Submission by Platform Trust

Productivity Commission's Issues Paper (October 2014)

More effective social services

24 November 2014

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Introduction

1. Platform Trust is a national network representing a wide range of community organisations that provide health and disability support, predominantly in the area of mental health and addictions. (See www.platform.org.nz).

2. Most members receive the majority of their funding for the provision of mental health and addiction services from the District Health Boards (DHBs). Other sources of funding include, but are not limited to, the Ministry of Social Development, Ministry of Health, ACC and Corrections.

3. Please note that the views in this submission reflect the experiences and views of a range of non-government organisations (NGOs) that are currently providing mental health and addiction services to local communities across New Zealand. We understand that many of Platform members are independently providing information to the Productivity Commission.

4. The submission is presented in five sections:
    a. Context
    b. Contracting issues
    c. Commissioning for outcomes
    d. Summary
    e. Appendix – summary of individual NGO responses

5. Platform Trust has three key recommendations:

    Recommendation One

    Develop one set of agreed rules for how all government and crown agencies must engage with, contract with and fund NGOs. For example, the following three documents could become the rules, rather than guidelines, for engaging with the social sector:

    - Treasury (2009) *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown and Good Practice*
    - Office of the Auditor General (2006) *Principles to underpin management by public entities of funding to non-government organisations*
    - Department of Internal Affairs (Community & Voluntary Sector) *Code of Funding Practice*.

    Recommendation Two

    Given our concerns around commissioning competency and capability, establish strict monitoring of government and crown agencies application of the rules proposed in recommendation one. Establish and include a pan-NGO body as an integral partner to the monitoring process.

Recommendation Three

Commission an independent report to identify what a contemporary, state provided, specialist mental health and addiction service could look like and what therefore could reasonably be devolved to NGO and primary care providers. Initiate a pilot in one or two DHBs that is benchmarked against the current model delivered by the other eighteen DHBs.

Establish a small team of highly skilled commissioners to oversee changes, working in partnership with participating DHBs, NGOs and primary care organisations but not employed by them.

Recommendation Four

Develop a single agreed contracting matrix (based on high, medium and low trust categories) that serves to promote 'choice and voice' for service users and their families. The matrix outlines the type of contract, the term, level of associated auditing, extent of reporting and the degree of provider autonomy at each level in the matrix.

Section one - context

6. There has been a wealth of national and international evidence on the damaging educational, health, social and economic impacts of childhood disadvantage, neglect and abuse which has resulted in a number of cross- government initiatives such as the Children's Action Plan, Addressing the Drivers of Crime initiative and the Prime Minister's Youth Mental Health Project.

7. We believe that it is critical to support a diverse range of high performing providers to help meet the needs of people, families/whānau, and local communities. The problems that people are contending with are complex and require cross-agency solutions that are built on good partnerships and close working ties amongst providers.

8. MH&A NGOs are well positioned to be part of this broad social network. They provide a wide range of mental health, addiction and wellbeing services as well as some highly specialised programmes to specific populations including Māori, Pasifika, Asian and Refugees. These services are situated within an even broader spectrum of community agencies, all of which are striving to improve social outcomes for people in their local communities. Examples of the diversity and different types of MH&A services are outlined in the table below:

Different types of mental health, addiction and wellbeing NGO programmes	
Social housing, housing brokerage and homeless services	Addiction counselling including methadone treatment
Employment facilitation	Residential rehabilitation and treatment services
Healthy lifestyles programmes	Vulnerable children and youth services
Family and friends support services	Eating disorder services
Whānau ora services	Respite, crisis and trauma services
Refugee and migrant	NGO workforce development activities
Peer support	Sector training and cultural competencies
Intellectual and co-occurring disability services	Strategic workforce development

9. In New Zealand, 90 per cent of people who experience mental health and/or addiction issues are cared for in the community. Successive governments have supported the development of the MH&A NGO sector, especially in the years prior to the establishment of the DHBs. In 2007 the Mental Health Commission restated its commitment to the NGO sector as having a significant role in the provision of front-line mental health services.

