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ABSTRACT

Critical to the success of initiatives to reform and restructure educational and community services to improve the lives of children is the way in which they are financed. This report explores the movement toward privatization through contracting in managing, financing, and delivering child and family social services and provides a conceptual basis to inform efforts to improve practical models. The report synthesizes the state of knowledge in the area, defines and frames privatization and various contracting models, identifies relevant issues, examines the advantages and disadvantages of these approaches, and highlights examples that enhance understanding of contracting practices. Following an introduction defining privatization, the report provides a historical overview of the privatization of social services. Three major contracting models--purchase of service contracting, managed care, and network contracting--are discussed, and advantages and disadvantages explored. The report notes that although scholars continue to debate privatization, administrators take it as a given and are interested in how to contract well. The report concludes that four developments in the social services field are converging, with potentially major consequences for child and family social services: (1) change in the locus of service delivery, leading to the use of purchase of service contracting; (2) a change in social service delivery models, increasingly stressing community-based rather than residential services; (3) a change in child welfare service delivery, emphasizing maintenance of children at home; and (4) a change in financing, stressing flexible and pooled rather than categorical funds. Contains 74 references. (KB)

PRIVATIZATION, CONTRACTING, AND REFORM OF CHILD AND FAMILY SOCIAL SERVICES

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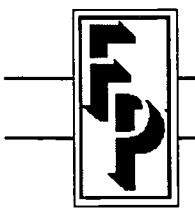

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PREFACE

Across the country, there is mounting evidence of efforts to reform and restructure education and other community supports and services in order to improve the lives and future prospects of children and their families. Critical to the success of these initiatives is the way in which they are financed. How revenues are generated and how funds are channeled to schools, human service agencies, and community development initiatives influence what programs and services are available. It determines how they are provided and who benefits from them. Financing also affects how state and local officials define investment and program priorities, and it creates incentives that guide how educators, other service providers, and community volunteers do their jobs. For these reasons, financing fundamentally affects how responsive programs and institutions are to the needs of the people and communities they are in business to serve.

In recent years, several blue ribbon commissions and national task forces have presented ambitious prescriptions for reforming and restructuring the nation's education, health, and human service systems in order to improve outcomes for children. While some have argued that public financing and related structural and administrative issues are critical to efforts to foster children's healthy development and school success, none has been framed for the specific purpose of inventively reconceptualizing public financing. Indeed, many of the most thorough and thoughtful reports have called for an overlay of new funds, but have neglected to provide cogent analyses of effective financing strategies, the costs of converting to these approaches, and the potential beneficial outcomes that might accrue from addressing financing reform as an integral aspect of program reform.

In addition, the past several years have witnessed a burgeoning of experimental efforts by mayors and city managers, governors and state agency directors, legislators and council members, program managers and school officials to make government work better and more efficiently. They have been enhanced by the work of people outside of government, including foundation executives, business and labor leaders, community organizers, and academic scholars. Some are creating new ways to raise revenues, manage schools, deliver human services, and spur community economic development. Others are designing new public governance and budgeting systems. Still others are developing and testing new approaches to more directly involve citizens in setting public priorities and maintaining accountability for public expenditures. Taken together, these efforts suggest the nascent strands of new and improved public financing strategies.

Against this backdrop, a consortium of national foundations established The Finance Project to improve the effectiveness, efficiency, and equity of public financing for education and an array of other community supports and services for children and their families. The Finance Project is conducting an ambitious agenda of policy research and development activities, as well as policymaker forums and public education. The aim is to increase knowledge and strengthen the capability of governments at all levels to implement strategies for generating and investing public resources that more closely match public priorities, and more effectively support improved education and community systems.

As part of its work, The Finance Project produces a series of working papers on salient issues related to financing for education and other children's services. Some are developed by project staff; others are the products of efforts by outside researchers and analysts. Many are works in progress and will be revised and updated as new information becomes available. They reflect the views and interpretations of the authors. By making them available to a wider audience our intent is to stimulate new thinking and induce a variety of public jurisdictions, private organizations, and individuals to examine the ideas and findings they present and use them to advance their own efforts to improve public financing strategies.

This paper, *Privatization, Contracting, and Reform of Child and Family Social Services*, explores a significant trend in the management, financing, and delivery of child and family social services—the movement towards privatization through contracting. By synthesizing the state of knowledge in this area, the paper helps to define and frame privatization and various models of contracting, identify issues and examine the advantages and disadvantages of these approaches, and highlight examples that enhance our understanding of contracting practices. As the paper emphasizes, many policymakers and practitioners take privatization as a given—the issue is how to do it well. This paper contributes to that goal by providing a conceptual basis that can help inform efforts to develop and improve emerging practical models.

This paper was prepared by Sheila B. Kamerman and Alfred J. Kahn with support from the Annie E. Casey Foundation. Helpful comments on a draft of the paper came from reviewers Bertram Beck, Barbara Blum, Sidney Gardner, William Gormley, Jane Ross, and Barry Van Lare. Carol Cohen of The Finance Project staff managed the production of this volume. The Finance Project is pleased to publish this paper and make it widely available to policymakers, practitioners, researchers, and other interested audiences.

Cheryl D. Hayes
Executive Director

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INTRODUCTION

This is a report on the current state of knowledge regarding the privatization of child and family social services by means of the contracting-out of publicly funded services to private non-profit and for-profit agencies.[1] Supported by the Annie E. Casey Foundation and carried out under the auspices of the Cross-National Studies Research program at Columbia University School of Social Work, this report is the first product in a project leading to the development of a manual of best practices in contracting. It is aimed at enriching the current discussions among administrators, concerned citizens, public officials, and policy scholars regarding the financing and delivery of child and family social services. The manual that is to be prepared at the project's conclusion will be designed for use by state and local government officials and the private agency personnel with whom they contract. The ultimate objective is to improve the delivery of social services to children and their families, and thus to promote their well-being.

The project has been undertaken at a time when (and because) three key components are all in play: First, privatization in the social services by means of contracting is reaching new levels. Second, child and family social services are in the midst of major reforms, and the organizational arrangements for the management and delivery of services are in flux. Third, there is growing concern about the costs of child welfare services, as well as fear that the new welfare legislation will add to the burdens of this system.

This report is based on a review of the published literature and several types of documents, working papers, and reports, as well as interviews with a selected group of experts (see appended list). Its focus is on the what, when, why, and how of privatizing child and family social services — in particular, through the use of contracting. The report is also intended to guide the selection of a limited number of "cases" of contracting child and family services for more intensive study, all on the way to the development of an end-product manual.

What Privatization Is

Privatization can be an ideology (for those who oppose government and seek to reduce its size, role, and costs, or for those who wish to encourage diversity, decentralization, and choice) or a tool of government (for those who see the private sector as more efficient, more flexible, and more innovative than the public sector) (Kamerman and Kahn, 1989; Gormley, 1991). Although privatization in the most general sense involves a reduction in the role of government, the process carries different implications depending on which function(s) of government are assigned to the private sector: financing; production or delivery of services; and monitoring or regulation (Kamerman and Kahn, 1989; LeGrand and Robinson, 1984).

Privatization may take many forms (Kamerman and Kahn, 1989; Gormley, 1994: Kettl, 1995), including:

[1] We use the term "child and family social services" here to include such services as child protective services, foster family care, adoption services, various forms of residential care, counseling services, family preservation and support services, parent education, independent living services, home visiting services, etc.

- the elimination of a public function and its reassignment to the private sector for financial support as well as delivery (police, fire department, schools); opponents characterize this as "load-shedding" (Bendick, 1989);
- deregulation, that is, the elimination of government responsibility for setting standards and rules concerning a good or service (Gormley, 1996 and 1997);
- asset sales, that is, the selling of a public asset (a city building, a sports stadium) to a private firm;
- vouchers, that is, government-provided or -financed cards or slips of paper that permit private individuals to purchase a good or service from a private provider (food stamps) or a circumscribed list of providers (Medicaid; a child care voucher);
- franchising, that is, the establishment of a model by the public sector that is funded by a government agency, but implemented by approved private providers; and
- contracting, that is, government financing of services, choice of service provider, and specification of various aspects of the services, laid out in a contract with a private-sector organization that produces or delivers the services.

Our focus in this report is on the last form, the privatization of the delivery of social services via contracting, which is also the most prevalent pattern. We begin with two premises: (1) that "load-shedding" is an inappropriate policy and that government should continue to support, regulate, and finance delivery of social services for children and their families;[2] and (2) that government continues to have a primary role in funding these services, but that the private sector may be the appropriate locus for delivering some or all such services. The issue is to ensure that services of good quality are delivered well — and effectively.

Contracting has been identified by many scholars and policy analysts as by far the most common form of privatization in the United States (Kettl, 1993; Gormley, 1991 and 1994; Smith and Lipsky, 1993; Kramer, 1994). It is viewed by some (Kettl, 1995, p. 3) as being "midway on the continuum between public and private." Most of the studies of privatization, including those directed at contracting, have focused on goods (armaments, for example) or so-called "hard" services — for example, transportation, garbage collection, or data processing — rather than "soft services," such as social services. Empirical studies of privatizing the delivery of social or human services are far fewer in number. Nonetheless, given recent trends regarding the contracting of social services, the need for a synthesis of such studies and other relevant literature on the contracting of child and family social services has become especially important.

After this introduction, we present a brief overview of the history of privatization and contracting for the private delivery of publicly funded child and family social services and next a discussion of why this subject has become especially important now. We follow this

[2] We use the term "load-shedding" to mean the relinquishment or abandonment by government of a series of responsibilities, including the financing, production, and regulation of social services, and the re-assignment of these responsibilities to the private sector(s) (Kamerman and Kahn, 1989; Gormley, 1991).

with a brief summary of the arguments for and against privatization and contracting, then a statement of what we see as the ongoing case for contracting — and therefore, the anchor point for criteria and guidelines. The major part of the report is devoted to a discussion of new developments in the contracting of child and family services. In the final section, we draw conclusions relevant to the project's objectives.

Purchase of Service Contracting (POSC) is the main form of contracting in the social services field and has received the most attention. (Vouchers and franchises are devices that may be incorporated in these contracts). As will be seen shortly, POSC emerged first as an important strategy for delivering child and family services at the end of the 1960s, and became dominant in the 1970s and 1980s. During these same years, social services expanded and child and family services were significantly transformed. Now, at a juncture in child and family social service reform, we take a new look at contracting — and at the newly emerging organizational modes.

The first part of our report relies largely on the extensive published literature (books, journal articles) about POSC. Next, we discuss the other types of contracting that have recently emerged in the child and family service field in response to a variety of developments both in the field and in the larger social protection system, broadly defined: Child Welfare Managed Care (CWMC) and Network Contracting (NC). Most of the information and data on these are not yet in the more formal literature. The best sources of knowledge concerning CWMC can be found in special reports and newsletters, unpublished documents, working papers, and our interviews (see appendix for list of interviewees). Information about developments in NC is even more limited, and for this we draw primarily on interviews and the experience of a few jurisdictions. For each type of contracting, we summarize what is known about the use of the strategy, and what the issues are.

