Healthcare of New Zealand Holdings Limited

Submission on “More effective social services”

HEALTHCARE OF NEW ZEALAND
FREEDOM MEDICAL ALARM
MCISAAC HEALTHCARE
PANACEA HEALTHCARE
PHARMACY 547

Introduction

For more than 25 years, Healthcare of New Zealand Holdings Limited (HHL Group) has enabled clients to enjoy greater wellbeing, independence and quality of life in their homes. We are a New Zealand-owned company with a dedicated team of over 7,000 staff who provide more than 18,000 clients with person-centred health, rehabilitation and disability support services.

HHL Group is one of New Zealand's largest non-government providers of community health services. We have contracts with a range of government entities including: district health boards; the Ministry of Health; ACC; the Ministry of Social Development; and the Department of Corrections.

We have grown considerably over the last 10 years, largely as the result of being successful in contestable processes (RFTs, RFPs, etc.) Our size, breadth and constant involvement in government procurement processes qualifies us to comment on the effectiveness of the government's approach to social service purchasing.

We have answered the questions that most directly reflect our role and experience. Our answers below are based on our experience from both a process point of view (our experience of contestable and contracting processes) and in terms of our efforts to have strategic discussions with government about the how social services are purchased/provided.

We would be happy to meet with the Commission to discuss the issues raised in the discussion document if it would aid the Commission's work.

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Q1. What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?

- As one of New Zealand's largest non-government provider of community health services, our primary interest is in the issues facing the health, disability and rehabilitation sectors.
- Treasury's affording our future document highlights the difficult choices that present and future governments face between increasing taxes, reducing entitlements or cutting funding to social services.
- Health in particular is an area that is predicted to experience a significant increase in cost rising from 6.8% to 10.8% of GDP (note some Treasury projections suggest it could rise as high as 12%-13% of GDP under certain assumptions).
- This growth is being driven by an ageing population with increasingly complex health needs. A significant cost driver is an increase in the number of people living with chronic conditions that cannot be cured and are expensive to manage.
- Experts such as Professor Nicholas Mays have suggested that to improve the performance of the health system we need to reorientate it to better manage the needs of people living with chronic conditions[1]. Such changes would include better integration of health and social services. The integration of health and social services is also being proposed in New Zealand and overseas[2].
- Managing the needs of people with chronic conditions requires the health and social care systems to take a long term investment view of cost, something that doesn't always occur in the current environment.
- The Government's primary means of controlling expenditure and improving performance has been to limit funding and to set performance objectives. Funding increases for health are set to remain at $350M per annum for the next four years which will equate to a decreasing percentage increase (2.3% by 2017) in funding.
- These increases reflect only a "contribution to cost pressures" of as low as 0.6% once demographic pressures are accounted for and therefore put the Ministry of Health, district health boards and NGO social service providers under considerable pressure to find efficiency savings to meet the rise in the cost of living and wages.
- While this has approach has been successful to date in terms of limiting expenditure growth, there is a serious risk that if the wrong expenditure decisions are made disinvestment may occur in services that are actually saving money therefore increasing cost pressures and reducing efficiency in the medium term.
- There is a lack of public discussion, evidence and data available against which to judge the decisions being district health boards and the Ministry of Health. NGOs and the public are therefore in the dark about the decision making the health sector and how those decisions support future sustainability.

[1] http://www.hiirc.org.nz/page/37816
[2] http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf

- Our experience has been that within the health sector there is a bias towards reducing expenditure on NGO provided services rather than hospital services provided by district health boards that are both funder and provider. District health boards are in a difficult position stuck between acute needs that cannot be mitigated in the short term and the need to invest in prevention initiatives that can reduce future demand in the medium term.
- The cost pressures on district health boards will only increase as the population ages. To effectively manage future cost pressures we need:
    - an evidence base on which to make informed decisions
    - an investment approach that prioritises spending on initiatives that reduce future costs
    - an objective process for investment in hospital, community health and social services that recognises the interconnectedness of social and health outcomes
    - local innovation and national leadership

Q8. Why are private for-profit providers significantly involved in providing some types of social services and not others?

- We are the largest for profit provider delivering services in the older persons, disability and rehabilitation sectors. Our focus is on providing services in people's homes and communities. We do not provide residential services except in the disability sector where we provide services through community group homes.
- While we are a for profit company we have found that we are able to compete in a number of areas with not for profit organisations/charitable organisations. The exception would be areas where government agencies deliberately fund services below the cost of delivery e.g. the Ministry of Social Development's "contributory" funding model for day services for people with disabilities.
- It is important to note that while the vast majority of the providers that compete in our sector are "not for profit" their provider arms often seek to generate a profit to support the activities of their parent organisation.
- Just because a provider's mission is not to make a profit doesn't mean they are willing to make a loss and in fact most would expect a margin for sustainability and reinvestment in their business. Therefore, there is not a significant gap between what is sustainable for us as a for-profit provider and what most not-for-profit providers would consider sustainable and reasonable funding.

