To the Productivity Commission

MINISTRY OF HEALTH
NGO HEALTH + DISABILITY
NETWORK

Submission on *More Effective Social Services* Issues Paper

The NGO Health & Disability Network is a membership body of 482 non-profit health and disability providers that receive Vote Health funding from the Ministry of Health and/or DHBs.

Members deliver government-contracted services throughout New Zealand in the following areas:

- Disability support services
- Māori health
- Mental health and addictions
- Pacific health
- Personal health
- Public health

Our 482 NGO Network members receive $1.3 billion in government funding and pay more than $1.1b in salary and wages to 18,883 part-time and 16,109 full-time employees, who work a total of 3.4 million hours in an average week[1].

These non-government organisations (NGOs) are extremely diverse in size and structure. Many are small-medium sized employers, while a few are larger:

- 50 employ between 100 and 499 staff each
- 5 employ between 500 and 999 staff each
- 6 employ between 1,000 and 4,200 staff each.

The Network's 13-member NGO Council (elected by members to represent their views) believes significant gains in productivity and effectiveness can be made through changes to the way the government commissions and purchases services from non-profit providers.

Our responses to some of the Commission's questions are below.

1. -

2. How important are volunteers to the provision of social services?

Statistics NZ's *Non-Profit Institutions Satellite Account* reported that more than one million volunteers gave more than 270 million hours of unpaid labour to non-profit institutions in 2004.

In an average week, a total of 146,309 hours are provided by 31,307 unpaid volunteers in the 482 NGOs that are members of the NGO Health & Disability Network.

Only 10% of the 97,000 non-profit organisations in New Zealand employ staff, meaning the other 90% are solely dependent on volunteers.

Some policy-makers and politicians bemoan the number of NGOs and try to orchestrate mergers through funding mechanisms, instead of viewing the number as a sign of healthy civic participation and social capital.

[1] Data sourced from Charities Register – downloaded 13 May 2014.

NGOs are the vehicle through which citizens can contribute to their communities and express engagement. There is strength in various sizes of organisations as they can respond to different needs and don't impose a 'one-size-fits-all' approach. There is economic sense in mobilising an unpaid workforce through NGO volunteers, but this enthusiasm will be lost if communities feel a loss of ownership of the community organisations they helped set up.

3. **What role do iwi play in the funding and provision of social services and what further role could they play?**

   Iwi organisations have stakeholders that will never change. As such, they take a long term view of everything to ensure the future for their people. Many iwi endeavour to devolve services and decision-making out to communities through hapu and whānau. This takes time, however the impact and long-term outcomes tend to be much more sustainable when communities are self-determining.

4. **-**

5. **What are the opportunities for, or barriers to, social services partnerships between private business, not-for-profit social service providers and government?**

   Barriers and opportunities are illustrated in fifteen 2011 case studies of non-profit NGOs' relationships with other health providers and their collaborative approaches to primary health care delivery. These are available online at: http://ngo.health.govt.nz/what-we-do/priorities-and-issues/primary-healthcare.

   They cover acute nursing services, health information services, virtual practices, youth one-stop-shops, mental health networks, community development approaches, cardiac rehab, Whānau Ora and Asiasiga models of care, and more – from North to South.

   Case study 5 on people with disabilities and case study 7 on a whanau ora approach may be particularly relevant to your own case study topics.

   Our 2012 older people's health and housing summary may also provide some additional contacts or reports to inform your case study on home-based care for older people: http://ngo.health.govt.nz/what-we-do/priorities-and-issues/older-peoples-health-and-housing

6. **What scope is there for increased private investment to fund social services? What approaches would encourage more private investment?**

   The market-driven procurement and competitive tendering models may be suitable for purchasing cars or equipment, but not for people-focused services affected by multiple social determinants. Complementary services need to work together and share information, but this is not supported by current funding models.

7. **What capabilities and services are Māori providers better able to provide?**

   Māori providers that are kaupapa-based have strong connections to manawhenua (tangata whenua with mana over a specified area or region). Because of this, their services will generally reflect the local needs of the community and will address issues not defined by funding mechanisms.

8. Why are private for-profit providers significantly involved in providing some types of social services and not others?

