

## Key observations – factors that make a difference

The case studies revealed some well-developed collaborative abilities among a range of providers – many with years of refining these skills and putting them into practice. Some survey responses indicated less effective attempts at relationship building and referrals, but a number of factors were common to many situations.

Frequently these affected a provider's ability (or availability) to collaborate – but more often, they also impacted on their services, sometimes limiting improvements to health outcomes or delivery of personalised health care.

Some of the recurring concepts and issues are identified below.

### On the same page

While some agencies are clearly crying out for more funding for their services, there seems a general acceptance that the overall level of funding is limited and cannot continue to increase at the levels of recent years. The consensus of opinion seems to be that what money is available could be better spent – but there is a wide range of views on what is 'a better way'. The fragmentation of funding decisions was identified as a significant part of the problem.

It was also clear from interviews and responses that virtually all providers want the same results – better health outcomes for our communities. This is a key driver of collaboration when it happens – bringing diverse providers together to achieve a common goal. Most also recognise that prevention is better and cheaper (in the long run) than treatment or cure.

### Willing and passionate workforce

People working in health-related services want the best outcomes for their patients/clients/consumers. Many go the extra mile to make sure individuals, families or whole population groups get the services they require. Many examples of collaboration in the online survey were one-off attempts to help a particular person.

This workforce resource is a huge asset, but many feel the system is working against them – they are desperate to help make things better.

### Fertile ground

There is an expressed willingness to work in collaboration with others and many can see the value in such approaches, but it seems some people's ideas of collaboration are different from others.

Some seem to have a 'take it or leave it' approach with little room for negotiation or identification of shared goals, while others exacerbate power imbalances by telling providers "you should come under us". A commitment to work in a more inclusive and collaborative manner will bring many benefits.

### **Relationships take time and effort**

While much feedback indicated that people recognise the need to have different relationships for different purposes, they struggled to find time to develop these or investigate new, potentially-beneficial relationships. Some struggle under management styles that don't value or prioritise this, but more cite resourcing as a hurdle.

Prior relationships had a significant bearing on successfully initiating collaborative activities. Even when these were not well-developed links, some type of connection proved more effective than a 'cold call' approach.

### **Silos of excellence**

There are many innovative approaches being put in place throughout the country, but few people seem to know about them. Even those involved in something new were often unaware of similar developments in other parts of the country – thinking they were the only ones working in that way. This seems most apparent in the IT area, where various approaches to shared care records are in progress.

With its broad reach, the Ministry has potential to be aware of new initiatives and could do more to promote these within the health sector and facilitate sharing of ideas between similar projects around the country. There is significant scope to celebrate and promote information associated with collaborative best practice.

### **One of us?**

All NGOs are not created equal. The 32 primary health organisations (PHOs) are all non-profit NGOs and some respondents' comments implied that when they talked about working with NGOs, this was the extent of their relationships. Other GP networks, such as Pegasus Health in Christchurch, are also charitable bodies – yet many in the broader community and voluntary sector view them as privileged and 'not one of us'.

These clear differences in power, resourcing and priorities present huge challenges to effective collaboration across the entire health sector. Some re-balancing of these inequities may be necessary, together with a few changes in attitude by 'traditional' NGOs.

### **Rapid change presents challenges**

Many in the sector are overwhelmed by recent structural and process changes resulting from amalgamation of PHOs and changes within the Ministry. People do not know who they should be negotiating relationships with and many provincial providers are feeling isolated from the 'seat of power'. National providers are equally disoriented, as the role of a PHO in one region can be drastically different from that in another. Targeted information is needed to fill these gaps.

### **Confusing complexity**

As people described contractual relationships or how they funded a service to a patient/client, it seemed unnecessarily complicated. Providers talked of having a contract with a DHB, through a PHO, via a charitable trust and being subcontracted for part of one service or another. Others described how they may be funded by a Ministry contract to see

a patient, but then providing counselling to that patient is through a PHO contract and to give a vaccination would be on a fee-for-service basis to the DHB.

Where multiple providers wanted to deliver an integrated service, they had established yet another entity, which could subcontract parts of the services to various parties, while other parts of the complete service package were funded via direct contract. Managing this complexity must be a drain on both funders and providers.

Equally confounding were the different bodies, layers, and entities in the health system itself. People described maintaining complex relationships with multiple people from 'X' board and 'Y' group' and 'Z' team and 'A' unit, and 'B' directorate, etc, before it became clear that all these relationships were within the Ministry, DHB and PHO triumvirate. No wonder no-one has time or energy to build broader relationships with other primary health care stakeholders.

For general practices, PHOs and others, the community-based NGO sector seemed as much a mystery – although often due to a complete lack of knowledge or information about NGOs, rather than confusion about which was which.

