



HEALTH + DISABILITY
NGO WORKING GROUP

The NGO Sector: Opportunities for reducing administration and compliance costs

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Summary

1. The Not For Profit Sector (or Third Sector in the UK and Australia) is a sizable and considerable contributor to New Zealand's social and economic wellbeing, accounting for some 4.9% of GDP. While the larger part of the sector (the “expressive”¹) consists primarily of a volunteer staff base and a charitable and grant funding base, the non government organisations (NGOs) who contribute services to the health and disability sector are a substantial employer, and have significant government funding, primarily through contracts. Not For Profit and NGO is not a perfect match, as it excludes some for profit NGOs, but is the best match we have available.
2. NGOs deliver services to help meet a wide range of health and disability needs. Considerable services are delivered in the mental health, addictions, and disability areas, and in some DHB districts, they may contribute up to 40% of the total funded value of services in these areas. As the challenges in health and disability care become more complex, with long standing and chronic conditions making up much of the social and economic burden of illness, the role of NGOs to deliver support and maximise social and economic participation of people with chronic conditions becomes more important.
3. This paper looks at the role of NGOs in contributing to government goals and objectives in the health and disability sector, and the future challenges facing that sector. To maximise the NGO contribution, NGOs have been trying to work with DHBs, PHOs, Ministries and each other to reduce the administrative, transaction, and compliance costs that potentially act as a drag on the productivity of the sector.
4. It highlights some best practices amongst existing collaborative efforts, while acknowledging that these are not as widespread as they could and should be. It then considers the potential from these and other practice improvements to improve the effectiveness and efficiency across the sector. The impact of these on small providers, Maori and Pacific service providers is also considered. Lastly, it points out some of the opportunities for government in taking a ‘valued partner’ perspective when dealing with the NGO sector, to both improve sector performance and reduce health and disability cost inflation.

¹ That is, concerned with recreation, culture, and the expression of values and beliefs. Expressive organisations, while outnumbering service ones 2-1, remain largely volunteer driven.

Delivering Health & Disability Services in the Twenty-first Century: The Challenge

5. Like other similar jurisdictions, New Zealand has been grappling with a rising demand for effective public services, both to address social problems, and to meet electorate expectations of public value² from government services. This occurs at a time when we face significant cost pressures on service delivery, within a very tight economic environment resulting from what has been described as an international private/public debt crisis.
6. Policy responses to the demand have included approaches such as Agile Government³, Achieving World Class Public Services⁴, Devolved Government⁵, and more recently Big Society⁶. 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; the government can't and won't succeed by itself.
7. 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 2026.⁷
8. 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 have an impact on health cost⁸.
9. New problems need new solutions. There is a growing recognition that innovation is critical to controlling health cost inflation.⁹ Innovation, furthermore, that is not just technical, but systemic. Health sector improvement must become a partnership between the public sector, its service delivery partners, the community and citizens at large.¹⁰ The solution requires innovation, old measures to address new problems and increasing complexity have not worked.

Public expectation, public value

² Michele Mahdon (2006:8) Public Value and Health, The Work Foundation

³ Demos (2008) Towards Agile Government. Victoria: State Service Authority.

⁴ Cabinet Office (2008) Excellence and fairness Achieving world class public services, United Kingdom

⁵ Australian Public Service Commission (2009) Policy Implementation Through Devolved Government, Canberra: Australian Government

⁶ www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf

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

⁸ Robin Murray (2009:12) Danger and opportunity Crisis and the new social economy

⁹ Management Advisory Committee (2010:VI) Empowering Change: Fostering Innovation in the Australian Public Service, Canberra: Australian Government

¹⁰ Paul Winton, (2009:31) New Zealand's addiction to healthcare: Diagnostic, trends and initiatives to manage cost growth DRAFT FOR DISCUSSION

10. 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. Government emphasis on shifting resource to the frontline is an explicit recognition of the value the public puts on service delivery.
11. 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.
12. 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.
13. 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 the health and disability workforce profiles show an average age increasing faster than the rate of population increase.
14. While the aging population can be seen as having a potentially catastrophic affect on public service delivery, developments and initiatives to relocalise service provision may 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 (collocating older residents) and other needs.

History ¹¹

Pre and Early Colonial period

15. Structures for delivering health and welfare services in pre-colonial times were collective, with iwi, hapu and whanau meeting these needs for their members. Maori also 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 but the most recent example. Church and other early social structures in the new colony began to fulfill many of the health and welfare needs that could not be met within families.