Economies of scale are a significant factor that attracts for-profit providers in some areas of social service provision. For example: aged residential care attracts significant capital investment in property and land, where contracted providers deliver service on a high volume/low turnover basis. Their per head costs will also be lower when operating on such a large scale and they aim to capture their clients (supported housing to residential care to nursing level care). Similarly, home based support is another area where high volume and low Return-on-Revenue attracts for-profit providers. These for-profit providers are significantly involved in large urban areas, however, you will find that smaller, non-profit providers will operate in the more rural or specialist areas where it is not so attractive for the for-profits to deliver.

Non-profit providers struggle in many cases because rates paid by government for NGO health services are usually lower than those paid for the same services in DHBs. This was highlighted in the recent aged care sector's pay parity campaign *Who Cares?* and by mental health and addiction NGOs' *Fair Funding* campaign. Equity of payment and access should be the norm.

9. How successful have recent government initiatives been in improving commissioning and purchasing of social services? What have been the drivers of success, or the barriers to success, of these initiatives?

Government rarely involves clients, communities and non-profit providers in commissioning discussions, i.e. the process to identify what outcomes are desired and how these might be achieved. It usually decides it wants to buy 'x' service and tenders for it – leaving little scope for innovation or new ways of achieving outcomes.

As for purchasing, the funding discrepancies between DHBs and the inconsistency in purchasing models compromise NGOs' ability to deliver nationally consistent services and provide equity of access – leading to a 'postcode lottery' for people using the health system.

The complex procurement process of different funding models used by multiple government funders requires a significant volume of administration for NGOs – especially those that provide services across multiple regions, or across multiple funders such as health and welfare. Some services are purchased per bed day, while others are fee-for-service or partially bulk funded. This is inefficient for both the NGOs and the government. Currently a single individual receiving home-based support or residential care services can be funded by ACC, the Ministry of Health and a DHB, all of whom have their own reporting and compliance expectations. A joined up, person-driven approach to funding is urgently needed to meet the diversity of needs.

Rates paid to health and disability NGOs across the country vary widely too,[2] despite the fact that NGOs are required to operate to the same *National Services Framework (NSF)* and *National Health and Disability Services Standards (NHDS).* It is only reasonable to also have a nationally agreed pricing structure in place.

[2] The *Fair Funding* campaign identified prices for the same NGO service varying by $33,389 per FTE across different DHB regions: www.fairfunding.org.nz/fairfunding

Despite the Government giving DHBs annual inflation-related *Contribution to Cost Pressure* (CCP) funding adjustments, these are not routinely passed on to NGOs. Furthermore, NGO services are regularly required to re-tender for contracts, but DHB services are not.

Meanwhile, the government has begun a 'streamlined contracting' initiative administered through the Ministry of Business Innovation & Employment (MBIE). The principles and intentions behind this initiative appear, on the face of it, to be positive and commendable – for example: Results-based Accountability (RBA) contracting for outcomes, a uniform contract for providers/NGOs across government departments, and co-ordinated or reduced auditing requirements.

It is still early days and there has not been much progress to date. There is potential in these initiatives provided that:

- the differences and challenges of defining outcomes in the health and social services sector (compared to say engineering or manufacturing) are recognised
- commitment and attention is given to successfully ensuring real culture and behavioural change and commitment by government departments, for example to adopt an outcomes-based contracting approach, and to co-ordinate audit activity with other government departments
- a 'one-size-fits-all' approach is not imposed on all providers, where this is clearly not beneficial to the service or the outcomes to be achieved.
- the 20 DHBS, which are major funders of many NGOs, are key participants in these new stream-lined contracts – as long as they continue to operate separately, a streamlined contract will have little impact on the compliance burden faced by an NGO with multiple DHB contracts.

10. Are there other innovations in commissioning and contracting in New Zealand that the Commission should explore? What lessons could the Commission draw from these innovations?

The aftermath of the Canterbury earthquakes saw increased trust and an open disclosure approach taken by the DHB, where providers felt comfortable discussing problems as they arose and learning from errors. This experience needs to be shared nationally, as it shouldn't require a major disaster to elicit collaboration.

The Ministry of Health and other lead government agencies could do more to enable a collective impact model using evidence-based ways of making major change. It is inherently difficult for government departments to engage well and harness the power of communities to collectively address health and social problems, but this should not stop them trying. NGO providers are well placed to lead change using such community-based initiatives and should be given more scope to do so – their advocacy role in leading community change should be welcomed by government.

Alliance contracting that trusts providers to understand each other's strengths and weaknesses is a good approach, but there are others too.

