

SUBMISSION OF THE NEW ZEALAND DISABILITY SUPPORT NETWORK (NZDSN)
TO
THE NEW ZEALAND PRODUCTIVITY COMMISSION
ON
MORE EFFECTIVE SOCIAL SERVICES – ISSUES PAPER (OCTOBER 2014)

1. NZDSN

The New Zealand Disability Support Network (NZDSN) was formed in 2010. It is an incorporated society of approximately 150 members and is represented by a Board of Governance. It is funded primarily via membership subscriptions, supplemented by income from conferences and forums, as well as specific contract work. The majority of NZDSN's members are providers of disability support services for intellectual, physical and sensory impairments for people up to the age of 65 years. Providers range from very large national organisations to small local organisations which support only a handful of people.

NZDSN's Vision is "An Inclusive New Zealand" and its purpose is to lead and influence change that supports inclusive lives.

In its work, NZDSN seeks to:

- provide a strong voice to government on matters of common interest;
- support and maintain strong networks across providers of disability support services;
- ensure effective communications with members;
- keep abreast of emerging trends and promote current best-practice standards;
- actively promote the continuous improvement of disability support services and foster the on-going development of skills, knowledge and capacity of members; and
- work collaboratively with disabled people, their families and allied agencies to foster an inclusive society.

2. The New Zealand Disability Support Sector

Statistical Overview

An increasing proportion of New Zealanders live with a disability. The 2013 New Zealand Disability Survey reports that 24 per cent of the population has a disability, compared with 20 per cent in 2001.¹ The age specific rates for the 2013 survey are 11 per cent for those under 15 years, 13 per cent for 15-44 year olds, 25 percent for 45-60 year olds and 54 per cent for

¹ New Zealand Disability Survey 2001 and 2013, Statistics New Zealand, Wellington. In the survey, disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities.

those over 65 years of age. The situation largely arises from an ageing population, combined with an increasing incidence of disability.

The 2013 Disability Survey reports that for adults with impairments, 47 per cent had a physical disability, 20 per cent had a hearing impairment, 12 per cent had a psychological/psychiatric impairment, 7 per cent had vision impairment and 12 per cent had a memory, learning or speaking impairment.

For children, 7 per cent had a physical impairment, 8 per cent had a hearing impairment, 21 per cent had a psychological/psychiatric impairment, 54 per cent had impaired learning or speaking or a developmental delay, 4 per cent had vision impairment and 5 per cent had an intellectual impairment.

In summary, disability comes in many different forms – and to different social groups, including age groups. While there are general characteristics of the sector, it is important to recognise that many of those who support disabled people are niche providers – whose services may not be easily adaptable to a different disability or different social group. In fact, the disability sector is highly balkanised; it would be misleading to assume a provider of, say, mobility services for older adults could easily switch to providing services for students with learning disabilities – even in the same locality. In so far as there is a unity in the sector, it arises from the funding arrangements.

The largest share of formal disability support services is funded by the State. (There is a dearth of information on the size and scope of the informal sector.) The largest purchaser of disability support services is the Ministry of Health (MoH). In the 2014/15 budget, \$1.118 billion (7.2 per cent of Vote: Health) was allocated to purchase national disability support services, which aim to support people to live as independently as possible in their communities. Currently, a number of new initiatives are being trialled by MoH, including the “New Model” which is focused on giving disabled people and their families/whānau greater choice, empowerment and flexibility concerning their support and its funding in their everyday lives.

The Ministry of Social Development (MSD) purchases vocational services (including community participation) for disabled people, often known as “day services”. In the 2014/15 budget, \$73.282 million (approximately 0.3 percent of Vote: Social Development) was allocated to *partially fund* “participation and inclusion of disabled people”. “Enabling Good Lives” is a promising new approach to service delivery which is being led by MSD. It involves pooling the funds of the Ministries of Health, Education, Social Development, as well as ACC in order to offer individuals greater choice and control over the supports they receive and the lives they lead.

The Ministry of Education provides support for children with disabilities, including through operating and funding the Ongoing Resourcing Schemes (ORS), which applies to people with severe disabilities.

ACC provides rehabilitation services as well as continuing support for people with injury-related disabilities. In addition, it provides earnings related compensation and is involved with numerous injury prevention initiatives.

Work and Income (of MSD) provides income to disabled people who meet specific criteria.

