



Collaboration in Primary Health Care

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# How NGOs MAKE A DIFFERENCE TO HEALTH CARE IN THE COMMUNITY

*Exploring ways non-profit NGOs help New Zealanders become healthier  
by using their relationships, connections  
and innovative models of care  
– and what gets in the way.*

**A report prepared on behalf of the  
Health and Disability NGO Working Group**

**January 2012**

## For discussion

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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.

The Health and Disability NGO Working Group is keen to have conversations with Ministry of Health staff, DHBs, PHOs and other funders and planners to explore what change is possible. It is up to a range of primary health stakeholders to work together to identify next steps and determine how we can make improvements.

The government's investment in NGOs, the Health and Disability NGO Working Group and the wider health sector must deliver results. Efficient use of taxpayer dollars is a priority and better value for money can be achieved through greater collaboration and streamlining systems. Health outcomes are not solely about health services, so we need to take a broad view of potential improvements.

Together we can identify how to do more with what we have and improve health outcomes by focusing on the activities that make a real difference.

We are keen to hear from and meet with a range of stakeholders to talk about how things can be better.

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## 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.<sup>1</sup>*

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 boards<sup>2</sup>. 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](http://www.ngo.health.govt.nz).

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

<sup>2</sup> 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*<sup>3</sup> 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 NGOs<sup>4</sup> 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.*<sup>5</sup>

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.

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

<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.

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

## **NGOs can add value to current primary health initiatives**

While the *Better, Sooner, More Convenient* approach<sup>6</sup> has resulted in some efficiencies, improved health outcomes, more collaboration and innovative approaches (some of which 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

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<sup>6</sup> [\*Better Sooner, More Convenient Health Care in the Community\*](#), Ministry of Health, June 2011.

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 contract<sup>7</sup>, 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

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

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.

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.

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## 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>8</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>8</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>9</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>9</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>10</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>11</sup> are still left out of much of the discourse on health care planning.

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<sup>10</sup> [Welcome to our world](#), media release from NZ Home Health Assn & Platform, 3 June 2011.

<sup>11</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>12</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>13</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>12</sup> [\*Enhancing engagement with NGOs: Summary discussion paper for the Minister of Health\*](#), NGO Working Group, March 2008.

<sup>13</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.

*The Health & Disability NGO Working Group*

## 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.)

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## Snapshots of reality – Working examples

The following profiles are grounded in reality – illustrating the daily challenges of working in the community-based health and disability sector. They feature a range of NGOs working collaboratively in different primary health fields and locations. They describe their experiences working with other primary health care providers (such as PHOs and GPs) to improve the delivery of integrated primary health care services. In some instances, the NGOs initiated the collaborative initiative; in the rest they responded to approaches from others. Examples include some collaboration in planning and development – not only in delivery of services.

As this project progressed, a lack of widespread understanding about what NGOs do emerged – with some people perceiving them simply as a group of well-meaning volunteers. While some NGOs in the wider community and voluntary sector do fit this description – most in health are professionally-led services – some employing large numbers of GPs, nurses and other health professionals, as well as a significant non-regulated workforce.

The case studies help build a picture of the non-profit sector by describing what some NGOs do. The examples are not intended to be representative of a sector or region, but simply a sampling of what is happening in community health care in New Zealand.

Where possible, participants have attempted to focus on identifying what works, what factors play a key role in success and what gets in the way. They also build a picture of the range of NGOs and the diversity of services they provide to improve health outcomes – often for our most high needs populations.

Due to their commitment and passion for improving the health of New Zealanders, many of those interviewed shared a range of ideas on how things could be done better in primary health – beyond simply talking about collaboration – and gave examples of how the system is working against them at present.

Most of the non-profits featured perform a range of roles and services. The examples are not intended to encapsulate all they do, but simply illustrate their varied roles and the contributions NGOs make when included in the discussion or delivery of care.

A recent Platform NgOIT project<sup>14</sup> categorises collaboration into three areas: Linkage, co-ordination and integration. For consistency, we have used a similar approach to capture the level of collaboration in our case studies. No one type of collaboration is better than another and the examples provided show how effective any attempts at working together can be.

You can gain an appreciation of the issues faced by NGOs and the contributions they make, by reading a few of the following case studies. We hope you will be inspired by them and share them with others working in New Zealand's health sector.

The case studies are:

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<sup>14</sup> [\*Towards integration: Building an integrated primary mental health and addiction service\*](#), NgOIT, Platform Charitable Trust, 2012.

**Case study 1: Team-based acute service helps patients avoid hospital**

In Canterbury, registered nurses from a non-profit NGO health provider and a general practice network are virtually interchangeable – thanks to the comprehensive training, professionalism and service standards common to both.

*Our organisations have learnt how to work together and we better understand and respect each other's different skill sets. It's built stronger connections between GPs and district nursing, and the community now has a large pool of community nurses with high skill levels.*

**Case study 2: Team gains neutral leadership from non-profit's persistence**

The dogged determination of the chief executive of a northern NGO led to him chairing a service-improvement committee he initially wasn't even invited to join.

*There was no deliberate strategy to involve or not involve NGOs – we just targeted those we knew.*

**Case study 3: NGO's reputation brings expanded role**

A trusted, national non-profit NGO was the “most natural partner” to work with according to the CEO of a health network developing new models of care in the Midland region.

*We had a good vision, and they had a good vision and we came together through a similar recognition of the issues. You've got two organisations that have fully recognised that the additional funding into health over recent years cannot be sustained. We need to be innovative and find new ways of doing things.*

**Case study 4: A synchronisation of mindset and priorities**

Four non-profit providers of mental health support services in different parts of New Zealand have come together to share ideas and resources to increase their effectiveness.

*We are like-minded people from like-minded organisations. We see there are huge opportunities to make use of resources that are available in the community – and developing that capacity further.*

**Case study 5: New tool helps NGO get better GP services for disabled people**

With initial support from a DHB, a non-profit service for people with disabilities has introduced an annual evidence-based assessment tool from Australia into New Zealand general practices.

*When you're getting great feedback or support from one funder about a proven tool or service that works, it can be incredibly frustrating when you can't offer it to all your people because of DHB differences in attitudes and priorities. The inequity of 'healthcare by postcode' is huge and processes need to be streamlined or be given direction from the Ministry when health disparities result from DHB and PHO indifference.*

**Case study 6: Non-profit NGO delivers convenient health care**

Recognising that many people in high needs areas get the health care they need only if you make it easy for them, an Auckland non-profit NGO brings related services together for greater effectiveness.

*Ideally, we should have one DHB in Auckland now that we have one Super City. People don't know the rules about where the boundaries are – they go to the closest or most convenient. You can't deal with just one of their issues, as they are interconnected. Money and resources would be more effectively used if diverted to primary health care services and non-profit providers.*

**Case study 7: Māori working for Māori – with support from others**

Collaboration is vital for a whānau ora approach to primary health services – and so is respect for professional integrity and skill.

*It would be useful for 'the helping professions' to see the whānau as the 'experts' and work alongside them to develop their strengths and realise their own aspirations.*

**Case study 8: The importance of a supportive champion**

With support from the local DHB and PHO, a non-profit's online health directory developed content to emphasise regional health priorities in Canterbury.

*Our bread and butter is NGOs – it's all about community development. We start with two points in mind. The first is that most things that have an impact on people's health – the health system has no control over. And if we want people to get well, we need to make sure we link them to other things like health NGOs, churches and social services.*

**Case study 9: Connecting with the community**

A non-profit Pacific health provider involves its local Pacific communities in the planning and delivery of many of its health promotion activities – generating community buy-in and large attendances in the process.

*Health and social services go hand-in-hand because it's about health and well-being – focusing on wellness.*

**Case study 10: Making the system work for everyone**

An accreditation process for NGOs is improving access to health services for high need populations, while generating enrolments with the local PHO.

*The primary health sector is complex, so there needs to be a mechanism that co-ordinates information. If NGOs are being paid by the Ministry or DHB to deliver a service and the contract has been satisfied, then that's an indication to us that an NGO's processes are robust and rigorous enough for us to consider using them. We're not going to subject them to multiple audits.*

**Case study 11: Linking rural communities to health services**

In remote parts of Northland, a grassroots non-profit NGO helps ensure patients turn up at GP, specialist and hospital appointments, while struggling to find funding to keep operating.

*We don't seem to fit the criteria for most government funding, so we have to scrape around for money. Before our service was here, often people just didn't turn up.*

### **Case study 12: In the heart of the community**

A collaboration between a DHB, a PHO, a Māori health provider and a non-profit sporting body has seen delivery of a Cardiac Rehabilitation programme successfully transition from secondary hospital services 'ownership' to the community.

*People are more likely to come if it's in the community. Looking at some of the people we've got on the programme now, I don't think they'd turn up if it were at the hospital. The location is more convenient and we can bring a lot more flexibility to how we deliver it. It's about making 'the invisibles' visible – reaching the people who the system doesn't usually get to.*

### **Case study 13: Multiple relationships vital for an effective one-stop-shop**

Running a youth one-stop-shop providing health and support services, means building and maintaining a vast number of relationships with providers in health, social services, education and justice; while cultivating community links and keeping multiple funders happy.

*The future direction of health talks about developing Integrated Family Health Centres – youth one-stop-shops have been working in this framework for many years. Having an integrated, multidisciplinary team of professionals and non-professionals means we are able to offer a variety of interventions, support, programmes and youth development initiatives.*

### **Case study 14: Demands of complex funding streams create inefficiencies**

A large, non-profit alcohol and drug treatment service finds much in common with others in its two key networks, but the benefits of working together are diminished by the onerous compliance demands of multiple government funders.

*If the government made a priority of simplifying and co-ordinating funding streams, that would massively improve the services we could deliver right now. Even with the DHBs, we are often providing the same services – unfortunately service specifications are often different.....so each quarter when reports are due, we have to pull out different information for each. It takes staff away from frontline clinical service delivery and the collaborative relationship building.*

### **Case study 15: Providing a space for the 'go-between' to have real impact**

A low decile (or in their words 'opportunity rich') Nelson community has put health and well-being at the centre of community life, as a non-profit community health centre and a primary school converge to help change lives for the better.

*It makes sense to add value to what already exists in a community – that is, sharing resources such as buildings, networks, and relationships to extend the capacity of the whole community to become better connected and further resourced. Community ownership is vital. Our whole ethos is about relationships. You need good trusted relationships before doing anything.*

## Case study 1: Team-based acute service helps patients avoid hospital

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*In Canterbury, registered nurses from a non-profit NGO health provider and a general practice network are virtually interchangeable – thanks to the comprehensive training, professionalism and service standards common to both.*

**Nurse Maude** and **Pegasus Health** general practices have collaborated on the acute demand nursing service for four years, with the primary aim of helping people avoid hospitalisation. The acute service complements traditional district nursing and GP services, but delivers a more intensive clinical service to patients who might otherwise be referred to hospital or the Emergency Department (ED). It is available seven days a week from 8am to 11pm.

Referrals usually come from GPs, but can also be via the after-hours surgery, ED or the ambulance service – depending on what is best for the patient. Referrals are assessed via the Acute Demand Co-ordination Centre, which is part of a wider Care Co-ordination Centre. After discussion with the referrer, the Care Co-ordination Centre processes a referral and liaises with relevant care providers – aiming to respond to a patient care request within one hour if required.

Pegasus Health provides a medical director who delivers support and medical oversight, and Nurse Maude provides the Nursing Team Leader. The division of labour is shared between eight nurses from each organisation and Pegasus nurses also provide support in the observation area at the local 24-hour surgery. Nurses may see around five or six patients in their own homes each day, but if patients are able to come into the service, then a nurse might see eight patients in a shift.

Before administering treatment, nurses assess how patients are coping and the severity of illness via respiratory assessments (e.g. for asthma and chronic obstructive pulmonary disease) and cardiovascular assessments (e.g. for heart failure, dehydration and gastroenteritis). Treatments delivered by the service may include the taking of ECGs and cardiac bloods, inserting a urinary catheter or IV access, or administering antibiotics intravenously (IV) for patients with illnesses such as cellulitis or pneumonia. The relationship with the patient is short-term – usually anywhere from three to seven days.

“We usually only see patients for a few days – while they’re experiencing an acute illness. As they get better, their follow-up care is provided by their GP or a district nurse and if they get worse, they might be admitted to hospital or their therapy added or changed. A few patients with chronic conditions such as diabetes or heart failure, who experience an acute illness more than once, we may end up seeing again at a later date,” say registered nurse, Sandi Evans from Nurse Maude.

Clinical records are maintained in both the Care Co-ordination Centre and electronically throughout care by the acute community team. Both Nurse Maude and Pegasus nurses have shared the same computer system and forms since the service began – helping to ensure consistency and a seamless patient health record, no matter which agency delivers treatment.

The two nursing teams initially worked from separate locations, but now share the same premises. This simplifies patient handovers, which are done in a daily face-to-face meeting where patient notes are shared and workloads managed. Decisions about which service’s

nurse should see which patients are based on nurse availability, proximity of other patients, travel required and specialist nursing skills in areas such as paediatric care, wound care, etc.

Pegasus Health started an acute service over a decade ago, but the service “changed its flavour” in 2007, when the DHB ran a competitive tender.

“One of the things they were looking for was being able to demonstrate teamwork,” says Paul Abernethy, Divisional Manager – Patient Services at Pegasus Health.

“Pegasus Health and Nurse Maude already had an MoU (Memorandum of Understanding) and had agreed to look for opportunities to work together, so it seemed a natural step on from this, to provide a joined up service,” explains Paul.

“So together with **South Link Health**, we formed a not-for-profit called the Canterbury Community Care Trust and were selected as the preferred provider.”

Initial implementation costs of the acute service were met by separate funding negotiated with the **Canterbury District Health Board**. Initially funded for two years, the contract has been rolled over each year since it started. A range of contractual relationships are involved – from the DHB, to the PHO, to Canterbury Community Care Trust (CCCT), which then subcontracts separate elements of the service to Pegasus (medical and clinical oversight and nursing) or Nurse Maude (nursing). In addition, Pegasus has a separate contract with the DHB via the PHO for the 24/7 observation unit, and Nurse Maude has a separate contract with the DHB for the co-ordination service. South Link Health is not an active service provider in this, but their inclusion in CCCT meant the service could cover a wider region, including Ashburton and Rangiora.

Pegasus Health’s Paul Abernethy says the advantages over delivering the service alone include reduced duplication, good collegial networking and Canterbury-wide cover.

“We had more to gain by collaborating,” he says.

“Our organisations have learnt how to work together and we better understand and respect each other’s different skill sets. It’s built stronger connections between GPs and district nursing, and the community now has a large pool of community nurses with high skill levels.

“Nurses come and go from the acute service, but they take those specialist acute assessment skills, confidence and collaboration skills to the new roles and workplaces they move to,” says Paul.

The integrated service is not without its challenges – patients are mostly urban-based due to travel limitations, and planning staffing levels to respond to unpredictable demand can be difficult.

“If you’re working alone, then you don’t have to ask others about decisions, but then you don’t get the wider input. It’s a challenge to achieve, but more clarity comes seeing the bigger picture,” says Paul.

“It takes effort not to be competitive and recognise that each has a part to play. We’ve developed systems for resolving challenges.”

Approval of new standing orders, (such as when a new IV antibiotic protocol is introduced or forms are changed), can take a bit longer as they have to go through the quality checks at two organisations, instead of one; but overall, the collaboration has been well-received –



especially by elderly patients and those who have limitations in mobility and transport. (An audit of cellulitis patients treated by this service between April 2009 and March 2010 demonstrated a saving of 4,154 hospital bed days.<sup>15</sup>)

“It’s a fantastic joint service,” says Paul “and it would be good to get some clarity of funding for the future.”

It is hoped that more hospital admissions will be avoided in the future as paramedics (and perhaps even emergency call centre operators) are able to assess whether a patient might be better assisted in their home by the acute demand service.

“It’s very exciting,” says Paul “and it has significant potential.

“A recent report from the hospital and home movement in Australia showed a 30-40% cost reduction in home delivery, so demand could double or triple in the future. It’s a very tangible way to respond to the increasing demands of an ageing population.”

For Jim Magee, chief executive of Nurse Maude, working in partnership to provide nursing care has always been a particular strength of Nurse Maude.

“We have long recognised the benefits of collaborating with others to advance nursing care,” says Jim.

“Working together to develop and provide those services will continue to be an essential part of meeting the demand for increased health care in the community.”

Founded in 1896, Nurse Maude is the oldest and largest of several non-DHB providers of district and other community nursing services in Canterbury, so the NGO was well-placed to deliver this service. As well as acute nursing, Nurse Maude provides community nursing and home support care in Canterbury, Care Co-ordination in Christchurch and Wellington, and in-patient care in the Nurse Maude Hospital and Hospice.

With more than 1,100 staff delivering over a million hours of diverse services and support each year, Nurse Maude is a driver for change in community healthcare. In 2007, the separate Nurse Maude Foundation established the NZ Institute of Community Health Care (NZICHC) to provide a centre of excellence to manage research and development projects that would lead directly to tangible improvements and relevant service developments in nursing and community health. (NZICHC funded the cellulitis audit mentioned above via its Campbell Ballantyne Fellowship 2009.)