PRIVATIZATION OF SOCIAL SERVICES: AN HISTORICAL OVERVIEW

There were church and other non-governmental social services long before what we now term the "privatization" of the social services (e.g., the turning to the private sector to take over or expand on a governmental measure). Indeed, it was the fact of the long history of private charities that became the foundation for privatization. The 19th century United States saw a veritable explosion of middle-class humanitarianism, some of it church-related and some non-sectarian; this paralleled the much-expanded poor relief of the period. The latter tended toward the punitive, and private charities were the "steam valve" that made the system viable: the more "deserving" could be "rescued" from the public policies (Kamerman and Kahn, 1989 and 1990; Kettl, 1993). Gurin (1989) reminds us that, more than a century ago, social reformers (Amos Warner, 1894) were arguing in favor of the government providing subsidies to private charities for the delivery of social services to the poor. There had been one-time or periodic subsidies to some programs from the early days of the Republic, the money usually coming from the states, but Warner was looking ahead to a more uniform system. Kettl (1995) points out that the real growth in contracting occurred during World War II. However, in the social services field it was the New Deal era and then the decade of the 1960s that provided a major turning-point, through the expansion of the

federal role in funding (Smith and Lipsky, 1993). For example, federally funded, neighborhood-based Community Action Programs constituted a major component of the War on Poverty. However, most of this funding was through grants, not contracts, and therefore was a very different device.[3]

Beginning in the late 1960s, contracting with voluntary agencies for social services expanded significantly. The enactment of an amendment to the Social Security Act in 1967 was a watershed; it permitted public agencies to purchase social services from private agencies for recipients of Aid To Families With Dependent Children (AFDC), and for those who had been recipients or were viewed as at risk of becoming such. The development expanded further with the enactment of Title XX of the Social Security Act in 1975, which significantly expanded eligibility criteria for receipt of social services, capped the funding at $2.5 million, and further eased the way for public social service agencies to contract with voluntary (non-profit) agencies. During these same years, federal funding for social services increased dramatically from about $350 million to more than $2.5 billion. The ideological commitment of the Reagan and Bush administrations to the private sector accelerated the process in the 1980s, as did the Clinton and Gore interest in "re-inventing government" in the 1990s (Osborne and Gaebler, 1992). The Council of State Governments reported that almost 80 percent of the state social service agencies surveyed in their 1993 study indicated that they had increased their POSC in the preceding years (Chi, 1994). The 1996 welfare legislation extended privatization still further by permitting for-profit agencies to be vendors of publicly funded child and family services as well.

In short, over the last two decades, both the extent of social service contracting and the nature of such contracting has resulted in public financing becoming the dominant source of funding for the voluntary social service agencies; private agencies have emerged as the major providers of services, especially in the child and family social service field (Smith and Lipsky, 1993). This entire process has reflected the large-scale social services expansion (government officials generally lack the program capacities and expertise called for), the pressure from interest groups (traditional private non-profit or voluntary agencies and new local community groups), and ideology about government and about the private sector. Few of these developments were based on rigorous evidence of superior results. Writing in 1989, Gurin concluded, "There is now considerable literature on contracting. Much of it is based on strong ideological assumptions that are difficult to demonstrate empirically" (p. 198). He stressed that until there is empirical evidence, there is a need to be "skeptical and cautious in accepting any general conclusions as to the superiority of one sector or the other in regard to issues of equity, effectiveness, or efficiency" (p. 198). More recent literature only confirms his conclusion. Nonetheless, the culture has continued to favor and support the privatization process.

[3] Grants carry few constraints on what should be done and how the funds are to be spent, while contracts usually specify both. Grants are usually awarded to enable the grantee to carry out an activity that the organization wants to do. Contracts are more likely to provide support for the contractee to carry out an activity that the funder wants done. But the motivation on either side can be more complex.

By the end of the 1980s, over 50 percent of federal social service funds went to voluntary agencies, whereas none did in 1960.[4] Non-profit organizations had become a larger provider of government-funded social services than government agencies themselves (Gronbjerg, 1993; Kramer, 1994; Salamon, 1993; Smith and Lipsky). Smith and Lipsky (1993) point out that in Massachusetts twice as many staff (66,000) were employed in publicly funded voluntary social service agencies in 1991 as in government agencies (32,000). Even more dramatic, in New York State in 1987, almost 90 percent of those employed in social service agencies were working in agencies supported at least in part by public funds. A 1988 survey carried out by the Child Welfare League of America (CWLA) found that 60 percent of its member agencies' budgets were publicly funded. And a 1991 survey of social service agencies in Massachusetts reached a similar conclusion. Public funds constituted more than 80 percent of voluntary child welfare agency budgets in Massachusetts at the close of the 1980s, and the proportion is even higher now. Gibelman (interview) indicated that in New Jersey, the only publicly operated social service is case management; all else is contracted.

Levine (Gibelman and Demone, 1998a), quoting a Salamon study, reports that of all money flowing into non-profit organizations, government funds accounted for 31 percent of income, private donations for 18 percent, and fees and charges for 51 percent. He documents agencies in the sectarian field for which the proportions are much higher, often 80 or 90 percent of public funding. As much may be the case for community-based organizations, programs targeting social and ethnic minorities and some specialized sources. In the full sense, such organizations are public agents. Between 1975 and 1992, a transformation of the social service delivery system had occurred, from a system of limited public provision to a system of extensive voluntary agency social services, funded by government through contracts.[5] According to a GAO review (1997), the process has continued. More than half the state and local governments contacted have "increased their contracting for services, as indicated by the number and type of services privatized and the percentage of social service budgets paid to private contractors" (p. 2).

Voluntary agencies that as a matter of principle had long avoided seeking public support (private child-welfare agencies, family service agencies, settlement houses) actively applied for grants as the federal government enacted many categorical programs. Such agencies competed with one another because these categorical programs were frugally funded. One result was to create permeable boundaries within systems. There was no longer a well-delineated child welfare, family service, or settlement agency model, as designed by its national professional reference group: the vagaries of funding defined each agency's character.

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[4] For some sense of the number, range, and expenditures for federal social services for children and their families, see the Congressional Research Service report for Congress (Robinson, 1992).

[5] Neil Gilbert had written earlier about "The Transformation of the Social Services", Social Service Review, Vol. 51, No. 4 (December, 1977). He focused on the way that Title XX of the Social Security Act changed the system by turning it from a means-tested system for assistance recipients to an almost universal system for those who qualified. The law required planning and consumer input, professionalized the staffing, and expanded social service delivery generally.

Then, after a period of expansion, federal funding for these services was significantly cut in the 1980s during the Reagan and Bush administrations, and the financial burden fell increasingly on the states and localities (Palmer and Sawhill, 1982; Kimmich, 1985; Burt and Pittman, 1985). In this context of reduced or constrained resources, many voluntary agencies turned to Medicaid as a potentially open-ended source of funds. Thus, for example, child welfare agencies added functions previously found only in child guidance clinics. At the same time, many family service agencies transformed themselves into mental health agencies, stressing provision of counseling services primarily, while their other services were paid for by consumers on a fee-for-service basis or were contracted with employers (Kamerman and Kahn, 1990). Another form of contracting had emerged, and the line between medical and social services was blurred further.

Children's services were transformed even more extensively. More categorical legislation was enacted in the 1970s and 1980s, targeting federal funding to specific types of services for specific types of problems, including: developmental disabilities; child abuse and neglect prevention; juvenile justice; runaway youths; and teen pregnancy – in addition to the traditional child welfare services of adoption, foster care, and child protection. The enactment of the Adoption Assistance and Child Welfare Act in 1980 established foster care as an entitlement program and added significantly to the availability of financial resources for foster care (but only modestly for "preventive" services). Legislation passed in 1994 attempted to address this last issue by providing funds – and philosophical support – for family preservation services (intensive family counseling and crisis intervention services in a child's own home) and family support services (parent education, drop-in child care, child care information and referral services, and counseling, for high-risk families with very young children, delivered in the neighborhood in which a child and her family lived).

Thus, despite funding constraints, publicly funded social services for children and their families continued to expand, often through categorical funding streams. At the same time, however, the demand for these services grew beyond the capacities of the public agencies to respond, as new and severe social problems emerged (e.g., AIDS, crack and other forms of drug abuse, homelessness) (Kamerman and Kahn, 1990) and the need to investigate mandatory reports of suspected child abuse and neglect overwhelmed agency staff. POSC increased also. Drawing on two surveys carried out by the International City and County Management Association in 596 cities around the country, Greene (1996) found that between 1982 and 1992, the privatization of child welfare increased by 175 percent, more than any other social service.

Public agencies (in the 1970s) turned to contracting with private agencies as a strategy for implementing rapid growth, as a device for obtaining needed expertise, as a means of lowering costs, or (in the 1980s) as a device for diversifying the delivery system and the providers. Van Lare (interview) has also suggested that interest in encouraging community development emerged in the 1990s as another aspect of this growth in POSC. Traditional voluntary agencies became vendors in order to survive or at least supplement existing resources. New agencies were established, specifically in response to public agency interests. At the same time, child advocates and child and family welfare reformers complained about

the fragmentation in the child and family services system, the unresponsiveness of the system to the new or changed needs of vulnerable families, and the lack of accountability of the voluntary agencies either to their funders or their clients/consumers, as well as the inadequacy of resources. There was, and is, abundant evidence of system failure.

Over the past decade, a debate about child welfare reform and the new initiatives designed to implement these reforms has developed. Nonetheless, the substantive reform agenda appears consistent, and includes an emphasis on the following elements (Kamerman and Kahn, 1990; Schorr, 1988):

- Child-centered and family-focused services clearly directed toward improving the conditions and functioning of children and their families.
- Community-based services designed to help resolve child and family crises within the family, at home, rather than removing the child from his family.
- Culturally competent staff providing services that are responsive to their ethnically and racially diverse clientele.
- Comprehensive and holistic services that are not organized around categorically defined problems, but cut across existing service systems to meet the underlying needs of children and their families.
- Coordinated child and family service systems that minimize fragmentation and maximize integration at the case and program levels, thus including not only child protective services, foster care, and adoption, but also child mental health services, juvenile justice, teen pregnancy prevention, and developmental disabilities. Some would also include education and child health care as part of this system.

To achieve such qualities, say the reformers, there is need once again for major change in the delivery of child and family social services. A system overwhelmed by the need to respond to problems of child abuse, parental substance abuse, and homelessness cannot address chronic or less acute, but still serious, problems. Moreover, it certainly cannot be reoriented from a focus on interventions into crisis situations to a stress on promoting child development. A variety of strategies is offered to transform the existing delivery system: Access to child protective services could be made narrower, and a supplementary set of services would be provided to support child and family well-being for those whose problems do not require child protective service (CPS) intervention. Or, an enhanced child welfare agency could be established that incorporates CPS in a larger context, but avoids letting CPS "drive" the entire system. Perhaps the way to go is to establish a more universal child and family service system, oriented to enhancing the development of children rather than treating their problems. Despite a large number of experimental, demonstration, and related initiatives along these several patterns during the last decade, the goals of the reform agenda have not yet been achieved. The efforts continue.

In short, over the last two decades we have seen a dramatic change in child and family social services: an explosion in funding followed by severe resource constraints; an increase in the supply and programmatic diversity among the services, accompanied by greater

fragmentation in service delivery; a proliferation of service innovations, not all of which have been proved successful; and a recent and disturbing rise in new and serious problems experienced by children and their families and, thus, increased demands placed on the service system. Many are convinced that the recent welfare legislation (P.L. 104-193) will increase the pressure placed on the system still more, and they are concerned about the consequences (Kamerman and Kahn, 1997). Criticism regarding the quantity and quality of services continues, and has led to new efforts designed to transform the child and family social service delivery system once again. Paralleling all this has been an expansion of privatization and of contracting. Some privatization could be seen as adding to fragmentation (Krauskopf, 1997). Some could perhaps be a vehicle for the above reform strategies. In any case, the society clearly cannot implement privatization oblivious to a reform agenda.

PRIVATIZATION OF SOCIAL SERVICES: THE ARGUMENTS FOR AND AGAINST

Apart from the ideological arguments for and against privatization, efforts to rigorously document the specific advantages and disadvantages of privatization have proved inconclusive. Evaluation studies have been limited, and the problems of measuring inputs, outcomes and costs with sufficient precision have proved intractable thus far (Gormley, 1991 and 1993; Kettl, 1995; Salamon, 1993; Smith and Lipsky, 1993). Gronbjerg (1993), Kramer (1994), Smith and Lipsky (1993), and Van Lare (interview) are among the significant number of analysts who stress that the empirical question of whether contracting promotes more efficient and effective social services is still unresolved. The literature does, however, provide standards against which evaluation of advantages and disadvantages of privatization might be measured in the future. The most frequently mentioned standards, emerging largely from several case studies, are costs and outcome or performance measures (Kettl, 1993; Gormley, 1991; Donohue, 1989; Salamon, 1993; Martin and Kettner, 1996; Barth and Needell, 1997). Unfortunately, one of the major limitations in the research and literature in this field is the paucity of empirically based evidence and the absence of any rigorous cost analyses.

