New Zealand Productivity Commission

Submission on *More Effective Social Services* Issues Paper

Public Health Association of New Zealand

Introduction

The Public Health Association of New Zealand (PHA) is a national association, with members from the public, private and voluntary sectors, which provides a forum to share information and debate about public health in Aotearoa New Zealand.

Public health action aims to improve, promote and protect the health of the whole population through the organised efforts of society[1]. The social services PHA delivers relate to the wellbeing of the whole New Zealand population and its sub-populations – however these may be defined - rather than to individuals.

PHA's primary source of funding is its contract with the Ministry of Health to provide leadership, support collaborative action and improve the capacity and capability of the public health sector.

PHA's interest in this inquiry aligns with the Government's mandate and the Commission's purpose to improve outcomes for New Zealanders. In this regard, PHA shares the concern to improve the way that commissioning and purchasing influence the quality and effectiveness of social services.

The Ministry of Health reports[2] that **"**Most New Zealanders are satisfied with health services and report a positive patient experience. Internationally, New Zealand compares well in terms of access to health care." However, in its 2014 BIM[3] the Ministry advised the incoming Minister of its major concerns:

- changing population health needs and burden of disease (especially the rising impact of long- term conditions and risk factors, such as diabetes and obesity)
- the growing impact of health-care associated infections, antimicrobial resistance and emerging infectious diseases, eg, Ebola
- rapid advances in technology, developments in personalised medicine and changing public expectations
- an ageing population, and a workforce that is ageing along with the population

[1] In this context, public health refers to the "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society." (Acheson 1988 cited in https://www.**health**.govt.nz/system/files/documents/.../birdseyeview.pdf)

[2] Ministry of Health. Annual Report for the Year Ended 30 June 2013 including the Director-General of Health's Annual Report on the State of Public Health. Wellington: Ministry of Health.

[3] Ministry of Health. 2014. Briefing to the Incoming Minister 2014. Wellington: Ministry of Health.

- a constrained funding environment for the foreseeable future
- a growing fiscal sustainability challenge as health consumes an increasing proportion of total government expenditure.

Public health – as distinct from personal health services – has the potential to make a significant contribution to managing these challenges, such as tobacco control, reducing alcohol-related harm, obesity and preventable infections such as rheumatic fever.[4]

1. Social, economic and demographic trends that will change the social services landscape in New Zealand

- **Demographic change.** The 2013 census demonstrated population trends that will change the character of the NZ population radically over the rest of the century. These trends relate to population size, age, urban migration (especially to Auckland), immigration and ethnic diversity (especially Asian). They are having, and will continue to have, significant impacts on wellbeing and the services required to maintain and improve the nation's health.
- **Inequalities.** Inequality, poverty and welfare all appeared to be high on the public's agenda in this year's election. UMR's research[5] suggested that over 70 percent of New Zealanders thought the gap between rich and poor is widening and that the overall effects of this are bad. This is a view shared strongly in the health sector, as deprivation is implicated in the burden of both infectious and non-communicable diseases requiring hospitalisation. Chronic disease associated with tobacco, obesity, alcohol and poor nutrition have long-term implications for employment, education and productivity.
- **Environment.** The origins of public health as a State responsibility derive from the spread of infectious disease in urbanising societies resulting from environmental degradation – clean air, water and waste disposal. While these remain fundamentals of health protection, the NZ College of Public Health Medicine[6] says that **"**Climate change is almost certainly already contributing to the global burden of disease and premature death, with larger health impacts expected over coming decades. These potentially catastrophic health impacts disproportionately affect developing countries, and the most disadvantaged and vulnerable within all countries. Aotearoa New Zealand will not be insulated from these consequences." These impacts include:
    - Consequences of heat waves, extreme weather events, and urban air pollutants;
    - Food yields, water flows, and infectious disease vectors;

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

[5] http://umr.co.nz/updates/mood-nation-2014

[6] http://www.nzcphm.org.nz/policy-publications

- Mental health in failing farm communities, displaced persons, and economically deisadvantaged groups;
- Conflict over access to essential resources e.g. water, food, timber and living space.

