the wheel Stronger Charities. Stronger Communities.

An informal briefing note for the review group examining the role of voluntary organisations in publicly funded health services

February 8th 2018

Introduction

The Wheel very much welcomes the opportunity that the review of the role of voluntary organisations in health and social services presents. Over 150 of the 1,300 members of The Wheel are organisations funded through Sections 38 and 39 of the Health Act. These members meet regularly to keep abreast of policy developments affecting the sector and to identify issues that impact on their ability to support the health and wellbeing of the people and communities they serve, and are rooted in.

Everyone in Ireland wishes to see an optimised health service focussed on maximising individual and community health, and this briefing note is aimed simply at providing an initial orientation for the members of the review group from the perspective of The Wheel and its HSE-funded members. The Wheel will be consulting widely with HSE funded members to make a full submission into the review process in due course. We are very grateful for the opportunity to meet informally with the panel.

About The Wheel

The Wheel is Ireland's national association of community, voluntary and charitable organisations. We are a representative voice and a supportive resource that offers advice, training, influence and advocacy for the sector. With over 1,300 members, we are the largest representative body for the sector. Visit www.wheel.ie for more information.

Ireland's voluntary sector forms a key part of Ireland's social infrastructure

Independent, community based, voluntary organisations have long played a key role in supporting and advocating for people and communities in Ireland – indeed it is often through the initiative and advocacy of self-organising communities that many health and social care services have been initiated.

Community and voluntary organisations are as a result involved in every community in the country in health and social supports, services and advocacy on behalf of people with disabilities, older people, young people, children, and people at every stage of the lifecycle.

Many such organisations are funded (to various degrees) by the state (through the HSE) and today comprise a *key element of our national health and social service infrastructure*. In 2015, the HSE alone made over 1,800 funding payments (with over 550 organisations funded to

€100k or more) disbursing over €3.6 Bn that year. At the same time, fundraising consulting firm *2into3* estimates that over €750 million was raised by Ireland's charities in the same year.

Our voluntary sector makes a big contribution to society in general…

The community and voluntary sector (of which health and social support organisations funded by the HSE comprise a significant part) makes a valuable contribution to our society. There are over 11,000 organisations in Ireland's non-profit sector. The sector has combined turnover of over €10.Bn, employs over 150,000 staff, benefits from the voluntary work of over 50,000 volunteer board members/directors and the work of over half a million "operational" volunteers, and makes available assets and facilities that our health and social services could simply not function without. The CSO estimates that the value of volunteering is around €2Bn per anum.

While over 50% of the funds for all this activity comes from the public purse – the sector itself makes a huge *financial and non-financial contribution* to services, generating over €2.5Billion per annum towards the cost of services from its independent activity each year. But the sector contributes much more than this big financial and voluntary contribution.

…through the societal value and social capital it creates and sustains in communities

These financial and voluntary contributions are enhanced by the *non-financial contributions* of the community and voluntary approach: the energy, endeavour, and commitment of all involved; the extent of funds added; the pride and sense of belonging the best organisations inspire; and all the other additional resources contributed (like premises, equipment etc) – none of which would otherwise be available to state. Taken together, all of this added-value contributes to the *Societal Value* that inheres in, and characterises, the holistic, whole of community, voluntary led approach when at its best including

- responsive, tailored and holistic approaches to identifying and meeting needs
- flexibility, innovation, integration and collaboration in delivery
- ownership, involvement and empowerment of service-beneficiaries and the wider community in shaping services and supports
- contributions to building social capital and social cohesion
- committee, motivated and person-centred staff
- bringing additional assets and sources of funding to support the work that would not otherwise be available to the State.

The review presents a great opportunity to maximise this contribution

As can be appreciated, such organisations contribute significant public benefit (or societal value) over-and-above the core service which they may be funded to provide. The review presents an opportunity, in line with the terms of reference, to

- understand the current role that community and voluntary organisations play in health and social services;
- understand the impacts on communities and funded organisations of the way that services are funded and administered;
- identify what needs to change if people and communities are to have access to the supports and services they need and
- identify what needs to change if we want to maximise the very significant contribution that voluntary organisations make to sustaining the communities they serve.

