as a means of finding an alternative to the free-market principles of neoliberalism and the strong state of social democracy [31]. It is subsequently characterized by an emphasis on social cohesion, social inclusion, social capital and human capital. For a more detailed account of the Third Way, see Giddens's [31] seminal work.
Third sector	The third sector is made up of not-for-profit organizations which are not part of the public or business sectors. Organizations in the third sector are: 1. Formed and sustained by groups of people (members) to provide benefits for themselves or others, and acting voluntarily without seeking personal profit. 2. Democratically controlled. 3. Organizations where any material benefit gained by a member is proportionate to their use of the organization. [37]
Welfare state	While different types (or levels) of welfare state exist, the extent to which a state is considered to be a welfare state is measured by the degree to which it uses its power (through politics and administration) to modify the play of market forces and correct structural of inequality within societies [15]. At its most basic level, the welfare state can be described as the state's responsibility for securing a modicum of welfare for its citizens.
Welfare state regime	Welfare state regime refers to the politics, power and ideology that both underpin and drive the welfare state and its related policies. Esping-Anderson's [15] seminal work categorizes welfare state regimes into three ideal types: liberal (modest welfare directed predominately toward the poor), conservative (market-based welfare with little state and redistributive impact) and social democratic (based on principles of universalism which promote equality at the highest level).

liberal states issue minimal welfare, while Social Democratic regimes provide universal and comparatively generous benefits. While this typology is widely used, it has been subject to much scrutiny because it simplifies diverse and complex approaches to welfare [16]). Liberal welfare states have been

found to have higher infant mortality rates, a higher rate of excess low-birth weight babies, higher overall mortality rates and greater inequalities in the social determinants of health [6–9, 17].

Coburn and Navarro point to the relationship between neoliberalism and inequality to explain these

significant differences. They argue that the global trend toward neoliberalism (seen under the Thatcher government in the United Kingdom, Reagan in the United States and Howard in Australia) has widened inequality and produced greater inequalities in the social determinants of health. Neoliberal ideology accepts social inequality as a necessary by-product of a well-functioning market [8]. Lynch ([18], p. 1002) argues that neoliberal ideology reflects individualist sentiments and fosters ‘a climate of economic self-interest by encouraging the view that those outside immediate family and friends should perhaps be viewed ... as competitors for scarce resources.’ Neoliberalism may therefore negatively influence a whole range of social determinants, such as income distribution, trust, social cohesion, social capital and social participation (see also [19]).

This evolving debate rightly expands the discussion of health inequalities to bring to the foreground questions of structural inequality and the role of governments in promoting or diminishing such inequality through the mechanisms of the welfare state. Increasingly, this work suggests that the structure of the welfare state is an important determinant of health. For public health, this presents some important questions: for the purposes of alleviating health inequalities, what would an optimal welfare state look like? And how do, or might, current Australian efforts at welfare restructuring affect the social determinants of health?

Like the United States, Britain and Canada, the Australian welfare state is a liberal regime; it favors residual and means-tested policy, which typically comes into play when other forms of welfare (e.g. family and voluntary) fail [20]. However, the Australian welfare state has always been considered ‘odd’ [20]. While most countries fund their welfare policies through social insurance schemes, Australia has used wealth generated through taxation revenue. For this reason, the Australian welfare state is sometimes referred to as the ‘wage-earner’s welfare state’ [21]. This method of financing welfare has led to the allocation of a relatively low proportion of overall government revenue for income support and social policy. While the social insurance scheme has allowed social democratic welfare states to introduce universal income support, Australia has tended to utilize means

testing in welfare policies [22]. Consequently, Australian welfare policies traditionally target pockets of need within communities rather than taking a structural approach to alleviating poverty [23].

While Australia operates within a liberal framework, governments in power and policy approaches vary over time. Since the 1980s neoliberal approaches and discourses of individualism have found strong footing in the Australian system. These discourses picked up pace in the early 1990s under the social democratic Labor governments of the time; the Hawke and Keating governments introduced a range of macroeconomic reforms, including increased privatization and deregulation. These reforms were later expanded under the conservative Howard Government, which placed an even greater emphasis on the principles of the free market and individualism [16]. Most notably, the Howard Government utilized unprecedented levels of welfare conditionality (e.g. mutual obligation policies) [23]. As a result of these growing neoliberal policy approaches, Australia—like many countries—has experienced widening inequalities in the social determinants of health [23, 24]. Income inequality in Australia is higher than European Union and OECD averages and has been increasing since 2005 [25]. Moreover, 35% of people in the lowest income quintile report fair or poor health compared with only 7% in the highest income quintile [25].