Q9. How successful have recent initiatives been in improving commissioning and purchasing social services? What have been the drivers of success, or the barriers to success, of these initiatives?

- The recent initiatives to improve commissioning and purchasing social services have had limited impact on our dealings with government agencies.
- We were one of the first providers to move to the new streamlined contracting framework for a new contract.
- Over the last two years we have experienced the following issues with the tender processes that we have been involved in:
    - Poor preparation from government departments and entities prior to advertising RFPs/Tenders.
    - A lack of evidence to back up the setting of budgets, pricing and service design.
    - Poorly written RFPs/Tenders that lack an adequate description of the service being purchased.
    - A secretive approach to answering questions during the procurement process
    - Out of date indicative service specifications being used to describe the service to be provided.
- In prioritising government work in this area assumptions have been made such as less contracts per NGO = less administrative work by both NGOs and government. These assumptions are often flawed. Efficient and effective procurement needs a well-resourced, informed and disciplined approach to procurement by government agencies and entities.
- Standardisation and national consistency has the potential to both help and hinder efficient and effective procurement. For example having all the providers who deliver the same service on the same service specification and terms and conditions is helpful for NGO providers and funders. However, moving every NGO provider across all of government to a single set of "framework terms and conditions" risks paving over important differences in contracting arrangements and creating additional complexity.
- The streamlined contracting framework developed with MBIE has in our experience made it more difficult to have discussions with funders about mutually acceptable terms and conditions since funders now lack the discretion to make changes that are in our shared interest and that of our clients.
- To improve the commissioning and social service purchasing:
    - Improve the strategic planning that informs commissioning and purchasing activities. This includes regular review of all services to determine whether a change in purchasing approach/new providers is required. Where an open market process is needed there should be a clear rationale for undertaking it that links to value for money and client outcomes.

- Ensure that procurement activities are well planned, informed by evidence and that the information provided to NGO providers is sufficient for them to understand the funder's expectations. Service design should be undertaken in advance of any tender/RFP process to ensure the requirements are defined.
- New frameworks are needed for managing relationships post RFP/Tender, building collaboration, measuring performance against outcomes and risk sharing. Procurement processes are expensive and resource intensive for funders and providers and it is often not desirable or cost effective to repeat these regularly for social services.
- For devolved services funded by district health boards a more coordinated national approach to procuring common services has the potential to reduce cost and improve outcomes.

Q15. 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 likely to be successful in areas where – the client (or their family) has the best information about what interventions/services will improve their quality of life, there is a defined amount of funding that they are entitled to (the client directed budget), an adequately objective process exists for determining that entitlement, adequate support is available to assist them to make decisions and plan expenditure, and there is an effective market of service providers for them to work with.
- The value from client-directed budgets comes from the ability for people to innovate in the use of their funding. Service models defined by funders are inevitably constraining in their attempt to define the best solution. Inevitably a system wide approach to design where the funder defines the service to be provided leads to some people being allocated services as a solution that don't meet their needs as well as another potential option or configuration.
- The experience in the disability sector has shown that the ability to take a client-directed budget and design a bespoke solution from scratch can allow clients and the people who support them to achieve outcomes that would be impossible under a traditional model of procurement, thereby improving value for money.
- In our experience it's often important that people have a choice about how much responsibility they have for planning/commissioning their own services and support. There is no one size fits all approach, some people relish controlling every detail and taking on the responsibility that goes with it while others want to choose a mix of responsibility and delegation.
- Rather than seeing client directed budgets and traditional social services as being two discrete options, social services are most effective when people are provided

with a continuum of options that allows them to customise their level of control. The nature and extent of the continuum will depend on the area of services/government being considered but the principle of allowing people to make choices about the things that are important to them without necessarily having to take full responsibility of all aspects of the provision of their social services is important.

Q.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?

