



HEALTH + DISABILITY
NGO WORKING GROUP

The NGO Sector Role: A Key Contributor to New Zealand's Health and Disability Services

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Executive Summary

The NGO sector has a long, well established and well regarded record of contribution to New Zealand's health and disability service delivery. It continues to take a key role in supporting government objectives to deliver more and better health and disability services, while adapting to changing public expectations of value and service delivery. Critically, however, it provides a locus for flexible, responsive and innovative frontline service delivery, and that innovative adaptability is critical to developing and sustaining effective and affordable twenty first century services.

NGOs make a considerable contribution to the New Zealand economy, and their geographical distribution and close community links make them invaluable in providing personalised, customised and localised health and disability services. Western governments face a significant challenge in providing the flexible and effective services demanded by their electorates, while at the same time managing risk and containing cost.

There is growing international recognition of the 'third sector' role in facilitating networked or devolved government, meeting government objectives by means other than direct intervention. NGOs provide a locus for local communities, cultural and ethnic groups, indigenous groups such as Maori to realise their aspirations to have a say in the direction of the delivery of health and disability services.

Maximising the NGO contribution requires some actions on the part of government.

1. Policy: active recognition and acknowledgement of the NGO sector as a partner in delivering government objectives in health and disability.
2. Funding and planning: investment in, and recognition of, a funding workforce that has skills in relational contracting, enabling and facilitation.
3. Sector investment: treat the NGO sector as a component of the overall health and disability system, and invest in it in sustainable ways, just as is the case for the Crown owned parts of the sector.
4. Disparity: respect the NGO contribution to addressing access to, and health and disability status of, Maori, Pacifica, and other population groups with significant health and disability challenges, through acknowledging needs for autonomy, sustainability, and efficiency.
5. Workforce: recognise the role of the NGO sector as a low barrier to workforce entry point for the health and disability sector, and its critical role in dealing with the demographic challenges we face in the next fifty years.

Lastly, as the examples in this report show, acknowledge that when NGOs collaborate, they are key drivers of innovation in the sector. NGOs are good at collaboration, it is their default position. The future sustainability of health and disability services in this country will, in significant part, depend on that capacity to innovate.

History

Not for profit (NFP) organisations have existed in New Zealand since pre-colonial times. Arguably it is for profit organisations that are the new comers to the New Zealand environment. Maori social, health and welfare needs were met through collective iwi, hapu and whanau structures, which while challenged at times by the for profit sector, have never been wholly displaced or extinguished. Maori contributed significantly to the health and welfare needs of settlers in the early colonial period. Maori aspirations to meet their own social, health and welfare needs have been expressed throughout New Zealand history, with the Government “Whanau Hauora” initiative the most recent example.

Since 2005, New Zealand has taken part in the international “Comparative Non-profit” study undertaken by Johns Hopkins University. That work has begun to fill a sizeable gap in our knowledge of the scale and economic contribution of the NFP sector.¹ As part of that work the history of not for profit organisations in New Zealand has been detailed in *The History of the Non-profit Sector in New Zealand*.² That history identifies three further periods of significance in the development of the sector:

1880-1945

A range of not for profits developed, built on a growing population, with increasing state support, and many interests in common with the state. A healthy citizenry, for example, was a goal of both the state and the Plunket Society. Giving, whether through charity or volunteerism, was a strong ethos from both secular and religious viewpoints.

Current NGO example: The Salvation Army commenced Alcohol treatment services in the 1880s.

The 1940s - mid 1980s

The role of the welfare state, and the closer relationship between the state and service oriented not for profits, heightened the division of the sector into “expressive”³ and provider organisations. Initial impacts of the welfare state constrain and limit some areas of not for profit provision, such as pensions, health and education. From the 1970s onwards, however, it became obvious that social problems persisted in spite of affluence and the welfare state. Social movements identified a range of un-met social services needs. New and existing agencies developed services to address these. Some remained small and community-based, while others organised nationally allowing different degrees of autonomy to local and regional branches.

The scale of central government funding also increased significantly from the 1970s, with a growing portion of health funding going to the non-profit sector. Community based services were developed to meet the needs of individuals with government income support, and initial individual level arrangement gave way to more consolidated welfare funding. The NGO sector as we know it began to take form.

Current NGO example: The IHC was established in 1949.

¹ Criteria to meet the definition of a NFP organisation include being: organised, private, non-profit distributing, self-governing and non-compulsory.

² Margaret Tennant, Mike O'Brien, and Jackie Sanders. *The History of the Non-profit Sector in New Zealand*.

Wellington: Office for the Community and Voluntary Sector, 2008.

³ Ibid, p33 - that is, concerned with recreation, culture, and the expression of values and beliefs, for example. Expressive organisations, while outnumbering service ones 2-1, remain largely volunteer driven.

1984 to the present day

Public sector reforms in the 1980s led to a major shift in the relationship between the NFP sector and the state. These changes included:

- a move from centrally delivered health support services to community-based facilities;
- de-institutionalisation of services;
- greater attention to cultural appropriateness in the delivery of services;
- a market based approach to service provision based on purchase of contracted services from providers;
- and by extension, the state playing a greater role in determining sector priorities.

The market based approach, complete with tendering and contracting processes, cemented the reliance of the NGO sector on government funding. Conversely, the government came to rely on the NGO sector as the core provider of community based services. Mental health and disability services for people with high support needs were historically provided within institutions, notably psychiatric and psychopaedic hospitals. De-institutionalisation fundamentally reshaped the provision of health and welfare services for people with longer term and non-acute health and disability related needs.

Opportunities arose for the development of new services and NGOs. The not-for-profit sector provision of mental health and addiction services grew substantially through the 1990s, with one survey estimating that over 50% of the current number of NGOs in the sector were established during the decade.⁴ The change enabled many Maori organisations and groups to begin to, or once again, meet their aspirations to provide health and welfare services to their own people.

However, the changes had perceived negative consequences for the NGO sector as well. The increased focus on accountability led to increased compliance costs and a loss of autonomy in determining their own priorities. Funding approaches increased competition for resources and the contract cycle led to greater insecurity of funding, particularly in the earlier stages of the market approach. Organisational life cycles, which had previously been determined by social needs, were now at least as frequently determined by funding priorities.⁵

Current NGO Example: Pathways commenced providing support services for people with mental health problems in 1989.

Recent changes in the political and economic environments of most western democracies indicate a further change in the role and participation of NGOs in Health and Disability sector service provision may be imminent. Those changes are explored in some detail after the next section, which quantifies the current contribution of NGOs in the Health and Disability sector.

