NGO Council Future Focus: An Exploration of Service Commissioning

A discussion paper written for the NGO Council by Richard Clarke, Melbourne, June 2016[1].

Summary

The NGO Council is seeking to understand how it should focus its activities so that it maximises its contribution to the non-profit health and disability sector, while also adding value for the Ministry of Health (MoH). This paper sets out themes in the NZ Health Strategy that provide opportunities for the Council to drive the shift required across the NGO sector. It describes how each of four pertinent service commissioning models are changing and innovating rapidly, and considers the implications of these changes for NGOs.

The rapidly changing environment is challenging for NGOs in the health sector but also provides opportunities for those that are sufficiently agile, relevant and responsive to the needs of the most vulnerable whanau.

1. Introduction

The NGO Council is seeking to understand how it should focus its activities so that it maximises its contribution to the non-profit health and disability sector, while also adding value for the Ministry of Health (MoH).

The Council considers that it will be able to focus its activities more effectively if it identifies:

- international and local examples of innovation in service commissioning that engage NGOs in service design and development, as described within the Productivity Commission's *More Effective Social Services* inquiry report (2015)
- key success elements for service commissioning models and for providers in differing commissioning environments.

This paper:

- explains how two key terms in the project brief ('commissioning' and 'service delivery model') are used in the paper
- sets out themes in the MoH's Health Strategy that provide opportunities for the Council to drive the shift required across the NGO sector
- describes how four pertinent service commissioning models (contracting out, shared goals, client based delivery and social impact bonds) are changing and innovating rapidly, and considers the implications of these changes for NGOs

NGOs engage with service-users and seek community input when developing relevant services. Many NGOs originated from people coming together to meet a need, and many have service users

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on their boards and staff. This means community-based NGOs have valuable knowledge and connections that can make a real difference in communities to inform client choice and deliver people-powered services, which is a key theme identified in the updated NZ Health Strategy.

Users of the health and social care systems expect that the correct mix of treatments will be provided seamlessly across the systems. However, achieving seamless integration is extraordinarily difficult, and is an objective of many of the innovations discussed in this paper.

2. Defining 'commissioning' and 'service delivery models'

The NGO Council is seeking examples of innovation in service commissioning and in service delivery models. We need to set out what we understand by these terms.

Sometimes, 'commissioning' is used in a narrow sense, restricted to ordering or authorising the production of a good or service. This use of commissioning is very similar to procurement. The UK Institute for Government has a broader view, recognising that commissioning is a process that includes gathering intelligence about the relevant market. They cite the Institute of Commissioning Practitioners' definition of commissioning: 'securing the services that most appropriately address the needs and wishes of the individual service user, making use of market intelligence and research and planning accordingly' (Moss, 2010, p. 4).

The Productivity Commission, in its inquiry into social services, used a definition that is broader again. It defines commissioning as the 'set of deliberative tasks that need to be undertaken to turn policy objectives into effective social services' (Productivity Commission 2015, p. 128). These tasks include choosing the service delivery model, designing it, implementing it, and ongoing service stewardship. By a service delivery model [2], the Commission means options for providing services such as in-house provision by government, contracting out provision to NGOs or to commercial organisations, client-directed service models, shared goals, or social impact bonds.

While there is debate about the precise meaning of commissioning, one reviewer concludes that it is 'clear that commissioning remains an important focal point in trying to develop improvements in the quality of health and social care and the outcomes they deliver, integration between the services, and the level of efficiencies across care systems to deal with pressures on public sector budgets' (Clark et al 2015, p. 3).

This paper uses the Productivity Commission's definition, because narrower definitions would not bring out the issues around commissioning of service delivery models in which the Council is interested. However, this paper mainly uses the term 'service commissioning models' to capture this broader approach.

Section 3 sets the discussion in context by drawing out relevant themes from the New Zealand Health Strategy. Sections 4 to 7 describe innovations in four service commissioning models and provide examples of innovations by NGOs working within these models. Section 8 describes other innovations that do not fit within the four service commissioning models. Section 9 identifies ongoing key success factors both for the models and for NGOs operating in them. Section 10 starts to explore implications for the NGO Council.

[2] The Commission refers to service models rather than service delivery models.

3. The New Zealand Health Strategy

Box 1 lists actions from the New Zealand Health Strategy that appear particularly relevant for NGOs, and may indicate areas where the MoH would be receptive to advice from the Council.

Box 1 Selected actions in the Health Strategy

- Develop and implement a monitoring framework focused on health outcomes, with involvement from the health and disability system, service users and the wider social sector. The framework will shift the focus from inputs to outcomes. This work will build on the Integrated Performance and Incentive Framework and results-based accountability and aims to increase equity of health outcomes, quality and value. (Action 14)
- Improve commissioning by using a wider range of service delivery models, expanding the use of contracting for health and equity of health outcomes and building capability to lift the quality of commissioning. (Action 17)
- Review funding, contracting and accountability arrangements for primary maternity and Well Child / Tamariki Ora services to better support access to, and integration of, health and social services for children, families and whānau with complex needs. (Action 17)
- Increase joint commissioning across the health and social sectors and quality improvement in youth services. (Action 17)
- Improve commissioning models for NGOs to enable streamlined and flexible contracting that supports providers to be sustainable. (Action 17)
- Build capability across health and social service providers, especially those delivering services to priority groups and the most vulnerable, to promote sustainable options and choice within communities (Action 17).
- To support the one team approach, the Ministry of Health will facilitate forums for the whole system every year (in advance of DHB planning activities) to discuss government priorities, share international and New Zealand best practices and build leadership. Feedback from the forums will be used to advise the Minister of Health on system priorities each year (Action 22).
- Put in place a system leadership and talent management programme to enhance capacity, capability, diversity and succession planning throughout the sector.
    - Develop a system-wide leadership and talent management programme aligned with the State Services Commission framework.
    - Use the same principles to strengthen skills and capability and expand support for the NGO/primary and volunteer sector. (Action 23)

Source: MoH 2016b

These actions indicate that the MoH wishes to:

- consider a wider range of service delivery models
- improve existing contracting arrangements
- shift from focusing on inputs and outputs to focusing on outcomes
- look for openings for joint commissioning
- seek opportunities to improve the capabilities of providers
- involve stakeholders in setting system priorities.

The following sections examine these themes through considering four service commissioning models:

- contracting out
- client-directed budgets

- shared goals
- social impact bonds.

They are all significant or potentially significant in New Zealand and are changing considerably.

4. Contracting out

Where is this model used?

