Home & Community Health Association

Productivity Commission Inquiry into Social Services

Response from Home and Community Health Association

Introduction

The Home and Community Health Association is the peak body representing organizations that provide home based support and community services, including (but not exclusively) home based care for elderly. Our members employ around 21,000 home support workers, nurses, allied health staff and coordinators. The workforce supports around 80,000[1] people who live with disabilities or health challenges, in their own homes.

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Case Study Comments, page 65-66 of the Productivity Commission report

In these pages the Commission states what it expects to learn about Home-based care of older people:

- How to make integrated services more cost-effective for funders and produce better outcomes for clients
- Which services and outcome areas are best suited to a devolved integrated approach
- The role of private (for-profit) providers.

Better services and support for home-based care of the aged can reduce the need for hospital admissions and residential care. Finding the right mix of services to achieve this is best worked out at a local level, and requires flexible budgets and decision makers sharing the same goals. Health alliances (Table 3) were set up to be networks of primary health services providers and District health Boards (DHBs), with objectives that include moving services to community based settings and supporting self and community care. Canterbury DHB was a leader of this approach in New Zealand.

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

General comment

1. Home based support is one of the very lowest funded labour-based health service in New Zealand (possibly **the lowest** outside of the very restricted paid family carer payments[2]) Unfortunately the proximity of the price paid to the minimum wage and the lack of any kind of rational funding framework drives high workforce turnover. Service sustainability is under immediate threat with close to 50% of the workforce on the minimum wage.
2. Whilst provider organisations can clearly see the benefits for health and disability consumers and for New Zealand Inc of a range of integration responses, there are some major barriers:
    a. Funding that is saved through the use of home support rather than residential services is either reinvested only in volume, or in other health services. As a result service quality, workforce sustainability, innovation and business survival are under threat.
    b. The most recent response of funders to increasing demand in both home support and residential care has been to decrease eligibility to home support and focus that eligibility support on the higher levels of need. This is understandable, but without additional funding it has required home support providers and their staff to manage increasing client complexity, without the resources to address it.
    c. Policy on developing community health services to meet the burgeoning need is haphazard and inconsistent. Despite rhetoric, District Health Boards and government policy makers are generally unwilling to take the steps necessary to gradually re-gear services and funding towards community health support.
    d. There is poor understanding about the needs of people within the funding reach, or the best way to reposition the broader range of services to meet those needs.
3. The introduction of Individualized funding (aka consumer directed funding) has resulted in around 12% of eligible disabled people taking up that option. That funding model has worked very well for some consumers, and it is also clearly not the best or chosen option for all consumers. The HCHA considers that consumer directed care would work in some situations in aged care, for example in relation to respite care, and for some cultural situations where there is a strong level of current family support. There are important differences between aged care and disability contexts, so options need to be available and accountability controls in place.
4. The Productivity Commission states that "Better services and support for home-based care of the aged can reduce the need for hospital admissions and residential care. Finding the right mix of services to achieve this is best worked out at a local level, and requires flexible budgets and decision makers sharing the same goals" [i] It is true that each NZ region has different levels and types of population health needs, and may need variations in services to meet those needs. But there is also a need for national consistency in terms of funding provided for essentially the same services between regions. It is also important to ensure

[2] MoH DSS pricing review 2013-14

that consumers get consistent access to services and to service quality no matter where they live.

5. Further to the Productivity Commission statement, "flexible budgets" is a phrase open to interpretation. From a positive perspective for us it means that funding is more responsible to the ebb and flow of people through the services. For that to happen we need a more mature approach towards funding community services. However, too often 'local flexibility' is a euphemism for reducing spending through the paying of lower contract rates and not passing through cost pressure funding to community providers. Flexibility can also mean 'risk shifting'. Providers under home support bulk funding situations have reported that after accepting capped bulk funded contracts, they are then put under pressure to accept increasing proportions and numbers of clients who have very high support needs all within the original contract price.

Consultation Questions

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

a) Ageing population (benefits and challenges)

b) Ageing workforce (benefits and challenges)

c) Fewer family carers available.

d) Increasing inequity, greater proportion of people in low-medium low wage incomes, less taxation. Impact of intergenerational poverty.

e) Lower asset base to support entry into residential care or co-funding of home care.

f) Exit of working age people overseas

g) Continuing depopulation of regional areas, erosion of regional employment systems.