4 NGOIT 2005 Landscape Survey, Te Pou o Te Whakaaro Nui The National Centre of Mental Health Research and Workforce Development, October 2006

5 Tennant et al (2008:26)

Scale

While New Zealand collects a lot of data on enterprise and economic activity, it is not always possible to correlate data to provide completely reliable information in respect of particular sectors. Matching the legal status of enterprises with their industry affiliation, for example, is not achievable using Statistics New Zealand's current data collection surveys.

6. The previously mentioned John Hopkins collaborative research into the not for profit sector has included Statistics New Zealand. To help facilitate the research they developed a "Non-profit Institutions Satellite Account".⁶ Their first and most recent report from the account is based on 2004 data.⁷ It is also the most reliable available information into the scale of the not for profit sector in New Zealand. Health and Disability sector NGOs would otherwise be included in a health enterprise grouping, which is problematic given the inclusion of DHBs, ACC and non NGO profit oriented health and disability providers. Not including the latter, means the NFP data, while best available, is still not inclusive of all NGOs.

Using the satellite account, not for profits are categorised into twelve major activity groups. Health and Disability sector NGOs fall within two groupings,⁸ social services and health services, defined as:

- Providers of social services, including Iwi providers (services provided include disability services, family services, support services for children, and community services for older people; and services to migrants);
- Non-profit employment services;
- Non-profit emergency services;
- Non-profit health services including public health organisations, private hospitals and child health services.

Data specifically on non-profit social and health services is analysed by Statistics New Zealand for the non-profit satellite account. The data reveals that:

- Non-profit social and health services are respectively the 1st and the 4th largest employer of non-profit institutions;
- Health services that employ staff average the highest number of all not for profits, at 33.5 FTEs. By comparison, social services average 18 FTEs, both well above the activity group average of 10.8;
- There are 2,210 non-profit health institutions of which 450 employ 15,090 people;
- Only 1,750 out of the 11,280 non-profit institutions operating in the social services sector, employ staff;
- Collectively they employ 31,480 people, more than any other non-profit grouping;

6 A satellite account is an internationally recognised way of re-arranging existing information included in the national accounts to analyse a particular are of particular national or economic interest.

7 Statistics New Zealand (2007) Non-profit Institutions Satellite Account 2004 Available from <http://www.stats.govt.nz/products-and-services/info-releases/non-profit-institutions-satellite-account.htm>

8 Differentiating between the two is not possible, for example "There is also the potential for overlap between health and social services with regard to mental health services. Generally speaking, institutions that provide treatment for those experiencing mental health issues are classified within health, while services providing primarily accommodation, information and support to individuals and families are placed within social services." Non Profit Institutions Satellite Account (2007:54), Statistics New Zealand.

- Health services income amounted to \$852 million and social services income \$1394 million in the period.

Social services provide the largest contribution to GDP (23%) and health the third largest of all the non-profit activity groups. The not for profit sector's overall contribution to GDP is 2.6% excluding volunteer activity, and rises to 4.9% of the latter is included.

Organisational scale can be assessed by the size of paid employment within organisations. The following table⁹ shows the number of organisations employing employees within 5 bands:

Number of Paid Employees	Health Service Organisations	Social Service Organisations
0	1,770 (80.1%)	9,520 (84.4%)
1-5	220 (10.9%)	930 (8.2%)
6-19	130 (6.3%)	540 (4.8%)
20-99	70 (3.8%)	230 (2.0%)
100+	30 (1.4%)	50 (0.4%)

Organisations provide services in different geographical areas, and this also affects scale. There are a number of single site national providers, who provide advocacy and lobbying services, or act as lead organisations (e.g. Platform in the mental health sector, NZ Disability Support Network in the disability sector). Other national providers deliver services in several localities throughout the country, and while they may be quite large organisations, individual workplaces may be quite small (e.g. IHC New Zealand, Richmond NZ.) Providers may be quite localised (e.g. Odyssey, Tui Ora), and range in scale from very small to very large. There is no specific data on the regional distribution of health and disability services.

Sector Funding

Quantifying the scale of funding to the NGO component can be a challenge, as different entities use different definitions and inclusions in their calculations. External agencies, such as the Mental Health Commission or the Auditor General's office are tasked with that review and comparison, and can provide a meaningful sense of scale across parts of the sector. However, the public reporting by DHBs on an annual basis of the total spend on NGO services in their district would provide a straightforward and transparent evaluation of the contribution of NGOs to service delivery, and the trends in the funding of that contribution.

For the present however, the recent report by the Auditor General on DHB spending¹⁰ provides a high level analysis of DHB spending which gives us some sense of the scale of spending on non-DHB delivered services, which include both primary health and the NGO sector. The report breaks down spending into 3 distinct areas:

⁹ Non Profit Institutions Satellite Account (2007:55, 57), Statistics New Zealand.

¹⁰ Office of the Auditor General (2010:11-13) *Spending on supplies and services by District Health Boards; Learning from examples*

- corporate - “ spending on the supplies and services needed for the efficient running of the DHB”
- provider - “spending on the hospital-based services that the DHB provides”
- funder - “money is spent on funding external organisations to deliver non-hospital services”

District health boards (DHBs) spend a lot of money on supplies and services from external suppliers and providers, about \$6 billion collectively in the 2007/08 financial year, and ranging between 36% and 70% of all the money that each DHB spends each year.¹¹ Of that DHBs estimate that their funding role amounts to between 41% and 77%.

“Smaller DHBs spend a larger proportion of their money funding external organisations to deliver non- hospital services. Larger DHBs spend proportionately more on providing hospital services.”¹²

DHBs and the Ministry of Health spend significant amounts of money on external service providers each year. The cost of those services, along with the cost of provider services is rising rapidly, as discussed in the next section. Greater transparency of reporting of DHB and Ministry expenditure on NGO services, as part of that external funding, will provide greater organisational and public confidence that service funding is being fairly applied, and that the burden of service cuts or funding pressures are being properly managed amongst the participants in the health and disability sector.

¹¹ Ibid, p9

¹² Ibid, p12

Environment

Governments in western democracies have been grappling with a rising demand for effective public services, both to address problems within their societies, and arguably to bolster their legitimacy in the eyes of their electorates. At the same time, they face significant cost pressures on their service delivery, within a very tight economic environment resulting from what has been described as a private /public debt crisis.

