



# Networks of care

Valuing social capital in  
community aged care services

Seuwandi Wickramasinghe & Helen Kimberley

2016



**Brotherhood  
of St Laurence**

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# Contents

Acknowledgements	iv
<b>1 Introduction</b>	<b>1</b>
<b>2 Context</b>	<b>2</b>
The nature of community aged care services	2
The changing landscape of community aged care	3
The value of social capital to care provision	4
<b>3 Research design</b>	<b>7</b>
<b>4 Networks of the Brotherhood's Community Aged &amp; Disability Services</b>	<b>11</b>
Exploring the structural characteristics of the services' external links	11
Reading network maps	11
Brotherhood Community Care North-Western external network map	12
Brotherhood Community Care Southern external network map	15
Brotherhood Dementia Program external network map	18
Brotherhood's Disability Program external network map	20
Relationship between frequency and strength of links	22
Exploring the qualitative characteristics of the services' external links	22
<b>5 Valuing social capital in a changing care environment</b>	<b>29</b>
Optimising social capital	29
Implications for building social capital	30
<b>6 Conclusion</b>	<b>33</b>
<b>References</b>	<b>35</b>

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## 1 Introduction

In Australia community aged care services, which include the Home Care Packages Programme and the Commonwealth Home Support Programme, offer a planned and managed set of personal care services and assistance delivered to users at home and tailored to their needs. The successful delivery of these government-funded services is heavily reliant on the resources and support that aged care providers draw on from their links and collaborations with each other and across other service sectors. Hence the outcomes for older adults wanting to remain in their homes have been significantly mediated by the collaborations and networks developed by community aged care provider organisations.

Currently community aged care services are undergoing major change with the introduction of Consumer Directed Care, which gives consumers the *control* over how they wish to spend their individual budget on services and the *choice* to pick their preferred service provider in an open and competitive market. The stated aim of marketisation combined with individualisation is to offer efficient and effective services and enhanced choice and control to consumers. This represents a major shift in human services delivery led by aged and disability care services in Australia.

In spite of the scale and direction of this policy change, little attention has been directed to its impact on service delivery and community engagement of organisations at the centre of these developments. One important question is whether a marketised service system might pose a risk to building and sustaining collaborative and cooperative relationships among provider organisation.

This report uses the concept of social capital to offer a fresh perspective on the value that networks bring to service provision and how Consumer Directed Care might affect the ability of providers to maintain effective and constructive collaboration with each other.

### Aims

This pilot research project<sup>1</sup> aimed to provide a greater understanding of the utility and value of social capital, in the form of networks and links, to community aged care service provision and more broadly to human services provision.

The study aimed to document the extent and importance of social capital through a network mapping exercise of one community care provider organisation.

An added benefit of this research is that it points to the potential value of network mapping to other service types (such as youth services and employment services).

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<sup>1</sup> This report draws on the findings of a larger study that examined both the internal and external links of Brotherhood's Community and Disability Aged Care staff.

## Scope

The study focused on one of three forms of social capital identified in the literature, *bridging social capital*, which is embedded in horizontal links that facilitate ‘access to resources and opportunities that exist in one network to a member of another’ (Ling & Dale 2014, p. 3). Bridging social capital is embedded in the relationships between Brotherhood Community Aged Care and Disability Services staff and other external organisations.

The research mapped the bridging social capital of three Brotherhood community-based aged care programs—Brotherhood’s Community Care North-Western and Southern, Banksia Community Respite Centre (Dementia Program) and Nexus Community Respite and Disability Services (Disability Program). It examined work-related links, with a focus on two types: *professional links* and *partnerships*. This research understands *professional links* as relationships that are initiated by individual staff and built on familiarity and rapport on a person-to-person basis; by contrast, *partnerships* refer to formal agreements between organisations for their mutual benefit.

This study is primarily qualitative, with a few quantitative components used for analysing network data and survey data. It does not statistically analyse networks and their properties.

## 2 Context

### The nature of community aged care services

Community aged care services offer a range of services to users, including allied health services, respite services, home help and maintenance services, transport, shopping assistance, food services and specialised support services. It is built on a service framework that calls for tailored, seamless and holistic support in which service users are connected to a wide range of services to meet their diverse and changing needs.

This requires community aged care providers to interact and work with multiple services across sectors to develop an effective referral system. The existing networks among provider organisations are connected through case management, referrals and joint services/programs. The quality and quantity of multi-sectoral links built by provider organisations impact on the outcomes achieved for their service users.

Such outcomes for users and the effectiveness of service delivery vary between provider organisations. Some of these differences could result from the types and amount of social capital available to them.

Nonetheless, very little is documented about the resources that provider organisations draw from their links with each other—or how they use these resources and links to benefit their service users and staff. UnitingCare (2013) undertook a small study in Queensland to explore how to leverage existing social capital to support successful

transition to the National Disability Insurance Scheme for people with disability. However, to date, there has been no study that explores the different types of social capital used by aged care provider organisations in Australia, how they influence the functioning of each organisation and, at a broader level, how this accumulated 'stock' of social capital shapes the community aged care service system. Addressing this research gap is particularly timely in the face of the changes and challenges presented by Consumer Directed Care.

### The changing landscape of community aged care

The Community Home Care Packages Programme is currently undergoing major changes due to the implementation of Consumer Directed Care. Under the previous funding model, service providers (predominantly community sector agencies) received block funding for a specified number of packages in a region through Aged Care Approvals Rounds (ACAR). Under CDC, packages are now paid to service providers as individual allocations (known as individualised funding) to be used entirely by the consumer.

This new service delivery model moves away from the previous quasi-market to an open market where the consumer chooses the service provider. It is designed on the premise that individualised funding and an open care market will lead to more 'flexible' and 'affordable' services that are responsive to the needs of the individual consumer and will give consumers both choice and control (Department of Health 2016). This is triggering changes to current roles and responsibilities of provider organisations and their existing service delivery models. The adoption of market-driven policies such as CDC may well conflict with the multi-sectoral links and collaborations which are fundamental to quality community aged care services.

### The impact of individualised funding on provider relationships

Under CDC, from 2017 provider organisations will no longer receive an allocation of packages from the government. Instead packages will be directly allocated to older adults, characterised as 'consumers', who will be able to move their funds to any provider at any location as they wish. Thus, consumers will no longer be restricted to receiving services from providers in specific aged care planning regions (Department of Social Services 2016). Although these changes will give consumers flexibility, they could also have an impact on the quality and strength of relationships between providers. Because providers will no longer have the surety of an allocated number of packages, they will need to compete with each other to attract and retain consumers.

### Expanding community aged care provision to other providers

Added to these immediate pressures is the proposed plan to streamline and simplify the approved provider process, aimed at expanding community care provision to residential care providers and others such as brokering agencies (Department of Social Services 2016). This could lead to a significant increase in the number of community packaged

care providers, thereby further intensifying competition and reducing interdependence, collaboration and reciprocity among providers.

### International learning about marketisation and self-directed care

Although the model of CDC in Australia has some different features, some relevant lessons can be learned from the international literature on marketisation of care. This reveals a range of consequences, among them the prioritisation of cost-effective services and short-term outcomes over high-quality ones (Bode 2014) and a decline in the capacity of community services organisations 'to incorporate social capital enhancing approaches into their service provision' (Butcher 2006, p. 73). Other impacts noted by Davidson (2015) are a risk to the viability of services due to competition and the increased presence of large provider organisations which might decrease opportunity to build sustainable and collaborative relationships among provider organisations.

Critiquing the introduction of individual budgets into English health care, Williams and Dickinson (2015) explain that the push towards individual responsibility for care (borne by the service user as a result of individualised funding) as opposed to the collective provision of welfare in the traditional service delivery model can risk the loss of 'the egalitarian principles and collective sense of identity' embodied in public institutions such as the National Health Service. They make an important point here, supported by Davidson (2015), that the community care sector, particularly the not-for-profits, is at risk of 'corporatisation'. Commenting on the marketisation of the welfare sector in the United States, Salamon (1993) and Eikenberry and Kluver (2004) have expressed concern that the promotion of competition and the commodification of care are likely to reduce the opportunities for collaborative and cooperative efforts in the community sector. In effect these impacts can result in an erosion of social capital.

### The value of social capital to care provision

Social capital (explained below) is embedded in the networks of links developed by care provider organisations with each other and is a valuable resource that facilitates service provision. A well-networked service system is essential to linking service users to other services and creating a seamless care pathway for them. Such an integrated approach is particularly important for responding to the diverse and changing care needs of service users especially in the later years of their lives.