Established in 1992, Pegasus Health is a not-for-profit organisation that supports 95 practices within the Christchurch/Canterbury area in delivering quality care to over 366,000 patients.

Both Pegasus Health and Nurse Maude are members of the Canterbury Clinical Network – a collaborative working group, whose constituency includes GPs, nurses, hospital specialists, pharmacists, physiotherapists, wider primary care providers and relevant community groups. It works in conjunction with the Canterbury District Health Board to transform health care – introducing innovative ways to avoid hospitalisation and deliver patient care in

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<sup>15</sup> [District Nursing Service Development in New Zealand](#), Ministry of Health, May 2011.

the community. This approach has benefited from the *Better, Sooner, More Convenient* initiative, which is enabling greater freedom to pool together existing funding (like SIA, Access, and PHO management fee funding) to deliver improved services beyond previous narrow contract outputs.

For others considering collaboration, Paul Abernethy offers this advice:

“You need good governance from the start – so get it sorted early. And you need clinicians in the mix – health services need to be clinically led. It’s important to understand the problem before creating solutions – so you solve the right problem.

“And expect the storming, forming, norming process – then you can work it out.”

**More information:** [www.nursemaude.org.nz](http://www.nursemaude.org.nz) or [www.pegasus.org.nz](http://www.pegasus.org.nz)

## Case study 2: Team gains neutral leadership from non-profit's persistence

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*The dogged determination of the chief executive of a northern NGO led to him chairing a service-improvement committee he initially wasn't even invited to join.*

The **Long Term Conditions Clinical Alliance Team (CAT)** was set up as part of the **Greater Auckland Integrated Health Network (GAIHN)** initiative to improve primary care and reduce acute episodes that result in unplanned hospital admissions. Rex Paddy from the **Stroke Foundation Northern Region** heard about the project through his networks and knew he wanted to be involved.

GAIHN is an alliance of health providers and funders dedicated to delivering *Better, Sooner, More Convenient* care for approximately 1.1million patients across Auckland. Current partners include four Primary Health Organisations (Auckland, East Health Trust, ProCare Health Ltd, and Waitemata) and three District Health Boards (Auckland, Counties Manukau and Waitemata).

The Northern DHB Support Agency (NDSA) and ProCare were the driving energy setting up this and other GAIHN projects, but Rex kept in touch with the GAIHN people via calls and e-mails until he was invited to join the team. They then asked him to chair the group as a neutral party who wasn't from a hospital or general practice.

The CAT included a broad range of clinicians (GPs, senior consultants and allied health professionals), but Rex was the only NGO represented. Despite this and possibly because of his previous experience in hospital management, he said he felt part of the group and listened to. Everyone gave their time freely – both during work hours and outside them, and Rex says it was well co-ordinated, with an excellent project manager. At the height of its activity, there were meetings two or three times a week, and the organisers did make a financial contribution to Rex's organisation since he was the Chair.

Some participants were concerned that their efforts would result in a report and nothing would happen, but Rex is hopeful that the ideas and projects identified will get implemented. Things faltered a little when the group tried to find out where the money was coming from, as all the desired initiatives totalled around \$6million.

"The DHBs were great at freeing up time for their people to be involved in the planning, but they are not so forthcoming with money. They never say no, but they don't say yes," says Rex.

"In the health sector it is discouraging when you don't see the changes you want to, but progress is being made slowly. It's often a case of three steps forward and two steps back."

From Rex's perspective, his involvement was worthwhile for the Stroke Foundation, as he was there "beating the drum" to get stroke recognised separately from "just the abbreviations". Initially, it was lumped in as part of CVD (cardiovascular disease), but Rex says "to most people, CVD means heart attacks," so it was important that stroke was clearly identified, otherwise it was likely to be overlooked further down the track.

"It might be one line in a 100-page report, but at least it's there," says Rex.

A key question for Rex is why other NGOs didn't get involved in the CAT, as many have interests in long-term conditions.

“Perhaps they were wary of putting time into things that come to nothing, or they didn’t have the time, resources or people to make available,” muses Rex.

GAIHN’s Project Director, David Tucker says there were very tight timeframes around putting together the clinical alliance teams, as they were working to a deadline dictated by the DHBs.

“These were short term projects and we mostly put them together with organisations we knew. We had other non-profits, such as St John’s and Otara Health, involved in some of the other workstreams,” explains David.

“There was no deliberate strategy to involve or not involve NGOs – we just targeted those we knew.”

David says with such a large sector, GAIHN would value any help getting to NGOs and keeping them informed about integration of activities.

A long-held concern of many NGOs is that they are left out of key planning and decision-making processes. This can be due to the reasons Rex suggests, but often it’s because opportunities are not well-communicated or promoted and NGOs find out too late that work is already underway. Organisers often claim that “there are so many NGOs” they don’t know who to include, but often they don’t ask for guidance. A number of national bodies and umbrella groups, such as Platform (mental health) and the NZ Disability Support Network, exist to help. The Health and Disability NGO Working Group is funded by the Ministry of Health to advise and inform on such matters.

“It may be a bit cynical, but I don’t think there is an understanding in the Ministry or the DHBs of just what NGOs do,” says Rex, who is disturbed by the constant state of NGO services in decline due to funding cuts or no cost-of-living increases.

“Because of their size, PHOs can do more prevention work,” he says.

The Stroke Foundation Northern Region is one of four regional non-profits affiliated with the national office of Stroke Foundation – but each region operates autonomously.

While the national office has a focus on awareness and prevention, around 80% of the Northern region’s work is supporting families whose lives are turned upside-down when a member of the whānau has a stroke. This includes advocating for people to get the services they are entitled to such as a Disability Allowance, or helping them get back to work by sometimes paying for an assessment or referring them to the vocational counsellor, which the Stroke Foundation is funding from reserves.

“These people are usually stressed and fatigued, but our field workers don’t take ‘no’ so easily and can quote a clause that says what people are entitled to,” Rex explains.

“Often people say to our field workers ‘you’re the first person who’s had time to talk to me’. So we give people hope that there is a future for them.”

A major step forward for the Stroke Foundation – at a branch and national level – has been the introduction of Stroke Units in all hospitals.

“The international publications show the difference these make and the Ministry recognised this,” says Rex.

“Since then, we’ve fought hard to have our field officers recognised as part of the multi-disciplinary team, so they now go to weekly meetings. It was a huge battle to convince the DHBs that it wasn’t a breach of privacy to pass on the contact information for the next-of-kin or family. Now as part of the team, they can legitimately receive referrals.”

Ninety-five percent of referrals to the Stroke Foundation come from hospitals, rather than from general practice. Interestingly, Rex says most GPs tell him that they don’t see stroke patients, but he thinks that’s more likely a case of not seeing them as ‘stroke patients’, but for other medical conditions.

“Practice nurses are good at making referrals to the Stroke Foundation or other services,” says Rex, “and we have good relationships with other NGOs dealing with the same people we are.”

The work of the Stroke Foundation is complemented by the activities of the Heart Foundation, because as Rex puts it: “almost everything done to prevent heart attacks, prevents strokes.”

Like others on the CAT committee, Rex is now waiting to see what happens next. The aim is to reduce admissions to hospital and bed nights, so good stroke prevention programmes and knowledge can contribute a lot to this. Research has also established that early mobilisation and early SUPPORTED discharge produces better outcomes after stroke, and reduces bed days in hospital.

A key emphasis in the GAIHN approach is to put the patient at the centre of planning and action, and to empower GAIHN alliance partners to manage a greater proportion of people’s health care needs in community settings. For the GAIHN programme to have a sustained impact, changes to both clinician and patient behaviour are needed. A key driver of change will be to modify the current contracting environment – creating positive incentives and removing perverse incentives that encourage unsustainable behaviours.

GAIHN’s David Tucker says work is now refocusing around a workstream to target the 5,000-10,000 people who are frequent users of the hospital ED (Emergency Department), and there could be opportunities to include NGOs in these discussions as they develop.

**More information:** [www.gaihn.health.nz](http://www.gaihn.health.nz) or [www.stroke.org.nz/stroke-support-northern](http://www.stroke.org.nz/stroke-support-northern)

### Case study 3: NGO's reputation brings expanded role

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*A trusted, national non-profit organisation was the “most natural partner” to work with according to the CEO of a health network developing new models of care in the Midland region.*

When **Midlands Health Network** began planning pilots with three NorthCare general practices in Hamilton, they focused on identifying the most appropriate response for patients – not just making traditional face-to-face appointments the fallback position. The new ‘0800 Its my health’ approach has seen a complete change in emphasis to focus on helping people stay healthy – and the network has a new partner in **St John**, which is playing a key role in putting their plans into action.

The average age of the region's doctors and nurses is 57 years; so this ageing workforce and an expected 20% growth in demand for services meant things had to change for the future. Chief executive of Midlands Health, John Macaskill-Smith knew they needed new systems to free up clinicians' time and deliver a better service to patients. Early on, Midlands Health Network identified St John as a service with a lot of experience in triaging calls and thought there was scope to consolidate.

“We saw St John out in our community and we liked them and what they did. Until now, we didn't always have a clear reason to work together, but we understood each other, so partnering with them was a natural next step,” says John.

The approach is focused on the whole patient journey and aims to streamline things from the patient's point of view. It started small, with the three NorthCare practices, and went live on 1 April 2011 after some telephone and IT system upgrades. Now, instead of going through to a busy medical practice, patient's calls are answered in the PAC (patient access centre) managed by St John. Design work for scheduling patient access started in 2010, and St John was involved throughout the process-mapping stage.

“We think of the PAC as a fourth site in the NorthCare practices. It might be that callers end up making an appointment for a face-to-face slot, but the PAC staff can offer a range of options,” explains John.

“We have a PAC nurse in with St John providing clinical governance, but staff can also see if a doctor is busy, so some patients are surprised to be popped through when the doctor is available. Others make a time for a planned phone consultation where the doctor calls them back, armed with a transcript of the earlier discussion. In some cases, when the doctor calls, they've invited their friends around because it's such a novelty.”

Prior to establishing the PAC, call data showed up to 20% of calls to the medical centres were abandoned due to engaged signals – especially at peak times, such as early Monday mornings. Once it started, they actually received more calls than expected and had to increase staffing levels and adjust the contract to meet demand. Early on, there was concern that people wouldn't want to talk about their health on the phone. In fact, the reverse has happened and the time on calls is doubling as people realise they can access more information and advice over the phone.

The IT system enables everyone (doctors, nurses, PAC staff) access to the health records, which are updated with every interaction – so whoever is dealing with the person has a

clearer profile of the patient and can understand their assistance needs. Initial worries that patients may be concerned about the information sharing also proved groundless.

“Every time a patient saw a doctor, nurse, or specialist they were usually tapping information into a computer, so people assumed the information was all shared anyway,” says John.

“We had to build the technology to make this possible, but now we’ve turned on a patient portal, so people can check their own information like they do with internet banking.”

Outbound calling takes place in the afternoons. In winter, eligible patients were called about flu vaccinations and a 78% success rate was achieved. During a recent measles outbreak, the team identified all those children with incomplete vaccinations and PAC staff called their parents to suggest the children came in for a shot.

For St John, their contract with the Ministry of Health simply requires them to pick up and transport patients to the emergency department (ED), so this new contract with Midlands Health presented many opportunities.

As an organisation that’s been in New Zealand since 1885, St John had recognised the need to change and adapt its service delivery model for the challenges facing the health sector. It had already begun to shift focus to ambulance officers treating patients in the community and not transporting wherever possible, and is supporting other alternative response pilots in different parts of the country – including an extended care paramedic service programme, an integrated paramedic and rural care service and a nurse response pilot.

“There are silos of excellence across health that could be joined up by telephony,” says Jaimes Wood, CE of St John.

“This is a really neat collaboration between a regional health provider and a national non-profit. We have had a good experience working with Midlands Health – from concept to something happening was pretty quick, which is always good,” explains Jaimes as he describes discussions kicking off in November and being up and running by April.

“We had a good vision, and they had a good vision and we came together through a similar recognition of the issues. You’ve got two organisations that have fully recognised that the additional funding into health over recent years cannot be sustained. We need to be innovative and find new ways of doing things,” says Jaimes.

Midlands Health and St John recently spent a day together discussing plans for the next steps.

“There are opportunities to scale it up or extend it nationally, but we need to prove it first. It’s about turning a vision into reality and getting all the protocols and procedures sorted,” says Jaimes.

“For both our organisations, the bottom line is not profits, it’s about delivering health and well-being to New Zealanders in most cost effective way possible.

“Midlands is keen and focused and motivated – it could turn into something greater,” Jaimes enthuses.

Contracting directly with St John was quite straightforward for Midlands Health, which has lots of experience contracting directly with NGOs. Prior to the amalgamation of many PHOs, there were around 700 contracts between PHOs and NGOs in the region.

“We’ve pulled back from some of the unmeasurable things – grouping up pockets of funding and making things more transparent and accessible,” says John Macaskill-Smith.

“Because of our size and capacity, the DHBs have been happy to step back from a raft of contracts with NGOs and focus on the hospitals, so that is different from many other regions.”

John’s experience working with St John means he’s receptive to the idea of working closely with other NGOs, but acknowledges there are a few challenges.

“There are so many of them,” he says, “but we have helped some of them come together for events and workshops – especially in mental health.”

The network has also put some money and support into helping community pharmacies come together and group up. More grouping up came when the DHB and PHOs realised they had multiple bits of funding going to Māori providers in the King Country, so the DHB ran an RFP process and joined it all up into a single contract – simplifying things immensely.

The fragility of many NGOs is also an issue.

“You can be dealing with a really fantastic one and then they fall over because they’ve been ‘running on the smell of an oily rag’,” says John, while acknowledging that many government contracts play a role in this by not contributing towards investment in IT and infrastructure.

“We have helped some NGOs access practice management systems and, where appropriate, we encourage them to use our systems rather than try and build their own.”

The other ‘quirk’ of NGOs is that some, especially rural ones, often think they and their communities are “so different” that you can’t possibly compare them or introduce changes that have worked elsewhere.

“Often the differences aren’t as major as they think, but it can be a barrier to trying new things or working more closely,” says John.

There has been lots of interest in the new patient-focused approach at NorthCare however. The PAC recently hosted visits from hospital service managers and older persons’ services, and there have been numerous conversations with other DHBs. Many don’t currently have the capacity to do it themselves, but are watching closely as things progress.

John Macaskill-Smith has also presented to the United Kingdom’s Nuffield Trust on the initiatives underway. A second wave of practices in Taranaki is due to be linked with the PAC in early 2012 and there is potential to make a referral tool to radiology, which could be managed through the PAC.

**More information:** [www.itsmyhealth.co.nz](http://www.itsmyhealth.co.nz) or [www.stjohn.org.nz](http://www.stjohn.org.nz)



## Case study 4: A synchronisation of mindset and priorities

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*Four non-profit providers of mental health support services in different parts of New Zealand have come together to share ideas and resources to increase their effectiveness.*

In 2009, the chief executives of **Wellink**, **WALSH Trust**, **PACT** and **Comcare** decided to take their professional connections to the next step by forming an alliance called the **Arc Group**.

They came together at a time when there were lots of messages about collaboration, but little else happening to put them into action. Their primary motive was a shared belief that they must rise to the challenges of a rapidly changing environment. They wanted to find and exploit alternative approaches to accessing expertise, resources, knowledge and support. Major shifts in demographics, technology, the economy and service expectations also signalled a period of rapid and significant change that the four medium-sized organisations could try to influence and face better together.

The range of services the organisations offer is similar, but each is distinct in different ways – offering specialist skills or leadership. For example, PACT has the most experience with people with both intellectual disabilities and mental health issues; while Comcare has a focus on housing for people with mental health issues, as well as peer leadership. WALSH Trust is a leader in supported employment, and Wellink has the longest and most extensive use of consumer voices in shaping direction and in encouraging their participation in frontline, service delivery roles.

Together the four providers employ 655 staff, support 3,000 clients and manage combined revenues of \$36 million per annum.

A memorandum of understanding was drawn up for the Arc Group, although developing trust took effort and commitment.

“Learning how to collaborate ain’t easy!” says WALSH Trust CEO, Rob Warriner.

However, it only took three meetings before the providers were sharing their financial and other ‘sensitive’ information with each other.

“We are like-minded people from like-minded organisations,” says Virginia MacEwan, chief executive of Wellink Trust.

All Arc Group partners promote the value of peer support services. Arc Group’s Statement of Intent says that concepts of recovery should be at the core of organisational activities. In its simplest form, recovery is based in genuine expressions of courtesy, respect and integrity. For services aiming to support positive change in people’s lives, the fundamental purpose is communicating and supporting people’s worth and potential so clearly that they are inspired to see it in themselves – in spite of their experience of mental illness.

“We share a belief that there are more cost-effective, alternative approaches to designing and providing mental health services that rely less on costly medical interventions. Instead, we see there are huge opportunities to make use of resources that are available in the community – and developing that capacity further,” explains Virginia.

The Arc Group enables the four providers to share best practices and increase their focus on excellence. They’ve been able to benchmark salaries, operating costs, staff turnover and sick leave, while getting a better understanding of sometimes significant differences in the unit prices for services.