10. In 2010/2011 there were approximately 395 NGO providers that offered a wide range of MH&A services to consumers and their families/whyānau. Collectively, this part of the sector attracted about 30 percent[1] ($379.9M) of all MH&A funding ($1.252 billion)

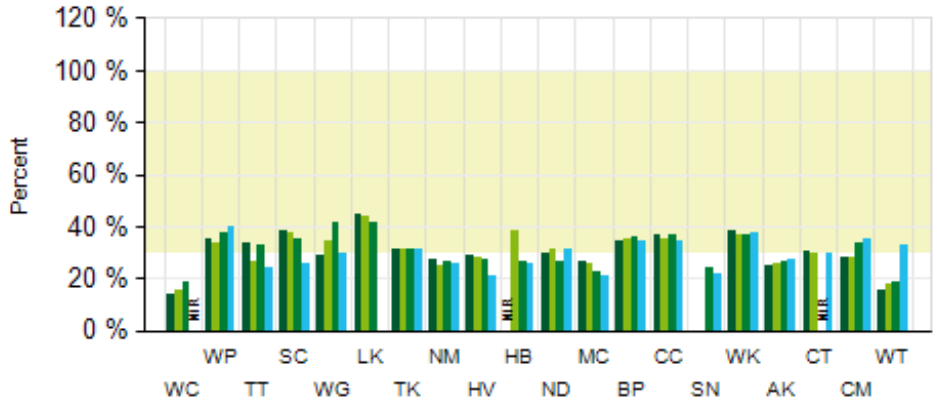
11. In 2013/14, the situation has been eroded with fewer numbers of MH&A NGO providers (the exact number is unknown) operating in the sector with a decreased percentage (28 percent) of the total spend for MH&A services.

12. The number of NGOs has declined due to mergers, services closing and some contracts not being renewed. Funders have been quick to reduce their transaction costs by encouraging fewer MH&A service providers in the market, but it remains to be seen if the drive for greater efficiencies will result in more effective services and better outcomes for people and their families.

13. The percentage of funding that is allocated to MH&A NGO services varies considerably around the country (see figure 1). In 2012/13 it ranged from 21 percent of the DHB's overall budget for MH&A services (Southern DHB) to 40 percent (Wairarapa DHB & Lakes DHB).

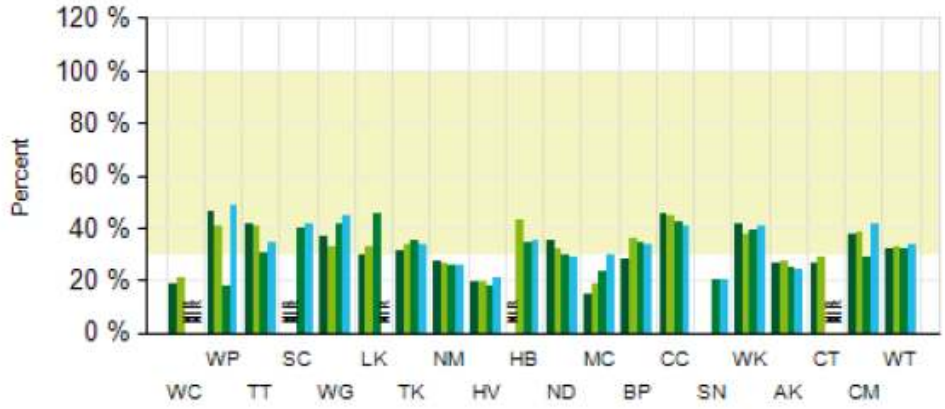
[1] Ministry of Health (2014)

Figure 1: Investment in MH&A NGO services overall (National KPI Project, March 2014, p39)



14. As the information is not readily available in a standardised format, it is difficult to make reliable year-on-year comparisons, but recent figures show that the adult MH&A NGO services continues to attract about 30 percent of all funding for adult MH&A services (see figure 2).

Figure 2: Investment in adult MH&A NGO services (National KPI Project, March 2014, p39)



15. If the information in these two graphs is correct, it would indicate that whilst the total investment in MH&A services has continued to increase over time, the erosion of the NGO share must be occurring in those MH&A services that target either child & youth and/or older persons. This is alarming given that both of these population groups are the focus of government policies which aim to address known social issues and population change pressures (eg, vulnerable children; meeting the health needs of an ageing population).

16. Note that NGO service provision is higher in the alcohol and other drug (AOD) part of the sector compared to mental health, with approximately 48 percent of all AOD funding (10 percent of the total MH&A spend) being directed to AOD NGO service providers.

Section two – Contracting issues

Fair funding

17. The values and tenets of market liberalism have dominated policy decisions in New Zealand since the mid-1980s, with the main form of economic control being through prices and competitive markets.