- **Technology.** Since 1970, the percentage of GDP spent on health in NZ has doubled, rising from 5.2 per cent to 10.1 per cent in 2010.[7] Much of this increase can be attributed to new technology, including pharmaceuticals, surgical procedures and information technology. These are welcome developments, and in some cases they relate to exponential increase in demand for treatment for preventable conditions, such as dialysis for the treatment of diabetes.

- **Political change.** The Commission's discussion paper draws attention to the changing role of the state and the mix of social service providers. Changes initiated in the 1980s opened up significant opportunities for both for-profit and not-for-profit non-government organisations to engage in the provision of social services. However, there has not always been a clear understanding among many of the actors in this expansion – including within Government and among government servants - of shared expectations of each other's roles, capacities, and accountabilities. Whatever direction future governments choose to take regarding the plethora of social service actors and divergent interests, there needs to be serious thought about how the non-State services can best be mobilised to make an effective and sustainable contribution to the wellbeing of all New Zealanders. While the dynamic nature of the social services market makes it difficut to quantify the contribution of the NGO sector, the inability of funders to provide accurate data suggests a lack of appreciation of the contribution of this sector.

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

Voluntarism is a tradition that has continued into modern life from our rural, village and small town history. It is an essential expression of our need to belong, to collaborate and to fulfill a shared vision for the future.

In response to the social and economic changes identified above, voluntarism has generally taken the form of spontaneous 'helping' of others perceived to be in immediate need (increasingly stimulated by media focus on 'human interest' stories), or is channeled via the not-for-profit NGO sector.

NGOs are vehicles through which citizens contribute to the common good. They are many and varied, responding to both perceived community needs and the particular interests and concerns of the volunteers. As NGOs grow and change in response to demand they often professionalise their management, adapting their voluntary component to governance, fund-raising and tasks that do not require specialised training or responsibilities that conflict with domestic life.

So volunteers may be contributing high level strategic advice and governance skills, policy, advocacy and public relations, strong social networks, or essential interpersonal skills. Regardless of the level of commitment or hierarchical role that any volunteer occupies, their contribution is both integral to the effectivensss and sustainability of not-for-profit social services and also extremely difficult to quantify.

[7] Woodward A & Blakely T, A Healthy Country. Auckland University Press 2014. p253f.

Volunteers, and the organisations that deploy their commitment, enhance social capital and save money. Their contribution to social wellbeing goes beyond pure service delivery, so their effectiveness needs to understood beyond the specific services they provide and their value for money needs to be measured by broader criteria than financial efficiency alone.

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

Iwi have been actively involved in the health sector since the public and primary healthcare markets were opened up to them in the 1980s. They have been and continue to make a significant contribution to improving Maori health and reducing inequalities as funders and providers. Their specific contribution is discussed further under question 7.

A recent study of philanthropic funding to benefit Maori conducted by BERL[8] on behalf of the JR McKenzie Trust found it very difficult to draw a clear picture of how much philanthropic funding went to Maori from the general pool of such funding, nor how much Maori philanthropy promoted Maori wellbeing from within te ao Maori. This is because most funders either did not bother or made a deliberate decision not to account for such funding. Further research may be able to identify how philanthropy is understood in the Maori world and what that might tell us about the role of Iwi as distinct from the state or private philanthropy.

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

Philanthropy and entrepreneurialism in the provision of health services in NZ have a long history. It is only since the Labour Government's 1938 Social Security Act that New Zealanders have expected the government to provide modern health care, health protection and promotion as of right.

Health system reform in the 1990s enabled an explosion of NGOs across the whole health sector, and the recent emergence of Government support for the concept of social enterprise holds considerable potential. However, government's risk-averse approach to contracting remains based on a very prescriptive purchasing model which inhibits innovation, collaboration and strategic thinking. Among the most valuable characteristics of NGO social enterprise are its independence and adaptability. A contracting model that unleashes the service provider from prescriptive inputs, throughput and output, and focuses instead on results and outcomes has huge potential.

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

In the context of public health, such partnerships are controversial. The promotion of health and prevention of illness have always required critical analysis and action that clashes with commercial interests where these involve privately owned products provided for the benefit of the owners: clean air, water and waste disposal; harmful

[8] http://www.jrmckenzie.org.nz/search/node/BERL%20report

products such as tobacco and alcohol; workplace safety; mental health; food, housing etc.