Q2 How important are volunteers to the provision of social services?

a) In our sector family, Volunteer roles supporting older people at home include whanau and aiga carers, as well as organised volunteers (eg Age concern, Alzheimers volunteers, iwi volunteers) are critically important because:

   i. there are limits on the financial support available to allow people to stay where they want to be, and

   ii. most people want and need to be connected to and feel valued in their communities

   iii. there is value for the volunteer or non-paid carer in supporting others.

b) Organised volunteer roles supporting older people at home include home visitors, assistance with shopping, meals on wheels, free classes such as tai chi and other church or community run activities.

c) Home support agencies do not currently, and could not, manage volunteers to provide personal care or household management for clients as an alternative to government funding. The majority of older clients have complex needs, and it would be neither safe, nor practical to expect volunteers to undertake this work.

Q3 What role do iwi play in the funding and provision of social services and what further role could they play?

a) In our sector, iwi are largely funded, not funders. In terms of home support we support iwi retaining and regaining the right to care for their own people within their own area.

b) We anticipate that as iwi take on more provision of services they will either commission provider organisations to do home support within iwi based models and philosophy or they will run their own provider arms. Iwi that currently directly provide home support face challenges making it work financially.

c) Maori, not tribally connected to the local iwi but living within their rohe should also have the choice of who provides their services including whether local iwi providers. That does not appear to be the case universally at the moment.

Q4 What contribution do social enterprises make to providing social services and improving social outcomes in New Zealand?

a) In our sector there have been some large social enterprises but they have all been purchased, or have lost contracts. In recent times, it is our experience that when social enterprises have grown to a particular size they become vulnerable to purchase, and it is more difficult for them to take the risk of expansion that their boards believe is necessary in light of the current commissioning and integrative environment.

b) In terms of achievement, those social enterprises which existed provided diversity on the one hand and specific services on the other. Whilst making a profit was a goal, their philosophy and approach to services also brought a philosophy of service that was not solely market driven.

c) This sector is in too great a change period for social enterprises to be sustainable at the moment. Other sectors will have more to say.

Q5 What are the opportunities for, or barriers to, social services partnerships between private business, not-for-profit social service providers and government?

a) Our sector is now largely populated by several private companies, some medium sized not for profits, community trusts or iwi based services and some 'ma and pa' private operations or smaller for profit organisations. We are not aware of social service partnerships operating between the players. There is contracting and subcontracting between government and the players and between service providers, and this will continue. Commissioning (actual or perceived future) is the driver of most change. It isn't clear what other drivers are needed, or are desirable, or, yet, what the outcomes will be for clients. One could expect that where private businesses dominate the market, they will put more pressure on government and on contracting arrangements to enable them to gain a higher return.

Q6 What scope is there for increased private investment to fund social services? What approaches would encourage more private investment?

a) **Social Bonds:** The numbers of people over 65 receiving care are too great (and growing) to be implementing social bonds in relation to home care. Social bonds need to be better tested in the New Zealand context. The UK trials are not showing great results as yet, and it is already difficult to make any return on home support, so adding a further layer of complexity is not the solution to the problems that dog home support.

   A potentially positive output of social bonds is that it offers potential for the risk to be shifted from charities. And it offers an opportunity to focus funding more closely on outcomes.

b) Other than that the other type of increased private investment for our sector could be user-pays through individual part-charging, or income testing that includes the home and other assets as in the aged residential sector. Unlike retirement villages that also provide continuing care, our providers are not able to access the assets of the person. That is what drives the retirement village industry, and now to a large extent the aged residential care industry.

   However, any decision to use the private assets of older New Zealanders to pay for their home support requires deep economic and social analysis by a range of government agencies, including consultation, because there are definitely benefits and negatives and a range of implications. The ACC does offer a model of insurance which is a further option for future payment of home support and age residential care.