- In our experience client-directed budgets tend to work best where there is a direct connection between the social service and the person's quality of life. This is true of disability support services where there is a direct connection between the support provided and the utility to the person. For these services the person is the foremost expert on the benefit of the support/service to them as a consumer.
- More technical services such as specialist or tertiary health and disability services do not lend themselves to client-directed budgets because the person is poorly placed to assess the efficacy of these interventions relative to other spending options or priorities. Further the markets for these services are complex and prices and quality specification are more effectively negotiated at an aggregate level.
- Relatively few social services have a client specific budget or allocation that can be prioritised. For example, the budget for health services is managed at a population level and no individual has an annual entitlement within which to make decisions.
- The more complex and technical the intervention, the more important the role of government in ensuring quality and efficacy.
- The key risks associated with client directed budgets include:
    - unsafe employment practices – where the client is responsible for employing staff there is a risk that they will not be a good employer in terms of ensuring a safe workplace and meeting their legal obligations to their employee.
    - a lack of training – client-directed budgets can encourage employing informal staff from the person's own networks, where this happens there is a risk that people performing key functions/roles are not adequately trained to perform their duties.
    - abuse – the risk of abuse (emotional, physical and financial) exists in relation to both formal services and the types of informal arrangements that exist around client-directed budgets. In the case of client-directed budgets people can be vulnerable to abuse because there are no formal checks and balances of the quality of the support/service they are receiving. If family members are both the beneficiaries of funding (employees) and the key people supporting decisions there is a significant conflict of interest that can lead to abuse.
    - poor management and prioritisation of funding – depending on how the budget is made available there is a risk that the funding is used in such a way that the persons essential needs are not adequately catered for.

- These risks are best managed by building formal supports around the management of client directed budgets that address the risks listed above. The additional supports need to:
    - ensure people are informed about the options available, the efficacy of the different options and the cost effectiveness of those options
    - ensure where people are employing staff that they understand and are able to discharge their responsibilities as an employer
    - ensure the person is in control of their budget and is not being taken advantage of by other parties who may not be operating in the person's best interest
    - monitor expenditure to ensure adequate provision is made for the duration of the arrangement (e.g. the entire year).

Q19. Are there examples of services delivery decisions that are best made locally? Or centrally? What are the consequences of not making decisions at the appropriate level?

- As noted in the discussion paper there are distinct advantages that come from local decision making. Devolution of decision making and funding can allow local decision makers who are better informed about the needs of the local community and the available local solutions to make better decisions based on that information.
- However, our experience has been that there are also several significant issues associated with local decision making including:
    - A lack of resources for planning and service development – the implementation of the restorative model of home based support services across district health boards has shown that small local funders often struggle to resource planning and funding activities. This has impacted on budgeting, the contract development process, the RFP process and the contract management process post procurement. Social services are complex and often involve large amounts of funding (relative to the size of the teams that manage those contracts), it is not realistic for a very small regional planning and funding team to design and implement a major service change effectively.
    - Reinventing the wheel – we have seen this with the restorative model of home based support services with 20 district health boards (eventually) all developing and implementing their own version of the model. This is:
        - time consuming (the rollout of restorative HBSS started in 2007-08, has no target completion date, and in 2011 the OAG commented on the slow pace of the rollout (http://www.oag.govt.nz/2011/home-based-support) which is as of 2014 still nowhere near complete)
        - expensive for social service providers who have to compete in multiple competitive tender process with different requirements and

for small funders who have to resource time intensive procurement processes
        - counterproductive in the sense that the national objectives can be undermined unwittingly by attempts at regional innovation that go against recognised best practice.
    - Conflicts of interest – we have seen a variety of conflicts of interests occur been local funders and national objectives. At a very micro level local communities are more connected to their own needs but also to local conflicts of interest. Our experience has been that where entities or individuals are involved in decision making who also have a stake (e.g. funding levels) in the outcome of that decision then there is a conflict of interest that undermines the decision making process. Further District Health Boards as the funders of NGO services in their areas and providers of services (funded by themselves) have a conflict of interest when making decisions about NGO funding since any additional funding given to NGOs is often at the expense of their own provider arms.
- If we take the rollout of restorative home based support services as an example, regional innovation has added little value (and has arguably undermined the model) but has significantly delayed the implementation and the financial and social benefits.
- Ideally local innovation would occur and be overseen by the Government within a national framework. This would balance the need for national leadership and an efficient national rollout with the need for local tweaks and innovations where those changes don't undermine the policy imperatives behind the national implementation.
- There also needs to be a process to ensure local innovation that is successful and has the potential to improve outcomes on a national basis is considered outside of the region that gave rise to it. Without national leadership guiding innovation local decision making is more likely to lead to the same mistakes being repeated across multiple areas than a unique regional innovation being developed that outperforms what other areas are doing.
- A key gap in the decision making processes as we experience it in the health sector is the lack of a publically available evidence base to inform decision making. Multiple local decision makers reinventing the wheel doesn't assist with the development of a consensus on what interventions work and are cost effective.
- In the DHB context short term financial imperatives appear to dominate local decision making with long term planning around quality outcomes and sustainability seeming to take a back seat. Local decision makers seem particularly poorly placed to make decisions that require an investment in the short term for the realisation of a future return. This may be because they lack the central government mandate to take a longer term view of finances.

