



Issues Paper: More Effective Social Services

Submission to the New Zealand Productivity Commission

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse.*

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the issues paper *More Effective Social Services* ('the paper') and appreciates the extension of time for submissions.
2. This submission is informed by consultation with members and staff, including members of our specialist Colleges and Sections, Te Rūnanga o Aotearoa ((Te Rūnanga), regional council and board and nursing, policy, research, and industrial advisory staff.
3. Te Rūnanga is the bicultural arm through which the Moemoeā, aspirations of NZNO's Māori members are expressed. It represents over 3000 Māori nurses (nurse practitioners, registered, enrolled and student nurses), midwives, and kaimahi hauora. NZNO policy adviser Māori Leanne Manson has provided Te Rūnanga's specific feedback on questions relating to cultural competency and te Tiriti o Waitangi.
4. NZNO is affiliated to the New Zealand Council of Trade Unions (NZCTU) and has contributed to, and fully supports, its submission and that of fellow unions and the Association of Salaried Medical Specialists. It is not our intention to repeat the substance of those submissions, but to provide specific feedback relating to the effectiveness of health services, the most fundamental component of social services.

5. While we have endeavoured to give as comprehensive feedback as possible, we question some of the assumptions underlying the paper, namely:
 - that universal public provision of social services is not effective or efficient;
 - that the current level of provision of social services is unaffordable;
 - that private provision of social services improve efficiency and productivity; and that
 - that 'contestability' is synonymous with accountability
6. No supporting evidence is offered for the above, yet the document reveals an ideological disposition towards devolving State provision of social services in Aotearoa New Zealand to community and private providers. Our experience over many years of change in the health sector is that the devolution of services often leads to the effective devolution of responsibility.
7. While initially there may be some protections in place to assure service quality and continuity, fiscal constraints and the independence of providers outside the State sector, can disrupt and undermine the government infrastructure supporting the delivery of safe, effective services.
8. Economies of scale are also relevant, and we draw your attention of Treasury's assessment that with a small and geographically dispersed population the opportunities for improvement driven by competition are limited¹.
9. As the paper notes, it is widely accepted that the provision of social services is a public responsibility based on the social and fiscal contract between (all) citizens and the elected government i.e. the provision of social services is based on universal human rights and public good.
10. From a public health perspective, there is compelling evidence that the dual provision of public and private health services (Social Security Act 1938) has, in fact, been a barrier to the most cost-effective means of

¹ The Treasury.(2014). *Briefing to the Incoming Minister: Health*, p7

improving population health and reducing future service demands, ie through the delivery of universal primary health care².

11. NZNO suggests ways to significantly improve the effectiveness of health services and productivity, by fully utilising the nursing workforce to deliver equitable access to primary health care.
12. Universal access to health care and health equity is essential, as population health is fundamental to productivity³ and is an important determinant of, and contributor to, economic growth and competitiveness⁴.
13. The weight of international evidence indicates that:
 - effective social services are supported by universal access to social services that are primarily focused on health and wellbeing, rather than targeted to meet social shortfalls i.e. prevention rather than protection/cure; and
 - that the best return on investment comes from services for the young because of the lifespan over which benefits are gained (we refer you to the Health Committee's *Report on the Inquiry into Improving Child Health Outcomes and Preventing Child Abuse, with a Focus from Preconception until Three Years of Age* (2013) and, for similar reasons, on ensuring women's access to sexual and reproductive health.
14. Effective social services are delivered by a skilled and educated workforce supported by appropriate regulation to protect public safety and ensure quality.
15. The way in which social services are commissioned and purchased affects employment in social services, and thus has a significant impact on workforce quality and sustainability. Both workforce and service quality and safety should be underpinned by, and consistent with, regulatory frameworks and standards, but this is not always the case, as NZNO illustrates with regard to the mental health and health support workforces, and aged residential care.

² World Health Organisation. (2008) *Primary health care: Now more than ever*. Geneva: World Health Organisation

³ Suchit Arora (2001). Health, Human Productivity, and long term economic growth. *The Journal of Economic History*, 61, pp 699-749.

⁴ Suhrcke, Marc, and Martin McKee. *The contribution of health to the economy in the European Union*. Luxembourg: Office for Official Publications of the European Communities, 2005.

16. Integrated planning to align education, employment, and quality goals is needed to ensure a safe, sustainable and effective social services, regardless of who is contracted to provide them.
17. NZNO believes that effective social services need to be:
- focused on health and wellbeing;
 - universally accessible;
 - primarily aimed at children
 - evidence-based
- and require:
- a strong, integrated public service;
 - long term workforce planning that aligns education, employment, immigration; to ensure self-sustainable service delivery; and
 - robust quality and safety standards.

DISCUSSION

1 Why is this inquiry important? & 2 What the Commission has been asked to do

18. NZNO agrees with much of what is written in these two sections, but take this opportunity to make a few observations.
19. We are not comfortable with the framing of the discussion. The resources available for social services are a political decision and as such, subject to electoral mandate i.e. people's choice. It is neither helpful nor accurate to simply state that resources are finite, particularly in the context of social services where such statements have often preceded funding cuts and privatisation of services.
20. Resources vary according to a range of interrelated policy decisions, including decisions about procurement, which cannot be assessed in isolation.
21. For example, the government's recent decision to fund fee GP visits for children under 13s at an estimated cost of \$90m over three years, is a significant primary health care initiative which ostensibly will improve access to primary care and reduce health demand and inequity. It is a popular policy supported by virtually all political parties in the recent election, the only caution sounded being whether the subsidy will be

sufficient to ensure GPs do not lose income by providing the service (a tricky administrative detail).