In the contracting out model, a funder, typically a government agency, contracts a third party to provide social services. This model has been used for a long time and is the most widely used approach for delivering social services in New Zealand.

In 2013-14, MoH and District Health Boards (DHBs) spent $1.848 billion in the health and disability services sector on funding 932 not-for-profit NGOs. MoH funded 570 NGOs and DHBs funded 620. Of the 932 NGOs that contracted with MoH and/or DHBs, 258 were funded by both MoH and by DHBs, 312 were funded only by MoH, and 362 were funded only by the DHBs (pers. Council Comm.)

The model is changing significantly. Early use of contracting out did not allow for the characteristics of NGOs, leading to concerns that this approach would undermine NGOs' special contribution. Submissions from NGOs to the Productivity Commission's social services inquiry identified problems with the way contracting is applied, and in particular the proliferation of small, prescriptive and often short-term contracts. Some providers have contracts with different agencies that are written differently and have different reporting requirements. Some contracts specify a narrow and inflexible range of outputs, which discourages service integration. Focusing on inputs or outputs, rather than on outcomes, discourages innovation. Funding is sometimes insufficient to enable providers to train or even retain staff. Poorly designed payment incentives can reward behaviours or activities that were not intended when the contract was written (Productivity Commission 2015, pp. 309-316).

The Government's response to these issues includes introducing streamlined contracting. Using lead agencies and joint commissioning to enable providers to deal with a smaller number of NGOs has also been discussed. Contracting for outcomes is a significant theme in the New Zealand Health Strategy. The Guide to the Commissioning Framework for Mental Health and Addiction recognises that input or output-based contracts have a place, although they can create perverse incentives that need to be managed (box 2).

Box 2: An example of one approach to input and output-based contracts in the current contracting environment

Input based: 'This type of funding is currently the most commonly used. It is simple and easily measured and reflects the overall cost of delivery. Usually the provider is only paid when a permanent FTE staff is in place (which can disadvantage providers who are covering roles with casual workers). Payment is not related to outcomes (either population or clinical) and is not dependent on the quality or quantity of service delivered. This type of funding can be helpful to ensure sufficient staff are in place (where minimum staffing levels are specified) or a specified number of beds are provided.

The type of FTE is also usually prescribed, which can create issues if the provider cannot recruit staff in a particular specialty. It can also restrict the use of cultural and peer support roles as these need to be specifically contracted for. Bed-based funding that is based on occupancy (or use) can

incentivise providers to maintain high occupancy; however capacity funding (funding as if full) is an alternative approach that addresses this issue.
Output based: This type of funding can be used to manage fluctuating demand for service (eg, forensic assessments) and pays providers for what they deliver. It can encourage increased demand, promoted by the providers themselves, and can also stifle innovation by leading providers to offer only the type of intervention that is funded.'
Source: (MoH 2015, p.51)

Outcome-based contracting

New Zealand, Australia and the UK are shifting towards outcome-based contracting. While this is an important trend in the contracting out model, outcome orientation is a feature of all of the service commissioning models discussed in this paper.

Health and social care systems exist to improve outcomes, and so in that respect the attraction of implementing outcome-based approaches is obvious. Focusing on outcomes can also encourage integration across and between systems, in contrast to the barriers to integration erected by input or output-based contracts:

> 'For mental health and addiction, desired outcomes are intertwined with social outcomes, reinforcing the need to collaborate across agencies working with people to understand how to capture all of the factors contributing to desired outcomes. Mental health and addiction outcomes are complex and highly interrelated and can occur simultaneously across the domains of people's lives. Contracts that are based on results will have agreed measures of success including measures of outcome, quality, equity and value for money. Using this approach, agreements can reinforce integrated, collaborative approaches and identify contributions towards desired population outcomes. (MoH 2015, p. 52)

An outcome focus is more conducive to innovation. Contracts that are written in terms of expenditure on inputs or the delivery of outputs do not leave room for a provider to change its approach when it finds a better one. When the contract requires the delivery of outcomes, there is room for the provider to change its approach.

Implementing an outcomes-based approach is, however, neither simple, nor always feasible. NGOs submitted to the Productivity Commission inquiry that meaningful outcome measures cannot always be developed; that it is sometimes not possible to attribute an outcome to a particular intervention; and that outcomes may only be achieved in the long term, beyond the reasonable life of any contract (Productivity Commission 2015, pp. 309-316). Paying on the basis of outcomes can also encourage providers to seek out cases where good outcomes can be achieved at lower cost, leaving the most disadvantaged untreated.

The Productivity Commission concluded that government agencies and NGOs should expand the use of contracting for outcomes, while recognising that this is not always the best option (Productivity Commission 2015, p. 324). The MoH's action item adopts a similar position, proposing to *expand* the use of contracting for health and equity of health outcomes, rather than applying this approach across the board. MoH also recognises that developing outcome-based contracts will require building the capability of commissioners.

Lead contractors

Lead contractors and alliance contracting are increasingly being used to increase efficiency and stimulate more integrated models of care. We discuss alliance contracting in the next section as it fits within the shared goals model.

Lead contractors, which could be for-profit or not-for-profit, subcontract to other providers in order to offer a pathway or package of care. In NZ, the PHO model offers a similar opportunity for a lead contractor approach, with some PHOs already contracting NGOs to provide services.

A partnership between for-profit and not-for profit providers may be attractive as the private sector contributes investment potential, while the NGO partner brings knowledge of local communities and needs. However, there may be concerns that such arrangements would compromise the values of NGOs, and that volunteers may not want to work for a private sector provider (Curry et al 2011, p. 21).

Use of the lead contractor model in Australia

For example, the Australian government contracted with the Brotherhood of St Laurence in 2008 to serve as the prime provider in the five-year roll-out of a parenting and early childhood learning programme known as the Home Interaction Program for Parents and Youngsters, in some 50 communities and with several hundred providers across the nation (Sturgess, 2015, p.26).

Use of the prime contractor model in England.

Since 2013, clinical commissioning groups (CCGs), of which every GP practice in England is a part, have commissioned most health services, including emergency care, elective hospital care, maternity services, and community and mental health services. In 2013-14 they were responsible for about 60% of the total NHS budget. Devolving commissioning is intended to move it to organisations that are better informed about their communities and their needs. CCGs are likely to value NGOs' knowledge of their local communities (Curry et al, 2011, p.8).