18. Brian Easton (2002) concluded that the New Zealand experience over the early 1990's provides strong evidence that comprehensive commercialisation – business practices within, market relations between institutions – does not make a significant contribution to the design of effective health systems. It is important to note that market contestability in the mental health and addiction sector only occurs where 28% of the investment occurs (in the NGO sector) not where bulk of the investment lies in the provider arm of the District Health Boards.

19. In a recent visit to New Zealand, Professor Julian Le Grand (2014) stated that most of the empirical evidence continues to support the use of a quasi-market rather than comprehensive commercialisation for the delivery of effective health care, especially when the price is fixed.

20. However, the situation in New Zealand is that the price paid for MH&A NGO services is not fixed. In fact the price paid for very similar MH&A services varies widely across the country without any clear justification for the variation (eg, there is a difference of $33,389 per annum for a community alcohol and drug FTE). [2]

21. The community sector often finds that they are in the position of having to accept a price rather than negotiating one. Some DHB funders have not changed the contract price for the same service over the past five years despite the growing complexity in client needs and the increase in costs to deliver those services.

22. The lack of information about price increases and the lack of transparency in the way that funders apply annual Contributions to Cost Pressures (CCP) to community organisations makes it difficult for NGOs to budget for service developments. At best, this level of uncertainty hinders the ongoing development of community MH&A services and, at worst, it risks the financial viability and sustainability of many community organisations.

23. The price that funders are willing to pay for NGO services is important because it influences workforce entry decisions, education and training decisions, the quality of labour, retention and productivity gains and the overall sustainability of the organisation over time.

24. The quality of labour is important for improved productivity as a higher skill level means that staff are more able to work more effectively with service users and their families. It requires a reasonable level of skill to support individuals who have a mental health and/or addiction disorder, who are more than likely also suffering from

[2] http://www.fairfunding.org.nz/

multiple morbidities, are socially and economically disadvantaged and possibly living in a household that is also in crisis.

> *Clients and their families continue to experience on-going and often multiple challenges (physical, emotional, mental, spiritual, social and cultural). The main concerns reported referred to housing, financial difficulties, food insecurity, barriers to adequate and appropriate health/social supports, severe life changes, personal and family members' safety, social isolation and disconnection from the family or community (Newtown Union Health Service Annual Report, 2014).*

25. It is almost impossible for NGOs to challenge funders about price or the significant and unfair differential between DHB funding and NGO funding. For example…..*our FTE rate is expected to meet all costs of service delivery, development, infrastructure and capital expenditure. (This is) not so for DHBs who are increasingly our competitors. We have lost a number of our top staff to DHBs and the statutory sector where significantly higher salaries have been the principle attraction* (Platform Trust, 2009).

26. If no action is taken to level the playing field with regard to what constitutes a fair price for NGOs, the national policies that aim to promote the shift of health care services from the DHB provider arm into the community sector are unlikely to gain any traction.

Funder competency

27. The lack of price increases experienced by many MH&A NGOs, particularly over the past five years, is very hard to accept when a number of DHBs are underspent against the Government's Budget allocations. Because of the national MH&A ring-fence policy, these surpluses are very visible; with a $22.85 million underspend being reported by DHB funders for the 2012/13 year[3] alone. Whilst any surplus has to be reapplied to MH&A services in the following year, it is not being used to help address the NGO pricing issue.

28. The Mental Health Commission commented on the surplus issue in 2007 and stated that one of the problems was that the DHB planning and funding capacity had not kept pace with the increases in MH&A funding. In the *Report on Progress 2004-05*, the Commission indicated that it would like to see more development in the capacity (and capability) of funders and planners to commission mental health services.

29. Based on the Ministry of Health data there appears to be a correlation between the removal of the funder/provider split (HFA to DHB) and the flat-lining of the development at the community/NGO end of the support spectrum.

30. A decade has passed since the Commission's *Report on Progress* and the situation has worsened rather than improved. Urgent action is now needed to address the deficit in skills demonstrated by many DHB funders.

[3] Ministry of Health (2014)

31. NGO service providers will continue to be hampered in their efforts to increase their productivity without some level of support from funders who understand their commissioning role and who possess the necessary skills to engage with service providers and local communities to address the health and social issues that are impinging on people.