“We’ve learnt how to use and analyse information, even if we don’t use the same instruments,” says Louise Carr, chief executive of PACT in Dunedin.

PACT is active in Southland, Otago and the West Coast; the WALSH Trust is based in West Auckland; Wellink in Wellington and Hutt, and Comcare in Canterbury.

Rob Warriner says one of the challenges to working together is that the four members are geographically separate, but he also believes this has been a key factor in the success of the alliance.

“We don’t have to be reticent about what we share because we are not in competition with each other,” says Rob.

“It is so refreshing, empowering and rewarding to share issues and perspectives and receive rich feedback and comment, based on many years of collective experience.”

The four chief executives and their deputies come together six-weekly on a face-to-face basis to share experience and challenge each other. Members prioritise the meetings, which Louise describes as “invaluable supervision time”.

All are involved in local, regional and national committees or groups, so are able to share valuable insights from these too. Each is also able to bring a rich source of international networks and connections.

“We all benefit from specific expertise that is around the table,” says Kay Fletcher, CEO of Comcare.

“For instance, the expertise of Comcare means that we are kept up-to-date with the development of best practice standards for social housing,” concurs Louise.

Members are always trying to lift their standards and make improvements to their systems and services, even when something goes wrong for one of them.

“One of our organisations had an experience in coronial court that took all of us by surprise. It’s something that would probably only happen once every three or four years, but we were all able to learn from it and make appropriate changes to minimise risk in the future,” says Wellink’s Virginia.

“Because we are not competing, we have supported each other with proposals, as well as being on the look out for opportunities to work together.”

Within the alliance, various partners have worked together differently according to needs. Pact and Comcare developed a joint proposal and worked together on services on the West Coast. WALSH Trust is sharing its staff development programme and information system with Wellink; for 12 months both organisations shared a Director of Operations, seconded from WALSH Trust.

The Arc Group’s ability to do things collaboratively and challenge current thinking had its most public exposure in December 2010, when the Arc Group brought Professor Roberto Mezzina from Trieste, Italy to New Zealand for a series of forums.

Since the early 1970s, mental health services in Trieste have been guided by a strong emphasis on social inclusion and citizenship as core values. This has meant less reliance on acute services, absence of restraints and little use of compulsory treatment. Easy access to services 24/7 has been a fundamental hallmark of services in Trieste.

Professor Mezzina was recently re-appointed Director of the WHO Collaborating Centre for Research and Training in Mental Health.

“He allowed us to expand our own visions of what change is possible,” says Virginia MacEwan enthusiastically.

“His ideas sparked a lot of interest with the funders, leading clinicians and other NGOs who attended the forums.”

In turn, this opened up new opportunities for Arc Group members, including a further collaboration with the NSW College of Psychiatrists and an invitation to present on the ARC Group at the Australia and New Zealand Mental Health Services (TheMHS) Conference in Adelaide. Professor Mezzina has now been invited back to the Southern Hemisphere to be a keynote speaker at next year’s TheMHS Conference in Cairns.

The Arc Group also takes an active interest in the activities and well-being of member organisations.

“Whenever we’ve got a key vacancy, we try to look to each other first for ideas on different ways of doing things before we recruit,” says Virginia.

Kay Fletcher of Comcare will shortly be discussing with WALSH Trust staff, options around using their integrated Client Information Management (iCIM) system, as well as other opportunities for further collaboration.

“Our commitment to the Arc Group encourages each of us to be as efficient as we can as a business. It is now far easier to explore ideas and opportunities with others who you know share your values and aspirations for the future,” says Kay.

Cost efficiencies have been made, but they are often hard to quantify or make direct links to. The organisational improvements, higher standards and sharper services are more obvious.

Wellink and PACT have just received seven excellence ratings between them in recent Ministry of Health Certification audits and Wellink has received an Australasian service achievement award for the second year in a row. Similarly, WALSH Trust was a finalist in local business awards; Comcare has award-winning housing services and is taking a lead role in innovative developments in post-earthquake Christchurch. PACT has initiated a project called MH3 that is influencing the shape of future mental health services in Otago, Southland and West Coast.

“We share in each other’s successes and when our partners are proud, we are all proud by association,” says Virginia.

“We’ve exchanged some board members between organisations and we are able to share so much without losing our unique flavours or our connections to our own communities, which we are pretty engaged with.”

ARC Group members consistently challenge themselves and each other and are supported to access tools that enable them to anticipate tomorrow’s challenges.

“We see this alliance as an option which values and upholds the uniqueness of organisations that have been shaped by and grown out of local communities,” says PACT’s Louise Carr.

***Linkage******Co-ordination******Integration***

“We have the opportunity to explore and recognise the benefits of being a part of a larger collective – and the potential economies of scale that might ensue.

“The Arc Group remains a group of four. However, we welcome opportunities to collaborate with a broader range of organisations.”

**More information:**

[www.pactgroup.co.nz](http://www.pactgroup.co.nz) or [www.wellink.org.nz](http://www.wellink.org.nz) or [www.walsh.org.nz](http://www.walsh.org.nz) or [www.comcare.org.nz](http://www.comcare.org.nz)

## Case study 5: New tool helps NGO get better GP services for disabled people

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*With initial support from a DHB, a non-profit disability support provider has introduced an annual evidence-based health assessment tool from Australia into New Zealand general practices.*

Due to growing concerns about poor health outcomes and relatively high mortality rates for the people with disabilities accessing its residential services, **Spectrum Care** commenced a journey in 2009 to change things for the better.

Spectrum Care is an independent charitable trust providing services for children, young people and adults with disabilities and their families. Services include 24-hour support for around 400 people living in residential homes throughout the Auckland and Waikato regions, and respite care in these regions and the Bay of Plenty. Spectrum Care also offers specialised home support, behaviour support and work and activity services in the greater Auckland region.

The journey began with Spectrum Care reviewing its health tools, processes and support systems to identify gaps between health outcomes for people with disabilities and the general population. This review identified that many of the poor outcomes were linked to breakdowns in primary health supports through:

- unrecognised or poorly-managed health conditions and diseases
- inadequate or non-existent health screening
- ineffective communication between the individual, their family/whānau, support workers and GPs.

“There’s a huge amount of research on disability and ageing, but very little information on how to address the identified issues,” says Judy Garriock, General Manager – Business Development and Marketing at Spectrum Care.

Through its research, Spectrum discovered the Comprehensive Health Assessment Programme (CHAP), which is an evidence-based health assessment tool for GPs. The CHAP was developed in 1999 by Professor Nick Lennox – an Australian GP with New Zealand experience. Professor Lennox is the Director of the **Queensland Centre for Intellectual and Developmental Disability**, which is part of the School of Medicine at the University of Queensland. The CHAP is funded by Medicare and used by GPs throughout Australia, and is currently being introduced in the United Kingdom.

In 2010, Spectrum introduced the CHAP as the health assessment component of a joint pilot with **Counties Manukau District Health Board (CMDHB)**. The pilot programme aimed to improve the health outcomes for ageing people with intellectual disabilities, who were aged over 50 and living in two Spectrum residential homes in South Auckland.

The partnership with CMDHB came about due to fortuitous timing on two fronts – Spectrum Care chief executive Chris Harris happened to meet CMDHB Aged Care General Manager Jenny Coles at a function, shortly after a similarly-focused CMDHB Adult Rehabilitation and Health of Older People (ARHOP) project had been completed at a local aged care facility.

CMDHB immediately saw the value of the pilot and positioned itself to support it. Dr Shankar Sankaren, the Clinical Head and consultant geriatrician for Community Geriatric Services – ARHOP, became actively involved in the pilot service design and research.

During the pilot, GPs completed health assessments using the CHAP to provide an in-depth health baseline. Many of the people accessing Spectrum Care residential services have higher and more complex needs (e.g. significant intellectual and physical disabilities with communication challenges), so support workers played an important part in these interactions with the GPs.

For Spectrum Care staff, the pilot challenged historical behaviours in the choice of peoples' GPs. Staff have begun to realise that the closest GP may not be the most appropriate and will now help people select a GP who has empathy and interest in supporting them.

To improve the support workers understanding of ageing and age-related conditions, an age-training programme was developed. The training increases support worker understanding rather than changing them into clinical caregivers.

"It's about changing our awareness and attitude, so our support workers feel empowered to challenge and engage GPs where necessary," explains Judy.

"Everyone has a voice, even if they can't communicate. Everyone has the right to be offered the same treatments and screenings as the general population, and to decide if they want to have them. Many significantly disabled people have never been offered breast screening or prostate exams because many GPs are unsure how to raise the topic or gain consent."

As part of the pilot, increased interaction was facilitated between the general practice and CMDHB clinicians, Spectrum Care staff and the people they support. The geriatrician from CMDHB was involved with medication reviews, age-related discussions and mentoring with the GPs.

Interviews with the GPs and support staff were completed in March and September 2011.

Feedback about the CHAP indicated that while some GPs were "very into it", others were more reluctant – perceiving the longer in-depth assessments and completion of paperwork as "not a valuable use of their time" – even though, in some cases, Spectrum Care booked a double appointment to ensure adequate time.

Much of the historical health information was unknown by the GPs and unable to be entered on the forms, so Spectrum Care is now exploring ways to summarise this for inclusion in future CHAPs.

Both staff and GPs were desperate for a digital version of the tool, which has been picked up by the Australian developer. Spectrum Care is assisting with advice on an electronic format.

"Going forward, it will be important to be able to connect in with the DHB and PHO IT systems," says Judy.

"A web platform for sharing health information between providers, PHOs and DHBs will help with real-time information sharing and records retrieval for new health providers."

Spectrum Care has now begun to roll-out the CHAP to residential services organisation-wide, commencing in the Waikato region.

Others in the disability sector, such as the New Zealand Disability Support Network, IHC, IRIS and Hawksbury Community Living Trust are watching progress to see what outcomes result, and Spectrum Care is keeping them informed through regular networking.

In Waikato, Spectrum Care has entered into a partnership with **Waikato DHB** to contract 0.3 of a Clinical Nurse Specialist (CNS), who has been crucial in improving the interface between staff and GPs and practice nurses. So far, Spectrum Care has been unable to partner with Auckland DHBs to contract CNS services, but is continuing the CHAP rollout regardless.

The different financial circumstances and priorities of different district health boards is a challenge for many non-profit providers – especially those whose services cover more than one DHB area. Even when multiple DHBs are able to support an initiative, the repetitive negotiation and contracting processes can be a major drain on an NGO's time and resources.

"When you're getting great feedback or support from one funder about a proven tool or service that works, it can be incredibly frustrating when you can't offer it to all your people because of DHB differences in attitudes and priorities. The inequity of 'healthcare by postcode' is huge and processes need to be streamlined or be given direction from the Ministry when health disparities result from DHB and PHO indifference to disability conditions," says Spectrum Care chief executive, Chris Harris.

Spectrum Care is keen to connect with one or two PHOs to help identify GPs with an interest in improving health outcomes for people with disabilities.

"It's important that we don't inundate a few keen GPs with too many high-needs patients, but it would be good to find some who have an interest and who might support and encourage their peers to spread the load," says Judy.

"We're exploring ways of identifying GPs with an interest in disability, but the endorsement of the CHAP by the Ministry of Health is vital to support constructive engagement with the GPs. Ideally, we'd like the CHAP recognised as the national health assessment tool for all people with disabilities".

**More information:** [www.spectrumcare.org.nz](http://www.spectrumcare.org.nz)

## Case study 6: Non-profit NGO delivers convenient health care

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*Recognising that many people in high needs areas get the health care they need only if you make it easy for them, an Auckland non-profit NGO brings related services together for greater effectiveness.*

The **Mangere Community Health Trust** (MCHT) was established in 1993 to solve the socio-economic determinants of health in the community of Mangere. The Trust offers a large range of services – all developed to fill significant gaps in delivery of health services in the community. These include an integrated general practice and pharmacy, an x-ray plant and soon-to-commence mammography service.

The Mangere Community Health Trust's latest collaborative venture will make treatment for diabetes more accessible and convenient for local people by "wrapping services around the patient" in one location. Its sister trust, the **Mangere Health Resources Trust** has just completed building a multimillion dollar health care facility to be opened in November 2011. This will house, along with a range of health care services, a multidisciplinary diabetes hub.

The new diabetes centre brings together a range of specialists previously scattered across different locations. MCHT will provide the dietician, podiatrist, mental health service, smoking cessation programme, oral health service, in addition to a retinal screening unit. The Sky City Trust funded the initial purchase of the retinal cameras. **Counties Manukau District Health Board** will provide access to the ophthalmology department's portable laser so eye surgery can take place in Mangere. The new diabetes hub will make services more convenient and cut down on delays caused by letters of referral to Middlemore and the Super Clinic, and other traditional barriers to treatment.

Michael Lamont, CEO of the Mangere Community Health Trust, explains the philosophy behind the collaboration this way: "If you put all the services together, people know 'that's where I go for X'. They don't have to travel all over the city or to the Super Clinic, which is some distance away. Currently many people lack transport so do not turn up for appointments, and seek treatment only when their condition has significantly deteriorated. There's some talk of 'virtual' Integrated Family Health Centres, but I believe that in a community such as Mangere where transport is a major issue for many residents, physical co-location will be more effective."

The relocation of diabetes services into the new building will allow a neighbouring service for at-risk and offending youth, the **Mangere Genesis Youth Project Trust**, to expand into one of the two adjacent premises owned by the Resources Trust. There are already strong connections between the two organisations as the socio-economic determinants of health<sup>16</sup> manifest in a range of problems seen by health care providers and youth offending. The social workers and sworn police officers based within Genesis see the same issues in the youth referred to them. Examples include hearing difficulties caused by glue ear, poor housing leading to chronic illness, drug and alcohol substance abuse, and relationship issues.

"You can't deal with just one of their issues, as they are interconnected," says Michael.

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<sup>16</sup> [\*The Social, Cultural and Economic Determinants of Health in NZ\*](#), National Health Committee, June 1998.



Michael is enthusiastic about *Better, Sooner, More Convenient* changes in primary healthcare that are encouraging closer team work and collaboration between GPs, nurses, pharmacists, and others involved in the delivery of health care and social services.

Mangere Community Health Trust became a PHO in 2003 when this was the political “flavour of the month”, but it lost this status in recent PHO amalgamations. This could have lost the community the services previously funded by the PHO Services to Improve Access (SIA) funding, as these were not going to be funded under the new PHO arrangements. These included a radiology service, dietician, nutritionist and podiatrist.

“When we suggested to the DHB that neither the community nor the DHB wanted to lose these, the DHB agreed and now contracts with us directly to keep these going. They are effectively paying twice, which is not particularly sensible,” says Michael, who is nevertheless pleased that the services can be continued under the auspices of the Trust.

“Now that we’re not a PHO, we have a bit more freedom to respond to community needs,” says Michael.

South Auckland’s needs include ‘third world’ rates of rheumatic fever, which pose an on-going problem for the large Māori and Pacific population in this area. The simplest intervention is the preventive one of diagnosing and treating Streptococcal A throat infections, which may lead to rheumatic fever and potentially rheumatic heart disease.

“There are issues around diagnosis and management of Strep A,” says Michael.

“GPs treat it extremely well once the child presents. While sore throats are common and most are viral, a strep throat diagnosis requires a throat swab to be analysed at a laboratory, on referral from general practice. The result takes a few days, by which time it may be difficult to find the child to treat the infection. To circumvent this, national guidelines recommend that children of Māori or Polynesian descent are given antibiotics when they present with a sore throat, irrespective of whether the infection is viral or streptococcal.”

Because of these national guidelines and the need for convenience, GPs will give antibiotics without waiting for test results. Michael believes this could be better addressed with near-patient testing to diagnose more accurately and quickly treat streptococcal sore throats.

“This technology is now available. It needs to be simple, so we are proposing to introduce a quick test service on a **marae** in Mangere. There are 200 residences around the marae and we taught a keen ‘Aunty’ how to swab sore throats. So if a child has a sore throat, they can have the swab done by Aunty and if it is positive for Streptococcus A, they can go to the GP knowing they need antibiotics,” explains Michael.

Mangere Community Health Trust feels so strongly about the advantages of the quick test service, it is currently funding it from its own cash reserves. (They’ve even shown the Minister of Health how to demo it for a Select Committee.)

While some have reservations about rapid tests, Michael is enthusiastic about research on near-patient testing that The Heart Foundation and the New Zealand Guidelines Group sourced from other countries. The NZ AIDS Foundation (NZAF) and Body Positive also advocate for greater use of near-patient testing.

“At the moment, testing is an essential ingredient in the way forward to identify people living with HIV. The only organisations that do rapid testing [for HIV] are the NZAF and Body Positive, and that is, in a single word, appalling,” says Bruce Kilmister, CEO of Body Positive.

“There needs to be a national discussion on testing in this country.....because there needs to be a national standard and national consistency.”<sup>17</sup>

Michael Lamont believes New Zealand could also learn from international funding approaches. Norwegian funding processes bring health, social and community funding together in one pot administered by a regional council. Michael gives examples of how these decisions are inter-related and impact on each other in ways that benefit communities, but he suggests starting with less radical funding changes in New Zealand.