Those imperatives driving this common interest in public sector service improvement have been identified as the shift from:

- outputs to outcomes
- welfare to social investment
- command and control to innovation and collaboration
- standardisation to personalisation and customisation.¹³

Policy responses to the demand have included approaches such as Agile Government, Achieving World Class Public Services, Devolved Government, and more recently Big Society. One thing those responses have in common is to see the role of the Government as that of a participant rather than as a sole or dominant actor:

One way to help government do this is to create new forums and networks to work in a collaborative way alongside existing institutions. ... This is important partly because many of the organisations that provide public services are no longer under the direct control of government. ... Governments can often foster agility through the way they fund, create incentives, and augment their external delivery partners.¹⁴

World class public services depend on governments providing leadership by setting a clear vision, a stable framework, adequate resources and effective incentives. This means rejecting the temptation for government to micro-manage from the centre. It also means rejecting the idea that public services can simply be provided by free markets. The health, welfare and education systems that succeed are not those where the government plays a very limited role, but rather those where the government's role is strategic and enabling.¹⁵

Strategic consideration is given to supporting the capability of non-government providers, particularly not-for-profit organisations...

At the service-wide level, consideration is given to:

- *facilitating a better understanding of third sector issues and the potential for collaborative work, and*
- *supporting productive relationships with the sector.¹⁶*

Building this Big Society isn't just the responsibility of just one or two departments. It is the responsibility of every department of Government, and the responsibility of every citizen too. Government on its own cannot fix every problem. We are all in this together. We need to draw on the skills and expertise of people across the

¹³ Demos (2008:4) Towards Agile Government. Victoria: State Service Authority.

¹⁴ Ibid, p23

¹⁵ Cabinet Office (2008:14) Excellence and fairness Achieving world class public services, United Kingdom

¹⁶ Australian Public Service Commission (2009:22) Policy Implementation Through Devolved Government, Canberra: Australian Government

*country as we respond to the social, political and economic challenges Britain faces.*¹⁷

The government can't and won't succeed by itself.

New Zealand has experienced the same downturn as other economies, ameliorated to some extent by the stronger economic activity in the Asian region, and our close relationship with Australia, whose economy was perhaps least affected by the worldwide economic crisis. Post crisis activity, particularly in the transfer of debt from the private to the public sector through, for example, government underwriting of finance company deposits, has led to severely tightened public finances, and a consequent reduction in funding availability to meet growth in health and disability sector demand and cost.

The cost of health and disability service provision is continuing to rise at a rate exceeding GDP. While that growth pattern is common to all OECD economies, New Zealand has been in the upper half of those economies in respect of that indicator for some considerable time. Current estimates put the total (public and private) New Zealand health (and disability) spend at 9% of GDP. 1 in 5 dollars of core government spending goes to health, only exceeded by social security and welfare. If current health expenditure continues to grow at the same rate, the figure is expected to almost double to 2 in 5 dollars by 2026.¹⁸

Approaches to controlling health cost inflation have been both technical (systems improvements, increased consolidation and specialisation) and fiscal (outsourcing, efficiency and productivity improvements, funding contestability.) These have yet to make a significant reduction in the rate of health cost inflation. Trends in the burden of disease (obesity related illness, depression and other mental health issues) and the shift in population mix to a much larger aged population both impact on health cost.

*These trends pose a double challenge to existing structures. First, there is a growing mismatch between traditional services and new needs – health services for example were originally designed to deal with acute rather than chronic disease, whereas it is chronic disease which is expanding. Second, it has proved difficult to offset the growth in service need by equivalent reductions in cost.*¹⁹

New problems need new solutions. There is a growing recognition that innovation is critical to controlling health cost inflation.

Ongoing financial pressures require the public sector to deliver productivity gains and improved services with minimal long-term funding growth. Incremental gains through continuous improvement can only achieve so much in this respect.

Larger and more intractable social and economic challenges, in particular, may require new and radical approaches. We need a public sector with the capacity to develop those approaches.

The pace and scale of change and the global and local challenges facing governments require an increasingly nimble and innovative public sector to develop

¹⁷ www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf

¹⁸ Paul Winton, (2009:7-9) New Zealand's addiction to healthcare: Diagnostic, trends and initiatives to manage cost growth DRAFT FOR DISCUSSION

¹⁹ Robin Murray (2009:12) Danger and opportunity Crisis and the new social economy

*effective responses. Increasingly complex policy challenges also make it unlikely that any one agency or, in some cases, any one government will have all the answers required.*²⁰

Innovation, furthermore, that is not just technical, but systemic. Health sector improvement becomes a partnership between the public sector, its service delivery partners, the community and citizens at large.

*To further reduce health care growth will requires innovative models beyond those discussed. These models will explore not only the means of delivering health services but also the services delivered. There is a strong argument for a shift from a centralised public health mindset to an increasingly distributed community and personal care health model as this reduces the dependence on dedicated health professionals. Under this scenario individuals take increasing ownership of their own health outcomes and possibly the resources to achieve these outcomes.*²¹

The solution requires innovation, old measures to address new problems and increasing complexity have not worked.

Public expectation, public value

As citizens our expectations of health and disability services have changed. This is partially a result of changes in socio-cultural factors such as the role and respect afforded to institutions and authorities, including public institutions and medical authorities. We are no longer prepared to accept a one size fits all approach to service delivery, but require to be consulted, and to have our specific individual, cultural, and community perspectives and preferences taken into account. We expect value from our public services, and our expectations of that value (both in quality and in quantity) are increasing. Governments which fail to meet those expectations (through for example, health service delivery failures) do so at a risk to their electoral futures. The concept of public value has been used to clarify this change in attitude to, and engagement with, public services;

Public value refers to the value created by government through services, laws, regulation and other services. As a general rule the key things that citizens value tend to fall into three categories; outcomes, services and trust. Citizens will give up resources (e.g. taxes) in return for specific services (education), desirable outcomes (increased educational attainment) and to see key public qualities underpinning those services (e.g. universality – universal healthcare for all).

Trust is a key component of public value, which occurs partly as a consequence of providing services and securing quality-of-life outcomes. Citizens expect to be able to trust:

- *those delivering the services*
- *the service delivered*
- *the way they are included in the process of creating and delivering the service*
- *the measurement of any process or product of delivery.*²²

²⁰ Management Advisory Committee (2010:VI) Empowering Change: Fostering Innovation in the Australian Public Service, Canberra: Australian Government

²¹ Paul Winton, (2009:31) New Zealand's addiction to healthcare: Diagnostic, trends and initiatives to manage cost growth DRAFT FOR DISCUSSION

²² Michele Mahdon (2006:8) Public Value and Health, The Work Foundation

Government emphasis on shifting resource to the frontline is an explicit recognition of the value the public puts on service delivery.

Changes in our perceptions of institutions and authority is only one of the drivers behind increased public expectations of health and disability services. The rapid and pervasive spread of technological innovations in communications and information (the so-called knowledge economy) has contributed to an increasing abundance of information about health and disability problems and potential solutions, as well as increasing the complexity of management of individual, community and societal health and disability needs.

Comparisons between the responsiveness of private sector organisations and those of the public sector highlight some of the technological impacts. For example, we can track the delivery of a package from one side of the world to the other, and know its whereabouts on an hour by hour basis. By comparison, the failure of timely transfer of health information between providers is frequently cited as causative in reports into failures or incidents within health systems.