We need to take a multi-sectoral, collective, integrated planning approach and work across government, while listening to those, such as community-based non-profit providers, who work with this country's most vulnerable and high-needs populations and are attuned to their communities. Government agencies must recognises they are only part of the system – many are still too siloed and are resistant to input to big picture thinking. Providers,

including non-profit NGOs, would welcome a co-ordinated approach across departments in seeking solutions to health and social issues.

Despite documents like *Kia Tutahi* and Statements of Intent (SOIs) that talk of being responsive to communities, current community engagement is not systemic – it is driven by a few insightful (sometimes courageous) public servants. Sadly when they move on, dialogue often ends. Community-led, co-design models should be more prevalent.

Whānau Ora, the social sector trials and Healthy Families are moves in the right direction, but so much more could be done to move services to primary care and community settings with adequate resourcing.

11. -

12. What are the barriers to learning from international experience in social services commissioning? What are the barriers and risks in applying the lessons in New Zealand?

There is a need to recognise the differences in scale and diversity in New Zealand, for example, and to adapt overseas experience to our environment. Failure to do so, and to simply transplant successful models from overseas often does not work. 'Kiwi culture' and our Māori population as founding inhabitants of our country are other factors to consider.

For example in disability support, the Ministry of Health imported an Australian model of 'Local Area Coordination' some four year ago and attempted to introduce it in New Zealand. Although the model certainly had some merits, it has not been particularly successful because:

- the commitment was made to bring the model as it had been used in Western Australia with no customisation to New Zealand
- the model was 'bolted on' to existing structures without proper planning or systemic re-design of the current system for accessing disability supports in New Zealand.

These two factors are indicative of risks in applying international experience to New Zealand.

13. Where and when have attempts to integrate services been successful or unsuccessful? Why?

Enabling Good Lives is still a work in progress and it is too early for it to be viewed as a success for integrated services. Anecdotally, we hear the funding across Education, MSD and the Ministry of Health is still highly siloed and it has only been demonstrated for a few clients who are school leavers.

14. What needs to happen for further attempts at service integration to be credible with providers?

Often key providers and service purchasers are simply not aware of the other services and supports in the community that could potentially be part of an integrated service. In health, GPs and hospital clinicians need better access to information on the range of community services available so they can make appropriate referrals and broaden the team involved in working with people.

A range of online databases and directories list NGOs and other health and social service providers. Each online source has a different level of information, while some are quite similar. Some make it easy to access information on multiple NGOs at once, while others are more suited to individual searches. Their coverage of geographical areas and provider types varies, as does their ability to connect with existing IT systems – making it difficult for services/providers/clients to update and access information on a regular basis. Streamlining how this information is collected, updated, accessed and shared would provide significant productivity gains and better connect service providers to deliver integrated services for clients.

The different directories include:

- Healthpoint
- Healthpages
- Webhealth
- Right Service Right Time
- Family Services Directory
- Contract Mapping
- Citizen's Advice Bureau Community Directory
- Charities Register

15. Which social services are best suited to client-directed budgets? What would be the benefit of client-directed budgets over existing models of service delivery? What steps would move the service in this direction?

Client-directed budgets are particularly suited to social services where the 'services' are significantly impacting a person/family's life over a medium or long term. Client-directed budgets in such situations have benefits for the client of:

- increased choice and control over services, which have personal and invasive impact on their lives
- increased flexibility in how such services are arranged and delivered to suit the particular need of the client and their family
- ability to make trade-offs and make choices within the allocated budget of what is particularly important for them.

There is also a benefit to the funder in an environment where there are constraints on the quantum of budget packages allocated to clients – the ability of the client to prioritise and make trade-offs within their allocated budget will sometimes enable scarce resource to go further.

Client-directed budgets or 'individualised funding' should not however, be seen as an overarching solution that is applicable to all clients and families. It works best and will only really work for individuals and families who are willing and competent to put the time and effort into making arrangements independently to 'purchase' the services they require. Individualised funding, while having many advantages, transfers significant responsibilities from the funder to the individual; e.g. getting value for money, assuring quality of service, etc.