1880 - 1945

16. From the 1880s 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 charitable gifts or volunteerism, was a strong ethos from both secular and religious viewpoints.

The 1940s - mid 1980s

17. Initial impacts of the welfare state constrained and limited 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 unmet 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 arrangements gave way to more consolidated welfare funding. The NGO sector as we know it began to take form.

1984 to the present day

18. Public sector reforms in the 1980s led to a major shift in the relationship between the not for profit (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.

19. 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

¹¹ For a detailed history, see 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.

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.

20. 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.¹² 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.
21. 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.¹³ 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.

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

13 Tennant et al (2008:26)

Scale

22. While New Zealand collects much data on enterprise and economic activity, it is not always possible to correlate data to provide completely reliable information about 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.
23. 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.¹⁴ One of the participants has been Statistics New Zealand. To help facilitate the research they developed a "Non-profit Institutions Satellite Account."¹⁵ While the first and most recent report from the account is based on 2004 data.¹⁶ It is 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 through 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.
24. Using the satellite account, not for profits are categorised into twelve major activity groups. Health and Disability sector NGOs fall within two groupings,¹⁷ 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.
25. 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 first and the fourth 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;

¹⁴ Criteria to meet the definition of a NFP organisation include being: organised, private, non-profit distributing, self-governing and non-compulsory.

¹⁵ A satellite account is an internationally recognised way of re-arranging existing information included in the national accounts to analyse a particular area of particular national or economic interest.

¹⁶ 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>

¹⁷ 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.

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

26. 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.

27. Organisational scale can be assessed by the size of paid employment within organisations. The following table¹⁸ 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%)

28. 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

29. 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.¹⁹ 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.”²⁰

¹⁸ Non Profit Institutions Satellite Account (2007:55, 57), Statistics New Zealand.

¹⁹ Ibid, p9

²⁰ Ibid, p12

30. 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. 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.

Existing Structural Barriers

31. There are a number of structural barriers that combine to limit the health and disability sector getting the best contribution from the NGO component. These barriers range from a lack of clarity at the policy level regarding the role of NGOs in the sector, and the necessary contribution to be made by the “third sector,” through short and long term funding approaches and the risk to existing sector investment, to the workforce pressures that effect the whole of the sector, which are compounded by the policy and funding approaches.

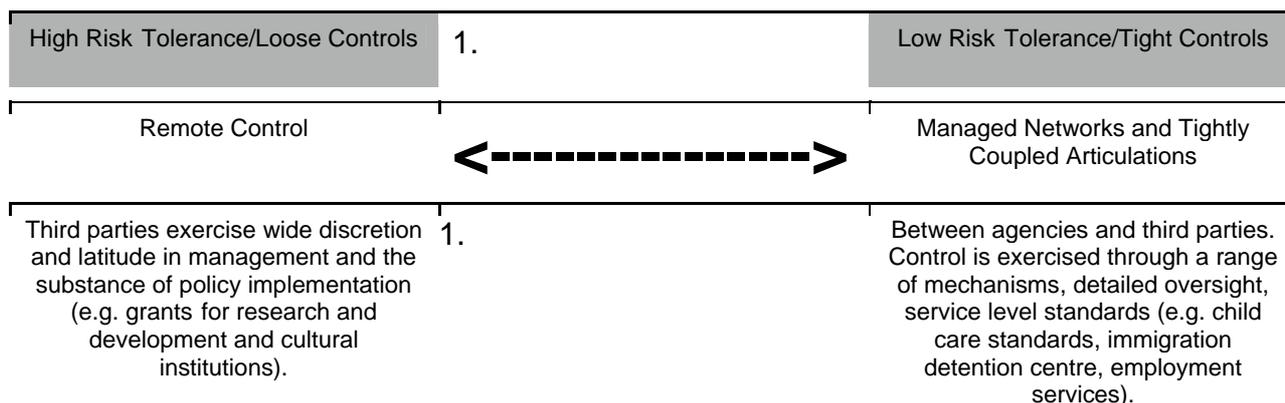
Policy changes

32. 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 by 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.

33. 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 continuum²¹ is one suggestion for a policy framework to guide funding and contracting accountability arrangements:

²¹ Ibid, p26

Risk Tolerance and Control Continuum



34. Fit for purpose accountability is a critical component to provide optimal NGO participation in and contribution to the Health and Disability sector.
35. 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 guidelines²² 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

36. 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.
37. 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. New Zealand NGO experience of the DHB contracting environment can at best be described as mixed, with concerns raised regarding funding transparency, onerous contracting and accountability processes, innovation stifling processes, and the loss of DHB institutional knowledge.