Key Protocols

Three centrepiece documents for the New Zealand disability sector are: the New Zealand Disability Strategy 2001 (NZDS); the United Nations Convention on Rights of Persons with Disabilities (UNCRPD); and the Disability Action Plan 2014-18.

The NZ Disability Strategy presents a long-term plan for changing New Zealand from a disabling to an inclusive society. It was developed in consultation with disabled people and the wider disability sector, so reflects many individuals' personal experiences of living with a disability. The Strategy's vision is of a society that highly values the lives of disabled people and continually enhances their full participation. It sets out a framework to provide guidance to government agencies making policy and providing services for people with disabilities. In taking the lead, the Government is required to do everything possible to influence the attitudes and behaviour of society as a whole. The strategy supports the notion that New Zealand can become a fully inclusive society if all New Zealanders consider the issues facing people with disabilities, including their aspirations.

New Zealand signed the UNCRPD at the United Nations on 30 March 2007 and ratified it on 26 September 2008. The convention makes explicit that signatory states must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability. This is already a feature of New Zealand law.

Like the New Zealand Disability Strategy, the UNCRPD covers all areas of life, and all ages and life stages. In doing so, it places obligations on government and the private sector. The Government, however, is accountable to the United Nations – and government agencies are required to take leadership in encouraging action by the private sector.

The Disability Action Plan 2014-18, which was approved by the Ministerial Committee on Disability Issues on 8 April 2014, sets strategic priorities that advance implementation of both the New Zealand Disability Strategy and the UNCRPD. The plan emphasises actions across sectors that require collaboration between government agencies, Disabled Person's Organisations and other entities.

The plan's shared vision is for disabled people to experience equal rights of citizenship. Supporting this vision are five person-directed outcomes that have been developed to focus activity on making a positive difference in disabled people's everyday lives. These outcomes are: safety and autonomy; wellbeing; self-determination; community and, lastly, representation.

Austerity in the Sector

Key features of the disability sector are the meagre resources available to it and the poor wages paid to the vast majority of workers in it. A key reason for this predicament is that the disability sector does not operate under competitive market conditions. In fact, it is inherently non-competitive for reasons such as the following.

Market competition requires that there be many providers and freedom for them to enter and exit the market. Commonly, for many categories of disability services, there are a limited number of providers – often only one – in particular localities and specialties and the incentives for others to enter the market are often weak, or virtually non-existent. Thus, disabled people often have little or no choice of provider.

Even when there is choice, it is not easy for the client to know which provider will best suit them.² Disability support services are not homogeneous, varying in quality of delivery, logistical/convenience factors and a host of subjective characteristics which, nonetheless, are crucial to the client. Clients with, say, an intellectual or sensory disability – or even those who just lack confidence – may be at a particular disadvantage in making good choices and even when someone else (such as a family member) acts as an agent for them, there can be problems. Often, it may come down to trial and error but, nonetheless, it can be cumbersome, awkward and distressing for a disabled person to change to another provider, assuming there exists the option of an alternative provider.

A further problem is that disability³ itself is largely a random event, unable to be planned for in advance through saving/budgeting and life adaptation. This applies to congenital disabilities as well as those caused through injury/accident. The consequences of such events can be life-changing for individuals and families. Insurance before the event is often not an option. Even when there may exist private insurance mechanisms, the longer term repercussions of a disability are not always adequately covered. Moral hazard and adverse selection add to the inefficiencies of relying upon private insurance for funding. Ultimately and understandably, for many of the more serious disabilities, New Zealand's choice has been social insurance funded from general taxation or a special levy – as in the case of ACC.

Altogether, it is concluded that markets often offer a seriously flawed response to the funding and provision of disability support services and this is a key reason why improving the funding, pay rates and status of the sector is proving an arduous task.

As a demand-side response to the failure of the private market, governments in many countries with mixed-market economies, including New Zealand, purchase a wide range of disability support services from providers.

This, however, leads to a further problem. In New Zealand, the Ministry of Health, as the dominant purchaser of disability support services, has monopsony power. Thus, it can develop contracts in such a way that prices for disability support services are driven down. Providers have no choice: they must accept the MoH purchase price if they want to receive funding at all for their service(s).

The situation is similar with “day services”, which are “partially funded” by MSD. Notably, many providers of day services have received nil increase in their contract payments for well over a decade. This situation has been sustained despite general price inflation, increases in the minimum adult wage, legislation mandating four weeks annual leave per year, as well as mandatory employer contributions to KiwiSaver.