Health disparities which mean that different groups in society have different health outcomes based on their ethnic, cultural or other group membership, are becoming socially unacceptable. Health services are expected to and required to cater to the specific cultural needs of a diverse population, not only through what they deliver, but how they deliver it. Like other human services, the health and disability systems capability to deliver responsive and effective services to Maori, relies on effective relationships with the communities in which Maori live. Maori governed organisations are critical to ensuring that public value is delivered, disparities are addressed and reduced, and Maori health and disability aspirations are met.

Populations in western democracies, and to a lesser extent elsewhere are undergoing a major demographic shift. The aging of the population mix means a substantial shift of numbers from the caring workforce (domestic, voluntary and paid) to those in need or potential need of care. Given that the former are also a large source of public funds through taxation which support current service provision, the impact is twofold. Existing care, treatment, and support services in the health and disability sector are unlikely to be sustainable in their present form in the medium term. While a shift in the balance of funding from the public to the private sector might address cost sustainability in part, it is unlikely to address the workforce issue, as caring roles are already undervalued, and all of the health and disability workforce profiles show an average age increasing faster than the rate of population increase.

While the aging population can be seen as having a potentially catastrophic impact on public service delivery, developments and initiatives to relocalise service provision may potentially counter that impact. Community destruction as a result of the private/public debt crisis has resulted in innovative partnerships between local governments and their citizens, repurposing facilities and land to meet needs for food (community farms) shelter (colocating older residents) and other needs.

NGO Contribution

The imperatives driving public sector service improvement were noted in the previous section as the shift from:

- outputs to outcomes
- welfare to social investment
- command and control to innovation and collaboration
- standardisation to personalisation and customisation.²³

NGOs are able to bring considerable value to addressing all of those imperatives. Shifting from outputs to outcomes requires a focus on effective service delivery, where the costs of services results in improvements in peoples' health and disability status. Flexible and responsive organisations can redirect resource and focus to quickly address outcome trends, as examples in the concluding section of this paper demonstrate.

NGOs working with their clients and their communities, lead the way in shifting from a 'done to' support model to a empowered community model. NGO structures have been pivotal in Maori development aspirations in the health and disability sector. Maori participation rates in the health and disability workforce, and improvements in Maori health and disability status are attributable in sizeable part to Maori establishment of those organisations. Likewise, Pacifica health and disability sector initiatives are contributing to both healthier and stronger Pacifica communities.

Acceptability of services increase when services are tailored to the personal, social and cultural needs of the client. NGOs, by virtue of their size, and their strong links to local communities, are able to facilitate health and disability service delivery that is tailored to the specific needs of individuals and their communities. Furthermore, they can do so without being seen as unfair or inequitable, because they are but one player in a wide range of health and disability services delivered to the community. Accordingly, they are to a degree less contested than may be the case when new service introductions or service delivery changes take place within the DHB.

Like those businesses that innovate most effectively, the public sector must work with its key stakeholders to help it improve and update policies, programs and services and to meet the new challenges of the 21st century. Partnerships can also allow governments to share risk and to leverage the investments that other organisations have already made in developing new ideas and systems.²⁴

Combing the flexibility, scale, and community connection of NGOs, together with a well established drive to work together and collaborate, provides a perfect seed bed for innovative development. As the concluding examples will show, NGOs are a, if not the, key contributor to sector innovation. If we wish to meet the environmental challenges the health and disability sector face in the twenty first century, then that capacity to innovate is absolutely vital.

²³ Demos (2008:4) Towards Agile Government. Victoria: State Service Authority.

²⁴ Management Advisory Committee (2010:47) Empowering Change: Fostering Innovation in the Australian Public Service, Canberra: Australian Government

Summary: Environmental Issues - NGO Contributions

Sphere	Issue	NGO Contribution
Political and Legal	Government is unable to solve new and complex social problems on its own	Capacity to partner and add value through flexible and responsive solutions and strong community and sector knowledge
Economic	Health and Disability service cost growth exceeds GDP	Suitable as a nexus of innovation, at comparatively low cost and risk, while engaging non-government resources in service delivery
Socio-cultural	Public expectations of the range, quality, and delivery of health and disability services continue to rise	A diverse, well established sector, with strong community networks and perceived value, providing scope for Maori and Pacifica development and self-governance
Technological	Changes in communication and information technologies increase system complexity and responsiveness expectations	Capacity to trial and innovate new technological approaches at less risk to core government activity, and increasing frontline engagement
Ecological	An aging human population affects both the need for health and disability services and the availability of a future health workforce	Lower barriers to entry, both for potential clients, and for a more diverse range of potential workforce participants

The NGO contribution to the challenges facing the health and disability sector is considerable, and the opportunities to enhance that contribution are likewise considerable.

Changes

Just as the approaches to policy implementation have evolved and diversified, so too must the framework for public administration. It cannot be assumed that the public sector architecture established to support traditional bureaucratic forms of public administration will support alternative delivery arrangements adequately. New approaches to accountability are required which call for strong strategic leadership.

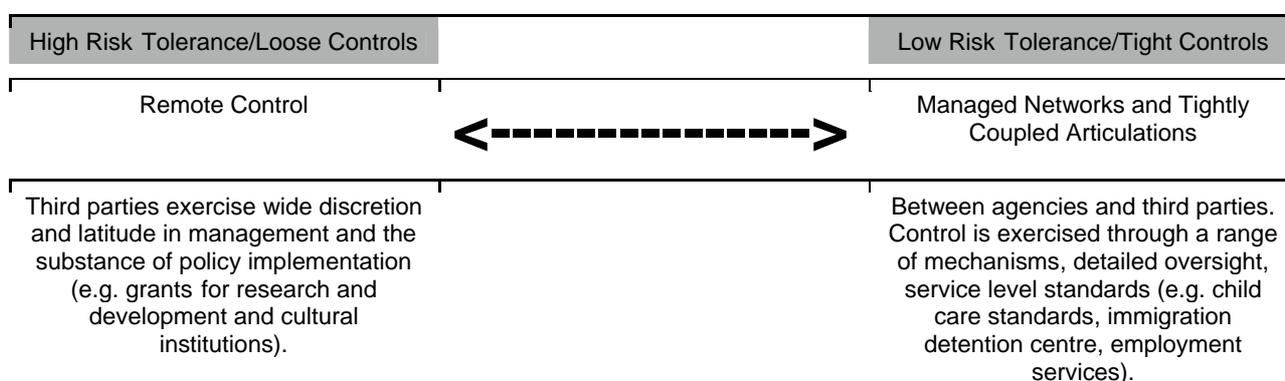
Concerted attention must be given to the implications of a shift for the public service, where appropriate, from a doing to a more enabling role.²⁵

Policy changes

Achieving government objectives to deliver public value through health and disability services in the face of growing expectations and costs require changes to the established ways of doing things. Underpinning such changes at the most fundamental level, is a recognition on the part of government and policy makers, that the default position for resolution of social problems is no longer necessarily a direct government intervention. Working in a networked or devolved way requires a policy framework that supports public services, private sector, and not for profits as equally valued participants in innovating and delivering solutions to complex and intractable social problems.