There should be a continuum of options available to people – for example:

- Direct funding – funding goes into the bank account of the individual for them to spend on broadly agreed services and objectives – with no further support required – likely to be suitable for large numbers of people accessing low packages of support e.g. < $5K pa, and for limited numbers of people on higher packages.
- Individualised funding – funding goes through an intermediary agency but is directed by the person – agency assists with e.g. recruiting staff and payroll and compliance matters etc. Differing levels of input and support required and sought by different clients – likely to be suitable for modest numbers of people on packages of all sizes who wish to be significantly involved in the way they access their services.
- Funding providers for a specified budget – a client takes their budget allocation to a service provider who designs and provides a bespoke service within the budget – likely to be suitable for a modest number of people who wish to engage directly with a provider to design a service relevant to their needs.
- Traditional access to services funded under contract to the government funder where referral is made to one or many providers for a range of services to meet the client's needs within their budget package. Likely to be suitable for a sizeable number of people and families who simply want appropriate support and services, with minimal involvement on their part.

Person-directed budgets are not silver bullets, however, and are not for everyone.

16. Which social services do not lend themselves to client-directed budgets? What risks do client-directed budgets create? How could these risks be managed?

The drawbacks in rearranging the disability support system (or other aspects of social services) by adopting self-directed or individualised funding across the board include:

- The provision of such support services is not a pure market such that price and quality will be reliably determined by the way that individuals with budgets purchase services.
- There are significant variances in the capacity, capability, knowledge and willingness of people and families to engage in the process of managing self-directed budgets.
- 'Employment' relationships may shift, creating greater uncertainty for workers and unwanted new responsibilities for unsuspecting clients.

It must also be recognised that identifying clients for individualised funding options is not easy – you cannot say people who need this service, or have this issue/need are ideal for client-directed budgets. Two people with the same health issue may have vastly different ability/desire to manage self-directed funding. One may have better family supports, have fewer other demands on their time and energy and be in a 'better space' mentally at any one time. A person who has just experienced a bereavement, relationship break-up, injury etc may not want the added stress of self-directed funding now, but in 6 or 12 months they may feel differently. Meanwhile another individual, who is self-directing their funding may experience a 'life bump' that means they want to hand this responsibility to someone else, such as a provider, for a period of time. Managing such an individualised, transitional funding process for multiple people will be challenging.

17. What examples are there of contract specifications that make culturally appropriate delivery easy or more difficult?

Contracts that co-design outcomes rather than specified outputs allow for a much more culturally specific response to human need. Narrowly defined outputs produce a silo that capture human experience inhumanely as data and diminishes their status as citizens. A broad focus on outcomes, value-added and strong communities requires contracts that reflect these complexities.

18. How could the views of clients and their families be better included in the design and delivery of social services?

Meaningful involvement in the process AND decision-making would be a vast improvement on the current 'tokenism' often evident in government's superficial processes where views are sought and often ignored.

19. -

20. -

21. How can the benefits of flexible service delivery be achieved without undermining government accountability?

Government could learn from the funding approaches of the more innovative funders in the philanthropic sector, who are often more flexible in their approach and have worked hard to reduce the compliance burden on fund recipients, while also ensuring appropriate levels of accountability and reporting. Philanthropy NZ could suggest some key people to talk to.

22. What is the experience of providers and purchasing agencies with high-trust contracts? Under what circumstances are more relational contracts most likely to be successful or unsuccessful? Why?

There are times when it is appropriate for purchasing agencies to trial new approaches to purchasing and service delivery. In such situations, contracts need to be much more relational and based on trust to jointly work towards broad objectives and outcomes. Specific outcomes which may or may not be achievable would be counter-productive in such situations.

Clearly, long-term providers that have consistently delivered high quality services and outcomes are prime candidates for high trust contracts.

23. -

24. Are there examples of where government agencies are too dependent on particular providers? Are there examples of providers being too dependent on government funding? Does this dependency cause problems? What measures could reduce dependency?

The pros and cons of contestable tendering are a factor here, especially for new services and new areas of business. Contestability has, over time, created competition between providers at the expense of higher levels of co-operation and collaboration – some approaches by funders to reduce the number of providers they fund, has led to a reduction in provider numbers in some instances. A loss of a single contract can make

some providers unviable and, over time, this can lead to just one provider in an area. Then, even if service quality is not of a high standard, government can be 'stuck' with funding that provider because no-one else is left to provide the service.

However, there are also areas in health and disability where whole sections of service provision and some providers have not been opened up to change in the last 20 years - the advent of Health Funding Authorities and the market approach. While there are benefits of continuity and stability, these are also possible negatives for government agencies that are then dependent on such providers, particularly if those providers rely almost exclusively on government funding and the government relies on those essential services. This can mean there are huge conservative forces for the status quo at play.

