An NGO Perspective on the Re-organisation of the Planning and Funding Environment

A Discussion Paper by the NGO Working Group

22 February 2010

This discussion paper has been prepared by the NGO Working Group[1] to provide an initial NGO perspective on the proposed re-organisation of the planning and funding environment resulting from recent changes announced to the health system.

We hope that this document will be used by government and the NGO sector to inform the debate about important principles and implementation issues to consider in this time of change.

Recommendations

The NGO Working Group recommends that the government:

Note that the NGO sector comprises a key (though sometimes under-valued) element of a unique system of networks, relationships, practices and interventions that support people living well in their communities.

Note that the NGO sector has evolved from "community groups" of interests to organisations based around sophisticated contemporary infrastructures, established models of practice, and a skilled and trained workforce and provide evidence based, cost effective, quality health and disability services.

Note that the latent potential of this sector in an environment seeking greater efficiency, effectiveness, and value for money should not be overlooked and that the planning and funding environment needs to be optimised to facilitate this potential.

Agree that the principles outlined in this paper be used to underpin decisions made about the devolution of health services.

Note the significant risks outlined in this paper involved in rushing implementation of devolution decisions and in making decisions not in line with the abovementioned principles.

Note that the impacts of devolution decisions will have different impacts on different sub-sectors and different organisation types and therefore devolution decisions should be made on a case by case basis informed by nationally agreed and uniform principles.

[1] The NGO Working Group is a group of senior managers from the NGO sector who have been voted by the NGO sector to be part of a Working Group. As a group, we are contracted by the Ministry of Health to further develop the relationship between the NGO sector and the Ministry.

Agree that the NGO sector be closely involved in the decisions made about devolution via direct discussions occurring with the NGO Working Group and umbrella groups representing specific funding streams (for example; NZDSN for Disability, Platform for Mental Health, Te Matarau for Maori providers).

Note that the NGO Working Group should be used as a key consultation route to the wider NGO sector to engage the sector on devolution decision impacts.

Background Context and Impetus for this Paper

In late 2009 the Minister of Health announced planned changes to the New Zealand health system in response to the recommendations of the Ministerial Review Group (MRG) report. These changes include[2]:

- the setting up of a new National Health Board (NHB) as a separate unit within the Ministry of Health to provide more focused national supervision of the $9.7 billion DHBs spend on hospital and primary health services. The NHB will also consolidate national planning and funding of all IT, workforce planning and capital investment and take national responsibility for funding and planning of specialist national services.
- creating a Shared Services Establishment Board to begin consolidation of administrative functions such as payroll and purchasing currently spread across 21 DHBs and regional shared agencies
- strengthening regional co-operation in service planning and delivery, which will require legislation
- devolving the programme of funding of up to $2.5 billion, currently managed by the Ministry of Health, where appropriate to DHBs.

Specifically Cabinet agreed, in relation to devolution[3]:

20.1 that the Minister of Health will determine, in consultation with the health sector, what health services should be planned and funded at a national level, and provide guidance as to what services should be planned and funded at region and local level by DHBs;[4]

20.2 to devolve the non-departmental expenditure funding for services directly purchased by the Ministry of Health to appropriate levels within the system, unless there is good reason for continuing with national purchasing / management, by October 2010;

20.3 that the centre should plan and fund only those services for which a national approach is genuinely required to achieve efficient and effective delivery.

[2] From "The Government's response to the Ministerial Review Group Report 'Meeting the Challenge'". 21 October 2009 available at http://www.beehive.govt.nz/release/major+push+lift+public+health+performance
[3] CAB Min (09) 37/13-15 released by the Minister of Health and available at http://www.beehive.govt.nz/release/major+push+lift+public+health+performance
[4] We assume that these decisions will include the disability sector although it is not mentioned in the cabinet minute

This series of decisions will have a large impact on the health and disability NGO sector in New Zealand. Much of the $2.5 billion non-departmental expenditure (NDE) that is to be devolved from the Ministry of Health to the appropriate national, regional or local structure to plan and fund will be services provided by the NGO sector. In addition, some NGO services that are currently planned and funded locally due to past devolution decisions (e.g. mental health) may be moved to a regional or national level of planning and funding.