---

## The SIA

---

In response to growing inequality, in 2007, the Australian Labor Party ran on a platform of increased equality and social inclusion. Since taking office they have instigated a broad-scale policy intervention, the SIA. The SIA articulates the government’s vision for a more just society, in which ‘all Australians feel valued and have the opportunity to participate fully in the life of our society’ [26]. At this early stage, it is unclear whether the SIA takes a whole of population approach to improving equity or targets pockets of disadvantage. At present, many of the initiatives explicitly labeled as part of the agenda focus on disadvantaged groups. These include helping jobless

families and children, addressing homelessness and a placed-based approach to areas of highly concentrated disadvantage. However, the agenda has also been explicitly linked with existing policies, which take a universal approach, including Medicare and the Australian Human Rights Framework [27]. The government has also enacted a number of structural changes under the name of the SIA. For example, social inclusion 'sections' have been added to several large government departments to support new policies and programs. These include Prime Minister and Cabinet, the Attorney General's Department and the Department of Education, Employment and Workplace Relations. A range of related advisory bodies have also been established external to government.

In the United Kingdom, social inclusion acted as a 'policy current': a guiding fluid policy that moved across departmental boundaries [28]. Social policy commentators have articulated a similar vision for how social inclusion could work in the Australian context. For example, Gallop [29] has suggested that social inclusion will be integrated into the mainstream objectives of government portfolios and departments, suggesting that all government activities and policies should, in theory, be measured against the ultimate goal of inclusion. From this perspective, a wide range of government reform efforts could be viewed as constitutive of the agenda. For example, the government has undertaken a range of nation building and modernization efforts, including changes to education, health and hospital reform and a substantial investment in public infrastructure. They have also engaged in a range of wide-reaching reforms targeted at reducing inequity, these have included the Fair Work Act that protects vulnerable employees and a paid parental leave scheme. Thus, social policy commentators have argued that the agenda is an opportunity to '[b]ring the social back in, and giv[e] all citizens a stake in their society' ([30], p. 9). Similarly, Gallop [29] argues that the SIA has the potential to be a 'fairness agenda' that holds society together in a time of acute change.

With its focus on social inclusion, the SIA draws strongly on Third Way discourses and social investment paradigms, popularized by New Labour in the

United Kingdom during the 1990s. The Third Way stresses new relationships between the individual and the state, where government has responsibilities to address poverty and disadvantage but also holds expectations of individuals to undertake paid employment and build the democratic state by participating in civil society [31]. These new relationships can be seen in approaches to the welfare state. Where neoliberal governments sought to shrink the welfare state through a greater emphasis on market and informal welfare, and social democrats to expand state welfare, the Third Way suggests that governments work with organizations outside of government to address social issues [31]. The Third Way embraces a social investment approach to welfare, emphasizing social and economic participation and equality of opportunity for increased labor force participation [23]. Like neoliberal approaches, the social investment paradigm is also future focused. While neoliberal approaches have increasingly been driven by concern over the budgetary burden of government spending on future generations, a social investment approach advocates for investment in human capital to create profits for the future [32]. This investment in human capital is evident in initiatives designed to give children the best possible start in life (for example, Sure Start in the United Kingdom and Best Start in Victoria, Australia). A focus on social investment strategies and early childhood development also emerged in Canada in the late 1990s [33]. In regards to health and well-being, the WHO Commission on the Social Determinants of Health also advocated investment in the health and well-being of children, CSDH [10].

Third Way approaches carry a concern for social exclusion. Through investing in the future, creating opportunities for work and encouraging participation, governments aim to assist disadvantaged groups to join the mainstream (or become 'included'), while also making the mainstream a 'fairer' place to be. Though, as Mendes [23] argues, these measures still need to be accompanied by a push for structural change to be successful.

While the SIA has reintroduced notions of equity to national debates, it is currently unclear how the

Agenda will reconcile intervening in the lives of the most disadvantaged ‘while’ intervening in the lives of the rest of the population. Put another way, how will they balance universal and targeted initiatives? This has been further complicated by Labor’s continued use, and expansion, of the welfare conditionality policies of the former government. In particular, Labor has controversially expanded compulsory income management or ‘welfare quarantining’, policies. The Howard Government originally introduced welfare quarantining to remote Aboriginal communities. Under Labor, they have been expanded to postcodes of concentrated disadvantage throughout the country [34]. Within these designated postcodes, 50% of government payments are ‘quarantined’ for spending on designated items such as food or clothing [34]. The government argues such measures help disengaged people put food on the table and pay their rent [34]. Individuals can apply to be exempt from the scheme on the basis of meeting certain criteria, such as sending their children to school.

