

## Online survey insights

A total of 364 responses to an online survey were received between 18 July and 22 August 2011. These included 223 from non-profit organisations, 39 from commercial operations, 69 from consumer/client groups and 44 from government agencies.

The 364 survey respondents held a broad range of roles in a variety of different types of organisations covering all DHB regions. The majority were non-profit organisations and/or primary health providers, but those from peripheral services also replied and are included to provide a broader picture of interactions and linkages. (A detailed breakdown of respondents is provided in the separate [Online Survey Responses report](#).)

As expected, the levels of collaboration between non-profit NGOs are much higher than those between non-profits and general practice, or between non-profits and PHOs.

Many of the challenges non-profits face in engaging and collaborating with others are mirrored in the comments from commercial health providers (e.g. pharmacies) and government bodies.

While many factors hindered greater service integration, some attempts to collaborate and communicate with different providers seemed under-developed and ineffective as a consequence.

### Relationships with GPs, medical centres and PHOs

It was difficult to identify any particular trends in engagement between PHOs, non-profit NGOs and medical centres across the country or in any particular health fields. Perhaps, the overall responses on this topic can best be summed up in these two comments:

*[The] situation is so different for each area, with no pattern as to why one PHO will be proactive and another disinterested. There is not a strong sense across the country that PHOs are actively engaged in the provider contracts – for this to be more equitable will require direction from DHB/Ministry.*

*We would welcome with open arms the opportunity to work collaboratively with PHOs, GPs and medical centres. Our philosophy is that we each have areas of strength and working together could ensure that more families/people in the community receive a more holistic level of care, as we each contribute our part and work together – as opposed to separately.*

Many respondents did not make any distinction between general practices and PHOs, whereas others clearly saw the different roles each has.

Connections between non-profits and GP/medical centres and PHOs are often at the linkage/referral level, rather than more in-depth service co-ordination or integration. Practice nurses are a vital link in generating referrals from GPs.

For every positive comment about PHOs, medical practices and non-profit health providers working together, there were examples where communication and co-operation do not happen. Reasons for this included:

- A lack of time
- Perceived sense of competition
- A lack of understanding of what non-profits could deliver
- An overly clinical approach to wellness and primary health care
- Too much change in the system – resulting in broken connections and changes of personnel
- Constraints on funding – where criteria seemed to prevent co-operation or new approaches. (In some cases, it was probably a lack of awareness that funding was available to support new approaches that was the barrier, rather than a lack of funding per se.)

Difficulties engaging with GPs or PHOs were expressed in these ways:

*We believe that our role in primary health is not adequately understood.*

*The familiarity of PHOs with our work varies from excellent to poor.*

*We have attempted to work with the PHOs, however we have found that they duplicate the functions that are already happening in the community, rather than work with the community.*

*Our observation is that PHOs keep clients within their own systems and GPs don't refer out to community-based experts.*

*We would value the opportunity to work with our local PHOs, but all attempts to date have not been responded to.*

*We have limited interaction with GP medical centres, not from want of trying on our behalf.*

*The doctors should have the charge of being a doctor. From what I have seen the changes are not being felt in the community.*

*Requests for information tend to be one-way, (i.e. from me to the practices.....) GPs [are] not always willing to accept information from other health providers to improve the care that a client is getting. GPs usually willing to furnish details requested about clients.*

External issues and other barriers sometimes get in the way:

*We have a problem that we work with a DHB and many different PHOs, and they do not get on – in fact, they are almost competitive with each other.*

*We often find that the definition of health promotion within primary care quite limited.*

There is a lack of understanding about the role of PHOs and even some provider member GP medical centres struggle to get to grips with PHO changes. In some cases, amalgamation has reduced opportunities for collaboration:

*Since the combining of PHOs, we have not had the same amount of contact with them and it appears that small community initiatives no longer happen with NGOs such as us. This is disappointing.*

*We don't feel we have certainty, status or fairness sometimes.*

*There has definitely been a loss of respect, trust and perceived level of support since the merger. What was once a welcoming office is now a skeleton of its former self. I have no idea who to call/contact if I have questions, need clinical guidance or support, have suggestions or complaints.*

*More education about PHOs, who they are, what they do – why they exist, how they differ from other groups – is it merely their funding sources that defines their difference to other NGOs?*

People identified a need for more communication from PHOs and DHBs too:

*Communicating, collaborating or having any meaningful contact is challenging as it is difficult to understand their structures, hierarchy and who the right person to link with is.*

*.....there does appear to be a lack of clarity re who is actually providing what, how to access these providers, what their criteria is etc. As a clinician on the ground, this becomes very confusing and often leads to disengagement and a 'do-it-yourself' attitude. Greater transparency around these issues would enable services to work better together.*

*It would be helpful if there were one place we could go to, to communicate with all PHOs at one time.*

Many recognise the importance of resourcing and prioritising relationships and collaboration:

*A co-ordinator of collaboration is key to our working together effectively, as is the building of relationships.*

*The PHO-NGO partnership needs to be encouraged and resources invested to help this happen. Many NGOs are now staffed with professional, competent people who deliver an important service in the community. This work has value, needs to be recognised and supported, along with the work done through the PHO.*