Despite the value of social capital to care provision, its intangible nature makes it difficult to quantify and measure and as a result it is likely to be overlooked by provider organisations in pursuit of more measurable outcomes. Nonetheless, social capital enables provider organisations to access different social and material resources through links maintained with each other. Therefore, developing an understanding of social capital can offer organisations a fresh perspective on community aged care provision both now and into the future.

### Different understandings of the concept of social capital

Social capital is loosely understood as a resource that brings benefits to individuals through their links with others. However it is a contested concept and multiple understandings of social capital have emerged. Despite this, there is agreement that networks are fundamental to social capital and that it brings benefits for some individuals and groups.

Among the many views on social capital, three writers have made prominent contributions to the development of the concept in different contexts: Peter Bourdieu, Robert Putnam and James Coleman. Bourdieu (1986) explains social capital with reference to inequalities between social classes, while Putnam (2000) focuses on social capital in terms of community ties. Coleman (1988) describes social capital in relation to human capital.

Bourdieu (1986) defines social capital as benefits available to individuals through membership of a group or network. Similarly, Coleman (1988) views social capital as a resource that is accessed by individuals to achieve certain objectives. Social capital according to both writers is embedded in the relationships between people and 'it is those others, not himself, who are the actual source of his or her advantage' (Portes 1998, p. 7). Shifting the concept from an individual to the collective level, Putnam (1993) describes social capital as a resource or a 'public good' belonging to a community or a nation. He emphasises that trust and reciprocity within networks are important for building social capital.

Bourdieu and Coleman's understanding of individual social capital in a way undermines the collective value of social capital as it becomes a resource used for individual gains. On the other hand, Putnam's view of social capital as a 'public good' is more useful in regard to organisational social capital in the community sector, as it recognises the importance of collective action and mutual benefits.

Coleman (1988) also makes a useful contribution by recognising that social capital is equally important and relevant to organisations as their relationships can also constitute social capital. Building on this, Gabbay and Leenders (2001) describe *corporate social capital* as the benefits that flow from the individual networks developed by employees, networks developed within and across teams and departments and across companies.

Bourdieu and Coleman make different observations on how social capital is built. Bourdieu (1986) considers it as a calculated pursuit/gain, or a 'social investment strategy', and a lengthy endeavour that takes time and effort. In contrast, Coleman (1988) states that relationships aren't always built consciously to gain benefits and that social capital is built largely through unintended processes arising from activities intended for other purposes. Although Coleman draws attention to the importance of serendipitous relationships, the concept of social capital is likely to lose its value if it is simply considered as a by-product of another action. Bourdieu's observation is useful as he implies that people can develop systems and structures (such as policies, activities,

organisational processes) that build, support and enhance social capital of both individuals and organisations.

### Different forms of social capital

Although most writers agree that social capital brings benefits, they also recognise that different types of links can bring access to different amounts and types of resources. Bourdieu observes that opportunities to build and accumulate social capital are not equally open to all and although social relationships facilitate access to resources, the amount and quality of these resources can differ. Consequently, three forms of social capital have been identified: *bonding*, *bridging* and *linking social capital*. While *bonding social capital* represents relationships with individuals and organisations having similar backgrounds (Putnam 2000), *bridging social capital* denotes cross-cutting relationships with different groups in society/organisations (Burt 2001; Putnam 2000). *Linking social capital* denotes vertical links between dissimilar individuals and organisations that have unequal power and unequal access to resources (Woolcock 2001).

Like-minded organisations with strong bonding social capital are better able to maintain their resources among themselves and have high levels of cohesion. By contrast, those with strong bridging social capital have more opportunities to expand their networks and share a variety of resources with others; these organisations have a better chance of 'getting ahead' within the sector than those with strong bonding social capital which may simply 'get by' (Woolcock 2001)<sup>2</sup>.

### Application of social capital theory in this study

This study makes use of the work by Coleman (1988) and Gabbay and Leenders (2001), who have extended the concept of social capital to organisations and institutions. Using Putnam's understanding of social capital as a 'public good', it considers social capital as a resource that brings collective benefits to community aged care staff and in turn to their clients.

The study considers two of the three forms of social capital identified in the literature: bridging capital and to a lesser extent bonding capital.

The methodology of this study was influenced by Franke (2005) and Stone (2001) who focus on both structural elements (networks) and normative elements (such as trust and reciprocity) as a means of examining social capital.

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<sup>2</sup> Woolcock uses the terms 'getting ahead' and 'getting by' with reference to the social capital of individuals.

### 3 Research design

This study explores the following:

- What kinds of links and networks are used by the Brotherhood's Community Aged Care & Disability Services staff to build social capital for their programs and for service users?
- What factors enhance or inhibit the creation of social capital?
- How is social capital used to enhance service provision?

The study used a qualitative method to map and assess the social capital of Brotherhood aged care services staff, applying three complementary and interrelated data collection tools:

- external network workshops (consisting of a mapping exercise and group discussion)
- an internal network questionnaire
- a survey.

These three tools were designed to capture and examine links and networks (described as structural elements of social capital) of staff and norms such as trust and reciprocity (described as normative elements of social capital) that underpin these links and networks.

#### External network workshops

The workshops explored the links that each of the three programs had with external organisations such as government departments and other service providers. They comprised two parts—a mapping exercise and a group discussion—which were used to identify and examine two types of links: *professional links* and *partnerships*. *Professional links* were defined as relationships that are initiated by individual staff and built on familiarity and rapport on a person-to-person basis; and *partnerships* were defined as relationships underpinned by formal agreements between organisations for their mutual benefit. This enabled the study to capture the different characteristics and benefits of these two types of links.

Five 90-minute workshops were conducted. One workshop was held with Community Care North-Western staff and the remainder with a mix of Community Care Southern, Disability and Dementia programs staff in the south. Up to 12 participants attended each workshop.

#### Mapping exercise

Social network analysis was used as a tool to map the links that each staff member had with external organisations such as health care services, government departments and recreational services. The data collection method was based on the guidance provided

by Durland and Fredericks (2005) and Landvogt (2013) who describe some key characteristics to look for in networks.

In addition to identifying two types of links (professional links and partnerships), the mapping exercise explored the staff members' subjective interpretations of the strength of links (strong/weak) and the reciprocity of links (in terms of the direction(s) that the benefits such as information flow).

During the mapping, each participant was asked to identify up to 20 organisations that they considered to be significant to their work role. They were then asked to draw their own map of work-based links. They used different colours (for professional links or partnerships), different thickness of lines (for strong or weak links), and arrows to show the direction(s) of benefits. Participants assigned themselves codenames that were double coded during analysis to preserve anonymity.

Data from the 51 individual maps were aggregated and entered into Gephi, network analysis software, to construct an external network map for each of the programs. Network analysis theory was used to explore the various characteristics of links (network size, level of connectedness, direction of benefits).

### Group discussions

The workshop group discussions included a set of open-ended questions about how participants developed links and how they used them for the benefit of their clients and work role. They further explored staff perceptions of the values, norms, expectations and obligations that underpinned these links. The discussions offered a more detailed examination of the nature of external links that could not be gained from the network maps alone. Group discussions were recorded and thematically analysed.

### Internal network questionnaire

A network questionnaire was used to identify and examine internal links among Brotherhood's Community Aged Care & Disability Services staff. The questionnaire was based on the 'name generator', a tool widely used in social network analysis to uncover the multiple relationships that exist between individuals within a group or a network. It uses a series of questions to draw out a list of names of people belonging to the respondent's networks. The questionnaire was guided by information provided by Marin and Hampton (2007), Lange, Agneessens and Waeye (2004), Merluzzi and Burt (2013), Thaden and Rotolo (2009) and Flap et al. (2003). The codenames from the mapping exercise were also used for the questionnaire.

The questionnaire asked about the kinds of networks that provided social support and exchange; access to resources such as information, ideas, external contacts; and

interaction (colleagues with whom the respondent worked most closely and enjoyed working). It revealed the level of connectedness between staff within each program.<sup>3</sup>

## Survey

The survey examined the normative elements (such as participation, trust, cooperation) of the internal and external work links of staff. It examined how staff used their links, how frequently they were used and for what purposes. To this end, the survey used six overlapping indicators of social capital selected from the literature:

- Trust (institutional and personal trust)
- Integration and inclusion
- Level of participation
- Openness to the new
- Sharing knowledge and information
- Cooperation and support

The survey was distributed and completed online, with 45 responses received. Data was analysed using Survey Monkey, in conjunction with the external network maps.