This ‘rights and responsibilities’ approach highlights a strong discourse of individualism emerging in the government’s approach to welfare state restructuring. It is worth noting that during the Labor government’s current term in office, there has been a shift in leadership from Kevin Rudd to Julia Gillard. Welfare conditionality was expanded under the Rudd government; however, these discourses have gained momentum under Gillard. For example, in the lead up to the 2012 budget, the government began targeting the disability pension as a means to generate welfare savings [35]. Similarly, under the leadership of Kevin Rudd, social inclusion was given cabinet status; answering to Julia Gillard, then the Minister for Social Inclusion. However, under Prime Minister Gillard’s leadership, responsibility for social inclusion has been shifted to the outer ministry.

---

### **Government partnerships and the role of local ‘delivery’ organizations**

---

Third Way discourses suggest that the programs to generate inclusion are best offered in partnership

with non-state actors such as not-for-profit organizations [31]. In keeping with this approach, the Labor government developed a National Third Sector Compact detailing their commitment in this area: ‘The Compact will provide a framework for building the capacity of non-profit and other non-government community organisations to improve community wellbeing’ [36]. The Australian federal government has also created a not-for-profit Reform Council within Prime Minister and Cabinet to implement and drive the reforms associated with the compact and the SIA. Thus, while the SIA is—in part—targeted at the reform of state institutions, significant emphasis is also being placed on supporting non-state actors to address disadvantage and deliver a more ‘just society’. Primarily, these actors are not-for-profit organizations operating in the welfare sector.

Both nationally and internationally, the not-for-profit (or ‘third’) sector has become implicated in the delivery of government social services, such as assistance with employment, housing or other forms of welfare. The Australian third sector first emerged as charitable and faith-based organizations during colonial times [37]. The majority of the sector, however, developed out of social movements in the 1960s–70s [37, 38]. These organizations were primarily small (although ubiquitous) and issue based. Today, the sector is very broad and made up of a diverse range of small and large organizations. These include charities, advocacy organizations, voluntary affiliations and services. While the sector as a whole can be said to be concerned with social justice, the mission, role and purpose of individual organizations varies considerably [37].

The third sector has an important, and increasingly prominent, role in addressing the social determinants of health. Since the 1970s, the sector has been an important facilitator of social and civic participation and is understood to build social capital and promote social cohesion [37]. The sector is also fundamental to more explicitly public health-oriented activities: not-for-profits operations encompass health promotion, community development, community empowerment and consumer participation. Over the last two decades, the sector has become increasingly in-

volved in the provision of social and public services, which support the health and welfare of the population [37, 39, 40]. They are seen as key players in delivering initiatives designed to address the social determinants of health (see [1]).

In part, the third sector has become (increasingly) implicated in the delivery of government welfare because of their close connections and networks with local communities, which enable organizations to undertake work such as advocacy, community development and address local-level social disadvantage [37, 40]. However, the position of the sector in the delivery of welfare has also developed due to governments wanting to share the responsibility and cost of service delivery. To achieve this, nationally and internationally governments have looked to the third sector: it is seen as more innovative, efficient and effective. Not-for-profits also have added benefits: organizations are perceived to strengthen civil society, deepen political engagement and provide advocacy [37]. However, it is worth noting that the evidence is rather thin when it comes to claims of superior performance compared with government services [41].

While the government has made a strategic commitment to the third sector to deliver on the SIA, the ways in which governments interact with, fund, and regulate not-for-profit organizations significantly impacts their internal and external functioning and their ability to address social disadvantage [38]. The Marmot Review ([1], p.160) points out that ‘[w]hile the real and potential contribution of the third sector to reducing health inequalities is recognized, there remains concerns about how the sector is supported, both to deliver its services and to effectively engage as a strategic partner’.

In a recent review of the not-for-profit sector, the Australian Productivity Commission (the Australian Productivity Commission is the Australian Government’s independent research and advisory body, it provides research on a wide range of social, economic and environmental issues) urged that selecting the right model for engagement between governments and organizations was paramount to forging new and productive relationships between the two

sectors [13]. This review has generated interest in two models of government—not-for-profit relations: ‘choice and competition’ and an alternative model based on trust, inclusion and reciprocity [13, 30].

In Australia, choice and competition models have been operating in selected areas for approximately 10 years [23]. Similar models were also used in the United Kingdom as part of an effort to address social exclusion. In response to the choice and competition model, Taylor-Gooby provides a detailed critique of the fit between such a model and social inclusion [19]. In response, Taylor-Gooby outlines an alternative model based on trust.

The uptake of these alternative models has the potential to affect all government funded welfare services. While the choice and competition model has been used most widely within the employment sector, services such as housing, disability and individual support programs could similarly be brought under a choice and competition model of funding. In the remainder of the paper, we examine these two models for government–non-government partnerships and discuss their implications for population health.