“Ideally, we should have one DHB in Auckland now that we have one Super City. People don’t know the rules about where the boundaries are – they go to the closest or most convenient,” says Michael.

An example Michael uses to illustrate this is Otahuhu, which is in the Auckland DHB area.

“It’s 30kms to Auckland Hospital from Otahuhu and only 4kms to Middlemore, so where do you think most people go? This creates a significant bureaucratic workload around the inter district funding flows (IDF). Money and resources would be more effectively used if diverted to primary health care services and non-profit providers,” he suggests.

Boundary issues exist based on cultural differences too.

“Tongan people want to go to a Tongan provider – they don’t know or care if the Tongan provider is out of a DHB area,” says Michael.

For many non-profit NGOs, significant costs are also tied up in reporting on multiple contracts. Michael says many of the DHB contracts his NGO has, still measure processes.

“We need to be outcomes-focused and move away from process. For example, with diabetes, your desired outcomes could be preventing blindness, or avoiding limb amputations through terrible circulation.”

Michael sees another collaborative opportunity to support young families within this community in the birthing area, which could help take pressure off the hospitals.

“Due to demand at Middlemore, most women are sent home 4-6 hours after birth, but re-admission rates are high and breastfeeding levels are low. A non-profit organisation like us could provide a stand-down unit where mothers and babies could stay for three days, so support staff could spend time to help them in the early days,” says Michael.

He suggests that with the right funding arrangements, Mangere Community Health Trust could do even more by providing a birthing unit for around 1,300 local women who have level-one uncomplicated births each year. Michael believes this would be particularly attractive to Pacific people, who make up about 60% of the local community.

“Many of them have seen their older parents die in Middlemore Hospital, so they are not keen to go there to give birth,” he explains.

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<sup>17</sup> Quote from: [‘Building bridges: NZAF and Body Positive’](#), published in Express, September 2011, p4.

Together with **HSA Global**, Mangere Community Health Trust has developed another innovation to support collaborative health services. Its shared clinical notes and health record uses cloud computing to enable different health professionals to change and add to a patient health record. Patients also have access via a portal and can control who they share information with. For example, if they were in hospital they could give access to their treatment team. Michael sees real value in patients seeing their records.

“If patients had a bit more information, they’d take better care of their health,” he says.

**More information:** [www.mangerehealth.org.nz](http://www.mangerehealth.org.nz)

## Case study 7: Māori working for Māori – with support from others

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*Collaboration is vital for a whānau ora approach to primary health services – and so is respect for professional integrity and skill.*

**Rangitāne o Tamaki nui a Rua Inc.**, (hereafter referred to as **Rangitāne**) in Dannevirke has always had a whānau ora focus to its work, i.e. taking into consideration the holistic well-being of whānau.

Rangitāne's mission is to preserve, protect and enhance the aspirations and well-being of whanau living both within, and outside of, Tamaki nui a Rua (Taranaki District Council region). The Kāhui Matarae is responsible for the governance of the organisation and is comprised of hapu members from **Ngāti Pakapaka, Ngāti Hāmua, Te Hika a Papāma, Ngāti Parakiore** and **Ngāti Mutuahi**.

Rangitāne's genesis as a formal organisation has its origins in the late eighties. It started as a social services provider and then extended into health. Originally run on a voluntary basis, over the years it gained funding from government agencies, most notably the Ministries of Health and Social Development. With a current staff of 40 plus, approximately 30 staff provide frontline services. Its services range from personal health, i.e. Tamariki Ora/Well Child services for under-fives, to whānau ora health care, cancer support, elder care, mental health support and counselling, through to health promotion and education. The free services cover the Taranaki area and work in collaboration with Taranaki-based **CentralPHO, Taranaki Health Group, GP services** and **social service providers**.

The implementation of Whānau Ora as government policy has provided the opportunity for the organisation to formally incorporate the whānau ora philosophy into practice, e.g. two kaimahi have undertaken Whānau Ora practitioner training and one kaimahi is currently employed as the Te Ara Whānau Ora navigator. As part of the organisation's regular in-service training, kaimahi are updated on Whānau Ora in all its different aspects, i.e. giving overviews of the key concepts of the expanded definition of whānau ora.

Dorothy Lock, one of Rangitāne's two registered nurses, says new assessment and peer management tools have helped strengthen the whānau ora approach. Dorothy is also enthusiastic about clinical supervision and regular dialogue with a social worker practising whānau ora social services.

Weekly face-to-face clinical reviews within the organisation help the team work as seamlessly with clients as they can, and they try to keep one key worker as the main contact with whānau.

Dorothy deals with patients from birth through to the end-of-life and is also involved in health promotion, where she uses her networks to encourage referrals. Some people self-refer, but GPs have recently started to make more referrals. Dorothy thinks this is partly due to a broader awareness of Māori providers and their connections with communities, but also a growing mutual respect for each other's place in the health care team. She believes this respect is born out of changes that affect the way health care is funded and delivered, and the need to be more flexible.

"Most GPs are hard-working and highly motivated to get the best outcomes for patients. It's very much about individual connections, but most are willing to engage and I have dealt

with many over a long period of time, so they know how I work. We share the same beliefs,” Dorothy explains.

Dorothy’s professional relationships in Tararua are especially strong. There she liaises with the leader of the health of older persons (HOP) team on an ‘as need’ basis (e.g. weekly). This enables the information shared to be brought to Tararua Health Group network as necessary. In addition, she strengthens connections with the **practice nurses** from the group’s GP practices who are able to bring relevant information to team meetings.

As a rural-based health provider, Dorothy encounters additional challenges to maintain strong networks. Travel can suck up lots of time, so Dorothy participates in urban Primary Health Care meetings via teleconference.

‘Healthy living with diabetes’ is a series of teaching modules for consumers or their whānau members who are affected by diabetes. Dorothy is also a part-time lecturer employed by the Manawatu, Horowhenua Tararua Diabetes Trust to deliver the modules when scheduled for Tararua.

Dorothy seeks out invitations to present an overview of her scope of practice to as many professional disciplines as possible – to save on having to do this on a piece-by-piece basis.

Time is the greatest professional challenge for many health professionals, but Dorothy uses opportunities at every nurses hui or training she attends, to promote the ‘Māori working for Māori’ perspective.

“It’s about putting it out there,” she says.

“I would like to see a greater awareness of ways of working with Māori. Workshops could be used as a means to achieve this awareness, which cannot be gained by just reading about it in a strategy document, or referring to it in passing. I’m always ready to make an impromptu presentation to groups when I’m working and networking, but this is a small contribution compared with what seems to me to be needed at this time,” Dorothy explains.

Rangitāne chief executive, Oriana Paewai agrees: “Whānau ora is well understood by whānau, although they may not be able to put it into words. The day-to-day practices of whānau demonstrate the principles of whānau ora. We also acknowledge that many whānau struggle to achieve whānau ora and that is one of the reasons why we exist as an organisation.

“It would be useful for ‘the helping professions’ to see the whānau as the ‘experts’ and work alongside them to develop their strengths and realise their own aspirations. Marae noho is one training ground where this transfer of knowledge can occur.”

Rangitane has played a role in familiarising those unfamiliar with the tangata whenua experience via marae visits, tours to sites of historical significance and one-on-one presentations and workshops. One such tour took place in 2006 with staff from GP services.

“The tour took the GPs out of their place of function and allowed them to get a wider view of the community and the local people by bringing in cultural elements, such as a powhiri. This appeared to have a profound effect on those participants who spoke to me of their experience,” says Dorothy.

In another example of opening people up to different perspectives, sixth-year medical students were welcomed at Rangitāne, where the staff did a presentation for them. One trainee GP exercised an option to accompany Dorothy on her afternoon house calls.

Rural communities are often disadvantaged through the loss of, and lack of, services so they appreciate visits by urban practitioners. Adequate notice can sometimes be an issue for those who are the last link on the communication chain. Administration support from a central source would help to ensure timely notice to a range of agencies, suggests Dorothy.

Oriana Paewai says there is a misconception that because Rangitāne is an Iwi-led organisation, the only people who can access services are Māori. While the majority of clients are Maori, the services are available to anybody who wishes to use them and accepts the whānau ora philosophy that Rangitāne works from.

Health promotion activities are held at events and places where whānau are likely to attend, e.g. the annual shearing and wool-handling competition at the A&P Show. A promotion held at a golf tournament a few years ago brought a large number of males into Rangitāne's services. These activities are also an opportunity for personal health checks, e.g. blood pressures and one-on-one discussions with individuals.

Four 12-week programmes focusing on physical activity and good nutrition are about whānau supporting one another to make beneficial changes in their lifestyles. There is no element of blame, failure or disappointment in the programmes. Individuals are encouraged to make incremental changes that can be maintained once the programme has finished.

Dorothy explains the philosophy behind these approaches: "If they have a positive experience confirming they are well or that they need to take action, then it creates the possibility of ongoing care. They start to trust us as individuals and will come in for other things."

In terms of collaborative relationships with other health providers, Dorothy does have concerns about the lack of referrals from hospital.

"We don't get discharge summaries from the hospital when someone is using our service," she explains.

"They need to make it easier for social workers in the hospital to ask if someone is using a Māori provider. Change the forms so they can tick a box, put up a flag. That way they could send us some kind of notification, so we could follow up."

Dorothy thinks there's a particular opportunity where children are involved, and it's not just related to suspected violence or abuse.

"If children have any kind of injury – falls, poisoning, burns – we could follow up if they asked the whānau if they'd like to have someone come and discuss safety in the home, environment or car.

"We discuss this at **Kohanga Reo** and through the **MidCentralDHB Well Child Forum**. It's already part of our contract, but there is an opportunity to do more and to do it better," says Dorothy.

**More information:** [www.Rangitāne.co.nz](http://www.Rangitāne.co.nz)

## Case study 8: The importance of a supportive champion

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*With support from the local DHB and PHO, a non-profit's online health directory developed content to emphasise regional health priorities in Canterbury.*

**Linkage Trust** is a non-profit, community organisation providing free, professional and confidential support and information services. Linkage Trust began in Hamilton in 1998 and launched the **Webhealth** website in 2004 to enhance community accessibility to self-assistance for health and well-being.

Webhealth is an online directory<sup>18</sup> of health and social services such as counselling, mental health support, medical services, doctors, community events, and health information. Around 7,000 New Zealand providers are listed on Webhealth – covering eight DHB regions (Waitemata, Auckland, Counties Manukau, Waikato, Bay of Plenty, Lakes, Taranaki and Canterbury). Each region's focus is different based on the targets and use that funders identify.

Linkage Trust has a strong presence in Waikato, where it began, and has gradually built relationships in other regions – often through word-of-mouth or positive referrals.

“Within each region we ascertain what priorities and focus a funder wants to take, and a Webhealth region could have multiple funders and priorities to meet local needs,” says Linkage Trust General Manager, Letticia Mincham.

There is scope for Webhealth to cover other regions too. Funders can choose to contract just for the website or for the “eyes and ears on the ground” as well. Funding for local staff ensures high quality information through networking with health and social service providers and inspires the local community and providers to engage and use the resource.

“Linkage Trust originated from a partnership between the **Waikato DHB**, **Pathways Trust**, and **Pinnacle** who at the time represented many of Hamilton's GPs. We are also involved in other groups and projects – so you develop a reputation for doing good work and that creates opportunities,” explains Letticia.

“Our involvement in national networks like **Platform Trust**<sup>19</sup> has also been very useful, as they help connect us with others and inform our relationship building.

“We approach DHB funding and planning people, councils and PHOs, as well as corporate, to grow Linkage services in their regions – but it works best where we have key relationships within the local community.”

There is no charge to be listed on Webhealth and providers can update their own contact information and service descriptions. A verification process and accreditation check is undertaken before provider details are made live. Webhealth's success has been recognised with awards including ‘Best of Health Awards 2008’, ‘Westpac Waikato Business Excellence Awards 2007’ and ‘Best Health Awards 2006’.

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<sup>18</sup> Various online health services directories exist, including [Healthpoint](#), [Healthpages](#) and [Health Connection](#).

<sup>19</sup> [Platform Trust](#) is a national network of 47 organisations that believe a modern mental health system requires strong community-based supports for people with mental illness and addictions.

In addition to access via the internet, Webhealth touch-screen information kiosks can be located in public places to enhance information available to communities. A number of kiosks are already located around the North Island. Placement of kiosks requires support from local communities, via DHBs, councils or community-minded businesses, as the installation and maintenance of these is around \$10-15,000 per kiosk.

Linkage Trust can also provide the Webhealth service via Mobile Apps that make Webhealth information available on mobile phones or tablets. The first is due to launch before the end of this year. There are currently no Webhealth kiosks funded in the South Island, but interest is being generated by recent activities.

“We applied through MSD’s earthquake fund to get some kiosks for Christchurch, but they said ‘no’ because they saw it as a ‘business-as-usual’ activity,” says Julie Noster, Webhealth representative for Canterbury.

While Julie explores earthquake support opportunities through CERA, the local PHO **Partnership Health Canterbury** has arranged for Webhealth to place a sample touch screen information kiosk at Earthquake Recovery Centres around Christchurch – in Avondale in September and Kaiapoi in October 2011. The free-standing kiosks help people in worst-affected suburbs connect and get information on health services.

“While people waited to be seen at the Centres, I was able to help people navigate through the options and services if needed,” says Julie.

“It also helped me to connect with other providers, assist earthquake support workers and CERA staff with finding services for their clients, and update the recovery information on our site.”

Canterbury’s Webhealth service is funded by **Canterbury DHB** to have a mental health focus, so local staff address the needs of mental health providers and community. Overall information on Webhealth is much broader, with potential to add a primary health or community focus to suit a region’s/funder’s key priorities.

Julie says one of the biggest challenges to keeping the information up-to-date is finding out when someone has gone out of business – especially in Christchurch, as so many providers have been displaced.

“After the earthquakes, I did lots of phoning around to check who was still operating, but I wasn’t the only one. The *Family Services Directory* people spent time updating and other major organisations were updating their own records too,” explains Julie, while acknowledging that it would have been smarter to share the workload through better co-ordination and collaboration by all those who maintain health-related databases.

Webhealth has a print functionality that allows anyone to print their own hard copy directory of selected health and social services on demand. As trends in health care continue to emphasise self-management, and individuals taking more responsibility for their own health<sup>20</sup>, the ability to create a customised, personal directory of relevant health providers will be an important tool for maintaining health.

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<sup>20</sup> [Trends in Service Design and New Models of Care: A Review](#), National Health Board, Aug 2010.



“People can do it themselves, or someone could do it for them – for example a social worker could compile a directory of services to help a family or a diabetes nurse could help someone to manage their condition more effectively,” says Julie Noster.

Webhealth’s print function has been acknowledged as assisting to create the *Blokes Book*, a post-earthquake handbook of services created by the **Canterbury Men’s Centre**, and Julie believes up to 30,000 were printed and distributed.

“Webhealth is also a potential source of information for GPs, who may not be aware of the many other health-related providers and support groups in their communities,” says Julie.<sup>21</sup>

Council directories, such as CINCH are available through libraries, but these are often out-of-date and hard to maintain. Webhealth is keen to work with others to reduce the duplication of time and effort in maintaining and updating information or to assist those requiring specialist directories.

“We worked with the PHO to create a directory for East Christchurch services after the earthquake to take stock of who was operating and to identify where the gaps were in services,” says Julie.

Julie sees organisations working in disability, mental health, with senior citizens, young people or people with cancer all trying to maintain up-to-date information on providers, and believes Webhealth could be a good starting point for many of them.

“I’ve met with some groups to discuss possibilities. Some are concerned about losing control. I know of one organisation that gets \$15,000 to develop a specialist directory – if they used our information, then perhaps they could negotiate with their funder to use that money for their speciality,” Julie suggests.

Some organisations won’t source their information from Webhealth because they currently have details on particular providers that are not yet on Webhealth, but a collaborative effort could lessen workloads down the track.

“We try to be responsive to community demand and priorities,” says Julie.

“In Canterbury recently, we worked with the Pacific manager at **Pegasus Health** to source all the information on Pacific providers, as the PHO saw a need to collate the information.

“Partnership Health Canterbury is a wonderful champion of what we do – they paid for the development of Webhealth’s print function because they saw the extra value it would bring,” says Julie.

“The PHO’s chief executive, Jane Cartwright, sees the future of health is in the community and technology will play a big role in that,” says Julie.

“It’s thanks to the support from the PHO that Canterbury is ahead when it comes to primary health information on Webhealth. They alert us to new health priorities and we are then able to connect at the right meetings and with the right people.”

Partnership Health chief executive, Jane Cartwright says Webhealth is a useful tool to help people see what services are available.

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<sup>21</sup> [See a review of Webhealth by a North Shore GP](#) in *NZ Doctor*, March 2011.

“One of our roles is to make sure practice nurses are up-to-date on what services may be good for their patients, so we encourage them to use Webhealth, as it’s better than notebook,” says Jane.

“It’s about building confidence in the information – they need to know it is up-to-date. Julie did great things to make sure the information was correct in September and February when lots of services had to move.

“Webhealth also links in with [HealthPathways](#), which is an integrated primary and secondary tool for health professionals who refer to specialist services,” explains Jane.