The difference between funding and commissioning

32. Heginbotham & Newbigging (2014) highlights the distinction between the funding of services and the commissioning of services. *Funders simply assess needs, procure services and then monitor service provision. Commissioners bring together the value of programme fidelity and the evidence base with a developed understanding of the local context, borne from the active participation of local communities and local people* (p53).

33. O'Brien (2013) describes commissioning as an iterative and collaborative process that requires a deep understanding of the evolving needs of the community as well as key priorities that need to be delivered. It requires the design and delivery of services that can meet these needs and utilise the full capabilities of providers and community groups. It also requires the identification and maximisation of opportunities for collaboration and innovation to challenge thinking and consider the best way to meet needs.

34. What NGOs experience at the moment is not commissioning, it is planning and funding, and not of a particularly high standard. As per the previous section on 'budget surpluses', some targeted investment is required to help funders learn how to become good commissioners. This is particularly important as the sector moves towards a more results based approach.

Recommendation one

Develop one set of agreed 'rules' for how all government and crown agencies must engage with, contract with and fund NGOs. For example, the following three documents could become the rules for engaging with the social sector:

- Treasury (2009) *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown and Good Practice*
- Office of the Auditor General (2006) *Principles to underpin management by public entities of funding to non-government organisations*
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Recommendation Two

Given our concerns around commissioning competency and capability, establish strict monitoring of government and crown agencies application of the rules proposed in recommendation one. Establish and include a pan-NGO body as an integral partner to the monitoring process.

Section Three - Commissioning for outcomes

35. The context of the government's reforms of the mental health and addiction sector in the 1990s was one of increased investment and rapid growth, based on some input resource guidelines published in the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998). The objective was to increase access to more and better services in response to some high profile failures of the MH&A system.

36. In many respects, the implementation of the Blueprint was a success, as it attracted a steady investment in additional MH&A services over a number of years. In more recent times there has been a greater focus on whether or not this increased capacity is actually delivering 'value for money'.

37. As funding agreements start to shift from using input and output measures to measures of outcome, concerns have been raised about the lack of attention that is being paid to the establishment of a transition period that includes some considered changes to the contracting infrastructure.

38. For example, the wide-spread introduction of outcome-based agreements into all health and social services will require a complete overall of the current accountability framework that takes into account the different requirements of a number of related sectors (eg, health, social development, disability).

39. It is possible that some existing contract reporting requirements may no longer be necessary or useful in an outcomes based contract, in which case organisations will need to be given time to transition their staff and their IT systems to accommodate a new way of reporting.

40. If we are really serious about looking at a whole of system, whole of investment approach then commissioning will need to take into account all the current use of resource including that which is currently directly funnelled into Crown agencies including DHB mental health and addiction provider services. This is currently where the greatest expenditure lies. This would urgently drive a the need to review or redefine what constitutes a specialist mental health and or addiction service and what could reasonably be considered as in the frame of contestability as originally discussed in Better Public Services Advisory Group Report (2011)

41. Such a significant shift in approach will also require a significant shift in mind-set. The establishment of an outcome-focused health and social sector will rely on major culture change at multiple levels in all parts of the sector. The government will need to be prepared to invest in a significant change management process that includes training and support for those community providers that have not had the benefit of being involved in the implementation of Results based Accountability (RbA) agreements funded by the Ministry of Social Development.

42. In addition, government will need to create opportunities to connect the business units throughout the Ministry of Health, Ministry of Social Development, Ministry of Business, Employment and Innovation, Health Workforce NZ, the Health Quality and

Safety Commission, professional bodies, District Health Boards and community organisations.

43. Whilst the Better Public Services work programme aims to increase the collaboration and sharing of resources across government agencies, most community providers continue to experience government departments as being fragmented and operating with little knowledge of complementary or parallel projects (eg, streamlined contracting pilot).

Recommendation Three

Commission an independent report to identify what a contemporary, state provided, specialist mental health and addiction service could look like and what therefore could reasonably be devolved to NGO and primary care providers. Initiate a pilot in one or two DHBs that is benchmarked against the current model delivered by the other eighteen DHBs.

Establish a small team of highly skilled commissioners to oversee changes, working in partnership with participating DHBs, NGOs and primary care organisations but not employed by them.

Desirable features of a new contracting framework

44. The proposed integrated performance incentive framework for primary health care (see figure 3) encapsulates some of the features of a more desirable contracting framework. It relies upon the concept of system level measures, which are set nationally and which are largely based on routinely collected datasets that already exist. The contributory measures are locally determined in response to the needs and priorities of local communities. Both sets of measures are useful from the perspective of promoting **collective impact**.