The problem may be, in part, that people have convictions as to the correctness of the program innovation and do not see the need to attempt rigorous measurement, or that they are not staffed with the necessary researchers, or that the contracting agencies neither assist on evaluation nor allow resources for it. However, there may also be the problem of the lack of standardization in child welfare services, which defeats many research designs.

More specifically, what is a child protection or child support or family preservation service varies with states, within communities, among agencies, and over time. A child welfare worker can be a paraprofessional, a community college graduate, the holder of a B.S. degree in social work, an M.S. degree child welfare professional, or a trainee from an agency "institute." Supervisory and management certifications vary as much, and thus the input and output expectations are not readily specified. Contracts are not easy to write nor results to evaluate. Further (Van Lare, interview), while the ability to specify in advance what is wanted is critical for successful contracting, too much contract specificity will constrain

innovation.

Standard setting is most developed in the child welfare field in the accreditation standards developed by the Council on Accreditation of Services for Families and Children (COA) for 57 different services. This organization now accredits about 3,000 child and family social service programs and about 1,000 child behavioral health programs in about 900 agencies, most of which are non-profit. Other child welfare accreditation systems are now also offered by two major accrediting bodies that have added child welfare to their major foci on hospitalization and mental health: the Joint Commission on Accreditation of Healthcare Organizations (JCAH) and National Committee for Quality Assurance (NCQA). Bilik and Ginzberg of the AFL/CIO (interview) stress the need for national standards, and therefore consensus regarding child outcomes in child welfare. The work of the COA appears to move the field in this direction. Other standards as suggested by Gormley, in addition to efficiency and effectiveness, include: equity, reliability, quality, accountability, empowerment (consumer/citizen control or participation), legitimacy or trust, and choice.

Costs, Efficiency, and Effectiveness as Objectives

To some extent, social service privatization has its origins not in proven advantages but in the political and cultural ideologies that have swept major industrial societies since the Thatcher and Reagan counter-revolutions in economic policy. "Liberalism," in its European sense, has dominated governmental philosophies in the European Union (EU), the Organization for Economic Cooperation and Development (OECD), the World Bank, and the International Monetary Fund for almost two decades now. It is now standard practice in Europe to talk of the new public-private "welfare mix" or the "mixed economy of welfare." Social service privatization in the United States is part of a shift that includes deregulation, governmental downsizing, and the introduction of market or market-like mechanisms where they were previously considered inappropriate.

It is in the nature of these shifts that their advocates are convinced that they are justified by objectively observed results. The most frequently stated argument in favor of privatizing social services is that it is an efficient and cost-effective process (Gormley, 1991 and 1994; Kettl, 1995; Sclar, forthcoming; Yates, 1997). Contracting is viewed as achieving significant cost savings through more efficient operations. For example, an APWA report (1994) states that when Michigan contracted statewide for Families First, its family preservation services, "The main justification for contracting family preservation services was cost savings, in that the service could be provided at lower cost by a contractor than by the state. In Michigan, the law requires justification to contract for services that could be performed by state employees. The cost justification was used for Families First. As such the cost difference between public and private must exceed 10 percent of the program cost. Families First was able to demonstrate such a difference" (p. 7). The data documenting these cost comparisons are not provided. Nor has there been adequate attention to the issue of where in the system the cost-savings actually occur – often, it is not in the agency that makes the "front-end" investment (Sid Gardner, communications, 2/1/98).

In contrast, a report of an effort at POSC of foster care services in Milwaukee, Wisconsin (Emspak, Zullo, and Rose, 1996) concluded that "privatization will not result in either improved services or reduced cost for foster care services." The study found that the direct labor cost per case for private agencies contracting with Milwaukee County was almost two-thirds more than the county's direct services. The study also found that the outcomes of services provided to children and families by the County workers were better than those of the private agencies, and that the crisis in Milwaukee's child protection services was due to a chronic shortfall in state funding to the county, rather than lack of capability in the public agency. A GAO study (1997) reports mixed results; some jurisdictions report savings, others do not.

Pack (1991), referring to an earlier and influential study by Schlesinger, Dortward, and Pulice (1986), notes that the Massachusetts Department of Mental Health maintained over 2,000 separate contracts with over 200 vendors and had planned its contracting arrangements to achieve more flexibility, lower costs from bypassing civil service and union constraints, and greater responsiveness to local needs. The result was that the Department's need for monitoring and oversight and the legislature's desire to maintain accountability led to a complicated contract review process that added to administrative costs and resulted in more bureaucratic rigidities. Wage costs declined by 18 percent, but staff turnover increased, and this led to a deterioration in the quality of care (and later, wages were raised, eliminating even that "benefit"). Pack argues that the pressures are against cost reduction because of the need for greater specificity in contracts, which in turn leads to a greater need for oversight and monitoring, which adds to the costs and increases pressures for wage parity.

Kettner and Martin (1996), in an opinion survey of state human service administrators, concluded that POSC did cost less than government service delivery and resulted in fewer government employees, but did not achieve gains in quality. Even those analysts who stress the cost-savings benefit point to the inadequacy of existing cost comparisons and the absence of systematic and comparable cost analyses. And some of those who doubt the cost savings argue that POSC enables the public agency to hide real costs if they can be disaggregated, or to keep them invisible because of the inability to disaggregate. Moreover, fixed administrative costs are often ignored in public-sector analyses, and these continue regardless of whether or not the service is contracted out.

Whatever the evidence or the lack thereof, contracting has continued and even increased. Some argue that political reasons, as much as any others, are responsible for these developments (Kettner and Martin, 1996; Smith and Lipsky, 1993; Sclar, forthcoming). In any case, the factors cannot readily be disentangled.

Gibelman and Demone (1998 a and b), Gronbjerg (1993), and Lipsky and Smith (1990), among others, conclude that the new relationship between government and the non-profits that has emerged as a consequence of POSC is one of mutual interdependence in financial and technical terms. Contract funds have come to represent the greatest source of revenue for many private agencies. The programs that they support have developed constituencies of their own, and there are internal agency, board, community, and client pressures to preserve them. Public agencies no longer have the expertise or staff to provide these services

themselves, and they have no alternative except the private agencies if they want social services to be available. How to maximize the benefits of POSC for both sides remains the issue.

Privatization as a Given

The arguments for and against POSC have not changed significantly over the last decade, but several have been sharpened and clarified. We here reproduce a "pro" and "con" list from the literature, not so that they may contradict one another but, rather, to summarize the prevailing rationale: privatization may facilitate the introduction of desired qualities and even reform in social service delivery and, if so, it should be undertaken even if the economy-efficiency case remains weak.[6]

These arguments in favor of contracting appear throughout the political spectrum (Gormley, 1994; Chi, 1991; Kramer, 1994; Salamon, 1993; Smith and Lipsky, 1993; Yates, 1997; Gibelman and Demone, 1989 and 1998, a and b).

- Voluntary agencies are more responsive to consumer needs and preferences than are public bureaucracies.
- Voluntary agencies are more innovative than public agencies.
- Voluntary agencies are more flexible than public agencies and, therefore, can expand or contract as needed.
- Voluntary agencies offer consumers more choice than monopolistic public bureaucracies.
- Efforts at privatization – the very process – may provide an opportunity to clarify boundaries, responsibilities, and relationships between the public and private sectors.
- Contracting permits a public agency to expand its service delivery activities without increasing its staff or confronting restrictive civil service regulations and/or state or county ceilings on hiring.
- Contracting provides access to expertise that public agencies may not have on staff.
- Contracting enlists the non-profit providers as allies and partners with government in achieving desired social-service reforms.
- Contracting may more readily promote volunteer citizen participation in program innovation, governance, and service delivery than most formal governmental bureaucracies.
- Contracting can expedite a response to new service needs, bypassing slower-moving public bureaucracies.
- Contracting may promote the creativity and efficiency that result from open competition.
- Public officials can purchase specialized services through POSC that would be

[6] We concentrate on the debate about child and family social services. The broader experience and research are well known and widely reported, but our question is, what of this field?

difficult to find or develop in a public agency.

- Contracting partly shifts the political and financial risks of providing services from a government agency to the non-profit sector.
- For those in favor of a smaller public sector, contracting reduces the scope and size of government.

Given the objectives of the present exploration, it is important to note these arguments about potential program qualities under privatization that would justify the process, whatever the outcomes of more rigorous research relating to the economy-efficiency arguments. The larger political and cultural context supports privatization, and the above listing suggests the qualities it should seek to enhance. In short, these arguments provide a foundation for privatization guidelines. Moreover, the "con" listing also makes a contribution to guidelines. We read the following not as making a definitive anti-privatization case, but as suggesting problems to be solved and challenges to be faced during the privatization planning and implementation process. Some of these considerations may point to functions that should not be privatized (adjudication and disposition in children's and family courts? Certain types of incarceration? Exercise of "police" power?)

- Cost projections are difficult to make, except as related to administrative or concrete services, yet contracting requires them (Gormley, 1991 and 1993).
- Cost savings are either nonexistent or far less than many expect (Chi, 1993; Kettl, 1993; Reason Foundation, website).
- Contracting is expensive to manage, due to such factors as: the cost of hiring and training sophisticated evaluators; the cost of obtaining quantitative evaluation data; administrative and negotiating costs, including the developing and writing of contracts, drawing up of specifications, and soliciting bids; and the cost of monitoring (Gronbjerg, 1993; Kramer, 1994; Smith and Lipsky, 1993; Kettl, 1993).
- The market – or the voluntary agencies – may siphon off the more affluent consumers or the more capable clients, while compromising access and quality for the poor by leaving the most difficult cases and least profitable services in the hands of an underfunded voluntary sector (Gormley, 1994; Salamon, 1993; Smith and Lipsky, 1993; Yates, 1997).
- Contracting opens more opportunities for fraud, especially when public agencies lack the capacity and expertise for careful monitoring (Gibelman and Demone, 1998, a and b; Dukakis, forthcoming; AFL/CIO, 1997; The New York Times, 3/30/96).
- Contracting may make it more difficult to ensure accountability for program results (GAO, 1997).
- The mission of the agency may be undermined if the contract reshapes the agency's program.
- Basing the choice of vendor solely on which agency submitted the lowest bid may lead to shifts in vendors from year to year, and therefore disrupt the continuity of care for a client.

- Contracting may reduce the ability of voluntary agencies to individualize responses to clients and force them to move toward more uniform responses; they may lose some of the autonomy that is a precondition of creativity and innovation.
- Contracting takes jobs away from public agency staff; it represents, in effect, a "downsizing" of the public agencies (Sclar, forthcoming).
- Contracting may create wage discrepancies for staff doing similar work in public and private agencies and/or place unfair constraints on voluntary agency staff salaries.
- Contracting may undermine confidence in government or reinforce negative judgements about government.
- Public agencies may lose their service expertise as they cease to deliver specialized services and, as a result, also lose their capacity to monitor contract agencies adequately.
- Contracting may divest the public authorities of their responsibility in certain areas, including protection or safety (Gormley, 1994; Krauskopf, 1997; Smith and Lipsky, 1993).
- Contracting may increase government intrusion into the previously autonomous voluntary sector and thus decrease pluralism and diversity.[7]
- Contracting may involve diverse service systems and standards, and thus sacrifice the "equal protection" of a standard public system.
- Contracting may lead to sacrifice of confidentiality and privacy, a situation where public authorities have access to information by virtue of their functions.
- Contracting may become so entwined in local politics as to lead to support for inferior services.
- If contracting involves a large number of vendors in autonomous, free-standing (and often politically protected) agencies, monitoring becomes very difficult.
- An accountable public sector may find itself dependent upon unreliable contractors.

To repeat: these arguments may not be reasons for avoiding contracting in a society that appreciates the "pro" case – or is politically committed to privatization. However, they do suggest how the specific contract may need to protect the enterprise.

With regard to the interests of public employees, it is urgent that appropriate public social service units, where they exist, be permitted to compete with regard both to cost efficiencies and to the quality dimension sought. It is simply not true that all public programs are inferior.