Clearly, the monopsony prices paid by government agencies are no reflection of the value of the services provided, in terms of what they are worth to society – taking into account the outcomes that are being achieved for people.

One way that providers can counter the status quo is to spread their sparse resources evermore thinly, reducing the quality of their services. Inevitably, however, the point is reached where such an approach becomes impracticable – and even unsafe. Numerous

² A good match is critical. Disabled people and their families greatly value providers that do things the way they want them done and, most importantly, with staff they can relate to and trust.

³ More correctly, it is “impairment” (e.g. physical, intellectual or sensory) which is random. The social model of disability views “disability” as a consequence of environmental, social and attitudinal barriers that prevent people with impairments from having maximum participation in society.

providers now report that they are near the brink of shutting down their day service programmes.

In practice, the monopsony purchasing situation has made the sector a low-pay labour market, despite aspects of the work being highly skilled, stressful, and physically demanding. The reality is that the vast majority of workers in the sector are not paid as much as workers in comparable occupations in more competitive sectors of the economy, because providers lack the government funds to pay higher rates. Further, there is a concern that the numbers of regulated (registered) workers are declining because of inadequate funding, as will be elaborated upon through this submission.

An NZDSN survey⁴ conducted in late 2012 found that the average minimum rate of pay of disability support workers in MoH funded disability support services was \$15.00 an hour, while the average maximum paid was \$18.50 an hour. The weighted average was \$16.36 an hour. The lowest reported salary paid by providers in the survey was the then minimum adult wage of \$13.50 an hour (as at 1 April 2012). In comparison, the average wage for all NZ workers was \$25.42 an hour (as at December 2011).

In 2008, the PSA conducted a job evaluation exercise⁵ which highlighted the pay and funding gap between disability support workers working in residential support, and i) therapy assistants (employed by District Health Boards) and ii) corrections officers (employed by the Department of Corrections). The exercise identified that the work of all three positions was comparable, yet the top pay rate for therapy assistants was 22 percent more than for disability support workers, while the top pay rate for corrections officers was 52.1 percent more than for disability support workers.

Dr Geoff Bertram⁶ (Senior Associate of the Institute for Governance and Policy Studies at Victoria University of Wellington) found that to achieve parity with therapy assistants, the average wage for disability support workers would need to increase in the range 8-16 percent and to achieve parity with corrections officers, an increase of about 50 percent would be required. From this, he calculated that to achieve parity with therapy assistants would cost around \$50million dollars in additional wage payments, while parity with corrections officers could not be achieved for less than \$250 million in annual wage costs.

There are labour shortages and high staff turnover across New Zealand in all roles within the disability workforce – disability support workers, home and personal care workers, clinical and allied professional staff, administrators and managers – because the sector cannot compete with the remuneration levels offered across the private and public sectors. The disability sector simply cannot achieve the level of workforce stability of other sectors, despite stability being a pre-condition for quality care and support.

A situation of lower quality care caused by high staff turnover and inadequately skilled (although usually very caring) staff, poses a number of risks. People with disabilities may not often complain in public but the likelihood is that there will be particular events that do come to the public's attention and cause an outcry – for there is no evidence that the public really want poor quality support services for disabled citizens. Such events will be just the tip of the iceberg of poor quality care. Whatever short term “bandage” measures might be applied,

⁴ NZDSN survey data as reported in: Improving Funding for Disability Support Services and Disability Support Services: A Business Case to the New Zealand Government, PSA, December 2012, page 13.

⁵ PSA (2008), Community Support Workers: a job evaluation exercise.

⁶ Bertram, G., *Cost of moving Community Support Worker pay rates up to parity with comparator occupational groups*. Schedule A in “Improved Funding for Disability Support Services and Disability Support Workers: A Business Case to the New Zealand Government”, PSA, December 2012, pages 8-13.

they will not address the long term structural issues. The government needs to invest in the disability sector now, in order to avoid future crises. In any case, the status quo is incongruent with government's future policy directions in relation to initiatives such as the New Model and Enabling Good Lives.

3. NZDSN's Submission

A number of larger members of NZDSN are making their own submissions to the inquiry. Thus, in recognition of the fact that the voices of small providers need to be heard, NZDSN has taken the step of liaising with some of them. NZDSN has advised a number of small providers about the inquiry and forwarded them copies of the Issues paper. Specific questions in the paper considered to be of particular relevance to small providers were highlighted, generating helpful responses from them. Further, the CEO of NZDSN and a staff member met with 25 members of the Christchurch Small Provider Network on 7 November, as well a group of 30 providers at the NZDSN Living Options Forum held in Wellington on 18 November 2014.