Tobacco is an example of where these interests are unreconcileable – there is no such thing as safe cigarettes. Consequently the international Framework Convention on Tobacco Control explicitly excludes health service collaboration with tobacco companies.

On the other hand, obesity is a much more complex problem, involving a wide range of intersecting factors. Some are amenable to a partnership approach - improving access to, engagement in and enjoyment of physical activity is one aspect in which collaboration with commercial activity is to be encouraged. Marketing of unhealthy food provides a much more complex challenge.

Private business is much more amenable to investing in results that can be identified, short-term, and profitable. There is a tendency to look for 'silver bullet' solutions to complex social problems.

The essential ingredients of any partnership approach to the provision of a social service are commitment to a shared goal and power-sharing. These may be obtained with careful negotiation, compromise and adaptation to changing circumstances. They are likely to require facilitation and monitoring by an independent agency - which may be government or government-funded. This does not happen by chance.

Power, especially the power of the purse, is a critical factor in any such relationship. There are plenty of examples of well-intentioned wealthy donors offering funds – but on their terms. Funder-capture is a risk to a service whether the funder is Government, corporate or philanthropic.

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

The answer above suggests that there is some scope, but at some cost. Active encouragement of social service partnerships requires government to go beyond just articulating the idea. There is a strong view that a social problem is not solved "just by throwing money at it". On the other hand, if shortage of money is part of the problem, then it has also to be part of the solution. But both government and the private investor need confidence that their investment will be justified, respected, and effective.

Private investment may be encouraged by being party to a comprehensive, coordinated approach where their contribution is recognisable, alongside that of other partners.

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

Maori providers are always more likely to appeal to Maori consumers, where cultural knowledge is a significant element of the service. This applies especially to health and education. Maori understanding of the impact of colonisation, deprivation and marginalisation often provides a basis for greater empathy and creativity in problem-solving. Maori are also survivors with a legacy of adaptabilty and perseverance.

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

The private for-profit sector has embraced opportunities for delivery of personal health services, because the relationship between inputs, throughput and results are easier to measure

More complex services, such as mental health and public health have been left with NGOs because they involve more complex issues, less easily measured, and require a higher level of commitment to sometimes intangible outcomes.

This mirrors the relationship between private and public hospital services, where the private sector focuses on high throughput of routine medical and surgical procedures, while the public hospitals pick up emergencies and complex conditions and procedures.

It is unfortunate that the Ministry of Health advised its Minister in 2011 that mental health and public health were the most inefficent parts of the health sector. What this reflected was not an in-depth cost-benefit analysis but the simple fact that both sectors deal with complex, hard to change ("wicked") problems and that measurement of outcomes in this context is challenging.

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

Initiatives such as contracting for outcomes, 'high trust' and integrated contracting have had little impact on the commissioning of public health services. This is partly because provider selection and contracting for services with long-term, hard to define outcomes does not fit well with a procurement model based on short-term results, a focus on measurability, and belief in the market to throw up a range of providers with the capacity and capability to deliver on 'wicked' problems.

Where there have been successful outcomes, there has been a well-developed programme logic to identify short and intermediate outcomes and measures, a high level of confidence in the capability of the organisation and well considered analysis of the capacity required. This then requires an open relationship between funder and provider, a willingness to share risks and engage in problem-solving as well as formative, process and impact evaluation. Such 'gold standard' commissioning and contracting has been compromised by reductions in Ministry of Health capacity, suspicion of relational contract management and a return to procurement as a purely adminstrative task. The other significant factor in the success of some public health providers is where their capacity and independence is complemented by non-government income streams from charitable bodies, bequests and private wealth (e.g. the National Heart Foundation).

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

The current work developing a simplified plain language contract document and application of the results-based accountability (RBA) model should be an improvement, but may still be compromised by the decreased capacity of the funding agency. There needs to be recognition that addressing complex 'wicked' problems (e.g. obesity, family violence, child poverty) requires a comprehensive coordinated and sustained investment strategy and the

building of provider capacity. This in turn requires capacity and capability in the commissioning and contracting agencies.

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

We have little knowledge of international models.