### Choice and competition

In the United Kingdom, New Labour established a choice and competition model of public service delivery [42]. The choice and competition model adheres to a mixed economy of welfare, where state and non-state actors, such as businesses and not-for-profits, compete to deliver public services in ‘quasi-markets’ [42]. Quasi-markets operate like other markets in the sense that independent providers compete for customers. They differ, however, in that customers are not purchasing goods and services. Rather, the services are paid for by the state [42]. Le Grand [42] argues that this model of public services provides the greatest incentive for organizations to deliver high-quality efficient services. Choice and competition models are based on market principles: the invisible hand of the market is assumed to address the greatest public good. Despite the third sector’s well-documented history of the benefits of altruistic community-based activities [42], within this model third sector organizations are viewed as analogous with for-profit and public providers [30].

The choice and competition model uses contracting and tendering processes guided by market principles rather than untied funding and grants [42]. The effects of contracting and tendering processes on not-for-profit organizations have been documented nationally and internationally (see, for example, [43–49]). Contracting is seen to present a ‘widespread challenge both to the way non-profit organizations have actually operated and to popular conceptions about how they are suppose to behave’ ([50], p. 8).

Top-down accountability and imposed targets within the choice and competition model often decrease organizational autonomy, which has in some instances diminished the ability of organizations to carry out work which addresses disadvantage and inequality, such as advocacy work and representing marginalized social groups [43–49]. As Howe [51] suggests, there is a concern that organizations or agencies become uncritical of the state and provide ‘disinterested’ services, with little incentive to engage with the interests and needs of users. This can be seen in the practice known as ‘creaming’: through the need to meet government imposed targets, large social services organizations have been known to avoid complex cases in favor of simpler cases with more readily achievable outcomes [52]. Such practices clearly do not progress an SIA, equality or address entrenched disadvantage.

Contracting is also understood to undermine organizations’ capacities ‘to develop trust and maintain networks (with communities) as well as limiting efficacy in promoting social change’ ([50], p. 117). In a survey of approximately 500 organizations involved in contracting, Rawsthorne [53] found that close to 50% of organizations felt that contracting had reduced their ability to seek and/or receive grants for innovative prevention or development activities. The stifling of innovation has been particularly evident in the case of community development. Decreased autonomy reduces the ability of many not-for-profits, particularly the small ones, to work effectively and innovatively in communities. In Australia, choice and competition models have seen the destruction of small

organizations, organizations that Lyons [54] argues are the richest in social capital.

Le Grand [42] contends the choice and competition model is egalitarian; users will ‘vote with their feet’ and therefore provide incentives for organizations to adjust to user needs. However, in Rawsthorne’s [53] aforementioned survey, 50% of organizations reported that under contracting, they were more accountable to the government than to the community. Moreover, Le Grand’s argument does not recognize the unequal ability of individuals to exercise choice. For example, those experiencing complex or intergenerational disadvantage are prohibited from exercising choice in different ways across the life-course due to factors such as social and family circumstances and conditions, attitudes, economic limitations and community-level structural factors in areas of concentrated poverty. These individuals are extremely vulnerable and are unlikely or unable to exercise choice [55]. For an in-depth discussion of the conceptualization of agency and welfare recipients (see Hoggett [56]).

Within the Australian context, the dilemmas of the choice and competition model are most evident in the experiences of the Job Network introduced by the former Howard Government. Here, public employment services were replaced with a national network of for-profit and non-profit agencies competing in a quasi-market place [57]. Under the Job Network, not-for-profits became faced with competition with private, public and other not-for-profit agencies. Some organizations embraced the greater flexibility of ‘outcome-based’ funding. The majority, however, were concerned by the responsibility of policing clients [57]. This responsibility sat at odds with, and in many cases diminished, the advocacy role of organizations. Furthermore, Considine [58] found evidence of a convergence in the approaches and activities of not-for-profit and for-profit agencies under these contracts. We might therefore question the nature and role of not-for-profit providers in a competition model. For example, are not-for-profits any different from for-profit providers? Is there space for advocacy?

Under Labor and the SIA, the Job Network has been reformed as Job Services Australia (JSA),

which still operates under competitive contracting arrangements. These arrangements appear to be limiting organizations' success in addressing disadvantage and promoting social inclusion. A recent review of JSA found that the contracting environment, which promotes efficiency and cost-effectiveness, diminished the ability of organizations to offer holistic services. The contracts do not allow enough flexibility for services to provide individualized and integrated assistance. Services that offer holistic support (i.e. assistance across a range of needs) have been found to be most effective for addressing complex disadvantage [25]. The choice and competition model may therefore create an arbitrary line within populations regarding who is and is not deserving of services and support. The Marmot Review [1] warns us about the consequences of drawing a line across the social gradient and only offering services or support to those on one side of it; the health of those on the other side is still worse than those above them [1].