### **New and emerging roles**

This sector complexity also impacts on patients and clients, which is evident in the increasing use of 'navigators' or co-ordinators to help people access the services and supports they need.

Navigators are just one example of new and emerging roles coming out of old disciplines, as people in the sector develop different ways of doing things.

### **The great unknown**

Many in the health sector have little idea of the size and scope of the health and disability NGO sector. They struggle to have any understanding of what NGOs are present in their communities or what services they provide – and have no idea how to find out. This is sometimes given as a reason for exclusion from projects. An alternative excuse is that there are "too many" NGOs and they don't know which one to ask.

Others, such as PHOs, want a deeper level of information, including details of what services various NGOs are contracted to provide – so they know who to work with on what.

There is a range of online databases and directories that list NGOs and health providers, yet many in the sector seem unaware of them. Each has a different level of information, while some are quite similar. Their coverage of geographical areas and provider types varies.

They include: [Healthpoint](#), [Healthpages](#), [Health Connection](#), [Webhealth](#), [Right Service Right Time](#), [Family Services Directory](#), [Contract Mapping](#), the [Charities Register](#) and others.

While many appeal to different target audiences, none of them provides the depth of knowledge and comprehensive coverage that some users, such as PHO purchasers, are seeking. The resource involved (from both directory staff and providers) in maintaining this information is not insignificant, while users face a complex choice of options.

An opportunity exists to bring directory/database service personnel together to discuss options for streamlining the maintenance of provider data through integration, co-operation or data mash-ups.<sup>1</sup>

### **Look more broadly at peripheral supports**

Populations with the greatest health need face some of the biggest barriers to accessing services. They include the elderly, those with childcare issues, low income workers, people without transport, etc.

Community shuttle services, such as Linking Hands in Northland, help people in remote communities to access services. Their largely hidden contribution improves the numbers of people who turn up for GP, specialist and hospital appointments, or follow through on GP-directed exercise programmes.

In high demand areas where people have to wait for appointments or travel long distances, NGOs already have good linkages and can offer local solutions to reduce access barriers. Yet they struggle to survive, because their services do not fit most existing government funding criteria – each department sees them as someone else’s responsibility.

There is a need to recognise the community interventions that help people access health services and support them accordingly.

### **Regional inequities**

NGOs that provide services across more than one DHB region are best able to describe the vast differences and inconsistencies that exist. Examples were given of innovative new services introduced in one area and getting great results for patients/clients, but they cannot be extended further because of the different financial circumstances or priorities of other DHBs.

These disparities in patient access are partly attributable to the ‘customised solutions responsive to local communities’ approach which, while appropriate in some circumstances, is not desirable for all.

This is not an equitable way to deliver services. There is a need to look for fairer approaches and consistent processes across the country – so people in the same situations get treated equally.

### **Hard-to-reach communities are engaged**

Community-based NGOs are often working with this country’s most vulnerable populations – the ones with the worst health outcomes and high mortality rates. Many NGOs are deeply embedded in these communities and strong connections exist between individuals/whānau and their NGO health workers. The people who most need help are often already engaged with these NGOs, so it makes little sense to try and attract those people elsewhere. Wise funders put the resources where the people are.

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<sup>1</sup> [A beginner’s guide to data mash-ups](#), Digital NZ – a unit of the National Library of NZ, Department of Internal Affairs, 2011.

In addition to delivering health services, many NGOs respond to clients' needs and reduce inequalities by providing information, support, advocacy and education.

Because many of these population groups face multiple challenges – social, economic, educational – the NGOs working with them are already skilled at working in multi-disciplinary teams and are well-networked with other providers in these fields to deliver a seamless, holistic, client-centred service. These integrated approaches need funding models that match, as many NGOs involved in health are also funded by the Ministries of Social Development, Education and Justice.

### **Medical models prevail**

The general practice focus of PHOs is frustrating for many in the NGO sector – especially given the need to encourage prevention of ill-health and promotion of healthy lifestyles. Most people see a doctor when they are sick – they want to talk to others about well-being and staying healthy. Rather than focusing on illness, an approach to maintain well-being is preferred by many when supporting people with chronic conditions. Opportunities exist for NGOs to play a key role in co-ordination of services to help alleviate pressure on a limited GP workforce – but system changes are needed to help this to happen.

While examples were given of GPs who work well with other service providers and make referrals – many are too busy to even learn what other services are available, or see some NGOs as competition. The current capitation model exacerbates this problem and is a frustration to many community-based NGOs.

There is a need to rebalance the *Primary Health Care Strategy* and reframe relationships in a more collaborative manner to involve a broader range of stakeholders from the primary health care sector.<sup>2</sup> Clinical leadership is appropriate for clinical projects/issues, but many of the challenges in primary health require a broader range of views and input. Many of the clinical tools and processes are used by others too, so working group memberships need to 'mix it up a bit' and include other voices.