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

The major barrier to learning from international experience is lack of confidence in our own solutions. NZ has some significant demographic, geographic, economic and social differences from others. We don't lack understanding of these, and are capable of inventing our own (e.g. Whanau Ora). But we do seem to look to the 'overseas' model, expecting it to fit here rather than taking an adaptive approach – and especially trying to do it cheaper (e.g. Healthy Families).

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

Integration has been resisted by all parties for slightly different reasons, but in all cases because their interests were insufficiently aligned. In some cases the lack of a shared vision among the funders resulted in the transaction costs falling so heavily on the provider that they reduced rather than improved the services.

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

Providers perceive the procurement and contracting processes as inherently competitive and exclusive of collaboration, and integration in the past has amounted to assimilation. Public health and mental health funding have been 'ring-fenced' because when they have been devolved to DHBs (or their predecessors) the money has disappeared into acute services.

Procurement should be an enabler of collaboration and integration not an ever-present threat to a provider's existence. Contracts should be as concerned about the risks to the provider as to the risks of the funder; often the below-capacity and lack of capability in the provider is the major threat to the funder, so it's in the funder's interest to be equally concerned about this risk and be open to helping to resolve it. Contracts currently identify a set of relationship principles including integrity, transparency and care for people, but the provider experience is that these are a one-way street.

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?

Although public health services could consider population groups or communities as their 'clients', their engagement with such 'clients' is not relevant in the context of individual persons as clients.

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

    Currently, public health service budgets are based on historical funding, and the requirement to make providers cut their coat according to the available cloth. The 'client' providers and communities must make do with they get.

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

    Because they address population groups, not individuals, some public health contracts might offer some very useful examples of culturally appropriate specifications.

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

    Public health contract specifications routinely require consultation with population groups and communities in the design of services.

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?**

    Ownership of solutions is fundamental to the success of public health interventions. Centrally-imposed solutions are resented. Regulations are a common tool in the public health repertoire, but there is ample evidence that neither education on its own nor regulation on its own works. The best solutions are where there is popular/ community support for a solution that might require enforcement from time to time e.g. seatbelts in cars; prohibition of the collection of sea-food where there is toxic contamination.

20. **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?** Refer 9 above.

21. **How can the benefits of flexible service delivery be achieved without undermining government accountability?** Refer 9 above.

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

The intention behind high-trust contracts was to reduce transaction costs for both funders and providers with considerable experience in their field. However, the model was politically driven rather than developed by experienced public health contract relationship managers. Trust emerges as a consequence of relationship development, not governmental fiat. In particular, some NGOs acquire a status in their sector comparable with a monopoly in the commercial sector, and have the same tendecy to manipulate their position at a cost to the funder and their intended beneficiaries. Because these NGO monoplies include some of the most trusted brands in the country, attempts to get them under control by going back to the market to stimuate competion usually fail. Their monopolistic behaviour is best managed by careful, strategic relationship management. Contract relationship managers with the right skill-set can do this.

23. 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?

Yes. But there must be both capacity and capability in commissioning and procurement. Some DHBs don't have this, nor have some NGOs. It can't just be done to reduce costs.

24. Are there examples of where government agencies are too dependent on particular providers? Are there examples of providers being too dependent on government funding? Does this dependency cause problems? What measures could reduce dependency? Refer 22 above**.**

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

The first barrier is the high cost, and the second is dubious benefit. New developments in IT need to be fit for purpose. If the purpose relates to very personal issues, family therapy or community development, inter-personal engagement may be essential. There is good evidence from social marketing that vicarious exposure can have a role in confirming or changing social norms, but comes well behind personal interaction.

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

Government is best at promoting social consensus and enforcing regulatory compliance. The more personal and complex issues are best addressed by service providers that are available, accessible and culturally appropriate to the client as an individual or a group. Government services are less able to to ensure innovation, flexibility and adaptability, because of the need for them to be consistent in their availability, quality and accountability.

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

New services or provider failure. Most services improve as a result of strong leadersahip, adaptability and investment in their sustainability.

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

Uncertainty inhibits NGOs. It is especially galling to NGOs that DHBs are considered too big to fail, when the issues they are set up to address are not necessarily any more complex and challenging than the 'wicked' problems addressed by community-based organisations.

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

Most rural and small town areas outside the three major metropolitan areas – Auckland, Wellington and Christchurch.