*Key relationships are important for getting the best results for our clients and the sector as a whole. Often who you know provides significant leverage in terms of getting results and/or addressing serious client needs promptly.*

*There is huge value for anyone involved in all help services to learn to network with all NGOs and PHOs in all areas as this can only benefit the consumers.*

*Future changes we would recommend to PHOs are:*

- i) nominate and make accessible a person/contact specifically for NGOs to discuss possible collaboration*
- ii) be willing to work collaboratively including joint applications for funding etc*
- iii) acknowledge the value of NGO support for patients, particularly in managing chronic health conditions and make referrals sooner rather than later.*

*Managers insisting these relationships are an important piece and need ongoing work to manage/maintain.*

A main driver of collaboration that does happen seems to be responses to a specific patient need – where an individual or a provider does everything possible to ensure a person or family get the care they require.

Few examples of systematic collaborative processes involving non-profit health providers working with PHOs or GPs were given. Examples where the non-profit played an integral part in the collaborative pathway seemed mostly one-off. Where a more systemised collaborative approach was taken around a key health issue (e.g. diabetes), the NGO provider seemed on the periphery or brought in as an addition once ‘the system’ had been established. Given the size and scope of the non-profit health sector’s range of primary health care services, this is not desirable.

The case study examples profiled in the latter part of this report show there are places where the broader primary health care sector has recognised the vital contribution non-profit health providers can play in an integrated delivery model.

### **NGO connections and other relationships**

Extensive, wide-reaching networks and connections are evident from analysis of individual responses:

*Because we work in management of a chronic condition, this takes a team approach – the more connected the members of the team are, the better supported is the client – similar messages and the valuing of all team roles.*

*Our relationships and collaboration all has one focus in mind: To assist referrers, providers and all users of the health systems in our region to navigate quickly and efficiently from one service or health professional to another – to ensure timely, appropriate services are put in place for clients.*

*One relationship that is important to us is with our local DHB. In our situation they provide a small amount of our funding, but they are also a good source of referrals for us – as we are to them. The relationship has evolved to the stage that we are invited to participate in the discussion and development of new initiatives and there is a more collaborative approach being embarked upon, as we recognise that partnership is the way to continue our service provision to a wider range and number of people on a limited budget.*

But there are still challenges:

*Well-built relationships are breaking down due to restructuring and re-jigging of certain services (such as the community nurse role).*

The desire for a more community-based, family-centred model of care is a common theme throughout many comments – emphasising the importance many NGO providers place on building links with social service agencies, education providers and other supports beyond pure health services. Comments indicate comprehensive understanding of patient’s/consumer’s/client’s life challenges and broader issues that may compromise their health and/or well-being.

*There is no point in expecting many of our patients to come into surgery or clinic – many won’t. Even when they do – people can pull themselves together very*

*well for a few minutes. GPs only get to learn of whatever the patient chooses to share with them. By establishing rapport with the patient and family/whānau in their own real messy world, we can identify change and proactively manage these patients – avoiding wasting valuable secondary level resources.*

*.....for the most part I don't yet see significantly more integrated models of care. What I do see are some specific programmes (e.g. Green Prescription, Smoking Cessation) that are funded by the PHO, but our clients are not asking for those and thus not engaging with them. Yes they realise they are overweight and that smoking is not good for them, but they are too overwhelmed by other life crises (e.g. family violence, other relationship breakdowns, extreme financial stress, urgent housing needs, addictions) to have the energy to get on board with healthier diet and exercise.*

Opportunities for extension of a Whānau Ora approach also exist:

*Support worker feedback indicates that the primary health care provided by Whānau Ora and Pasific centres are more person-centred and cost effective than services provided by mainstream PHOs.*

### **Making a difference**

A wide range of sometimes contradictory suggestions and ideas were identified by respondents. A read of [pages 86 to 107 in the Online Survey Responses report](#) is suggested for researchers and planners, as all the ideas cannot be adequately captured in summary.

The following quotes give a flavour of the issues and suggestions:

*Better communications – especially from GPs and their nurses. Openness to other models of care or wellness.*

*The DHB remains unclear on its strategy to support collaborative and integrative relationships in the primary setting.*

*Fragmentation of mental health services in Auckland is a big problem – with PHOs, DBHs, contracted NGOs, voluntary sector and private sector all offering services with different funding and criteria – very complex even for people working in the field to navigate and get clients to the right service.*

*One thing that pushes fragmentation is the funding process.....[we need] an over-arching body, which could put more rationale into funding decisions to drive better collaboration.....my own view is that there is a lot, and I mean a LOT of money swishing about, but it is poorly directed and not well-used.*

*The health system is complicated and getting more complicated all the time. Different funding streams, repositories of information, services, criteria, etc, etc. It is impossible for health professionals to be aware or have up-to-date knowledge of all of these factors.*

*A streamlined way to access information about how we can contribute to other primary health care providers' models of care and support to do this would enhance our ability to work together.*

*If we had a single liaison person who understood exactly what we could offer and could then help us link into current projects, we would be well-placed to contribute more effectively.*