- Where decision making is devolved to local entities, it is critical that those local entities be subject to a robust accountability framework that measures the outcomes achieved over the short term, medium term, and long term. In terms of the governance of district health boards there is little monitoring occurring of population health outcomes and the success at ameliorating the demand for health services despite these being critical objectives for the health system.

Q20. Are there examples where government contracts restrict the ability of social service providers to innovate? Or where contracts that are too specific result in poor outcomes for clients?

- Undoubtably. At a general level government departments/agencies often tender for services and providers respond to those tenders. Based on this process providers are often responding to the designs of government rather than having an opportunity to respond to the needs of communities as they see them.
- Provider innovation is constrained by a range of factors including traditional boundaries (e.g. professional silos), funding methodologies, government silos, contract requirements and specifications. While a poorly written or prescriptive contract can certainly constrain innovation, system design factors are a bigger barrier to innovation.
- In the disability sector the government's policy objective is to ensure disabled people live ordinary (good) lives like other New Zealanders. The barriers to provider innovation in this area include:
    - Responsibility for the overall outcome being split across multiple agencies preventing any one agency taking a holistic view. Further, if providers want to take a holistic view they need to contract with multiple agencies (who aren't coordinated) to work with one person.
    - Funding often has arbitrary thresholds and is often tied to service models that have prescriptive requirements, for example residential services attract the highest level of funding but those services require a person to live in a home with no tenancy rights and give up most of their benefit (if they are in receipt of one). In the case of residential services the contract locks in a model that actively works against the government's objectives.
    - Government contracting and accountability processes not keeping pace with sector and international innovation.
- In summary, based on the disability sector, inflexible contracts are part of a wider issue about how the government conducts its business. It is not enough to simply make the contract more flexible, delegate responsibility to the provider, or devolve decision making, you need to look at how the government goes about its business and how this supports the outcomes it is trying to achieve. The current thinking in a number of areas – health, disability, rehabilitation, education, etc supports a flexible package of care/support being placed around the person and their family and those

people having influence over how that is delivered. The current contracts in these areas are definitely a barrier to this approach but so are the funding silos, flawed funding methodologies, traditional professional boundaries, and the accountability frameworks. Any steps to improve flexibility and innovation need to address these barriers.

Q21. How can the benefits of flexible service delivery be achieved without undermining accountability?

- Flexible contracts, flexible service delivery and outcome reporting go together. If the government effectively implements outcome based accountability then there will be sufficient accountability to monitor these contracting arrangements.
- The challenge is that the government still largely relies on input/output based accountability to measure its own performance and that of NGO providers delivering social services. Counting FTEs, bed days, hours delivered or procedures performed is relatively simple and gives a degree of confidence that money has been spent as intended.
- Rather than start with the assumption that our present accountability arrangements are sufficient and that any change to more flexible contracts might undermine a system that is already working satisfactorily, we should recognise the flaws in the existing accountability arrangements. The current predominant approach to accountability for social services is usually effective in ensuring money is used for its intended purpose and gives a reasonable insight into the amount of activity that is purchased, but it is woefully inadequate when it comes to giving insight into the effectiveness of that activity.
- Input/output measures are particularly problematic in the current environment where more activity doesn't necessarily equal success. In many areas the objective is to reduce activity (e.g. prevent unnecessary ED presentations through timely community care) and therefore judging performance based on how much activity is undertaken reinforces reactive rather than proactive interventions.
- If you look at the current health targets, all seven targets measure activity in the health system and none are truly outcome based. Shorter waiting times could be considered an intermediate outcome but the true outcome is improved an improved clinical outcome which is not included.
- True outcome reporting is difficult and in some cases more expensive as it requires measuring and monitoring factors that are not directly linked to service delivery activities. For example, a PHO may be accountable for the number of presentations at the local ED department but they don't collect this data. Further, with social services such results exist in a social context and are therefore influenced by a range of factors. The primary factor influencing ED presentations may be poverty rather than the quality of GP care and therefore holding the GP as the only person accountable may be unreasonable.

Q27. Which social services have improved as a result of contestability?

