

Introduction

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community.....at a cost that the community and country can afford to maintain.....in the spirit of self-reliance and self-determination..... It is the first level of contact of individuals, the family and community with the national health system – bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

..... health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.¹

The NGO sector is a major provider of public and personal primary health care in New Zealand. Its expertise and community reach ideally position it to assist the government to achieve better health outcomes for New Zealanders.

Non-government organisations (NGOs) receive significant funding (in the order of \$2 billion to \$4 billion per year [approximately 25% of the overall non-departmental health operating budget of \$12.8 billion]) from the Ministry of Health and district health boards². Many of these non-profits provide services to consumers and valuable contact at community level.

Health purchasing changes in the 1990s, aimed at improving competition and choice, led to a proliferation of providers. The NGO sector grew in response to complex needs of key population groups and to government policies and funding models. The introduction of primary health organisations (PHOs) in 2001 added further complexity. The sector is now at a crossroads, as government reforms aim to add value and efficiency at a time of fiscal restraint.

Greater co-ordination between **all** providers will deliver integrated primary health services that improve effectiveness and efficiency across health and disability services.

In July 2011, the Health and Disability NGO Working Group initiated a project to inform policy, and learn more about non-profit NGOs' collaborative approaches to primary health care delivery, by exploring their relationships with other health providers.

This report profiles 15 examples from around New Zealand and combines those insights with the findings of an online survey identifying common practices and experiences.

The full survey responses are available in a separate report on the Health and Disability NGO Working Group website: www.ngo.health.govt.nz.

¹ [Drawn up by the International Conference on Primary Health Care](#), Alma-Ata, USSR, WHO, 6-12 Sept 1978.

² Source: [Ministry of Health website](#) – accessed 10 May 2011.

Executive summary

Most primary health care services have traditionally been provided by GPs and practice nurses. New Zealand's *Primary Health Care Strategy*³ places a greater emphasis on the broader multi-disciplinary primary health care team – GPs, nurses, pharmacists, allied health professionals (including physiotherapists, dietitians, psychologists, counsellors and occupational therapists) and disability professionals – so people have direct access to a range of primary health care providers. Care continuity, co-ordination and integration are key components.

With technology advances and an increasing range of health services delivered in communities, concepts of primary health care in New Zealand are evolving to include a broader range of health and preventative services, including health education and promotion, counselling, disease prevention and screening.

Government acknowledges the significant contribution that community-based, non-profit NGOs⁴ make to health care in New Zealand:

*Non-government organisations have a long, well established record of contribution to New Zealand's health and disability service delivery. Health and disability NGOs include a wide range of organisations that provide flexible, responsive and innovative frontline service delivery. Diverse services are offered in primary care, mental health, personal health, and disability support services, and include kaupapa services, such as Māori and Pacific providers. Many of these providers/groups/organisations provide valuable input into the well-being of the community.*⁵

The majority of primary health funding, however, is channelled from the district health boards (DHBs) through 32 primary health organisations (PHOs), which are predominantly focused on GPs in general practices.

As a result, many aspects of primary health care function with little integration, co-ordination or collaboration with the community-based health and disability NGO sector. These silos of professional ownership and control complicate care pathways and miss opportunities to improve health outcomes and efficiency. This creates gaps in care, duplication and confusion for consumers and providers alike.

NGOs can add value to current primary health initiatives

While the *Better, Sooner, More Convenient* approach⁶ has resulted in some efficiencies, improved health outcomes, more collaboration and innovative approaches (some of which

³ [The Primary Health Care Strategy](#), Ministry of Health, Feb 2001.

⁴ [Johns Hopkins Centre for Civil Society Studies](#) identifies five key characteristics of community sector NGOs. They have some degree of internal organisational structure and non-compulsory membership, and are non-profit, separate from government and self-governing.

⁵ Source: [Ministry of Health website](#) – accessed 10 May 2011.

⁶ [Better Sooner, More Convenient Health Care in the Community](#), Ministry of Health, June 2011.

are profiled in this document) – the community-based NGO sector is often marginalised in planning and development discussions.

NGOs' experience delivering one-stop-shop health services and working with high need population groups would provide vital insight to those currently developing Integrated Family Health Centres, planning a wider range of care and support for patients and shifting some secondary care services to primary care. Dialogue with a broader range of NGOs is essential to avoid 'reinventing the wheel' and wasting resources.

The Health and Disability NGO Working Group suggests the greatest impact on health outcomes for individuals, whānau and health populations will arise from better integration and co-ordination of services **with** community-based NGOs.