22. However, the evidence is clear: cost is not the only barrier to GP visits, the greatest need is for more primary health, rather than medical, care, and there are simply not enough doctors in the right places to be able to meet demand even if those who most needed it were enrolled and did access GPs. Some families will undoubtedly benefit, but they will not be the most needy; health disparities will increase not decrease.
23. Having nurses in schools (currently a role supported only in low decile schools) would be better placed to meet the health needs of the estimated 400,000 6-12 yr olds affected, including the most vulnerable, and ensure access to medical care through appropriate referrals, at a fraction of the cost of \$30m pa.
24. It is unlikely that any political party would risk the political fall-out of cutting free funding for children under 13 now, but it would still make sense to introduce nurse in schools to rationalise and make better use of the free GP visits. We are not sanguine, however, that more health funding will be made available for this purpose.
25. In this context we also observe that while the paper acknowledges that ideally there should be a choice between providers (p2), the health system is basically predicated on access to GPs, effectively removing the 'choice' to access healthcare any other way.
26. NZNO supports the inquiry's focus on outcomes, rather than outputs (p5), and we particularly welcome the recognition that improving effectiveness is not about "working harder or accepting lower wages" (p1), which for many wage earners and temporary contractors has been the outcome of structural reforms since the 1980's.
27. The rise in 'precarious' work⁵ is a significant factor in increasing *demand* for social services, and this points to a serious omission in the paper which is that it does not consider reducing demand for social services as part of an overall strategy for improving effectiveness, or as a measureable outcome of the effectiveness of social services.
28. To use a health analogy, investment in immunisation programmes is an effective public health strategy because it hugely, and measurably, reduces demand for future medical and disability support services.

⁵ New Zealand Council of Trade Unions, 2013 *Under pressure: Insecure Work in New Zealand*. NZCTU:Wellington.

29. Conversely, the effectiveness of the highly targeted Rheumatic Fever Prevention Programme (RFPP) is undermined by living conditions in the communities where rheumatic fever is prevalent, prompting the recommendation in the RFPP Implementation and Formative Evaluation Report to "...widen (the) focus on addressing primordial determinants of health..." i.e. the cold, damp overcrowded housing which actually determine health outcomes, rather than the service.
30. Although the context in which services are provided is fundamental to determining their effectiveness, it is difficult to see how this is, or even can be, reflected in an inquiry which focuses on contracted services (regardless of provider) and models a "continuum of contract obligations" (p8) based purely on measureable inputs and outputs.
31. Other notable omissions in the paper are the lack of reference to the need for either careful development of evidence-based policy and long term planning to inform strategic action, or a well educated and trained workforce to deliver services, both of which are essential to "long term sustainability" and "improving outcomes from social services".
32. In the health sector, for instance, lack of long term workforce planning has led to New Zealand's sustained reliance on a very high proportion of immigrant practitioners, despite an equally high number of new graduate nurses unable to find employment here, and in the face of predictable increases in health demand and skills shortages.
33. We suggest that a more productive emphasis would be on identifying the factors that enable people to live healthy, productive lives, and determining the social services that best support them. Fortunately, the World Health Organisation's Commission on the Social Determinants of Health has made an exhaustive cumulative study of the best international evidence available of the actions needed to support the healthy family, community and workplace environments, which sustain equity and prosperity⁶.
34. Apart from the tautology, we also question why difficult social problems need to be tackled in "new and innovative ways"(p6) and suggest the emphasis for the delivery of fundamental social services should be on proven effectiveness.
35. Similarly, we suggest that examining "the lessons learnt from recent initiatives and new approaches" is less important than implementing/rolling out proven initiatives.

⁶ http://www.who.int/social_determinants/thecommission/finalreport/en/

36. It has been over a decade since the nurse practitioner (NP) model was developed, for example, yet the glacial pace of regulatory change has delayed uptake (<0.2 percent nursing workforce) and implementation of this innovative role to improve health service delivery. And, three years after the successful nurse prescribing pilot for diabetes nurse specialists (DNS), there are just 25 DNS prescribers, with no development of the model for other areas of nursing!
37. NZNO is wary of examining and implementing initiatives, particularly from overseas and/or without long term evaluation, before applying our own research, knowledge and experience to services developed for our own unique circumstances and people.
38. We agree that there are vast differences in how providers are staffed and understand the impact of staffing on health and social service outcomes. Safety, quality of care, and accountability for core services must be assured by having an appropriately trained and qualified workforce as is the case in the health sector, for instance, where the Health Practitioners Competence Assurance Act 2003, assures the competence and fitness to practice of health professionals.
39. The privatisation of aged care services in the late 1980's, *without protection for safe staffing*, has led to serious instances of substandard care and sustained substandard wages and conditions for nursing and support staff⁷ and increasing dependence on migrant workers⁸. 'Devolution' of services, without protection for public safety, is effectively the devolution of the State's responsibility⁹ to the public.
40. NZNO concurs with the following statement in the Public Service Association's policy paper *Respective roles: the public sector and the community and voluntary sector* (September 2011) which provides a useful commentary on the respective advantages of state and community and voluntary sector provision, given the growth of the latter in delivering services previously provided solely by the state or local government.