*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.*²³

38. This perception and problem is not unique to New Zealand. Skills in funding, contract management, systems design and management are critical capabilities that the health and disability sector requires 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

²² for e.g.; Devolved Government p14,15

²³ NGOiT (2008:5) NGO-DHB Contracting Environment

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.

39. 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 compact²⁴ with the “third sector”, as a critical component in the delivery of public services in the twenty-first Century. New Zealand has a range of commissioning guidelines developed by both the Treasury²⁵ and the Audit Office,²⁶ and some workforce development initiatives²⁷ in the funding and planning area. 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.

Sector Investment

40. 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 costs and improve their service delivery and financial sustainability, as the next section shows in a range of examples.
41. Government has, at times, taken an investment approach to the not for profit sector, one notable example being Maori mental health and disability sector capacity building throughout the 1990s. 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 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 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).
42. 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

43. 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

²⁴ Ibid, p51

²⁵ Treasury ref

²⁶ Office of the Auditor General (2006) Principles to underpin management by public entities of funding to non-government organisations

²⁷ e.g.; Te Pou <http://www.tepou.co.nz/page/235-planners-and-funders>

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.

44. Government policy in the 1980s and 90s 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 affect, 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.
45. Maori NGOs are 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.
46. Many of the conditions faced by Pacific people and the NGOs serving their health and disability needs are similar to those of Maori. An over emphasis on compliance and risk management in the current funding environment runs the risk 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.
47. 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

48. 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.
49. 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.

50. 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.
51. NGOs have two significant ways in which they can help reduce that barrier. First, they provide an entry to the health workforce to people who are not traditionally oriented towards a scientific/technological education. The introduction 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.
52. Second, 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.

Best Practice Example and Discussion

53. While there is a great deal of collaborative activity throughout the NGO sector, driven by service and system improvement as well as cost reduction, fully developed collaborative efforts, particularly involving DHBs and the primary health sector are not so common. Ideal exemplars will have several participants, involve both the DHB as funder and provider, and have been in operation for sufficient time to evaluate both the process and the benefits. Given the focus of this paper on reducing the costs associated with administration and compliance, some well-established collaborative activity that is primarily service and system improvement has not been included, but should not be overlooked as a significant NGO contribution to a dynamic Health and Disability sector.

Exemplar: Counties Manukau Mental Health and Addictions Partnership - CHAMP

54. 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.²⁸

55. 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. That initiative has led to an expanding partnership of 18 member organisations, including the DHB provider services. The partnership umbrellas both DHB and NGO improvement activities. Of particular relevance to this paper are the “Lets Work Smarter” project, and its Infrastructure/Procurement (InPro) Group. Further detail regarding CHAMP is available at their website.²⁹

56. CHAMP is an example of a ‘loose’ partnership, a forum or venue for partnering activity. While it has a well developed collaborative agreement, it is loose in the sense that participant organisations are not required to participate in all CHAMP activities or work-streams. The InPro group mentioned previously, for example, currently has 12 active participants. This ‘loose’ approach is well suited to an organisation mix that includes crown owned and NGO entities, with the latter ranging in size from local Counties Manukau only through regional and national bodies.

57. Some of the key characteristics of the CHAMP partnership are:

- DHB funder initiated and supported, but the funder is a guest of the forum. CHAMP is a provider forum, with benefits in terms of perceptions of fairness and equity.
- The ‘loose’ partnership enables easy entry by new participants, and means that organisations can participate in those things of most benefit to them, without the overheads of trying to keep up with much larger organizations.
- The ‘loose’ partnership avoids a lot of the potential issues collaborative activity might face in respect of the Commerce Act

²⁸ CHAMP Strategic Workplan 2009/10 - 2012/13,

²⁹ www.champ.org.nz

- The partnership is focused on Counties Manukau health and disability needs and services, providing a point of common/shared benefit, enabling all organisations to bring something of value to the partnership.
- The workplan and priorities are closely tied to the DHBs priorities, with each objective aligned to one or more of CMDHBs triple aims.
- The collaborative explicitly targets processes and infrastructure as critical areas of improvement to ensure sector sustainability.

Objective: Explore economies of scale in provision of infrastructure and services

Realise savings associated with building maintenance services

Explore savings with IT service provision ...³⁰

- The collaborative looks to develop and enhance the systemic capability to respond effectively to Maori and other cultures.