45. Please note that the collective impact model was described in an article in the winter edition of the Stanford Social Innovation Review (2011). It requires partners from the community, government and private sector to come together and systematically align their activities around clearly defined goals. The five conditions for a successful collective impact initiative are as follows:

- Common agenda – participants have a shared vision for change
- Shared measurement – collecting data and measuring results consistently across all participants
- Mutually reinforcing activities – participant activity must be differentiated while still being coordinated through a mutually reinforcing plan of action
- Continuous communication – consistent and open communication across all participants to ensure trust, shared objectives and common motivation
- Backbone support organisation – a separate organisation with staff to be backbone of the entire initiative and co-ordinate all participants' efforts.

Figure 3: Integrated Performance and Incentive Funding Framework (Ministry of Health, 2014)

46. The integrated performance incentive framework also sets a clear direction and provides incentives for providers to move towards a breakthrough level of achievement. At the highest level (i.e. high trust) providers are afforded maximum flexibility along with reduced levels of compliance and contract monitoring. Conversely, organisations that are new entrants, or that have a history of poor performance (i.e. low trust), have stricter parameters within which they can operate, have to report more information about what they are doing and have to demonstrate compliance with a number of relevant standards.

Recommendation Four

Develop a single agreed contracting matrix (based on high, medium and low trust categories) that serve to incentivise providers and to promote 'choice and voice' for service users and their families. The matrix outlines the type of contract, the term, level of associated auditing, extent of reporting and the degree of provider autonomy at each level in the matrix.

Summary

47. It is important to offer service users a choice of providers/services (where this is possible) and to use other drivers (eg, consumer choice and voice) as well as incentives to encourage providers to become more effective and efficient. However, poor pricing practices coupled with increased compliance, complicated contract reporting requirements and unrealistic performance targets are compromising the capacity of community organisations to deliver high quality services.

48. If the priority now is to make the health and social system more responsive to the needs of the local population, then the current model for commissioning community services needs to be reviewed in the light of the evidence about what works in other sectors and in other jurisdictions. The scale of productivity improvements now required means that funders and organisations will need to look across care pathways and services – not just within organisations – to reduce waste and eliminate inefficiencies. The collective impact model may offer a way for key stakeholders to achieve this.

References

Department of Internal Affairs (Community & Voluntary Sector) *Code of Funding Practice*
Easton, B. (2002) *The New Zealand Health Reforms in Context*. Retrieved on 6 November 2014 from http://www.eastonbh.ac.nz/2002/06/the_new_zealand_health_reforms_in_context/
Heginbotham & Newbigging (2014) *Commissioning Health + Wellbeing.* Sage Publications Ltd.
Kania, J., & Kramer, M. (2011). *Collective Impact.* Stanford Social Innovation Review.
Le Grand, J. (2014) *The Reform of Social Services: Problems, Pitfalls – and Prizes.* New Zealand Treasury Guest Lecture Series: Practice and innovation in social services: lessons from the UK.
Mental Health Commission (2006) *Report on Progress 2004-2005. Towards Implementing the Blueprint for Mental Health Services in New Zealand.*
Mental Health Commission (2007). *Te Haererenga mo te Whakaoranga 1996-2006: The Journey of Recovery for the New Zealand Mental Health Sector.*
Mental Health Commission (1998). *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington: Mental Health Commission.
Ministry of Health (2014) *Mental Health, Alcohol and Drug Sector Performance Monitoring and Improvement Report 2012-13.*
New Zealand Treasury (2009) *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown and Good Practice.*
Newtown Union Health Service (2014) *Annual Report.*
Northern Regional Alliance (2014) *Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services: National Adult Mental Health Services FY 2013*. Published version.
O'Brien, S. (2013) *SA Health Clinical Commissioning Framework. Adelaide: SA Health Policy and Commissioning Division.*
Office of the Auditor General (2006) *Principles to underpin management by public entities of funding to non-government organisations.*
Platform Trust (2009) *NGOIT: 2008 NGO-DHB Contracting Environment.*
State Services Commission (2011) *Better Public Services Advisory Group Report*

APPENDIX ONE: Summary of individual NGO responses to the questions in the discussion paper