⁷ See for instance *Caring counts: Report of the Inquiry into the Aged Care Workforce* HRC: Wellington accessed December 2014
<http://www.hrc.co.nz/eo/caring-counts-report-of-the-inquiry-into-the-aged-care-workforce/>

⁸ Juthika Badkar, Paul Callister & Robert Didham. 2009 Ageing New Zealand: The growing reliance on migrant caregivers. INSTITUTE OF POLICY STUDIES WORKING PAPER 09/08.accessed December 2014
<http://ips.ac.nz/publications/files/c1cd9eae533.pdf>

⁹ i.e. as mentioned on p50 "the states statutory or common law responsibility to provide the service

The delivery of public services by the state is the clearest way to ensure accountability (through its democratic institutions) for the use of public funds that have been raised through the coercive powers of the state. It also ensures that public good interests are not overridden by private or sectional interests, as the state has a wider obligation to the community as a whole. The state's overview of services, if it is providing and not just funding them, allows it to take a coordinated approach to complex problems, maintain national standards, and ensure equitable access to services.

Lacking a profit motive, the state as a provider is not concerned with market power, and looks to the public service ethic rather than personal benefit to motivate employees. Together with its accountability to the public, these factors make it a natural provider of public good services. In addition, the sheer size of the state suggests that there may be some services that only it can provide because of the capacity required and the economies of scale it can achieve.

3. The Social Services landscape

41. The Treaty section underplays the significance of te Tiriti o Waitangi and the role of Māori in social service provision. The importance of te Tiriti cannot be recognised without explicit reference to the articles, and particularly to the concept of partnership and shared authority; it is not about the "recognition of Māori as the indigenous people", but about a contractual agreement to honour te Tiriti articles. The agreement to share authority was and is unique to Aotearoa New Zealand and underlines the qualitative difference in the State's relationship with Māori in Aotearoa New Zealand, compared with that of other colonised peoples.
42. "various Māori chiefs" is, we feel, a slightly pejorative and disrespectful way of describing the 500 or so rangatira who signed the treaty.
43. Note that though people are living longer, they are also in better health; the highest health costs are generally associated with the last six months of life, whenever that may occur.
44. However, aging will definitely affect workforce supply, and this should be noted as the average age of all professional social services workers - police, social workers, health practitioners, teachers etc. - is high. Integrated planning (i.e. aligning education, employment, and regulation) will be needed to address the wave of retirements and loss of experience and leadership over the next decade or so.

45. We draw your attention to NZNO's research into flexible working hours and career planning for nurses in the latter stages of their careers¹⁰.

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

46. We suggest:

- Aging population and workforce and how that will impact on social service usage. Eg integrated aging in place support services.
- Rise in non communicable diseases (NCD) - will require primary health care focus at all levels of care to prevent and manage NCDs (see NZNO Models of Care); and an overarching model of public health care, such as *Te Whare Tapa Whā*, to empower both individuals and communities to optimise their health potential.
- Increased proportion of Māori and Pacific people: The younger age and fertility profile of Māori and Pacific women in comparison with Pākeha (Aotearoa New Zealand/ European ethnicity) indicates the urgent need for appropriate sexual health and family planning services for these communities to mitigate increasing inequality across all social indicators. (We note, however, that lack of access to such services is not confined to vulnerable groups.)
- Migration - global mobility and competition will continue to affect the stability and composition of New Zealand's workforce, particularly in service areas such as health where we have a high dependency on internationally qualified health practitioners, comparatively lower wages, and well qualified practitioners. Balancing 'push pull' factors and maintaining quality will require aligning policy and regulation in education, employment, and immigration.
- Information and Communications Technologies (ICT) - opportunities for improved integration, information sharing, provision of distance services etc. and, hopefully, opportunities to counteract increasing urbanisation and regional contraction.
- Increased inequity /social division - significant disparities in income, access to services, home ownership, linked to ethnicity, and location particularly in Auckland where there is clear evidence of "ghettoisation". (Statistics New Zealand's aggregated data and mapping tools are very useful in this regard).

¹⁰ Clendon, J., & Walker, L. (2013). Nurses aged over 50 and their experiences of shift work. *Journal of Nursing Management*, 21(7), 903-13.

Walker, L., & Clendon, J. (2013). Ageing in place: retirement intentions of New Zealand nurses aged 50+. *Proceedings of the New Zealand Labour and Employment Conference*, Wellington, New Zealand. Available: <http://ojs.victoria.ac.nz/LEW>

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

47. Volunteers have always been, and will continue to be important in providing ancillary services, mostly to support particular consumer groups. However, it is important to get both the balance and boundaries between volunteer contribution and paid employment contribution right to ensure safety, quality and accountability.
48. Responsibility for core social services that protect the health and wellbeing of vulnerable people, rests with the government, however volunteers can play a very important role in initiating and demonstrating new service models.
49. At Victory Community Health (VCH), for instance, an after-hours nurse-led clinic staffed by volunteer registered and enrolled nurses and practice assistants is proving highly effective (Liddicoat et al., 2014¹¹). VCH is a charitable organisation, located within the Victory Community Centre, on the campus of Victory Primary School. It is led by a governance board of local residents whose mission is 'to provide community-owned, low cost, affordable and accessible services and activities that support health and wellbeing' (VCH Governance Board, 2013). It has been in operation since 2007 and, using a hub approach, offers a range of funded and volunteer services including:
- a 'Be well' Community Nurse during office hours who provides a range of health services and liaison with community members including B4 school checks, Quit Smoking, cervical screening;
 - an after-hours nurse-led clinic staffed by volunteer registered and enrolled nurses and practice assistants;
 - a range of activities including cultural, sporting and after school/work activities catering for all ages;
 - a community garden;
 - 'Keep Victory Safe' a unique community development project designed to work collaboratively with community

¹¹ Liddicoat, L., Nelson, L., Varney, J., Hughes, H., & Davies, D. (2014). *An evaluation of the effectiveness of the nurse-led services including the new Nurse Led Clinic (NLC) initiative implemented at Victory Community Health*. Business Development Company: Nelson, New Zealand.