Some CCGs' approach to commissioning is to contract with a single organisation (or consortium), which then takes responsibility for day-to-day management of other providers that deliver care within the contracted scope or pathway. The prime contractor manages the supply chain of individual providers through individual sub-contracts. It takes on considerable risk, as it is ultimately responsible for the performance of the sub-contracted providers, and manages this risk through the terms of the sub-contracts and mechanisms for holding those within the supply chain to account. Using this approach enables the commissioning agency effectively to delegate commissioning to the prime contractor, and to make it responsible for integrating service provision (Addicott, 2014, p. 15).

Addicott (2014, pp. 11-14) illustrates the lead contractor model through the example of how Macmillan Cancer Support and four CCGs in Staffordshire are working together to design and deliver new models of care around cancer and end-of-life services. She also provides the example of the Bedfordshire CCG, which is using a prime contractor to reduce fragmentation and improve care pathways. She points out that:

> 'typically – but not exclusively – the prime contractor is allocated a capitated budget to manage all care for the specific population or disease group. To varying extents, a proportion of this budget is 'at risk', dependent on the prime contractor (through its supply

chain) meeting stipulated outcome measures. The model is based on the premise that these measures are more likely to be achieved if the prime contractor manages the pathway and encourages providers to work together more efficiently. In this sense, the CCG contracts the prime contractor to be the service integrator. (Addicott 2014, pp. 15-19)

A variation on the prime contractor model is the prime provider model, which stipulates that the contracted organisation also provides some services directly. This gives the prime provider more leverage for transformation, by directly building its provider capacity and delivery model to meet the terms of the contract. Addicott (2014, pp. 20-24) illustrates this through the example of the Cambridgeshire and Peterborough CCG, which is using the prime provider model to deliver an integrated service for older people.

Box 3 illustrates the types of characteristics that the NHS expects lead providers to have.

Box 3: Characteristics of lead providers.
'The following organisations have been approved to join the Commissioning Support Lead Provider Framework, following a rigorous procurement process. They successfully met the quality and value for money criteria required to deliver the best support services to Clinical Commissioning Groups (CCGs) and other commissioners of health and social care services. … The organisations bring together a range of partners to deliver the very best services in areas like innovative contracting approaches (including outcome based commissioning); transformation change and service redesign for the Five-Year forward view (including embedding the NHS Change Model); supporting patient involvement and engagement and robust approaches to reactive communications; renegotiating contracts; and using innovative business intelligence tools and skills to drive improvement.'
Source: (NHS 2015)

Implications for NGOs

Large NGOs that might take on the role of prime contractors would need to develop the commissioning skills that the role requires, including managing a complex supply chain. This approach could strengthen the dominant position of a small number of providers. Hence while this model relieves smaller NGOs of the transaction costs of negotiating with government commissioners, they may find it no easier to deal with a prime contractor (Rees et al, 2014, p.40).

There have been concerns that the payments system under the new arrangements will shift from block funding to payment in arrears for delivery of outcomes, and that NGOs that typically have small reserves will find this difficult to manage. The shift in the payments system also makes it vital that NGOs are able to demonstrate how they contribute to outcomes (Curry et al, 2011, pp. 13, 15). There is a risk of further proliferation of contracts, as NGOs have yet another body to contract with, unless their contracts with the lead contractor replace existing contract relationships completely, which is unlikely.

There may be scope for NGOs to take on a coordinating role. For example, in the UK, the Newquay Pathfinder project run by Kernow Clinical Commissioning Group and Age UK focuses on bringing voluntary, health and care services together. Age UK, which is the UK's largest charity working with older people, supplies volunteers who act as a link between these services, with the aim of helping older people to stay healthy. Early evaluations suggest that the pilot has reduced emergency hospital admissions by as much as 35 per cent (Bull et al, 2014 p. 19).

5. Shared goals model

The Productivity Commission defines the shared goals model as one that 'reflects a view that complex social problems are best addressed by the organisations and social services personnel who are near to clients working together to share information, resources and expertise for the benefit of those clients' (2015, p. 141). It uses the Canterbury Clinical Network (CNC) to illustrate this model.

Alliance contracting

The CNC appears to be an example of an alliance contract, under which a set of separate providers enter into a single agreement with a commissioning agency to deliver services. The key difference from the prime contractor model is that the commissioner(s) and all providers within the alliance share risk and responsibility for meeting the agreed outcomes. They are not co-ordinated by a prime contractor or integrator, and there are no sub-contractual arrangements. All organisations within the alliance are equal partners and must instead rely on internal governance arrangements to manage their relationships and delivery of care. The intention is that integration is formalised within the contract, and the contract partners have an incentive to innovate and look for efficiencies across the system (Addicott 2014, p. 26).

The justification for alliance contracting is that collaboration creates value because each organisation is dependent on others to deliver the overall project (Clark et al 2015, p.6). However, given that success is judged on the outcomes of the alliance overall, there will need to be a governance framework that determines how rewards will be distributed between members. This model therefore depends on a high degree of trust between alliance members. It is most likely to work where there are well-established relationships between providers (Addicott 2014, pp. 26-27).

New Zealand is a pioneer in this form of contracting in social services, which has recently been applied in the NHS in England.

In New Zealand

DHBs and PHOs

Alliance agreements are now in place with all 20 DHBs and the PHO/s operating in their districts. In some DHBs, additional alliance partners have joined these Alliance Leadership Teams and are working together to plan, prioritise and determine investment. The intention is to deliver integrated health services and bridge the gap between primary and specialist services. MoH argues that alliancing can support outcomes-focused approaches for mental health and addiction by supporting groups of NGOs, primary care providers and social services to work together on common goals and incentivise collaborative approaches to achieving these (MoH 2015, p. 4).

Gauld (undated pp. 567-568) argues that alliances have improved:

> … support for complex patients in primary care settings by enabling general practitioners to work together with hospital specialists and other providers. While early days, there is some evidence of reductions in emergency department admissions and of more services traditionally provided in hospital settings being delivered in the community, such as specialist outpatient consultations, older people's health, and emergency response services that might otherwise require a hospital visit.

He also suggests that the alliances 'have provided a powerful method of bringing health professionals together from different parts of the system and motivating them to work collaboratively on what services should look like from a patient and clinical perspective' (Gauld undated, p. 568).

There is currently little NGO involvement in Alliance Leadership Teams, which increases the risk of service fragmentation and duplication, preventing streamlining of services and limiting their reach into communities. However, NGOs are involved in the Service Level Teams, where many decisions about services are made.

Whanau Ora

Whanau Ora is an example of devolved commissioning, rather than alliance contracting.