4. Preliminary Comments on "More Effective Social Services"

We note from the Inquiry's terms of reference that the principal focus of the Inquiry is determining the institutional arrangements that would support smarter purchasing/commissioning, as well as determining what market arrangements, new technologies and contracting or commissioning tools would help achieve results.

Thus, the Inquiry clearly has *efficiency* as its key focus. NZDSN supports efficiency as a goal of all social services and notes that it is a very different concept from the concept of "cost containment / cost cutting" and its manifestation known as "cost shifting".

In fact, the disability sector has become very weary of cost-shifting, having been subjected to its pervasive negative impact over many years. Effectively, in the disability sector, costs are shifted from government onto private individuals and households, because of systemic underfunding. Rather than the reasonable costs of disability services being met by government, effectively they are shifted onto, i) sector workers (who receive lower pay) and, ii) clients and their families (who get less service at a lower quality than they might reasonably expect). Fundraising, charitable donations (including bequests), income from "business enterprises" and the work of volunteers help ease the burden. Nonetheless, the situation does not accord with any notion of efficiency.

NZDSN notes that there appears to be a lesser emphasis on equity in the Inquiry. We make this point because both economic efficiency and social equity are often seen as being key "twin goals" of social services. Clearly, the pursuit of technical and higher-level allocative/social efficiency would be in vain if the output of social services was not distributed in a way which is perceived as being equitable. When the Issues paper mentions "improving outcomes for New Zealanders from social services funded or otherwise supported by government" (page 5) we read this as capturing the notion of distributional equity. Nonetheless, in the body of the report, the equity dimension appears to have been somewhat marginalised.

As already signalled, another issue that needs emphasising is the quality of disability support services. Quality of service delivery needs to be centre-stage if disabled people are to enjoy good lives. By way of background, with the move to institutionalisation from the 1940s, there developed greater recognition of the need for adequate staffing and adequate training for staff. Better staff:patient/client ratios and better training were introduced across the country,

so that there was a growth in regulated (registered) workers in the disability sector. For example, at the Kimberley Centre near Levin, there was not only an on-site School of Nursing for the training of psychopaedic nurses but also a National Training School that ran courses for training officers that worked alongside nurses. These were both closed more than 20 years ago so that by the time the Kimberley Centre was closed in 2006, a substantial proportion of staff was untrained and unqualified.

While much of the training of staff in the institutional era reinforced the now outdated paternalistic and medical models of care, it was replaced with very little training for staff who worked with disabled people from around 1990 onward. Training was then left largely up to providers. Being severely constrained by funds, their response has been inconsistent to say the least.

Clearly, although the move to deinstitutionalisation and community services has required a higher level of autonomy from support staff – and therefore a higher level of skill and expertise – paradoxically, the shift has been characterised by reduced access to training, reduced levels of supervision, and reduced access to peer support and expert advice. The fall in the numbers of regulated (registered) workers, as discussed earlier, is one manifestation of the situation. Notably also, in the present era, well trained people in the disability sector are at risk of being poached by other employers – both public and private sector – where the pecuniary rewards are much larger.

Further, the separation from the funder and provider that is a hallmark of the contemporary era of deinstitutionalisation has enabled government to distance itself from the adverse effects of its underfunding, including any concerns about quality standards, as well as the poor wages and conditions of workers. We note that workers directly employed by the State have, historically, been able to maintain fairer wages and conditions than their counterparts in contracted out services – as well as share in the benefits of systemic upskilling programmes.

We conclude here that the whole area of government funding, pay rates and quality of service delivery is inextricably bound together and a source of major concern. It is in need of urgent thought and resolution.

We also have concerns in the area of social services about the efficacy of markets or quasi-markets in promoting efficiency through competition. It would be easy to be seduced by a more market solution to the disability sector. Nonetheless, NZDSN accepts that there is a need for more prudent design of the regulatory framework for the sector and that the design may incorporate some elements of the market mechanism.

Internationally, however, the evidence cautions us that the processes of competition in health and social services are notoriously difficult to create and sustain – even with extravagant investment. The uncritical adoption of the market results in failed outcomes, undermining both efficiency and equity goals. There may be some gains that are achievable through prudent competition/contestability measures but, as discussed in section 2 of this submission, commodities such as health care and most social services (including disability support services) do not bear close resemblance to the types of commodity for which markets can be demonstrated to yield economically efficient outcomes.