The remainder of this report assumes that, for our purposes, how it is done is currently more relevant than the abstract debates as to whether privatization and contracting are, per se, good things. As indicated earlier, the major "hows" are: Purchase of Service Contracting

[7] The New York Times reported on August 22, 1997, that the City's Administration for Children's Services (ACS) had made more explicit in recent contracts with non-profit foster-care agencies that monitor most of the City's 42,000 foster care children that their caseworker employees "shall cooperate with and not oppose the position of ACS" in family court and administrative hearings. The caseworkers may testify, as they always have, about the facts of the case, "but when it comes to giving an opinion or a judgment about appropriate disposition, that is the responsibility of the agency (ACS)."

(POSC), Child Welfare Managed Care (CWMC), and Network Contracting (NC). It will soon be clear that each of these has its variations and ambiguities and, therefore, that there is a degree of overlap and a need for increased specification. We look at each in succession.

PURCHASE OF SERVICE CONTRACTING: WHAT IT IS AND HOW TO DO IT WELL

POSC has emerged as the dominant approach to delivering publicly funded child and family social services. POSC can take several forms, depending on the nature of the buyer/seller relationship and the nature of the services to be purchased. Thus, for example, it may involve a contract with an entire agency to deliver services to all who qualify, or it may be designed for a practitioner to provide services for a few individuals whom a public agency defines as qualified for aid. Contracting arrangements may be for a few months or for several years, but are most often for one or two years. The provider may offer services to all who come to the agency, or only to those referred to it by the public agency, or have its clientele limited in some other fashion. The contracting process may involve a Request for Proposals (RFP), in which the state tells bidders the services it wants to offer and/or the objectives it wants to achieve, and the bidders submit plans and cost estimates for meeting the specified requirements. Or it may involve a Request for Quote (RFQ), where the state has a specific model it wants to implement and specifies in advance not only the services required, but also the staffing patterns, case-load size, supervisory ratios, working hours, and so forth. Michigan's approach to contracting for family preservation services using the Homebuilders Models is an example of an RFQ, an approach often referred to by others as "franchising" (APWA, 1994). Florida, too, followed a franchise model (Kamerman and Kahn, 1990). Contracts may be terminated if the provider fails to live up to the agreement or if public funds dry up (for example, during the Washington, D.C., fiscal crisis several years ago (Gibelman and Demone, 1998b).

POSC is very different from the earlier pattern of funding voluntary agencies by government subsidies or grants. Several public officials reminded us how different the contract world is from the grant world, and that this could present real problems to the community-based organizations (CBOs). To handle contracting, an organization needs a legal staff or resource and a sophisticated billing, bookkeeping, and budgeting capability. It is not clear that most CBOs will be able to cope with the administrative and management requirements of the contracting agencies, despite anecdotal evidence of successes.

Lipsky and Smith (1990) point out that there are different types of social service agencies, and that POSC can have different impacts, depending on the types of agency. They identify three types:

(1) The traditional social service agency with its own clearly defined mission, which may have substantial endowments, offer many different services, and thus be less dependent on government funds or on demand for any one service (e.g., a Children's Aid Society or a Catholic Charities Family Service).

(2) New agencies founded in the past two decades in response to the availability of government funds in special areas such as mental health, substance abuse, and

runaway services for adolescents, which may be completely dependent on their government contracts, but have less conflict about mission.

(3) An agency established in response to new community needs, such as a battered women's shelter or a hospice for AIDs victims, which may have emerged with a minimum of support, may be dependent on volunteers, and may be seeking government contracts to survive.

The authors argue that government funding of non-profits transforms the management of these agencies and often their programs. They conclude: "For all these agencies, however, some degree of change is virtually inevitable as government contracting increases. While contracts may allow an agency to expand services, pay their staff better salaries, and move into new service areas, contracts bring administration and accountability demands that may conflict with an agency's mission" (p. 630). Gibelman would argue further (interview) that it is impossible to really compare public and private social services because, as indicated above, many of the agencies now on contract are delivering services that never were provided by the public agencies, and most other agencies are delivering services that no longer are publicly delivered anywhere.

Curran (1998) points out that legislation may dictate the content of contracts or may specify much of what might otherwise be included in a contract. For example, legislation may specify and require:

- Open and competitive bidding for all contracts.
- Acceptance of the lowest bid where quality is considered equivalent.
- The contract agency to deliver the service at lower cost than the public agency.
- Active discouragement of conflicts of interest by government officials who are negotiating and awarding contracts, by prohibiting former government officials from working for contracting agencies for a specified period of time after government employment, or restricting officials from contracting with the agencies in which they have a financial interest.
- Severe penalties for misconduct or fraud in seeking, negotiating, and carrying out contracts.
- Cancellation of contracts for good cause or for budgetary reasons.
- Universal access and non-discrimination in serving clients.
- Job security for civil servants whose jobs are eliminated by the contract.
- Evaluation of contract services and monitoring of performance.
- Oversight by a trained government official.

Curran concludes that, whether through legislative provisions or contract specifications, the POSC must spell out clearly the types of services to be provided, the quantity of each, the qualifications required for professionals and others delivering the services, and the eligibility criteria for the clients. He argues that the contractee has the greatest leverage in the earliest phase of the program's existence, when the market is small, there are few potential vendors,

and the public agency has had limited experience in negotiating and awarding contracts. In contrast to Sclar (forthcoming), Curran would argue that the public agency gains more leverage with time, experience, and a larger number of vendors seeking a contract.

Curran, Sclar, and Krauskopf (1995) are among the many who see monitoring and evaluation as critical to successful contracting and an essential part of good contract management. Contract monitoring is a key part of the public agency's responsibility to assess the success or failure of a particular privatized service. In this context, the contract agency should be required, also, to collect the data that are essential to the monitoring. McGowan (interview) added the importance of self-monitoring, as well as outside monitoring.

Kettl (1995, p. 4) points out that "The great lesson of the nation's now lengthy experience with privatization is that it is competition, not the public-ness or private-ness of a program that drives costs down and performance levels up" (emphasis added). Sclar (forthcoming) agrees that much of the literature stresses the importance and desirability of competition, but notes how rarely true competition exists in those situations where government has moved to contract. Moreover, even where there is competitive bidding initially, it is likely to have disappeared when the time comes to renew the contract. GAO staff (interview) observe that even if a competitive environment exists for hard services, the number of qualified bidders for social services may be limited in certain circumstances, such as when the contracting government agency is located in less urban areas or requires higher skilled labor. In the social services field, one is much more likely to be dealing with oligopolistic situations than with competition. Smith and Lipsky (1993) and Salamon (1993) would concur, arguing that relatively few social service agencies provide particular specialized services, and thus the likelihood of finding real competition for a given service is doubtful. Furthermore, given the high cost of entry in a field providing services to hard-to-reach populations, sole-source contracts or limited competitive bids are more likely to be the norm than full competition and open bids.

Several people mentioned Illinois as an example of a state where the social services system is highly privatized (Interviews: Stagner, ASPE; GAO staff). The evidence suggests that it may not have achieved the goal of efficiency, but often does quite well by children. The system is controlled by a small number of providers, really an oligopoly. There never was a competitive market there, yet it has been reasonably successful in achieving its goals. In Kansas, the state agency contracted for adoption with the one agency that submitted a bid – clearly not competition.

Assessing performance is viewed increasingly as integral to successful POSC. Kettl (1993) and Gronbjerg (1993) agree that a public or private auspice may not be the key factor affecting efficiency, but they would insist that the issue is what the goals of the service are and how effectively those goals are achieved. Thus, they would emphasize the role of performance measures (PM) to be built into contracts for assessing or comparing effectiveness. Performance measures have received growing attention over the last decade, as noted earlier, but one problem is that they require specificity of outcomes, and this is not always possible in this field, despite intensive attention and some encouraging reports.

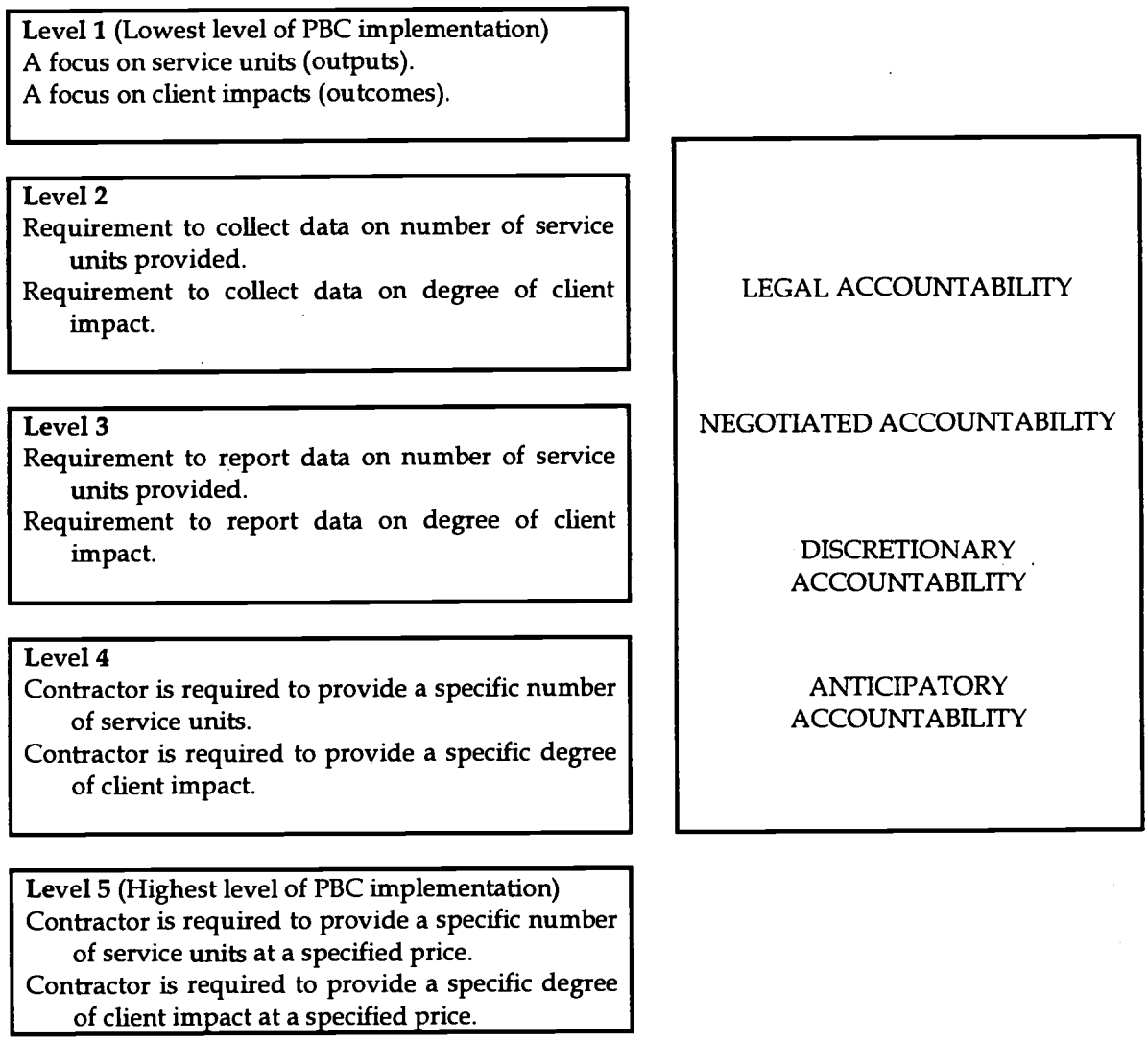
A second problem is, according to Gormley (memo, 1998), that performance measures often require statistical controls for different client characteristics, which can be time-consuming and expensive. A third problem is that trying to specify and measure outcomes are different tasks in both a public and private environment (GAO memo, 1998). Martin and Kettner (1996), Roberts (1997), and View (and) are among those who have stressed PM as a new device for ensuring accountability. Martin and Kettner define PM as "the regular collection and reporting of information about the efficiency, quality, and effectiveness of human service programs" (p. 3). They view PM as a core strategy for ensuring program accountability, and argue that specifying these measures in contracts would provide information about what services are provided, to whom, at what costs, and with what results. They conclude that, since most social service programs today are operated totally or partially through POSC, government agencies could significantly improve the functioning of their contractees by requiring that contract agencies collect and report PM data and adopt performance contracting, tying at least a portion of a contractor's compensation to the achievement of PM (Kettner and Martin, 1993; Martin and Kettner, 1996).