Q7 What capabilities and services are Maori providers better able to provide?

a) Maori providers are better able and well able to functionally provide home support within the context of the other services they provide within their communities, i.e. whanau ora. However, not all Maori providers have the capacity to grow, either because their catchment is small or because their growth capacity is limited to their kaupapa or iwi, or by financial or environmental constraints (eg geography). For some Maori providers the low home support contract rate combined with the low service volume mean that they have to subsidise the service in order to provide it to their people.

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

a) There is increasing involvement of private for profit providers of aged care home support in our sector in recent times, but some notable areas where they do not choose to provide service:

   i. In the past there were few barriers to entry - it was a relatively easy service to enter via an ACC contract. A great number of 'ma and pa' operators got going this way. It has recently (last two years) become harder for them to sustain their operation because of ACC and DHB commissioning, there has been considerable consolidation, through purchases and exits. Some smaller private services may remain and may even grow (slowly) in niche areas. There are few regulatory controls to entering the market or setting up a new service, though commissioning is the only actual entry point for government funded services.

   ii. As stated earlier in the question about social enterprises. Whilst social enterprises and not for profit trusts grew their services to a significant level, they remained vulnerable either because they were/are essentially regional in what is moving towards national service provision, or because they did not/do not have the capacity to take another major step of growth – to move cross regional or into the national space or to take on the substantial financial risk of bulk funded contracts involving millions of dollars and increasing client complexity.

   iii. The nature of home support business is that it is highly transactional, requiring significant volume of individual assignments and transactions around those assignments in order to generate any return, which is generally quite low, and in some regions operating at a loss. This is a disincentive to both for profit and not for profit agencies. The larger private agencies that have been in the market for a while have grown substantially during the recent round of commissioning, size (revenue, hours of service being undertaken, range of services offered) over the last several years, largely through the purchasing of medium sized agencies following ACC and in anticipation of DHB commissioning. Their margin is not substantial but the volume, their spread of services and some more profitable service elements enable them to cross subsidise where losses are experienced.

iv. It is yet to be seen whether the market attracts further external for profit agencies. One external agency has recently purchased a very large, previously social enterprise operation. In another example a new for profit entrant onsold its ownership to a more long standing for profit agency within two years of purchase, following commissioning changes.

v. Some service elements such as day programmes for the elderly are insufficiently funded, to the extent that organisations providing that service are having to use volunteers. Private organisations generally require full cost recovery.

vi. Marginal services and services to isolated areas tend not to be favoured by private organisations.

vii. In summary the following are generalized statements.

- The for-profit providers are able to take a different attitude towards risk, eg accepting short term loss for longer term gain.
- They can move quickly and be aggressive in terms of purchasing and marketing either at the individual client level or at the larger business level.
- For profit providers are less likely to be involved in marginal or contributory funding services.
- The profit motive drives for profit providers towards harder bargaining and towards meeting a profit outcome for their owners/shareholders. This does not mean they don't have meaningful service ethics.
- Some of the not for profit organisations have been restrained by their geographical positioning (geographical or service type) but that is not the case for the for profit organisations. All organisations are more aware of the need to protect their intellectual and business capital, and this is resulting in less sharing of ideas and resources.
- For profit providers may have access to more sophisticated commissioning expertise.

Q9 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?

a) We cannot say that we have noticed any overall improvement in the quality of commissioning in the sector. There are examples (listed in 10) where we have moved a little from the 'take it or leave it' approach. Usually they have been generated from the community or from individual funders rather than 'government' in the broader policy sense.

Q10 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?

a) Alliance contracting

b) Providers involved in service design

c) Extensive consultation prior to service commissioning

d) The development of transparent pricing and costing models

Lessons:
a) appreciate the expertise and skill close by
b) the establishment of trust and a sense of shared integrity and fairness cannot be underestimated in terms of achieving outcomes.
c) A primary focus on price will result in poor outcomes and post commissioning 'rarurarau'.

Q11 What other international examples of innovative approaches to social service commissioning and provision are worth examining to draw lessons for New Zealand?