Greater co-ordination between **all** providers, including NGOs, will deliver integrated primary health services that improve effectiveness and efficiency across health and disability services. Given the opportunity, community-based NGOs can help reduce acute demand pressures on hospitals by helping people better self-manage chronic conditions. NGOs' delivery of health education and promotion can also prevent illness and disease. The efficiencies in terms of dollar savings and improved health outcomes, through intentional service planning and co-ordination can exceed those made by sharing back office functions.

Barriers to greater effectiveness must be addressed

A range of factors limit the return on the investment in primary health sector NGOs. While some NGOs deliver services at peak performance – others are constrained by a lack of investment in capacity and capability building, onerous compliance practices or exclusion from health sector planning.

Barriers to providers forming collaborative relationships and delivering integrated services are time constraints (i.e. networking/relationship building is often not prioritised and is the first thing to suffer when resources are tight); and a lack of knowledge about who to engage with.

Community-based NGOs' capacity to collaborate is hampered by competitive funding models and multiple contracts that swallow precious resources – providers need time to develop relationships and the skills of their staff.

Concern about PHOs building their own capability, instead of using and resourcing existing NGOs is not new. Redirection of some funding from general practice to proven performers in the community sector would make a big difference, as it would address issues of influence, resourcing and reach currently constraining working relationships with other primary health providers.

A lack of communication is also an issue – exacerbated by high levels of recent changes of PHOs and within the Ministry of Health. Established relationships have been lost and many people in the sector do not know who to contact. Training is also a factor, especially for professionally trained staff who often have low awareness of the wider networks and resources offered outside the DHB provider arm.

Painting a picture of what NGOs offer

It is challenge for anyone, including DHBs and PHOs, to develop a comprehensive understanding of the breadth of experience and services that the NGO sector offers.

Ongoing and systematic effort is needed to address this knowledge gap and create a better-connected health service. Enhancement of portals and public databases like Webhealth could assist with this process.

The NGO health sector must also look at ways to make it easier for funders, planners and providers to discover what it can offer. While the sector's wide reach, diversity and difference are strengths, they are also challenges to anyone wanting to engage. If health planners and providers have a better understanding of the services and value delivered by other parts of the sector, such as NGOs, they are more likely to recognise the benefits of involving them.

The examples identified in this report illustrate how integrated health services involving NGOs can help lift taxpayers' return on investment in health – reducing the use of secondary and tertiary health services and encouraging personal responsibility for wellness. They also illustrate the challenges, battles and burdens community-based NGOs must overcome, just to be included.

NGOs have many years of experience working with high needs population groups. They are used to working from a community development model; they offer an extensive range of services including health promotion, clinical services, client and whānau support in homes and social support for a wide variety of health conditions. Some NGOs focus on specific issues (e.g. cancer or asthma) or particular populations of need (e.g. children) or particular communities of need (e.g. Māori providers).

This project identified a number of promising examples of collaboration and innovation – by PHOs, DHBs, general practices and NGOs, yet many were not known beyond the group or region involved. In many cases, such as IT projects like shared care records, it would seem beneficial for those tackling similar challenges to exchange ideas and resources – but innovation is often happening in isolation. Greater sharing of progress on new developments would do a lot to lift the mood of those working in the sector, who often expressed the view that 'X' should be happening, when in fact it already is somewhere else.

Commitment to involve NGOs needed for better results

New models of co-ordination and co-operation involving NGOs can potentially provide measurable health gains to disadvantaged populations by reconfiguring the shape and delivery of services in the primary health sector. NGOs can also add value beyond service delivery, models of care and care pathways – they can inform planning and development when given the opportunity.

Ongoing issues of equity and access to primary health services, as well as the appropriate mode of delivery to Māori as tangata whenua and Pacific groups have yet to be fully achieved, but the NGO sector clearly has better reach and connections into these communities than many other health providers.

Not just a 'health' issue

It is already recognised that social, cultural and economic factors are the main determinants of health – and the current health system has little control over these. Partnership with community-based NGOs, which already take a holistic, strengths-based, client-centred approach to their promotion and prevention work with individuals and families, can enable

early detection and treatment of chronic health conditions before they become critical and costly.

The Whānau Ora approach has been welcomed by many community providers and is making a difference to the way joined-up services are funded and delivered. Many other parts of the community health and social services sector are also working in this manner, but are still battling the multiple contracts and siloed focus of government agencies. A few fortunate ones (mainly social service agencies), have been offered a High Trust, Alliance or Integrated contract⁷, and the benefits of these joined-up funding mechanisms is clear.

Greater use of multi-party contracts with shared outcome measures and expectations would help to support integrated care pathways. Extension of the Whānau Ora funding model and Integrated/Alliance contracts approaches should be given high priority in 2012.

Promote and enhance people's natural supports

The Health and Disability NGO Working Group supports a primary health care philosophy that is centred on a person/whānau approach – not always automatically relying on medical models. The delivery of primary health care needs to be flexible, adaptable, appropriate and responsive to individuals, families and communities. NGO health and disability sector providers have experience working in this way and a willingness to collaborate with others in delivery of services.