Overall, in producing disability support services we would anticipate the gains from a “more market” approach (or attempting to make an inherently non-competitive market behave like a competitive one) to be very restricted. After allowing for transaction costs and the transition

costs (of moving from one regime to another) the net return from a substantially altered regime is likely to be negative. Greater gains to society might well be attainable from:

- i) better training and upskilling of management and workers
- ii) the adoption and sponsoring of new IT technologies
- iii) the systematic trial of new, innovative ways of delivering disability support services, as is taking place now with regard to demonstrations such as The New Model and Enabling Good Lives – and rigorous evaluation of such innovations with regard to their effectiveness and cost-effectiveness from a broad perspective
- iv) placing more emphasis on the value of service delivery and outcomes for people, in contracts
- v) Incentives and strategies to further promote and develop the social capital which is a hallmark of the sector, such as contracts that build in incentives for cooperation/collaboration between services and localities
- vi) Strengthening measures to assist disabled persons to find employment

Accordingly, this submission is prefaced with three tenets:

Tenet one: Whatever eventuates, the provision of high quality disability support services should not be compromised.

Tenet two: There is no case for cutting government funding to the disability support services sector. Conversely, there is a strong case for additional funding to improve the quality of support and care.

Tenet three: The transaction costs and transition costs of any new regime should never be ignored or underestimated.

5. Responses to Selected Questions in “More Effective Social Services”

Question 1: What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?

Perhaps the issue of greatest concern for the disability sector is the growth in the proportion of New Zealanders living with a disability, which seems likely to continue, given the projections from the New Zealand Disability Surveys and the aging of the population.

A critical issue will be the declining availability of volunteers, which has been a worsening problem for several decades. The situation is unlikely to change, testing the resilience of disability support service providers into the future.

It is true that until around the 1980s, there were disability providers which received zero government funding but were supported by women volunteers who, i) provided services to disabled people and, ii) carried out fundraising to ensure the services were financially sustainable through time. The fundraising typically consisted of knitting, weaving, sewing, embroidery and home baking – and the sale of such home-made merchandise through community stalls. Today, this model of service delivery has become largely irrelevant because the supply of women who can engage voluntarily with the disability sector has steadily reduced over time as a result of the surge of (married) women into the formal labour force in the 1970s. A much increased proportion of women of working age are now in paid employment.

Given that, as a result of women working, the State is gathering more tax revenue, there is a case for some of this additional tax revenue being channelled back to the sector to compensate it for the loss of women's voluntary input.

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

Volunteers have made a significant, worthy contribution to disability support services in New Zealand. In using the word "volunteers", it is appropriate to include the family and friends of disabled people. Collectively, these people make a sizeable (unpaid) contribution to the support of disabled persons, so that they may achieve better quality lives. Without volunteers, provider organisations would be subjected to higher levels of anxiety and stress – and there would be commensurate pressure on the State to fund services at a higher level.

Even so, (the diminishing number of) volunteers cannot be expected to possess the levels of expertise and skill that is associated with regulated (registered) workers. Thus, if volunteers substitute for regulated workers in MoH-funded support services and MSD-funded vocational services (day services), then issues may emerge concerning the quality of service delivery.

It may be convenient for the State's finances, in effect, to cost-shift care and support onto volunteer workers (who nonetheless give of their best effort) but there is the risk that there might be some negative impact on the quality of service delivery. This issue is well illustrated with respect to vocational services (including community participation) funded by MSD. Many providers of these services have not experienced any increase whatsoever in their bulk funding for well over a decade. Thus, there has been substitution of volunteers for trained/registered teachers, as well as for other professions such as occupational therapists and social workers. This discussion is in no way a criticism of volunteers. It is the inadequate level of government funding and consequential low pay in the sector, and their negative impact on the quality of support services that needs addressing – and rapidly.

Question 10: Are there any other innovations in commissioning and contracting in New Zealand that the Commission should explore?

New Zealand exhibits the familiar problems of all other social service systems. Cost data are few and outcome measurement is largely absent. There are large variations in actual practice, while incentive structures are underdeveloped and can induce perverse behaviours. Contracts are notoriously constrained by the absence of cost-effectiveness data. As well, information flows are almost entirely restricted to processes rather than outcomes.