- members to address violence and improve safety in our community; and
 - Counselling.
50. Other projects/providers operating out of Victory, include Plunket, a NZ Police community constable and midwives, but volunteerism is a mainstay of VCH. A core element of work at Victory is a wrap-around approach to health and social needs - the "Victory Way" - which has much in common with "whānau ora" approach. Research by the Families Commission (Stuart, 2010) demonstrated the 'hub' approach at Victory results in:
- enhanced family and community relationships and sense of belonging;
 - reciprocal care and respect between families, the school and VCH;
 - C=collective responsibility for child and family wellbeing; and
 - improved child participation, wellbeing and achievement
51. The challenge now is to support the model with appropriate resourcing, and not let it fall over by continuing rely on skilled volunteers, whose continued involvement cannot be guaranteed.

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

52. Iwi services will be targeted at their people and support for education, housing and health access will be important. The sound financial basis for continuous service provision will be critical, as will be self determination in allocating and prioritising funding to the identified needs.
53. We strongly recommend that you firstly engage with iwi who are social services providers and/or iwi representative groups such as the Iwi Chairs Forum to discuss this further. NZNO and Te Rūnanga believe that the responsibility to provide funding and resources for social services sits firmly with the government, not with iwi, since iwi do not have access to government revenue. We trust that this question does not in any sense foreshadow the government's intention to delegate responsibility, without funding, to their te Tiriti o Waitangi partners. While many iwi have received te Tiriti o Waitangi settlements for past historical grievances, this funding was not intended to provide state run social services.

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

54. The term 'social enterprises' (SE) is not one that is commonly used among New Zealanders, who would be more familiar with community

groups, charitable organisations, not for profit organisations, and service clubs, though it could equally apply to businesses such as GP practices. We assume that it identifies the application of business principles and acumen to an organisation focused on social good, but we question the implication that 'business enterprises' have a monopoly on efficiency and/or that social service providers are not efficient. In fact all organisations, regardless of their purpose, span a continuum of efficiency, and will affect social outcomes.

55. Those businesses/organisations with a focus on social good can contribute significantly to social cohesiveness, and population health, safety and wellbeing, to the extent possible within the context of the social, economic and political / regulatory environment which shapes them.

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

56. Clearly there are extensive opportunities for private providers of aged residential care (ARC) which receive upwards of \$800m public funding and provide a range of healthcare and residential options for older New Zealanders. However, there is a potential conflict between the commercial interests of the providers, increasingly dominated by large multinational corporate chains, whose profits are predicated on the value and turnover of the real estate, and the State's interest in, and responsibility for, care of the elderly. Maximising the value of both private business and government contributions to the welfare of older New Zealanders requires a sound regulatory environment and workforce infrastructure (education, employment, immigration), so that expectations are managed fairly and transparently and the safety and quality of services is ensured.
57. This is not currently the case in private aged residential care where there are significant barriers to quality and safety, namely the lack of mandatory standards for safe aged and dementia care; lack of workforce planning; and lack of comprehensive data to inform the continuous improvement of standards of care (a 'given' with rapid advances in knowledge and new technologies) and ensure accountability.
58. Union health centres (UHC) fulfil a primary objective of the visionary Primary Health Care Strategy 2001, the first step towards a health system that focused on optimising the health potential of New Zealanders, by providing low cost access to primary health and primary (medical) care. As well as low fees, they have proactive strategies for prevention and management of health issues for their populations. For example, some employ nurses to actively seek out and monitor the health of homeless people, providing health care which is often critical to preventing the need for other social, justice and police interventions.

59. The barriers that UHCs, and indeed many PHC providers servicing vulnerable and/or high needs populations are inadequate, unreliable, and inequitable funding, for reasons cogently explored in a paper by Don Matheson and others¹² which also offers some solutions.
60. Population based capitation funding has stimulated innovative primary health care partnerships, for example GP/Nurse owned practices optimising the value and integration of nursing and medical expertise; practices that employ primary care nurse assistants who give free walk in blood pressure checks etc. A significant barrier, however, is the inequitable costs associated with high needs populations.
61. The Poison helpline is another example of a long standing highly successful government, research, commercial collaboration which provides a critical health service. See NZNO [Position Statement](#) (2014).

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

62. Without an evidence based rationale supporting more private investment this question is premature.

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

63. The whānau ora model of wrap around services able to be responsive to need (as opposed to those that are funded for a specific activity) are a model for future development. Inter-sectoral social services should be embraced rather than siloed as they are currently by the funding, contracting and purchasing models.
64. Māori providers may be better able to determine the priorities each iwi or community group may wish to focus on, which may differ from those prescribed by government. For example: currently providers are funded to provide services relating to specific diseases or conditions (diabetes, obesity, rheumatic fever) or by specific age groups (Kaumātua health, Tamariki ora) rather than focus on a collective approach based on the priorities of the community need and what they determine are their goals.