25. What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?

The current IT environment is extremely fragmented and there is no clear picture of what the future 'end game' is. Most current databases do not 'talk to'/allow exchange of data with others in the broader sector. Providers in the health and social services sector are second guessing which way the environment is going to move, which platform/ database is going to be relevant in the future.

The biggest contribution the government can make is to design a structure of information technology with a network of inter-related databases so providers can align with a particular platform with reasonable certainty that the investment they make in an IT environment will be relevant to future needs.

26. What factors should determine whether the government provides a service directly or uses non-government providers? What existing services might be better provided by adopting a different approach?

It is not clear how government currently determines this, however it should be based on the strengths of the potential providers.

The following non-profit sector strengths were identified in our NGO Network 2011 primary health report *(How NGOs make a difference to health care in the community)* and earlier 2008 discussion paper.

The non-profit health and disability NGO sector:

- is experienced in working in communities
- is client-centred and offers clients choice
- can be innovative and creative
- provides a range of services
- is more likely to support clients across the continuum of well-being, rather than take an episodic approach
- is experienced in collaboration
- employs holistic approaches
- works across the health sector and inter-sectorally
- provides value for money
- facilitates access to primary care and entitlements
- is experienced in management of populations with chronic conditions
- traverses communities locally, nationally and regionally.

27. -

28. What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?

Uncertainty in the tenure and viability of short-term contracted services creates anxiety for health consumers in the wider community and is a particular issue for the most vulnerable populations.

29. -

30. -

31. -

32. What additional information could tender processes use that would improve the quality of government purchasing decisions?

All government purchasing processes would be vastly improved if government agencies adhered to the three core funding guidance documents that already exist:

- *Principles to underpin management by public entities of funding to non-government organisations*, Office of the Auditor General (2006)
- *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown*, Treasury (updated 2009)
- *Code of Funding Practice*
  The seven core codes are respect, cultural context, transparency, open communication, flexibility and innovation, integrity and accountability. They are supported by 22 key standards and a range of success indicators that can be used in funding arrangements. Examples of good practice also exist.
  Department of Internal Affairs – Community & Voluntary Sector (2010).

33. What changes to commissioning and contracting could encourage improved services and outcomes where contestability is not currently delivering such improvements?

Alliance contracting that trusts providers to understand each other's strengths and weaknesses and decide how to allocate funds based on a consensus about the most suitable provider can be an effective approach in a region or field where providers have good knowledge about each other.

34. For what services is it most important to provide a relatively seamless transition for clients between providers?

Vulnerable clients, such as those with high/complex needs due to disability or mental health issues need seamless transitions.

35. -

36. -

37. How well do government agencies take account of the decision-making processes of different cultures when working with providers?

Government agencies have to be repeatedly reminded of the need for longer consultation periods to allow for meaningful input from community and voluntary

organisations, which often have branch systems to filter information to or boards that only meet on a monthly basis.

Similarly longer timeframes are needed for Māori and Pacific communities, where hui and coming together for discussion are important for meaningful processes.

38. Do government agencies engage with the appropriate people when they are commissioning a service?

Sometimes, but health is usually too focused on the DHB clinicians and GPs and does not broaden their scope to the wider sector, allied health services or consumers in a meaningful way. Examples of some genuine attempts include the Health Quality & Safety Commission's consumer engagement activity.

39. Are commissioning agencies making the best choices between working with providers specialising in services to particular groups, or specifying cultural competence as a general contractual requirement?

Commissioning agencies are simply the first step in recognising that government are not the most efficient purchaser of services. The second step will be moving to more regionally specific commissioning agencies focused on co-producing outcomes with their communities. A failure to move to the second step will result in the 'iron law of oligarchies', which is concerned only with their own survival. Commissions can be resource hungry institutions with a tendency to become both purchaser and providers. For an example of this see PHOs and DHBs.

40. -

41. Which types of services have outcomes that are practical to observe and can be reliably attributed to the service?

Services to address a single issue or health need are easier to measure and attribute to a provider/service. Complex issues that have multiple causes and where individuals are working with multiple agencies are difficult to attribute.

42. -

43. -

44. Do government agencies and service providers collect the data required to make informed judgements about the effectiveness of programmes? How could data collection and analysis be improved?

Much of the data collected is transactional and does not inform practice or outcomes in a meaningful way. Support for small/medium NGOs with reporting templates and IT systems that were aligned to reporting to multiple funders would be of assistance, but these also need to fit with the clinical reporting systems providers use for their client outcome tracking, to avoid time-consuming 'repackaging' of data.