Nonetheless, disability support providers do understand the relevance of contracts to the funding and provision of support services. Arrangements which make contracts and the process of contracting straightforward and transparent will win favour with them.

The managers of small providers are very often working managers, having hands-on involvement with (as well as responsibility for) the everyday routines and challenges of providing quality support to clients. Typically, they see their primary function as working with staff to achieve the best outcomes for their clients and do not necessarily aim to become expert at contracting and competitive tendering processes. A contestability focus might produce a new cadre of (higher-paid) managers who are good at competing but that does not necessarily imply that they will also be good at delivering support to disabled people. (Presumably, the increase in their salaries would be funded by government.)

As well, providers do not want to incur high costs in working through the contracting process, as that effectively uses money that would otherwise be devoted to providing support. It

follows that a focus on minimising transaction costs is essential for an efficacious contracting regime.

NZDSN is observing with interest the development of the new public sector procurement initiative (led by MBIE) and, in particular, i) the new contracting framework for streamlined contracting with NGOs and, ii) the Results Based Accountability (RBA) system for outcomes management.

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

Most disability support services are well suited to client-directed budgets. (The disability sector prefers the term “person-directed budgets”, as this recognises the right of citizenship of persons with a disability.)

A few services, however, are not suited to client-directed budgets. These would include behavioural support services, as well as services to support the administration of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. The Act provides for the compulsory care and rehabilitation of individuals with intellectual disabilities that have been either, i) found unfit to stand trial or, ii) convicted of an imprisonable offence. There are two different levels of care – Secure Care (hospital level or community based) and Supervised Care (community based). Care is in designated secure or supervised facilities, respectively, and the care recipient is required to remain in the designated facility, other than for periods of approved leave.

Client-directed budgets, in being person-centred and allowing choice, empower people with disabilities and their families so that it becomes easier to tailor support to individual needs and goals. Implicit is a recognition that individuals, in fact, usually know what is best for them and that it is a positive, enriching experience for them to be in better control of their own lives. The evidence suggests this is a key way through which people can be enabled to lead meaningful lives and feel like other members of their communities. This approach is in accordance with the vision of “inclusiveness” and moves away from a State-driven, paternalistic model of decision making.

The “Enhanced Individualised Funding” scheme and the “Choice in Community Living”⁷ scheme (both of which are parts of MoH’s “New Model”), as well as the individualised funding packages of MSD’s “Enabling Good Lives”, all embrace client-directed budgets. Currently they are being implemented on a trial/demonstration basis in parts of New Zealand. The results, to date, appear promising. There is a growing expectation that these programmes may be systematically extended through New Zealand and funded in a way that will underpin their continuing success. NZDSN’s members assert that carefully designed and monitored local experiments are a far more efficacious way of introducing change than is the full-blown, radical imposition of a new regime based on theory (or ideology), rather than (empirical) evidence.

Note that the sector is moving to “supported decision making”, whereby the disabled person makes their own decisions. This is replacing the now outmoded method of substituted decision making using a third party, albeit the latter remains in common use.

⁷ Choice in Community Living offers particularly good examples of client-directed budgets for people who cannot easily manage their own money, staff and administration.

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

Many disability support providers employ people with disabilities (and family members) at a range of levels and roles (from CEO's to front-line support workers). Governance Boards of providers typically include family members of the people they support.

Clients and families are also well represented when there are: regular opportunities to observe the service in action; a formal and open feedback/complaints system; and other opportunities for clients and families to comment as they wish on any aspects of the service.

Those designing and delivering services need a high level of skill to interpret how particular local factors/characteristics can be incorporated into the structure of service delivery. Services face the challenge of developing the means to involve families within these constraints. Advisory groups can be effective in this respect. Notably, this approach is being built into the Enabling Good Lives demonstration.

Question 19: 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?

In the commentary in the Issues paper preceding this question, it is stated (page 45) that "Delivery of services by small local units is typically more expensive and less efficient than delivery by large units." The disability sector would be very interested to know what evidence NZPC has to verify this comment.

With regard to smaller providers of disability support services, we certainly challenge the statement. Largeness is not necessarily a prerequisite for achieving efficiency in the delivery of many disability support services. In fact, we would question whether economies of size or scale commonly exist in the sector. In bygone days of institutionalisation, there may have been economies of size/scale with large groups of disabled people sharing the same premises. Deinstitutionalisation, however, has been a hallmark of the modern era. With many people now living in homes in the community and accessing services such as supported living, and home and community support services, economies of size and scale (if they exist[ed] at all) are less relevant.

