Home & Community Health Association

Productivity Commission Inquiry into Social Services draft report

Response from Home and Community Health Association

Introduction

The Home and Community Health Association (HCHA) is the peak body representing organizations that provide home based support and community services, including home based care for elderly, home based support for people with disabilities living independently (including as Individualised funding hosts), as well as rehabilitative and 'Independence support' for people who have experienced an injury, and support for people living with chronic medical conditions. Our members employ around 21,000 home support workers, nurses, allied health staff and coordinators. The workforce supports around 100,000[1] people in their own homes.

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HCHA intends to comment only on specific parts of the report and its appendices.

Comments

1. The Home and Community Health Association acknowledges the broad and deep consultation and thought that has gone into the Commission's report. We also acknowledge the breadth of scope of both the reports and the appendices and supporting papers. The Commission has engaged deeply in the subject. HCHA acknowledges that the Commission has used the voices of many submitters in its report.

2. The report includes some important statements on social services for Maori, particularly around enabling greater rangatiratanga under the application of Article 2 and equal citizenship rights under Article 3 of the Treaty of Waitangi. However we query how well the elements of Maori service delivery described in Chapter 13 sit with other recommendations in the report such as encouraging more competitive commissioning and focusing services towards individual need.

3. Appendix D on services for people with disabilities is a very good summary of the initial response of the government to its responsibilities under the United Nations Declaration on the Rights of Disabled People.

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[1] through DHB (Health of Older people funding over 65 and under 65 chronic conditions), Ministry of Health Disability Support (under 65 living with disabilities), and ACC (injury related)

4. The HCHA supports in general the Commission's findings in **Chapter 4.** In relation to insights into the impact and worth of programmes, the HCHA comments that the problem in our sector is not a lack of information coming from providers to funders, it is a lack of analysis of available data.

5. The HCHA supports in general the Commission's findings and recommendations in **Chapter 6.** HCHA in particular fully supports Recommendation R6.9 and R6.10 in relation to full funding.

    R6.9 Full funding is appropriate when governments are paying non-government organisations to deliver the government's goals or commitment, and want full control over the service specification.
    R6.10. "Fully funded" social service payments to non-government providers should be set at a level that allows an efficient provider to make a sustainable return on resources deployed. This funding level will support current providers to invest in training, systems and tools. It will also encourage entry by new providers.

   The HCHA refers the Productivity Commission to a very recent report undertaken by Deloitte [2](commissioned by HCHA) which looked at the cumulative impact of funding not keeping pace with the significant regulated price increase (minimum wage), and how it is directly affecting provider sustainability.

   The HCHA does not agree with the Commission's finding (R6.14) that provider subcontracting is an efficient way of improving the quality of relationships overall. Our members operating under subcontracting arrangements have reported that it reduces responsiveness as a result of a loss of connection between the funder and the point of service delivery. They also report a loss of incentive to be innovative in a subcontracting environment, where the lead contractor takes an element of the contract fee reducing the margin in the contract and where it is the lead contractor's brand that is foregrounded. Several of our members have given up being subcontractors because of unsatisfactory subcontracting relationship. Others have expressed concerns about being connected to organisations whose values may not match with theirs. We acknowledge that some smaller subcontractors have appreciated the ability to gain access to policies and procedures through connections with lead contractors and with other subcontractors.

6. HCHA agrees with the Commission's finding in **Chapter 7** that the social services system appears to be too focused on central government as a source of new ideas. We promote either co-production, or the use of innovation or incentive funding to test new ideas.

7. HCHA is not convinced by the need for a further structure such as an Office for Social Services.

[2] http://www.hcha.org.nz/assets/FINAL-Financial-Review-Risk-Analysis-Report-Final-13-April.pdf

8. Chapter 11: Client choice and Empowerment

In relation to Recommendation R11.1

> R11.1 When commissioning services, the Government should look to empower clients where such empowerment would not be detrimental to the client or the broader interests of society. Disability support services, home-based care for older people, respite services, family services, and drug and rehabilitation services are good prospects.

HCHA wishes to make the following comments:

a) The HCHA supports client focused supports that enable more client choice and flexibility. Clearly contracts need to manage the tension between flexibility, eligibility and allocation.

b) HCHA supports client directed funding options in particular situations (such as a family wanting to mix funded supports with existing and present natural supports in order, for example to allow a relative to be given palliative care at home). We do foresee tension between flexibility and eligibility; it is important to ensure that this type of allocation is fair relative to that provided to other citizens.

c) We think that the assumption that a broader move towards full consumer empowerment in home support for all older people would be a good prospect, ignores or understates some important big and small picture factors:

   i. Enabling client choice creates tension between efficiency and cost, service models and workforce conditions (and therefore supply). The Commission very clearly explains that the elements of choice are who provides the service, what services are provided, when a service is delivered, where service is delivered and how a service is delivered.

   ii. Individualised funding for disabled clients enables broad elements of choice. In relation to services for disabled people who are not under an IF arrangement, for those receiving support as a result of injury, for those under 65 receiving support under personal health budgets and for older people, the 'where' element is entirely client directed at present.