Not all participants will be the right fit for every social problem, and the policy framework must include mechanisms to evaluate participant suitability to address particular problems. For example, governments are highly sensitive to risk. NGO accountability is seen as critical to limiting government risk, while at the same time, government seeks to get more frontline effectiveness through the transfer or concentration of resources at the frontline. Policy frameworks are required to explicitly balance the tension between accountability (with its related compliance costs, data management, audit and reporting) and flexibility and innovation, necessary to bring responsiveness to the frontline. A risk tolerance and control continuum²⁶ is one suggestion for a policy framework to guide funding and contracting accountability arrangements:

Risk Tolerance and Control Continuum



²⁵ Australian Public Service Commission, (2009:17) *Policy Implementation Through Devolved Government*. Canberra: Australian Public Service Commission

²⁶ Ibid, p26

Fit for purpose accountability is a critical component to provide optimal NGO participation in and contribution to the Health and Disability sector.

Policy too, must provide guidance as to which implementation approach is required to meet a particular social problem, whether direct government delivery, not for profit sector, or market approach. Rational and explicit guidelines²⁷ help ensure a sense of equity and fairness, and establish the trust relationship between funders and NGO providers which is key to highly devolved accountability mechanisms and effective NGO contribution.

Funding, Planning

Funding and Planning is the critical interface between government policy implementation and community or market participants. They are challenged to ensure effective and efficient service delivery against rising demand (both volume and quality) while trying to manage and contain costs. The former is the delivery of “public value” in the health and disability sector, and the latter the delivery of economic value.

Delivering value in both the spheres requires innovation, to meet rising expectations and contain rising costs, while balancing the tension between them. NGOs, as noted in the section regarding their contribution, are a site of innovation, and a reservoir of untapped innovation. What then, is the NGO experience of funding and planning?

Feedback has highlighted that the present environment stifles service growth, development and innovation in this sector. The costs to community organisations tendering for new work are significant. Contractual processes are unsatisfactory, with significant delays in contract completions, ambiguities in documentation, and cumbersome reporting regimes. This also frustrates community organisations' abilities to do what they do best.

... The general lack of transparency in many aspects of the contractual environment is concerning to community organisations...

The crucial role of DHB funding personnel is highlighted in terms of relationship and contract management and service knowledge. There are pockets of excellence characterised by consistent and knowledgeable funding and planning managers, but overwhelmingly it is a picture of high turnover, lack of experience, and concern that the loss of institutional knowledge about the nature and purpose of contracts makes NGOs extremely vulnerable.

The most significant recurring issue in the report is the fundamental need for mutually respectful relationships between funding and planning managers and community organisations and increased understanding of what each has to offer.²⁸

The Ministry of Health, particularly DSS, and the Ministry of Social Development are also key funders to the NGO component of the health and disability sector. NGO perception of their funding ability is on a par with the comments above concerning DHBs. Ministries critical expertise is usually not in the funding or operational areas, and it is easy for their funding and planning responsibilities to be overridden by the requirements to support their Minister and develop policy. Funding expertise, which is a scarce resource, may not be suitably valued within the Ministry.

²⁷ for e.g.; Devolved Government p14,15

²⁸ NGOiT (2008:5) NGO-DHB Contracting Environment

This perception and problem is by no means unique to New Zealand. Skills in funding, contract management, systems design and management are critical capabilities that the health and disability sector requires in order to effectively structure a sector and engage participants in it in such a way as to deliver government requirements. Funders without enabling and facilitation skills will default to working with providers that they trust, and where those funders sit alongside colleague providers (in a mixed mode of service delivery such as we have in the health and disability sector) the temptation to seek advice and default to those colleagues must be strong. Hoping that funders and planners working in the sector will develop the necessary skills to deliver a fully effective and participative health and disability sector can be seen as wishful thinking.

Managing networks and relationships has significant implications for, and makes major demands on, agency systems, skills sets and orientations. Indeed, it has been described as ‘a full-blown cultural transformation’ which requires ‘changing the very definition of “public employee”.’ Performance in such a setting depends increasingly on the ability to manage partnerships and hold partners accountable, requirements that represent a different form of public management.

Operating in network mode calls for a high level of systems thinking as well as the skills needed for ‘activating, arranging, stabilising, integrating, and managing a network’ which are qualitatively different to those required for more traditional delivery modes. Connectors will be valued—people who can build up relationships across the public, private and profit sectors and leverage these relationships to build networks of mutual benefit.²⁹

The government in the UK has seen this as a cross government problem, and instituted a number of national approaches to improve not for profit commissioning practices. Australia is exploring the development of a national compact³⁰ with the “third sector”, as a critical component in the delivery of public services in the 21st Century. New Zealand has a range of commissioning guidelines developed by both the Treasury³¹ and the Audit Office,³² and some workforce development initiatives³³ in the funding and planning area.

The recent report on DHB Spending by the Audit Office³⁴ highlights a range of considerations for DHBs in their procurement of services from the NGO sector, including the appropriate use of ‘relational’ purchasing rather than conventional purchasing, the critical importance of experienced and capable staff, and the need to explore collaborative procurement possibilities. The Office of the Community and Voluntary Sector, together with other MSD initiatives such as “high trust” purchasing point the way towards improved funding capability. Achieving a “full-blown cultural transformation” will require considerably more.

²⁹ Australian Public Service Commission, (2009:40) *Policy Implementation Through Devolved Government*. Canberra: Australian Public Service Commission

³⁰ Ibid, p51

³¹ The New Zealand Treasury (2009) *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown*

³² Office of the Auditor General (2006) *Principles to underpin management by public entities of funding to non-government organisations*

³³ e.g.; Te Pou <http://www.tepou.co.nz/page/235-planners-and-funders>

³⁴ Office of the Auditor General (2010) *Spending on supplies and services by District Health Boards; Learning from examples*

Sector Investment

Health cost pressures and the private/public debt crisis have contributed to a focus on short term gains, whether in service delivery or in cost savings. NGO providers respond to tenders with marginal pricing, and long term sustainability of both the individual provider and the sector is at risk. Providers are undertaking their own strategies to reduce cost and improve their service delivery and financial sustainability, as the next section shows in a range of examples.