- Recently the Ministry of Health undertook a contestable process for a national behaviour support service. There were several factors that suggested a contestable process would improve outcomes and value for money including:
    - Concerns about the quality of the services being provided, including whether the staff providing it had the right skills and qualifications and whether the right practices were being applied.
    - Concerns about access to services under a bulk funding arrangement that didn't incentivise access.
- We as the incoming national provider (we were one of 11 regional providers prior to the competitive process) consider that the services provided and the access to those services will improve considerably as a result of the competitive process. In part this is because a national provider will consolidate the expertise in what is a specialist area.
- Having said this, it would not have been impossible for the Ministry of Health to address the performance issues through performance management and results based accountability. Contestable processes are perhaps seen as a less confrontational way of dealing with contract under performance than a direct termination of a contract.
- It's doubtful that contestability alone delivers enduring results. Where contestability is successful it is likely because it is combined with fresh ideas, improved monitoring and a renewed approach to contract management.

Q28. What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?

- Before embarking on a competitive process for social services government departments should be clear on what the problem is to be solved and their intervention logic which demonstrates how a contestable process will achieve the objectives.
- Contestable processes can be detrimental where:
    - The contestable process loads significant additional cost on to providers relative to the revenue in that area.
    - Where the relationship between the provider and the person receiving the service is very important.
- As with the government's approach to power companies, in many cases the benefits of competition can be achieved by encouraging people to change providers where they are unhappy. This is often a more effective and efficient way of boosting quality through competition than a competitive process.

Q31. What would reduce the cost to service providers of participating in contestable processes?

- The biggest challenge we face in participating in contestable processes is understanding the funder's requirements including the scope of the service, the eligible population, the budget available, their expected methods of service delivery, and the scope for innovation. The quality, accessability and usefulness of some of the information put out by funders during contestable processes is highly variable. In many cases the description/definition of the service to be provided is substandard increasing the amount of time and effort we need to dedicate to preparing our RFP.
- As an example, in one recent case, a district health board included as indicative of their requirements for a new innovative restorative home based support service an old service specification that predated the devolution of the service by the Ministry of Health in 2003. Clearly this had no bearing on their expectations for the service or the future contract we would be asked to sign.
- Our experience has been that some funders are not doing the required preparatory and service development work prior to going to tender/RFP which results in a poor description of the service requirements and inadequate consideration of issues such as the budget required to meet their expectations. This results in RFP documents being produced that are a riddle to be solved rather than an informative document that guides the respondent towards the funders intended goals and methods.
- There is an important opportunity prior to going to market to work with the sector to define the requirements so that the best outcome is achieved for the community. This kind of sector collaboration prior to such processes is not happening often enough or in a way that improves the quality of the process.
- Some organisations shift their uncertainties about their requirements onto the market under the guise of the RFP process which is intended to be more open to provider solutions. There is a big difference between leaving scope for provider innovation and being unclear about what you expect the provider to be responsible for in delivering the service. Even questions like "what population groups does the RFP pertain to" or "who would be eligible for the service" have not been answered in some processes and have been left to the provider's imagination.
- We have also struggled with mandated formats that are poorly thought out. In our experience funders like to control the ordering and presentation of our responses to ensure a degree of uniformity amongst the documents their evaluation team need to review. This is understandable, however, there are three areas where we consider this is mismanaged adding unnecessarily to the burden on respondents:
    - Word limits by section – one trend we have seen is funders trying to limit the size of the document by imposing a word limit by section. Constraints on the length of the document can help both the evaluation team (who has to read the document) and the submitter (who has to write it) but word limits by

section can create great difficulty because they remove flexibility for the respondent to prioritise content. If brevity is important it would be preferable to have a word/page limit for the entire document and leave it to the submitter to prioritise space/words. A soft guide of words per section could also be a compromise to guide the length of a given section.
    - Mandatory tables – another trend is the requirement to populate the response in a mandatory table format. The suitability of this depends on the type of response but in many cases this is highly frustrating with much effort and resourced focused on managing the formatting within the table. Further this approach inevitably requires a left hand column in the table with the question that often creates an enormous amount of wasted space as the question might have 20 words compared to a 500 word answer.
    - Mandatory order – many RFPs require the submitter to present their response in a prescribed order.
- Ultimately whether these formatting and length specifications are a help or a hindrance depends on the forethought put into their development. If the person creating these requirements has thought them through well then they can work but more often not they require significant additional work to meet in our response.
- The efficiency of the procurement process and the cost for us as a submitter comes down the experience of the person running the procurement, their knowledge of the subject matter and the amount of effort they put into specifying their requirements. If there is a deficit in any of these three areas then the procurement process becomes burdensome for us a responder and risks not achieving the desired outcome for the funder.
- Please note we have seen the full range of procurement processes from high quality well planned procurements through to incredibly poor quality procurements with ambiguous requirements.