*..... incorporate a stronger psychosocial model into primary health care; particularly for mental health, where social indicators have such a weight on consumer well-being.*

*[Need] time and resources to really develop good working relationships between agencies, not just individuals.*

*.....most of the effective collaborative work I have achieved in the community has been because of the enthusiasm and commitment of a handful of key people wanting to make things happen.*

*More support and funding needs to be given to the development of advanced nursing roles across all primary care settings.....we need to make better use of our GPs, and develop innovative ways of supporting the services they provide.*

*Removal of the business structures that separate secondary and primary, and a joint way forward with all professional groups included, where the dominant discourse is client and family access and not a medical model.*

*The \$\$ that are available for primary care could be used much more effectively if less 'red tape' were involved and the need to 'pilot' new services was stopped. When something has proved successful in other areas, I can't see why the whole project plan and pilot needs to be re-developed in each area.*

*We are limited not by our imagination, drive or ability, but by the financial resource to deliver services.*

*Shared vision for consumer/client, not for organisation.*

Many comments throughout the responses express disappointment and frustration that those involved on the frontline and in the community are not involved in planning and discussion of issues as they would like to be. Often their knowledge seemed unappreciated, unacknowledged and unfunded. This is perhaps best summed up by this comment:

*Some of the solutions are so bloody basic...and yet apparently so bloody 'invisible' to those who make all the decisions!*

### **Any major differences between sectors?**

Interestingly, the challenges that non-profit NGOs face in building collaborative relationships with GPs/medical centres and PHOs, and working within the system generally, were echoed by the government bodies and commercial providers that responded to the survey.

In the main, their responses to various questions mirrored the trends of the wider group. One exception was referral levels to non-profits health providers, where non-profits showed significantly higher levels of referrals to these, than did the commercial or government providers. Government providers received a much larger level of referrals from GPs/medical centres. Commercial providers had initiated contact with PHOs at almost double the average rate, yet did not appear to have stronger relationships/referrals than the average.

## The PHO view

A separate online survey was sent to the 32 primary health organisations, but only 11 completed this and sometimes the people doing so were not the most informed about the PHO approach to collaboration.

However, the following comments from PHO responses show much in common with the views in the broader survey....

.....on both the issues:

*Often services are delivered in isolation with little thought on how another service could integrate with the current model or service.*

*Poor take up of programmes delivered through traditional general practice approaches.*

*Often the conversation is too focused around funding for a single/narrow issue. Real value comes from contribution to strategic planning.*

*The weak link sometimes occurs when a relationship has been established and the person resigns – it takes a good 6/12 months before the contact is re-instated.*

.....and the solutions:

*When planning services to be delivered to identified communities and populations, it will be in the interest of all to get all stakeholders around the table to ensure all parties are able to contribute and work in a smoother flow (collaboratively).*

*Having co-ordinated funding streams to minimise duplication.*

*More flexible funding would help both parties.*

*Offering flexible funding to other providers when we can make the bureaucracy (usually DHB or MoH) easier for smaller providers.*

*DHBs not delivering services better provided by NGOs and PHOs.*

*Audit procedures should catch up with collaborative approach and auditors share information instead of duplicating effort for no added value.*

*Better co-ordinated care pathways/intervention models that all agencies agree on and commit to.*

*Common philosophies. Shared values. Strong relationships based on trust, integrity and long-term goals.*

*Planning services around the clients, with a recognition that this may mean doing things differently with existing funding.*

Pleasingly, 89% of PHO respondents had sought NGO input to service planning and direction-setting, with the same level stating that they'd gained real value from this.

## **A wealth of ideas in the survey comments**

Many respondents took the opportunity to share ideas and suggest a raft of changes for health issues – far beyond just working together.

Browsing the responses [in the Online Survey Responses report](#) is recommended for many working in health – especially in the following areas: Irlen Syndrome, diabetes, asthma, dialysis, cardiovascular disease, stroke, mental health issues, cancer, pharmacy, podiatry, youth health, Māori health and health services for Pacific people or older people.

## **Response breakdowns or analysis**

If you think it may be useful to analyse online responses from a certain type of provider or region, please contact the NGO Secretariat at [secretariat@ngo.health.govt.nz](mailto:secretariat@ngo.health.govt.nz) or phone 04 233 0178. The NGO Secretariat will endeavour to provide this where possible. (No identifying details will be provided without permission.)

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](http://www.ngo.health.govt.nz) for more of the report.

The report illustrates how the NGO sector is a major provider of public and personal primary health care in New Zealand. It profiles 15 case studies of non-profit NGOs' relationships with other health providers and their collaborative approaches to primary health care delivery. It also features insights from a 2011 online survey identifying common practices and experiences.

While the *Better, Sooner, More Convenient* approach has resulted in some progress, many aspects of primary health care function with little integration, co-ordination or collaboration with the community-based health and disability NGO sector.

It is up to a range of primary health stakeholders to identify next steps and determine how collectively, we can be more effective across the health sector. The Health and Disability NGO Working Group is keen to work with Ministry of Health staff, DHBs, PHOs and other funders and planners to explore what change is possible in order to improve outcomes.

*The Health & Disability NGO Working Group*

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