Three commissioning agencies are contracted by Te Puni Kōkiri to act as brokers, which match the needs and aspirations of whānau and families with initiatives and services to achieve Whanau Ora outcomes, such as that whānau are self-managing and empowered leaders and are participating fully in society. Each commissioning agency works differently. For example, Te Pou Matakana contracts services from established Whānau Ora provider collectives as well as from other community providers. Te Pūtahitanga o Te Waipounamu works differently because it does not purchase services. It invests in examples of disruptive innovation and collaborative models of care and supports joined up funding arrangements across government.

Whānau may use the services of a navigator: a practitioner who helps them work together to identify their needs and aspirations and develop a plan for the future. Navigators tailor their approaches to the particular needs and circumstances of each whānau, assisting them to set long-term goals and to take charge in working towards them. They help whānau to connect with services and advocate on their behalf to service providers. Once whānau have been assisted to deal with their immediate needs, navigators continue to help them build their capability to be self-managing. The navigator then supports the whānau to access co-ordinated services in areas such as education, primary health and employment, in order to carry out the plan (Te Puni Kokiri, not dated).

In the UK

Addicott (2014, pp. 26-29) describes an alliance contract model being developed in Lambeth, south London, to integrate personalised support services.

The South West London Collaborative Commissioning Plan is an example of 'collaborative commissioning'. This may fall short of alliance contracting, but it illustrates CCGs working closely with providers in planning for service delivery (box 4).

Box 4 Collaborative commissioning in South West London

'Analysis conducted during the development of this plan suggested that local providers would face significant financial and clinical challenges that would affect their ability to continue to deliver high quality services. This prompted the CCGs to collaborate closely with providers on developing innovative solutions to addressing issues in the local health economy. Providers agreed to engage fully in this process, and CCGs set expectations for them in designing and delivering the strategic plan, including:

• contributing to the development of the 5 year strategic plan through clinical engagement

• driving realistic solutions that will deliver the commissioner outcomes
• share responsibility for delivering sector wide solutions
• engage with commissioners around realistic options.'

Source: South West London Collaborative Commissioning p. 272.

Implications for NGOs

It is too early to judge the contribution of alliance contracts to integrating the delivery of health and social care (Clark et al, pp. 4-5).

The introduction of the new commissioning arrangements in the UK – with the devolution of commissioning to CCGs and the use of prime contractors and, to a lesser extent, alliance contracting has created considerable opportunities and challenges for NGOs operating in the health sector. Opportunities include:

- NGOs may be able to break into markets from which they were previously excluded and to expand in markets in which they are already involved.
- NGOs may provide advocacy and signposting services to individuals trying to navigate the system and make complex choices about who provides their treatment and where.
- The CCGs may want help from NGOs, which know their communities very well, particularly about how to reach disadvantaged groups.
- NGOs may be able to offer commissioning support and advice to CCGs about specialist conditions where consortia members do not have the requisite knowledge to develop effective care pathways. One recent example of such a model is Neurological Commissioning Support (NCS) Ltd, which is a joint initiative by the Multiple Sclerosis (MS) Society, Parkinson's UK, and the Motor Neurone Disease (MND) Association to offer support and advice for those who are planning and commissioning care for people with chronic neurological conditions (Curry et al 2011).

There are also challenges that are the flip side of most of these opportunities:

- The role of specialist providers is unclear in the new commissioning environment. As approaches to commissioning move towards larger contracts, and look to bundle services relating to specific groups or conditions under single contracts, providers that carry out an array of services will take preference over specialists.
- Spending cuts make it difficult to shift money to prevention. Charities that focus on preventative action and whole person care may struggle to win public contracts.
- Charities struggle to make the case for their impact on health and lack the data to do so, when their impact is less direct.
- Clinicians need convincing that charities offer complementary expertise and can be a barrier to improving coordination between the voluntary and statutory systems. (Bull et al 2014 p.4).

Another review suggests how NGOs can respond to such challenges.

- NGOs need to engage closely with commissioners throughout contract development, to define the problem the contract is intended to solve and to develop solutions.

- Both models require a high level of trust among the providers and integrators taking on these contracts. Providers will need to consider how they can build trust, share information and manage financial and clinical risk.
- Providers must establish an organisational model and/or collaborative governance arrangement to manage the flow of money, develop and monitor services, and hold each other to account for their contribution to meeting outcomes and other terms of the contract. New provider partnerships will need to establish a legal framework and terms of reference setting out how they will work together, make decisions and manage risk. (Curry et al 2011, pp. 48-53)

6. Client-directed budgets

Where are they being used?

Under this model, instead of competing for Government contracts, providers compete for customers who can switch between them. Consumer choice creates pressure for integration, depending on the breadth of the services included within the scheme and between which consumers can choose.

Not all services are suited to this approach. Services most frequently mentioned as candidates for client-directed budgets are:

- disability support services
- home-based support for older people
- respite services
- some family services
- drug and rehabilitation services (Productivity Commission 2015, p. 291).

MoH is contemplating wider use of the client-directed services model. The New Zealand Health Strategy suggests that the health system can learn from disability support services about how to provide more people-powered services. It mentions the 'Individualised Funding' model, under which some people receive their disability support funding as a personal budget, which gives people choice and control about from whom and when they get support (MoH 2016, pp. 16-17). MoH also comments that: 'a response that addresses the identified needs and maximises opportunities may involve providing a service, but not necessarily. For example, in some situations a better solution might be to tailor care around the needs of individuals and individualised funding'. (MoH 2015, p. 48)

Whanau Ora also has features that are similar to client directed budgets, placing whanau at the centre of decision making about the services they need and how they access them. Community, government and iwi agencies are expected to work in an integrated way that is responsive to whanau needs:

> Other essential integration characteristics include a dedicated budget based on assessment of what is needed, local decision rights over the use of that budget, and effective resource allocation to where resources can have the most effect (Productivity Commission 2015, p. 20).

Disability Services in New Zealand

MoH's Individualised Funding (IF) programme is an example of a client-directed budget approach, although the MoH uses the term in two senses. The first is that IF gives eligible disabled people the option of developing a personalised plan for their Home and Community Support Services. The second is arrangements where people manage their agreed budget and purchase interventions of their choice, either managing the budget themselves or having a host provider or an authorised guardian to manage it.

> 'Packages of care are usually delivered by a lead provider who provides the support staff but some are managed by a third party, with an option of purchasing hours or services from external agencies. Packages of care allow for more responsive and flexible approaches tailored to support the individual (including their family or whānau if deemed appropriate) and are better able to respond to changing needs. However, significant resource is required to allocate, review, coordinate, manage support and monitor/evaluate the outcomes of the support' (MoH 2015, p. 51).