Q33. What changes to commissioning and contracting could encourage improved services and outcomes where contestability is not currently delivering such improvements?

- There is significant scope for improvements to the contract management process including:
    - Shifting to outcome based accountability arrangements
    - Renegotiating contracts and revising service specifications to better reflect the funders requirements
    - Where appropriate facilitating competition and choice by service users
    - Using performance incentives
    - Managing out poorly performing providers
- Funders often struggle to evidence poor performance in a way that allows them to act on these concerns. One of the reasons that contestable processes do not always

yield the desired result is that funders struggle to objectively measure the performance of their existing providers.

- There are also very few levers for funders to use to address underperformance. Consideration should be given to adding new tools that funders can use to encourage providers to improve performance short of cancelling a contract.

Q44. Do government agencies and service providers collect data to make informed judgements about the effectiveness of programmes? How could data collection and analysis be improved?

- There is too little information about social services and social outcomes available in the public domain. In the health sector there is little or no publically available information available on ED presentations, inpatient hospital admissions, the use of home based support services and aged residential care, or even where money is spent. There have been recent reports about a lack of information on the number of people who meet the clinical criteria for a procedure but who cannot access it because of a lack of financial resources.
- It is very difficult to have a conversation about the state of the health system and the innovations that might be beneficial when there is a lack of information in these key areas. More worrying perhaps is the fact that there is little forward thinking analysis of the system's ability to meet population demand need over the next five years.
- No programme operates in isolation of other services or social factors. Therefore to evaluate what works both in terms of providers but also in terms of funding decisions, the government should be measuring health sector outcomes alongside the social factors that influence them. ED presentations are a classic example; our analysis shows that these are rising faster than the population even when you account for age. Why is this happening and how are the social services provided by NGOs and DHBs impacting on this? We don't know.
- The number of people in rest home level care (the lowest level of aged residential care) has decreased in recent years despite an ageing population. A fantastic result likely due to an increase in the number and complexity of people being supported in the home. How have the number of people and the needs of those people supported in their own homes changed over the last five years? We don't know.
- In health which is our core area there are a number of very important policy decisions/outcomes that aren't publicly monitored or discussed. This stifles innovation because without core government agencies recognising and publishing information on key service trends in the health sector there is no basis for having a conversation about what innovation is necessary.

Q46. Is there sufficient learning within the social services system? Is the information gathered reliable and correctly interpreted? Are resulting changes timely and appropriate?

- There is a lack of information on outcomes and system performance and the lack of an evidence base to support decision making.
- The health sector is highly resistant to change despite significant evidence to suggest that a fundamental reorientation of the health system is required to cope with the challenge of an ageing population. This resistance to change is likely the result of a combination of factors including: entrenched interests, fiscal concerns and a short term horizon for decision making.
- Most of the strategies guiding the health sector were published in 2000-2002 and haven't been reviewed since meaning that the sector lacks a call to arms guiding innovation.
- These issues are further frustrated by the fragmentation of decision making. 20 district health boards means a given innovation has to be shopped to 20 different decision making teams which is time consuming and repetitive.
- There needs to be significantly more investment in data collection (on the performance of social services including those provided by government agencies/entities), research and policy leadership. In many of the sectors that we work in there is too little evidence of what works even for services that have been delivered for decades.

Q47. Does the commissioning and purchasing system encourage bottom-up experimentation? Does the system reinforce successful approaches and encourage reform of less successful ones?

- No and no. The health system is geared towards supporting the status quo. District Health Boards who themselves provide the majority of the services make the decisions about whether those services continue in their current form. Recent history shows that this decision making process effective at maintaining the status quo.
- As a service provider in the health and disability sector it is almost impossible to propose a new service idea and have it funded. This is in part because there is a scarcity of funding and in part because the procurement guidelines discourage agencies from purchasing services based on unsolicited proposals. It is far safer and simpler to go to market with an idea than to adopt a proposal that has been sent to you.
- An exception to this is the government's Better, Sooner, More Convenient (BSMC) business cases. We were successful in getting an innovative care coordination service called Te Whiringa Ora funded as a pilot in the Eastern Bay of Plenty. This service ran for over three years and was very successful for both Maori and non-

Maori. A service evaluation showed significant benefits for the participant's quality of life and an economic evaluation showed significant financial benefits over and above the service cost (copies of these reports are available on request). Our pilot has attracted international attention in the area of long term condition management and is used as a case study for international audiences.