¹² Matheson et al. 2013. *Towards an Equitable Primary Health Care Policy for all New Zealanders* accessed December 2014
<http://www.nzdoctor.co.nz/media/3133589/equity.pdf>

65. *Capacity of Māori providers:* While some iwi play a vital role in the delivery of social services this is not consistent across all providers; some iwi do not currently have the capacity or the capability of a trained workforce to deliver these types of services.
66. Established iwi social service providers are contracted to provide a range of services that can include:
- assisting tangata whaiora whose lives and their whānau are affected by mental health and/or addictions and require social services support; assisting with community housing;
 - providing insulation in houses programmes; assistance clients to find employment;
 - delivering strengthening families projects;
 - delivering whānau ora programmes,
 - providing alcohol and drug services and delivering stop violence programmes.
67. Most of these providers work with vulnerable and so called hard to reach communities. There are many highly capable Iwi social service providers doing excellent mahi with their communities, for example:
- He Oranga Pounamu, is a Christchurch based health and social service and whānau ora provider, affiliated to Kai Tahu, that works alongside vulnerable whānau to achieve or identify their priorities and support them to navigate the myriad of post-earthquake services and manage the exacerbation of pre-earthquake social and health issues.
 - Ngati Hau health and social services delivers support to the members of Ngati Hau and the wider community in the Whangarei District, and tackle challenging issues such as homelessness, violence, assisting with employment, and focuses on restoring safety and wellbeing where whānau live free from violence.
68. *Māori Provider Development Scheme:* The Ministry of Health Māori Provider Development Scheme (MPDS) was established in 1997 with the aim to increase the capacity and capability of Māori providers to deliver effective health and disability services for Māori and to support activities to develop a highly-skilled Māori health workforce. Funding for providers has been available in four categories: infrastructure support, workforce development, service integration and “accreditation and best practice”.
69. An evaluation of the scheme was carried out in 2009 by CBG research limited and provided a range of recommendations for improving the

scheme. Nearly all the Māori health providers indicated that they would not be able to sustain core infrastructure and capacity improvements without grants from MPDS, and noted that current service contracts do not incorporate funding for that type of investment.

70. *Government strategies for Māori Health Workforce:* There are numerous government strategies that focus on improving Māori health inequalities for example the Primary health care strategy (2001); He Korowai Oranga: Māori Health Strategy (2002); Raranga Tupuake Māori health workforce development plan (2006); Whānau ora: Report of the Taskforce on hānau centred initiatives (2010). These strategies are all reliant on a Māori workforce to deliver 'Māori for Māori by Māori' health services to address disparities.
71. We agree that a strong, capable and proportionally representative Māori health workforce is a key factor in any long-term strategy to improve Māori health outcomes. However, strengthening the capacity and capability of the Māori health and disability workforce requires dedicated development and resourcing, not just policy statements. It is essential that investment in this work is grown and robust evaluation of outcomes is undertaken.
72. *Institutional racism research within the public health contracting environment:* We also recommend that you review Dr Heather Came recent research (2011) involving a survey of public health providers, which informed a wider study (2012) into institutional racism highlighting racism and privilege within the public health contracting environment. The survey found that Māori providers were six times as likely to describe their access to DHB funders as 'limited' than other providers, and 50% of Māori providers also described their access to Ministry funders as 'limited'.

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

73. Where there is growth and profit potential there is an incentive for business, especially if government funding is assured. The aged care sector is a case in point. Smaller local providers are gradually being overtaken by large multinational providers yielding sustained high returns to their shareholders. Their target in development is around the profit share, and this can and has resulted in service gaps, and poorer, less equitable, access than with other models.
74. Poorer staff conditions and terms have also been an outcome of privatised aged care, but this is not necessarily attributable to the profit driven focus of some providers, but rather to the lack of mandated standards for aged care and dementia care which has basically meant that there is no bottom line of accountability, and considerable room for disparity around resourcing expectations.

4 New approaches to commissioning and purchasing

75. While we acknowledge the potential of new "approaches", it is essential that they are introduced into a stable well regulated environment based on established, understood and widely accepted principles. PHARMAC's approach to the extension of its procurement to community medicines and medical devices through careful, comprehensive consultation on both its decision making criteria and procurement processes is a good example of how changes to purchasing have been managed in a way which maintains the trust of clinicians and the public.
76. By contrast, the flawed processes and, in some instances, entirely inadequate business cases developed by Health Benefits Limited which failed to fully engage with and understand the (highly complex!) health sector, has not delivered the integrated procurement of backroom services for DHBs that was widely supported by NZNO and others. We refer you to NZNO's several [submissions](#) over the past two years on HBL's proposals.
77. Indeed, HBL's legacy with regard to food services for the Auckland DHBs is, we believe, one that increases risk and decreases health and safety, as it is reminiscent of the model which precipitated the poor care and increased mortality rates at Mid Staffordshire NHS foundation Trust (UK) prompted a major inquiry. NZNO's [analysis](#) of findings and recommendations of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust provide useful learning for Aotearoa New Zealand (2013).
78. With respect to "social bonds", including the international Peterborough Social Impact Bond initiative and the Ministry of Social Development's programme to implement a trial, is NZNO is strongly opposed for a number of reasons, primarily lack of supporting evidence.
79. NZNO has noted, for example, that the Peterborough initiative, to reduce reoffending by 7.5% is a very modest goal in the light of Department of Corrections' goal of reducing reoffending by 25% by 2017, which it is already halfway to achieving (12.6%), and the 5% reduction that almost *any* programme to reduce recidivism will result in, let alone one that targets first offenders and volunteers. Peterborough initially achieved a 6% reduction but attempted to claim a 23% reduction in the light of a 'national trend'¹³, which highlights the most

¹³ The first SIB project involving inmates released from Peterborough Prison s failed to meet the target for early repayment - <http://www.thirdsector.co.uk/peterborough-prison-social-impact-bond-pilot-fails-hit->

significant flaw with funding of this nature - the difficulty of measuring the impact of outside variables against the quality of services.