## Research participants

**Table 3.1** Number of staff who participated in the research

Name of program	Number of participants		
	External network workshops	Survey	Internal network questionnaire
Brotherhood Community Care North-Western	15	7	14
Brotherhood Community Care Southern	22	18	25
Banksia Community Respite Centre (Dementia Program)	6	6	8
Nexus Community Respite and Disability Services (Disability Program)	8	6	8
<b>Total</b>	<b>51</b>	<b>37</b>	<b>55</b>

<sup>3</sup> The findings of the internal network questionnaire were reported in a separate internal report.

## Limitations

The findings of this study are dependent on information given by participants and reflect their perceptions and attitudes. Responses may have also been affected by variations in organisational climate over time due to the implementation of the Brotherhood's new Consumer Directed Care model. Network maps present a snapshot in time only, as work links evolve and change.

As the research was conducted over a twelve-month period, it was subject to a number of changes:

- Not all staff members in Community Aged and Disability Services were available for all phases of the research, so the rate of participation varied.
- Several participants left Brotherhood employment during the research period.

In order to avoid identifying individual respondents, the research did not examine how the building of social capital is influenced by the different work roles (managerial, frontline, administrative/support) that the respondents had within Brotherhood's Community Aged and Disability Services.

The research focused on bonding social capital (internal links among staff within their own program) and bridging social capital (external links). It did not examine linking social capital as that is only relevant to hierarchical relationships that enable access to individuals and institutions with relative power and influence (and exist mostly among managerial staff within an organisation). An examination of linking social capital would have required a separate data collection method and increased the complexity of this research.

## Ethics

This research adhered to the requirements of the Brotherhood's Human Research Ethics Committee accredited by the National Human and Medical Research Council (NHMRC). A clear and concise information statement was provided to participants, outlining the aims and purpose of the research. To preserve privacy and confidentiality, participants were not individually identified in analysis or reporting of the research.

## 4 Networks of the Brotherhood's Community Aged & Disability Services

The first part of this section includes the external network maps of the Brotherhood Community Care North-Western, Community Care Southern and the Disability and Dementia programs in the south, with an analysis of the maps. These findings are accompanied by data from the survey. The second part of the section presents the findings from the group discussions.

### Exploring the structural characteristics of the Brotherhood's Community Aged & Disability Services' external links

#### Reading network maps

The network maps in Figures 4.1, 4.2, 4.3 and 4.4 display the following characteristics:

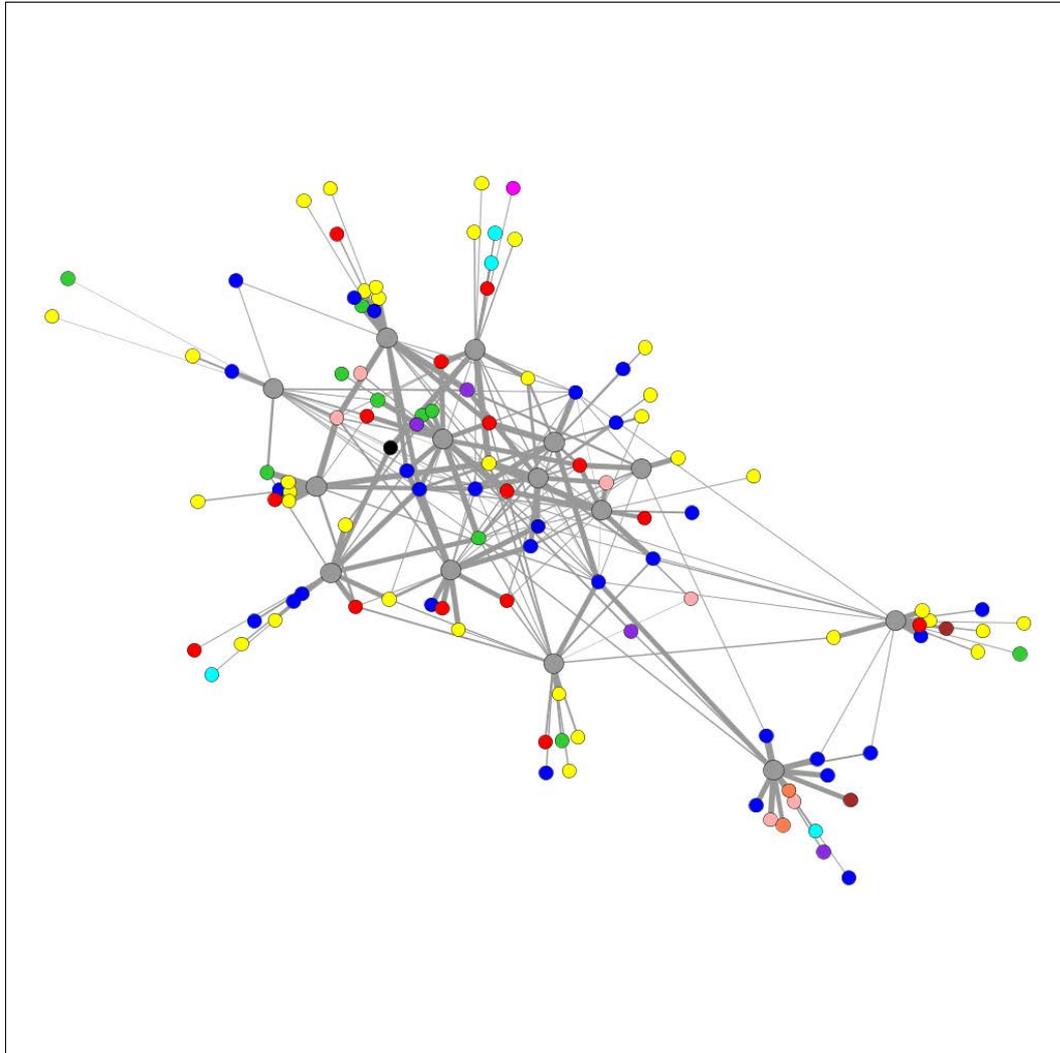
- Each grey circle represents a program staff member who participated in the mapping exercise.
- Coloured circles represent external organisations that they have links with.
- Colours represent industry sectors such as health care and aged care.
- Circles located close to the centre of the network show staff who have the most shared links with external organisations.
- Circles located near the periphery of the network show staff who have the fewest shared links with external organisations.
- Thick lines represent strong links (more frequent contact) and thin lines represent weak links.

The network software Gephi used in network mapping can also indicate the direction of benefits through the use of arrowheads; however, the arrowheads are not easily displayed with a large number of links.

## Brotherhood Community Care North-Western external network map

Figure 4.1 shows a network of the links that Community Care North-Western staff have with external organisations.

**Figure 4.1 External network map of Community Care North-Western**



	Health and mental health care services		Disability services		Retailers, gardening and home and mobility equipment suppliers
	Aged care services		Community organisations		Social participation and recreational services
	Local councils, government agencies/departments		Educational Institutions		Employment services
	Housing services		Transport		

**Network links:** The Brotherhood's Community Care North-Western network consists of 228 links among 15 staff with 109 external organisations. Not all staff are linked to all of the organisations, making this an open network as expected in a community care services setting, offering opportunities for staff to develop and expand their links. Given the small number of staff, the map shows a high level of connectedness with external organisations.

**Strength of links:** The effectiveness of a network is determined by a mix of strong and weak links. Strong links enable high levels of trust and cohesion. They also increase staff willingness to cooperate with other organisations and opportunities to access support from others (Burt 2001). Strong links, however, are also counter-intuitive as network members who are strongly linked to each other are less willing to develop new links outside their existing networks (Granovetter 1973), limiting chances to access and exchange new resources. Having weak links is important as they can sometimes act as bridges facilitating a flow of new ideas and information from the outside to the inside of the network (Granovetter 1973). Those who are 'weakly' linked and act as bridges are likely to move in different professional circles and therefore have access to different information from other members of the network (Granovetter 1973).

The Community Care North-Western network map shows more weak links than strong links. Most of the strong links are concentrated closer to the centre of the network while weak links are dispersed across it.

**Reciprocity of links:** Although the reciprocity of links is not displayed in Figure 4.1, data from the mapping exercise revealed that the majority of the 228 links were considered to be reciprocal by staff. Reciprocal links are a necessary precondition for building social capital because they enable the exchange of resources with others, preventing an unequal distribution of resources within the network. Of the remaining links, most links were considered to be more beneficial to staff and the Brotherhood than to the other organisation.

