**The future of contracting: alternative models to competitive tendering**

A presentation to: Health and Disability NGO-MoH Forum
"NGOS and Contracting in today's health and disability environment"
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I offer these thoughts on contracting wearing two hats.

I am Chair of the Hutt Valley District Health Board, with a budget of around $300 million of public money. We are charged with three main tasks:

- To improve, promote and protect the health of communities
- To reduce health disparities by improving health outcomes for Maori and other population groups
- Foster community participation in health improvement, in planning for & changes to the provision of health services

The main way we do this is through funding the provision of health services –

- through our own provider arm – our hospital, Community Nursing and mental health services, and our Public Health unit
- through the payments for demand driven services – pharmaceuticals, laboratory tests
- through primary and community health services – PHOs, palliative care, health promotion, Maori and Pacific health services, mental health and addiction programmes
- through aged care and mental health residential or hospital services

Given this responsibility, and the fact that we are spending public, taxpayer, money on behalf of the Crown – I have a high interest in ensuring that the money is spent effectively, and that we can account fully for its use.

As **Colleen Pilgrim**, Sector Manager for Health and Primary Production, said in November 2005, in a paper prepared for the Office of the Community and Voluntary Sector's *Good Practice in Action* conference **What does the Auditor-General expect of the funding arrangement?,** the Auditor General expects that our funding arrangements are:

• Based on principles of good management of public resources
• Public resources for the public benefit: accountability, transparency
• Equity and fairness
• Meets public standards of competence and integrity

Recently, our DHB went through the difficult process of cancelling a contract with an NGO provider. This followed many months of dialogue and interaction with that provider. At the end of that process, we concluded that the provider was not providing the services in a quality or quantity that was satisfactory, and that they were not going to be able to "raise their game".

It's a tough call.

The second hat I am wearing is as Co-Chair of the Community Sector Taskforce. That's a group of ten people, working on behalf of the whole of the tangata whenua, community and voluntary sector, to continue work which began in 1999. We aim to bring together the whole sector, to raise the profile of the sector, to strengthen the capacity of the sector, and to strengthen relationships between the sector and the state.

We have been enormously grateful for the support of your Health and Disability NGO Working Group, who have attended all our key events, and have sent out material on our behalf to the health and disability NGO networks.

Recently, at a Research Forum convened by ANGOA, we heard of research being done by Massey University about how the contracting environment is impacting on Maori health providers. What we heard is repeated constantly throughout the sector. The contracts, while being the source of funding for our work, actually get in the road of us delivering on our kaupapa. We become focused on what the contract requires of us, which may not be the same as the needs of our community. We must count numbers, in order to report on those numbers, and that means we can't always respond appropriately to the living situation of people.

These concerns echo strongly for me, and for the Taskforce.

They have a strong resonance for me from my previous work as a local and national NGO leader in primary health.

So, I thought I would share a few thoughts about it.

I'll start with a confession.

I think we were partly responsible for the emergence of contracting in the 1990s!!

I recall how the national network of eight Union Health Services in the early 90s entered into dialogue with the then Dept of Health. We were running capitated practices serving very high need, and very low income populations. The Dept of Health was very sympathetic to our situation, since it was obvious that the service we provided was desperately needed, and well regarded. We said to them, "We would like additional funding from you. We are happy to provide information to about what we are doing – the numbers and types of people we are seeing, the services we are providing, and so on. We see you – the government – as our natural allies, and we suggest that our relationship of mutual trust and respect could be formalised through some form of written agreement. In exchange for X dollars, we'll provide you with information."

The Dept was very interested because they were working in a virtual information desert – they knew almost no details of what was happening in General Practice, despite paying out many millions of dollars in subsidies.

We also talked with them about a change in the funding arrangements for maternity care. Rather than paying us for specific items of service by GPs or midwives, we proposed a bundling together of services, with a single payment for each trimester we cared for a woman before, during and after her labour. Again, this proposal was mutually agreed and willingly entered into.

Fifteen years later, we have a contracting as the normative – probably the only – mode of funding of health services. Maternity are now funded exclusively by single payments covering the whole process of ante-natal, labour, and post-natal care.

And the system is characterised by greater or lesser degrees of mistrust, complicated processes of auditing and monitoring, enormous transaction costs for both funders and providers, and a lingering suspicion of malfeasance.

NGOs are told one day they need to cooperate and collaborate - the next that they must submit a competitive tender, when they don't know who else is tendering, or at what price. In my region, for example, I watched the Pacific community being torn apart by these processes, setting group against group.