At the same time, other initiatives are underway or being planned that may also impact on the way in which health services are planned and funded, including:

- Whanau ora framework development[5]
- Better, Sooner, More Convenient primary healthcare developments – with 9 proposals initially being taken to business case development stage[6]
- Investigation of Local Area Coordination and further development of Individualised Funding in the disability sector[7]

All these changes are being made to create a more efficient and cost effective sector, to move services closer to the point of need, to increase collaboration within and beyond the sector to facilitate new models of care and to increase community and whanau leadership and responsibility for maintaining health and wellbeing.

There is some concern in the NGO sector that the focus for some of these changes is on the DHB / PHO sectors with little regard being given to the potential for the NGO sector to contribute to addressing the issues raised above. There is a risk that if the changes are focused on treatment services and PHOs / GPs alone without fully integrating the wider sector then the changes made will not result in the desired impacts; a focus on treatment without an associated focus on prevention, community support, inclusion and rehabilitation will simply perpetuate and reinforce the cost of ongoing treatment.

The NGO sector comprises a key (though sometimes under-valued) element of a unique system of networks, relationships, practices and interventions that support people living well in their communities. The NGO sector has evolved from “community groups” of interests to organisations based around sophisticated contemporary infrastructures, established models of practice, and a skilled and trained workforce. High volume, low cost services have become synonymous with NGO service delivery and NGOs in partnerships with communities and businesses can promote greater social investment that enhances greater social well-being.

NGOs[8] are uniquely positioned in the health sector and offer a number of advantages:

- NGOs have very strong links to the communities they serve, most often having been formed as a direct result of a community need and are able to easily facilitate community and natural supports for the people they serve. NGOs have been doing this work for a long time, in some cases over 100 years, and many NGOs have community links and networks that have developed over the many years they have been working with their communities.

[5] A final report has been developed but has not been made publically available at the time of writing this paper
[6] See http://moh.govt.nz/moh.nsf/indexmh/phcs-bsmc-proposals
[7] See latest MoH Disability newsletter for information on current status of these initiatives http://www.moh.govt.nz/moh.nsf/indexmh/disability-news-newsletters-dec09
[8] In this context NGOs are not-for-profit, community initiated agencies.

- They work at the frontline and most often support the most vulnerable populations (including those experiencing mental health issues, the aged care sector, Maori, Pacific and refugee populations and those with disabilities), those with the poorest health outcomes likely to need secondary care.
- NGOs are good at prevention and identification, assessment and support of early treatment which works to 'slow the spin' of the revolving door back to secondary care.
- They are very cost effective and live within their means, putting any unspent dollars directly back into service delivery.
- NGOs are adaptable, flexible, and open to innovation.
- And finally, NGOs are well connected with one another and are used to working collaboratively across sectors with other NGOs and government agencies.

It is therefore critical that the NGO perspective is fully considered in the deliberations about health and disability planning and funding in order for NGO capacity and potential to be fully realised.

There is an opportunity in this time of change to do things differently, to ensure that the planning and funding environment of the future is configured and operates in such a way as to maximise the health and wellbeing of the population. The NGO Working Group, on behalf of the sector, put forward the following principles, implementation considerations and recommendations as our initial contribution to making this happen.

Principles

The NGO Working Group put forward the following principles that we believe must underpin any decisions that are made about the reorganisation of the planning and funding environment. We believe that decision-making based on these principles will ensure patient centred care that is delivered more effectively, more conveniently and sooner.