The PHO sees potential for Webhealth as a tool to help with co-ordination of services in fields such as youth work.

The PHO’s CE says the relationship with Webhealth is not unusual, as evidenced by various profiles in the PHO’s latest Annual Report.

“We look where we can have an influence and then work together,” says Jane, citing the fact that all parks in Christchurch are smokefree as an example of what can be achieved when NGOs unite.

“Here in Canterbury, our bread and butter is NGOs – it’s all about community development.

“We start with two points in mind. The first is that most things that have an impact on people’s health – the health system has no control over. And if we want people to get well, we need to make sure we link them to other things like health NGOs, churches and social services.”

Jane says historically Christchurch is different because it has a long tradition of NGO providers.

“For example district nursing has always been done by Nurse Maude, not the DHB,” she says.

When asked if there are any barriers to working with NGOs, Jane says “if you start off thinking about funding – that’s not going to work.

“There needs to be a willingness to find a way forward. In Canterbury, we always begin with a mythical patient called Agnes and look at what difference we can make to her.”

The PHO also makes a difference for Webhealth’s Julie Noster, who is based with other NGOs in the same offices as the PHO and is included in appropriate internal messages and meetings. This helps keep the lines of communication open and maximises opportunities to enhance awareness campaigns by adding relevant providers to Webhealth – such as when Partnership Health was working on smoking cessation.

Local Webhealth representatives like Julie are backed up by a support team who make a lot of the initial contacts, approve all new providers and notices, and check details regularly. Providers can self-register on the site, but the verification process is a vital step to check individual’s accreditation.

Linkage Trust also provides data capture from Webhealth to their funders. This includes most popular keyword or category searches, which provide insights into who is using the directory and what information they are seeking – helping to identify gaps in knowledge or services, or particular concerns in a local community.

A *Live Chat* and *Ask Webhealth* email address are available in the Waikato region, where people can seek health and social service information from Linkage Trust staff. This is not an online counselling service, but replicates the face-to-face services that Linkage Trust Service Navigators offer.

Internationally, online health information services are providing forums for peer-to-peer health advice and information through sites such as [Patients Like Me](#) – but nothing this comprehensive and interactive is yet available in New Zealand. There are sites such as [Treasures Community](#) where parents can learn from each other and share experiences, a bulletin board on the [Everybody website](#) that has some topic-based discussions and [Plunket's Facebook page](#), which welcomes conversation and information sharing between parents of under-fives.

Linkage Trust has also worked with **Health Navigator NZ**, which was started by a group of GPs, nurses and allied health professionals to assist their colleagues and patients. The project is led by the Health Navigator Charitable Trust in collaboration with a range of partner organisations including Heart Foundation, Asthma Respiratory NZ, SPARC, Mental Health Foundation, Arthritis NZ, Diabetes NZ, and local district health boards.

The key aim of Health Navigator NZ is to reduce duplication by linking all key health resources together through an online gateway or portal to simplify the process of finding educational resources, tools and quality-tested health information. This will support and enable individuals and their whānau to manage their health and long-term conditions more effectively in partnership with their healthcare team. The website also includes a portal to various health directories.

As Letticia Mincham of Linkage Trust says: “Our work is very much about collaboration and relationships.”

**More information:** [www.webhealth.co.nz](http://www.webhealth.co.nz) or [www.partnershiphealth.org.nz](http://www.partnershiphealth.org.nz) or [www.healthnavigator.org.nz](http://www.healthnavigator.org.nz)

## Case study 9: Connecting with the community

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*A non-profit Pacific health provider involves its local Pacific communities in the planning and delivery of many of its health promotion activities – generating community buy-in and large attendances in the process.*

**Pacific Health Services Porirua** (PHSP) delivers a local community nursing service and regional smoking cessation programme from a complex of buildings in Cannon's Creek – a low socio-economic area with historically poor health and social outcomes. In a neighbouring building (a former lawn-mower shop), is the third arm of the organisation – a general practice, with a full-time Pacific GP and two locums.

**Pasifika communities** are well-represented in both the governance and staffing of Pacific Health Services Porirua – with representatives from the Cook Islands, Samoa, Niue, Tokelau, Fiji, Tonga and Tuvalu on the board, together with Mana Whenua.

Incorporating Pasifika values, principles and practices into the delivery of services is important, and there's a strong focus on family (aiga).

"It's about healthy living with family at the core," says Eleni Mason, General Manager of Pacific Health Services Porirua.

"We call our model Asiasiga after the Samoan word that means to visit, to inspect, in order to support, advocate, promote and educate. We have to stop thinking about people being sick and think about preventing them getting sick and keeping them well."

Whenever possible, services are delivered in a culturally appropriate way, by staff most likely to engage effectively with the client (e.g. a Tongan case worker for a Tongan client).

Subtle elements make the difference at the general practice too – for example, consulting rooms are larger with extra seating, as it is common for Pasifika families to visit the GP together – especially grown adults bringing their elders.

Community is important in Pacific cultures, so when the service started to refocus in 2006, they "took it back to the community."

"A community fono was called and many people attended from a diverse Pacific ethnic range. We asked 'what do you want'. They broke out into different ethnic groups and discussed in their native languages what services they would really like to see in the community," explains Eleni.

"There was a strong call from every community for a Pacific GP service – doctors, nurses, social and community workers who they could identify with, and a walk-in clinic. There was real concern about the difficulty getting timely appointments elsewhere because the existing clinics were at capacity. For many, transport was an issue and people wanted the comfort and assurance that comes from communicating in their own languages."

Not all the priorities were expected.

"One of the four priority services requested was circumcisions," says Eleni.

Now each year, the board and staff have a planning day – put everything into the PHSP health calendar and ask the community: "Is it challenging enough? Is it too challenging?"

“In the past few years, we added nurse specialist-run gout and asthma clinics because the community identified these as something they needed,” says Eleni.

“We also talk with them about policy and funding changes and how that will affect our services. We share it all with the community. This is a partnership and the community have invested in it with their time and energy. More important though, is the sense of investment and positive decision-making about ‘our health and the healthy futures we want for ourselves and our communities’. It’s also addressing social issues at the same time.”

Eleni says the calendar is known by the community, who all pitch in to help arrange and co-ordinate the health workshops at the Cook Island hall, the Pacific Arts and Crafts Exhibition, the multiple sporting activities (volleyball, touch rugby, kilikiti or Samoan cricket), the community garden project competitions, and the annual Celebration Day where all the nations come in their native dress and celebrate achievements. At this event, awards are given to those who excel, e.g. who had the best kept gardens, who attended their nominated healthy lifestyle programme consistently, or who improved their health status.

While it sounds like a lot of work for an organisation with only 14 staff, Eleni says the *Specific Pacific* groups mostly organise themselves and provide support and cultural advice for the team.

“We work with the community, and make sure there are lots of healthy living messages at all the events,” she explains.

What is really pleasing is that other groups and event organisers recognise this contribution and have approached PHSP to present on how these are run. The Healthy Lifestyle Pasifika Programme (HLPP) is being mirrored in other communities outside of Porirua.

“There is a lot of health promotion activity. For example, when we are visiting or discussing gardens, we talk about planting and eating healthy foods.”

Pacific Health Services Porirua also works closely with neighbouring providers. These include Pacific providers **Vakaola** and **Maninoa Community Care Trust** who provide mental health support and residential services. PHSP and **Pacific Health Services Hutt Valley** are working on a joint initiative to enhance Pacific-led clinic services in the Hutt, and have already started GP satellite clinics. This provides easy access to the GP for clients living out in the Hutt Valley. Between GP visits, clients are monitored by the nurses from PHS Hutt Valley.

A Māori and Pacific collective, Waka E Tasi (One Waka), has also been formed to strengthen the health and social service connections and capability of local services. The members include Pacific Health Services Porirua, the **Fanau Centre** and its associated early childhood centre, **Maraeroa Marae Health Clinic** and **Whare Tiaki Maori Women’s Refuge**.

Fanau Centre General Manager, Liz Kelly says the collective enables the four providers to offer a wrap-around service for all ages.

“Health and social services go hand-in-hand because it’s about health and well-being – focusing on wellness,” explains Liz.

“In a low socio-economic area like Cannons Creek, Māori and Pacific Island working together for the good of our community is the key. We can refer to each other and help our partners, rather than taking a siloed approach.”

“We think alike and we have gelled,” agrees Eleni, “the formal aspect is undertaken through regular management meetings.”

The Fanau Centre has a High Trust Contract with the Ministry of Social Development (MSD) and Liz sees real benefits for the sustainability of all four services in the collective approach. A recent joint proposal for a MSD-funded initiative was successful and is encouraging strategies for progressing shared goals that will benefit the people of Cannons Creek and Waitangirua. One possibility is strengthening existing connections with Housing NZ and Work and Income for the benefit of shared client groups.

Having access to more facilities enables PHSP to respond to the community in other ways too – such as when a group of young people were hanging around with nothing to do after their pastor died.

“They approached us for help, and we worked together to find them some space and equipment. They started a dance group and now they are performing at events on invitation, and they are receiving donations for their efforts. We still provide them with support but they lead, create and act on their own ideas. They are so much happier and healthier,” says Eleni.

Working collaboratively requires adaptability explains Eleni. PHSP and the local Māori health provider, Maraeroa Marae, used to meet regularly as part of the same PHO, but now each is in a different PHO, so finding a new and ‘efficient’ way to work together is a positive step forward.

“There are some advantages to being in a bigger PHO, but you don’t have the same regular opportunities for face-to-face meetings with doctors and managers that you get in a small PHO who are operating in the heart of your community – it’s harder to stay in touch, to get all the managers round the table and develop closeness.”

Pacific Health Services Porirua has experience in sharing backroom functions too – sharing its IT database server and software with two other providers – and is always looking to collaborate in ways to deliver more efficient services.

“We talked with Pacific health providers from Whangarei, Invercargill, Hawkes Bay and Wellington about how to standardise a number of things, the possibilities of sharing backroom services, and how we were working with the same types of clients in different areas,” explains Eleni.

“We still interact with some, but we haven’t really progressed to the place we would like. It’s challenging to find time for wider issues, when organisations are focussed on sustaining services to their respective communities.”

Eleni is pleased to read about the Ministry of Health’s interest in Advance Care Planning<sup>22</sup>, which assists an individual to identify their personal beliefs and values and incorporate them into plans for their future health care.

“It’s normal for Pasifika people to look after their elders,” says Eleni “and dying at home is important to us.”

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<sup>22</sup> [\*Advance Care Planning: A guide for the New Zealand health care workforce\*](#), Ministry of Health, Aug 2011.

Referrals drive the PHSP service. The community nursing services assist in homes and also work closely with the Pacific General Practice – especially on immunisations and those with long-term conditions. At the GP, after three phone calls and recall letters are sent and the patient still has not shown up, the case is referred to the community service for follow-up and home visiting if necessary. Unless the families have moved out of the area, the team has close to a 100% rate of finding Pasifika clients.

Eleni says because the community nurse-led services had been funded through the DHB, there is scope for it to assist a wider range of general practices, regardless of which PHO they are part of.

“We can find people through our Pacific networks and groups. They could send us their hard-to-reach names and we will find them and deliver them to the practice. There are no patch protection issues and they won’t lose any of their capitation,” she explains.

PHSP’s community services are often called in to translate for other health services, which may involve accompanying people to their treatment.

“We’re not just there to translate, we’re there as part of community continuity of care, ensuring people who don’t have a good understanding of English know about free screenings, community activities and support at home,” says Eleni.

The ‘for Pacific, by Pacific’ community focus means Pacific Health Services Porirua delivers more than just health services – a fact it plans to acknowledge at a community fono soon, when it confirms a name change to ‘Pacific Health & Social Services’.

**More information:** [www.youtube.com/watch?v=PPPmAzM\\_Q-0](https://www.youtube.com/watch?v=PPPmAzM_Q-0) or [www.fanau.org.nz](http://www.fanau.org.nz)

## Case study 10: Making the system work for everyone

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*An accreditation process for NGOs is improving access to health services for high need populations, while generating enrolments with the local PHO.*

Statistics show that the Māori population across Otago and Southland is growing faster than in the rest of New Zealand. Much of the Māori population is young and has a lower social-economic status. *Tatau Kahukura*, the Māori Health Chart Book provides accessible information on key Māori health indicators to assist the **Southern PHO** and other service planners to develop policy and services, and allocate resources.

To help transform services, the Southern PHO is encouraging the wider health sector to build strong clinical networks and collaborative support and engagement with Māori providers and other community agencies.

The Southern PHO, which has 94 general practice members, has engaged an independent expert from a North Island Māori NGO to set up an accreditation system that establishes the credentials of various providers. The IT platform records what services they provide, that appropriate systems are in place, nurses' specialist skills, and if they have contracts with the DHB or PHO, or have done accreditation through Telarc, DAA, Quality House or others.

"It means if a patient is sitting with a GP, the GP can scroll through a menu and give them a choice about whether they have a Southern PHO-funded clinical service done there or with another accredited provider," says Southern PHO chief executive, Ian Macara.

"The GP can make an electronic referral to accredited NGOs via MedTech using the NHI tracking number. The referral is acknowledged and once the NGO has provided the service, they invoice the PHO."

Three health programmes (sexual health, cardiovascular and diabetes) have begun in the past few months, and ultimately 15 programmes will be part of the referral system.

Ian Macara says many NGOs are aware of people not enrolled with a PHO, so they can refer them to a general practice, which then enables the patient and NGO to tap into a range of support. Once enrolled, the PHO can use its discretionary funding to improve services for high needs patients, such as Māori and Pacific Island people or those classed as Deprivation 9 or 10, or in high needs areas like Bluff, where 43% of the population is Māori.

While Ian is keen to work with a range of NGOs, he admits it can be difficult to find out which NGOs work in different communities and what services they offer.

"In some cases, we know they are providing health care but we don't know what contracts they hold or what they are for. We have asked the DHB for this information, but haven't got it yet," says Ian.

Ian's desire for this information should be a welcome relief to many NGOs, as he views a successful government contract as satisfying the process for accreditation with the PHO.

"If NGOs are being paid by the Ministry or DHB to deliver a service and the contract has been satisfied, then that's an indication to us that an NGO's processes are robust and rigorous enough for us to consider using them. We're not going to subject them to multiple audits," he explains.



“The primary health sector is complex, so there needs to be a mechanism that co-ordinates information. We don’t have a comprehensive database that we can tap into yet. For example, I know the Arthritis Foundation is in our communities, but I don’t know how many people they can service, what staff they have, how they are funded or what services they provide.”

While some NGO and provider information is publicly available through various databases such as the [Charities Register](#), [Webhealth](#), [Healthpoint](#), the [Family Services Directory](#) or the [Contract Mapping website](#) – none of these provides a complete picture, and each has its own challenges in maintaining and accessing data.

“It’s also a challenge to get information out to the sector about the PHO’s progress and priorities,” says Ian.

The Southern PHO already has **30 non-GP accredited providers** across the Otago/Southland region and Ian says there are various areas where NGOs can deliver a superior service.

“For example, GP skills have waned in the insulin initiation area – because this service has gravitated to DHBs.

“By appropriately using non-profit providers, we can assist to unclog the secondary care system.”

Ian is especially enthusiastic about the outreach nursing services, which are reaching the non-enrolled population who haven’t engaged with primary health care.

“Some can’t afford it, others live remotely or are transient so end up being treated as a casual patient, which costs them more. We also have a significant migrant population here for work, but they can’t enrol until they’ve been in the country for 24 months,” Ian explains.

In Invercargill, the Southern PHO worked with **Nga Kete Matauranga Pounamu Charitable Trust, Māori providers, GPs, government agencies and church groups** on a mobile community nursing project targeting high needs patients. In Dunedin, **Arai Te Uru Whare Hauora** is one of the providers of mobile nursing services. It covers a large Otago area from Balclutha to Oamaru and inland to Middlesbrough, and has government contracts of around \$2 million from the Ministries of Social Development and Health and ALAC.

**More information:** [www.southernpho.health.nz](http://www.southernpho.health.nz)

## Case study 11: Linking rural communities to health services

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*In remote parts of Northland, a grassroots non-profit NGO helps ensure patients turn up at GP, specialist and hospital appointments, while struggling to find funding to keep operating.*

**Linking Hands Inc** struggled to get accepted by funders and officialdom when they began the service. But, after proving its value to the community, its good reputation is starting to be noticed – now a lot of support comes from the communities that it serves.

Linking Hands Inc is a rural health shuttle service covering the mid-Kaipara, Whangarei and Rodney districts – which encompasses a large part of rural Northland. In reality, it is so much more than this – enabling elderly people to stay in their homes and follow the advice of their GPs or other health professionals, and other remote residents to maintain their health and well-being.

Doreen, a resident of Maungaturoto for 50 years and user of the shuttle, describes her experience in this way: “I had a needle in my heel. By the time it was healed, I couldn’t walk. The doctor suggested if I’d like to go swimming, would I like to get in touch with Linking Hands. So Linking Hands took me down to the baths to help me with my walking.