The growing unregulated workforce in areas such as disability, mental health and aged care can also add value. Community support workers have rich relationships with people who use health services, but their input is often discounted by the professional workforce or not fully considered when planning care pathways.

Improved integration will require greater acknowledgement of the wide range of practitioners/professionals and funders that contribute to primary health care and a commitment to engage with the NGO sector. Building of relationships, collective understanding of each other's roles, and trust, will be vital to the development and success of any future primary health care models.

Ministry and DHB support for change is needed

Where meaningful collaboration does occur between different types of providers (e.g. PHOs and community NGOs, or between GPs and community NGOs), relationships have usually been formed through other activities or previous connections – a degree of trust, respect and 'being on the same wavelength' has been established. Ministry actions and processes could help this to happen more often. Similarly, DHB funders need to use their funding levers to encourage collaborative innovation and achieve shared health outcomes.

The Ministry of Health is well-positioned to help the sector to understand and navigate the raft of providers working in health. A range of databases and directories exist, but each has limitations and none has the complete range of detail that would prove useful to the sector – there is an opportunity to make this information more usefully available.

⁷ [High Trust](#) and [Integrated Contracts](#) are led by Family and Community Services in the Ministry of Social Development.

The NGO health sector recognises that money is tight and the Government is managing large deficits – so it must get better ‘bang for its buck’ from the money it is already investing. Greater certainty of funding, which covers the full cost of delivering specific services and relevant overhead costs, is needed by many well-performing community groups.

Government could maximise the effectiveness of NGOs in primary health and get better value for money by reducing the wasteful compliance burden. Standardise contracts, eliminate the culture of multiple audits, reduce the frequency and output-focus of reporting, increase the use of multi-party contracts and simplify the complexity created by government processes.

A sensible monitoring approach is already Government policy – it simply needs wider implementation so primary health NGOs can focus on value-adding tasks.

If we work differently, we can improve health outcomes

For all the difficulties experienced by NGOs within the primary health sector, wonderful things are being achieved – as the 15 case studies in this report show. They cover acute nursing services, health information services, virtual practices, youth one-stop-shops, community development approaches, mental health networks, cardiac rehabilitation, Whānau Ora and Asiasiga models of care, and more – from North to South.

Let’s celebrate these successes and work in partnership to make more happen. Together, we can achieve improved health outcomes and better value for money.

The full 96-page report
How NGOs Make a Difference to Health Care in the Community
was published by the Health and Disability NGO Working Group
in January 2012.

See www.ngo.health.govt.nz for more of the report.

Creating solutions – An invitation

As this report developed, several people asked “*but what are they going to do with it?*”

Clearly there was a fear this report would sit with others produced over the years, which have made little difference at the coalface or in key planning decisions. Change is vital. We hope this report goes some way to illustrating the added value that non-profit community NGOs can bring to health services and outcomes.

Collaborative activities deliver better value for money. If they are to become the norm rather than the exception, systemic changes are needed to enable greater uptake and removal of barriers. It will need the Ministry of Health, DHBs, PHOs, NGOs and other health providers to all adapt and make a commitment to change.

The Health and Disability NGO Working Group is keen to have conversations with Ministry staff, DHBs, PHOs and other funders and planners to explore what change is possible. It is up to us all to work together to identify the next steps and determine how we can make improvements. Health outcomes are not solely about health services, so we need to take a broad view of potential improvements.

As you read this report, various issues, ideas and approaches will resonate with you – we want to hear what you think will help deliver greater effectiveness and better health outcomes – especially for those with the greatest needs. Together we can identify ways to make further improvements. This is not about more money or power – it is about doing more with what we have and improving health outcomes by focusing on the activities that make a real difference.

Two areas stand out to us:

- If we can improve the understanding of how non-profit NGO health providers help to improve health outcomes, then other health providers and planners will recognise the benefits of working with community-based NGOs.
- If we extend joined-up funding models and reduce the purchasing and contracting compliance burden (including multiple audits), then more of the resources government currently invests in NGOs can be directed at frontline services. This will deliver better value for money and better results for no extra overall cost.

You may have other ideas. We are keen to hear them and partner with you to make them happen. The status quo will not meet any of our needs – especially those of the wider population, whose health and well-being is the focus of our collective work.

The government’s investment in NGOs, the Health and Disability NGO Working Group and the wider health sector must deliver results.

We are keen to hear from and meet with a range of stakeholders to talk about how things can be better. Together, we can show leadership and develop solutions that align to government priorities and allow us all to lift our game and operate at the top of our professions – to strengthen, extend and refocus first-contact care.

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