As part of the "re-inventing government" movement, Vice-President Gore has also urged the development of what the British have termed "Performance-Based Organizations (PBO) (Centre For Public Services, 1997). Corbett (1997), in a Foreward to a report on "Indicators as Tools for Managing and Evaluating Programs at National, State, and Local Levels of Government: Practical and Theoretical Issues" (Koshel, 1997, p. iii), points out that "The reinvention movement in government purports to shift public sector management from a focus on process and inputs – that is, what organizations and programs do – to a focus on outcomes, or what organizations and programs accomplish." Such an approach, Corbett states, could facilitate the emergence of outcomes-based accountability strategies and performance-based competition service models, among other developments.

The American Public Welfare Association (APWA) is currently organizing a seminar to explore how states can do performance contracting. Staff want to develop a model that can be passed along and tested. It should deal with how to write contracts, how to negotiate contracts, how to get data, how states might monitor, and so forth (interview). Despite their agreement regarding the value of performance contracting, U.S. Government Accounting Office (GAO) staff completing a report on privatization stated that they found it very difficult to specify results in child welfare and to integrate them into outcome measures (interview). Nonetheless, the pursuit continues because they must clarify the federal policy implications from increasing privatization, especially the impact on responsibilities of the Department of Health and Human Services (DHHS).

Reporting to an APPAM (Association for Public Policy Analysis and Management) research conference in November, 1997, Michael Lahti of the University of Main identified in the relevant literature four dimensions of POSC accountability, each more demanding than the previous one, with some potential indicators for each (see Figure 1).

FIGURE 1
Accountability in Performance-Based Contracting
(after Lahti)



Source: Michael Lahti, 1997, with permission. Adapted from L.P. Kearns, Managing for Accountability: Preserving the Public Trust in Public and Nonprofit Organizations. San Francisco, CA: Jossey Bass.

New York City probably ranks above all other cities in the share of publicly funded social service spending that goes to voluntary agencies through POSC. Krauskopf, a former Human Resources Administration Commissioner (1995, p. 4), points to the importance of management: "The most critical factor is not so much what services are privatized, but rather how well government manages the overall human services network, which includes both private and direct public service provisions." He emphasizes that contracting does not eliminate government responsibility. From the standpoint of management and accountability, Krauskopf suggests that the key questions are: "How does government plan, select, monitor, and evaluate the services provided by contract agencies?" and, "Can government terminate the contracts of agencies not fulfilling their contract provisions?"

Krauskopf (1997) argues further that what is critical is a view of government and voluntary agencies as parts of the same social service delivery system, which must be managed well if it is to operate successfully. He points out that New York City has a very long history of voluntary agencies providing child and family services with public funds. In many ways, child welfare is the most complex, controversial, and important service that the City provides. The City's child welfare agency is required by law to carry out both a child protective function and a family preservation function, and sometimes the two conflict. Despite long-standing efforts at coordination, City and private agency child welfare services are operated separately at the neighborhood level, and they are not integrated. New York State's Child Welfare Reform Act (1979) required strict accountability of providers, but this led to extensive paperwork and reporting rather than to improvement in either child protective services (CPS) or coordinated public/private social service delivery.

Sclar (forthcoming) and Bilik and Ginzberg (interview) argue that the issue is not public or private but, as Krauskopf (1995) asserts, an issue of management. Improving management is the key, regardless of auspice. For Bilik and Ginzberg, the critical issue in contracting is for the public agency to keep control of oversight, accountability, and evaluation, and therefore to monitor quality. They, Barbara Blum, and Frank Farrow (interviews), are especially concerned about the for-profits moving into the child welfare field, and fear that these commercial organizations may go into the field briefly, cream any possible profit, and then walk away, leaving the serious problem cases for the public agency, now drained of resources. As yet, there is no research base to judge this.

Many scholars emphasize that, because of the limited number of providers, political factors are likely to play an important role in selecting vendor/contractees rather than expertise or even costs (Kettner and Martin, 1989; Smith and Lipsky, 1993; Salamon, 1993 and 1995; Kramer, 1994; Wallin, 1997; Yates, 1997). They suggest that, despite the best efforts at identifying the factors that make for better or worse contracts, ultimately contracts may be awarded and shaped by political factors. In addition, Fuchs (interview) is convinced that, as important as evaluation is for assessing the performance of POSC, public agencies are increasingly ignoring it and awarding contracts for political and ideological reasons. Thus, for example, she believes that the New York Mayor's decision to bypass existing voluntary agencies with long-standing expertise in facilitating naturalization for immigrants and to

establish six new centers around the city to handle the process was the result of the Mayor's interest in maintaining control of a high-visibility issue. It was clearly not a matter of expecting city agencies to be more effective in delivering services.

Among the other recommendations scholars and analysts have urged regarding successful POSC (and which we regard as advice to consider with regard to our task) are the following:

- Define the public agency's mission clearly, in order to clarify which services to privatize and why (Gormley, 1991 and 1993; Kramer, 1994; Sclar, forthcoming).
- Set uniform standards for accountability, so that feedback and evaluation can provide the basis for designing better future contracts (Zieg et al, 1995).
- Yet, at the same time, ensure sufficient flexibility and discretion to permit innovation.
- Provide multi-year contracts to ensure continuity of services (Kramer, 1994).
- Issue RFPs that include specific performance and outcome expectations.
- Select appropriate vendors that clearly have the needed and relevant expertise.
- Have trained professional contract management staff, who know both the substance of the service(s) and the contracting process.
- Develop incentives for the contractees to meet program goals in a cost-effective and timely manner (Donohue, 1989).
- Develop clear compensation measures (Gormley, 1996; Yates, 1997).
- Negotiate flexible compensation measures that are closely linked with specific program objectives.
- Specify what the contract agency is to provide and how it will be demonstrated – for example, which services are to be delivered, to which population groups, with what expected results, in what time frame.
- Try to establish compatible rather than separate and inconsistent budgetary periods.
- Establish criteria and procedures regarding consumer rights.
- Develop monitoring and evaluation procedures, in order to ensure that contract terms are implemented (Salamon, 1993; Gormley, 1996).
- Establish payment rates and risk-sharing arrangements.

Given the growing concern with management problems and the importance of contract specifics and capacity to assess performance and outcome measures, it should not be surprising that a new approach to contracting via tighter management has caught the eye of public officials and child and family social service professionals.

MANAGED CARE IN CHILD WELFARE: WILL IT IMPROVE SERVICE DELIVERY?

Managed Care: What It Is and How It Developed

Managed care is an approach to the delivery of services that began in the field of medical and physical health care, was adopted by the field of behavioral health care, and is now being widely discussed and proposed as a strategy for reforming child and family social services.

This goal is expected to be achieved by facilitating the development of a more integrated service delivery system, while constraining costs. Several child welfare professionals characterized managed care as "the contracting model of the future" (Hornburger and Beck, interview; McCullough, interview), and almost all the states are said by the Child Welfare League Managed Care Institute to be exploring whether – and how – to apply managed care to child welfare.

The term "managed care" encompasses many different ways to organize, deliver, and finance care, so that the label gives very little information about a specific system and how it really operates. Lourie et al (1996) point out that managed care can be made into anything people want it to be, but it is not a magic bullet. Most advocates of managed care view it as a strategy to reduce costs by coordinating care, increasing reliance on primary care, and decreasing inappropriate use of expensive specialist care by the use of gatekeepers.

Scallet et al (1997, p. 1) define managed care as a variety of mechanisms designed to control service utilization and costs of services. There is no one model of service delivery; the managed care organization (MCO) may or may not provide direct care. "Managed care's defined characteristic is that it specializes in using certain techniques to manage the utilization of resources" (emphasis added) including: pre-authorization for care; utilization review; limitations on benefit packages; capitation; and case management.

According to Edmunds et al (1997), MCOs "differ in their organizational structures, types of practitioners and services, access strategies, payment for practitioners, and other features. Their goals, however, are similar: to control costs through improved efficiency and coordination so as to reduce unnecessary or inappropriate utilization, to increase access to preventive care, and to maintain or improve the quality of care" (p. 15).

In contrast to a traditional fee-for-service system, where the payer agrees to reimburse for every specified service provided to an insured individual, in managed care a set fee or "capitation rate or payment" is established for each person or family to be served, regardless of the number and type of services provided. In the health care or behavioral health care field, the fee might be paid by a public agency – as in the case of Medicaid managed care – an insurance company, an employer, or a family or individual; in the social services, the fee is paid by the state or local public agency.

Koyanogi (1996, p. 3) points out that this is often described as "risk-based contracting," because the MCO assumes the financial risk of providing services beyond those routinely anticipated, on the basis of the agreed fee. MCOs, therefore, have an incentive to closely control the use of services. They often control costs by constraining providers' decisions about treatments and services. Service providers may need to get advance approval for certain services, and the MCO will consider both the cost of the service and the client's need in responding.

In the physical health care field, managed care systems include HMOs, preferred provider networks (PPOs), primary care case managers, and point-of-service plans. In the field of behavioral health, managed care takes the form of capitated payments for the provision of mental health and substance abuse services, and may be part of a physical health care plan, a "carve out" through a completely separate mental health managed care plan, or

some combination. The U.S. Department of Health and Human Services (DHSS) Health Care Financing Administration (HCFA) has given waivers to states to permit them to establish Medicaid managed care plans. By March 1995, the Child Welfare League of America (CWLA) reported that 38 states had taken steps to assign some Medicaid recipients to participation in a managed care plan. It is being promoted, also, as a voluntary Medicare option that would help solve financing shortfalls. In several states, private for-profit MCOs operate managed care systems on a contract basis with the state.

In child welfare managed care plans – which are thus far limited in number – where there is a contract with a private firm (largely voluntary agencies at this point), the contract specifies (Koyanogi, 1996, pp. 3-4): (1) who will be served; (2) what services will be provided; (3) how much money the MCO will receive for the adult and child enrolled; (4) standards for evaluating the services; (5) what reports will be produced; (6) how families can appeal decisions they do not like; and (7) all other aspects of the managed care system. Unfortunately, Koyanogi adds, much of managed care emphasizes cost controls and profit-making over quality care. Nonetheless, the diversity of approaches remains, with the major distinction between the behavioral health managed care programs and those designed specifically for the child welfare system.

Child Welfare Managed Care

At its best, it would seem, managed care in the social services could be an administrative device ensuring client-focused case management or services integration, utilizing a case manager with clout and resources who can call upon specialists, draw upon an array of services, effect referrals, and respond to case developments. At its worst, it could be a control system like the most criticized of the medical managed care systems: minimizing or delaying expensive interventions or referrals; postponing action; stressing acute care over prevention; and calculating costs each step of the way for each case, even though the premise of the system is that risks are pooled.

Apart from specific state or project activities, there are several significant organizational or institutional explorations of Child Welfare Managed Care (CWMC) under way. The APWA is considering the relevance of managed care to welfare reform in general. The National Technical Assistance Center (NTAC) for Child Mental Health, with funding from the Child, Adolescent and Family Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA), has funded a study of managed care organizations and mental health care for children (Lourie et al, 1996) and is co-sponsoring a training institute. The Annie E. Casey Foundation commissioned the Policy Resources Center to carry out a three-phase project involving: (a) an exploratory expert meeting, (b) the commissioning of a set of papers by authors who could "extrapolate managed care knowledge accumulated from the health and mental health fields to other child- and family-serving systems" (Scallet et al, 1997), and (c) the preparation of a "managed care guide for state and local officials in child and family service systems" (Drissel, 1997).

The most ambitious effort, and largest commitment to date, is that of the Child Welfare League of America, which over the past several years has developed a "Managed Care

Institute for Children's Services." With a core staff of experienced professionals and a cadre of 20 expert consultants with various organizational bases, the Institute conducts workshops and training sessions, offers consultation services nationally, and has recruited a Leadership Circle of child and family service agencies, advocacy organizations, and leaders in the managed care industry. Committed to the advancement of "best practices," the League is also actively promoting managed care in child welfare while exploring the phenomenon: It co-launched a related newsletter in 1996 and conducted a major symposium in September, 1997; a meeting on legal and ethical issues in October, 1997; and a session on implementing managed care and child welfare, with particular attention to contracting, in November, 1997.