### **“Talk to us”**

Rolling over contracts or last-minute contract negotiations stifle innovation and mean opportunities for improvements are often missed. Many NGOs have evidence-based examples of how things can work more effectively, but they struggle to get Ministry or DHB funding and planning staff to engage with them.

Interestingly, NGOs are not the only ones who feel excluded from direction-setting and planning – survey responses show pharmacists, physiotherapists, nurses, mental health consumers and others have the feeling that no-one with influence will listen to them.

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<sup>2</sup> [Critical Analysis of the Implementation of the Primary Health Care Strategy Implementation and Framing of Issues for the Next Phase](#), J. Smith, Nuffield Trust for the Ministry of Health, March 2009.

## **Cost pressures**

The fragility of NGOs due to funding constraints is noticed by more than just the NGO sector – with a variety of providers observing that many operate on the ‘smell of an oily rag’. The lack of inflation-adjusted contract payments places additional pressure on non-profits, which must then tighten their belts further – inevitably impacting on their ability to collaborate with other providers.

For the 2011-12 year, the government is giving all DHBs 1.72% to allow for additional cost pressures, but in June 2011 Platform and the Home Health Association publicly questioned<sup>3</sup> how many will actually pass this on to providers. This lack of flow through was noted by various case study interviewees. Many said it had been years since any CPI increases had been passed on to them, meaning their already tight budgets must absorb ever-increasing costs.

## **Bureaucracy burden**

Funding-related administrative and reporting procedures are perhaps the biggest constraint on greater collaboration and service integration. For many, the burden of output reporting is getting worse – not better – and often these are proven providers with good reputations for effectiveness and quality. The variety of timeframes, different reporting requirements, constant negotiation of numerous short-term contracts, ad hoc changes and multiple audits are a drain on resources – wasting the money government has provided to deliver services. (It is likely a comparable burden on the public service too.)

High Trust contracting, Whānau Ora, Alliance contracting and Integrated contracts are welcome attempts to reduce this burden and support service delivery, but their implementation has been slow and few in the health sector have benefited – despite the fact many have contracts with multiple government agencies.

As a result, ‘servicing the master’ takes the focus away from delivering frontline services and achieving better health outcomes.

Joined-up and flexible funding mechanisms can be used to encourage more collaboration and innovation. Together with performance frameworks that assure value for money and quality of care, streamlined funding models will deliver real efficiencies – potentially reducing the cost of access to services.

## **Old news – but little improvement**

Most of these issues and observations are not a surprise as many have been identified before – yet community-based NGOs<sup>4</sup> are still left out of much of the discourse on health care planning.

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<sup>3</sup> [Welcome to our world](#), media release from NZ Home Health Assn & Platform, 3 June 2011.

<sup>4</sup> [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. The NGO Working Group’s 2010 report [The NGO Sector Role: A Key Contributor to New Zealand’s Health and Disability Services](#) features descriptions of NGOs and background on the non-profit NGO sector.

The Health and Disability Working Group's March 2008 summary discussion paper<sup>5</sup> for the Minister of Health identified that the NGO sector offers the following key characteristics.

*The NGO sector:*

- *is experienced in working in communities*
- *is client-centred and offers clients choice*
- *can be innovative and creative*
- *provides a range of services*
- *is more likely to support clients across the continuum of well-being, rather than take an episodic approach.*
- *is experienced in collaboration*
- *employs holistic approaches*
- *works across the health sector and inter-sectorally*
- *provides value for money*
- *facilitates access to primary care and entitlements*
- *is experienced in management of populations with chronic conditions*
- *traverses communities locally, nationally and regionally.*

That discussion paper also states:

*In some areas, PHOs are building their own capability, when it would be more effective and cost efficient to utilise the capability already existing in NGOs (and particularly so in a tight labour market). The NGO sector is experienced in working in primary support and health promotion contexts, and is well-positioned to promote the full implementation of the primary health strategy and play a more influential role.*

These benefits of working with the NGO sector still exist, but NGOs remain on the periphery, or excluded completely, from service delivery or key planning discussions and bodies – with few exceptions. Strong leadership and changes to purchasing and contracting processes that incentivise broader collaboration will help new approaches to service delivery and health promotion evolve.

In the spirit of *Kia Tutahi Standing Together*<sup>6</sup>, now is the time to develop a deeper partnership with the health and disability NGO sector to improve the health outcomes of all New Zealanders. As the *Kia Tutahi* Steering Group's report states:

*When government and community work well together, we all benefit.*

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<sup>5</sup> [Enhancing engagement with NGOs: Summary discussion paper for the Minister of Health](#), NGO Working Group, March 2008.

<sup>6</sup> [Kia Tutahi Standing Together: The Relationship Accord between the Communities of Aotearoa New Zealand and the Government of New Zealand](#), August 2011.

## 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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