Suggest: Lloyd J, Kings Fund, *Options for funding care,* Commissioned by the Independent Commission on the Future of Health and Social Care in England (Kings Fund). http://www.kingsfund.org.uk/sites/files/kf/media/commission-background-paper-options-funding-care.pdf

Suggest: TIimmins, Hamm, Kings Fund *The quest for integrated health and social care. A case study in Canterbury, New Zealand* Kings Fund https://www.cdhb.health.nz/What-We-Do/Projects-Initiatives/kings-fund/Documents/Quest-for-integrated-health-final-low-res.pdf

Case study on Te Whiringa Ora: http://www.kingsfund.org.uk/publications/providing-integrated-care-older-people-complex-needs

Q12 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?

For our sector, any model, international or otherwise, needs to incorporate consumer/client focus, the organisations that will deliver the services, and those who are connected to the services, their workforce, local community health/service needs, and national consistency.

Q13 Where and when have attempts to integrate services been successful or unsuccessful? Why?

a) See Q11 above.

b) With reference to the 'six uses of the term 'integrated' on page 39, whilst we understand that there are many papers on integration, and positions on it, there are other types of integration possibilities, and some very good work has been done on this in New Zealand. We recommend you look at:

An Integrated Framework of Care for the Central Region DHBs:

http://www.centraltas.co.nz/LinkClick.aspx?fileticket=vHg5MPCWG0M%3D&tabid=252&mid=912

This was developed to provide some shared understanding and language around integration. The framework primarily uses the Leutz definitions, and is particularly relevant to chronic conditions and aged care services. The project resulted in the development of a number of resources, all of which are available at:

http://www.centraltas.co.nz/RegionalGroupsNetworks/CentralRegionHealthofOlderPeopleNetwork/tabid/252/Default.aspx

c) That resource talks about different types of integration – linkage, coordination and full integration, and offers a view of how integration can closely match the dimensions of need.

d) For our sector successful efforts include:

i. The integration of home care and community nursing (ACC, CREST, Canterbury)

ii. The devolution of non-complex needs assessment (Interrai home care) to the provider. (Auckland, Wellington, Canterbury) This has dramatically reduced the wait time for assessments and re-assessments and means a much more prompt and accurate allocation of support.

iii. The use of nurse practitioners as experts in training and in the support of clients with high and complex needs

iv. Close connections between palliative care and home support

v. Te Whiringa Ora, diverse range of local health and social services working in partnership to connect each community's existing health resources and to reduce the number of unplanned hospital admissions, actively promoting the holistic values of Whānau Ora and sharing information through the use of an electronic patient record.

Te Whiringa Ora/Care Connections was recently selected by the King's Fund/Commonwealth Fund as one of seven international case studies on integrated care in the community. The first paper was release in January 2014 It provides compelling evidence that integrated care for older people with complex needs can be successfully delivered in the community.

vi The development of services focusing on chronic or specific conditions (haemodyalisis in the home) and on more intensive recovery following a hospital event (CREST)

Q14 What needs to happen for further attempts at service integration to be credible with providers?

a) There would be value in shared national discussions **involving community providers** about integration using community services. The discussions so far have largely been held between primary care and government, or primary and secondary care.

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?

a) Home care providers are reasonably familiar with client-directed budgets in the disability sector, with the introduction of individualized funding, initially only focused on home support, enhanced individualized funding (incorporating other disability supports) and now 'enabling good lives' which is a more long term approach.

b) We agree that individualized funding works for some. It does not work for all, as has been shown already in the IF programme in the disability sector.

c) Client-directed budgets are being rolled out for all over 65 clients in Australia. We think it would be best for New Zealand to monitor that, as there are quite different characteristics between the services in each country, not to mention a substantial difference in the contract price, which is in general more than 30% higher in Australia than in New Zealand, and where also part-charging is allowed. Providers involved in IF for under 65s have commented that they can see how it could work in individual over 65 cases. It could suit, for example situations where families wish to keep their older family member in the home, and can use a mix of family and employed support, by using available allocated funding.

d) We think that there needs to be a great deal more flexibility around respite care, and suggest that client directed budgets could be effectively applied in relation to that element of community support.

e) There has been an Individualised funding for older people project running for nearly ten years in Otago. To our knowledge no assessment of its efficacy or worth has been undertaken.

Q16 Which social services do not lend themselves to client-directed budgets? What risks do client-directed budgets create? How could these risks be managed?