The Enabling Good Lives demonstrations in Christchurch and Waikato take the individualised funding approach further by offering disabled people access to flexible funding pooled by the Ministries of Education, Health and Social Development. This funding may be used for a variety of things including supports in the local community, employing people to assist or using supports from a provider or agency (Enabling Good Lives 2016, Productivity Commission 2015c).

The Productivity Commission (2015a, pp. 279-280) lists other examples of client-directed budget approaches in Australia, Austria, Canada, Finland, France, Germany, Sweden, the Netherlands, the United Kingdom and the United States.

Mental health services in the UK

In the UK increasing attention has been paid to a holistic approach to mental health, recognising the contribution that a range of social services can make. User-held budgets are recognised as a means through which to introduce market pressures. Take up of direct payments has been slower in relation to mental health than other service areas, although national evaluations highlight that the benefits may in fact be greater (Jones et al., 2013 cited in Rees 2014, p. 10).

A review of the experience of third sector organisations (TSOs) found mixed views about the shift to more personalised funding mechanisms. Positive aspects included additional flexibility, as TSOs could negotiate directly with the individual rather than having to go back to a commissioner or care manager to seek approval. There was also support for the principle of service provision being led by the individual who needs care and support. Those who were less positive were principally worried about the financial instability that could result from personal budgets in comparison to the guaranteed annual income provided through a block contract arrangement (Rees et al, 2014 p.19).

Disability services in Australia

The Australian National Disability Insurance Scheme (NDIS) is a large scale example of the client-directed budget approach. It is currently going through extensive trialling, with full implementation anticipated in 2019.

Central to the NDIS is a shift to directing funding and resources to NDIS participants, whose individual choices will drive and shape the market. The National Disability Insurance Agency (NDIA), which is responsible for developing and implementing the NDIS, would 'like to see a market with a diverse array of providers that maximises choice and control for participants but also enables strong links with mainstream services and family and community support to help achieve the overall NDIS aspirations of increased social and economic participation for people with disability' (NDIA 2016, p.i).

The NDIA expects the number of participants in the Scheme to grow from about 25,000 today to 460,000 by 2020. There are currently over 2,300 registered providers in the NDIS, representing a growing range of supplier business types and service models. The NDIA expects providers from adjacent sectors such as health, aged care and other human services to enter the market. Experience in trial sites demonstrates many examples of providers restructuring, and aligning practices with the NDIA model (NDIA 2016, p. 5).

There are many issues to be resolved as the scheme develops. PWC in 2011 listed challenges for NGOs operating in the NDIS. Five years on, these may not all be relevant today, but they illustrate the significant adjustments that NGOs may need to consider in this type of model (box 5).

Box 5 Challenges for providers in the NDIS

In moving towards a model of growth and sustainability, NGOs within the NSW disability services sector need to:

- realign their funding profile to become less dependent on the contract-defined/ government-funded service model
- move towards an individual-choice/ market-funded paradigm. This will require the development of skills in innovative support planning and delivery, and social networks to leverage their impact
- be more targeted and effective in the way they use and build their resource base – always keeping in mind the needs of disability services users. As a first step, NGOs need to fully appreciate their financial position and the unrealised net assets at their disposal. … For example, an NGO:
    - with a strong balance sheet may consider partnering with Government to raise a SIB as a mechanism for financing targeted early intervention activities, which could contribute to better outcomes for individuals with disability, while also realising economic benefits
    - could expand existing partnership arrangements with large corporate organisations, which may be limited to philanthropic contributions, to more integrated collaborations that include business skills transfer and targeted campaigns to boost profile and attract community support
    - that provides housing and accommodation services could maximise multiple capacity building strategies to provide more and better services to its client.

Source: PWC 2011, p.8

Implications for NGOs

The success of this model depends on consumers being empowered to make informed choices. NGOs may be well placed to advise consumers, provided they can demonstrate that they do not have a conflict of interest. The regulatory and funding arrangements are also critical. Transitioning towards competition can take a long time. Governments may decide to regulate prices if competition is not yet effective. This could combine with regulation of service quality and specification to limit the areas in which competition can occur and to delay the transition to competition.

The shift away from government provision should create substantial opportunities for NGOs that can adapt well to new sources of funds and demand. NGOs' closeness to their clients should be a source of advantage.

NGOs working within this model need to develop relationships with customers and with new regulators. They need to understand new regulatory frameworks, which may include new quality standards and price regulation. Some NGOs may respond to enhanced competitive pressures by sharing back offices or the delivery of some services, or even merging. Organisations would need to invest in developing their skills and capability, and may search for ways to share the cost of skills developments.

Increased competition from for-profit providers may add to pressures for not-for-profits to perform and to demonstrate their performance. There may also be increased pressure to incorporate new technologies, which could advantage larger providers over small ones. And not-for-profits will need to manage the tension between becoming more commercial in response to competitive pressures, while protecting their special status in the community as non-commercial organisations.

In the report mentioned above, PWC (2011) argues that to succeed in this model, NGOs must focus on how they can attract clients, through:

- using "knowledge capital" to design and implement innovative individual support packages
- offering services and supports to users at the right price, which takes into account the individual nature and quality of support services delivered
- building social capital by contributing to community capacity, whilst also increasing the NGO's profile in the market (and ability to attract service users)
- assessing the NGO's core service delivery model and understanding how best it fits in the market place. This may involve reallocating resources from specialist disability support to other non-specialist areas, moving away from direct service delivery to providing intermediary/ coordination services, or identifying other areas of need in the community and broadening service delivery into those areas
- using partnership arrangements to help them to shift from the current way of working to a mindset where the user of disability services is the payer. This includes collaboration with large and medium corporations, as well as alliances within the sector. Partnership alliances offer smaller agencies the opportunity to share resources and maximise their utilisation.
- fully appreciating their financial position and any unrealised net assets at their disposal (PWC 2011, pp.56-57).

7. Social impact bonds

What are they?

A social impact bond (SIB) is a

> 'financial mechanism in which investors pay for a set of interventions to improve a social outcome that is of social and/or financial interest to a government commissioner. If the social outcome improves, the government commissioner repays the investors for their initial investment plus a return for the financial risks they took. If the social outcomes are not achieved, the investors stand to lose their investment. Social Impact Bonds provide investment to address social problems and look to fund preventative interventions. As such, they present an opportunity to provide support to reduce the strain on acute services' (Social Finance, nd).