**Types of links:** Although types of links are not shown in Figure 4.1, data from the mapping exercise revealed that Community Care North-Western had similar numbers of partnerships (developed under formal agreements) and professional links (developed by individuals). However, it was apparent from the individual maps that staff felt that partnerships and professional links sometimes overlapped.

**Location of staff on the network map:** Several Community Care North-Western staff are mapped closer to the centre of the network because they have links with the most external organisations that are shared with others. These external organisations are also located closer to the centre of the network and this indicates their significance to multiple staff and their work role. In contrast, two staff members who are loosely connected to the network are mapped at the furthest edge of the network, with only a few links with organisations shared by others; instead they each have their own cluster of links. Staff with their own cluster have the opportunity to broker new links (Burt

2001) for their colleagues if their contacts become shared with others. On the other hand, clusters can also result in an unequal distribution of resources if the resources accessed through these links are not shared with others in the network.

**Diversity of sectors:** The network map shows links with 11 sectors in total, with most links developed with the health care sector followed by the aged care sector. The nature of older client needs is likely to influence the higher number of links with these two sectors. Only one staff member had a link with an employment service and one with a housing service.

### Sustainability and use of external links

Complementing the findings from the mapping is the information from the survey, which collected a limited number of individual staff insights about the frequency of communication/interaction, maintenance and uses of their external contacts in their day-to-day work. External links can soon lose their value if they lie dormant. Sustaining links is fundamental to the preservation of social capital.

**Frequency of contact:** Of the seven staff who completed the survey, only a few kept contact 'frequently' with external organisations.

**Exchange of external contacts:** Only one staff member had introduced most of their professional links to their co-workers in the past 12 months. Of the remaining six respondents, half had introduced a few of their professional links to their co-workers.

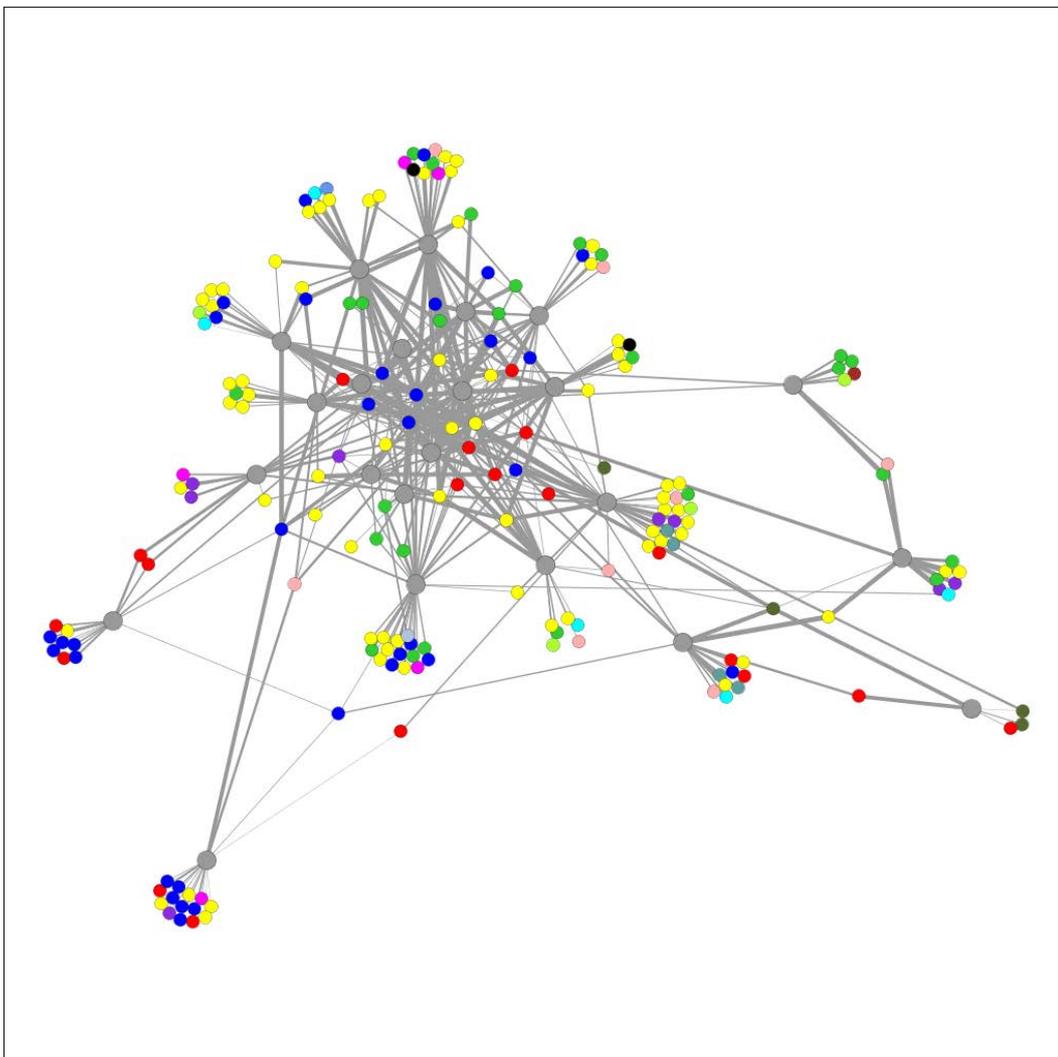
**Use of external links:** External links were used often by three staff members to achieve short-term targeted outcomes for their clients (for example, case managers organising home care, domestic and personal care services and social activities for clients) and to establish referral pathways for their clients (for example, to respite, medical and allied health services). Two staff often used their external links to share expertise, ideas and information on 'good practice' service models. External links were seldom used by a majority of staff to broker/develop new links with other organisations and to deliver services in collaboration. Some of these responses may reflect the different roles of responding staff; but this information was not collected so as to preserve anonymity.

Considering the large number of external links that are available to the Community Care North-Western, the survey results suggest that the value of these links and the potential benefits they bring to the program and to staff are yet to be fully utilised.

## Brotherhood Community Care Southern external network map

Figure 4.2 shows a network of the links that Community Care Southern staff have with external organisations

**Figure 4.2 External network map of Community Care Southern**



Health and mental health care services	Disability sector	Retailers, gardening, home and mobility equipment suppliers
Aged care services	Community organisations	Social participation and recreational services
Local councils, government agencies/departments	Aboriginal services	Employment services
Housing services	Transport	Advisory and information services
Legal and advocacy services	Religious institutions	Dementia care

**Network links:** Community Care Southern network consists of 399 links among 22 staff with 190 organisations.

**Strength of links:** The Community Care Southern network map shows a large number of strong links, mostly near the centre of the network, indicating their importance to staff and their work role.

**Reciprocity of links:** The majority of the 399 links for Community Care Southern were considered by staff as reciprocal.

**Types of links:** The great majority of links were professional links. Only a very small proportion were partnerships. Unlike Community Care North-Western staff, staff in Community Care Southern appear to rely more on professional links that they themselves initiated. These professional links represent social capital built by staff. However, data from the individual maps suggested that Community Care Southern staff, like the Community Care North-Western staff, felt that partnerships and professional links sometimes overlapped.

**Location of staff on the network map:** In the Community Care Southern network map several staff are near the centre of the network and a larger number at the periphery. Six staff mapped at the furthest edge of the network are loosely connected, having only a few links with organisations shared by others. The majority of staff have their own cluster of links. This may indicate that staff are more inclined to develop their own professional links displaying their social skills. Clusters are useful as they may represent diverse contacts (with different expertise, skills) who can bring in new information, ideas and knowledge into the network. Individuals belonging to clusters can also mediate new links for others in the network.

**Diversity of sectors:** Community Care Southern staff have links with at least 15 sectors, ranging from health and aged care to more specialised services such as Good Shepherd's Financial Counselling Service) and legal and advocacy services (for example Leading Age Services Australia and Council on the Ageing). Community Care Southern staff predictably have numerous links with health care services, aged care services and retailers/suppliers. There were relatively few links with Aboriginal and dementia services.

### Sustainability and use of external links

**Exchange of external contacts:** Of the 17 staff who completed the survey, the majority had introduced a few of their professional links to their co-workers in the last 12 months.

**Frequency of contact:** Despite the significant number of external links available to Community Care Southern, the majority of staff said that they sometimes contacted external organisations.