Can't comment on which social services, but we can comment on which situations within the home support context, mainly around risk, which we think would not be best suited to client-directed budgets.

a) High and complex clients where the client's physical state is deteriorating quite rapidly and there is a need for constant review and monitoring, and also for expert support

b) Short to medium term Rehabilitative care where the person needs specialized workers, working together, for example with allied health professionals.

c) Situations where the client has a cognitive impairment or is functionally not able to manage the budget and be the employer or contracting person, or where there is no other person who can act in this role on their behalf.

d) Situations which encourage carer dependency and/or which reduce the ability of the client to make their own decisions.

e) Situations which potentially leave the person and/or their family vulnerable to financial or social abuse. There have to be good mechanisms in place to ensure support and monitoring, so that the person gets the support they need.

Q17 What examples are there of contract specifications that make culturally appropriate delivery easy or more difficult?

1. Providers have commented that the contract price does not allow them to afford interpretive services, even though it would improve communication with families where there are language barriers.
2. In general providers try to acknowledge the cultural needs of clients. It isn't always easy to match a client with the worker they want. Also, increasingly, as with residential aged care, the service is reliant on migrant workers, because the wages and conditions are not good enough to recruit New Zealand born workers. That sometimes creates problems with communication. At other times it presents opportunities.

Q18 How could the views of clients and their families be better included in the design and delivery of social services?

a) Ensure there is targeted and separate consultation with clients and families during the consultation phase

b) Ensure that a client and/or family member is on the design panel or there is a separate client advisory group to critique and contribute to the design.

c) Ensure that agencies regularly and actively seek input from families and clients about the quality of services

d) Ensure that agencies run a continuous quality improvement programme, linked closely to their complaints service, and that this includes using clients as advisors.

e) Promote agencies to include an element of client or family engagement in their governance structure.

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

Locally:

- Using alliance contracting and good use of reliable data to tracking population needs
- Actively addressing population needs through locally agreed targets.
- Allowing for and incentivizing innovative locally based outcome based solutions.
- Celebrating successes, acknowledging the value of home based support services and workforce
- Including home based workforce in local workforce development planning

Centrally: Overarching policy framework including:

- Policy on using community care to support people with chronic conditions to live at home
- Policy on supporting closer collaboration between secondary care and community care for people in hospital and during recovery
- Workforce retention and development policy
- Policy on how to prioritise home and community care over residential care.
- Policy on how to ensure expertise is available to community care providers
- Work to identify safe levels of supervision and clinical oversight relative to client case mix
- Policy on and resourcing for the use of Interrai to inform providers and the funders.
- Serious attention paid to needs assessment, to reduce delays, improve integration and efficiency.
- National funding agreements to reduce uneven funding for essentially the same service and to ensure equal access to the same services.
- Requirement of agreed tools such as pricing and costing models.

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?

The two main causes of stifling innovation in our sector are

a) consistently poor resourcing over a long period of time, and

b) contracts that focus only on functional support and do not incentivize client goal setting, recovery and rehabilitation, self-management and innovative use of technology and staffing.

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

Restorative and rehabilitative models operating in New Zealand vary but they all offer some level of flexibility for both the provider and the client whilst also focusing on goals. Where the restorative model is delivered within a bulk funded case mix model that also enables providers to undertake non-complex Interrai assessments, this further incentivizes supporting clients to achieve goals.

Aligning like services, such as needs assessment and home support, community or district nursing and home support.

Establishing a multi disciplinary team approach between secondary, primary and community support.

Q22 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?

We do not have high trust contracts in our sector. We do have instances of alliance contracting and we support that general approach.

Q23 Do Crown entities and non-government commissioning agencies have more flexibility to design and manage contracts that work better for all parties? Are there examples of where devolved commissioning has led to better outcomes?

1) In our sector there has been considerable sub-contracting going on following the 2012 ACC service review. We have not seen any evidence that it has made any measurable difference in terms of better outcomes.
2) We would be very concerned if the commissioning of home support for older people was devolved from District Health Boards to non-governmental organisations for the larger population based contracts. The examples from the ACC service review would apply to any other devolved commissioning:
    a) Providers working under sub-contracts have found that they have lost incentive to innovate because the administrative rate that is taken off the contract rate by the commissioning agency is what used to be their profit.
    b) Providers working under sub-contracts lose their ability to put in place their own quality measures and sometimes feel compromised by the ethics and quality of the commissioning agency.
    c) Providers working under sub-contracts lose their direct connection with the government agency.