80. It is disappointing and misleading for the highly contested early results to be cited in this context, and without explaining why the experiment was abandoned.
81. NZNO has confidence in the long term health centred approach of the Dept of Corrections because it is underpinned by substantial robust evidence; the same cannot be said of social bonds. We note that the Public Service International Research Unity recently published a draft paper by Jane Lethbridge *Peterborough HMP Social Impact Bond Highlighting the problem of SIBs* (September 2014) examining the structure and contractual relationships of the trial and reasons for its termination. It identified several problems with the Social Impact Bond model, including:
 - contractual complexity and transaction costs;
 - measuring outcomes; and
 - lack of overall control by government department/ public sector
82. These are significant problems, which warrant caution, particularly in the context of global trends towards increasing privatisation, international trade agreements (TPPA, TTIP, CETA, TiSA) seeking regulatory conformity controlled by the most powerful, and the drive to 'liberalise' public services by opening them up to public investment.
83. Dowling & Harvey's 'big picture' analysis of the UK governments' plans to create a social investment market warns that the introduction of the metric of 'social value', ostensibly aimed at empowering local

target-trigger-repayments/finance/article/1307031. in spite of a method of measuring success that increase the likelihood the project would meet its targets - <http://straightstatistics.org/article/peterborough-prison-pilot-through-glass-darkly>.

The full report on the performance of the Peterborough SIB project can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341684/peterborough-social-impact-bond-report.pdf. Apparently it took 11 months just to, "agree the sample and obtain all the data needed to begin analysis."

communities , "may actually foster the further financialisation and a deepening of capitalist disciplinary logics into the social fabric"¹⁴

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?

84. We believe some of Ministry of Social Development's social sector trials have proved successful. What we have seen in the current funding and contracting models is a lack of flexibility to respond to a need because of the rigidity in the contracts.

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?

85. The socio-economic, cultural and educational determinants of health can be addressed for longer term health gain by having an intersectoral approach, particularly in areas of poverty.eg housing, healthcare, minimum wage etc.

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

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?

86. Aotearoa's population size, ethnic composition, distribution and its ability to sustain some of these models needs to be taken into account For example the National Disability Insurance Scheme talks about a range of providers and choice. However, our population is unable to sustain a number of providers and providers are unable to sustain the infrastructure to support them eg workforce planning, education, development and enforcement of standards to ensure a level playing field for all providers.

87. The risk is a monopoly (so little change to the status quo), non sustainable service organisations, and duplication rather than competition.

¹⁴ Emma Dowling and David Harvie. Harnessing the Social: State, Crisis and (Big) Society. *Sociology* 2014 48: 869. Sage publications. DOI: 10.1177/0038038514539060 Online access <http://soc.sagepub.com/content/48/5/869>

88. For many social services, 'choice' is irrelevant because there is no service available (eg sexual health and family planning services, mental health services etc) and/or access is restricted because of location, financial or cultural barriers.

5 Issues for the inquiry

89. **Equity** is a significant aspect of service integration that has been overlooked. Health disparities are evidence that public funding is not evenly distributed/accessed.
90. **Q13 Where and when have attempts to integrate services been successful or unsuccessful? Why?**
91. WAVES, an integrated youth and health service established in 2007 by Louise Roebuck, a Nurse Practitioner in Primary Health Care and Youth Health, with help from charitable trusts and corporate sponsors was a highly successful integrated service used by thousands of young people. Following successive funding cuts it was forced to close its nurse led clinics in October 2012¹⁵.

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

92. Best practice integration in health services ie across primary/secondary is often confounded by the commercial reality of general practice businesses. This mixed model of public/private provision can be problematic.

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?

There are significant risks to workers and to clients in a deregulated labour market with limited resources. The ability to make informed choices is predicated on the necessary information, education and access to clinical care/professional advice as well as the availability of resources.

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?

¹⁵ See NZ Doctor, 26 October 2012

93. The fragmentation and sustainability of service providers mentioned in 12 needs to be kept in mind. There is a case for disability support services but only if the provision is limited to those who can make informed choice.
94. With regard to the section on culturally appropriate services (p42) we note that cultural competency is part of regulated health practitioners' scopes of practice and we believe that commissioning agencies need be assured of the cultural competence of its workforce rather than just specify protocols. That may mean training needs to be provided.

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

95. There needs to be some flex as within a culture there is individual difference too.
96. *Form of structural discrimination the under representation of Māori Health Workforce:* Again issues such as workforce, infrastructure and pay parity impact on the delivery of a culturally appropriate health services have not been appropriately addressed. The Human Rights Commission document 'A Fair go for all' indicated that in health another form of structural discrimination is the under representation of the Māori health workforce. A recent Health Workforce New Zealand report indicates that although Māori make up 15 percent of the general population, 2.9 percent of doctors and 6.6 percent of nurses are Māori; the government have not developed a Māori health workforce strategy to address this under representation of the Māori health workforce. Data supplied by the Nursing Council shows that despite workforce initiatives implemented over the past decade, the total number of nurses registering for the first time who identified as Māori each year has remained static.
97. *NZNO Te Rau Kōkiri campaign:* As you may be aware of the recent NZNO Te Rau Kōkiri campaign Māori and Iwi multi-employer collective agreement (MECA) it is fighting for pay parity for these NZNO members in the primary health care sector. This is a significant issue for the Māori nurses, who are already underrepresented in the nursing workforce, are again disadvantaged for wanting to work with their communities, by getting paid 25% less than their counterparts who work for District Health Boards.
98. *Funding practices disadvantage Māori providers:* We refer you again to Dr Came research (2013) which found in relation to fund practices confirmed the pattern of Māori providers were being disadvantaged by the Crown administers public health funding. Dr Came provided the following suggestions on how funders could reduce, minimise and/or eliminate racism with contracting:

- develop transparent criteria for the allocation of discretionary and/or one-off public health funding and publish it on-line and consistently follow it;
- make the application of the prioritisation guidelines mandatory in funding decisions and ensure Crown Officials have access to the relevant training to apply these guidelines; and
- ensure a consistent approach is taken to the allocation of costs of living and/or Forecast Funding Track (FFT).

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

99. We agree that client participation in directly informing the design of services is the exception rather than the rule and would add that the same is true of workforce participation. Both are equally desirable.
100. Consumer consultation/engagement by service providers.
Recognised lobby/interest groups.

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?

101. Individual funding and contracting of services is good in theory, but there are a number of issues to be considered, for instance
- many clients/families will benefit by having arrangements better suited to the individual need however others may not have the skill set to take on this responsibility. There needs to be flexibility in the system or provision so that these do not fall through the cracks ie protection of the more vulnerable.
 - some consumer groups may need to take on a brokering role for advising on service provision under a package of funding approach
 - some clients/families will find the direct employment of service provision complex and difficult. What support will they have as employers?
 - NGOs providing services will need some financial surety so that they have a viable organisation.
102. National quality guidelines and local credentialling are needed to address the tension between accountability and flexibility.

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?

103. Te Rūnanga could provide evidence of health funding/ purchasing/ contracting models of NP in PHC that constrain the scope of their proposals of holistic health care and constraining it to mental health provision for example. Janet Maloney-Moni's original proposal was for a comprehensive and holistic health service to a population however this would not be funded because it did not 'fit' the DHB model of contracting for services. There are probably more recent examples. Plunket 5 visits is an example. Some mothers will require less and others more – clinical judgement should determine need.

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

104. Compliance costs and reporting need to be balanced with effective monitoring.

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?

105. Firstly we question the validity and purpose of the statement on p47 that "In contrast to many public sector contracts, long term relationships form the basis of many private sector contracts". Long term relationships form the basis of many, if not most, public sector contracts in the health sector.

106. While high trust contracts provides security to those providers fortunate enough to be a preferred supplier, who are able to secure contracts for 2-3 years, it does not however, benefit or security to those non preferred suppliers who have to negotiate yearly contracts. The overall control of these contracts sits with the DHBs and the providers have to deliver on it. NZNO members state that Māori and Iwi providers like the high trust contract approach as the funding is based on how to best meet the needs and outcomes of the service providers that use a collaborative approach to deliver services. These services are not based on innovate practice but rather on working collaboratively as a group to deliver services. Most preferred providers are chosen individually with limited focus on collective regional consolidated approaches. We do not agree or believe it is not appropriate for national providers, such as Plunket not to have a high trust contract, and have to rely on annual fundraising appeals.

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? Are there examples of where government agencies are too dependent on particular providers?

107. With regard to the ability and capability of providers we note that while there may be a degree of dependency, long term providers also

provide stability, e note that may have. Local knowledge is useful in establishing a design that works

Q24 Are there examples of providers being too dependent on government funding? Does this dependency cause problems? What measures could reduce dependency?

108. I think one must keep in mind Aotearoa's size of NZ and what degree competition can be achieved while retaining a viable organisation. We are a small country where multiple providers cannot always be supported.

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

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?

109. We question the point of the statement on p 49 that "Government agencies lack the information, relationships and capability to directly deliver all social services", and suggest that, freed from commercial restraints and with access to national data collections and expert personnel across government, government agencies are in a prime position to ensure the delivery of social services, which is their function.

110. Regardless of which agency delivers a social service, a strong public sector is essential for ensuring good decision making and direct government accountability

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

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

111. see Q 24

112. Contestability can be detrimental where highly specialised services are involved.

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

113. Probably everywhere except Auckland.

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

114. I would think that the number of district nursing services in Chch can be a bit confusing for providers and users but that is just an assumption – nothing to go on really here

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

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

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

115. The attitudes and knowledge of decision makers may be a barrier. For example some DHB Funding and Planning general managers do not have an understanding and openness to different ways of service provision.

116. We suggest retaining staff is an important factor in ensuring continuity of service.

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

117. Core public health services ie primary health, child health, mental health, hospital services, disability services, aged care

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?

118.

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?