1. Services must be **focused on** the **outcomes** for the individual / population served

Primarily services must be client / patient-centred and make a difference for the individual or population they serve; and providers should be funded to deliver these outcomes. As noted in the MRG report, funding that is too rigidly tied to specific purposes and contracting that is too focused on the service provided rather than on meeting genuine need and producing improved outcomes can sometimes result in relatively expensive care options. A re-organised planning and funding environment should focus on how services can be planned and funded to deliver flexible funding arrangements that focus on outcomes[9].

[9] An example would be the “High Trust” contracts being piloted by the Ministry of Social Development at present.

2. Services must be **integrated across the spectrum of care**

Focusing on the outcome for individuals also requires that care is integrated not only across the health and disability sector but also across the wider social service sector. NGOs already contract with a number of social service government agencies to provide integrated care solutions and the development of cross-sector collaborative contracting mechanisms and consistent funding policies are needed to maximise the efficiency of this[10] and to provide an integrated outcome for the individual / population being served.

3. Services must be **high quality** and based on **evidence based best practice**

It is important that services are of high quality and it will be important to preserve what is currently working or beginning to work well and build on that and not introduce change for change's sake.

4. Services must be **culturally appropriate** and serve **to reduce inequalities**

Services that are culturally appropriate to Maori, Pacific, Asian and other populations are important and need to be retained and nurtured as they serve to reduce inequalities to access and treatment.

5. Consistent with the **principles of Whanau Ora**

The need to work in a cohesive and integrated way towards increasing social inclusion, building on the strengths already within families and communities and the greater use of natural supports within the whanau and community are important principles.

6. **Delivers consistency as well as choice** for the individual / population

It is important that there both be choice of provider for an individual as well as consistency of provider over time once that choice has been made. Planning and funding arrangements need to work to ensure choice as well as arrangements that deliver sustainable providers, such as long term contracts as outlined in the MRG report. Contract terms should be lengthened to build certainty and to ensure ongoing investment in staff development and shared service collaborations. Short term contracts amount to a dabbling of toes in the water and create provider strategic uncertainty rather than an efficient investment towards long term health outcomes.

7. Services need to be delivered in a **cost effective and efficient** way

Services need to be planned and funded in a way that maximises the effectiveness and efficiency of the service. Issues such as reducing duplication, creating centres of excellence for small but dispersed populations, minimising transaction costs (see a later principle) and the need for national

[10] For example, ACC, MSD and MOH often have different funding strategies and policies that complicate a consistent approach and serve to confound both providers and recipients of service delivery.

co-ordination of some services (such as workforce development) needs to be considered in order to deliver efficient services.

8. Service access must be **equitable and fair**

Access to services must be equitable across the country. Nationally consistent funding methodologies and service specifications, and processes to ensure their implementation, are required to ensure a fair and even playing field.

9. There must be **transparency and lack of bias** in planning and funding decision making

Planning and funding decisions must be based on best outcomes and not be unfairly biased towards one provider or another. Explicit division between funder and provider is considered best practice. There is some concern that there have been examples of provider capture within the DHB environment[11] and a reorganisation of the planning and funding environment must seek to eliminate this possibility. It is important that pressures to manage costs in DHBs do not create perverse incentives by the funder to redirect revenue streams away from the NGO sector toward the DHB provider arm.[12] There is compelling evidence that the provider arm services are high cost and NGO services will consistently provide the most effective return on investment by achieving cost effective health outcomes in the community.

10. **Transaction costs** must be **minimised**

In order to deliver a cost effective and efficient system it is important to minimise the transaction costs for all parties involved in tendering, contracting, managing and monitoring service providers. For service providers, the less time, money and focus spent on transaction costs, the more that can be spent on service delivery. Managing multiple contracts with multiple funders (either multiple DHBs with often different philosophies and ways of working and/or funders across government departments), multiple audits and significant reporting requirements is a fact of life for many NGOs[13] and a reorganised planning and funding environment must work to reduce these rather than increase them.