Q24 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?

a) In the home support sector providers are almost entirely dependent on government funding because that is the market we are operating in. However there is regular competition for contracts. It remains a hand to mouth funding situation in most areas. Government should be promoting the use of packaged or bulk funding, providing, through gearing of services opportunities to do non complex needs assessment, with incentives to encourage client restoration, aligning community nursing services closer to community services.
b) In terms of providers being fully dependent on government funding, that is the case for most of our providers. An option for reducing dependency would be allowing providers to put in place part charging. However that needs deeper and broader thought and analysis.

Q25 What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?

a) There is much opportunity for improving efficiency and effectiveness for organisations and clients through further use of technology. Technological advancements include rostering and client management, use of cellphone and app technology for support workers, further use of GPS, use of remote client health monitoring and use of medical alarms.
b) We need greater connectivity around New Zealand to allow community nurses to link and input, no matter where they are, to shared records and other centralized data stores.
c) Many of our providers simply don't have the capacity within the contract price to develop their technology.
d) In some instances secondary care technology is running behind community services technology and its incompatibility frustrates community innovation.

Q26 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?

a) Internal capacity to manage client volume
b) Ability to recruit and develop a competent workforce
c) Capacity and high level of motivation to run a person-centred service (rather than an institutional centred service)
d) Capacity to manage the highly transactional nature of the service whilst also being very responsive (that is not a feature of services directly provided by government)
e) Ability to understand varying complexity and to have the organizational and workforce flexibility and size to match the right worker to the right person
f) Ability to meet the cultural needs of the client
g) Ability to be cost effective
h) Ability to integrate like services. The prime example is non-complex needs assessment and home support
i) Ability to be innovative.

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

It is our view that over the last several years contestability has used primarily as a means to cut costs. We cannot say that overall the service has improved through that method. We think that it is more likely that any improvements have resulted from the imposition of required standards.

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

a) Where there is significant client volume
b) Where the provision of service is broadly similar nationally
c) Where there is potential for integration of like services

Q29 For which services in which parts of New Zealand is the scope for contestability limited by low population density?

- West Coast
- South Westland and Central Otago
- East Coast of North Island
- Large Parts of Northland
- Parts of Nelson Marlborough
- Bay of Plenty
- All populated offshore islands
- Tairawhiti and parts of Coromandel Peninsula

Q30 Is there evidence that contestability is leading to worse outcomes by working against cooperation?

a) Our sector has a great deal of contestability over the last several years, and it has been very disruptive to capacity, workforce retention and in some areas service delivery. It has fostered more inter-agency competition than was going on prior. We haven't seen it result in any significant increase in cooperation. Organisations are less keen to share because of the threat to their intellectual capital.
b) It depends what structure is set up following contestability and how well that works. A positive alliance contracting arrangement can help providers and funder work towards outcomes.
c) Larger providers have been able to employ agencies to run their tender bids for them, which makes it harder for smaller to medium providers to compete at the point of commissioning

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

a) Contestable processes are by their nature expensive.
b) Pre-consultation briefings and information sessions, ensuring all those expressing interest get the same information.

Q32 What additional information could tender processes use that would improve the quality of government purchasing decisions?

a) Ensure they get the case mix information right
b) Ensure staff receive training on fair process
c) Ensure that commissioning panel members have the competence to understand the complexities of business and financial calculations, statistical information and to be able to synthesise and analyse all of the information rather than just go on a 'gut feel' or on the presentation.
d) Ensure that more cognizance is given to local providers who currently provide the service, know the area and their staff.

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

a) Enable collaboration and shared goal setting through the use of reliable, shared evidence
b) Ensure case mix information provided in the commissioning stage is accurate.
c) Allow providers to bid on price using a common costing model
d) Where prices are set use the common agreed costing model as a key tool in setting prices.
e) Include in any contracting or commissioning clear agreements about where risk lies, who takes responsibility for significant changes in client case mix.