   iii. In some home support contracts there is the ability to flex the 'what' and there is considerable potential for further client empowerment in this aspect of care, through allowing flexibility of support responses and through further engagement of clients in the development of their support plans and goal setting.

   iv. Other choice areas raise different and for time greater challenges in the context of current service volume, the cost-efficiency of the service, models of care,

workforce availability and concurrent moves towards regularization, and these are explained in the following paragaraphs.

v. Clients currently have some choice around who provides the support to them. They are able to ask for a change of worker or a change of provider. In some areas and under some contracts family members can be employed by the organization to provide support.

vi. A wholesale movement to choice of ‘who’ and also to ‘when’ would pose a significant challenge to the volume of service delivery, and to the current drive by the government and providers to ‘regularise’ the workforce. The aim of that process is to improve recruitment and retention through providing more security of hours, and to improve the productivity of the workforce as a whole. Regularisation will necessarily create teams of support workers who will respond to the needs of groups of clients with specific needs (dementia, injury, disability, chronic conditions), and that is the case in those areas where regularisation is already underway. Choice around ‘when’ is also a challenge in relation to client volume. Most clients want support in the morning and in the evening, but the number of clients being supported each day (72,000 clients per year, 10 million hours per year in health of older people services alone) require rostering that cannot always be as flexible as may be sought.

vii. A wholesale movement to choice of ‘how’ could undermine current, very successful models such as rehabilitative and restorative care. An example is where intensive periods of support are provided by trained workers, to improve recovery following an injury or medical event and to promote recovery of functions. Providers are incentivised to maximise the quality of this support, which then leads to a reduction in the level of ongoing support. It takes specific training and a cultural shift to move from doing for to encouraging people to regain their independence by doing for themselves as much as possible. The model is also most successful where there is a close alignment between community support, allied health, community nursing and needs assessment. It is difficult to envisage how this could occur in consumer empowered models.

viii. Two important features of the uptake of individualised funding is that it has tended to be taken up by those holding larger packages of funding over a longer period of time (many years), and by those can manage the complexity of the process and to take on the role of employer and fund manager or who have a strong advocate (eg parent) to do this for them. The majority of older people getting home support receive quite low hours of support per week. Many are alone, supported at a distance by a relative or at home by a frail partner. People do not tend to receive support for longer than a few years and during this time for many their health and sometimes capacity is in declining. Our point is that the client group is quite different to those receiving disability support services.

ix. Each of the elements 'when', 'what', 'where', 'how' and 'who' can be achieved under any model, but volume, cost, workforce availability, and demographics are such significant factors that we would advise much deeper consideration is needed.

d) A review is currently underway by a reference group appointed by the Director-General of Health, into regularisation of the home support workforce, and a general review of the broader home and community support service (health of older people, disability, injury, future demand, service models). In addition the Health of Older Person's Strategy and the Health Strategy are being reviewed. These are expected to result in significant pieces of policy and planning. Any recommendations by the Productivity Commission should recognise this context.

e) We query the choice of the 'prospects' that the Commission has chosen to highlight. What is the problem definition for those services? We challenge the Commission to consider recommending greater consumer empowerment in major service areas that, for example, currently attract the highest numbers and most serious types of consumer complaints to the Health and Disability Commissioner (specialist medical services, general practice, hospital services, and aged residential care).

9. HCHA agrees with the Commission's findings in **Chapter 12.** In relation to Recommendation 12.2 we submit that when assessing bids a panel ought to be able to also consider the broader connections that an agency has within the community/ies it serves, and the range of services it provides, including volunteer services and services relating to other areas of government expenditure.

10. **Commissioning Appendix E. Home Based support for older people**. This is a good broad summary of home based care, however we think that several key points are missing or understated:

    a. The delivery of home based support for older people is integrally linked to the delivery of home based support for clients living with and recovering from injuries and to the larger portion of people living with disabilities and also medical conditions. Clearly there are many advantages of using the same workforce and infrastructure to provide broadly similar services across funding streams.

    b. The nature of the service (providing services to people in their homes on an hourly and sometimes daily basis) results in a high number of transactions, requiring multiple administrative inputs. There are opportunities for further efficiency through the use of technology, but the service will always retain a transactional character. That is not necessarily a problem to be solved.

c. The 2011 report by the Office of the Auditor General, and also the report by the 2012 Human Rights Commission (Caring Counts) reported high levels of consumer appreciation for the support received and the quality of that support. There are also low numbers of complaints against the service to the Human Rights Commission, and certainly no indication of systemic quality issues. The success story of this service needs to be told. Despite it being the lowest funded human based health service apart from funded family care (and acknowledging that this has created very serious funding pressures) nevertheless the services continue to support around 100,000 New Zealanders each year. The annual amount expended by government on supporting 72,000 older people at home is less than one third of the government's expenditure on aged residential care. The service is very transactional, but the organisations that operate in the sector are skilled at that and we would challenge any government agency to match the level of efficiency in terms of direct service to overheads relativity that we have. The service also very successful in halting the increase of reliance on aged care beds. There is great potential for this service to also be useful in reducing ED admissions and helping people manage chronic conditions. Our staff, whilst very concerned about wages and conditions, love the work they do. We think that home support for older people is an amazing success story.