Debates raised in the public health literature as to whether some prevention strategies at a population level increase social inequalities in health are worth mentioning here (see [59–61]). These debates have led to an increased understanding of the importance of both a population and 'vulnerable' population approach when designing public health interventions [59]. Frohlich and Potvin [59] argue that interventions with 'vulnerable' populations should be both intersectoral and participatory in nature. This view is also consistent with the concept of 'proportionate universalism' advocated in the Marmot Review in the United Kingdom [1]. Such conclusions are more aligned with a 'trust' than 'choice and competition' model of social service provision. Organizations need independence to support participation and drive partnerships to address the often complex and multilayered forms of exclusion experienced by the most marginal. However, the choice and competition model utilizes government imposed targets and top-down accountability. This has been found to limit autonomy and flexibility in addressing the needs of users, centering the attention on the needs of government. Le Grand claims that organizations remain accountable to users through the exercise of

choice, but if users are disempowered or unable to exercise that choice, they become further marginalized from services. The problem here is not so much the existence of government targets but rather the existence of inappropriate targets. Whitehead *et al.* [11], in their final Task Group report to the Marmot Review on delivery systems for reducing health inequalities, argue that organizations involved in government partnerships can be under pressure to deliver short term gains to meet government targets, resulting in them 'hitting the target but missing the point' ([11], p. 93).

### Trust

In his critique of the choice and competition model, Taylor-Gooby [19] puts forth an alternative model of social and public service provision for the advancement of social inclusion. Taylor-Gooby's model is based on trust. Trust is in fact an important component of any welfare state: as citizens we trust that social services, such as employment services and welfare services, will be there should we need it. Under a trust model of welfare, a government sets the budget for public services but leaves service delivery decisions to providers, such as not-for-profit organizations [30]. Providers are assumed to allocate services in an efficient equitable manner and to provide services that are highly responsive and targeted to the specific needs of user groups. The trust model is based on a broader perspective of social responsibility and citizenship. Within this framework, individuals are responsible to society through the promotion of social solidarity and cohesion. In service delivery, a trust model of funding is believed to promote more holistic and integrated services. Organizations have greater flexibility to work in partnership with other organizations and services and thereby offer more integrated and individualized support [27]. This is because under this model organizations are driven by client outcomes and need rather than government targets or profitability.

Under the trust model, organizations are valued for their position within, and networks with, local communities. They become accountable to commu-

nities rather than to top-down targets and directives [30]. Small organizations, which work to meet the needs of specific marginalized groups, would be able to offer their embeddedness in communities as a kind of currency [30]. This is in stark contrast to the experiences of small not-for-profits under the competition model: as in any market model, small providers find it difficult to compete and can be bought out of their market share by larger operators [30]. Within the trust model, the unique contributions of the third sector (which have made it desirable for the delivery of state services) are valued rather than co-opted by the state. That is, organizations' networks and relationships with communities and the ability to address local-level disadvantage that this provides. However, it is worth noting that this is not a new or completely untested model. A similar model operated in Australia in the 1960s and 70s, with a more directed approach to funding emerging by the late 1970s [37].

At the heart of Taylor-Gooby's argument for a trust model of social service delivery is the belief that we need to implement new values for society and citizenship. As Lynch [18] argues, the individualistic and competitive underpinnings of neoliberalism are harmful to society: they erode trust, cohesion and social capital. Taylor-Gooby suggests that we ought to promote a notion of social citizenship that engenders trust, cohesion and responsibility to fellow citizens. In using these principles to guide the delivery of government-funded services, we might begin to promote a more inclusive society. The concept of social citizenship, however, presents its own complexities, namely a tension between universal definitions of entitlement and the differential needs of particular groups. Social citizenship is based on the principles of equality and universalism; all individuals who possess the status of citizen have equal rights (in accordance with their social needs) and have equal responsibilities to the state. Scholars, such as Lister [62], have called into question the saliency of having a universal concept of need at the heart of definitions of social citizenship. Different social groups experience different needs and similarly have different capacities to fulfill duties to the state.

The trust model also presents certain difficulties with regard to implementation. For example, how is accountability measured or ensured and to whom? How does government decide which organizations get funded? And is power likely to pass from professionals (working in not-for-profit) to the citizenry? Taylor-Gooby argues that the citizenry has collective ownership of services, and organizations are therefore accountable to them. However, the model places money and control in the hands of professionals rather than the citizenry directly, assuming that due to the altruistic character of the sector, organizations will 'do the right thing' and control will be passed on. This also raises questions about efficacy: organizations may do some good but are they doing the maximum good? An absence of comparative performance measures means, we are unable to determine what level of good is being done and whether it is worth the investment. In 2010, the government established a not-for-profit Reform Council, which may assist in dealing with these limitations of the trust model.