119. Flexibility to offer wrap around services for people with complex needs is an important benefit.

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

120. *Inconsistent funding processes:* NZNO members have reported that there appears to be no national standard or consistent transparent process for assessing or monitoring providers. It would appear that the decision making process is subjective depending on "on who you are, who you know, your personalities and who you are connected to." In her PHD thesis Heather Came (2012) notes: "*Remedies in relation to funding practices involve developing a consistent approach in the allocation of cost of living adjustors and enforcing a standard level of financial reporting across providers. Prioritisation processes also need to be consistently applied and providers given equitable opportunities to apply for discretionary funding*". (page 291)
121. She gives an example of inconsistent monitoring processes: "*Berghan recalls talking to a Pākehā General Practitioner who had been in practice for twenty-five years and had never been audited. In contrast, a Māori provider disclosed that they had been audited every three to four weeks over one of their multiple of Crown contracts in an eighteen month period*".
122. With regard to cultural competency training, we agree that training in cultural safety should be mandatory for all frontline staff across all government agencies, but also recommend that this should be mandatory for all Ministry policy makers, funders, planners and contract managers as the following examples, also from Comes' thesis, highlight the lack of cultural competency training for either Crown policy makers or managers.
123. "*Cultural competency is a core element of professional practice for a range of public health disciplines¹³³ (see Health Promotion Forum, 2011; New Zealand College of Public Health Medicine, 2008; Public Health Association, 2007). It appears not to be a requirement for either Crown policy makers nor managers (see State Services Commission, 2007)" (p 192 and "She suggests even when policy documents emphasise the importance of responsiveness to Māori, policy makers and senior managers consistently avoid access to treaty or cultural competency training. Rather front line staff with client contact is often sent to complete such compulsory courses. Shortland (2010, September 17, p. 1)". (p193)*

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

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?

124. We strongly question the syllogistic juxtaposition of "the overrepresentation of poor social outcomes for Māori" with "the substantial number of Māori providers". The two are not related though both are historic.
125. We are also disappointed that there are no specific related questions to whānau ora in all the 56 questions you requested feedback on. While we have interpreted that question 39 relates to the whānau ora commissioning agencies, we believe that the Productivity Commission should have asked more relevant questions about the effectiveness of whānau ora services.
126. *Te Pūtahitanga o Te Waipounamu*: NZNO members suggests that this agency were ill equipped, under staffed, and overwhelmed with the number of providers and iwi seeking funding. The short timeframes for the expression of interest phases left providers and iwi struggling to meet deadlines and using different processes to assess applications. For example: Te Pūtahitanga o Te Waipounamu, the South Island whānau ora commissioning agency received 201 applications for whānau ora funding. The funding criteria was limited to four areas; enterprise and job creation, wellbeing, education and leadership and inspiration and catalyst. The funding round opened for one month, and is only opened on an annual basis. The funding timeframes were very tight, with the agency only being established in July 2014, with applications opening on the 1st August 2014 and closing on the 1st September 2014.
127. The application process, differed to previous whānau ora funding rounds, with iwi having to answer 10 question written response along with submitting a video clip of them 'pitching their investment innovations'. If providers were successful, the second phases included pitching your investment innovation to a team of 'dragons den' judges. We are unaware of any specific cultural competencies that are used as a general contractual requirement, but we would be very interested in reviewing copies if available. Our members struggle to understand how this funding process aimed to build sustainable whānau capacity.

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)?

128. We note the recent announcement of the establishment of the Whānau ora Partnership Group to determine the Whānau ora outcomes that the Commissioning Agencies need to achieve. The aim of the group is to identify opportunities that the Crown and iwi can contribute to, that support the aims and aspirations of whānau, hapū and iwi, in relation to Whānau ora. The group will hold there first meeting next month, and will develop strategies that ensure whānau and communities who can benefit from Whānau ora, have that opportunity.

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

129. There are services with easily measurable outputs eg number of immunisations, screening programmes, etc but these are not necessarily related to outcomes

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

130. As above

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?

131. A range of indicators, over time, is needed i.e. comprehensive, accurate data from multiple sources (eg social, clinical, education services etc,) and the ability to integrate and utilise that information to drive evidence-based service improvement, new models of care etc.

132. Otago University's [Burden of Disease Epidemiology, Equity & Cost-Effectiveness Programme](#) (BODE³) offers such a tool.

Q44 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?

Frequently there are additional reporting requirements added to existing ones adding to the compliance burden rather than looking at what are key indicators and what should be left out.

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

133. As referred to earlier, the extension of PHARMAC's purchasing brief has and will continue to deliver benefits.

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?

134. NZNO's main concern with

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

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?

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

135. See para 133 - BODE³ offers a really significant opportunity to use an extraordinary range of national data to inform policy and interventions that will improve health service outcomes.

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?

Q51 How do the organisational culture and leadership of government agencies affect the adoption of improved ways of commissioning and contracting? Q52 In what service areas is the impact of culture and leadership most evident?

136. We suggest Canterbury DHB has been a leader in organisational improvement – see [Kings Fund report](#) into *The quest for integrated health and social care: A case study in Canterbury, New Zealand*

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?

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

137. Transformational leadership style and inclusiveness.

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?

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

138. Our concern is that none of the case studies address the long term implications for sustaining a well educated flexible New Zealand workforce, and high quality integrated services. In the health sector changes to the purchasing of services have led to the *ad hoc*

employment and training of a large number of unregulated, often poorly paid social, health and support care workers, the introduction of new and competing roles, and the displacement of New Zealand workers, undermining education, regulation (quality and safety standards), and employment conditions. We suggest that consideration of the potential impact on the workforce should be integral to the commissioning of social services.

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

139. Both NZNO and Te Rūnanga would like to meet with the Commission to discuss more effective social services, and to acquaint you with our research programme and the 20 specialist colleges and sections which all offer relevant information and expertise.
140. We recommend that the Commission also meets with Dr Heather Came who has done extensive research on institutional racism and the public health system which includes funding and contracting of Māori and Iwi providers.
141. Once again, thank you for the opportunity to contribute to the development of this paper.

Nāku noa, nā

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