Questions	Your Response
Q1. What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?	Increasing complexity of mental health issues due to early child abuse/neglect, social stress and illicit drug use, particularly in Christchurch and Auckland, homelessness/low grade accommodation. Housing, family violence, crime, health, education, employment, skills training etc. The ageing demographic of both clients and workforce will have significant impact on the work of our sector.
Q2. How important are volunteers to the provision of social services?	They are important, but cannot replace dedicated, trained and paid staff in the majority of roles. Training volunteers shifts resources (particularly time) from client/organisational focus. Volunteer workers can be transient due to their life needs, and the effort and training required for them to competently work for an organisation may be wasted should there be volunteer turnover. Vital in many organisations. It can also be a stepping stone to personal and professional development. Volunteer governance if crucial to the community organisations.
Q3. What role do iwi play in the funding and provision of social services and what further role could they play?	They have an important role if they are prepared to support existing NGOs who are well established and proven outcomes. Role of iwi varies hugely across the country. The role of urban Māori organisations is critical.
Q4. What contribution do social enterprises make to providing social services and improving social outcomes in New Zealand?	Can only speak on actual experience from community perspective, they are like mushroom season; they sprout up when manure is spread in the field and disappear when it is used up. Social enterprises will only succeed if there is financial start up and support as we have seen in other counties.

Questions	Your Response
Q5. What are the opportunities for, or barriers to, social-services partnerships between private business, not-for-profit social service providers and government?	Private are contract/business driven, not-for profit are sustainable and socially driven. Whilst there is government enthusiasm for these partnerships there is little incentive both financially and for reduction of bureaucracy. The welfare state culture continues to preclude private business wanting to engage in partnerships.
Q6. What scope is there for increased private investment to fund social services? What approaches would encourage more private investment?	To address the social inequalities that affect New Zealand today can be best approached collectively and by every means as a country not by the minority.
Q7. What capabilities and services are Māori providers better able to provide?	Knowledge of their working environments, in most their cultural dynamics and protocols to be prioritised, being able to strategically utilize and access resources such as human and natural (people, environments (marae/forest, seas), cultural understanding (one box does not fit all).
Q8. Why are private for-profit providers significantly involved in providing some types of social services and not others?	Profit return and not social return (dependence over independence).
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?	Although we have no direct experience of these initiatives, we understand that difficulties arise for NGOs when the final tranche of contract payment is paid only at the conclusion of the project/contract time. Such a business model is unsustainable when contracting with NFPs (Not for Profit organisations) who, by their nature rely on regular and predictable injections of contract funding for their cash flow.

Questions	Your Response
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?	Commissioning agencies need to focus on those who deliver outcomes effectively and not favouritism. Those organisations that are well established in their communities are adaptable because they keep things simple and achievable. MSD seem more succinct in their processes than many of the DHBs. The argument for short term contracts used by some funders is so that they can deal with poor performance. However, in practice, funders spend more time processing renewal of short-term contracts for everyone, including strong performers, and thereby making all NGOs use their time less efficiently. It would be far better to have longer term contracts, and for funders to spend more time with individual NGOs that may struggle, to help raise overall performance. We have successfully "mentored" other NGOs when they were struggling. Communicating to NGOs when they are new to a contract, or suggesting a link to one that is performing stronger would pay dividends. The Prime Minister's Youth mental health initiatives were piloted through MSD and Health. Feedback from the sector indicates that MSD process was inclusive and they left it to the 'community experts'. On the other hand in health when this work transferred from the Ministry of Health to District Health Boards they preceded to micro-manage and destroy innovation.
Q11. What other international examples of innovative approaches to social service commissioning and provision are worth examining to draw lessons for New Zealand?	Many external strategies continue to do more harm as statistics show Māori have and continue to increase no matter what strategy is put in place because its understanding has no significance to one cultural world. The approach has to be something one can relate to giving it significance/reality (why).
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?	In most cases they have no relevance to differing cultures with differing beliefs and values. The New Zealand environment is characterised by aversion to risk and bureaucracy.