What is clear is that many small providers do not have extensive (or expensive) capital requirements (aside from the few which own the homes where their clients live) and operate from areas of small space. Typically, their management costs are low and there may be input from volunteers. Flexible working arrangements are common. Almost invariably, low cost habits are evident. Notably, liaison/networking and cooperation with similar providers, as well as with supplementary/fall-back services, tends to be strong. Further, goodwill and loyalty both within and between (small) local communities is a characteristic feature.

Clearly, these factors promote lower average costs of operation – as low, or lower, than might be achieved by larger providers, including for-profit operators. The situation also provides for equity in that the services of small providers – for example, those operating in localities with small populations – are likely to be more accessible by disabled people than the services of large providers operating in a city which is some distance away.

Page 52 of the Issues paper states that the Commission has heard that current (tendering/contracting) practices favour larger providers, who have more resources to draft funding submissions and work through the contracting process. NZDSN is also aware of such allegations. Our view is that most small providers strive to provide good quality

services, as well as offering extremely good value for money. Very often, the close proximity to a smaller number of clients means they can easily tailor their services to the specific requirements of disabled people in their communities. With various types of care in particular types of context, small providers have a comparative advantage.

Without small providers, the whole system of service delivery would become less flexible and worse integrated. (See the earlier comments on “balkanisation” in section 2 of this submission.) Foreseeably, if small providers in some localities were to shut down their operations, there might be no provider to replace them, leading to disruption in the lives of their clients. The notion of a “seamless service” would be put at risk as a consequence of fragmentation.

NZDSN believes that government contracts should be administered on a level playing field and without prejudice to the size of individual providers. Any barriers to small providers entering into contracting with government agencies should be eliminated or mitigated.

Question 20: Are there examples where government contracts restrict the ability of service providers to innovate? Or where contracts that are too specific result in poor outcomes for clients?

Providers will no doubt describe numerous examples of problems and anomalies with contracts in their submissions.

NZDSN frequently hears concerns about government contracts being unnecessarily restrictive – to the detriment of disabled people – and offers the following as examples as a brief selection.

Commonly, there are complaints about contracts that prescribe set hours for client contact with support people. For example, MSD vocational services can only be delivered between 9:00am – 5:00pm on weekdays. Logistically, however, there are some educational activities that would be more conveniently scheduled in the evening or weekends – yet such arrangements are not possible under the contracting regime.

Further, MSD vocational funding cannot be used for services delivered in the client’s home. In many circumstances, however, the client’s home offers the optimal environment for the client to engage in particular activities. Thus, the current regime creates an obstacle for disabled people in getting a service tailored to their specific needs.

MOH’s vocational funding, as well as certain other streams of MoH funding, sometimes prohibit any work outcome from being specified in contracts. There are many circumstances, however, where a work outcome would not only be relevant – but highly desirable. There can be no good justification for work outcomes not being recognised, where they are potentially achievable. The current regime creates a perverse situation – to the detriment of disabled people, their communities and wider society.

Further, MOH funding of supported living services only allows providers to provide staff as support – even when other modes of support (e.g. technological) would be more effective and more cost-effective. This is economically inefficient.

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

For many disability support providers in many parts of New Zealand, competition and contestability have little, if any relevance. It would be a folly to imagine that potential

providers are poised waiting to exploit commercial opportunities in the sector, in pursuit of lucrative profit-making opportunities. Even if this was the case, it is unlikely that such “firms” would have the culture required to become effective/virtuous providers of disability support services.

Further, adversarial relationships (implicit in competition/contestability) between disability service provider “competitors” would bridle against the cooperative, collegial (sharing) relationships that the sector is renowned for. Any such clash of cultures would compromise the goodwill across the sector. Effectively, there would be a detriment to the sector’s stock of social capital – and, thus, the very efficiency with which the sector operates. Inevitably also, recognition of the value (to society) of disability services in contracts would risk being further undermined.

Most disability services across New Zealand are provided by NGO’s who do not have a profit motive. Instead, they juggle their meagre resources to provide the best quality service that they reasonably can, to as many clients as they can reasonably cater for. Often, however, there remains a large unmet need for support services within their communities, because funding is inadequate. Workers at all levels in the disability sector earn low pay, with many of them not earning sufficient income to cover their opportunity cost.