- The challenge we face is that there was no process built into the BSMC process for pilots to be evaluated (we self-funded our evaluation) and considered for wider application. So despite all the evidence suggesting the pilot was an overwhelming success and despite international experts considering this model has merit and can be learned from we cannot engage the Ministry of Health or DHBs in a conversation about taking it further.
- In the health sector pilots have become an end in and of themselves, rather than a means to an end. This is perhaps because setting up pilots is relatively easy, generates good press and gives the appearance of progress. On the other hand taking the lessons learned from experimentation and making changes to a national system is politically difficult, time consuming and often expensive.

Q56. Are you willing to meet with the Commission? Can you suggest other interested parties with whom the Commission should consult?

- Yes we would welcome an opportunity to meet with the Commission if that would assist the Commission in its work.

Case Studies

Services for people with disabilities

- To understand the challenges that providers and people with disabilities face in relation to the lack of integration in the disability sector you need to understand how the funding is currently siloed and how this impacts on the lives of people with disabilities and their family and whanau.
- There are several major funders of support and assistance for people with disabilities including the Ministry of Health, Ministry of Social Development and Ministry of Education that have responsibility for funding support for people with disabilities.
- In 2005 "The NHC has found that adults with an intellectual disability have difficulty accessing rights of citizenship. Their lives are very different from other New Zealanders and not consistent with the vision of the NZDS. Adults with an intellectual disability are seldom integrated into community life on their own terms, individual choices in the most fundamental of life decisions are not available to them, and their aspirations and goals are not supported."[3] Although there have been some improvements on the periphery, many of the factors that gave rise to this finding still exist today.
- There are obvious gaps in between these organization's funding silos and between the services they fund which themselves have siloed responsibility. For example transportation is an area that is very important for getting out and about in society but assistance for this is limited. Support for medical expenses is another area with research by the Ministry of Health showing people with intellectual disabilities have significantly poorer outcomes than people without disabilities. A lack of access to health services (e.g. nursing input) is one of the reasons why there are still hundreds of young disabled people inappropriately placed in rest homes.
- The collective impact of this is that disabled people rely on services that are neither coordinated nor designed to ensure a seamless continuum of support. There is little or no allowance for substitution as each agency protects its budget from creep.
- A classic example of the inflexibility of the existing government silos would be a situation where the Ministry of Health allocates a person with $70,000 of residential support in a group home. The person wants to live in a flat instead with two other friends who also have funding a similar level of funding. Collectively they have $210,000 worth of funding to purchase their support (basically hours of support in their home and community). However, because they are all beneficiaries they can't afford an accessible home that is near their family and local shops. The existing silos mean they can't take $5,000 from their Ministry of Health funding to subsidise their rent despite this being the key to them living an ordinary life in their own home. Under the current system the entire outcome of a good life is undermined by a lack

[3] http://nhc.health.govt.nz/system/files/documents/publications/NHCOrdinaryReport.pdf

of portability between difference agencies areas of responsibility (in this example between health and housing).

- What disabled people need to create truly flexible funding and support arrangements is:
    1. A cross government budget with each agency providing an appropriate level of funding based on the person's assessed needs
    2. A continuum of options for managing this funding including:
        - Direct management by the person
        - A provider acting as a fund holder
        - Receiving services as they have traditionally been provided (if this is the person's choice)
    3. A set of fair and permissive rules that govern how the money is used.
    4. An accountability framework that ensures the funding is used for its intended purpose and ensures the person isn't subject to abuse.
- Although Enabling Good Lives is a promising initiative many of the requirements listed above have not been adequately addressed. For example the Ministry of Health has developed a funding allocation tool that allocates money rather than services (this is a necessary precursor for flexibility) but the ministries of Social Development and Education have not to our knowledge not committed to a similar approach for their funding pools. Options for managing funding are limited under EGL and don't give people a range of options for how to manage their funding.
- Our proposed approach would work as follows:
    1. The person is allocated a budget.
    2. They identify what individual/organization they want to assist them to manage that budget (could be a host, family member or provider organization).
    3. They develop a plan for their life and any expenditure.
    4. They implement the plan with the assistance of their selected individual/organization and make changes to the plan as they go.
    5. They review the plan annually (or more frequently) to determine if it is working for them.
- The approach above is a simple method of implementing a client directed budget and it is incredibly powerful. If you look at the Choice in Community Living project ((http://www.health.govt.nz/our-work/disability-services/disability-projects-and-programmes/choice-community-living) in Auckland and Waikato which is well worth reviewing as part of your process, you will see that disabled people are working within the same budget they had previously but are achieving significantly improved outcomes when it comes to quality of life. The people participating in this pilot have much greater control over what the money is used for and this is unlocking additional value through creativity and flexibility. The only component that is missing

in this way of working is flexibility across government silos because this is a Ministry of Health only initiative.