A SIB involves five principal actors:

- *The service provider(s):* Delivers social intervention to a specified target population.
- *The investor(s*): Provides capital to fund programme delivery and bears some or all financial risk.
- *The government or commissioner*: Pays investors if agreed outcomes are met. These payments repay the principal plus a financial return that depends on the degree to which outcomes improve.
- *The SIB delivery organisation (intermediary)*: The counter body to the outcomes contract with government.
- *The third-party evaluator*: Conducts independent evaluations of the achievement of outcomes (Mars 2013, p.3).

When can they be used?

SIBs can only be used where a specific, measurable outcome can be set, based on sufficient historical data and a known baseline. They should not be used where cessation of services would harm a population, or to finance critical public services such as primary and secondary education. The intermediary organisation has a strong incentive to stop offering services if it begins to think it is unlikely that it will achieve the outcome, and will not be paid. SIBs are difficult to negotiate and require a significant investment of time and resources from all parties. This means that they should only be used when they are expected to yield considerable value (Shah and Costa 2012, pp. 8-9).

SIBs have been used in Australia, the UK and the US to reduce recidivism rates among prisoners, and restore children in out-of-home care to their families (Productivity Commission 2015a, p. 77*).*

What are the benefits and risks for providers?

MaRS (2013) lists the benefits and risks for providers of SIBs[3].

Benefits

- *Long funding horizon*: SIBs provide a stable and predictable revenue stream, allowing service providers to improve their financial planning and resourcing, and operate on a timeframe required to achieve the target social outcomes.

[3] This reference also documents mitigation strategies for each of those risks.

- *Flexibility and innovation*: SIBs create room for responsiveness to user needs, flexibility, innovation, and solutions-oriented thinking.
- *Culture of collaboration*: SIBs foster collaboration across programmes and service providers that have shared goals and offer complementary services.
- *Growth capital to scale*: SIBs provide access to growth capital.
- *Opportunity to demonstrate value*: SIBs enable service providers to demonstrate their value to governments and to make their case for continued funding.

Risks

- *Reputational risk*: In the event a SIB programme does not achieve the required social outcome, the perception of failure may damage future funding opportunities.
- *Execution risk*: SIBs often require service providers to form partnerships to deliver a single social outcome. Execution problems may occur as a result of unclear delineations of authority and accountability or poor communication and information systems.
- *Perverse incentives* (leading to undesired results): The pressures to meet outcome targets may encourage service providers to cherry-pick easy-to serve persons while neglecting needy individuals.
- *Sole reliance on SIB funds*: SIB providers that neglect fundraising activities over the duration of the SIB may risk losing their donor and funder base (Mars 2013, pp. 8-9).

Implications for NGOs

The Economist (23 April 2016, p. 65) suggests that this approach is 'promising' but 'still very new', and that at the moment every bond is tailor-made, which holds back their growth.

The NZ Government is using a Pilot to test whether SIBs could be used more widely and to learn lessons for payment-for-result and outcome-based contracting more widely. Wise Group and ANZ Bank New Zealand were negotiating with MoH as the potential partners in the first SIB project, which involved providing employment support through GP clinics to people experiencing a mental health issue (MoH nd).

SIBs are potentially attractive to NGOs as they provide a new and stable source of funds, and their outcome focus offers scope for flexibility and innovation. Governments and investors, however, are likely to have complicated negotiations about risk allocation, and NGOs would need to be closely involved to ensure that they do not end up bearing unacceptable risks by, for example, having a large proportion of their payment linked to outcomes.

MaRS (2013, pp.26-27) suggests that NGOs wishing to enter this area could:

- explore learning resources and education opportunities
- identify champions for SIBs within the organisation
- enhance their performance monitoring and evaluation systems
- seek support for developing the SIB concept, by defining the social issue and target population, determining outcomes and assessing government interest, identifying intervention and outcome metrics, and conducting financial modelling and analysis.

8. Other developments

This section considers other significant innovations, which do not fit into the service commissioning models in the previous section.

Social investment approach

Under this approach, which is likely to be used by iwi and Whanau Ora commissioning bodies, social investment is undertaken on a rate of return basis, where government expenditure today is justified on the basis that it will reduce spending in the future, by improving social outcomes. The results of the investment need to be measurable, to establish whether it was successful. Uptake of this approach has been held back by a lack of clarity in government agencies about agreed outcomes, accountability measures that focus on spending rather than outcomes, and weak incentives for adopting the approach (Deloitte 2016, p. 3).

Proponents of this approach, such as Deloitte (2016) and the Productivity Commission (2015), argue for an increased focus on outcomes, and the establishment of a new agency, to commission projects for vulnerable consumers, where the return on social investment may be higher. The agency would take a whole of government perspective, focus on outcomes, collect and become a repository of data, and be responsible for developing incentives for providers to achieve outcomes. It could become a source of information on the performance of providers and programmes.

The Government's commitment to the social investment approach is indicated by its investment of around $330 million per year to purchase services from social sector providers to achieve better results for vulnerable young children, young people and adults (MSD 2016).The 2016 Budget's social investment package, which provided $641.6 million of operating funding over the next four years and $10.5 million of capital, included additional support for vulnerable children as well as initiatives in corrections, education and health (English 2016).

This approach would be focused on outcomes and so could have similar implication for providers as were discussed in the section on outcomes above. Providers would need to form relationships with a new commissioning agency, if the government decided to go down that path.

Values based commissioning

Values based commissioning (VBC)appears to have developed as a reaction to the weight that is given in the UK to evidence-based commissioning. It 'moves away from the dominance of clinician experience and scientific evidence that has been prioritised over service user values and experience in traditional commissioning processes' (Perry et al 2013, p.6). It aims instead to enable service users and carers, both directly and through representative bodies, to set commissioning direction and strategy.

A driver for this approach appears to be that focusing commissioning on the person would encourage the development of integrated or seamless services. This also seems to have been a motivation behind devolving commissioning to CCGs, so the pressure for VBC must reflect a feeling that the new approach to commissioning is not achieving that outcome and is not involving users sufficiently in commissioning. However, the limited coverage of VBC in the literature suggests that it is not achieving traction.

Other innovations

This section describes other innovative commissioning approaches that have been suggested or implemented in the health or other sectors. It is selective, based on two review articles (Sammut 2016 and Sturgess 2012) and is in no sense comprehensive.