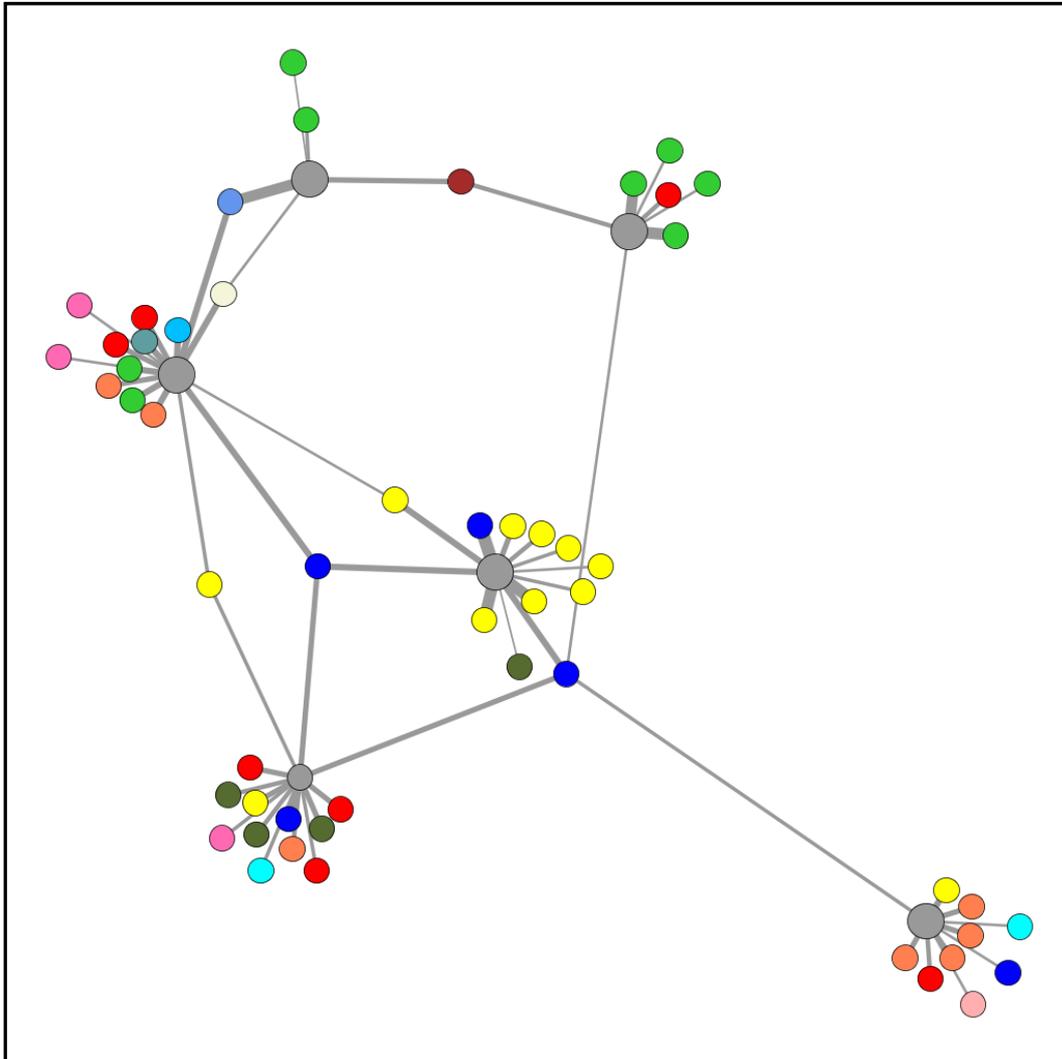
***Use of external links:*** External contacts were often used by around half of the staff to achieve short-term outcomes for clients, establish referral pathways for them and to share information about 'good practice' service models. External contacts were occasionally used by over half of the staff to develop new links with other organisations and to share each other's expertise and ideas. An equal number of staff seldom developed and delivered programs in collaboration with their external contacts.

Overall, the findings from the Community Care North-Western and Southern maps indicate that staff had numerous links with external organisations from a range of sectors. Although they had invested their time and effort in developing these links, responses indicate that not all staff were able to maintain regular contact with their links. This could be due to their work roles, as their need to maintain contact is influenced by the frequency of client requests. Staff are also more likely to contact their external links when there is an intake of new clients and when transitioning existing clients to higher care. Given the importance of external links to effective case management and service coordination, increasing resources and time to maintain regular contact with their networks would be beneficial for staff.

## Brotherhood Dementia Program external network map

Figure 4.3 shows a network of the links that staff from the Dementia Program have with external organisations.

**Figure 4.3 External network map of the Dementia Program**



Health and mental health care services	Aged care	Retailers, gardening, home and mobility equipment suppliers
Legal and advocacy services	Community organisations	Social participation and recreational services
Local councils, government agencies/departments	Transport	Dementia care
Educational institutions	Religious institutions	Migrant and refugee services
Protective services		

**Network links:** The Dementia Program network consists of 63 links among 14 staff with 45 organisations. Like the networks of Community Care, the Dementia Program network is an open network with opportunities to develop new links with other organisations.

**Strength of links:** Overall the Dementia Program has more weak links than strong links. In other words, they are relationships that are arm's length.

**Reciprocity of links:** Most links were considered to be reciprocal by staff.

**Types of links:** The Dementia Program had more professional links than partnerships.

**Location of staff:** The network consists of a constellation of clusters, some staff having more external organisations in their clusters than others. Staff have shared links with only a few organisations. As a result, the network is less interconnected, with staff reliant on their own links. The high number of clusters could be due to the type of work role or program.

**Diversity of sectors:** Staff in the Dementia Program have links with 13 diverse sectors including specialised services such as dementia care, migrant and refugee services, protective services (such as the Country Fire Authority) and educational institutions.

### Sustainability and use of external links

**Exchange of external contacts:** Of the six staff in the Dementia Program who completed the survey, most had introduced a few of their external contacts to their co-workers in the past 12 months.

**Frequency of contacts:** In the Dementia Program<sup>4</sup>, half maintained contact with external organisations frequently, while the remainder made contact sometimes.

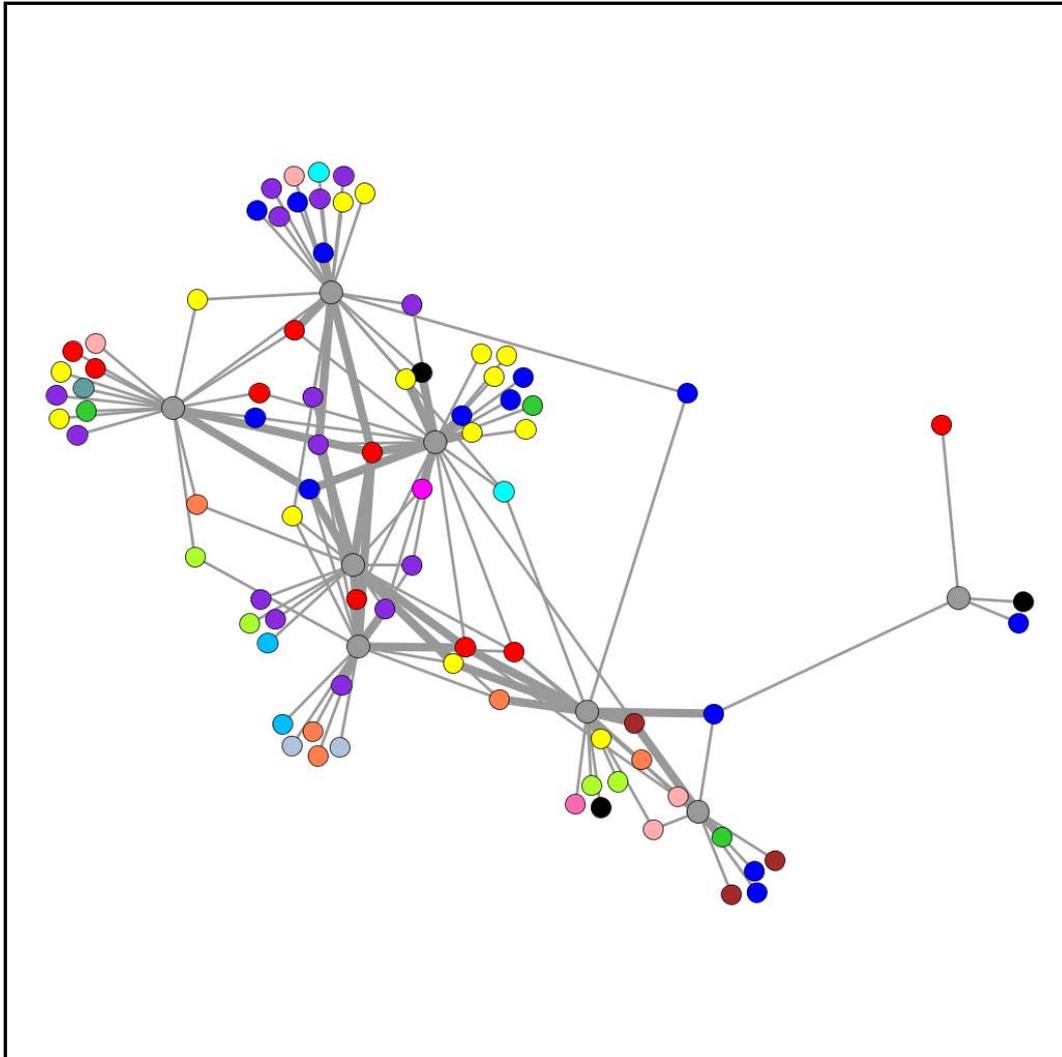
**Use of external links:** While a few staff often used their external organisations to share expertise and ideas (3) and information about 'good practice' service models (2), a couple of staff often worked with external organisations to create referral pathways and achieve short-term, targeted outcomes for their clients. External links were also used often by a couple of staff to develop new links with other organisations. Of the five staff who responded to this question, the same three staff used their external links for all of the above purposes. External contacts were seldom used, however, by most staff to develop and deliver programs in collaboration.