Finally, Le Grand [42] questions the relationship between organizations and policy within this model. Within the choice and competition model, not-for-profit organizations are contracted to deliver government policy. Under the trust model, no such formal contract exists and organizations may therefore subvert policy to the benefit of users or indeed themselves. So how can a national agenda be maintained with such disparate policy actors? Fairclough ([63], p. 5) argues that for partnerships with government to flourish governments should move away from direct control and toward the creation of a coherent policy vision to 'shape the culture, discourse and language of the dispersed agents of government'. The welfare system then unites over a common vision of the future.

The trust model appears to hold more potential for sub-populations unaffected by whole of population health intervention. By being flexible and responsive, it can meet the complex needs of individuals and communities experiencing multiple forms of disadvantage. By not diverting the efforts of not-for-profits toward the delivery of policy, it enables them to contribute to health through build-

ing social capital, participation and social inclusion. In promoting a broader view of social responsibility, it is more likely to foster social cohesion: individuals are not expected to be enterprising, rational actors who must make assessments and choices regarding the range of services on offer [19, 30].

This model is reflective on the trend toward complexity science evident in population health intervention research [64–66]. This work argues that not enough attention has been paid to the nature of the communities (or systems) in which interventions (such as the SIA) are expected to interact and be effective [65]. Here, understanding and flexibility in the adaptation of initiatives and their context is of paramount importance [65]. The trust model is a relational one and one in which historical experiences of exclusion can guide future direction. However, to take a population health approach, not-for-profit organisation must be accountable to more than their communities. A National Agenda such as the SIA requires effort at all levels of government and other sectors as well as performance measures and targets. The key is to identify appropriate targets for action at a local, state and national level to ensure broader accountability in the creation of a more socially inclusive and healthier Australia.

---

## Conclusion

---

This paper has critically examined two models for government—not-for-profit relations currently under debate in Australia, choice and competition and trust. The choice and competition model stems from a neoliberal approach to welfare, introducing market-based approaches to the delivery of services. Consistent with Coburn and Navarro's research on the influence of political ideology on health, we argue that this model is unlikely to improve health inequalities. It offers limited flexibility and is likely to result in an arbitrary line being drawn between who is and is not deserving of services. In contrast, the trust model is more consistent with a social gradient approach. However, the efforts of delivery organizations would need to be tied to the national agenda to ensure broader accountability.

While the Marmot Review has drawn attention to the critical role of service delivery organizations, more attention needs to be given to the political and regulatory environment in which these organizations operate. The types of relationships governments form with such organizations, and the concomitant funding and accountability arrangements, significantly impact the contributions they are able to make to the social determinants of health, via national initiatives like the SIA.

---

## Funding

---

Australian National Health and Medical Research Council Australia; Sidney Myer Foundation (to G.C.); Victorian Health Promotion Foundation (to T.R.).

---

## References

---

1. Marmot M, Atkinson T, Bell J. *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010*. London, UK: University College London, 2010.
2. Marmot M, Wilkinson R. *Social Determinants of Health*. New York, NY: Oxford University Press, 1999.
3. Siegrist J, Marmot M. *Social Inequalities in Health. New Evidence and Policy Implementations*. Oxford, UK: Oxford University Press, 2006.
4. Bambra C, Fox D, Scott-Samuel A. Towards a politics of health. *Health Promot Int* 2005; **20**: 187–193.
5. Raphael D. Getting serious about the social determinants of health new directions for public health workers. *Promot Educ* 2008; **15**: 15–20.
6. Coburn D. Income inequality, social cohesion and the health status of populations: the role of neo-liberalism. *Soc Sci Med* 2000; **51**: 135–46.
7. Coburn D. Beyond the income inequality hypothesis: class, neo-liberalism, and health inequalities. *Soc Sci Med* 2004; **58**: 41–56.
8. Navarro V. *Neoliberalism, Globalization and Inequalities: Consequences for health and quality of life*. New York, NY: Baywell, 2007.
9. Navarro V, Shi L. The political context of social inequalities and health. *Soc Sci Med* 2001; **52**: 481–91.
10. CSDH. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. Geneva, Switzerland: World Health Organization, 2008.
11. Whitehead, M., Doran, T., Exworthy, M. *et al. Delivery systems and Mechanisms for Reducing Inequalities in Both Social Determinants and Health Outcomes*. Task Group submission