Current arrangements distinguish unhelpfully between essential and ancillary services

As can be seen, community and voluntary organisations funded by the HSE have grown out of a spirit of community self-help, rooted in and connected to the need in the community they were voluntarily established in. In most cases, securing funding from the local health authority (or latterly the HSE) was a step along their journey (which often involved, and for many still involves, significant fundraising activity), with many such organisations now in receipt of significant HSE funds to provide what they would understand are *essential* supports and services in their communities. Indeed, this issue of when a service is regarded as essential, or non-essential, cuts to the heart of the matter.

Section 39 funding doesn't recognise the essential nature of services

Yet the regime these organisations are now funded under hasn't developed to keep pace with the changing nature of the supports and services expected – and the extent to which most people would regard them as being "essential". The work of most of the hundreds of organisations supported by the HSE is funded under Section 39 of the Health Act, a provision that doesn't recognise the "essential" nature of the services and supports funded, instead treating these services as ancillary to the services that the state is obliged to provide.

Section 38 funding does recognise essential nature of services

Some forty two organisations are funded through the provisions of Section 38 of the Heath Act, which provides for the funding of services that the state would be obliged to provide if there was not an organisation already providing those services which the state has agreed to fund – in effect recognising Section 38-funded services as being essential services. An important consequence of Section 38 status is that the staff of such organisations are regarded as being public servants, counted as such, and entitled to public service terms and conditions. While there are benefits to organisations that have secured Section 38 status, in comes at the cost of organisational autonomy and the freedom to advocate that should accompany it.

While Section 38 status does not represent a panacea – we need to recognise the "essential" nature of the majority of Section 39 funded services and provide for them accordingly

The roots of the current discord in the Section 39 landscape where some trades unions are indicating strike action, where cases are being decided in the WRC, and where the Boards of Section 39 organisations subsequently seek funding increases from the HSE to enable them to comply with WRC judgements and maintain service quality and retain staff, have their origins in this failure to appreciate the essential nature of these services: most Section 39 organisations are providing "essential" health, social and community services, but in circumstances where the state does not see an obligation to fund these services in the same way that they fund Section 38 services they understand themselves obliged to deliver. This issue needs to be considered and addressed by the review group. This will not be easy however.

…and that will involve engaging with current policy relating to employees of Section 39 organisations

The unwillingness to recognise the essential nature of Section 39 services is closely connected to a general policy of the state to minimise exposure to liabilities attaching to services it funds – especially to ensuring that the state is not regarded as the ultimate employer of the staff of funded organisations. In line with this general policy stance, the state has historically rejected suggestions that it has any responsibility for the people employed by Section 39 funded organisations - and there is a general resistance to any proposal that could result in such employees being regarded as public servants.

Boards of Section 39 funded organisations placed in very difficult positions

Current arrangements put the Boards of Section 39 organisations in difficult IR positions when seeking to retain staff doing the same work as their Sector 38 counterparts, but on inferior remuneration and terms and conditions. It could be said that the Department of Finance and Public Expenditure and Reform (and in all of their previous incarnations) have strongly resisted any and all initiatives that could be interpreted as acknowledging any liability to the state from Section 39 staff.

A lot of store is put by the HSE in moving to a commissioning model for services, but there is concern that this may result in a "lowest-cost-wins" tendering approach with a "bigger is better" subtext

In recent years the HSE has been transitioning towards *commissioning* services (identifying the outcomes that people and communities require and then working out the best way of achieving this). The sector is broadly supportive of this approach if it is understood as taking a strategic approach to identifying the services people need, then determining who will do the work, and only then determining how it will be funded.

There are however concerns that commissioning could result in the increased use of competitive tendering, possibly disadvantaging communities if approached on a "lowest cost wins" basis without regard for the holistic approach that characterises the community and voluntary approach and the added "societal value" and "social capital" that community based organisations contribute to their communities.

There is also a sense that there may be an unstated policy assumption underpinning commissioning that "bigger is better" when it comes to services. There is a concern that keeping a real and lived connection between services and supports and the communities that require them - and facilitating communities to shape these services (a crucial role of community organisations engaged in services) - could be endangered by further moves in this direction. The HSE has stated that they believe there are too many organisations in the sector, and has invested considerable resources in recent (unsuccessful) initiatives aimed at achieving mergers in the sector. We believe that he HSE should be called on to provide the evidence that larger organisations are more cost effective or deliver better outcomes.