“Linking Hands introduced me to the pool – I did not know the pool existed down there at Te Hana....and they put me in touch with Aqua Swim. It made quite a lot of difference to my quality of life because since I’ve been like this, I haven’t wanted to go out much, and getting my weekly outing down to swimming has enabled me to meet other people and I realise perhaps I’m not so badly off.”

Linking Hands originated from an information service managed by Jayne King in late 2007. Local Maureen Davis broadened her involvement from Homebuilders (a child and family support service) and joined Linking Hands – bringing with her a van loaned from **Kaipara Community Health Trust**. Maureen incorporated the organisation, but still needed funding to get the service up and running.

The Kaipara Community Health Trust had formed in 1996 when local surgical services were greatly reduced and Dargaville Hospital was under threat of closure by Northland District Health Board. As a result, Kaipara residents joined together and formed the Trust, eventually gaining 46% ownership of the Dargaville Hospital – another example of rural people struggling to access services.

Kaipara Trust had been running a health shuttle in Dargaville for many years but, when its own vehicle needed replacing, the Board decided the old 8-seater Hi-Ace still had some ‘life left in her’.

“The Board’s foresight envisioned a community group using this vehicle to provide a similar health-related transport service in the central part of the district, which our Dargaville shuttle couldn’t service,” says Debbie Evans, chief executive of Kaipara Community Health Trust.

Debbie explains that it can be a chicken and egg scenario for groups like Linking Hands, who often need someone to make a leap of faith to help get things going.

“To apply for funding, you usually need statistics to prove yourself – but you can’t get statistics without money to get started. That’s why we were prepared to form a joint venture with Linking Hands Inc,” says Debbie.

With a borrowed van and \$35, Maureen and Jayne got on to the local newspapers and then began: The Linking Hands Inc Health Shuttle service. They started with a team of 12 drivers, all dedicated and committed to help make this service work.

For awhile, Linking Hands was caught in the middle of complex relationships between multiple PHOs and a DHB, but has soldiered on, confident in the knowledge that its services were valued and needed by local people.

Four years on, Linking Hands has three branches and six vehicles, and a core team of 41 volunteers. Thanks to Lotteries, they can also employ an admin person for three days a week at a grand sum of \$195 per week.

Most of Linking Hands' funding comes from Lotteries, but they've also had grants or donations from COGS, ASB Trust, JR McKenzie and Catholic Caring – although some of these have changed their focus or tightened up on funding during the recession. Lions, Rotary and churches also make donations, and signs in the vans read 'Thank you for your donations', but people are not obliged to pay anything for the service.

Maureen says she's a big user of [Fundview](#) (the online directory of funding information) and had a good knowledge of funding sources from her time with Homebuilders.

"We don't seem to fit the criteria for most government funding, so we have to scrape around for money," laments Maureen.

"We are prepared to go wherever we have to, to keep our service running. I seem to spend half my life filling in application forms!"

When things look grim, Maureen contacts the local papers, such as last year when they were low on funds and a few articles generated a much-needed \$12,000 in donations from the community.

"We thought we could run on the smell of an oily rag but at that time, we didn't even have enough to buy the smell," says Maureen.

"Most of our vehicles are 1995, '96 or '97 models," says Maureen, "so they need a lot of upkeep. We have huge bills to pay with insurance, registrations, road user charges, warrant costs, new tyres, general maintenance on the vehicles, as well as petrol and diesel costs.

"We cover a big area," says Maureen, "with scattered little towns such as Ruawai and Tinopai, from the east coast to the west coast, and down as far as Warkworth. A round trip to some places can be 277 kilometres.

"There are no taxis or buses to most of these areas.

"Before our service was here, often people just didn't turn up at Whangarei Hospital.

"We'll take people to any medical appointment," explains Maureen.

"Ears, eyes, nose, toes, GPs, ACC. We don't do alcohol and drug treatment, and we don't do the courts, but we do other appointments related to well-being like WINZ or Inland Revenue, or day care for people with Alzheimer's."

A wide range of people use the service – the elderly, those who can't see, people with broken legs or simply those who don't like to ask family or friends to take them to appointments. Many people only use the service once or twice, but others with chronic conditions may use it over several years.

As Ian Wilson, an elderly user of the shuttle service, explains this is the real value of Linking Hands: “I’d just be a pest to my relations.....the first few times it’s easy. The next few times it gets a bit harder and after three or four years that are still ongoing, it would be a horrible nuisance,” say Ian, who’s a strong advocate for the service and values the sense of independence it gives him.

Maureen says there’s not very good awareness in the medical profession about how difficult it is for people to get to things.

Because shuttle users live remotely, they often have several different appointments in one day, but the health providers’ delays can make things difficult.

“We can drop people off for an appointment, and when the driver comes back hours later, they are still waiting. They can end up missing the other appointment or getting left behind,” says Maureen.

“Hospitals are the worst, ’cos they give everyone the same appointment time and then they all have to wait their turn. It’s badly co-ordinated. We had someone whose appointment was 12 noon, and they finally took her in at 4:30pm.”

An official hospital shuttle is a recent addition to the region, which Linking Hands welcomes, and they work in conjunction with the travel co-ordinator at the hospital to plan trips.

“It’s a good service to have,” says Maureen, who is eligible to use the hospital shuttle herself for regular dialysis treatment.

“In the past, the hospital sometimes used a taxi to transport people from Whangarei to Auckland. That can cost \$200 to \$300 each time.

“We don’t get any money from government – not from the Ministry of Health or DHBs,” says Maureen, “although we did receive a donation of \$2,000 from the PHO in Rodney recently, with a letter saying they were most appreciative of our Linking Hands service.”

Maureen explains that passengers can make claims in some circumstances, such as when a patient has more than six appointments in six months – but it doesn’t cover the costs.

“For example, if we take someone from Tinopai to meet the DHB shuttle, the round trip for us from our base to pick them up and drop them off and return is 240kms, but the DHB will only pay the direct route from the person’s home to the shuttle pick-up, which is 45kms,” says Maureen.

People find out about the service through free columns in the local papers, word-of-mouth and some referrals from **hospitals and medical centres**, although there is scope for greater awareness among health providers.

“We initiated contact with all the **DHB social workers** and this has enabled us to work smarter and in a more timely way with the hospital discharge system. They all know about us on the wards now,” explains Maureen.

Kaipara Trust has continued to take an interest in its ‘sister service’ and receives regular reports on progress and client numbers. It will often write letters of support for Linking Hands’ funding applications – such as when they wanted to extend the service to Mangawhai and surrounding districts in 2010.

“This is a much needed service and we wish to see it succeed for the people of our rural communities. Linking Hands has a passionate team of volunteers and has scoped the community’s needs to identify where its services are required most. They have attracted huge amounts of community support and we fully endorse their vision,” says Kaipara Trust’s Debbie Evans.

Linking Hands has been asked to extend the service to Whangarei, but Maureen says they don’t have the resources at present, so they have to set boundaries – but she recognises that travel issues can be just as difficult for some urban people.

In exceptional cases, they have taken one or two people to Auckland, but that is rare.

The travel time with patients and the relationships that Linking Hands develops with their regular users mean they are privy to reactions and opinions about health changes.

“We get lots of complaints from elderly people about the fact that the medical centre has patients see the nurse before getting an appointment to see the doctor – so now some don’t bother to go. The use of locums is also annoying to many people as they don’t know the patients’ backgrounds and this appears to them as unprofessional,” says Maureen, who perhaps could be a useful ally to help communicate health changes to rural communities.

If Maureen had two messages for the health providers that Linking Hands connects their passengers with, the first would be “keep to appointments”.

The other would be a plea for sustainable funding for services to remote communities.

“People should be entitled to live where they choose without being penalised – they shouldn’t have to move because of travel issues.

“If government can’t fund the services in the communities, it should at least support the services that help people to get there,” she says.

**More information:** [www.youtube.com/watch?v=FugWeYicZLY](https://www.youtube.com/watch?v=FugWeYicZLY)

## Case study 12: In the heart of the community

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*A collaboration between a DHB, a PHO, a Māori health provider and a non-profit sporting body has seen delivery of a Cardiac Rehabilitation programme successfully transition from secondary hospital services 'ownership' to the community.*

At the beginning of 2010, **Tairāwhiti District Health Board** sought to divest itself of services that could be more appropriately provided in the community.

The DHB approached the PHO as contract holder, and two other local providers (**Turanga Health** and **Sport Gisborne Tairāwhiti**) partnered with **Turanganui PHO** (now part of the **Midlands Health Network**) to deliver a community-based Phase II Cardiac Rehabilitation Programme. Each organisation brought different skills, resources and connections to the collaboration, which continues to go from strength-to-strength.

The PHO contributed a half-time nurse co-ordinator, as well as the support systems for receiving and processing referrals, direct linkages to general practice IT systems and fund-holding functions. Clinical leadership, quality monitoring and maintaining excellent collegial relationships with clinicians at the hospital are vital parts of the co-ordination role.

A key requirement for the new initiative was a suitable venue, and Turanga Health was able to contribute use of its gymnasium, as well as a registered nurse to work in the team during gym sessions. A kaiawhina was made available so programme participants with transport difficulties could be 'taxied' to and from the venue.

"The Gisborne programme had previously been run at the hospital's physiotherapy department and the facilities were not ideal. The hospital is located on the outskirts of town and public transport in Gisborne is not fantastic, so people without cars were largely excluded," says Carol Ford, registered nurse and rehab programme co-ordinator from Midlands Health Network.

"As well as this, the hospital is generally perceived as a place to go when you are sick. This programme focuses very much on wellness, so is so much more appropriately located in a community setting, closer to where people are living their lives day-to-day."

As an iwi health provider to three Turanga iwi (Ngai Tamanuhiri, Rongowhakaata, and Te Aitanga a Mahaki), Turanga Health is influential in the Gisborne community. Turanga Health's vision is 'kia whai oranga-a-whānau mo nga whakatipuranga' or 'building family wellness for future generations'.

"Whether it be promoting healthy lifestyles, giving health advice, attending health meetings or simply answering the phone, our behaviour will be consistent with the implicit teachings of our tipuna," says Reweti Ropiha, chief executive of Turanga Health.

These teachings fit well with Cardiac Rehab programmes, which are internationally-recognised best practice for people after a heart event or surgery.

"The aim is to prevent further cardiovascular events by educating, motivating and empowering people to initiate and maintain healthy lifestyle changes. When they begin, the majority of participants have not been regularly physically active. Their recent cardiac events create a unique motivator for making changes, [but] people experience great uncertainty as to what level of exercise is safe and desirable," says Carol Ford.

Toni Hoskin, Leader of Sport Gisborne's Active Health team contributes her expertise in exercise motivation and coaching to the Cardiac Rehab programme. Sport Gisborne also provides the Green Prescription service in Gisborne, which empowers individuals and whānau to make positive lifestyle changes with respect to physical activity and food choices through practical information, relevant/appropriate support and genuine encouragement.

The Cardiac Rehab programme provides 'coaching' appropriate to the needs and preferences of each person. Activity levels are increased incrementally and heart monitoring is provided during exercise.

"Naturally there are benefits from the experience of sharing this journey with others who have similar health issues," observes Carol.

Referrals come from both the DHB cardiac services team and from general practice, and a comprehensive assessment in the person's home, looking at their whole situation is the first step.

"Issues not directly related to health but which may be impacting greatly on people's capacity to look after themselves well are commonly revealed and we are able, when necessary, to link people into a variety of support services before they even begin the programme," explains Carol.

Examples include advice and support to address unmanaged health issues of other family members, referral to a social worker for assistance to purchase suitable walking shoes or dentures, help with housing issues or assistance with transport to the programme and to specialist appointments.

"Problems with understanding medications are more easily identified and addressed when you sit with a person at their kitchen table and observe first hand their handling of the pills," says Carol.

"The assessment provides many wonderful opportunities for educating and reassuring both the patient and their whānau. Maximising the services of their general practice is very strongly encouraged."

The programme's multi-disciplinary delivery team comprises staff of all the joint venture partners.

"When the programme is running in the gym it can be 'full-on'," says Toni Hoskin, "so we need to communicate well with each other during the sessions.

"An important element is building each person's confidence to decide for themselves what is safe and what is enough," explains Toni.

"We help them develop an exercise routine – something they will like and therefore be more likely to stick with after the eight weeks is finished – and at the end of the programme, we can also link individuals into suitable community exercise activities."

"We also use other community providers for the education components," says Carol, before giving the examples of the pharmacist, dietician, St John, Presbyterian Support and primary mental health services.

"Family members are warmly welcomed as well, since we know that support at home for people making significant lifestyle changes is very important."

The Toi-Ora (*towards optimum wellness*) Cardiac Rehab programme is co-run with a *Better Breathing* programme for people with long-term breathing disorders.

“This programme helps a group of people who are very breathless (for example as a result of emphysema or heart failure) and who are likely to slowly get more unwell over time,” says Carol.

In *Better Breathing*, people learn exercises appropriate to their age, condition and preferences and experience how even a small improvement in fitness can reduce their breathlessness and enhance their sense of well-being and ability to participate in life.

“We have witnessed some amazing transformations,” says Carol.

“For both programmes, there is pre and post-testing. The pre-testing helps us assess the individual’s current level of fitness, their balance and their strength, which guides their exercise programme. Post-testing numbers enable us to monitor the effectiveness of the programme,” explains Toni.

“All participants are provided with certificates at the end of the programmes, which include these recordings and show the improvements they make. This in itself is motivating,” says Carol.

Health literacy is always on the minds of the delivery team, who have committed to monitor each other’s language and continually check with participants that messages are understood. A recent innovation in dissecting sheep hearts, in a bid to approach education around heart disease in a less verbal way, has been extremely well received.

“This has resulted in people asking some very down-to-earth questions, which they were too shy to ask before,” continues Carol.

“We’re fine-tuning and trying new approaches all the time.”

Each organisation’s reach into other areas or support is an overall strength of the service.

“For example we frequently refer people from the *Better Breathing* programme to Turanga Health’s Mirimiri (massage) service,” says Carol enthusiastically.

“This especially helps with relaxing the shoulders, improving the posture, slowing down breathing, opening up the chest to make more room.

“At the end of the programme it is valuable to be able to link some of the men into the very supportive and sociable Turanga Health men’s health programme, which provides a bus service to the local pool and gym, a walking group and a wonderful Kaumatua programme. Ill health sometimes results in social isolation and this group can really help.

“Sport Gisborne has walking groups and gym groups at different levels, a nutritionist service, and direct links to a number of other community activities. We link people in with these.”

Toni thinks the fact Gisborne is a small community is also an advantage.

“A lot of our spheres of influence cross over, so we are in a better position to offer a whole service or holistic approach, and be quite responsive.

“When we bring all that together, it means we are able to really personalise and individualise what we can offer people. The different skill-sets, coupled with the personalities means the service we offer can be quite life-changing,” says Toni.



“We did have inter-organisation relationships before, but they were not as strong. Now we have a lot more comprehensive understanding and knowledge of what each other does,” explains Toni.

The partners all agree that being based in the community and closely linked with primary care, rather than the hospital, is a key to their programme’s success.

“People are more likely to come if it’s in the community. Looking at some of the people we’ve got on the programme now, I don’t think they’d turn up if it were at the hospital. The location is more convenient and we can bring a lot more flexibility to how we deliver it,” agrees Reweti.

“It’s about making ‘the invisibles’ visible – reaching the people who the system doesn’t usually get to.”

Almost all other Phase II Cardiac Rehab programmes in New Zealand are delivered by hospital staff, although not always on the hospital site. (Kaikohe, Whangarei, Auckland, Hamilton, and Christchurch provide programmes based in church or community halls, Napier, Whanganui, Dunedin and Invercargill have programmes in local gymnasiums, and Palmerston North, Horowhenua and Kapiti deliver theirs at local health centres.<sup>23</sup>) The Gisborne team believes theirs may be the only fully-integrated programme provided by a collaboration of community-based organisations including NGOs.

“It would be great to have more time, more money, more groups so we can provide maximum opportunity for maximum change. It would be great to find a way to help people over a longer period of time, and link with more providers,” says Toni, who is keen to meet with the DHB and Midlands Health Network to discuss possibilities.

“There’s great potential for the programme to grow. Almost everyone who suffers a long-term health condition can benefit from understanding and experiencing how increased physical activity can help them,” agrees Carol.

Expansion into rural areas is another possibility. Currently people living outside the city boundaries are unlikely to participate because of travel distances. The Heart Foundation has a programme suitable for home use, however this is not presently resourced in the Gisborne area.

“The team is currently working to support one rural nurse to provide home-based coaching and support for a particular cardiac client. This may be the beginning of improving access for our rural people,” explains Carol.

**More information:** [www.turangahealth.co.nz](http://www.turangahealth.co.nz) or [www.sportgisborne.org.nz](http://www.sportgisborne.org.nz) or [www.Midlandshn.health.nz](http://www.Midlandshn.health.nz)

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<sup>23</sup> [NZ Directory of Cardiac Rehabilitation Programmes](#), Heart Foundation, January 2011.

### Case study 13: Multiple relationships vital for an effective one-stop-shop

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*Running a youth one-stop-shop providing health and support services means building and maintaining a vast number of relationships with providers in health, social services, education and justice; while cultivating community links and keeping multiple funders happy.*

**Kapiti Youth Support (KYS)** is an innovative youth one-stop-shop based in Paraparaumu on the Kapiti Coast. It provides free health and support services for young people aged 11 to 25 years. It currently has 4,500 young people registered with the service.