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<sup>4</sup> Of the six Dementia Program staff who filled in the survey, only five answered this question.

### Brotherhood's Disability Program external network map

Figure 4.4 shows a network of the links that staff from the Disability Program have with external organisations.



	Health and mental health care services		Disability sector		Retailers, gardening, home and mobility equipment suppliers
	Aged care services		Community organisations		Social participation and recreational services
	Local councils, government agencies/departments		Aboriginal action groups		Employment services
	Housing services		Transport		Advisory and information services
	Legal and advocacy services		Religious institutions		Dementia care
	Educational Institutes		Service provider networks		Migrant and refugee services

**Network links:** The Disability Program network consists of 134 links among eight staff with 81 organisations.

**Strength of links:** Like those in the Dementia Program, staff in the Disability Program have more weak links than strong links, bringing in opportunities for new ideas and information if contacts and resources are exchanged across the network.

**Reciprocity of links:** Most external links were considered to be reciprocal by staff.

**Types of links:** There were more professional links than partnerships in the Disability Program. A striking difference between the two service regions is that programs in the southern service region had more partnerships than the north-west program.

**Location of staff:** The Disability Program external network does not show a clear pattern. All staff have their own cluster of links and only a few organisations are shared with others.

**Diversity of sectors:** The Disability Program has links with 18 sectors among 14 staff. These diverse sectors include service provider networks (Respite South Services Network), Aboriginal action groups (Mornington Aboriginal Reference Group), legal and advocacy services (Dying with Dignity, Communication Rights Australia) and advisory and information services (such as Peninsula Carer Council). The variety of sectors could reflect the program's deliberate aim to enable clients to develop or maintain links with their local community and engage in community and social activities.

### Sustainability and use of external links

**Exchange of external contacts:** Of the six staff in the Disability Program, two introduced most of their external contacts and the remaining three introduced a few of their external contacts to their co-workers.

**Frequency of contacts:** Most staff said that they sometimes made contact with their external organisations.

**Use of external links:** In the Disability Program<sup>5</sup>, external links were often used by a couple of staff to create referral pathways and to achieve short-term targeted outcomes for their clients. One of these two staff members also used external links often to share information about 'good practice' service models and to develop new links. External links were seldom used by staff to share expertise and ideas or to deliver services in collaboration.

The survey responses from the Disability and Dementia programs show a variation in the use of external links by staff. While some staff found external links beneficial for their clients, others considered these links as an opportunity to increase and share their own human capital such as knowledge and information.

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<sup>5</sup> Of the six staff from the Disability Program who completed the survey, only five answered this question.

## Relationship between frequency and strength of links

The overall findings from the survey and network mapping of the three programs cast some doubts on the relationship between frequency of contact and strength of links. Social capital theory states that frequent contact contributes to stronger links. Despite the occasional contact with external organisation as indicated by survey responses, the network map in Figure 4.2 shows a large number of strong links. These findings may indicate that certain norms and values such as common interests, similar personalities and shared views between individuals may contribute to a link being regarded as strong. Reflecting on the strength of links, Granovetter (1973, p. 1361) describes it as a combination of 'the amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services which characterize the tie'. It remains to be seen how operational measures or weights could be designated to assess the strength of a link.

## Exploring the qualitative characteristics of the Brotherhood's Community Aged and Disability Services' external links

This section presents the findings from the group discussions which complemented the network mapping exercise. In these discussions, staff perceptions of professional links and partnerships and the values and norms that underpin them were explored in more detail. Participants also discussed some of the benefits these links bring to staff and their clients.

### Developing new links

Community Aged and Disability Services staff developed new contacts in many ways:

- through their current work role at the Brotherhood
- communicating with current and former colleagues
- communicating with clients and their families/carers
- participating in networking meetings, expos and conferences
- engaging with peak bodies
- cold calling
- seeking out contacts from service directories/phone lists
- using organisational procedures such as team meetings and referrals.

Although building social capital was not an explicit objective of the Brotherhood's Community Aged and Disability Services, staff explained that team meetings, client assessment and referral processes enabled them to discover and exchange new contacts with colleagues. Some of these organisational processes have thus incidentally become a means of building and transferring social capital.

## Defining types of links

### Partnerships

Community Aged and Disability Services staff described a partnership as ‘someone with whom there is a contract or agreement or a memorandum of understanding’. Staff explained that partnerships involve organisations that work together to ‘benefit the majority’. They explained that formal partnerships have prescribed outcomes for all parties to deliver and involve mutual expectations and benefits.

While the Brotherhood’s Community Aged and Disability Services may have different types of partnerships, in the group discussions the staff focused on service contracts (providing funds to an external agency to deliver direct care services to Brotherhood clients).

Partnerships represent organisational social capital, as the collective benefits from partnerships are accessible to all staff. Although initiated and coordinated by managerial staff, certain types of partnerships continue to operate independent of the individuals who created them. In other words, they exist long after employees who initially developed them leave the organisation (Gabbay & Leenders 2001).

Partnerships can take different forms, such as voluntary associations, alliances and collaborations. They may vary in their level of connectedness (or the degree to which organisations are willing to work together), their purpose and the amount and types of resources organisations are willing to commit to one another (Mandell 2002–03). Different types of partnerships bring different levels of social capital. With respect to partnerships in Community Aged and Disability Services at the Brotherhood, most can be considered as ‘regular coordination’ where ‘two to three organisations through a formal arrangement agree to engage in limited activity to achieve a purpose or purposes’ (Mandell 2002–03).

### Professional links

Professional links, on the other hand, were described by Community Aged and Disability Services staff as relationships that are initiated by individuals and underpinned by similar interests, qualities, etc. Professional links were understood by all staff to refer to people with whom they have a close (usually positive) working relationship. In the words of one staff member, they are ‘people that you can connect with or click with’ and involve informal collaboration. A professional link consists of ‘personal and social aspects’ which were identified as familiarity, trust, rapport and people whom one feels ‘comfortable to talk to’. Professional links are also unique to each individual: ‘it is particular to you, your personality and your relationships and the way you build relationships with every person’.

Professional links indicate social capital built by individual staff, as such links are influenced by staff inclination, networking and social skills. Echoing this, senior managers in the two regions explained that developing professional links requires good

networking skills and being strategic in identifying which links might bring new opportunities. They saw existing links with external organisations as ‘fertile ground’ for developing new links.

### Features of a strong and successful partnership and professional links

#### Partnerships

When describing the features of an effective and successful partnership, staff from Community Care (North-Western and Southern) and Dementia and Disability programs emphasised slightly different elements, perhaps reflecting the differences in their service objectives. For example, having a clear and shared purpose was considered integral to the strength of a partnership by Community Care staff (North-Western and Southern), as they relied on direct care agencies to deliver personal care services for Brotherhood aged care clients. They added that good negotiation skills are essential to navigate rules and regulations to achieve desirable outcomes for clients.

For staff from the Dementia and Disability programs in the southern region (who deliver day and respite support such as onsite social activities, support groups, outings and referrals to other services), determinants of a strong partnership were responsiveness, professionalism, reliability, flexibility and accuracy.