Q34 For what services is it most important to provide a relatively seamless transition for clients between providers?

a) Home support definitely, as clients rely on staff to help them with activities of daily living, and often build up a close relationship with one staff member.
b) Staff sometimes need to transfer between agencies as a result of commissioning changes, and this creates a tension for clients who have a good support relationship with a particular support worker. Home support providers do have a good deal of experience at transitioning clients.
c) Needs assessment is one area where there is potential for much easier transition.
d) There is more potential for an easier transition from hospital to home (CREST)

Q35 Are there examples where the transition to a new provider was not well handled? What were the main factors that contributed to the poor handover?

a) Legal challenges in relation to the transfer of workers between agencies
b) Lack of clarity in the law (now being amended)
c) Animosity and high level of activity and resistance from exiting providers
d) Funders change from initial decision when facing pressure

e) Poor or incorrect data available pre commissioning. Discovery post commissioning about significant errors in data and formula, causing dispute.
f) Differences in IT systems and HR capacity between transitioning providers
g) Successful provider ignoring legal responsibilities relating to transferring workers.

Q36 What are the most important benefits of provider diversity? For which services is provider diversity greatest or most limited? What are the implications for the quality and effectiveness of services?

Most important benefits of provider diversity in home support

a) It allows for client choice
b) It allows workers to choose the ethic and organisations they like
c) If offers the funder options
d) It can support cultural responsiveness
e) It potentially allows for local innovation

Implications for quality and effectiveness of services

a) Diversity can generate competitiveness in terms of quality
b) There can be variations in competency depending on local management and staff, whether they are training, have a TQM approach etc
c) Funders have more work to do in checking and monitoring quality and effectiveness of the services that they purchase.

Q37 How well do government agencies take account of the decision-making processes of different cultures when working with providers?

a) In our sector almost never. The funder sets the decision-making process from the start, under a risk management paradigm. I can't recall any situation in the DHB or ACC sector where the decision-making processes of different cultures have been taken into account in service reviews or in service design.
b) A different model has been successfully used in the disability scene, with Ministry of Health opening up decision making processes much more to the inclusion of service users.

Q38 Do government agencies engage with the appropriate people when they are commissioning a service?

a) Generally, though pre-commissioning service consultation to assist with service design is more likely to lead to a better service model.
b) There appears to be a lack of trust in or respect of the knowledge that providers have about running their own businesses. This sometimes leads government agencies to seek 'independent' advice which then makes incorrect assumptions about the services being commissioned.

Q39 Are commissioning agencies making the best choices between working with providers specializing in services to particular groups, or specifying cultural competencies as a general contractual requirement?

a) Generally yes, with some marked exceptions eg ACC's service review which completely ignored Maori and Pacific services.

Q40 How well do commissioning processes take account of the Treaty of Waitangi? Are there examples of agencies doing this well (or not so well)?

b) In terms of commissioning almost entirely just an inclusion of words as a 'cover off' without any real intention for it to be applied.
c) In terms of ongoing relationship, the Ministry of Health funds Te Piringa, a Maori disability providers network
d) The Ministry of Health Disability Support Services funds a Maori service user group and the development of the Maori disability strategy. It includes Maori voices in strategic reference groups etc. It also funds a Pacific disability strategy.

Q41 Which types of services have outcomes that are practical to observe and can be reliably attributed to the service?

a) Home support most definitely. They are not measured often. All are also dependent on willing service users. Some are also dependent on other services. They include:
    a. Achieving goals in goal based programmes
    b. Stepping down of services where a person has restored some level of ability or rehabilitated
    c. Increased independence and confidence (eg individualized funding, restorative care, brain injury recovery)
    d. Over a population - Reduction in unplanned hospital visits to hospital
    e. Over a population - Shorter stays in hospital
    f. Over a population - Shorter stays in end of life residential or hospice care
    g. In specific programmes – increased health and wellbeing (nutrition, movement, self-monitoring and self-care, community connections)
    h. A good death at home.

Q42 Are there examples of outcome-based contracts? How successful have these been?

Isolated restorative care contracts include measurements looking at unplanned hospital admissions, length of stay in hospital, time periods for service delivery, results from Interrai home care assessments.