In the health sector, the Australian Government is trialling a 'Healthier Medicare' programme, which enrols chronic patients in a 'Health Care Home' to better coordinate their care, with capitation funding for primary care service and coordination costs provided on a quarterly basis. This trial is taking place in the context of considerable debate about how to improve the health system. Sammut (2016) describes this trial and a range of other proposals and trials in Australia and elsewhere, including:

- a Grattan Institute proposal to set up region-based health agencies responsible for coordinating and integrating care, for fostering innovation in payment mechanisms and for setting targets and measuring outcomes
- payment-for-performance mechanisms that link payments to pre-established performance targets
- integrated payment models that are designed to ensure that financial risk for hospital and non-hospital costs is shared with health service providers, by combining traditional funding streams into one bundled payment
- the Gesundes Kinzigral scheme in Germany, where a health management company has contracted with a government insurer to provide, in partnership with a local physicians' network, both primary and hospital care for insured patients
- experiments with new purchasing and payment arrangements in the Netherlands
- accountable quality contracts in Massachussetts, under which health management companies agree to manage the care of members in return for an annual risk-adjusted budget based on historic per-member spending
- Sammut's own proposal that health funds should hold the full financial risk for members' healthcare needs across the full service spectrum.

Sturgess (2012, pp. 35-45) describes contracting arrangements that are used in various sectors, including:

- outsourcing the management of business processes, such as the helpline for the Equality and Human Rights Commission in the UK
- through-life management of physical assets, involving the inclusion of ongoing service support contracts for the purchase of equipment, initially in defence contracts but subsequently in physical assets such as accommodation and training facilities
- availability contracting, where commissioners pay for access to facilities and equipment rather than acquiring ownership.

Shared services models

The literature reports a range of models for sharing services in order to achieve efficiencies, such as:

- sharing services within an organisation
- partnerships between large and small providers
- management service organisations or shared service centres

- peak bodies providing business centres
- entities forming into an umbrella organisation
- amalgamation or mergers
- group buying schemes (NCOSS 2015, p.2).

9. Key success factors for service commissioning models and for providers in differing delivery models

The project brief asks for identification of the key success factors for service commissioning models and for providers in different commissioning environments. These success factors have been outlined in previous sections, and this section draws together that discussion.

Success factors for service commissioning models

Earlier sections have outlined four broad service commissioning models. None is unequivocally better than the others. Each may be best suited to particular circumstances. Table 1, which draws heavily on a similar table in the Productivity Commission report (2015, p. 145), summarises the strengths and weaknesses of these models, and the innovations outlined earlier in the paper that are intended to address these weaknesses.

Table 1: Strengths, weaknesses and innovations in service commissioning models

Model	**Strengths**	**Weaknesses**	**Innovations to address weaknesses**
Contracting out	Well-designed contracts create incentives for good performance.	Over-prescription discourages innovation. Over-reporting. Excessively short-term. 'Siloed' approach discourages integration.	Outcome-based contracting. Lead contractors. Streamlined contracting processes.
Shared goals	Increased integration. Provider commitment. Intrinsic motivation improves performance.	Need complex governance arrangements to ensure accountability and commitment.	
Client-based budgets	Places the user in control. Increases efficiency and innovation.	Not suited to situations where consumer empowerment isn't feasible. Market design issues are complex.	Major applications being developed in Australia and the UK.
Social impact bonds	Outcome focus encourages integration and innovation. Builds in efficiency incentives. Brings in private sector funding.	Only works where outcomes are measurable and baseline data exists. Risk allocation is complex. High negotiation costs.	Whole approach is innovative.

There appears to have been little research to assess whether involvement of providers in service design and development is a key success factor in model design and development, although there would probably be little disagreement that it is good practice. It is acknowledged that co-designing services and involving the sector early can mean that situations are well understood and available options are explored together (MoH 2015, p.50). For example, MoH points out that:

> It is also important that they [commissioners] work in partnership, taking a multidisciplinary and inclusive approach, as all those who will be involved in service delivery need to understand the model and the principles that underpin it. Expectations of roles and responsibilities need to be clear, and philosophical differences explored as these will impact on service delivery if not resolved. As the model of care will drive how the service is configured, it must be an evidence-informed, agreed model that will meet the needs of the community/people identified. (MoH 2015, pp. 45-46)

The alliance and lead contractor models are the ones that most explicitly involve providers. (Provided that providers become alliance partners, and that a lead contractor effectively takes over the commissioning role.)

The Canterbury Clinical Network is an example of the involvement of NGO providers in an alliance agreement:

> In 2007 Canterbury's health system was under pressure and beginning to look unsustainable. …
>
> Health leaders realised that they needed to do things differently. Canterbury's health services came together to develop a shared vision for the future: one integrated health system that keeps Cantabrians healthy in their own homes by ensuring the right care is provided, in the right place, at the right time, by the right person. The new way forward aimed to better integrate and coordinate primary, secondary and tertiary health services through health alliancing and new ways of contracting.
>
> With the development of the shared vision and the empowerment of teams at all levels and from across the system to be innovative, the Canterbury health system started to recreate its future. A number of Canterbury's Service Providers signed a District Alliance Agreement, committing to work together for the people of Canterbury. The alliance agreement became the platform for the Canterbury health system's journey towards rapid large-scale transformation (Canterbury Clinical Network).

Success factors for providers in different service commissioning models

Earlier sections have identified success factors for providers in different service commissioning models. Table 2 indicates that some key success factors are specific to particular service commissioning models, but that five are important in all of the models:

- demonstrate capacity to deliver outcomes
- develop mission and distinct competence
- understand financial position and how to leverage it
- understand risks and how they are allocated
- become familiar with new technologies.

Table 2 Success factors for providers in different service commissioning models

Success factor	Contracting out	Shared goals	Client-based delivery	Social impact bonds
Demonstrate capacity to deliver outcomes	√√√	√√√	√√√	√√√
Develop mission and distinct competence	√√√	√√√	√√√	√√√
Work with government on streamlined contracting	√√√			
Develop commissioning skills for being a lead contractor	√√√			
Be able to take on a coordinating role as lead contractor	√√√			
Engage closely with commissioning agency	√√√	√√√	√√√	√√√
Build trust with other providers	√√√	√√√	√√	√√√
Establish governance arrangements for alliance contracts		√√√		
Understand financial position and how to leverage it	√√√	√√√	√√√	√√√
Understand risks and how they are allocated	√√√	√√√	√√√	√√√
Develop new relationships with customers			√√√	√√√
Become familiar with new technologies	√√	√√√	√√√	√√√
Learn how to develop individual support packages			√√√	

10. Thinkpiece: Implications for the work of the NGO Council

Introduction

The NGO Health and Disability Network has more than 500 NGO members represented by an elected NGO Council. NGOs deliver mental health and addiction services, disability support services, as well as public health, personal health, Maori and Pacific health services. They range in size from small providers with one FTE employee, to large multi-million dollar agencies with more than 1,200 paid staff. Member NGOs received more than $1.5 billion in combined annual government funding during 2014-15 and 34,500 paid staff worked 1.25 million hours in an average week. At the same time, more than 28,420 unpaid volunteers provided 124,196 hours (Charities Register, 2015).