45. What have been the benefits of government initiatives to streamline purchasing processes across agencies? Where could government make further improvements?

Government's recent streamlined contracting initiative and commitment to reduce the audit burden are welcome moves, but so far they have only impacted on a very small

number of providers. As long as ACC and DHBs are not part of the streamlined approach, the burden of compliance will not reduce significantly for non-profit health providers.

See also comments about streamlined funding at question 9 above.

46. Is there sufficient learning within the social services system? Is the information gathered reliable and correctly interpreted? Are the resulting changes timely and appropriate?

Much of the information collected through contractual reporting seems to be ignored or filed away, never to be used in any meaningful way. A system that encouraged learning, the sharing of successful approaches and interpretation of trends would be a great boost for providers and the families they work with.

47. Does the commissioning and purchasing system encourage bottom-up experimentation? Does the system reinforce successful approaches and encourage reform of less successful ones?

The risk-averse nature of most government contract managers makes bottom-up experimentation and innovation virtually impossible.

48. Would an investment approach to social services spending lead to a better allocation of resources and better social outcomes? What are the current data gaps in taking such an approach? How might these be addressed?

A prevention/public health approach (prevent, promote, protect) is less costly than treatment[3] and non-profit NGOs can be the answer to this.

There is a desperate need for cross-party approaches to issues like child poverty, which have a huge impact on demand for health services. These are not quick-fix problems that can be solved in one, two or even three political terms – they need consistent support and long term strategies over decades to ensure an enduring focus on public health issues.

An investment in child health pays off as it results in better health outcomes in adulthood – while the short-term costs may be higher, the long term savings are significant. Treat health as an investment, not a cost.

49. How can data be more effectively used in the development of social service programmes? What types of services would benefit most?

Some non-profit providers working together in communities with families with complex needs are collecting and sharing information with each other (with permission from clients), to eliminate the need for clients to tell their stories over and over again. This saves time for providers and also helps clients access services more quickly and retain a greater level of dignity.

More sharing of data collected through government surveys and contract reporting would be useful to providers and communities and build a better picture of need and outcomes achieved.

[3] Morgan and Simmonds, *Health Cheque 2009* cite US evidence of a 4:1 return (in terms of quality adjusted life years gained) from investing in prevention and primary healthcare, as compared to hospital treatment.

Your issues paper commented on the lack of data available, but often government has the data and cannot access it, or could make simple adjustments to its collection process to build its knowledge. For example, currently most government funders cannot identify the extent to which they contract with/services are provided by non-profit NGO, as opposed to for-profit/commercial entities. The majority of non-profit NGOs that government funds to provide services are registered charities, so it seems sensible for a government agency to collect and record a charity's registration number when setting up a contract. This would then allow them to search that field and collate funding and other data based on all providers with a CC number – alternatively they could record their profit/non-profit status in a field. Statistics NZ brought this issue to the attention of various government agencies in 2004 when it was compiling the Non-profit Institutions Satellite Account, however little progress seems to have been made on addressing such a simple data collection issue.

Government could also make better use of the data it already collects about providers. Information on employee numbers is an area where some collection occurs, but government struggles to access it, even when it has a compelling reason to do so. (Calculating the number of workers affected by the impact of possible change, such as that highlighted in the recent aged care sector pay equity case, for example.) In some instances government funds on a FTE basis or requires providers to report on their different types of employees to ensure capacity to deliver, but this information often seems inaccessible.

The Charities Register holds significant detail on providers, which is often not accessed by other government agencies that ask providers to provide the same information over and over again (e.g. DIA Charities requires charities to report on full-time and part-time employee numbers and estimated work hours), but this data seems rarely used and its accuracy questioned by some – if data is unreliable and un-used, why collect it?

50. What are the benefits, costs and risks associated with using data to inform the development of social service programmes? How could the risks be managed?

Complex social issues are difficult to capture effectively in data as so many factors impact on the people and the outcomes achieved. The growing diversity of New Zealand's population and significant numbers of people with mixed ethnicity can also make measures based on race or culture misleading – especially when used as a quasi-measure of risk or poverty.

51. How do the organisational culture and leadership of government agencies affect the adoption of improved ways of commissioning and contracting? In what service areas is the impact of culture and leadership most evident?