Q43 What is the best way to specify, measure and manage the performance of services where outcomes are not easy to observe or to attribute?

Alliance contracting allows the opportunity for the collective agreement on performance goals.

There are measurable features of some of the services, for example, numbers of clients who have had a full clinical assessment, numbers who have had a home care assessment; identification of delays in home care assessments across services.

Also there is standardization being developed around complaints, which should offer a further indication.

Some authoritative and indepth analysis can be done on the relative spend on home care across DHBs, accounting for area specific variations. This should then be compared to rates of ED admissions, length of stay, falls in homes, and also picking out measurements from clinical assessment or reviews, which can show measurements of health and wellbeing. There is a lot of data available, it is not being used as a form of measurement.

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

There is a lot of data gathered in our sector, but not a lot done with it. Parties need to understand the benefit of using the data.

Q45 What have been the benefits of government initiatives to streamline purchasing processes across agencies? Where could government make further improvements?

Less time needs to be spent on the form of commissioning, and more on process, and the competency and quality of the people involved in the purchasing.

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

There are few studies of the impact of commissioning and purchasing on agencies, on service users or on the workforce. That would be a great area for research.

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

Where the aim of commissioning is cost cutting then it is less likely to reinforce successful approaches.

Q48 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?

We can only speak for home support (DHB, ACC and disability). An investment approach would be an improvement on what currently exists, but it should not be all-encompassing and should still allow for regional design. The significant gaps in terms of an overarching investment approach is coherent policy and an eye over national consistency rather than operational or service design. Using the example of the MSD investment approach:

- We lack clear long-term outcomes based on external valuation and which can be influenced by both the Ministry of Health and the individual District Health Boards.
- There are accountability mechanisms. Some of these are built into commissioning in all areas, some are built into commissioning in some areas, some exist only in one area. They should be more consistent, but cannot be applied unless the price reflects what is being purchased.
- There is some flexibility of funding in some areas, but not enough, and this should be driven by national and regional policy. In relation to DHBs funding flexibility should not be centrally controlled. Notably there is considerable and increasing flexibility in relation to individualized funding for personal care and other related services for people with disabilities. We support that.

Q49 how can data be more effectively used in the development of social service programmes? What types of services would benefit most?

a) There is significant data (Interrai assessments including both full clinical and homecare assessments) which is not being analysed at all on a broader basis, nor does there appear to be any coherent planning to use this data to inform service planning and outcomes. It needs fuller analysis. It should also be available for providers to measure their service against it. This would be a great contribution to the sector. It is currently not being used, because of a lack of will to resource it, and analytic competency.

b) This data then also informs the development of case mix formula for Health of Older people services. The formulae are flawed, there is more than one operating and there is no oversight from the IT Board, nor of the Interrai Board of their quality.

Q50 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?

No comment

Q51 How do the organizational 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?

Ministry for Social Development appears to be a leader in commissioning and contracting.

District Health Boards, operating in a deficit world, focus on commissioning as a way of reducing costs. They are also clinician driven and so tend to prioritise secondary and clinical services over community services.

Q52 How do the organizational culture and leadership of government agencies affect the adoption of improved ways of supplying services? In what service areas is the impact of culture and leadership most evident?

Again, MSD appears to be leading in some respects, in terms of whanau ora and contracting.

Same comment as in 51 re focus of services.

Q53 What institutional arrangements or organizational features help or hinder the uptake and success of innovative approaches to service delivery?

Q54 have recent amendments to the Public Finance Act 1989 made it easier to coordinate across government agencies? Are there any examples where they have helped to deliver better social services? What further measures could be effective?

The change to the PFA that allows for funding to be combined across funding streams (MSD, Health, Education etc) is a breakthrough for disability services and those who use them. There is a great deal of potential for whanau ora outcomes to be achieved as well. Mental health is another area where services could be better aligned to the client's need.

Q55 Are there important issues for the effective commissioning and contracting of social services that will be missed as a result of the Commission's selection of case studies?

We cannot comment, as our service was chosen as a case study.

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

HCHA has met with the Commission. We are happy to meet again should that be felt necessary.

[i] Pge 65-66, Productivity Commission Issues Paper