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

Yes**.**

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

Plain language service specifications.

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

Not sure.

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

Investment in skills of commissioning and contracting staff.

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

Personal health services.

35. 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? N/A

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?

Provider diversity is most important for personal health services. In public health, cultural appropriateness is extremely important. Many public health services, however, are so poorly funded (and governed or managed) that quality – and hence effectiveness - is a significant concern.

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

Patchy – depending on the skill set available. Refer 33 above.

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

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

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

Public health commissioning and contracting does this quite well – in comparison with personal health services.

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

Attributability is very difficult in public health because of the complexity of most issues. Hence the importance of building capacity and capabilty, incentives for collaboration and investment in evaluation.

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

A few. But measurement of results and quality is underdeveloped so its hard to determine how successful they have been in terms of effectiveness.

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

Require a proportion of the cost of a service to be spent on evaluation in order to build the body of data required to do this a lot better. This may mean less activity in order to better understand quality, effectiveness and attributability.

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

Much of the data collected is transactional and does not inform practice or outcomes in a meaningful way. Refer 43 above.

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

The draft plain language contract looks like an improvement. We understand RBA is to rolled out across all government services and this should also be a significant improvement but it hasn't reached public health services yet. RBA is very suitable for public health because it empowers the provider to engage fully in developing the performance measures.

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

The science (and art) of measurement of intangible social outcomes is poor, hence data collection is poor, unreliable and often misinterpreted or mistrusted. Nevertheless, there is good work being undertaken in all of our university health faculties, but which is often not taken into account in the commissioning and procurement of services – mainly because of failure to buld and sustain productive working relationships. The cost of evaluation has already been commented on above.

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

Sometimes. Prescriptive service schedules – especially those that specify inputs and throughput rather than results - discourage experimentation. More outcomes focused service schedules might, but at the risk that the programme logic is not well evidenced. Good evaluation is essential to building confidence in both the funder and provider to undertake experimentation.

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

Yes. Because the outcomes are necessarily medium to long-term, there needs to be strategic approach requring longer term contracts, service specification, evaluation and organisational sustainability. There's sufficient science behind most public health interventions, but data on quality and effectiveness of specific providers and contracts is weak.

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

Public health services would benefit a great deal from a closer collaboration with universities, funders, providers and evaluators.

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

The potential for up-to-the minute IT systems to produce datasets of the level of sophistication described in the issues paper (p61) is encouraging. However, whether these systems can collect data relevant to the design and measurement of effective public health interventions needs to be demonstrated. There can be no doubt that robust evidence has great potential to improve public health interventions, but the country's investment in public health is so marginal (less than 4% of Vote Health), we remain deeply sceptical that such data will be available to us any time soon.

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

Organisational culture and leadership are extremely important. What is valued by the leadership determines where the organisation's members pay attention and what is neglected. Since 2007 public health has not been a Government priority, in spite of its potential to improve people's health and happiness and reduce the costs of the health (illness) system over time. There are some signs that political attention is shifting, but large institutions are often slow to adapt. The work on plain language contracts and RBA are grounds for optimism. However, since public health is still not a strategic priority in comparison with the clinical services, there is very little investment in improving workforce capacity and capability. This includes capacity and capability of those who specialise in commissioning and contracting for public health services.

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

A sense of marginalisation in the sector arising from its neglect in government institutions is reflected in the culture and leadership of some providers. However, increased marginalisation can also lead to more determination to innovate and experiment. There are two protective factors at work: one is that the NGO sector especially is values-driven and close to its communities; another is the fact that many in the sector, including among the leadership, are not part of a regulated workforce, so are more independent minded. What is missing continues to be the ability to reliably measure results and their contribution to outcomes.

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

Governance is a significant issue for NGOs dependent on the goodwill of volunteers to steer their organisation's course. Low organisational incomes also mean low pay for senior staff so that management positions may not attract the best candidates.

54. 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?

Don't know.

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

Possibly. Whanau Ora is the nearest to a public health approach, and hopefully may provide very valuable insights into the complexity of the work and the importance of sustainable investment in change - not only of the individuals and their families but also the wider environment in which they live, work, learn and play.

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

We are happy to meet with the Commission to discuss our experience in person.