Typically, the disability sector and its workers (including volunteers) aim to “do good for those less fortunate” rather than to “do well for themselves”: it is factors such as altruism, selflessness, fairness, compassion, goodwill, generosity and a sense of service/purpose that make a positive difference to the lives of disabled people that drive the sector. Most providers merely aim to survive (profit being irrelevant) and in the current environment they are being sorely tested.

Question 36: 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?

Undoubtedly, one of the most important benefits of provider diversity is that it promotes choice for clients and, thus, the likelihood of getting a better match between client and provider. This is one of the most important issues for disabled people and their families, as discussed in section 2 of this submission.

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

Lack of transparency at the commissioning stage can lead to problems. Sometimes, NGOs do not know which individuals or organisations are involved with advising government agencies and, thus, the approach being taken by government may be uncertain, or seem irregular. This can lead to confusion and awkwardness.

There is a widespread belief across disability support providers that government officials are less insightful and/or have a less in-depth understanding of the service being commissioned, than individuals who have had direct personal experience in the field. This risks misunderstandings and terse interactions.

Consultants are sometimes involved with Ministries’ commissioning and purchasing functions. It has been observed that their for-profit commercial imperative – and the mentality it yields – can mesh awkwardly with the underlying social imperative shared by NGO disability service providers.

Question 52: How do 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?

Organisational culture and leadership are pivotal in creating innovative environments which foster continual improvement in the delivery of good outcomes for disabled people. A healthy, functional and open culture, where there is a shared respect for clients and staff will lead to the optimal type of organisational culture for disability providers.

Where providers achieve this environment, it is important to recognise them as model providers and offer a means for them to share their success with others – who might benefit. NZDSN pro-actively supports this approach, through offering the sector opportunities to network and communicate – via forums, workshops and its annual conference. Leadership in the sector is recognised by NZDSN in a number of ways. For example, an integral part of the NZDSN annual conference is the Awards Ceremony – which specifically recognises providers and individuals that make an outstanding contribution.

Disability service providers tend to measure their success in terms of delivering positive outcomes for their clients. Attainment of such outcomes depends largely upon strong, innovative leadership and its alignment with the needs and wants of clients. Further, providers are likely to embrace a philosophy of social justice – while a sense of community will also be evident.

Question 53: What institutional arrangements or organisational features help or hinder the uptake of innovative approaches to service delivery?

An open, pro-active management culture is a healthy one and one that is conducive to successfully implementing innovative approaches to service delivery. Other features of organisations that promote innovation are: a well-trained and properly skilled workforce; having processes/procedures/templates which help promote and encourage new ideas; the dissemination and sharing of success stories; and systems of recognition/reward for individuals and groups that think of useful innovations.

Providers are well aware that their existence hinges upon service delivery that meets with the purchaser's service specifications – the latter not necessarily equating with the reasonable requirements of clients. Further, new services that fill a genuine need for disabled people but lack a track record, are often difficult to obtain funding for. Processes for funding approval tend to be drawn out and tedious. They are a source of vexation for clients, their families and providers alike.

Small, agile NGOs that can access philanthropic funding/grants often have a better chance of being innovative and creative. If they do not receive any government funding, they have little to lose in experimenting with new ideas and approaches, in the best interest of improving the quality (and quantity) of service delivery.

6. Conclusion

As the provider association of a considerable number of New Zealand providers of disability support services, NZDSN has been pleased to present a submission to the Inquiry.

One of the things that struck us in preparing the submission was the stress that the sector is under in sustaining services. Provider organisations are typically busy and stretched – and daily routines are often punctuated with crisis situations.

Many providers became aware of the Inquiry through NZDSN's communications to them. They have responded with a good amount of information and commentary, despite the pressures they are under.

The sector as a whole is committed to striving for efficiencies but in an on-going era of cost-containment and austerity, the likelihood is that there is no fat left to be trimmed. The cupboard is not so much empty, as missing.

The sector would like to move into a new era, where its work in supporting disabled people to live better lives is properly recognised and valued. It sorely needs a boost to its morale and status.

This can only come from better funding and resourcing. Without that, service quality and quantity are at grave risk of being compromised – to the point where the outcomes for disabled people are not acceptable to New Zealand citizens.

A handwritten signature in cursive script, appearing to read 'Clare Teague', is centered on a light-colored rectangular background.

Clare Teague
Chief Executive Officer
New Zealand Disability Support Network
December 2014