Explore opportunities for sharing cultural resources across the sector resulting in key cultural resources identified and information shared with all providers³¹

- CHAMP sees itself as a hub for, and focus of, innovation.

58. Through the InPro group noted above, CHAMP has been successful in significantly reducing the cost of a range of services and supplies to members of the collaborative. Realised savings in a range of areas such as fuel, insurance, cleaning and maintenance are approaching \$200,000 per annum, and a range of other service areas are being actively explored. When this is combined with collaborative activity between CHAMP members to reduce costs in, for example, information technology, collaborating organisations are seeing significant benefits, and are able to reduce infrastructure costs and invest in greater frontline delivery.

59. CHAMP has undertaken commissioning work on its own behalf in line with its objectives. This has included the placement of a funded position with the NDSA to support PRIMHD implementation, and a member organisation holding a Smokefree Coordinator position. CHAMP led initiatives such as Audit Preparedness and a Shared Training Calendar are also aimed at reducing duplication of effort and compliance costs.

Other Exemplars:

60. While other collaboratives are not quite as extensive as or well developed as CHAMP, NGOs are collaborating and cooperating with each other to reduce their back office costs and achieve greater economies of scale. For example, Community Connections Supported Living Trust estimates it makes annual savings of between \$70-80,000 by having MASH Trust, another disability provider, deliver all of its admin, finance and payroll functions on contract. Substantial one-off and ongoing benefit is obtainable by reducing data management costs. Examples include work by CCS Disability Action and the recent tender by the ACE collaborative³².

³⁰ CHAMP Strategic Workplan 2009/10 - 2012/13, (2010:15)

³¹ Ibid, p12

³² Affinity, Connect, Equip, three Auckland based NGOs

A Future Shared Services Strategy

61. The key characteristics of the CHAMP partnership, and similar exemplars, form a good basis for a future shared services strategy, whether implemented at a district, regional, or national level. The model or approach is based on:

- DHB funder initiation and support (both materially and through encouragement);
- close alignment with DHB priorities;
- 'loose' organisational arrangements, that do not compromise participant's autonomy and own objectives;
- explicit objectives to get the best out of both shared resources, such as cultural competence, shared systems and shared procurement;
- an innovation focus;
- a willingness to take a medium to long term view, allowing collaborative relationships to develop and benefits to appear;
- measurable and quantifiable goals and cost savings; and
- a clear operating protocol, whether MOU or some legal form.

62. Fora or partnerships similar to CHAMP operating in different DHBs have the potential to develop within the district across service lines and by network across DHBs. A grounded local approach, where network development leads to greater benefits, and participation is voluntary, is likely to get a wider range of organisational buy-in, and a more sustainable longterm solution to containing and reducing administrative and compliance costs.

Combinations

63. A number of NGOs are exploring the potential to combine a range of back office functions. Methods of combination being developed include shared resource, either as separate shared entity, or jointly held, and specialist back office provision, where one of a group of providers focuses on a particular function that is supplied to others. Opportunities also exist for larger organisations to partner, support or umbrella smaller ones, through providing a range of functions from specialist management to finance, HR and IT.

64. When considering the possibility of combinations to reduce cost and enhance front line resourcing, the following areas have been demonstrated as worth consideration:

- Human Resources: recruitment, employment law, training.
- Finance: the gamut of financial functions, transactional, reporting, treasury.
- Procurement: sourcing, contract preparation and negotiation.
- Quality Systems: audit preparation and support, governance and management policy preparation.
- Marketing: the full range of marketing activities.

65. Previous changes in the sector, such as separation of the brokering and service provider roles in disability, or separation of the support and housing functions in mental health, have been managed with varying degrees of effectiveness. Where providers have been given the opportunity to identify their preferred or most appropriate direction for development, creative solutions have emerged.
66. Purchasers/funders can take an incentive oriented approach to encouraging and supporting back office collaborative developments. If funders try to impose a structural change on the sector through compliance mechanisms they risk the loss of innovative solutions. Clear statements of intent and desired outcomes are required to deliver effective incentives. Funders can use scale, geographic location, similar services, similar clients, and a range of other options as the pivot on which to drive reduced back office costs.
67. A scale based approach might require providers to collaborate or contract for back office functions below a certain annual turnover. The scale could slide, with organisations at the smaller end required to move everything from client information to recruitment to a collaborative or contracted entity. In particular, contracting at the small scale is uneconomic, and funders would either be required to use a grants based approach below a certain scale, or contract a raft of smaller services to a collaborative, possibly an umbrella organisation.
68. If funders took an investment approach to back office collaborations, providers could be incentivised to divest the back office functions by shifting part of their existing overhead to the collaboration, with the funder picking up the balance. Funds remaining with the provider would then be directed to increased frontline services. Providers could be given the option of becoming back office umbrella organisations in much the same way that some NGOs have taken on a pure housing role, as housing and support functions have been separated. Early signals of an approach provide important time for NGOs to consider their options and reorient to meet funder requirements, without compromising their autonomy or sustainability.