Questions	Your Response
Q13. Where and when have attempts to integrate services been successful or unsuccessful? Why?	Te Hau Awhiowhio o Otangarei Trust is an example of integrated service as intended by whānau ora, working as one with a common goal (being whānau transformation) and not as competitors (silo/contract driven). Over-specification of contract deliverables drives people to remain only within the scope of the contract, which may not encourage integration. For example, the differentiation of primary and secondary health spend - it may be better to allow a percentage of spend more frequently to flexibly work in the margins between the two? Many NGOs work very collaboratively with other NGOs to achieve social outcomes – Like Minds Like Mine has some good examples of that in the past. Longer-term contracts help support that collegiality and leads to integration of services. The command and control of many government departments makes it extremely difficult to integrate particularly health and social services at a local level (e.g. MSD children's teams).
Q14. What needs to happen for further attempts at service integration to be credible with providers?	Governance and policy seem to be the obstacle in achieving integration not relationship as it is still working in isolation. Culture change within purchasers.
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?	Budgeting, counselling, youth services, whānau ora navigation/ pathway, social housing, health, justice etc. Longer-term rather than shorter term individual services. A better focus would be on encouraging client-directed service provision regardless of who has budget control in terms of efficiency. There is no reason why individual funding models cannot be implemented; however the risk is moving the level of bureaucracy from service organisations to individuals.
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?	This depends on those tasked with the responsibility of facilitating this process Māori/ non- Māori. In some cases Māori whānau are at risk to those trusted as their own to protect and take care of.

Questions	Your Response
Q17. What examples are there of contract specifications that make culturally appropriate delivery easy or more difficult?	I revert back to Waitangi claim Wai 414 which relates to a claim by Whānau Waipareira Trust and urban Māori, many Māori organisations are located in the urban settings as Māori whānau (80-86%), on winning their case it is still hard for those organisations to gain equity preference over their Iwi authority. Over specified, standardised contract specifications in the mental health environment do not lend themselves to a contemporary New Zealand view.
Q18. How could the views of clients and their families be better included in the design and delivery of social services?	Whānau ora processes have shown the way.
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?	All of the above, for who knows their community best but locally. If it can be achieved locally then it has its merits regionally. Over reliance on centralisation or decentralisation has its draw-backs either way. The consequence of not making decisions at the appropriated level is disillusionment, which then leads to poor outcomes for clients.
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?	Yes as the preference is given to large favoured organisations that have no relationships with those communities and considered authorities of the state causing barriers at the go. Yes. Continual or steady erosion of funding value is the main factor. We have introduced innovations over the last three years, which are now in danger of being discontinued due to their ongoing cost The most ridiculous response has been government contracts that require responding RFIs for innovation.
Q21. How can the benefits of flexible service delivery be achieved without undermining government accountability?	Only through an integrated approach can this be achieved.

Questions	Your Response
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?	Some organisations have those high-trust contracts but still struggle to convince funders for long-term investment and yet there outcomes for other social services contract have the same standard as an organisation.
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?	This process is ongoing; it is hopefully to be more streamlined for NGOs.
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?	This is best answered by those who analyse data and outcomes of funding agencies. It is a reality that the Crown is dependent upon the community sector to deliver services that it is unable to or uneconomic for them to deliver. This is not a dependency issue, the Crown needs to resolve that it will pay a fair price for the services that it has a responsibility to ensure is delivered to New Zealanders.
Q25. What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?	That all stakeholders including whānau/ client can view progress or issues relating to transformational wellness. IT moves very quickly, and NGOs are forced to look for efficiencies in the cost of running IT. There is opportunity there to enhance the consumer experience, and also to minimize costs, particularly for smaller organisations. While cost is a limiting factor, I think it is access to well thought-through expertise that often holds back smart change. The community sector is already using information technology and data and this could be hugely increased. There are already some exciting examples of this (e.g. Linkage www.linkage.co.nz and NZ Navigator www.nznavigator.org.nz). Government departments are so fragmented that the IT delivery is not integrated with service purchase. Government systems are out dated and inefficient (e.g. PRIMHD)