Something has gone wrong, and new modes must be sought.

What's the problem?

To start with, I believe the whole nation remains in the grip of some philosophical ideas which underpin contract theory, and various other esoteric economic theories.

Central to these, is the belief that people are selfish, will always pursue their own interests, and will try and cheat the system if given the chance. (I was told this last week at a Greater Wgton Regional Council meeting, by a submitter, suggesting that Senior Citizens would rob other people's Superannuation Cards to get cheaper bus or train fares!)

This belief means that systems must be set up to minimise the danger of "cheating" or "theft". It means that funding relationships must be in writing, and must provide maximum protection that people won't just take the money and run, or take the money but not produce the goods.

For the NGO sector – I believe for the whole nation of Aotearoa/NZ – this assumption is not in fact true. Yes, there are rogues – there always have been. But our whole society is actually based on the assumption that people will adhere to certain rules, will comply with agreed limitations, and will cooperate with one another for the common good.

The sad result of the last decades of contractualism is that we are building, within the NGO sector, a whole new class of people who see the state as the enemy – the funder as an opponent, who must be appeased, worked around, and sometimes lied to.

Audits and monitoring are not opportunities for mutual learning and development. They are exercises in one party trying to find out how bad you are, and the other party trying to hide any non-performance.

I think it's time to have a much more open discussion about whether it's possible to do things differently, and try those ways.

Can I tell another story, to show that it is possible to do things differently. In 1998 the then Minister of Health, Bill English, authorised a grant of $1 million to Health Care Aotearoa. We were to use this money to make grants to groups who wished to set up community-owned and driven primary health services serving high needs populations. In the end, from memory, seven new services were established with support from that fund – in Whangarei, Auckland, Gisborne, Masterton, Wainuiomata, and Christchurch (and somewhere else – I think Hawera!).

From the beginning, we agreed we would distribute that funding, not using a competitive framework. Rather than putting out an EOI or RFP, with a deadline, we invited groups to approach us when they felt they were ready. We set out some standards against which we would test the group, and their proposal – judging each one on its own, not against one another.

The testing of each proposal was undertaken by people who were experienced in community owned primary health services, and the final decision was made by a group of HCA members. As I said to the Minister, "Our bullshit detectors are better than anyone in government."

We accepted that some groups would get funding who were more advanced, and that others would miss out because they were not yet ready. We accepted that there were many new initiatives which were, in their own right, extremely worthy, but would not be funded because they did not fit the fairly tight focus on community-owned comprehensive primary health services.

I believe that this programme showed an extraordinary level of faith on the part of the Minister, and demonstrated that it was possible to do things differently. In the end, of the seven – one General Practice fell over (but continues with a wide range of community health services within a PHO), one has become part of a PHO without achieving its own goal of including General Practice in its services, and five continue to work, also as part of PHOs.

I believe the nation got pretty good value for its money.

I have the sense that the government in general is ready to explore new ways of working. One important new factor is the talk of "joined up funding", "whole of government" programmes, and especially "funding for outcomes".

As long ago as July 2004, Colleen Pilgrim and Robert Buchanan, of the Office of the Auditor General, wrote a paper entitled Risk based approach to contracts In that, they say,
*"Use of the contracting model is nevertheless problematic for a number of reasons. For example:*

- *specification of services and quality measures is difficult, especially for services that are intangible;*
- *lack of specificity of outcomes makes evaluation difficult: "whole of government", collaborative or partnership emphasis in some contracts only adds to the difficulty of evaluation*"

If you have an outcome like people living two years longer, how can you possibly write a contract that anyone would sign?

Yet, having people live two years longer is exactly the kind of outcome we as DHBs and you as NGOs wish to see.

What we need are some new relationships, based on mutual respect, shared goals, and trust.

Out of this may grow funding relationships and accountability regimes that are rigorous, professional and even tough – but are above all, real.

I see the NGO sector as the ideal partner for the government in this venture:

- this is the sector where innovation and risk-taking happen
- this is the sector where people have a real passion for making a difference
- this is the sector where there is a long history of getting value for money
- this is the sector with strong community connectedness.

In summary, I'm keen to open that dialogue in a tangible way. I believe that now is the time to try something new.

We can work towards new funding relationships where the focus is:

- outcome-based funding

- relationship-based funding
- no lawyers!
- a greater stress on personal accountability, on the part of the people who are involved.

Thank you for the chance to share my ideas.

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