All staff from the southern region said that a successful and effective partnership is grounded in transparency, integrity and trust. Furthermore, the reputation and standing of the partnering organisations in the community were vital. All staff also stressed the importance of partnering organisations having good communication skills.

Staff also pointed out that partnerships can have different levels of trust. For example, trust in government agencies (for the delivery of services) is likely to be formal, as these partnerships are built on binding conditions and contractual guidelines. Such partnerships are purely transactional. Conversely, some partnerships are transformational, as they are underpinned by high levels of ‘voluntary’ trust, and built on good reputation and recognition of similar interests.

One case manager noted that staff perspectives on partnerships were shaped by their work role and position in the program:

It depends on where you are sitting in the organisation: at case management level you are looking at whether they can provide that service and meet client needs.

Case managers said that strong partnerships depended on organisational practices underpinned by knowledge of client needs. For example, a partnership was considered strong and successful if the partnering organisation had a thorough understanding of the needs and circumstances of Brotherhood clients. This included being sensitive to each client’s cultural background and showing empathy as this provided ‘assurance’ that the partnering service would take a relationship-centred approach. For managers and senior

staff, integral features of a strong partnership were quality of service, performance history, reputation and ability to negotiate.

However there was concern that, in the face of competition between provider organisations and the increased marketisation of care, organisations might become more cautious about sharing information and ideas with each other. Staff suggested that previously voluntary informal or verbal partnerships might need to be formalised to preserve their integrity and to avoid the risk of opportunism. As a program coordinator underlined:

There is going to be a changing face of partnerships and it's going to be more strategic. It's getting more closed which is unfortunate ... and probably these partnerships which were informal before may need to become formal.

A senior manager commented that 'in the competitive environment that we find ourselves in, the capacity to build relationships [might] be seen through a much stronger sense of self-interest'. Managers stressed the importance of preserving goodwill among organisations in the face of competition. A senior manager explained that in the new operating environment:

It takes a lot more effort to actually build a rapport and to enable someone to understand what we do when we are talking about dollars and cents, income-tested fees ... some of that stuff, I think we have to work hard not to let that erode some of the relationships that we have built up over time.

In response another senior manager suggested there was a need 'to collaborate with other not-for-profits and people who have that shared vision to work more collaboratively and to address some of the gaps that might occur as a result of the [aged care] reforms'. Some of these gaps resulted from individualised funding (as opposed to the traditional method of block funding) where clients would need to prioritise the types of services they purchase. Clients are more likely to prioritise health care services, leaving them with insufficient funds to pay for social activities or other services.

### Professional links

Professional links (links between individuals rather than organisations) become strong with regular contact, especially face-to-face meetings, as these enhance ongoing trust and confidence. Staff raised several factors by which they assessed the strength of a professional link: ongoing trust, equality, flexibility, reliability, communication skills, responsiveness, consistency and confidence in the person. They pointed out that the sustainability of a link depends on these factors.

Staff agreed that on the whole these relationships, be they partnerships or professional links, were developed and sustained through humour, banter, loyalty, commitment and equality (of treatment towards each other). These partnerships and professional links are not static and the relationships are constantly evolving. Examples were given where

staff developed their own professional links as a result of partnerships, while well-established and strong professional links sometimes led to partnerships.

### Benefits of partnerships

Community Aged and Disability staff explained that established partnerships reduce the time and effort needed to look for new services for clients. They mentioned that longstanding partners understand the Brotherhood and its philosophy of care, which is built on the framework of the Capabilities Approach to enable clients to achieve their own vision of a 'life of value' by supporting their capabilities and strengths. Sharing this philosophy with partnering services is essential for consistent quality in the services delivered to clients by all partners. This also helps to maintain the Brotherhood's reputation in the community and in the sector.

Staff pointed out that when partnerships are prescribed or based on precedents, they in return offer security, redress and accountability in respect to achieving agreed outcomes and expectations in difficult situations. Conversely, staff also advised that the very rules and processes that protect them can make a partnership inflexible, limiting the possibility of developing informal links. This points to the need to strike a balance between the protection offered by rules in partnerships and the flexibility to manoeuvre around them.

### Benefits of professional links

All staff agreed that professional links are built on the mutual expectation that the person in a work relationship can draw on favours and access additional information. As one staff member expressed it, professional links are 'people [who] look after you better' and 'they go that extra mile'. They may be willing to negotiate or forgo some of the bureaucratic processes to find solutions for clients.

Staff also valued professional links as they facilitated their work: '[having links] is essential to our role because we are relying on other people to provide care'. It also strengthened their knowledge base and skills, which could be passed on to other staff and clients. Having professional links enabled staff to expand the choice of affordable services for clients, thereby improving their quality of life and supporting them to continue living in their homes and in the community.

Staff offered further insight into the benefits that both partnerships and professional links bring to their clients in general.

### Providing joint solutions for clients

Community Care services clients have complex care needs: their combination of health, personal and social care needs requires Ageing and Disability staff to work with other provider organisations and professionals to provide joint solutions. One case manager gave the example of how a longstanding work relationship she maintained with a geriatrician enabled her to prevent one of her clients from moving prematurely into

residential aged care. Another case manager valued the effort made by an occupational therapist in testing multiple wheelchairs to find a suitable one for her client.

These examples also illustrate the importance of case management and show that effective case management requires sufficient resources such as funding and time to build networks of links.

#### Filling service gaps

Overall both partnerships and professional links enable case managers to fill the gaps in standard care services by joining together to coordinate mainstream support services and sometimes specialised services such as culturally specific home care services and recreational activities for Brotherhood clients.

For example, the Banksia Younger Onset Dementia Support Group—a program co-produced by participants and involving social activities, peer support and referral services—was developed after consulting with other dementia services to address a lack of social support services for people living with dementia under the age of 65. In addition, services that are not available within the Brotherhood are offered to clients by working together with external organisations.

In another instance, the Brotherhood's Community Aged and Disability Services worked with several individuals from the local community in Frankston, supporting them to set up the Frankston Peninsula Carers Group to provide accommodation for adults with intellectual disability and for their ageing carers. Eight years later, the group opened a housing and accommodation complex.

Staff from the Get About Program (an outings program) at the Banksia Day and Respite Centre spoke about their relationship with a local restaurant in Sorrento that offered lunch to participants living with dementia.

#### Increasing clients' social capital

Not only do networks have direct value to their members but also this value can extend to those outside the network or 'bystanders' (Helliwell & Putnam 1999). Benefits of links between provider organisations are passed on to their clients, building *their* bridging and bonding social capital. External links between Community Aged and Disability Services and provider organisations increased clients' social capital by improving their access to resources (such as support services, information and opportunities for social interaction) and to formal and informal support networks in their community. For example, the ongoing links between Community Aged and Disability Services and two hardware shops enabled case managers to link some of their clients to volunteering roles, where they could contribute their social and human capital to the community. Engaging clients in activities or volunteering can in turn increase their self-esteem, confidence and dignity. It brings social benefits such as rekindling personal interests and hobbies, and increasing opportunities to socialise and build friendships.

Such links can also build the bonding social capital of clients in the form of formal and informal support networks. Case managers had matched suitable care workers with clients, and some of these care relationships had gradually developed into supportive relationships resulting in an increase in the clients' bonding social capital.

One case manager spoke about a close working relationship with a care agency that enabled her to find a new support worker for a client with a speech impediment who was unhappy with her previous support workers. She said that 'the support worker had been with the client for a year and half now and is working really well'. The client's family believed that having a more suitable support worker had contributed to improving her wellbeing. The case manager said that 'they [support worker and client] sing in the car, her communication is a lot better and her confidence is back'.

Such care relationships were particularly valued by clients living alone or those with limited informal support from family and friends.

## 5 Valuing social capital in a changing care environment

This section discusses the implications of competition and the marketisation of care for the building and maintenance of social capital for community aged care providers in light of the findings.

### Optimising social capital

This research shows the extensive links that the Brotherhood's Community Aged and Disability Services staff have developed and sustained with external organisations in diverse sectors. It highlights some factors that need consideration in terms of how existing social capital can be enhanced.

### Availability vs accessibility

The four network maps show that, while some external organisational links appearing on the maps are shared among staff, there are many others that are specific to individuals. They appear as clusters of links on the network maps and represent the bridging social capital built by individual staff members. These staff can act as 'bridges', bringing in new information and brokering new connections between others. Social capital developed through these clusters of links by individual staff is not accessible if other staff are unaware of these existing links. Although staff share contacts with each other, the process is mostly irregular and incidental. This calls for organisational processes to enable the regular exchange of external contacts between staff.