- This is an example of the future of disability supports. The challenge is reforming government to work in an integrated way and for government agencies to allocate people a fair share of funding based on their particular circumstances. One of the challenges with allocating money is you have to be transparent in deciding how much an individual gets. With multiple agencies there may be disagreements about the contribution from each agency. Agencies can't just assess funding based on what they fund today in terms of services (disability specific or otherwise) - after all it would be foolish to assume what we haphazardly fund today just happens to be the optimal level of funding for new system - they need to assess based on the outcome of an ordinary life and the support needed to achieve that. This doesn't mean disabled people and families should expect an unlimited budget, there will always be scarcity and prioritisation, but at the same time an area like housing probably should allocate a disabled people extra money (compared to a non-disabled person) if they need accessible and centrally located accommodation. A person with a disability might need more funding for medical expenses, or more support to get a job. The funding tools should account for these needs.
- There has been some really good work done in the disability sector in recent years but like most initiatives in the health sector it is stuck in the pilot phase and the challenge of working effectively cross government has not been addressed yet.

Home-based care of older people

- There is huge potential for support in people's home and communities to reduce wider system costs - reduced ED presentations, inpatient admissions and rest home placements. The last of these can already be seen clearly in the data with the number of people 65+ in rest home level care decreasing in absolute terms while the population has aged. We also believe that home based support has reduced the number of ED presentations and inpatient admissions but this is harder to evidence.
- The gains mentioned above have been achieved with a relatively basic model of home based support services. The introduction of the restorative model of home support is designed to improve the quality of these services by better targeting the amount of support provided, focusing on maintaining people's functional ability (avoiding functional decline) and improving the training and stability of the workforce providing the services. Improved quality is expected to lead to improved outcomes including living longer at home, less tertiary/secondary hospital care and less rest home placements.
- One of the challenges we as a sector face is that some funders have misconstrued the intent of the restorative model (primarily about improving quality) and have used it as an opportunity to extract direct savings from the home based support services they fund in the face of an ageing population and rapidly increasing

demand. The extraction of savings from this critical service undermines the wider savings to aged care numbers, ED presentations and inpatient admissions.

- We have had issues with DHB's setting budgets based on too little information. In some cases these budgets have subsequently had to be revised upwards significantly to meet demand. More worryingly some DHBs have attempted to shift risk to providers by asking us to work within a capped budget where we as providers have limited control over the amount of support allocated by the DHB NASC.
- While the introduction of restorative home based support services may yield some savings in terms of improved prioritization and a focus on supporting people to regain function (where appropriate) the major emphasis must be on the quality of the service and the link between this and the wider system outcomes.
- In addition, while restorative services represent what should be considered a basic quality of home based support services there are other additional advanced models of care that can be provided by community support workers and other health workers in the community that should be considered. Models of early supported discharge (called START in Canterbury and CREST in Waikato) have demonstrated huge potential to reduce system costs following discharge from hospital if implemented nationally and improved through evaluation. Our service model Te Whiringa Ora mentioned earlier in our response is a model of chronic care management that utilizes both regulated and unregulated workforces. This model has been shown to achieve considerable savings for district health boards and could be used as an extension of the existing home based support service contracts.
- Improving the quality, scope and effectiveness of home based support services (and the extensions mentioned above) requires national and local leadership, an evidence base that defines what works, and an investment of money upfront to realise medium term savings. If the savings are accruing to district health boards through decreased hospital activity and reduced placements in aged residential care then it makes little sense to simultaneously extract funding or suppress funding increases into the home and community sector that is delivering those savings as has been the case in recent years.
- In completing the case study we encourage the Commission to review the pace of rollout of the restorative model of home based support services, its effectiveness and the regional differences in its implementation and whether those differences add value or merely create confusion, additional cost and delays. We also encourage the commission to review the investment that has been made in advanced models of home based support services to determine whether district health boards are investing in innovative models of support in the community in a meaningful way. We also encourage the Commission to review the regional and national information available about the performance of the relevant services in terms of key quality of life and system outcomes.

- As the largest provider of these services in New Zealand we have extensive knowledge of how these services have evolved and we would welcome the opportunity to discuss this case study with the Commission.