[11] For example see HSRC Health Reforms – Devolution report, 2007
http://www.victoria.ac.nz/hsrc/reports/downloads/Report%20No.%205%20Devolution.pdf

[12] OECD Economic Survey Of New Zealand, 2009.
"The 2001 reform reorganised the hospital sector, then consisting of the corporatised public hospitals and an arms-length national purchaser, into 21 District Health Boards (DHBs) that simultaneously own the public hospitals and purchase most health-care services for their districts. The diminished emphasis on competition and profitability, together with a greater appeal to responsibility and co-operation to achieve results, were popular with both the public and health professionals. Yet the new arrangements probably went too far in downplaying incentives. Some adjustment to enhance their role now appears necessary. In particular, the amalgamation of the functions of purchase and provision of services may have distorted incentives, with DHBs tending to direct business to their own hospitals, to the detriment of private entry. This discourages potential efficiency-raising competition and exacerbates supply shortages."
http://www.oecd.org/document/31/0,3343,en_2649_34569_42539359_1_1_1_1,00.html

[13] See NGoIT 2008 NGO-DHB Contracting Environment report for detail of this in the mental health and addictions sector – http://www.platform.org.nz/page/14-Platform-Publications

11. **Innovation and service development** should be **encouraged**

Mechanisms to encourage innovation and the development of new models of care are important. Collaborations across the NGO, PHO and DHB continuums will provide the most lasting population health outcomes. Current contracting arrangements encourage silos of care and encourage risk shifting rather than shared commitment and collaborative engagement building on the strengths of multiple providers towards agreed and shared targets. The Better, Sooner, More Convenient development strategy for PHOs is a sensible initiative but could be developed further to promote a broader range of cross sector shared service initiatives to better manage the chronic health conditions and the associated escalating costs for ageing populations in particular.

12. There is a requirement for **world class planning and funding capability and capacity**

Effective, efficient and high quality service delivery requires first class planning and funding capacity and capability. It is vital that funders fully understand the sector they are dealing with and have the capability and capacity to develop positive, trusting relationships with service providers and other funders to work in a collaborative, partnership building manner. Concerns expressed about funder capability[14] would need to be considered before planning and funding is devolved.

Implementation

The NGO Working Group believes that the abovementioned principles can be used to guide decisions about the level at which specific services and functions are best planned and funded (i.e. national, regional or local).

It is important to acknowledge the complexity of the task that is in a large part due to the diversity as well as interconnectedness and mutual dependencies of the NGO sector; no one decision will work for all functions, services or providers and decisions made may have unintended consequences if there is not due consideration given to the interrelatedness of the sector. It will therefore be important to ensure that decisions are made in a considered manner involving full consultation with the NGO sector and are implemented with the full involvement of the sector (rather than to it).

As an example of the complexity, services may have a national, regional and local component and there needs to be flexibility in the devolution decisions to allow for this. For example a current national contract providing specialist information services to people with Autism Spectrum Disorder, their families and whanau includes a national planning of services and national systems component with service delivery occurring locally; this assures the best possible outcomes for people accessing the service and consistent quality control at a local and regional level. To administer this service with multiple regional contracts will not only create extra administration workload and additional extra funder relationship management time, it may also compromise the integrity of the service with inconsistent regional funder expectations.

[14] For example see NGoIT Contracting report (link above) and 2007 NGO relationship survey - http://www.ngo.health.govt.nz/moh.nsf/pagescm/7527/$File/ngo-survey-results-2007.pdf for issues such as high staff turnover, lack of knowledge and experience in the sector, poor communication and lack of respectful relationships.

Similarly there will be some planning and funding functions that are better suited to be at different levels of the sector. For example, the setting and monitoring of national service specifications and funding methodologies and alignment of these with other government agencies needs to occur nationally whereas relationship management could occur locally.