Government has, at times, taken an investment approach to the not for profit sector, one notable example being Maori health and disability sector capacity building throughout the 1990's. Arguably, current funding pressures contribute to NGO and sector fragmentation. There are a range of possibilities open to government to strengthen and enhance the not for profit component of the health and disability sector. These might be minimal cost measures, such as requiring each DHB and the respective Ministries to report on the level of its annual funding into the NGO component (a practical measure of the degree of value afforded NGO participation in the sector) to supporting the sector through establishing longer term relationship agreements with larger NGOs or umbrella organisations (based on shared commitment to strategic goals and innovation.) Government could take an expanding lead in delivering practical support to the sector, supporting sector initiatives to develop shared support services, through requiring DHBs and Ministries to include NGOs as parties to developments such as shared purchasing, or through funding or driving specific initiatives to reduce compliance costs, (right sized funding and accountability mechanisms for smaller organisations, incentives to drive collaboration and innovation).

Underlying these is an assumption that governments of whatever political persuasion will continue to see the value of a healthy not for profit sector as a partner to solving social problems, rather than competitor to government service delivery. Given the history of the not for profit sector, that is a well founded assumption.

Disparities

New Zealand is self evidently not a homogenous society, and like other New World western societies, is the product of colonialism, and post colonial economic development. This paper does not have the scope to address the impact of those events on the health status of either Maori as the indigenous population of New Zealand, nor of their Pacifica cousins who have become part of New Zealand society as in part, at least, a result of those colonial and post colonial events.

Maori health and disability status is not on a par with that of other New Zealanders. Maori have developed their own initiatives, both tribally and pan tribally to address their health and disability needs, and this paper's focus on more recent NGO development should not be seen as understating the contribution of such bodies as the Maori Women's Welfare League or Kohanga Reo to the health and wellbeing of whanau, hapu and iwi.

Government policy in the 1980's and 90's began to address the use of NGOs as a means to address Maori health disparity. As noted, this led to a growth in numbers and scale of these NGOs, to a greater or lesser degree Iwi supported. Investment in infrastructure contributed to growth and impact, both through direct service delivery and enhanced access, and through raising the standard of mainstream health service delivery in respect of cultural sensitivity and appropriateness.

However, policy changes and inconsistencies as different governments changed their approach, have led to Maori NGOs being challenged by the same issues as the rest of the NGO sector, from a background of greater health and disability need, and less development and history to sustain them during tough economic circumstances. Maori health disparities are finally beginning to show some areas of improvement, and threats to the sustainability of Maori providers are a critical threat to those improvements. Any solutions to that sustainability that threaten organisational rangatiratanga will be worse than the problem, not least because they open the Crown up to further challenges to their appropriate delivery of services to Maori.

Many of the conditions faced by Pacific people and the NGOs serving their health and disability needs are similar to those of Maori. The perceived hostility of the current health funding environment, with its over emphasis on compliance and risk management, is at the risk of losing access and expertise at the frontline, where services are critical. Experience has shown that services that do not treat people with respect and acknowledge their differences (personalisation) will not be accessed as early, readily or often as those that do. The outcome is poorer health on an individual level, costlier health on a systemic level, and considerable political anger in communities. NGOs, whether mainstream, Maori or Pacifica, are looking to operate in an environment that safeguards their autonomy, sustainability and operational efficiency. A policy and funding failure to treat those providers with respect and address those organisational needs puts the health and disability sector itself at risk, because growing health disparities are no longer a politically sustainable position for any government.

Workforce

Like other technical and specialist workforce areas, there is a growing pressure on the health and disability workforce caused by social and demographic changes. The number of young people entering science oriented subjects in secondary and tertiary education has decreased, and health is no longer seen as the desirable career option it once was. Health is thus in competition with areas such as food technology, manufacturing, information technology, and engineering for those young people who have a bent towards science and technology.

The demographic changes are indicated by the aging population, coupled with the aging of the health workforce. Average ages in the medical, nursing, and associated professions are all increasing, and usually increasing at a rate faster than the general population.

The training time for health professions is also increasing, as technological and sociological changes are increasing the specialisation and complexity required in all health and disability areas, such as micro-surgery or palliative care. The increased training time, coupled with the cost of the education, are seen as an increasing economic burden on those seeking to enter the health professions, and a significant and rising barrier to entry.

NGOs have two significant ways in which they can help reduce that barrier. Firstly, they provide an entry to the health workforce to people who are not traditionally oriented towards a scientific/technological education. The introduction of and rapid expansion of community based support services has seen the development of a substantial new health and disability workforce. While the majority of that workforce has foundation or core competency level training it has expanded the workforce to also include people with tertiary level training whose primary interest is in human services.

Secondly, as our health and disability knowledge increases, techniques and approaches that once were “bleeding edge” become systematised and transferable. Skill and service transfer from clinical services to community services has been a feature of health services for many years. NGOs are a ready repository for the transfer of skills. Health professionals in clinical services who can work with and partner NGO services effectively, can with confidence transfer elements of their service delivery to the NGO sector, with benefits including reduced cost, wider accessibility, and greater cost benefit from the increasingly costly health professional.

Summary: Changes

Sphere	
Policy	Direct government intervention is no longer the default to resolving social problems. We require a policy framework that supports public services, private sector, and not for profits as equally valued participants in innovating and delivering solutions to complex and intractable social problems. Policy frameworks are required to explicitly balance off the tension between accountability and flexibility and innovation, necessary to bring responsiveness to the frontline.
Funding and planning	Skills in funding, contract management, systems design and management are critical capabilities that the health and disability sector requires. Funders without enabling and facilitation skills will default to working with providers that they trust, such as their DHB colleagues, or deferring to their Ministry colleagues in respect of [policy drivers ahead of funding needs]. Government messages of support for the not for profit sector must translate into effective funder behaviour, relational purchasing, and the investment in a skilled and capable workforce.
Sector investment	Current funding pressures contribute to NGO and sector fragmentation, putting at risk both established service delivery and untapped innovation. Government measures that could strengthen and enhance the not for profit component of the health and disability sector include: <ul style="list-style-type: none"> • require DHBs and Ministries to report on their annual funding of the NGO component • establish longer term relationship agreements with larger NGOs or umbrella organisations • require DHBs and Ministries to include NGOs as parties to developments such as shared purchasing • fund or drive specific initiatives to reduce compliance costs
Disparity	Treat NGOs with respect and address the critical organisational needs of self-governance, sustainability and efficiency in order to maintain the engagement of those communities whose health and disability status is less than the general population.
Workforce	Recognise that NGOs provide a lower barrier to entry into the health and disability sector workforce. They also provide a locus for skills and service transfer, as innovative practices become standardised.

To get the most value from the NGO contribution, barriers to innovation must be removed.

