24 June 2015

Submission on More Effective Social Services Draft Report

The Public Health Association of New Zealand Inc.

Introduction: who are we?

The Public Health Association of New Zealand (PHA) is a small voluntary association for all those who see themselves as part of the public health workforce, established in 1988. We provide opportunities for this wide diversity of occupations from public, private and voluntary sectors to join together, share their expertise, and have a collective voice on public health issues facing New Zealand. The PHA contracts with the Ministry of Health to provide services that support capacity and capability development in the public health sector. The PHA is a member of the World Federation of Public Health Associations.

Context

The PHA is supportive of the Government’s desire for ‘smarter strategies and deeper capability to achieve desirable outcomes’, and generally in agreement with the findings of the inquiry and its recommendations. Members of the PHA include some who have worked or still work as policy advisers, managers and funders as well as service providers, so we have access to a wide range of experience and knowledge of the strengths and weaknesses of the current system.

One difficulty in responding to the inquiry findings and recommendations arises from language that implies that all service users are individuals, such as ‘client’, ‘consumer’ or ‘customer’, when public health generally provides services to populations (the whole population of New Zealand, or groups based on categories such as ethnicity, age, gender or locality) and social and physical environments. In some cases it is possible to extrapolate a finding or recommendation to apply to a population, but in much of public health the ‘client’ is a community not an individual. This applies especially to Chapter 6 – Commissioning and Chapters 9-11, but even here we have tried to interpret the concept of ‘client’ as inclusive of communities of people.

Comments on findings and recommendations

Chapters 2-5

The PHA endorses the three recommendations following these chapters, and endorses these findings with some caveats, except for F3.1, since public health services do not administer financial entitlements to individuals.

1 The classic definition of ‘public health’ in this context is “The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society.” (Acheson D. Independent Inquiry into Inequalities in Health, 1998)
F3.2 We endorse the importance placed on independent evaluation, but note that care must be taken to ensure this is undertaken by organisations with expertise in public health.

F3.3 We support the potential of social bonds as described and the caveat that they may be more useful in relation to new approaches rather than being applied widely across the social services.

F4.2 We endorse the concern about highly prescriptive contracts that work against innovation in services, and recommend the ‘tight-loose-tight’ approach that focuses on clear description of outcomes and performance measures, and flexibility about activities and outputs.

F4.6 The gap between ‘information’ and ‘knowledge’ is a major concern. Reasons for this are complicated, including organisational siloes, overloaded and under-staffed capacity and lack of training.

F4.7 Government agencies might not have the capacity or capability to understand the market which they are expected to serve, for similar reason as those in F4.6. In the public health context it may be questionable whether there is a market, since a lot of what public health is expected to address are changes that people do not actually want to make. This includes a range of activities such as regulatory enforcement (e.g. clean air, water and waste disposal), and behaviour change (e.g. diet, sexual practice). So while we agree that there is always potential for agencies to shape and manage a market for particular social services, it is counter-productive to assume there is always a ready market, and it takes considerable skill and patience to develop one. We endorse the findings in F6.2.

F4.8 This requires the same caveat as above. Monopoly service provision is not uncommon in public health (e.g. Plunket), as issues are often not geographically defined but are defined instead by specialist knowledge and understanding of particular social environments. Competitive tendering can be a disincentive to innovation and adaptability. Incentives for providers to deliver good services require effective relationships, involving good faith and transparency and the flexibility to innovate, fail and adapt.

F5.2 We agree with the finding that large-scale devolution is not popular. However, there does need to be much more work to ensure that decision rights are located where they can be most effective. The Ministry of Health has done work on determining what can best be planned, funded and delivered nationally, regionally and locally. However, the existing institutional architecture is insufficiently sophisticated to support its implementation, notably at regional level.

F5.6 We strongly endorse the concept of Ministries as ‘system steward’ and that the current system falls well short of what is required.
Chapter 6 – Commissioning

We generally endorse these findings, with the same caution expressed above regarding markets (F4.7 and F6.2).

F6.4 We endorse the finding regarding shared goals, so long as the term ‘client’ can be understood to apply to population groups as well as individuals.