Lourie et al (1996) are more cautious. Committed to the "system of care" model (or what we might call a cross-system integrated and accountable service delivery system) of the federal Child and Adolescent Service System Program (CASSP), long promoted by the National Institute of Mental Health (NIMH), they find positive potential in managed care, particularly commitment to providing a full array of services and the most appropriate, least restrictive alternatives. These are rare guarantees in general. But Lourie et al conclude that the managed care medical insurance model over-emphasizes "medical necessity," favors acute care, and does not offer the access services, multi-system integration, and preventive services that CASSP adherents consider essential. However, Lourie et al do not dismiss managed care: If there can be a shift in philosophy from cost containment to service delivery and a readiness to accept moderate profits, then the technology has a potential contribution, in their view.

The two Policy Resource Center reports (Scallet et al, 1997; Drissel, 1997) were deliberately commissioned from experts with commitments to managed care in health and mental health. The "Guide," in particular, is the most comprehensive and informed resource available, and is especially valuable for those who would explore managed care and child welfare. It describes managed care as a "breath of fresh air" in the health and behavioral health fields, but cautions that some of the methods, procedures, and funding principles may not be directly transferable to child and family services. There could be "negative consequences for the clients." The authors therefore offer their explanations of managed care, a guide to a planning process, details about specific steps, and cautions for those who move forward in adapting managed care to child welfare.

The explorations of CWMC leave one in a situation analogous to the weighing of privatization in general in child and family services. With little reported experience and no rigorous research, one is again limited to lists of potential "advantages and disadvantages." For example, we derive the following from Scallet et al (1997) and Feild (1996), who, in turn, combine what they know about managed care generally with what they see in child welfare. CWMC may be said to:

- Support cost containment and savings.
- Permit staff downsizing.
- Allow provider agencies to diversify their funding streams.

- Encourage pooled or flexible funding.
- Have considerable potential for transforming the social service delivery system.

McCullough (interview) finds in her explorations that managed care also:

- Reduces fragmentation, gaps, and duplication of services.
- Increases client choice and satisfaction.
- Improves quality.
- Improves accountability.
- Stresses outcomes and performance measures.
- Creates some level of risk sharing.
- Creates a system that is data driven.
- Ensures that clients get the services they need, when they need them, in the right amount.
- Improves access to care in underserved areas.
- Shifts the focus from crisis driven treatment to preventive care and wellness.

Scallett et al (1997) and Feild (1996) hasten to cite cautions, concerns, and reasons to go slowly:

- Cost reduction goals may eclipse quality goals.
- Public officials may not have the skills to be "smart purchasers."
- Cost models may lead to over- or under-funding.
- Outcome measures being used may not be appropriate for diverse cultural groups.
- CWMC may drain funds from the system.
- CWMC may lead to creaming, serving the less severe problems and shifting the more severe cases to poorer quality care.
- CWMC may lead to exclusion of community residents from planning and managing services.
- CWMC gives "case" workers little control over decision-making.
- CWMC is more oriented to adults, more pathology-based, and more concentrated on a single sector; therefore, it is unlikely to implement the goals of the child welfare reform agenda that stress a child and family focus, a developmental focus, and a cross-system and community-based system.

Feild also points out that, traditionally, the child welfare workers are responsible for making sure that clients get what they need. However, under managed care they have little control over decision-making, cannot take clients to the provider the worker thinks appropriate, and cannot authorize treatment.

It would take experiments, demonstrations, or at least more documented experience in more places to respond fully to the enthusiasms or the caveats. Nonetheless, the literature and interviews do add to the picture.

Child Welfare Managed Care: The Special Aspects

We have not found any evidence of significant CWMC programs evaluated after a period of operations or described analytically in any books or journal articles based on systematic observation. There is reference to a few small demonstration projects run by community providers and targeting expensive "deep end" cases (severely disturbed or problem children). One state has now launched a state-wide program (Kansas), and a few other jurisdictions are in the planning stage, just beginning. Thus, most of what we summarize here is from reports of theoretical or hypothetical efforts, plans, or proposals, or from reports presented at the September, 1997, symposium of the Managed Care Institute for Children's Services of the Child Welfare League of America and from papers discussed at the November, 1997, Research Conference of the Association for Public Policy Analysis and Management (APPAM). Like the early developments in POSC, the primary focus of much of the published material is on whether to move toward managed care and how the existing physical and behavioral health models could, or should, be adapted for child welfare. The Symposium and Conference presentations are more specific as to experience and plans.

There is general agreement about the context, some of which is addressed earlier in this report. For example, Feild (1996) stresses that the child welfare system is "broken" and in need of fixing. Future changes in federal policy are likely to require system changes and impose funding constraints. Managed care is becoming the dominant mode for Medicaid clients, and expanding rapidly for publicly and privately insured behavioral health clients. It could become the preferred strategy for controlling social services budgets, generally. Those private child welfare providers whose agencies have developed multi-system affiliations (child welfare, juvenile justice, child mental health, disability, education) have been negotiating managed care contracts for child mental health and juvenile justice through the behavioral health system, and are now considering child welfare services for similar arrangements.

Feild points out, with regard to this process, that child welfare differs in fundamental ways from other fields that have implemented managed care and, therefore, will need to develop different models. Among the differences are: the involuntary nature of much of child welfare – most clients do not come looking for help; the different goals for child welfare intervention (e.g., protection and permanency, not just stabilization and improved functioning); concern with the family, not just the child; a view of the voluntary child welfare agencies as a resource, not as a partner; and financial incentives that encourage agencies to keep children in placement, rather than return them home. Scallet et al (1997) add that the state assumes a parental role in child welfare that does not exist in other fields.

Allen (interview) points out further that managed care systems assume that one can predict the problems and needed interventions (and that such predictions are essential to financial arrangements), while child welfare is essentially very unpredictable with regard to the service needs of the child and family. Child welfare involves the court, which can supersede any other decisions regarding services and interventions; how would managed care fit in? Managed care assumes that the parameters of the service delivery system are known and can be controlled by the worker, while child welfare requires the use of collateral

services, including the health care system and the schools, two powerful and independent institutions.

There is much else about the child welfare services that would complicate efforts to apply managed care procedures: Diagnostic skills are weak, and there is little systematic empirical evidence linking symptoms, diagnoses, interventions, and outcomes. Outcome data are limited, even when available, and there is little consensus regarding appropriate measures. In child welfare, these relationships often are measured anecdotally, rather than empirically, and there is no evidence that some services provided do any good. Turning to contract negotiations and management: Utilization data are fragmentary or unavailable, making the development of capitation rates very difficult. Managers often find it difficult even to identify how many clients receive which services, at what cost, and over what period of time, let alone with what success. Contracts now are often paid based on costs, rather than service units provided individual clients, or outcomes. These are all important issues, and addressing them would serve the field well, regardless of the managed care question.

There are some similarities between behavioral health care and child welfare, such as historical incentives for providers to deliver as many units of services as will be reimbursed, higher and more available reimbursements for expensive services, and the absence of clearly defined goals. But it is not clear that the cost savings effected in behavioral health managed care to deal with such matters would also apply to child welfare. Feild found four competing factors within child welfare that could lead to a cost stand-off:

- Reducing residential placements will save money.
- Serving the currently underserved will raise costs.
- Ensuring an adequate level of provider payments may raise costs.
- Screening cases more or less stringently could raise or lower costs.

Several scholars (Scallett, 1997; Feild, 1996; Lourie et al, 1996) urge that CWMC be adopted only if the objective is to improve the service delivery system, not to reduce costs, because the reverse may occur. Furthermore, they urge requiring accreditation, convinced that setting and enforcing standards are an important strategy for ensuring quality. They also caution that to make sure that clients have the services they need, when they need them, a full array of services must be in place at the onset. However, this is not the case in many communities.

Child Welfare Managed Care: Some Examples

As indicated above, there are few operating examples of CWMC.

Kansas became the first state to privatize the administration and delivery of its child welfare services under managed care concepts, when its Department of Social and Rehabilitation Services (SRS) completed contracting out all its children's services, except for child protection, between 1996 and 1997. Family preservation services were contracted out to five non-profit private agencies in 1996, adoption services to one voluntary agency, also in 1996, and foster care services to three voluntary agencies in 1997. The contract with the foster

care agency covers in-home as well as out-of-home placement and after-care services. The agency can choose to send a child home and refer for family preservation services, or to place the child.

CWLA reported that Kansas moved more rapidly than other states to issue RFPs to establish a CWMC system because of: (a) the growing interest of advocates in child and family social service delivery reform; (b) a new state administration with extensive experience and interest in the social services; and (c) a burgeoning child abuse and neglect caseload that was overwhelming staff's capacity to respond. The primary rationale was that contracting out these services would free the public agency staff to better manage the CPS agencies. Kansas is taking the public agency staff who previously had delivered the services and giving them responsibility for monitoring the managed and contracted services, which, as several experts have pointed out, is fine as long as they do not leave the agency and their expertise remains current.

Many Kansas providers fear loss of referrals and income under the new system, but others are enthusiastic. State officials do not anticipate major savings under the contracts, but expect some long-term savings as preventive services gradually reduce the number of new cases entering the system. Not unexpectedly, given the poor tradition of cost analysis in child welfare, Kansas ended up accepting three different cost rates for services and being limited to rates based on what had been paid in the past.

Ohio illustrates another approach. The state has received federal approval and waivers to implement a five-year child welfare research and demonstration project called "ProtectOhio," designed to reduce the number of children in foster care, decrease the time spent in foster care, and promote adoption. The plan is to be implemented October 1, 1997 (CWLA, 1997).

The project is staffed by the Ohio Department of Human Services, Office of Family and Children's Services. The waiver permits flexible use of federal child welfare funds for early intervention and preventive services, as well as placement, and "reflects the latest application of managed care to child welfare services " (p. 1). All 88 counties in the state have already implemented mandatory and voluntary Medicaid managed care (in addition to fee-for-service arrangements) and publicly funded mental health and substance abuse services under the state's Medicaid behavioral health care.

Under the child welfare waiver, county agencies will have financial and regulatory flexibility to develop new programs, create incentives to reduce costs, and reinvest savings in other child welfare services, in particular, preventive services, early intervention services, intensive case management, and parent education. Local agency participation is voluntary. Thus far, 17 counties have indicated an interest in participating, including Hamilton County (which includes Cincinnati).

Hamilton County's CWMC plan is being implemented through a five-year contract with a for-profit MCO and the Departments of Human Services, Mental Health, and Drug Addiction. In addition, the County will participate in ProtectOhio, and the same MCO will provide clinical management of services to those clients "at high risk of long-term use of child welfare services" (the "deep end clients"). In contrast to other state plans, case

managers will be able both to make referrals and to authorize treatment.

Tennessee, constituting a third illustration, implemented a Medicaid Managed Care program (TennCare) and expected to include child welfare and mental health services in the program, but children's services were gradually carved out (Culler, 1997). Instead, a new consolidated Department of Children's Services (DCS) was established, which provides a single point of entry for children in state custody or at risk of state custody. The department is separate from, but closely linked with, TennCare and TennCare Partners, the state's managed mental health care organization.

Tennessee State officials rejected the concept of a private MCO for child welfare, and instead incorporated a managed care approach into the new department's contract services system. A key component is an emphasis on prevention and early intervention and a continuum of care; a performance-based contracting strategy with private providers is also planned. Under this model, more treatment decisions and delivery of services are in the hands of private agencies, and their staff have greater flexibility and authority to move children through levels of care. The total dollar amount available to providers per month is capped, and the amount varies by type of beneficiary. Each provider agency is required to accept a previously negotiated number of new admissions per month, and "success" involves maintaining a child with his or her parents for at least nine consecutive months, improved school attendance, and a decline in juvenile arrests.