Young people see KYS as a safe and confidential place to come, and know that when they engage with the service they will be treated with respect and care. The services and programmes are holistic, strengths-based, focus on improving overall health and well-being and encourage long term independence.

A different approach to young people's health is necessary, as causes of ill health are often psychosocial rather than biological and young people may engage in risky behaviours. Their health status is also strongly influenced by family, social and cultural factors such as family breakdown, physical/sexual abuse or neglect.

The youth one-stop-shop model of care improves access to services and support by reducing barriers and stigma, such as fear, anxiety about privacy or discomfort with the provider<sup>24</sup>. Improving access to services is crucial for addressing health issues of young people.

KYS manager, Raechel Osborne acknowledges that it is important to take a collaborative, intersectoral approach when supporting young people.

"Young people's lives cross many domains such as education, employment, family and the community, therefore it is important that KYS has well-established relationships with these groups if we are to support young people as they transition to adulthood," she says.

The list of agencies Kapiti Youth Support works with looks like a directory of **youth, community, social services and health providers** – but there are clear purposes for each relationship. Local networks include the Youth Workers Network, Voices Against Violence, CYF/ Youth Justice, Birthright, Midwives, the Kapiti Youth Council, Regional Public Health, Safer Community Trust, Police, Youth Aid, Work & Income, Youth Quest – to name a few.

Sometimes it is easier for a young person to be seen at KYS, as it is less threatening – especially if they are already engaged with KYS. It is not uncommon for services such as **Child Adolescent Mental Health Services (CAMHS)** and **Early Intervention Services (EIS)** to see young people at KYS, which provides a more seamless approach. Other providers also deliver services at the KYS facility, such as **Careers NZ**, which comes fortnightly, and **Schools Out**, which has a weekly meeting.

Raechel says KYS's success comes from really good relationships, engagement and trust.

"Others seem to like working from here," she says matter-of-factly.

"We don't advertise our service – it is all word-of-mouth."

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<sup>24</sup> [Youth 2000 Survey](#), Adolescent Health Research Council, 2003.

KYS also has positive, collaborative relationships with the two local **secondary schools** – with weekly nurse-led clinics part of the service. Working together means students can access services at KYS in school holidays or after they've left school (until age 25) – providing some continuity of care and reducing fragmentation.

KYS works closely with **Child, Youth and Family's Youth Justice social workers**, and will provide comprehensive alcohol and drug assessments and health assessments as required. It is common practise for these young people to then access other support from KYS such as the mentor/coach or social worker.

Raechel says the fee-for-service CYF work helps financially, but is difficult to predict and adds to the stress of forward planning for service programmes and employing staff.

"How can you plan?" she asks.

Other fee-for-service work includes ACC, maternity and sexual health.

Internal systems are important, especially given KYS's considerable growth and increased demand.

"In 2006, we had 3,029 GP/nurse consults, and in 2010 we did 12,591," explains Raechel.

KYS first started in 1997 with a part-time doctor and a nurse – now the range of staff includes peer support workers, doctors, nurses, social worker, coach/mentor, counsellors, alcohol and drug counsellor, a Young Mums co-ordinator, and administration and reception support.

"KYS's staff is its greatest asset. They are all amazing. They are not only highly skilled and experienced, but are passionate about supporting young people," says Raechel.

"Having an integrated, multidisciplinary team of professionals and non-professionals means we are able to offer a variety of interventions, support, programmes and youth development initiatives.

"We very much work as a team – sometimes the issues or concerns for young people are complex and their lives are chaotic. We may need to be flexible and it can vary in what that looks like and how it works for the individual young person."

KYS is one of only **12 youth one-stop-shops** in New Zealand – many of them in the lower North Island. Development of these models occurred under the former Central Regional Health Authority (CRHA), which actively supported their establishment in the nineties to respond to the findings in *Whiti te ra*.<sup>25</sup> A follow-up survey indicated that young people wanted to access health and support services at one place – a theme still strong in 2011.

"Young people do not want to be accessing different silos of care where they have to constantly repeat their story," says Raechel.

"We have found that each time we refer a young person on, that often engagement does not occur."

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<sup>25</sup> *Whiti te ra, Young and healthy: Health and disability support services for young people in the central region*, Central Regional Health Authority, Feb 1995.

Today, the existing youth one-stop-shops assist each other in many ways. This includes sharing policy and programmes, keeping up-to-date with current and international information and generally supporting each other.

“The future direction of health talks about developing Integrated Family Health Centres – youth one-stop-shops have been working in this framework for many years,” says Raechel.

**Capital and Coast District Health Board** is KYS’s main funder, but Raechel has a total of nine main contracts and three other minor contracts to manage. These contracts come from a variety of sources – including ones from the Ministry of Social Development, Kapiti Coast District Council and the PHO. KYS is not part of the PHO, but has relationships with it. All contracts have different reporting timeframes and some are one-offs, which places KYS in a very tenuous position.

KYS applies for one-off contracts and has provided several innovation programmes, which take time to research and develop. Once implemented however, there often seems little desire by funders to evaluate the effectiveness of them or recognise the critical features for success. The KYS team has found themselves in the situation where they have implemented innovation programmes and when funding finished, it was unsafe for a young person not to continue to be supported by KYS for a longer period. The question then becomes “who then funds that?”

“Sustainable funding is a major issue – it’s really stressful and difficult to plan,” says Raechel.

KYS is able to put all the government funding it receives into service delivery thanks to overwhelming community support and funding from other organisations such as Pelorus, Endeavour and the Lion Foundation.

“This has allowed us to extend our existing building to meet the increasing demand on the service and purchase equipment, which means we do not have big overheads and we own the building freehold, so we don’t have to pay rent,” explains Raechel.

Raechel makes it a priority to keep the **local community** informed of KYS’s work. That means regular meetings with local MPs, presentations to service groups like Probus and Rotary, which all take time but are an important component of being a community organisation.

Overall, Raechel thinks resources need to be targeted where young people are accessing services.

“The Gluckman report<sup>26</sup> commissioned for Prime Minister John Key emphasised the need for long-term commitments to appropriate policies and programmes. It’s promoting evidence-based, prevention and early intervention strategies as being effective, but we need to put more resource into our young people now,” she says.

Evidence and research are a passion.

“Being part of national and international research provides an opportunity to capture the voice of our local young people, and exposes our staff to the research process,” explains Raechel.

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<sup>26</sup> [\*Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence\*](#), A report from the Prime Minister’s Chief Science Advisor, May 2011.

She describes how KYS has sought out opportunities to work with **leading academics** and be part of ongoing research studies, such as the *Pathways to Youth Resilience*<sup>27</sup> research driven in New Zealand by Professor Robyn Munford and Dr Jackie Sanders at Massey University, but led from the Canadian Resilience Research Centre under the direction of Professor Michael Ungar of Dalhousie University.

The study aims to explore the factors that make the most difference to the lives of vulnerable young people who, for varying reasons, require support or intervention from major government agencies.

Dr Munford's project report states: *"Your focus on positive youth development, your relationship with other key agencies and the integrated approach your agency has, contributed to young people's positive development."*

KYS also took part in Dr Sally Merry's *E-therapy*<sup>28</sup> research project for the Werry Centre for Child and Adolescent Mental Health Dept. of Psychological Medicine, Faculty of Medical and Health Sciences at the University of Auckland.

"We're constantly trying to prove what we do is effective, so our relationship with academics is important," explains Raechel.

"We can't afford to do these ourselves – so we engage with opportunities as they arise."

Other qualitative opportunities have included KYS's recognition in the 2008 Wellington Regional Community Awards and being *Small Business of the Year* in the 2008 Electra Kapiti Horowhenua Business Awards.

The latest exciting opportunity for KYS will have positive implications for other youth one-stop-shops too. KYS and research partners Robyn Bailey and Rae Torrie, with other supporting advisors, evaluators and researchers recently received funding for an 18-month project from the Health Research Council of NZ. The researchers plan to develop a comprehensive monitoring and evaluation framework that links the integrated approach driving the work of KYS activities and delivery mechanisms with youth outcomes.

"I've been in health all my working life and have worked with young people for most of that time— this model works for young people," says Raechel.

#### More information:

[www.kapitihealth.org.nz/?Support\\_Organisations:Youth:Kapiti\\_Youth\\_Support\\_%28KYS%29](http://www.kapitihealth.org.nz/?Support_Organisations:Youth:Kapiti_Youth_Support_%28KYS%29)

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<sup>27</sup> [Pathways to Youth Resilience research](#) – eight-year research project.

<sup>28</sup> [E-Therapy project](#) – The Werry Centre for Child and Adolescent Mental Health.

## Case study 14: Demands of complex funding streams create inefficiencies

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*A large, non-profit alcohol and drug treatment service finds much in common with others in its two key networks, but the benefits of working together are diminished by the onerous compliance demands of multiple government funders.*

**Odyssey House Auckland** has treated New Zealand adults and adolescents with serious substance abuse, gambling, and other associated problems since 1980. Its services are delivered in a variety of settings, including in-residence, in people's homes, in schools, in prisons and in workplaces.

Chief executive, Phil Grady says mental health and addictions services don't fit so neatly into the primary, secondary or tertiary categories.

"The nature of our service means there are overlaps – we provide residential treatment services, but we do important work in the community supporting harm reduction and helping people stay well," says Phil.

Odyssey's community services provide advice, guidance and support to people who have previously participated in an Odyssey House treatment programme – the service aims to provide support on a "whatever it takes" basis to support clients living in the community. Professional staff teach clients coping skills and help them access appropriate community supports, to maintain employment and a healthy lifestyle.

Although Odyssey House receives some government funding, many of its services are also reliant on sponsorship and donations.

One of Odyssey's strongest collaborative relationships is with **CHAMP – the Counties Manukau Mental Health and Addictions Partnership**, which Phil describes as "a shining example of demonstrable savings that can be made by working together."

CHAMP is a partnership group representing NGOs and clinical provider services in the mental health and addictions sector across the Counties Manukau region. The DHB set it up in 2003, but handed it over to the group members to progress.

"CHAMP have undertaken a lot of development by working more closely together and that flows through to our services. We've made efficiencies and savings by sharing training resources, getting into bulk purchasing and combining HR functions.

"It's a provider-led group, which ultimately benefits the service user," Phil explains.

But Phil's time for building better services and collaborative relationships is often hampered by the compliance burden generated by Odyssey's multiple funding streams via different contracts and agreements with multiple district health boards, Child, Youth and Family – both nationally and regionally, the Ministry of Health and the Department of Corrections

"Whilst each contract enables Odyssey to deliver important services to some of the most vulnerable people in our community, each contact has its own reporting requirements and service specifications," says Phil.

"Even with the DHBs, we are often providing the same services – unfortunately service specifications are often different and each may require their own reporting. So each quarter when reports are due, we have to pull out different information for each.

"In addition, funders may request ad hoc reports, which add complexity – and that's even before you look at other compliance requirements, such as audits.

"Sometimes it seems like we have almost a rolling audit situation. One week one auditor wants to look at residents' files, the next week there may be a certification audit and the next week another checking the contract requirements.

"It takes up staff time and creates additional cost," says Phil.

"It takes staff away from frontline clinical service delivery and the collaborative relationship building."

Phil says sometimes different auditors are looking at the same things repeatedly, but they don't seem to take into account the findings of another audit.

"We will say 'we've just had X in', but that doesn't matter to them," says Phil, adding that it's not clear why they will not accept another auditor's findings.

"It's unusual – the actual service being purchased can be the same, but each can have different measures and expectations.

"The Northern region's DHBs have worked hard to co-ordinate audits so they are all happening at the same time, but a co-ordinated solution didn't seem to suit the other funders," Phil laments.

Integrated Contracts<sup>29</sup> have been discussed, but so far Odyssey has not been able to access them, and High Trust Contracting<sup>30</sup> seems limited to very few providers, even though Odyssey is one of the largest addiction treatment services in the country.

"There have been so many changes in a number of agreements this year along with changes in funding staff, that we weren't able to get them together to review the contract prior to a variation," explains Phil.

"It seems over-complicated and there's no alignment – it's difficult to understand why some are 12-month contracts and some are for three years," says Phil before adding "irrespective of all this, people with serious addictions and mental health problems still receive excellent services and go on to do well at life – it is all about providing better outcomes for people."

Phil believes there are various opportunities to improve things and find a better way.

"Across the DHBs, you could have one lead DHB managing the contract on behalf of the other DHBs – that would potentially mean one reporting system, one audit, and one lot of invoicing. DHBs have already got inter-district flows processes in place, which allow for funding transfers between DHBs for their population who receive services, so as providers we don't need to get caught up in what often seems like burdensome processes," he suggests.

"Across all the government departments, you could potentially have a lead organisation that takes responsibility for managing the contract with a provider," Phil offers as an alternative idea.

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<sup>29</sup> [Integrated Contracts](#) are led by Family and Community Services in the Ministry of Social Development.

<sup>30</sup> [High Trust Contracting](#) is also led by Family and Community Services in the Ministry of Social Development.

When asked if any agency stands out as being better at contracting than another, Phil says that while the Northern region's DHBs try to work in a co-ordinated manner, there is significant potential for all funders to do better.

"One of the key deficits within funding staff is they lack understanding of how an organisation works – especially a non-government or not-for-profit organisation with multiple funders. There needs to be a training component added for government funding staff.

"Many of us have multi-million dollar contracts, and there needs to be more strategic thinking and alignment when it comes to contracting. The Government focus on value for money and outcomes is welcomed. Outcomes for individuals, particularly with a serious or chronic substance illness can take many years, but funding is often only short-term – like 12 months.

"No sooner than you've got one contract signed and in place, and you're starting the discussions for the next year's contract.

"We need to lift the vision to have a strategic relationship with funders and government agencies."

Phil suggests there are better things than inputs that they could measure if given the opportunity.

"There's a recognised alcohol and other drugs outcome measure, where you can track people's outcomes clinically. And there are short-term outcomes too.

"So much crime is associated with alcohol and drug use," explains Phil, "so when someone is in-treatment – those are crime-free or alcohol and drug-free days – and that has a flow-on cost-saving to wider New Zealand."

Phil's views on funding are supported by the **National Committee for Addiction Treatment (NCAT)**, of which he is a member.

NCAT is a group of service leaders, educators, representative groups and elected individuals who provide leadership to the alcohol and other drug (AOD) and problem gambling treatment sector and its stakeholders. NCAT includes a number of non-profit NGOs and reflects the work and diversity of the addiction treatment sector in New Zealand

Robert Steenhuisen, co-Chair of NCAT, says Odyssey is typical of providers in the mental health and addictions sector, with many agencies receiving various funding amounts from DHBs, the Department of Corrections, and the Ministries of Social Development, Education and Health – each with different reporting requirements and accountability systems.

"Having to jump through different hoops for different funders is impacting heavily on services, and will make it impossible for the sector to meet increasing demands," says Robert, who is also regional manager of Community Alcohol and Drug Services for the Waitemata District Health Board.

"We must look at ways of streamlining the funding model so workers can get on with the job, instead of wasting time and energy pleasing so many masters.

"Often there's no co-ordination or consistency between them either," he adds.



"A person may turn up for treatment, but a lack of communication means the clinician often doesn't know what offending has been involved. At the same time, the criminal justice sector may have little idea about what treatment the offender has undergone or what bearing that may have on their case.

"Treatment workers' time gets taken up dealing with these sorts of problems when they could be actually helping the people and families in need."

Robert says the government silos and associated compliance demands mean the services can't adequately support the families of those struggling with addiction – especially their children.

"Many of whom will grow up with similar problems themselves," he adds.

"Treatment workers would be able to help more of these struggling families and make more of a difference if they spent less time dealing with disparate bureaucracies.

"If the government made a priority of simplifying and co-ordinating funding streams, that would massively improve the services we could deliver right now," says Robert.

Phil Grady says the funding issue has been on the table for multiple years but, while there appears to be a willingness from some funders to contract in a more co-ordinated manner, more tangible improvements could be made.

"Government are really supportive of the important services we provide. In real terms, a reduction in the reporting and compliance bureaucracy requires a co-ordinated response from senior people," says Phil.

**More information:** [www.odyssey.org.nz](http://www.odyssey.org.nz) or [www.champ.org.nz](http://www.champ.org.nz) or [www.ncat.org.nz](http://www.ncat.org.nz)

## Case study 15: Providing a space for the 'go-between' to have real impact

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*A low decile (or in their words 'opportunity rich') Nelson community has put health and well-being at the centre of community life, as a non-profit community health centre and a primary school converge to help change lives for the better.*

**Victory Village** is a partnership between **Victory Primary School** and **Victory Community Health Centre**. It is the result of years of challenging discussions as a small, ethnically diverse community with many refugee families and loads of poor social, educational and health outcomes turned things around by tapping into the shared resources within the community.

The Victory Village partnership led to the establishment of a physical 'community hub' at the school. The hub is a multi-purpose community, health and recreation centre and school hall located on the school grounds. The centre provides one-to-one health services for residents, as well as many recreational and social programmes and community events.