- to the Marmot Review London: University College London, 2009, 187–193.
12. Stephens U. *Address to the 12th National Conference on Volunteering*. Gold Coast, Australia: Australian Government, 5/9/08, 2008.
  13. Contribution of the Not-for-profit sector. *Productivity Commission*. Canberra, Australia: Australian Commonwealth Government, 2009.
  14. Langille D. The political determinants of health. In: Raphael D (ed). *Social Determinants of Health: Canadian Perspectives*. Toronto, Canada: Canadian Scholars' Press, 2004.
  15. Epsing-Anderson G. *Three World's of Welfare Capitalism*. London, UK: Polity Press, 1990.
  16. Bessant J et al. *Talking Policy*. Sydney, Australia: Allen & Unwin, 2006.
  17. Chung H, Muntaner C. Welfare state matters: a typological multilevel analysis of wealthy countries. *Health Policy* 2007; **80**: 328–339.
  18. Lynch J. Income inequality and health: expanding the debate. *Soc Sci Med* 2000; **51**: 1001–5.
  19. Taylor-Gooby P. *Reframing Social Citizenship*. Oxford, UK: Oxford University Press, 2009.
  20. McMahon A, Thomson J, Williams C. *Understanding the Australian Welfare State: Key Documents & Themes*. Victoria, Australia: Tertiary Press, 2000.
  21. Castles FG. *The Working Class and Welfare*. Sydney, Australia: Allen & Unwin, 1985.
  22. Deakin N. *Origins of the Welfare State*. New York, NY: Allen & Unwin, 1957/2000.
  23. Mendes P. *Australia's Welfare Wars Revisited*. Sydney, Australia: UNSW Press, 2008.
  24. Vinson T (ed). *Unequal in Life: The Distribution of Social Disadvantage in Victoria and New South Wales*. Victoria, Australia: Jesuit Social Services, 1999.
  25. Social, Inclusion Board. *Social Inclusion in Australia. How Australia is Faring*. Canberra, Australia: Australian Commonwealth Government, 2010.
  26. Australian Commonwealth Government. *The Social Inclusion Agenda*. Available at: <http://www.socialinclusion.gov.au/Partnerships/Board/Pages/default.aspx>. Accessed: June 2011.
  27. Australian Commonwealth Government. *The Social Inclusion Agenda*. Available at: <http://www.socialinclusion.gov.au/Partnerships/Board/Pages/default.aspx>. Accessed: June 2011.
  28. Bills D. Tackling social exclusion: the contribution of voluntary organisations? In: Harris MR, Rochester C (eds). *Voluntary Organisations and Social Policy in Britain*. Hampshire, UK: Palgrave, 2001, 37–48.
  29. Gallop G. In defence of federalism. In: Drenfurth NS, (ed). *All That's Left: What Labor Should Stand For*. Eds Drenfurth, N. & Soutphammassane. Sydney, Australia: New South, 2010.
  30. Smyth P. *Religion, Welfare and the New Social Contract in Australia*. Submission to the Productivity Commission Inquiry into the Contribution of the Not for Profit Sector. Available at: [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0005/90491/sub172.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0005/90491/sub172.pdf). 2009.
  31. Giddens A. *The Third Way. The Renewal of Social Democracy*. Cambridge, UK: Polity Press, 1998.
  32. Jenson J. Lost in translation: the social investment perspective and gender equality. *Social Politics* 2009; **16**: 446–83.
  33. Mahon R. Varieties of liberalism: Canadian social policy from the 'Golden Age' to the present. *Social Policy and Administration* 2008; **42**: 342–61.
  34. Macklin J. *Media Release: Major Welfare Reforms to Protect Children and Strengthen Families*. Australian Government. Available at: [http://www.jennymacklin.fahcsia.gov.au/internet/jennymacklin.nsf/content/welfare\\_reforms\\_protect\\_children\\_25nov2009.htm](http://www.jennymacklin.fahcsia.gov.au/internet/jennymacklin.nsf/content/welfare_reforms_protect_children_25nov2009.htm). Accessed: 25 November 2009.
  35. Dunlevy S. Julia Gillard's first budget to tighten disability, pension support to get more to work. *The Australia*. 2011. Accessed: April 2011.
  36. Australian Government. *National Compact*. Available at: <http://www.socialinclusion.gov.au/Partnerships/Compact/Pages/default.aspx>. Accessed: July 2010.
  37. Lyons M. *Third Sector: The Contribution of Nonprofit and Cooperative Enterprises in Australia*. Sydney, Australia: Allen & Unwin, 2001.
  38. Melville R. "'Token participation' to 'engaged partnerships'" Lessons learnt and challenges ahead for Australian not-for-profits. In: Barraket J, (ed). *Strategic Issues for the Not-For-Profit Sector*. Sydney, Australia: University of New South Wales Press, 2008.
  39. Dalton B, Lyons M. Advocacy organisations in Australian politics: governance and democratic effects. *Third Sector Rev* 2005; **11**: 59–77.
  40. Fyfe N. Making space for 'Neo-communitarianism'? The third sector, state and civil society in the UK. *Antipode* 2005; **37**: 536–57.
  41. Davies S. Contracting out employment services to the third and private sectors: a critique. *Crit Soc Policy* 2008; **28**: 136–164.
  42. Le Grand J. *Delivering Public Services Through Choice and Competition: The Other Invisible Hand*. Princeton, NJ: Princeton University Press, 2007.
  43. Carey GE, Braunack-Mayer AJ, Barraket J. Spaces of care in the third sector: understanding the effects of professionalization. *Health: An Interdisciplinary Journal for the Social Study of Health. Illn Med* 2009; **13**: 1–18.
  44. Casey J, Dalton B. Best of times, worst of times: advocacy in the age of compacts. *Aust J Polit Sci* 2006; **41**: 23–38.
  45. Fyfe N, Milligan C. Out of the shadows: exploring contemporary geographies of the welfare voluntary sector. *Prog Hum Geogr* 2003; **27**: 397–413.
  46. Jenkins K. No way out? Incorporating and restructuring the voluntary sector within spaces of neoliberalism. *Antipode* 2005; **37**: 613–18.
  47. Laurie N, Bondi L. Introduction. In: Laurie N, Bondi L (eds). *Working the Spaces of Neoliberalism: Activism, Professionalisation and Incorporation*. Oxford, UK: Blackwell Publishing, 2005, 1–8.
  48. Salamon L. *Holding the Center: America's Nonprofit Sector at a Crossroads*. New York, NY: Nathan Cummings Foundation, 1997.
  49. Wolch J. Decentering America's nonprofit sector: reflections on Salamon's crises analysis. *Voluntas* 1999; **10**: 25–35.
  50. Owen S, Kearns R. Competition, adaptation and resistance: (re)forming health organisations in New Zealand's third sector. In: Milligan C, Conradson D (eds). *Landscapes of voluntarism. New Spaces of health, welfare & governance*. Bristol, UK: The Policy Press, 2006, 115–34.