The DCS hopes to organize its 175 contracted provider agencies into 4 to 10 "social treatment networks," and it is encouraging providers to collaborate and develop consortia. The model that DCS has developed is one in which the public agency is the MCO, and it manages assessment and outcome measures for individual cases, shaping service delivery through its contracts with the private agencies that deliver the services. In many ways, vocabularies aside, this is closer to a POSC model or to a network model as described in the next section than it is to CWMC.

Tennessee officials believe that there are lessons to be learned from managed care that can be adapted and incorporated into the public agency to improve it. A close public-private collaboration, including a strong public role in planning and assessment, is essential, in their view.

All this said, a second national survey reported by the CWLA Managed Care Institute in September, 1997, found somewhat less managed care activity than implied by first reports. While 31 of 50 states were planning or implementing initiatives "that include privatization of certain management functions or use of managed care approaches" in child welfare (p. 2), "the evidence of wide diversity among state plans is significant...There is no single, universally accepted managed care or privatization model for child welfare services" (p. 3). Some initiatives cover very narrowly defined populations; others cover all of child welfare. Some are tied to medical or mental health programs, others are not (p. 4). Thus far, "The costs or benefits of the managed care plans for child welfare and related systems are unknown" (McCullough et al, 1997, p. 17). The CWLA Director, David Liederman, urged using the next few years for "learning what is good for kids" (September 17, 1997, presentation).

NETWORK CONTRACTING

Concern with an overemphasis on cost saving rather than quality may be generating interest in still a third form of contracting for child and family social services, one that we term "networking." We use this term to describe the identification or creation of a cluster of agencies with which the public agencies contract for services; these agencies, in turn, subcontract with individual or agency providers. The network can also consist of several informal arrangements among a group of providers serving a community. The lines between POSC, CWMC, and Network Contracting (NC) thus are fuzzy, but we see useful distinctions, nonetheless: POSC may add to the supply of social services or purchase slots in an existing agency or lead to the establishment of new agencies, but it is unlikely to involve initiatives to change the social service delivery system. Managed care implies a direct and much larger span of finance-based control over service delivery, and a deliberate effort at increasing efficiency and case coordination; it implies changing the service delivery system by various strategies. Networking suggests an intermediate position between POSC and CWMC, in which the public agency adopts some of the principles of managed care, but retains more control and does act to re-shape the delivery system; or an informal network of providers is put into place or develops over time without formal contracts or letters of agreement, but also has the goal of improving services and transforming the neighborhood social service delivery system. In effect, networking may be managed care through a decentralized group of relatively small management organizations.

Perhaps Lourie et al's (1996) suggestions could turn the CASSP "system of care" model into a sucessful melding of NC and CWMC. A recently announced workshop for June, 1998, would appear to have such a premise ("a special focus on developing systems of care in a managed care environment," brochure, Georgetown University Child Development Center).

A reporter derived this formulation from interviews in New York City's new Administration for Children's Services (ACS) in the spring of 1997, with its Commissioner Nicholas Scoppetta:

> He and (Mayor) Giuliani want to weave a net of public and private agencies to catch signs of danger to children. Scoppetta plans to re-deploy his own caseworkers and those from private foster-care agencies by neighborhoods, and to have them create a network with neighborhood-based social-service agencies, schools, police stations, hospitals, shopkeepers, tenant associations, day care centers — anyone who can detect extensive stress in families and report it before a child's life is jeopardized" (Russakoff, 1997).

In the sense of our present discussion, the "network" would collaborate not only in case finding (the Scoppetta plan), but also in the case advocacy, treatment, rehabilitation, helping, developmental and investment services, and secondary prevention activities that may be called for. Public contracts would require such cooperation.

There is no research literature regarding network contracting as yet, but there are occasional references to this approach in the discussions of managed care (see above, in re:

Tennessee). Thus, for example, Scallet et al (1997, p. 4) describe network models that include: community provider networks (groups of neighborhood agencies located in a community that agree to work together); integrated provider networks that contract with MCOs (such as physician/hospital organizations); specialized MCOs, such as Administrative Service Organizations (ASOs) that handle management (billing, legal, etc.) functions; and jointly owned partnerships between MCOs and community providers, whereby both bear risks and share profits.

McCullough et al (1997) point out that public agencies may contract with a for-profit MCO for certain administrative functions that support both the public agency and the lead agency responsible for network development and management, as, for example, Commonworks in Massachusetts (see below), which uses a lead agency network model supported by an ASO.

Some community providers are developing alternatives to functioning as MCO subcontractors, and, indeed, may compete with MCOs where the latter exist. Churches and other religious institutions, schools, and YMCAs or YWCAs may join informal networks to support families and provide preventive and early intervention services. "Lead agencies" may be selected that will help community-based organizations (CBOs) by providing accounting services, legal services, management information systems (MIS), etc. One important issue is how the community providers can both sustain their values and place client needs first, yet ration care when financial pressures demand it, and, in effect, function like a business and a social service agency at the same time.

The Center for Family Life in Sunset Park, Brooklyn (NY), views itself as constituting an informal network model, in direct contrast with an MCO (McGowan, interview; Janchill, interview). The hub of the network is the school- and community-based universal and developmental services for children and their families. In contrast to the one-door approach of the MCOs, here clients enter by multiple doors, based on their own preferences and definition of their needs, be it jobs, training, education, child care, counseling, etc. Staff see their mission as building the community through developmentally oriented, school-based services. Their extensive social service and mental health services are non-categorical and supportive. Multiple agencies work closely with the Center, but without formal letters of agreement or contracts. The Directors are concerned that CWMC will constrain innovation and creativity, and will limit the capacity of the agency to individualize the interventions used based on client needs. There is concern that for-profit MCOs may restrict access at the doorway or cream claimants.

County and state government agencies, too, are experimenting with functioning like an MCO and organizing decentralized networks of provider agencies.

California, a state with 58 counties, has a state-supervised, county-administered social service system in which almost all benefits and services are delivered by the county. Los Angeles County has a recently re-organized Department of Children and Family Services, experiencing many of the same problems as almost all other big city child and family agencies: increases in child abuse reporting and in the problems of substance abuse; increased foster care placements; tension between child protection and family preservation;

and concern about the future impact of P.L. 104-193, the 1996 welfare "reform."

The County's current stress is on the establishment of neighborhood networks. Rather than removing a child from his/her family or community, an effort is made to offer protective services, family preservation services, and other supportive and helping services for families at risk or in trouble in the neighborhood in which the family lives. Peter Digre, Director of the Department, has stated that "because families need to be embedded in an ongoing community infrastructure, one of the most basic things we can be doing is building that infrastructure" (Kahn and Kamerman, 1998).

With limited resources, the Department selected those communities with the most foster care. A community organizing process was then implemented in each neighborhood selected, and a cross-section of the area leadership was called together to hear the concept and select a lead agency. The County contracts with these agencies, and they, in turn, subcontract with a group of non-profit providers, who together constitute members of the network. Sometimes there are two lead agencies. The proposed system of what are here called "family preservation" services is required to stress child safety, a multi-dimensional understanding of families, and a comprehensive approach to intervention. A total of 23 "essential" services is provided through this network, which is funded largely out of child welfare, mental health, and juvenile justice funds. Funding is pooled and follows the child. Despite an increase in child abuse reports, placement rates in these networked communities have not increased. As of the spring of 1997, there were 30 community-based networks in 17 communities, encompassing 196 contracted agencies and 336 linked agencies. A parallel network is devoted to family support (prevention).

Despite this impressive community infrastructure, the public agency still maintains a presence, and public accountability remains. The public child welfare workers continue to carry a caseload and must visit each protective case monthly, as a way of meeting their child protection responsibilities, setting standards, and staying related to what the network agencies are doing. Foster care is not covered by the network.

Massachusetts provides still another example. Massachusetts has two separate public-sector programs that affect the state's child welfare population. One is Massachusetts Behavioral Health Partnership, the state's Managed Medicaid Behavioral Health carve-out program serving Department of Social Services (DSS) children. The other is Commonworks, a community-based, specialized foster care and family support services program developed by DSS for abused and neglected children aged 12-17 who are in the care and custody of the state. The main goal is to achieve permanency or prepare them for independent living.

The model is a network of providers that incorporates some managed care principles and devices, but is not a managed care program because it does not involve capitation or risk-sharing, and DSS maintains its case management and custodial responsibility over the movement of children to and from placement. Six lead agencies are under contract to DSS with responsibility for creating networks to provide case planning, care, treatment, and other social services for Commonworks Youth. Lead agencies may not reject any child referred by DSS, nor "eject" any, once in the system. More than 150 private for-profit and non-profit providers make up Commonworks' network. In the first year there is no risk-sharing. Both

funding and service follow the children and their individual needs. About 500 children are served now, with 800 expected by the close of 1998. In effect, this is a highly coordinated/integrated and tightly managed program for serving high-risk, high-cost, "deep end" youth.

CONCLUSIONS

Four developments in the social services field are converging, with potentially major consequences for child and family social services:

- A change in the locus of service delivery, leading to the use of POSC with private (non-profit and for-profit) agencies, rather than direct delivery by government agencies.
- A change in social service delivery models, now increasingly stressing community-based, where previously there may have been residential, services.
- A change in child welfare service delivery, with an emphasis on maintaining children at home, with their families and in their communities, rather than in foster care.
- A change in financing, including Medicaid, mental health, and IDEA funding, as well as social service funding, and stressing flexible and pooled, rather than categorical, funds.

As these trends converge, they have significant implications for the delivery of child and family services. Consequently, for those concerned with service delivery reform, the focus cannot be limited to contracting and its technology. In order to determine the kind of contracting that should be developed, child and family service planners, advocates, reformers, and decision makers must be clear about what kind of child welfare system they want, and what the mission of this system is to be. POSC is well established, but certainly can be improved. CWMC is being launched with much fanfare, but there is little operating experience in the child welfare field, and there are important unresolved issues, as discussed below. Network contracting, both formal and informal, has appeal, but has received little focused attention thus far. Some see it only as a variation on CWMC and, therefore, vulnerable to the same problems, while others argue that its existence depends on special and unique contextual situations.

As we turn to such issues in the next stage of our work (a series of case studies), we expect to explore particularly insights with regard to networking offered by Sclar (interview). We note the possibility of identifying contingency guidelines, the specifics being shaped by aspects of context.

It is not yet clear how to choose among the three major contracting models and the many variations of each, or whether choosing is necessary. Each strategy maximizes different values, but not always consistently, as we have seen. Traditional POSC assumes that the public agency has a clear concept of what it wants with regard to staff, capacity, and expertise, and that a major objective is to increase the supply of services. CWMC assumes

that cost control through control of utilization by gatekeeping is the key issue, and that the supply is adequate. It tends to maximize centralization and control (but these perhaps need not be). Networking focuses most on decentralization, coordination, and collaboration, and creating cross-system linkages. Its advantages may be capacity for diversity and neighborhood initiatives. There is little validated information about its management and administrative requirements.

Once there is clarity as to mission, however, attention can and must turn to contracting strategies and devices, and the issues regarding whether and how to choose among them in a particular instance -- and how to maximize or protect the desired characteristics.

Although scholars may continue to debate what and when to privatize, in the real world of current U.S. political culture and social service delivery practice, administrators take privatization as a given. The attention is increasingly focused on how to contract well. The issues of "what and when" to privatize and contract may be raised with regard to "making or buying" protective services or prisons, or whether to turn to CWMC and NC mechanisms, but they are no longer center stage. The more detailed "how to" issue is clearly the point to which attention must be directed.

The basic questions are, first: How do POSC, CWMC, and NC affect the administration/management of child and family social services, the financing of these services, and the organization and delivery of these services at the ground level, including gatekeeping, risk-sharing, and client outcomes? All of these models involve contracting, and all involve public- and private-sector agencies in the delivery of child and family social services. All involve some hope that costs will be contained, if not reduced. However, increasingly, the desire to improve service delivery and outcomes seems to be driving child welfare professionals to explore and experiment. Despite the strong pressure to reduce costs, there still remains some question as to whether any of these devices necessarily will lower costs; existing data provide a mixed picture. There is also a question as to whether the inability to lower costs should be a decisive consideration. Furthermore, there are serious concerns regarding the implications for quality of care.