While there will be different views within such a large and diverse membership about what really matters, one of the Council's roles is to provide a platform for NGOs to engage with MoH and to identify common issues to explore (box 6).

Box 6 Objectives of the NGO Council

The NGO Council has three objectives:

1. Maintain a national strategic policy relationship for not-for-profit health and disability NGOs to engage with government agencies – particularly the Ministry of Health, National Health Board and District Health Boards (DHBs).
2. To provide platforms and opportunities for not-for-profit health and disability NGOs to engage with the Ministry of Health and establish relationships to facilitate:
   - access and influence across the Ministry of Health's areas of policy development
   - relationship building within the not-for-profit health and disability sector
   - identification of common issues (positives and negatives) to advocate
   - dissemination of information within the not-for-profit health and disability sector
   - consultation and collaboration on policy development, needs assessment, strategic planning, annual planning, workforce and sector development, infrastructure issues and emerging issues.
3. Work with the Ministry of Health in organising the NGO-Ministry of Health Forums.

Source: Terms of Reference, Ministry of Health NGO Health and Disability Network.

Over-arching actions

For the most part, possible actions fit into the five themes from the New Zealand Health Strategy identified in section 3; namely, to:

- consider a wider range of service delivery models
- improve existing contracting arrangements
- shift from focusing on inputs and outputs to focusing on outcomes
- look for openings for joint commissioning
- seek opportunities to improve the capabilities of providers.

Since these actions relate to the review of service commissioning models in sections 4-8, box 7 provides a short recap of the main conclusions from that review.

Box 7: Recap of the service commissioning models

There is not a 'best' model that is always preferred. Rather it is a question of selecting the model that suits particular circumstances, and then designing the best possible model within those circumstances. The review highlights the breadth, depth and rapidity of change in the commissioning environment:

- The contracting out model has been around for a long time, but remains particularly important and is changing significantly through streamlining, and more use of lead contractors and of outcome-based contracts.
- Alliance contracts are used extensively in the health sector in New Zealand and the UK, but there is not a lot of evidence yet about how well they are working.
- The MoH has indicated interest in client-based delivery models and they are being implemented in significant programmes overseas.
- The SIB model is in its infancy but there is considerable interest in it in New Zealand, Australia, the UK and the US.

Theme 1: Consider a wider range of service delivery models

Significant innovations are happening in all service delivery models. As well, the Government is developing the social investment approach.

MoH is more likely to anticipate benefits from involving the Council in model development and implementation, if its members can demonstrate that they bring expertise and information that is not available elsewhere. To achieve this, the Council could continue to share real examples of how NGOs contribute to achieving better outcomes for clients in well-established models and expand this to include relatively new models such as individualised funding and alliance contracts.

Theme 2: Improve existing contracting arrangements

The significant changes in contracting arrangements create opportunities for Council involvement in issues such as shaping the streamlined contracting approach; spelling out the benefits of longer term contracts; considering how to take advantage of lead contractor arrangements; seeking to influence funding arrangements; and building capability across the sector about the new contracting processes.

The Productivity Commission's review of contracting in its inquiry into social services concluded that government agencies had a more favourable impression than do NGOs about how well contracting arrangements are working, although they did agree that there is room for improvement (Productivity Commission 2015, p. 316.) Submissions from NGOs to that inquiry provided powerful examples of weaknesses in current arrangements. MoH recognises that input and output-based contracts can create perverse incentives (box 2).

In many ways, the case has been made for improvements to current contracting processes, with government responses including streamlined contracting, acknowledging the need to reduce audit duplication, and MBIE's recent workshops to inform development of guidance for social sector government agencies on the procurement and management of social services.

The Productivity Commission also discussed funding of NGOs (2015, pp. 162-173). It suggested that the Government should 'fully fund' NGOs at a level that allows an efficient provider to make a sustainable return on resources, including investment in training and systems. It pointed out that

providers should be explicit about their mission and that those who wish to pursue goals not necessarily aligned with those of government should not expect full funding. The Commission also pointed to other difficult issues such as whether NGOs with multiple contracts can recover their overheads.

These contracting and funding issues are complex. There is a good case for the Council to maintain a watching brief in this area, and to share significant examples with MoH.

Theme 3: Shift from focusing on inputs and outputs to focusing on outcomes

The shift towards focusing on outcomes is happening in all of the service commissioning models discussed in this paper. It will substantially alter the way in which NGOs operate, providing more flexibility to innovate while exposing them to risk of non-payment if they don't achieve outcomes. This suggests a case for the Council to seek to Influence the development of outcome indicators and the way they are built into contracts.

One example is the mental health commissioning framework, which requires moving from a focus on inputs and outputs to one focused on outcomes, and ensuring accountability for public funds and continuous quality improvement so that investment produces improved outcomes (MoH 2015, p. 12). The Council could work with MoH in the introduction of this or another outcome framework.

Outcome-based contracts are not possible everywhere, because suitable outcome measures cannot always be developed. Because they are so significantly affected by contract design, NGOs are likely to be aware of the risks of poorly designed outcome measures or payment arrangements. The Council can bring that perspective to any MoH work that is developing general principles or approaches for outcome development or outcome-related payment arrangements.

Theme 4: Look for openings for joint commissioning

This theme may refer to sector engagement in managing current and new alliance arrangements, as well as the development of other models such as SIBs. The development of Whanau Ora and alliance contracts between DHBs and PHOs illustrate both the potential opportunities for NGOs to be involved in devolved commissioning, and the risk of exclusion. The MoH is seeking to improve service integration, in the first instance in the Alliance Leadership Teams regionally between primary and secondary care. The NGO sector is not closely involved in this work, and so has more capacity to enrich the development of service integration.

An initial potential step is for the Council to work with the MoH to clarify both organisations' responsibilities in developing commissioning models of care focussing on service integration.

There are many ways in which NGO providers could be involved in commissioning. In the lead contractor model, for example, the provider may effectively become the commissioner. This does not happen in alliance contracts and, as noted, they currently allow little NGO involvement in commissioning. This could be changed, but change may be easier to bring about with suitable governance arrangements to avoid conflicts of interest.

An effective way for the Council to understand and shape these issues could be to work with the MoH commissioning team, to help it to develop model(s) that allow for greater NGO provider input in commissioning processes. This might be most effective if it were focused on a specific area of health services, but the area could be negotiated with MoH.

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