Examples

NGOs have a long history of working together for the mutual benefit of their clients and their organisations. Indeed, working together, collaborating, is arguably the default behaviour within the sector, though it is notably strained in circumstances where funding scarcity or competitive pressure is driving decision making.

Inter organisational collaboration has been identified as a critical factor in addressing complex human service needs.³⁵ Such collaboration has been shown to correlate with a high level of health service efficiency and responsiveness, while being very dependent on the development of trust, as critical to both knowledge sharing and learning (innovation) and stakeholder engagement.³⁶

NGOs have and do collaborate for a wide range of reasons:

- to bring our own special/niche expertise together
- to manage resource use, cost containment, efficiency
- to work as part of a system, to facilitate system improvement
- to produce quality improvement, innovation.

As the following examples illustrate, **when NGOs collaborate, they drive innovation in the health and disability sector.**

Collaborative Form: Takeover/Merger

Takeovers and mergers have not often been used as collaborative strategies by NGOs. From time to time they have come about through organisations relinquishing contracts due to changed trading conditions, or through significant events that limit the ability of an organisation to carry on in its existing form. Effective takeovers or mergers will use service efficiencies to lower costs and increase frontline service delivery.

Example: Richmond NZ / Framework Trust

Participants: NGOs (2)

Purpose of collaboration: *“Framework and Richmond see real opportunities to enhance the quality of services and optimise the resources dedicated to front line services by coming together... Both Framework and Richmond share a value base which is premised on core fundamentals such as client-centred services, excellence, integrity, collaboration and sustainability.”*

Key innovative activity: Amalgamating the organizations is intended to provide an extended range of services and at the same time reduce the higher transaction costs that result from multiple contracts with multiple funders.

More information is available at: www.framework.org.nz or www.richmondnz.org

³⁵ see for example, Stool, Edwards, Mynatt, (2010:51) *Interorganizational Coordination and Awareness in a Nonprofit Ecosystem*, CSCW 2010, Savannah, Georgia, USA.

³⁶ D'Amour et al (2004) *Comparative study of interorganizational collaboration in four health regions and its effects: the case of perinatal services*; University of Montreal
Luna-Reyes, Anderson (2007) *Towards a Theory of Interorganizational Collaboration: Generic Structures of Cross-Boundary Requirements Analysis*

Collaborative Form: Joint Venture

A joint venture as distinct from a partnership, where two or more organisations have come together to create a new entity.

Example: Altogether Autism

Participants: NGOs (2)

Purpose of collaboration: *“In 2006 the Ministry of Health determined a need for a national disability information and advice service (DIAS) in autism spectrum disorders. Parent to Parent and Life Unlimited jointly tendered to provide the service. The Ministry of Health awarded the contract to this joint proposal and Altogether Autism was established.”*

Key innovative activity: Using a tiered communication and information strategy to disseminate core and specialist information nationwide to anyone who has a need for information concerning autism, in a cost effective way.

More information is available at: www.altogetherautism.org.nz

Example: Webhealth (Linkage Trust)

Participants: NGO, DHB, PHO (as founding entities)

Purpose of collaboration: *“Webhealth is your free link to your community through 24 hour anonymous access to quality, local, up-to-date information and resources related to a broad health and well-being focus. If you have issues or concerns in your life, you can assist yourself through Webhealth. Webhealth is part of Linkage Trust, a Waikato based not for profit, community organisation.”*

Key innovative activity: Linkage Trust was established to improve the access to and transition between primary and secondary mental health services, by developing a high level of knowledge about resources in a local community, and facilitating both client and provider access to those resources. Webhealth became a means of doing that using web technologies, and now serves over half of the population of New Zealand through partnerships with local DHBs.

More information is available at: www.webhealth.co.nz

Collaborative Form/Mode: Partnership and Partnering

Two or more organisations working together to achieve one or more common goals, in a more or less formal relationship.

Example: Community Living Services, Counties Manukau

Participants: 6 NGOs, DHB

Purpose of collaboration: CLS services started in 2004 – an innovation by CMDHB to improve the quality of life for people using mental health services, while supporting

community based recovery and reducing respite or hospital usage. Six NGO's partnered with clinical services delivering to a geographic locality. The four unique features of the service are:

- Low case loads
- Use of flexible funding to maintain recovery supports
- Building community capacity / community development
- Personalised support and recovery planning

Key innovative activity: A challenge by the DHB to use information to drive global improvements in service delivery and outcomes led to the CLS Benchmarking Forum. Agreed outcome information collated by the funder is reported back to all participant organisations, and performance is analysed and challenged in an open and participative way. Participants can compare themselves against each other and the system average. Positive trends can be generalised to other providers, and negative trends can be addressed and reversed quickly. This high trust environment is a particularly effective example of collaboration driving huge quality outcomes.

More information is available at: www.tepou.co.nz/file/PDF/Outcomes-Forum/outcomesprescommunity.pdf

Example: Improved Health Outcomes for Ageing People with Intellectual Disability Pilot

Participants: NGO, DHB, Client GPs

Purpose of collaboration: *"Spectrum Care Trust Board (Spectrum) and Counties Manukau District Health Board (CMDHB) Adult Rehabilitation and Health of Older People (ARHOP) will work in partnership to achieve the joint goal of providing specialist geriatric care to improve health outcomes for ageing people with intellectual disabilities (ID), who are over fifty years of age and living in Spectrum residential homes within the CMDHB catchment area. The service will ensure people with ID have improved quality life outcomes as they age and reduce or eliminate avoidable referral or admission to acute care services."*

Key innovative activity: World leading research into the costs and benefits of supporting 'ageing in place' programmes with people who have an intellectual disability. The pilot acknowledges the early onset of ageing processes that people with an intellectual disability may experience, by including clients from age 50, rather than the usual 65+. The pilot involves a fully funded research component to complete a proper evaluation process.

More information is available from: judy.garrick@spectrumcare.org.nz

Example: CHAMP

Participants: 18 NGOs, DHB (Provider arm, Funder arm as Guest)

Purpose of collaboration: *"Counties Manukau Mental Health and Addictions Partnership (CHAMP), is a collaborative network that aims to develop and enhance service delivery, through collaboration, with the aim of improving outcomes for consumers, families and*

*whanau. The group focuses on linking the Counties Manukau District Health Board (DHB), contracted NGO mental health and addiction service providers and the community.*³⁷

Key innovative activity: CHAMP developed out of a CMDHB funding initiative some seven years ago, which included a forum to consider service and system improvements, particularly involving improved transition from hospital services, and substantial seeding money to improve system infrastructure. The partnership umbrellas both DHB and NGO improvement activities. For example, the “Lets Work Smarter” Project incorporates workforce development, infrastructure/procurement and quality work streams, and the CMDHB Workforce Development Group sits within the CHAMP project umbrella. Innovation as a key driver of the project is recognised through the DHB/NGO Innovation Awards.