- 
51. Howe B. The church and the markets. In: Nichols A, Postma M (eds). *The Church and the Free Market*. Melbourne, Australia: Victorian Council of Churches, 2002, 1–12.
  52. Frumkin P, Andre-Clark A. When missions, markets and politics collide: values and strategy in nonprofit human services. *Voluntas* 2000; **29**: 141.
  53. Rawsthorne M. Community development activities in the context of contracting. *J Soc Issues* 2002; **40**: 227–40.
  54. Lyons M. Non-profit organisations, social capital and social policy in Australia. In: Winter I, (ed). *Social Capital and Public Policy in Australia*. Melbourne, Australia: Australian Institute of Family Studies, 2000, 165–98.
  55. Webster M. A view from the Church Agency Perspective. In: Nichols A, Postma M (eds). *The Church and the Free Market*. Melbourne, Australia: Victorian Council of Churches, 2002.
  56. Hoggett P. Agency, rationality and social policy. *J Soc Policy* 2001; **30**: 37–56.
  57. Eardley T. Mutual obligation and the Job Network: the effect of competition on the role of non-profit employment services. *Aust J Soc Issues* 2002; **37**: 301–14.
  58. Considine M. *Enterprising States: The Public Management of Welfare-to-Work*. Melbourne, Australia: Cambridge University Press, 2001.
  59. Frohlich KL, Potvin L. Transcending the known in public health practice. The inequality paradox: The population approach and vulnerable populations. *Am J Pub Health* 2008; **98**: 216–21.
  60. Frohlich KL, Potvin L. Commen. *Int J Epidemiol* 2010; **39**: 378–9.
  61. McLaren L, McIntyre L, Kirkpatrick S. Rose's population strategy of prevention need not increase social inequalities in health. *Int J Epidemiol* 2010; **39**: 372–7.
  62. Lister R. From equality to social inclusion: new labour and the welfare state. *Crit Soc Policy* 1998; **18**: 215–25.
  63. Fairclough N. *New Labour, New Language?*. London, UK: Routledge, 2000.
  64. Hawe P, Shiell A, Riley T. Complex interventions: how "out of control" can a randomized controlled trial be? *BMJ* 2004; **328**: 1561–3.
  65. Hawe P, Shiell A, Riley T. Theorising interventions as events in systems. *Am J Commun Psychol* 2009; **43**: 267–76.
  66. Rickles D, Hawe P, Shiell A. A simple guide to chaos and complexity. *J Epidemiol Commun Health* 2007; **61**: 933–7.
  67. Knox TM. *Translation: Hegel's Philosophy of Right*. London, UK: Oxford University Press, 1952.
  68. Lukes S. *Individualism*. Colchester, UK: ECPR Classics, 2006/1973.
  69. Hayek F. *The Road to Serfdom*. Sydney, Australia: Dymocks Booksellers, 1944.
  70. Sawer M. *The New Right in Australia*. Sydney, Australia: Allen & Unwin, 1984.
  71. Wolfenden L. *The Future of Voluntary Organisations. The Report of the Wolfenden Committee*. London, UK: Croom Helm, 1978.