It is important to note that decisions about the devolution of NDE and reorganising some local planning and funding to a regional (and perhaps national) level will have differential impacts on different sub-sectors of the health and disability sector and the principles above may be more or less relevant to particular sectors. For example, the principle of effectiveness may be of high priority in the public health sector where national co-ordination is vital to the effective and efficient delivery of services whereas the disability sector may be concerned about the capability and capacity of funders to understand their sector and not place it within a medical paradigm. In addition, it will be important to ensure that devolution decisions for particular sub-sectors do not create unintended barriers to the fulfilment of committed government strategies such as the Disability Strategy and Te Tahuhu / Te Kokiri.

It is therefore very important that each sub-sector has the opportunity to be involved in decision making and is able to reflect back the specific concerns of their sub-sector.

The NGO sector is diverse and encompasses organisations of national reach with significant track records and history through to much smaller, local organisations which are newly established. The impact of devolution will be different for these different types of organisations and it will be important to treat each organisation on a case by case basis and not try and take a sector wide or service wide approach.

The application of the principles will similarly be differentially relevant to different organisation types. For example national organisations may emphasis minimising transactions costs by having a national contract, a local organisation may place more emphasis on the principle of equity and require standard funding methodologies across different DHBs and Kaupapa Maori services and Pasifika services may well align with Whanau Ora principles and opportunities.

In order to successfully manage this complexity, NGOs need to be closely involved in the devolution decisions as they are made in order to maximise the opportunity for a smooth transition that optimises NGO potential to deliver cost effective and efficient services to communities of need.

We recommend that the NGO Working Group be used as an established network that will enable a broad range of NGOs and established umbrella groups and sector representative bodies to be contacted for the purposes of consultation.

Risks and Mitigations

The NGO Working Group wish to highlight a number of risks that have been identified and put forward some suggested mitigations.

Timing

There is a risk that devolution decisions and their implementation will be rushed, resulting in unintended consequences including diminished service capacity and efficiency. We suggest that the time should be taken to fully work through decisions, allowing for the full impacts to be considered by the sector and plan for devolution to actually occur several years into the future when new structures (such as legislation for regional service planning) and capacities are in place, and other sector changes, such as PHO consolidation, is further advanced.

Funder capability and capacity

There is also an associated risk that current funding capacity at a local and regional level will not be able to cope with a sudden increase in responsibilities for areas in which they have had no prior involvement if decisions are implemented too quickly. Retaining planning and funding at a national level for those areas where specific capabilities are required and/or delaying the timing of devolution until capacity and capability is in place are mitigations that can be considered.

There are also risks that the reallocation of the back office functions of funding in particular will force a rationalisation of contracts and create a functional need to reduce the number of NGO contracts to reflect the reduced funder capacity to service the range of contractual relationships. This will certainly lead to reduced consumer choice and the potential loss of significant NGO capacity and community reach. Whilst such an impact may have short term cost benefits, the long term efficiency impacts will need to be carefully considered. It takes a short time to destroy capacity but a long time to rebuild or regain it.

Silo funding continuing

There is a risk that silo funding, resulting in expensive care options and increased transaction costs will continue to occur unless there is a fundamental change in the way that services are planned and funded in collaboration with other government agencies. Devolution to another area of the health sector will not in itself reduce this risk.

Increased inefficiencies

Services will be less cost effective if transactional costs increase as a result of devolution decisions. Nationally consistent contracts and reporting frameworks and streamlined audit as per MRG report will help to mitigate this. A lead DHB model could also mitigate some of the risk of an inconsistent approach across DHBs and the increased transaction costs associated with developing multiple relationships.

Inconsistent access

Devolution to a local level may result in inequities in service access unless this is accompanied by the development and enforcement of national funding methodologies and service specifications.

Objections from key vested interests in health and disability sector

We believe fundamental reform is required to position the New Zealand health sector where quality, community-based health and disability service provision is cost effective and sustainable. This may require review of the use of existing roles and the potential of development / enhancement of new roles.

Recommendations

The NGO Working Group recommends that the government:

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