More information is available at: www.champ.org.nz

Example: Partnership for Sexual Health screening and service for gay and bisexual men in Auckland, Wellington and Christchurch.

Participants: NGO, 3 DHBs

Purpose of collaboration: *New Zealand AIDS Foundation and Auckland, Capital Coast and Christchurch District Health Boards – Community based Sexual Health Services and HIV Rapid Testing working together to increase screening and treatment of STIs for gay and bisexual men who are at disproportionate risk of HIV and STIs.*

Key innovative activity: Sharing of client data, with patient’s permission, as the patient receives a free STI screening service and treatment provided by the Sexual Health Service and a rapid HIV and syphilis rapid test with pre and post test risk assessment as a public health intervention provided by NZAF. Both services needed to record attendance and the nature of service provided.

More information is available at: nzaf.org.nz

Collaborative Form: Alliance

An ongoing relationship between two or more organisations who share common purposes.

Example: The New Zealand Federation of Disability Information Centres

Purpose of collaboration: *“The Federation nationally promotes and supports the local provision of generic disability information and referral services that are community integrated, needs driven and focused on achieving the aims of the New Zealand Disability Strategy Document. Our objective is: To provide an impartial information and referral service, through a network of independent community Centres nationwide who operate to established National Standards.”*

Key innovative activity: By working together in a voluntary alliance, the Centres become a focal point for consistency of information, standardised practices, training, promotion, information gathering and lobbying, while being able to engage with and speak as one

³⁷ CHAMP Strategic Workplan 2009/10 - 2012/13,

voice to other organisations within both the health and disability sector and the wider range of humane services,

More information is available at: www.nzfdic.org.nz

Example: ARC Group

Participants: 4 NGOs

Purpose of collaboration: *“The ARC Group is an alliance of organisations (Comcare (Christchurch), Pact Group (Dunedin), WALSH Trust (Auckland), Wellink Trust (Wellington)) that provide mental health services in the community; it was established in 2009. Members of the Arc Group have expressed a commitment to share “what works” and “what could work better”, between member organisations, as a way to support them to more efficiently realise their goals, objectives and potential. Members now recognise and acknowledge their interest in the success of each other.”*

Key innovative activity: Arc Group members apply their collective knowledge, experience and expertise to support the provision of outstanding community-based mental health support services, the refinement of evidence-based practice, and the development of a high quality, dedicated and capable workforce. Most critically, members of the Arc Group are committed to sharing resources and expertise in order to minimize duplication, exploit an enhanced critical mass of resources and interests, and maximize efficiencies.

More information is available at: www.walsh.org.nz

Collaborative Form: Umbrella

An organisation which provides services and support to collaborative participant organisations through formal structures. Participants may come together to form the umbrella organisation, or the umbrella may seed new participant organisations.

Example: Wise Trust

Purpose of collaboration: *“We’re proud to work with organisations that really do make a difference in people’s lives every day. We help them focus on doing what they do well, by providing centralised business infrastructure services through our company WISE Management Services. We believe in being experts in what we do, so that our customers can be experts in what they do.”*

Key innovative activity: The provision of a centralised infrastructure support service to group members, enabling service provider participants to focus on service delivery, rather than organisational infrastructure. Benefits include cost reduction, consistency, and standardised quality.

More information is available at: www.wisegroup.co.nz

Collaborative Mode: Membership

A group established to and by peer organisations to represent, advocate, and advance common interests in the sector.

Example: NZ Disability Support Network

Participants: open to all Disability Support Providers

Purpose of Collaboration: *“VISION: A strong community disability support sector that, working with disabled people, achieves an inclusive New Zealand.*

MISSION: To support and promote the capacity and capability of disability support providers to meet the needs of disabled people.”

Key innovative activity: Consciously established as a sector peak body, with a view to using collaboration to influence locally, nationally and internationally, through the use of strategic partnerships.

More information is available at: www.nzdsn.org.nz

Example: Platform

Participants: open to all Mental Health and Addictions service providers, and individuals who support the work of Platform

Purpose of Collaboration: *“Our vision: A flourishing, innovative, well connected community based mental health and addictions service sector that makes a difference in the lives of individuals and communities. Our Mission: To connect, develop and promote a resilient and cohesive community mental health and addictions service sector.”*

Key innovative activity: the preparation and dissemination of information including commissioned research into the state and future of the NGO component of the mental health and addictions sector

More information is available at: www.platform.org.nz

Note: a number of further examples of NGO innovation and collaboration are available in the Platform document Frontline.³⁸

Collaborative Modes: Colocation, Shared Activities, Mentoring/Supporting

Collaboration is arguably a default position of NGOs, they work with people and organisations, whether as providers, partners, or in a range of other modes.

Example: Community Connections Supported Living Trust (and a number of other NGOs)

Purpose of Collaboration: many and varied, for example:

- *Community Connections & Options in Community Living: Worked together to deliver ACC supported living services in Palmerston North. CCSLT had the contract and Options had the staff. We worked collaboratively to deliver with Options supplying staff on contract to CCSLT*
- *Community Connections and Options sharing in staff training since both have the same outcome expectations. This reduces costs and increases frequency*

³⁸ Peters, J; (2010) Frontline; The community mental health and addiction sector at work in New Zealand, Platform, NZ

- *Community Connections and MASH Trust. All admin, finance and payroll functions for CCSLT are undertaken by MASH on a contractual basis. Saved CCSLT \$70k-\$80kpa with a better and more robust process happening*
- *CCSLT runs a small day service from the premises of Hutt Valley Disabled Resources Trust. Given participants access to a much wider array of activity. HVDRT gets rent for otherwise empty space.*

Key innovative activity: willingness to work with a wide range of other parties to deliver local, sustainable and innovative programs to support people to live the life they choose in their own communities.

More information is available at: www.ccslt.org.nz

These are but some of the variety of forms or modes that collaboration can take. The examples above show their use within the NGO sector, or in collaboration between NGOs and other health and disability or human service sector organisations. In many cases, a collaborative engagement between organisations may result in more than one form of collaborative activity.

Collaborative activity has occurred through a wide range of funding types, from NGO contribution to a shared pool, through one-off and pilot initiatives that are preferred provider or tender driven, to full on competitive tenders for new projects. This highlights the fact that it is not the nature of the funding process that drives the collaboration, but the nature of the collaborative participants' relationships. The more that participants see both systemic (client) and organisational benefits from collaborative activity, the more they are driven to initiate and participate in such activity. A positive feedback loop ensues, where new challenges are welcome, and collaborative innovation steps up to quickly address them.

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