"From the start, there was an agreement that we would do things differently," says Kindra Douglas, Victory Community Health Centre manager.

"We decided to integrate education, health and social well-being using the school as a hub."

A community development approach was taken from the outset, with expert practitioners assisting the community to identify its needs and priorities. As progress was made, deliberate processes were in place to help those involved reflect on what they did, what they had achieved, and how.

This identified concepts such as looking outward to find others with a similar vision, looking inward at your own culture and practices, investing time in relationships, capitalising on bridging practices to build systems for professional interdependence and being open and responsive.<sup>31</sup>

Support from **Inspiring Communities** and the **Families Commission** played an important role in assisting the community with this process. The Families Commission's Innovative Practice Fund research has shown that Victory Village created an environment where people took collective responsibility for child and family well-being, with great results.

"It is a fantastic example of social innovation, where solutions to complex and seemingly intractable problems have been found by establishing new ways of working,"<sup>32</sup> says Chief Families Commissioner, Carl Davidson.

Community centre services are open to all residents – not just parents of children at the school. The school itself has a family-centred philosophy and involves parents in a number of ways, from social and curriculum events to adult education. These systems of education and community health and development positively overlap and intersect in many ways to nurture families.

Before the community centre was built, a fractured collection of health and social services operated randomly from school meeting rooms. Now families can access a range of clinical

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<sup>31</sup> Drawn from [Paths of Victory: Victory Village – A case study](#), D. Stuart, Families Commission, Nov 2010.

<sup>32</sup> Quote sourced from [Victory shares lessons](#), The Nelson Mail, 25 July 2011.

and social services at the Health Centre, as well as counselling, playgroup, a community garden and adult education – with ‘easy and often’ supported referrals to all other agencies in the city.

In the community centre, two office spaces are home to other agencies: **Parents as First Teachers (PAFT)**, **PATHS (Pathways to Health Solutions)**. Other services offered at the Centre on a free and regular basis include: cervical screening, Work and Income, hearing tests with Hearing Unlimited, a Plunket nurse, three independent midwives, counsellors for face-face confidential sessions, and PHO dietitians and a respiratory educator who use spaces as needed. In 2008, the centre took over the PHO contract for the Be Well community nurse role.

“What makes this unique, I think, is the connection with the school and the connection with so many different agencies that come in and bring their services here. So not only does that make it really easy for the families in this area to connect with those services, but all the services get to know each other better. It’s just a really good example of interconnectedness,” says Be Well community nurse, Penny Molnar.

**Nelson Women’s Centre (NWC)** has a multi-faceted, collegial and client-centred relationship with the Victory Community Health Centre – with many clients of one being connected with the other, and staff involved in both.

“Nelson is well-networked,” says Carrie Mozena, Co-ordinator at the Women’s Centre.

“Anyone who comes into work in the area spends a lot of time meeting with other agencies and finding out what they do – it’s common to do a lot of visiting when you come into a role.

“It means when people who need help and are ready to face challenges come in, they can have a positive, productive relationship with people who are skilled and can help them navigate the system. It’s not just about making referrals, it’s about working alongside other organisations and to people’s strengths,” Carrie explains.

Kindra has a similar view, explaining that the Health Centre sees itself as a first stop for residents, some of whom may become clients, and others of whom may enrol for an activity, or participate in activities or events in a support role.

“We can also be the go-between. We provide the space for the community and the services to come together. It’s not about doing TO people, it’s about working with people,” she explains.

“We have an easy, welcoming friendly environment – people come in for one service and realise there are so many other things they can access – like our ‘Victory on the Move’ programme or free counselling, which is offered by final year students from NMIT,” explains Kindra.

Carrie says NWC sees a lot of women with mild to moderate mental health issues, sometimes relating to relationship breakdowns or sexual abuse. They also see many low income women living in cold, damp homes and women with physical injuries from domestic violence. As a drop-in centre, there are also women with chronic and significant mental health issues following the shift to people living in the community, rather than institutions.

“Women may have one presenting issue, such as not being able to pay a bill, but there can be so much more going on. Our social workers can help them unpack this,” she explains.

Carrie says the large state bureaucracies are over-worked and understaffed and not very nimble because their paperwork requirements are huge.

“There are not many people in their frontline positions who have the time to be kind and compassionate. NGOs try for much less paperwork, and have a more caring culture – so we will spend more time with people.

“Many of the women who come in here have incredibly, complex and sometimes, dysfunctional family systems,” says Carrie.

Health centre manager, Kindra Douglas says the Victory team is always looking for ways to take down the barriers and help people access vibrant, low cost programmes unlike anything others offer.

“It makes sense to add value to what already exists in a community – that is, sharing resources such as buildings, networks, and relationships to extend the capacity of the whole community to become better connected and further resourced,” she explains.

In July 2011, Victory Village was host to 250 people from around New Zealand at the Victory Village Forum<sup>33</sup>, where the social innovation approach was explored from a variety of angles by people hoping to make similar life-changing improvements in their communities.

Kindra says when Victory was named the *2010 Community of the Year*<sup>34</sup>, there was a huge increase in people from around NZ wanting to visit Victory and see what had been done.

“The forum was our way of sharing our experiences and managing that level of interest. It was about sharing ideas about community-led, family-centred development,” she says.

Kindra is quick to emphasise that you can’t pick up Victory Village and place it down in another community and expect the same results. She refers rather to principles around development, leadership, relationships and professionalism, and the *Paths of Victory* research<sup>35</sup> and Inspiring Communities report, *What we are learning about community-led development*<sup>36</sup>, which examines this approach in detail.

“Community ownership is vital. Our whole ethos is about relationships. You need good trusted relationships before doing anything,” say Kindra.

“It’s all about working together to grow strong, nurturing communities, in which children and families can thrive. People can make a change for the better by tailoring their own responses to their own unique circumstances.”

Victory Primary School Principal, Mark Brown agrees.

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<sup>33</sup> [Victory Village Forum: An Overview](#) – The 2011 post-forum report also includes key milestones since 1989. It is available on the Families Commission website and from [Inspiring Communities](#).

<sup>34</sup> [New Zealander of the Year Awards](#).

<sup>35</sup> [Paths of Victory: Victory Village – A case study](#), D. Stuart, Families Commission, Nov 2010.

<sup>36</sup> [What we are learning about community-led development in Aotearoa New Zealand](#), Inspiring Communities, Dec 2010.

“We see the absolute positive benefits in our young people – their behaviour, their health, the engagement of our parents, the health of the parents, the way they talk more positively about their families. For those who doubt, I think they need to examine their true belief of their investment in people. If it makes a difference to strengthen our families and to nurture them, it is worth doing it every single day,” says Mark.

Community Initiatives Funding from the Ministry of Social Development in 2005 supported the initial community work from which the centre (and other initiatives) has resulted.

A range of government funding has been important in the success of Victory Village, but Kindra estimates that this currently comprises just 35-40% of the centre's backing, with the rest coming from about 15 community funding sources.

As for future funding, Kindra says the consensus at the Forum was that the whole structure of funding needs to make a paradigm shift.

“The silos created at the top create silos and competition further down the chain. If the funding could be done differently, who knows what would be possible. We are commonly working toward the same goal, but end up being set up against each other for resources.

“The current pressures on secondary and tertiary health services mean the current government is now reducing and even eliminating prevention and promotion. This is counter-intuitive and so contrary to the primary health strategy,” says Kindra.

“Look at smokefree – that’s taken long-term investment and legislation change to make smoking less socially and economically acceptable. We need the same type of investment in other key health determinants, and housing is one of the biggest.”

Kindra goes on to describe the impact of the Healthier Homes programme, which retrofitted over 500 houses in the local community over three years. The local **Nelson Tasman Housing Trust** drove the project but they “collaborated with everyone” to get as many houses done as possible. That included EECA, Energy Smart, the Asthma Society, Cystic Fibrosis, and liaising with Nelson City Council’s warm homes project.

“We were staggered by the level of support from the DHB – it was wonderful and meant we could improve the health of so many more families, but then the funding stopped.

“There are still so many more houses to do – especially rental accommodation where most of the poorest families live,” says Kindra.

When asked to identify some of the health outcomes at Victory Village, Kindra says they’ve supported people stopping smoking, enrolled many with GPs who weren’t before, and given free counselling. Previously, the community had high residential mobility, with many people not enrolled with a GP or accessing primary health services.

“And we’ve got people becoming more active, more often – walking, cycling – people don’t use their cars as much. At the softer end, there’s involvement in the community garden, plus we have older people coming in for the *Sit and Be Fit* classes.

“Our health focus is more about well-being – not a medical model. It’s the pride and self-esteem that really shows. ERO (the Education Review Office) told the principal that Victory Primary School doesn’t look and feel like a decile 2 school.

“No-one is just the trouble they present with, they can participate and contribute too. One day they might be here seeing the nurse or the counsellor, but the next day they are here helping an event happen. We have a virtual waiting list for helpers for Matariki, because there is such a sense of community,” she says enthusiastically.

Victory Community Health Centre is an alliance partner with the PHO and on the community advisory group, however, Kindra says she’s surprised at how slow the implementation of the *Primary Health Care Strategy*<sup>37</sup> seems to be.

“There are community reps of course on the PHO board, yet it’s been very poor performance around low cost access, and the PHO itself seems to just grow – and they still seem to have mostly a medical view. The whole model there still seems oriented around GPs.

“From our understanding, the Ministry of Health allocates funding via DHBs to PHOs specifically for improvements in primary health outcomes. Some of this is then contracted to organisations like us at the minimum they can give, for the maximum they can achieve. And yet PHO staff get paid at high government rates, while we struggle to make ends meet,” Kindra explains.

“We’ve battled to get respect for doing things differently. Our PHO contract is more constrained than we’d like it to be, and it’s now even more output driven than our original contract of four years ago. This seems like a backward step and maintains a hierarchical process in what is already a frustrating sector.

“New Zealand could be doing so much more in the prevention of diabetes, for example. Our area is the fourth highest recipient of refugees in New Zealand and, within a few years of being here, we see them starting to have the same weight issues as the rest of the population. Why doesn't the government put a tax on high sugar drinks such as V and Coca Cola as a disincentive and a revenue builder for prevention?

“A new approach is needed to do prevention work, and it needs to be multi-pronged,” suggests Kindra.

**More information:** [www.victorycommunitycentre.co.nz](http://www.victorycommunitycentre.co.nz) or [nnwomenscentre@ts.co.nz](mailto:nnwomenscentre@ts.co.nz)  
[www.familiescommission.govt.nz/research/culture-and-community/victory-village-forum](http://www.familiescommission.govt.nz/research/culture-and-community/victory-village-forum)  
or [www.confer.co.nz/VictoryForum/](http://www.confer.co.nz/VictoryForum/)

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<sup>37</sup> [\*Primary Health Care Strategy\*](#), Ministry of Health, 2001.

## Appendices

- Methodology
- Case study interview process
- Data on the non-profit health and disability sector
- Selected bibliography

## Methodology

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Several online questionnaires were available via Survey Monkey between 18 July and 22 August 2011. Survey links were circulated to 130 NGO health and disability providers registered with the Health and Disability NGO Working Group and a further 1,200 health related organisations selected from the Family Services Directory.

Separate survey links were initially used for NGO health providers and others, but as the links were also promoted on various websites and through a range of newsletters and e-mails, a number of NGO health providers completed the survey aimed at the wider group, so the results are combined in the report.

The questionnaires were essentially the same, except that the survey targeting the broader group sought their observations of others' practice, as well as their own experiences.

A total of 364 responses were completed. These included 223 from non-profit organisations, 39 from commercial operations, 69 from consumer/client groups and 44 from government agencies.

A further online questionnaire was developed and sent to the 32 Primary Health Organisations (PHOs) in existence as at 1 July 2011. Responses were received from 11 PHOs.

Full details of the online survey findings are provided in the [separate Online Survey Responses report](#). (The original project scope is also included in that report.)

Case study subjects were identified through survey responses, word-of-mouth and referrals. Interviews were conducted mainly by telephone during August, September and October 2011.



## Case study interview process

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A flexible approach to interviews was undertaken, but the general line of questioning followed a selection from the following:

### Basic Description

- Core data about the organisation
- What is the service/example and what does the service deliver?
- What providers are involved in the delivery? (e.g. health, other types?)
- How is the service integrated and connected to other providers?

### Patients/consumers/clients – how they benefit

- What population groups does the service work with/target?
- How have the services reduced inequalities or improved access for disadvantaged groups?
- How does the patient/consumer benefit? How is their experience different?
- Is the collaboration about targeting or delivery?
- How do non-profit NGOs help target services to address issues of long-term disadvantage and complexity for marginalised population groups?

### Getting the collaboration to happen

- Who led the initiative to its current delivery model?
- How involved are the PHOs – were they the drivers of the integrated approach?
- How did the collaboration come about? What did it take to make it happen?
- How long did the process take?
- How is collaboration systemised? Made part of the organisation's culture/working style?
- Who benefits most from the collaboration?

### Funding

- How is it funded?
- Does it require any 'out-of-the-ordinary' purchasing arrangements contracts?
- How does the funding model affect integrated models of care? Does it present any challenges?
- How were costs able to be reduced?

### Location

- What impact do location and community connections have on the service?
- What role (if any) does integration with other non-health agencies play? (e.g. welfare, education, police, etc)
- Is this example unique to a region/population or is it a local response to a national issue?

### **Workforce matters**

- What skill or knowledge gaps had to be filled?
- What role has training, upskilling and/or workforce development played in supporting the collaborative approach?
- What does an 'ideal' primary health care team look like in this example? Who is involved?
- Is there room for others to be involved? If so, who?

### **Information systems/sharing**

- What roles do IT systems or technology play in supporting or preventing service integration?
- How is demographic information shared to enable all parties to understand the nature and extent of the needs?
- What performance measurement processes are in place to inform and/or improve quality of care?

### **Processes and pathways**

- If there is a central access point for both practitioners and clients/patients, how does it help to facilitate a smooth journey for the client/patient and enable easier collaboration for health practitioners?
- How do the different providers connect into a clear and transparent care (treatment and support) pathway with well-delineated responsibilities for engagement of key personnel at each stage of the pathway?
- How are referrals supported and encouraged and what systems are in place to provide important feedback to the referrer? What specifically do nurses, doctors etc do to support referrals?

### **Lessons learned – what insights can we share to help others?**

- What lessons can the wider health and disability sector learn from the approaches used?
- How could this approach be replicated elsewhere or adapted for use more widely? What learnings could others take from the example?
- Where integration does occur, what factors help it to happen, and what gets in the way?
- What were the key factors that help them succeed?
- What **specific** levers or triggers helped make a difference? What is done differently?

### **Questions specific to the example**

- As appropriate.

### **Next steps**

- What other providers/agencies could be involved?
- What system or process changes are needed to support even greater success/better results?
- What will you do next to progress this further?

## Data on the non-profit health and disability sector

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### Statistics NZ data<sup>38</sup>

Statistics NZ's *NZ Non-Profit Institutions Satellite Account: 2004* identified:

- 2,210 non-profits in the health sector contributed \$466.8 million to GDP
- 450 of these health non-profits employed a total of 15,090 employees.

### Charities Register data<sup>39</sup>

The Annual Returns of registered charities show:

- 1,821 charities in the health sector
- An additional 820 registered charities indicate their main sector is 'disability'<sup>40</sup>
- Health charities receive nearly \$3.4billion income from all sources
- 554 health charities receive government funding totalling more than \$1.4b
- 484 health charities (in receipt of government funding) pay more than \$1.3b in salary and wages to 18,735 part-time and 14,141 full-time employees
  - 30 of these health charities each employ between 100 and 499 staff
  - 3 of these health charities each employ between 500 and 999 staff
  - 4 of these health charities (Order of St John, Plunket, Nurse Maude and Access Homehealth) each employ between 1,000 and 3,800 staff
- The Priory in NZ of the Most Venerable Order of the Hospital of St John of Jerusalem is the 6<sup>th</sup> largest charity on the Charities Register, based on total assets and income combined (\$506m)
- St John of God Healthcare Inc is the 2<sup>nd</sup> largest charity on the Charities Register based on total assets and income combined (\$1.9b). It is the largest health employer of staff (9,335).

### The Health & Disability NGO Working Group

- 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. While NGOs are major employers of non-regulated health staff, they also employ significant numbers of clinicians, such as public health and Plunket nurses.
- As at 10 October 2011, 210 non-profit NGOs were registered to nominate and vote for members of the 13 person NGO Working Group. The NGO Working Group represents the views of the sector, through three Māori health representatives, and two representatives from each of the following: Pacific health, Mental health & addictions, Personal health, Public health, and Disability support services. **Learn more at:** [www.ngo.health.govt.nz](http://www.ngo.health.govt.nz)

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<sup>38</sup> Charities are a sub-group of non-profits

– i.e. all charities are non-profit, but not all non-profits meet the criteria to be registered charities.

<sup>39</sup> Information supplied by charities and displayed on the Charities Register is not verified by the Charities Commission. Not all registered charities have yet submitted an Annual Return. (*Data accessed August 2011*)

<sup>40</sup> Some disability charities also provide health services, but their data is not included in the summaries here.

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## Acknowledgements and disclaimer

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