Implications

69. The NGO sector has a rich and varied range of providers, who are able to meet local requirements and client need (and preference) due to their diversity. NGOs, like the bulk of New Zealand enterprises, are small businesses, and operate in an environment that is one of the most business friendly in the OECD. Taking a topdown, economy of scale driven approach to reducing administrative and compliance costs in the sector, would run the significant risk of driving out much of the diversity that makes the NGO component such a valuable part of the New Zealand Health and Disability sector.
70. Taking an incremental approach, as in the CHAMP example, is shown to produce a partnering environment which is supportive and enhancing of both diversity and innovation within the sector, while producing significant economic benefits for participant organisations and sector sustainability. Small local providers can benefit from the improved procurement conditions, as well as the peer support and supervision. They can contribute unique perspectives and focus, and feed into the innovation focus of the collaborative.
71. Maori providers can share their valued cultural expertise with other participants, while benefiting from the economic and system benefits of the collaborative. System transitions, which can be so disruptive to the effective engagement of the health sector

with Maori service users, can be minimised by effective collaborative relationships. Maori organisations with local Iwi endorsement or support add legitimacy to the efforts of DHBs to deliver on Crown obligations to Maori and Maori health improvement.

72. Likewise, Pacifica providers are able to bring their expertise into the whole of the sector, while developing their service delivery and enjoying the economic advantages that good collaborative activity brings. However, collaborations that undermine organisational autonomy are likely to be particularly unwelcome in both Maori and Pacific contexts.
73. The opportunity exists for a sector wide discussion of issues of appropriate organisational scale, which balances issues of autonomy and engagement with cost and efficiency. Scale need not be a threat to small organisations. If, for example, the funder requires a contract approach to back office functions for providers contracted to or delivering below a certain scale, affected organisations could, given reasonable notice, pursue a range of different strategies, including both collaborative and commercial solutions.
74. A national forum to present collaborative efforts in the NGO sector and share these with other organisations would seem an obvious way of disseminating many of the learnings that have been made in existing collaborations. Such a one-off event could well lead to the networking process envisaged in the future strategy section.

Opportunities

75. If the government chooses to take a 'valued partner' perspective of the NGO component of the health and disability sector, it has a range of options for working with NGOs to get better value from their contribution. An investment approach, that uses NGO umbrella groups or existing partnerships to drive sector innovation and improvement, is likely to be more effective than the sole use of audit, risk management, and payment mechanisms to compel performance. Innovation, quality improvement and outcomes development may be more timely and cost effective through direct government investment in the NGO sector umbrella groups to drive change than through departmental policy arms.
76. There are significant opportunities to replace the routine cost and function of certification and auditing with an alternative of peer review and mentoring. There is wide agreement across the NGO sector that certification is high cost and low value in terms of quality improvement. The current regulatory directions seem to indicate a determination to drive up costs and there is a lack of accountability back to the sector to consider the true benefits of regulation and scrutiny. NGOs experience multiple audits on an annual basis, where different funders are looking for the same thing, that is reassurance that government funding is being wisely used. Half a dozen audits of the same provider in 12 months, where there is no prior evidence of service delivery failure, are on the face of it, just the sort of wasteful use of government funds the audits are supposed to be detecting.
77. Peer review, mentoring and support provide a better basis for dealing with struggling providers than management replacement or contract termination. Unless funders see their contracts as part of a long term capacity building investment in the sector, every terminated contract is potentially a waste of intellectual and systemic capacity and capability built up over time. Using NGOs natural collaborative behaviour will lead to the same or greater system improvements than the excessively legalistic and

compliance driven framework adopted by inexperienced funding organisations or funders.

78. This paper only touches on the range of possibilities in using collaborative efforts to manage and contain the cost of health and disability service delivery. Joint Crown and NGO procurement possibilities exist, remembering the caution noted earlier of taking a pure 'economy of scale' driven approach. The challenge in realising such possibilities is to do so in a way that maximises NGO engagement, through effective relationship management.