In addition, the growth of private sector providers in recent years doesn't give confidence in relation to the value placed on the voluntary sector role or that commissioning will be aimed at maximizing the added "societal value" the sector contributes

There has been exponential growth in the amount of the public health budget that is finding its way into the private sector. This poses a number of issues:

- Assets purchased with State funding by organisations with charitable status remain available to the State to be used for the common good. Assets purchased by a private sector company with State funding are forever lost to the State.
- The growth in HSE funding allocated to the private sector has largely been on the back of the regulatory environment created by HIQA. It takes six months to purchase/lease a property and have it approved by HIQA. Private sector organisations have the resources to invest in properties and reserve this stock for HSE referrals. The C&V sector do not have the resources to purchase properties unless there is a service agreement in place with the HSE. In effect this means that the private sector is the only player in the market for emergency placements. The result of this is the HSE pay well over the national norm for residential placements in the private sector.
- private sector organisations are not subject to the same compliance requirements as the community and voluntary sector.

General administrative complexity is a key issue for HSE funded organisations and needs to be reduced and streamlined…

In the case of both Section 38 and Section 39 funded organisations, the administration of the funding relationship involves complex annual negotiations around budgets, service planning, monitoring and reporting of progress; compliance with the requirements of detailed Service Level Agreements (contracts essentially) which significantly reduce the operational autonomy of voluntary boards and involve large, often unfunded, costs to organisations (especially when added to the increasing compliance costs associated with charity regulation, GDPR etc). All of this risks organisations expending ever-increasing resources on meeting compliance costs and governance itself being reduced to "ensuring compliance with the requirements of the service agreement" (and the "tick-box" approach to governance that this can encourage).

...and there is a sense that the autonomy of boards and the advocacy function of voluntary organisations is disrespected and that while references are often made to the importance of the voluntary sector and to partnership working, lip service is paid in practice.

Many organisations report that the added value they deliver in their communities is not appreciated and that there as is a general disrespect for operational autonomy and a disrespect for the crucial advocacy function that many organisations perform with the communities they support. Achieving health and social services oriented to maximise individual and community wellbeing is a complex task that can only be achieved, in our view, through a partnership approach to planning and implementation rooted in a holistic, whole-of-community perspective.

Conclusion

If we recollect the "backstory" to the current section 39 funding arrangements (self-organising communities coming together to ensure health and social services were available in their communities) and the continued advocacy role that many voluntary organisations understand they are obliged to fulfil on behalf of the communities they serve, then we need to see an arrangement that

- puts achieving positive health and social outcomes for people, and the communities they are a part, of first
- Recognises the essential nature of the work done by most Section 39 organisations (making the necessary legislative, administrative and funding changes required)
- Recognises and seeks to support the financial and non-financial "added-value" contribution made by community and voluntary organisations to current health and social supports and services – especially in commissioning practice which should take place in a societal value framework.
- Respects and enhances the advocacy role of autonomous funded organisations and better integrates autonomous organisations and the communities they support in development of health and social policy and strategy
- Adequately funds the work
- Reduces and streamlines the complexity, ineffectiveness and inefficiency of current budgeting, monitoring, reporting and compliance systems and processes
- Brings more coherence to planning processes and ensures people and communities have access to the health and social services they need to a high and consistent quality standard across the country

Issues identified by HSE-funded members of The Wheel at recent HSE Network meetings:

The Wheel liaises regularly with our HSE-funded members, and to give panel members a flavour of the issues and perspectives of members on these matters, we include in the below appendix a short synopsis of points made by members at recent network meetings. These points should not be taken as the view of The Wheel, rather they are intended to assist the panel in encountering perspectives from with the community and voluntary sector in Ireland.

We wish the panel well in its crucially important work and look forward to making a full submission with our health and social service members later in this process.

Appendix

Points made by members of The Wheel at recent HSE Network meetings:

General

1. The core purpose of health and social care organisations is being crowded out by an over-specification of performance and reporting requirements by the HSE. This is not indicative of the constructive collaborative / partnership relationship between organisations and the HSE that is supposed to hold.
2. There is a lot of rhetoric around partnership working, but in practice this doesn't happen.
3. Voluntary "partner" organisations are often expected to compete with private sector providers who do not face the same compliance requirements – such private firms don't have to complete detailed Service Level Agreements (SLAs), or face onerous reporting, compliance and transparency requirements. Members desire a level playing field.
4. There is a general view that the HSE doesn't respect what the sector does or value the sector's work in society.
5. Policy-makers do not appear to consider the practicality for organisations of rolling out services with insufficient resources, and the great difficulties this causes for people who require unavailable services and supports.