The *NZ Public Health and Disability Services Act 2000*[4] empowers the Crown and DHBs to organise national, regional and local services for optimum effectiveness, but a properly co-ordinated approach to community health services is not evident.

District Health Boards are responsible for achieving population health outcomes, but the NGO sector contribution to local health outcomes is rarely acknowledged.

[4] Excerpt from Section 1 of the NZ Public Health and Disability Services Act 2000. "Purpose of the Act [paragraph (5)]: "*the Crown and DHBs must endeavour to provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services*."

Government investment in workforce development is currently focused on the needs of DHBs, with few opportunities for NGOs to engage as part of a robust, system wide workforce planning approach. The NGO sector is critical to resolving some of the complex problems that exist in NZ communities and the workforce that supports the NGO sector must be recognised.

Many DHBs, predominately those with large deficits, do not engage with the NGO sector and subsequently reduce funding or access to community services as a way to manage annual budget deficits. We are aware of instances where DHBs actively resist funding community services because they will reduce demand for DHB services and result in empty beds. This type of patch protection is not the intention of the *Public Health and Disability Services Act 2000* and will fail to deliver the population health gains expected in our country.

Many areas are reaching crisis point as NGOs struggle to maintain focus on delivering quality services with this sinking lid approach to funding.

52. How do the organisational culture and leadership of providers affect the adoption of improved ways of supplying services? In what service areas is the impact of culture and leadership most evident?

Innovative, community-focussed and consistent solutions are needed to address the growing complexity of New Zealanders with long-term conditions. Investment in self-management support and enhancing workforce capability across the sector are examples where the NGO sector can work closely with government agencies (including DHBs) to achieve a system-wide approach.

NGOs' diversity, agility and flexibility are vital to addressing chronic conditions like smoking and obesity. Community groups' advocacy often draws attention to such issues and works to change public attitudes over many years. Government, however, is often slow to get involved and first to leave. Government funders actively discourage (and even penalise) advocacy and speaking out, despite the Auditor-General's guidance acknowledging the independence of NGOs. Then, when progress is made, government is too quick to turn its attention and resources to a new issue.

In March 2011, the New Zealand Government committed to a goal of NZ becoming smokefree by 2025. Smoking numbers are well down on previous years, so government already appears to be diverting resources away from smoking cessation services as the problem is perceived as solved. This is not the case – those who still smoke face multiple challenges (often intergenerational and environmental), so they require more intensive services and support. Of particular concern is the impact of maternal smoking during pregnancy on the child – an area where we have seen the fewest gains.

With other long term issues, government must be more responsive to community advocacy and resource organisations over many years to achieve results.

53. What institutional arrangements or organisational features help or hinder the uptake and success of innovative approaches to service delivery?

If government wants greater accountability and evidence of service effectiveness to support funding decisions, it needs to fund research and evaluation when purchasing services, as current service provision rates do not enable NGOs to fund this themselves.

There are many examples of new initiatives being trialled by government funders without prior research or robust evaluation during and after the trial. A financial commitment to an evidence-based approach to commissioning is needed.

The NGO voice is absent from too much decision-making.

Ministerial appointments to DHBs and other statutory bodies can address gaps, such as the need for particular skills or representation of ethnicity. Our analysis of DHB members' profiles shows good levels of clinical, financial and governance experience on most Boards, but we perceive a lack of non-profit experience, and therefore limited knowledge of the range and value of effective community services.

While we recognise the need for balance when making decisions on Ministerial appointments, we recommend Ministers and their advisors view experience in the non-profit community sector as a useful and important factor that can make a valuable contribution to DHB/statutory body governance.

54. -

55. -

56. Are you willing to meet with the Commission? Can you suggest other interested parties with whom the Commission should consult?

The NGO Council would be particularly interested in meeting with the Commission for discussion and feedback once the Commission's draft report is released for comment.

We are also willing to share information with our 482 members through our mailing list or at our National Forum (likely to be held in May/June 2015).

We are particularly keen for the depth of knowledge that you compile during this process to be shared more widely as we know not all that you learn will make it to your draft/final reports. Perhaps sharing it through the Community Research website and network may be one option.

Donna Matahaere-Atariki
Chair, NGO Council
NGO Health & Disability Network
secretariatngo@gmail.com
www.ngo.health.govt.nz
www.facebook.com/HealthDisabilityNGONZ
https://twitter.com/NZHealthNGOs

2 December 2014