### Actual vs nominal benefits

The sheer number of links developed by staff does not necessarily indicate a greater amount of social capital. It becomes irrelevant if links are not underpinned by shared norms and values such as reciprocity, trust and mutual understanding of expectations and obligations. Building social capital is a lengthy endeavour requiring an investment in time and effort (Bourdieu 1986). Organisational processes can support the development of social capital by providing staff with opportunities to interact with external organisations. This could include reshaping work routines to facilitate participation in community events, conferences and expos. Other networking activities could include sessions to discuss case management practices, and meetings between case managers and service providers.

While it is important to introduce processes to encourage the building of social capital within an organisation, the exchange of social capital between community aged care provider organisations could become challenging due to policies of marketisation and competition.

This next section examines the implications for community aged care services in the current climate of marketisation.

## Implications for building social capital

Community aged care services rely on their existing networks to deliver services to users. Social capital is embodied in these networks of links; however the potential to protect and expand the existing social capital of community aged care providers is put at risk by the fundamental shift towards marketised service provision and individualised funding. The Productivity Commission report released in 2003 warns of the risks of public policies that 'can either reinforce or undermine social capital, depending on their design' (p. ix).

Fundamental to social capital are the principles of collectivism, interdependence, collaboration and reciprocity, as opposed to market doctrines built on individualism, independence, competition and economies of scale. The contrasting principles of social capital theory and market economics are likely to create a challenge for community aged care providers as they attempt to meet the requirements of individualisation driving Consumer Directed Care while striving to maintain their links that benefit service users.

## Threat to building and exchanging social capital

Human service provision is reliant on relationships (ACOSS 2014); however, marketisation of community aged care services could threaten organisational relationships as it requires providers to compete instead of collaborating. Within this environment, provider organisations would be less likely to refer service users to other organisations for more appropriate services, a practice that is common in the sector (O'Shea & Darcy 2007). Competition 'requires commercial confidentiality between potential competitors' (O'Shea & Darcy 2007, p. 59), which then becomes a barrier to trust, as the fear of opportunism can make providers less willing to share resources (such as new ideas, information, knowledge and skills) with others. Thus, deepening of competition can lead to a loss of collegiality (Butcher & Freyens 2011), and a consequent loss of social capital.

Operating in a competitive environment can also affect the power relations between provider organisations: smaller organisations are likely to be at a disadvantage, with insufficient resources to compete efficiently with larger organisations and particularly with private providers (O'Shea & Darcy 2007).

## Impact of competition on provider relationships

The Productivity Commission report on competition policy (2011, p. xxix) claims that 'competition would be a powerful incentive for providers to improve quality and efficiency, and to offer care solutions that best address the needs of individuals'. The needs of service users in community aged care are often complex due to fluctuating health conditions and changing circumstances. Offering tailored services to fulfil these diverse needs therefore requires effective coordination among providers. This is acknowledged in the same Productivity Commission report (p. xxvi): 'coordination of

aged and health care, and of the providers of that care, becomes increasingly important for older people as the scope and complexity of their needs increase’.

Individualised funding and the abolition of the allocation of home care packages to provider organisations mean that they will need to compete with each other to attract and retain consumers in this new consumer-driven care model. As a result, providers will have less incentive to collaborate with others to find solutions unless they are clear it is to their mutual benefit. Unlike before, when provider organisations received potential clients through referrals from other organisations, they will now need to ‘market’ themselves in terms of price and the flexibility and the types of services they offer, to attract new consumers. In these circumstances, interdependence among provider organisations is likely to diminish.

Such constraints resulting from competition also require a re-think about the impact of government policies that hinder the building and enhancement of social capital within community aged care services. The earlier Productivity Commission report suggested the need to assess policies in consideration of social capital to ensure ‘that government policies, programs and regulations do not unnecessarily and unintentionally erode social capital, and that any beneficial side-effects on social capital are taken into account’ (Productivity Commission 2003, p. 68).

### Impact on broader community work

Community aged care services tend to have a good understanding of the variety of groups that they work with, which enables them to advocate for their clients and participate in policy debates. Under CDC, organisations are more likely to become merely providers of services to individuals, undermining their role in community development and advocacy.

Services such as the Brotherhood’s Dementia and Disability programs go beyond service provision. They support clients to participate in their community by linking them to volunteering opportunities (such as gardening, woodwork), developing peer support groups (such as dementia support groups, support networks for carers) and developing programs with benefits that flow into the wider community (such as awareness raising on dementia by engaging with local schools and libraries). All of these activities enable sharing of social capital between clients and their local community, creating social value that extends beyond the service.

### Building social capital in a marketised system

The central challenge for community aged care services is to explore how social capital built through existing networks of links can be maintained in a marketised system. The market itself is not independent of social relationships and does not simply consist of functions that are performed within an economic system; the market has its own social structure (Granovetter 1985). Coleman states that:

norms, interpersonal trust, social networks, and social organization are important in the functioning not only of the society but also of the economy (Coleman 1988, p. 96).

Therefore, there is a need to 'recognize the importance of concrete personal relations and networks of relations' (p. 97) that occur within a market and how they influence the functioning of the market. The functioning of the market is dependent on relationships between people and organisations. Moreover, relationships do not always naturally 'spring into place' when there is an economic opportunity, as they take time and effort to develop. Relationships between people and organisations have history and continuity and it is costly to simply abandon existing, well-established relationships. As Coleman observes:

social organization and social relations [should be seen] not merely as a structure that springs into place to fulfil an economic function, but as a structure with history and continuity that give it an independent effect on the functioning of economic systems (Coleman 1988, p. 97).

Networks and links are forged among provider organisations for the purpose of achieving the best possible outcomes for clients. Collaboration becomes difficult if provider organisations are competing with each other to attract and retain service users. They may then need to find new and alternative forms of collaboration that are viable and sustainable in the face of competition. Developing such collaborations would require provider organisations to examine their existing types of links and networks, the resources they hold and the organisations with which they wish to share their resources. They may need to harness existing stocks of social capital to forge collaborations with like-minded organisations with similar philosophies of care to work together for the best interest of their clients and carers.

## 6 Conclusion

Community aged care service provision involves networks of links and resources that organisations draw on to provide services for their clients. The complex and changing needs of older adults living in the community require a coordinated service delivery system; and voluntary collaboration among organisations and sectors has become a common practice. Such links build the bridging social capital of the sector.

Network mapping provides a way to visually identify existing links/networks and their qualities that can be applied across other service types (for example youth, employment services). The maps generated in this study show that community aged care providers such as the Brotherhood leverage resources from organisations in diverse sectors. These networks of links represent social capital that enables providers to take collective action by coordinating their resources.

However, the expansion of competition policy into human services has resulted in the introduction of Consumer Directed Care into community aged care services. Its emphasis on marketisation and individualised funding pose a risk to the quality and sustainability of these relationships and may threaten the interdependence in the current service system.

The challenge for community aged care providers is to find ways of adapting to a market environment while continuing to build social capital within the sector. Organisations that are particularly rich in social capital have the capacity to come together to develop new models of collaboration within a competitive environment. The community care services sector already has stocks of social capital which contribute to trust, willingness, cooperation, coordination and a common effort among provider organisations. As Putnam notes, 'working together is easier in a community blessed with a substantial stock of social capital' (Putnam 1993, pp. 35–6). A better understanding of social capital across the community aged care sector may suggest new forms of collaboration that could be developed by provider organisations within a marketised service framework.

Policy reforms such as CDC give little prominence to the value of relationships and networks to care provision. By providing a glimpse of the networks that exist within community aged care providers such as the Brotherhood's Community Aged & Disability Services, this report highlights the significance of building and harnessing social capital within the sector.

This also brings to attention an important point raised by the Productivity Commission report in 2003, which noted that public policies have the opportunity to support the building of social capital in industry sectors and communities. In this regard, policy makers have the opportunity to consider how public policies can be re-shaped to harness social capital to deliver services effectively. Public policies have a significant role in supporting and bring together the webs of established care relationships that generate trust, collegiality, cooperation and collective action. A greater appreciation of

social capital among policy makers can be achieved through more detailed research documenting the types of social capital existing across community aged care services and the collective benefits it brings to care provision. Such research has the potential to inform both policy makers (by considering the relevance of social capital in structuring policy options) and human services undergoing similar policy changes in the near future.

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