Funding

6. There is no real acknowledgement of the (up to 50%) of independently earned/fundraised income that many cv organisations contribute to the cost of services – yet the HSE often insist on claiming the credit for the total output an organisation delivers – even if only a proportion of that can be attributed to the statutory funds provided.
7. There are reports that for some organisations where the HSE fund, for example, 70% of the total cost of services, the HSE requires their 70% contribution to be identified discretely in reports, while at the same time requiring that 100% of the organisation's output be reported against the 70% HSE contribution. This creates a sense that there is an "expectation" of future voluntarily-raised or earned funds that constitute an effective "unacknowledged and disrespected" subsidy to the public purse.
8. Clarity is needed on whether CV organisations are obliged to permit the HSE to "take credit for outputs produced using other sources of income". Are the HSE effectively imposing their requirment on other funding streams?
9. Regarding services that are in deficit – the HSE won't sign-off on a service which is in deficit. This means that organisations are required to manage an zero-balance at year's end, to ensure that they will be considered again for funding. This has major impacts on continuity of service for service-users and creates a lot of work for service providing organisations. There are reports that local arrangements are often made to deal with this. Complicated solutions are arrived at locally where orgs and the HSE have perennial discussions, creating additional workload.

Restoring funding to Section 39s to enable them to restore pay

10. The relationship is felt to be one-sided: while the HSE demands compliance with all of its requirements, personnel in voluntary organisations are not benefiting from general public sector pay restoration. A side effect of this is that many members are losing staff since the moratorium on recruitment was lifted, with people leaving for better paid jobs elsewhere. There is an issue of principal here – why is there a double standard for Section 38 (where pay is being restored) and Section 39 organisations? Government needs to provide for funding models that recognise the increased cost of personnel.

Reducing and providing for the "cost of compliance" and the need for streamlined reporting

11. While the administrative requirements associated with statutory funding are understood - on the face of it - to be necessary, they need to be streamlined as the aggregate effect of all the reporting and compliance requirements is a negative impact on the ability of organisations to carry out their core work. Funding needs to be included in all statutory allocations to support the "cost of compliance".
12. It is recognised that the problem isn't "the rules" in themselves but the cost that they represent to organisations in complying. It is understood that organisations entrusted with public funds should be expected to account for their financial performance – but that the cost of compliance should be provided for in statutory allocations.
13. There is a sense that "demonstrating value for money and minimising risk is all that things seem to be about now".

Need for prompt service agreement sign off

14. Re Service Level Agreements – for some organisations who have multiple Service Level Agreements there is a lot of reporting / paperwork / compliance / contracts to go through but often organisations find that the HSE doesn't "have its own affairs in order". There have been, quite frequently apparently, incidents where the HSE has not completed the sign-off of documentation, requiring funded organisations to sign agreements only partially completed by the HSE. It is felt that for the HSE to expect organisations to sign contracts without completing their own side is unreasonable.

Commissioning

15. Given the move towards a commissioning funding model – it was felt that it is important that there is consistency in the approach nationwide – and that it is not understood as an "instruction to put everything out to competitive tender". Guidance from DPER would be helpful in this regard
16. Even if commissioning is understood in a reasonable way, there is still a risk in it. But the way it has been understood in the past is that it's an invitation to tender. It was agreed that there is no point in avoiding the reality of the language and the use of the term commissioning – we need to explain clearly what we understand commissioning to be.

Concluding observations

17. Strongly felt by many that the relationship with HSE is just one of financial reporting – there is no real interest or collaboration about what we are doing, what the projects are etc. We just need to send in the papers for finances. It's not a collaboration.
    - Some felt that the sector was being abused by the HSE.
    - Felt that the sector needs The Wheel to be an honest broker between members and HSE. Request that The Wheel could bring umbrellas together to highlight the value of the sector and that perhaps the voluntary sector needs to become more political again.
    - All in all morale in the sector is felt to be very low at the moment – members wish to see these issues, and many, many more, addressed in a comprehensive strategy to support the community, voluntary and charity sector (ass committed to in the Programme for Government) in services
18. Where is the appreciation of the value of the voluntary sector relative to the alternative? Does the HSE see value in this sector and what's the alternative if they don't?

ENDS

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