Questions	Your Response
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?	Again policy and governance dictate whether an organisation will or/not shift its approach as a service provider.
Q27. Which social services have improved as a result of contestability?	Major non- Māori organisations, Iwi providers.
Q28. What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?	Many NGOs struggle under the same criteria as mainstream services and agencies to justify its capacity and capability.
Q29. For which services in which parts of New Zealand is the scope for contestability limited by low population density?	Taitokerau/ Northland, East Coast, Nelson region.
Q30. Is there evidence that contestability is leading to worse outcomes by working against cooperation?	Contestability has been a destructive force in undermining community cooperation, however if we are to use a contestable system it should be applicable for all services including those currently run by the Crown.
Q31. What measures would reduce the cost to service providers of participating in contestable processes?	Already reductions in provider purchasing.
Q32. What additional information could tender processes use that would improve the quality of government purchasing decisions?	Outcomes evidence based assessments and audits.
Q33. What changes to commissioning and contracting could encourage improved services and outcomes where contestability is not currently delivering such improvements?	Identify key areas of need and identify those consistent providers.
Q34. For what services is it most important to provide a relatively seamless transition for clients between providers?	Inmate release's re-integration and ministries (work & income) youth suicide, family violence, diabetes, youth justice.
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?	Communications, and professional respect (community NGO/ Ministry), information sharing.

Questions	Your Response
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?	Flexibility, and adaptability, the willingness to or/not to adjust appropriately, or policy, or behaviours. Providing services to isolated rural communities is difficult and expensive and limits diversity.
Q37. How well do government agencies take account of the decision-making processes of different cultures when working with providers?	Agencies are accommodating but are rigid on protocols and processes, and in some cases ignorant of cultural beliefs or values. On the whole those responsible for purchasing services have very little experience of different cultures and this is reflected in the decisions they make.
Q38. Do government agencies engage with the appropriate people when they are commissioning a service?	The use of the word of commissioning is over used in the health system. The behaviour that is experienced is that of 'funding' services. Commissioning will require a totally different mind-set and paradigm shift, including engagement with communities.
Q39. Are commissioning agencies making the best choices between working with providers specialising in services to particular groups, or specifying cultural competence as a general contractual requirement?	No, again they have chosen their own preferred providers not proven providers. I'm only talking of our North Island commissioning agency.
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)?	It is hard to determine if they are accommodating within the intent of the treaty as it's still about contractual protocols and preference.
Q41. Which types of services have outcomes that are practical to observe and can be reliably attributed to the service?	Whānau ora practicing organisations in its true intent. (Whānau aspiration/ organisation assistance.
Q42. Are there examples of outcome-based contracts? How successful have these been?	Otangarei Trust (Out of Gate), corrections re-integration. Otangarei Trust/ Te Puawaitanga health centre merge, under the intent of whānau integrated servicing.
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?	Review of the plan of action by an organisation, if there are any variances from its original positioning.

Questions	Your Response
Q44. Do government agencies and service providers collect the data required to make informed judgments about the effectiveness of programmes? How could data collection and analysis be improved?	Yes, as part of the organisation audit process and ministries policy for accountability. Government has a key role to support and promote the use of evidence based tools for providers to select from. There is a significant role for co-production between government and community organisations to collect and use data.
Q45. What have been the benefits of government initiatives to streamline purchasing processes across agencies? Where could government make further improvements?	The need for Government agencies to review performance outcomes and fund appropriately to those services adequately and appropriately. Most important, value those services and acknowledge their values and achievements. Government could make better use of intermediaries who know and understand the sector e.g. Platform.
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?	One hopes to think so, but some believe that change is too hard or just not prepared to change, organisation/ practitioner.
Q47. Does the commissioning and purchasing system encourage bottom-up experimentation? Does the system reinforce successful approaches and encourage reform of less successful ones?	NGOs don't normally get that reply or recognition.
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?	It is ok to have that approach but what is concerning is that some services are asked to extend into another region, where I believe investment need to be more supportive of services through training or other resourcing to meet the regions capacity. (Makes each other another competitor threat).
Q49. How can data be more effectively used in the development of social service programmes? What types of services would benefit most?	Those with more training needs and resourcing requirements.
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?	Organisational review, collective practitioner review, service provider review.

Questions	Your Response
Q51. How do the organisational culture and leadership of government agencies affect the adoption of improved ways of commissioning and contracting? In what service areas is the impact of culture and leadership most evident?	Government agencies are a law unto themselves - example: When an allegation is made against an organisation they are ostracized within that sector, when a clear breach has been made by an statutory practitioner he/she has the luxury of the act to fall back on, something of a grey area.
Q52. How do the organisational culture and leadership of providers affect the adoption of improved ways of supplying services? In what service areas is the impact of culture and leadership most evident?	It is definitely evident in most Māori organisations.
Q53. What institutional arrangements or organisational features help or hinder the uptake and success of innovative approaches to service delivery?	Criteria for outcomes in ministerial protocols of achievement.
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?	Haven't experienced any benefits as of yet.