A fundamental tension exists between efforts at ensuring accountability (and, therefore, standardization) and the desire to encourage and support innovation, creativity, and flexibility. Related to this is the tension between a stress on centralization, to ensure standardization and accountability, and decentralization, to ensure consumer participation and responsiveness and individualization. There is concern, as well, that the voluntary agencies are assuming full responsibility for delivering services based on the assumption of public funding. If public funding is cut and if contracts are eliminated, many of these agencies will go bankrupt.

Some participants in the policy discussion see contracting in its various forms as a strategy for transforming the social service delivery system into a community-based, culturally competent (ethnically and racially diverse staff/program/clients), and comprehensive and coordinated child and family social service system, with all the attributes of the reform agenda. Others continue to stress cost savings and efficiency as the core objectives of change. Still others have single-program goals, such as decreasing the use of

foster care or the length of time in foster care, or increasing the number of adoptions, rather than achieving more broadly formulated child and family goals. And some believe that even if the traditional voluntary agencies become MCOs, they can provide services to needy communities by subcontracting with a network of CBOs. If contracting becomes the norm for social service delivery, regardless of the type of contracting, then government agencies will need to improve their capacity for monitoring and evaluation. Right now, however, government seems to be going in the reverse direction, in part because, to many people, "load-shedding" remains a major policy goal.

Although all agree that monitoring and evaluation assume some clarity and consensus about goals, outcomes, and performance standards, there are other issues regarding comparability as well. Neither the terminology, the content, nor the interventions employed by child and family services are standardized across states, which makes it very difficult to obtain comparable data. Moreover, practitioner/staff often have different levels of training and credentials.

It seems clear that the contracting model that is employed will have to reflect the political, economic, social, cultural, and religious makeup of the community/county/state. Taking note of the contrast between New York and Los Angeles underscores this: Los Angeles has no history of strong, large voluntary agencies, and has had an all-public but limited social service delivery system. For Los Angeles to transform this into a neighborhood-based system, the obvious answer was to establish a new system, with the public agency taking public dollars to fund a network of lead agencies and satellite providers. In contrast, in New York City there is a long history of large, expert, and professional voluntary organizations that provided social services for years before there was a public system. There is also a myriad of small ethnically and racially based specialized categorical agencies created by the public sector in the years since the War on Poverty. When the public agencies were first established, there never was any question of their competing with the voluntary agencies. Now, to transform its delivery system into a community-based system means re-negotiating with existing powerful providers, already heavily invested in a POSC model; informal community networks might be able to be established in some neighborhoods, but the big voluntary agencies cannot — and should not — be ignored.

Contracting, whether POSC, managed care, or networking, is a tool. If the goal is to increase funding flexibility and to transform the delivery system into a neighborhood-based system, oriented to the child welfare reform agenda, and prepared to experiment with alternative models, then there needs to be a local capacity for writing effective contracts, for monitoring, for oversight, and for evaluation. Many communities still do not have this capacity.

At this time, there are very few CWMC programs in operation. Nonetheless, there is extensive discussion about this development, and some tendency for promotion by some professional organizations even as they explore the field. Several scholars (Feild, 1996; Gibelman and Demone, 1998, a and b) and practitioners (McCullough, 1996) think that states will rapidly move toward some kind of CWMC model. Most current plans to implement managed care appear to affect only a portion of the child welfare population, and involve

limited services. Initially, most states may only include children needing out-of-home care, and some plans may restrict service to children in need of the most expensive or restrictive forms of out-of-home care (the "deep end cases"), perhaps because the costs of placement and residential care are easier to predict, and financial risk to the provider is much less than in relation to other child welfare services or preventive interventions (McCullough, 1997). Some states view this as a first step and intend, subsequently, to move the doorway further down the service continuum, eventually including voluntary access to the managed care system by children and families at risk of abuse and neglect, but without substantiated instances of maltreatment or open CPS cases (ibid, p. 7). Although some states are contracting with a private MCO, others are transforming their public agencies to perform this function, creating a public MCO (e.g., Tennessee, Wisconsin, West Virginia) for the "management" part and contracting for service delivery, as in the POSC model. Some of these states are convinced that if they apply managed care "principles," then they can improve the public agency and deliver services more efficiently and effectively. Thus, managed care does not have to be based on privatization of the management function, but can depend on privatized delivery/production via POSC.

A big issue for the future, if CWMC grows, is whether the behavioral health–medical model or the social services model will predominate in the child welfare field. There are many operating programs in behavioral health already, and some commercial behavioral health organizations are now exploring opportunities in the child welfare field. States that already have a behavioral health program in place may find it easier to extend that model for child welfare, rather than establishing a new program; and social service agencies funded by Medicaid or seeking Medicaid funds may also see advantages in adopting a medical model. The problem, however, is that the medical model tends to be much more expensive and much less likely to stress prevention. Moreover, in states with this model, there is very little family and community involvement. To some, community involvement, a neighborhood base, and local innovation are the essence of child welfare reform, and are not encouraged by the central management of CWMC. Further, some are concerned that if child welfare becomes a separate managed care system, with the limited goals of reducing foster care placements and duration of stay, then the CASSP concept of a "system of care" will be undermined. Thus, there remain potential conflicts between the mental health and child welfare professionals.

Many advocates and scholars are convinced that another big issue will be the for-profits and the consequences of their entry into the field. The fear here is that interest in cost savings will lead to a significant reduction in quality and a movement toward standardization, rejecting the individualized care that is a hallmark of good quality in this field. There is also concern that monitoring will not be carried out responsibly or that the public agencies will lose their capacity to monitor, although some argue that a requirement for accreditation could offset some of the consequences of limited monitoring capacity.

On the other hand, Levine, Gibbs, and Hayes (interviews) are sure that CWMC has enormous potential as a strategy for transforming child and family services into a community-based, integrated, service delivery system. Lipsky (interview) also seems

optimistic about the new trends toward CWMC. He sees this as an opportunity to pool risks, and thus achieve much greater flexibility in the social service arena. Managed child welfare could lead to an approach to funding comprehensive social services for children and their families, rather than the present situation of categorical, fragmented service delivery. The major issue for Lipsky is, who gets the money that is saved through greater efficiency? Is the profit re-invested in the program, thereby expanding services, or is it given to the managers to withdraw from the program? McCarthy and Pires (interview) point out that the states do not have to be the victims of big managed care commercial companies. They can control what their vendors do by designing contracts appropriately, but they do not do this most of the time.

Only a few advocates (Farrow, interview; Allen, interview) seem concerned about possible negative effects: that the system will become more centralized rather than decentralized, and that the CBOs will lose out to the private MCOs; that the medical model may take over, imposing standardization rather than individuation, and stressing treatment rather than prevention; and that the public agencies will lose control and accountability. Still another problem is that one cannot do "risk sharing" in small community-based organizations (CBOs). Managed physical health care is based on an insurance model with many healthy participants and only a few very ill cases. The CBOs are located in communities with many severe problems — deep end cases — and only a few with no or few problems. The CBOs will not be able to afford to participate in risk-sharing here because they will drown in the deep-end cases. Moreover, they lack significant resources from other-than-public sources and tend not to have reserves, and therefore have no way to participate.

It may be useful to repeat that much of what is described here is based on early reports and plans, not on program operations.[8] Even efforts at evaluating POSC have been limited, and Lipsky (interview) reminds us that widely accepted and used performance measures still do not exist in child welfare. There is usually a large gap between theory and practice, and thus far we are faced in the CWMC field with theory and little practice, and, in the networking field, without even theory.

Finally, a statement from the theoretical literature about contracting relationships between government and the non-profits (VanSlyke and Connelly, 1997):

> Government, in seeking competitive and efficient relationships, will consciously or unconsciously employ principal-agent models which seek to structure contract relationships where goals are aligned through incentives and outcomes are monitored through various reporting mechanisms. This also creates the opportunity for contracts to be reviewed and re-bid in a competitive contract environment with the underlying assumption that competitive marketplaces exist for all types of service delivery. This then accomplishes government's goals of seeking to serve citizens, through multiple vehicles, where efficiency, equity, and quality of service are hallmarks.

[8] A Chapin Hall group is launching four case studies, even as others prepare further exploration (Wulcyn, interview).

Non-profits, in seeking to stabilize their funding for service delivery, consciously or unconsciously employ tenets of stewardship theory where long-term contracting relationships are sought and established based on perceived good alignment with their principals. They do this both through their reputation and expertise in delivering a specific service, and by utilizing their board of directors, advisory boards, relationships with similar providers and associations. Stable contracting relationships are sought in order to maintain the integrity of services, clientele, and adherence to organizational mission. Another reason for seeking a stable relationship is to develop, implement, and support programs they might otherwise be unable to conduct.[9]

The real world of contracts is, however, shaped by the efforts of government and the non-profits to influence the contracting relationship through the use of "issue networks." The non-profits make use of their boards, associations, and other contacts, while the government agencies use legislative and judicial bodies, as well as service providers. VanSlyke and Connelly point out that where their respective networks are part of a culture that supports mutual conceptions of stewardship, and where goal alignment is the norm, there is a foundation of trust, collaboration, and mutual partnering that enables government agencies to contract out service delivery effectively. But not all networks are benign; there is corruption, unfair political manipulation, and inability to learn and progress. Thus, the ultimate question is: How can one protect government by contracting procedures and goals, while building interest networks whose sense of stewardship advances public goals? How, in short, can government and the non-profits achieve and sustain mission-sensitive contracting?

[9] Quoted with permission.

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MaryLee Allen, Director, Child Welfare and Mental Health Division, Children's Defense Fund, Washington, D.C.

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Barbara Blum, Director, Research Forum on Children, Families, and the New Federalism, National Center for Children and Poverty, Columbia School of Public Health, New York, NY.

Frank Farrow, Director for Children's Services Policy, Center for the Study of Social Policy, Washington, D.C.

Ester Fuchs, Associate Professor, Barnard College and Director, Barnard-Columbia Center on Urban Affairs, New York, NY.

Linda Gibbs, Deputy Commissioner, and Elan Melamed, Assistant Commissioner, Management Development and Research, Administration for Children's Services (ACS), New York, NY.

Margaret Gibelman, Professor, Yeshiva University, New York, NY.

William Gormley, Jr., Professor of Public Policy and Political Science, Georgetown University, Department of Public Policy, Washington, D.C.

Cheryl Hayes, Executive Director, The Finance Project, Washington, D.C.

Judith Hines, President, and Jean Elder, Vice President, Council on Accreditation of Services for Families and Children, New York, NY.

Steve Hornberger, Director of Managed Care, Leake and Watts Children's Agency, New York, NY.

Sister Mary Paul Janchill, Director of Clinical Services, Center for Family Life, New York, NY.

Jack Krauskopf, Dean, Milano Graduate School of Management and Urban Policy, New School For Social Research, New York, NY.

Michael Levine, Program Officer, The Carnegie Corporation, New York, NY.

Michael Lipsky, Senior Program Officer, The Ford Foundation, New York, NY.

Lawrence Martin, Associate Professor, Columbia University School of Social Work, New York, NY.

Jan McCarthy, Director, National Technical Assistance for Children's Mental Health, Georgetown University, Washington, D.C.

Charlotte McCullough, Director of Managed Care Institute, Child Welfare League of America, Washington, D.C.

Brenda McGowan, Professor, Columbia University School of Social Work, New York, NY.

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Sheila Pires, Partner, Human Service Collaborative, Washington, D.C.

Alan Siskind, Executive Vice President, Jewish Board of Family and Children's Services (JBFCS), New York, NY.

Jane Ross, Director; Mark Ward, Senior Analyst; Kay Brown, Assistant Director; Barbara Bovbjerg, Assistant Director; David Bixler, Assistant Director; and Karen Lyons, Senior Evaluator, U.S. General Accounting Office (GAO), Income Security Issues, Washington, D.C.

Barry Van Lare, Executive Director, and Jessica Yates, Research Associate, Welfare Information Network, Washington, D.C.

Fred Wulczyn, Project Director, Chapin Hall, University of Chicago, IL.

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