The PHA generally endorses the recommendations relating to commissioning, with the following caveats.

R6.4 considering client-directed service models, needs to be applied equally to public health services, so long as ‘client’ is interpreted to mean populations not individuals.

R6.12 A public health perspective would consider grant-funding as simply one option and not reliant on co-funding, as a significant proportion of public health addresses issues in communities that do not have the capacity to raise funds.

Chapter 7 – A system that learns and innovates

The PHA strongly endorses most of these findings, but strongly objects to the following assertions that are simply not true for public health:

F7.2 Public health services have experienced frequent, major disruption as a result of different political world views and constant organisational change in the health sector. This has been at times a distressing barrier to innovation.

F7.3 Public health services have had few opportunities to benefit from advances in communication technology as a result of constant disruption, reduced funding (F7.6) and overly prescriptive contracts (F7.7).

However, we strongly endorse all the recommendations, especially R7.1 and R7.6.

Chapter 8 – Leveraging data and analytics

The PHA strongly endorses every one of the findings and recommendations in this section.

Chapter 9 – Investment and insurance approaches

The PHA endorses F9.1 and F9.2 but has serious reservations about the applicability of a social insurance model that is designed to address the health of individuals not communities.

We endorse recommendations R9.1 and R9.2 regarding the investment approach.
Chapter 10- Service integration

Our caution regarding the assumption evident in the findings that ‘clients’ are always individuals applies to this chapter, but we endorse the recommendations as they apply equally well to services at population health level.

Chapter 11 – Client choice and empowerment

The same caution about the assumption that ‘clients’ are individuals applies, and we endorse the recommendations.

Chapter 12- Better purchasing and contracting

The PHA has noted the discussion regarding different models for delivering social services and agrees with the assumption that contracting out will continue to be an important service model, and that there is significant scope for improvement.

However, we again note that there are significant differences between contracting for services to individual clients and the need to sustain capacity and capability to deliver services to whole communities or population groups.

Nevertheless, the PHA endorses all the recommendations arising from this chapter.

Chapter 13 – the Maori dimension

The PHA strongly endorses the two findings noted, but is extremely disappointed that the recommendation R13.1 does not provide meaningful advice for commissioning agencies.

In the discussion of the Maori dimension the report casts Maori as ‘a client group’. This ignores the Maori person as an individual service user and as a member of a population with ‘duties of care’.

The findings that Maori are disproportionately represented in the client base of some services, and that Maori aspirations for greater rangatiratanga are a Treaty entitlement, do not excuse the Crown from its Article three responsibility to ensure the Maori right to the same level of service as other citizens, as well as its Article two responsibility to enable Maori to exercise their inherent mana whakahaere.

Hitherto, social services have predominantly cast Maori as a client – and often as a recalcitrant one when Maori are unwilling to comply with patriarchal services and systems. Furthermore, government agencies considering the health needs of Maori have tended to construct them solely in the context of whanau, hapu and iwi, failing to recognise the diversity of the Maori population in relation to other characteristics of identity, such as age, gender, sexual orientation, disability etc., and whose health needs may be better met through other organisational constructs.

A better process is proposed on p.20 of the Summary version:
• The Government provide a standing opportunity to Maori groups to pose how they might like to be involved in commissioning;

• The nature of the proposed process coming from Maori rather than being a model that Maori groups are co-opted into, or have imposed on them.

Unfortunately, the third bullet point undermines these premises:

• The Government placing reasonable constraints on what is possible.

This demonstrates unwillingness for the Government to engage in real partnership by surrendering its authority to determine what is ‘reasonable’ – that is, what should be funded and at what level.

The successful development of ‘by Maori for Maori’ health services over the last twenty years has set the benchmark for a respectful partnership. It should be emulated in future commissioning practise, and it is the responsibility of the Crown, as the more powerful partner, to ensure this happens.

**Chapter 14 – Implementation**

The PHA endorses these recommendations.

Thank you for the opportunity to engage in this consultation process.

Warren Lindberg
Chief Executive Officer
Public Health Association