BEST FIT FOR NON-GOVERNMENT ORGANISATIONS IN PRIMARY HEALTH CARE

CONTENTS

EXECUTIVE SUMMARY

The purpose of this report is to:

- report on the results of sector meetings held in July 2006, to hear the views of non-government organisation (NGO) providers of primary and population health services, primary health organisations (PHOs) and District Health Boards (DHBs) on how NGOs can best fit within the primary health care setting
- advise how key messages heard at the July sector meetings, and also feedback from the Health and Disability NGO Working Group received in August 2006, will be incorporated into the Primary Health Care Strategy Implementation Work Programme
- advise on key policy planks concerning NGOs and PHOs that have been confirmed by Hon Pete Hodgson, Minister of Health, so that policy settings are clearer, particularly with regard to NGO contracts for primary and population health services.

The following key policy planks concerning NGOs and PHOs have been confirmed by Hon Pete Hodgson, Minister of Health, so that policy settings are clearer, particularly with regard to NGO contracts for primary and population health services.

- In order for the Primary Health Care Strategy's vision of better population health outcomes and reduced health inequalities to be fully realised:
  - all key stakeholders, including PHOs and NGO service providers, need to be fully engaged, working collaboratively and 'fit for purpose'
  - the Ministry of Health and DHBs need to ensure that their strategic approach promotes collaboration among key stakeholders to realise the vision, rather than competition for resources.
- NGO service providers will be encouraged to affiliate and contract with PHOs, however this remains voluntary for NGOs, as is the case for health practitioners.
- PHOs are expected to work with other providers within their regions to ensure that services are co-ordinated around the needs of their enrolled populations and services are more joined up. However, this does not necessarily require a contractual relationship between PHOs and other service providers.
- If NGO service providers are to agree to their service contract being transferred to a PHO, mutual benefits for PHOs and NGOs will need to be identified.
- NGO service providers can be reassured that there is no national policy for funding for all community services to be distributed through PHOs.
- Given the diversity of NGO service providers and PHOs, and the relationships between them and local needs, a flexible approach is required – a one-size-fits-all approach will not work.
- With the exception of national NGO service providers, NGO–PHO engagement will be locally rather than centrally driven.
- Because national NGO service providers face a different set of issues in relation to devolving primary health care funding, any decisions about their contracts will be made following service reviews.

Further work on NGO issues and opportunities and their best fit within the primary health care context will be incorporated within the service development workstream of the Primary Health Care Strategy Implementation Work Programme. The first project to get under way is a project to identify the capabilities required of PHOs and other key stakeholders to successfully implement the Primary Health Care Strategy. The other two projects planned focus on business models and service delivery models. The co-sponsors of the service development workstream will see that work on how best to achieve effective collaboration among all key stakeholders, including PHOs and NGOs, and their full engagement and 'fitness for purpose' to fully realise the vision of the Primary Health Care Strategy is firmly embedded in each of the three project areas. To successfully achieve this, the co-sponsors have committed to including NGO expertise, where required, in the service development workstream projects.

1. INTRODUCTION

Purpose of this report

The purpose of this report is to:

- report on the results of sector meetings, facilitated by Joanne Hayes, a Ministry secondee, in July 2006, to hear the views of NGO providers of primary and population health services, PHOs and DHBs on how NGOs can best fit within the primary health care setting
- advise how key messages heard at the July sector meetings, and also feedback from the Health and Disability NGO Working Group received in August 2006, will be incorporated into the Primary Health Care Strategy Implementation Work Programme
- advise on key policy planks concerning NGOs and PHOs that have been confirmed by Hon Pete Hodgson, Minister of Health, so that policy settings are clearer, particularly with regard to NGO contracts for primary and population health services.

Scope of report

This report outlines the range of relationships that currently exist between NGOs and PHOs, and views on future funding arrangements. Although NGOs often have an advocacy role, this report focuses on NGO providers of primary and/or population health services and how they fit within the primary health care setting.

The report does not look at specific services provided by NGOs, such as sexual health or well child services. How such specific NGO services link with PHOs will need to be considered as part of service reviews. For example, a review of the Well Child Framework commenced in July 2006 and includes within its scope determining how to link well child provision to PHOs and deliver appropriate services in the new primary health care environment.

NGOs and PHOs

In December 2001 the Government signed a *Statement of Government Intentions for an Improved Community–Government Relationship*. The Government expressed its commitment to building strong and respectful relationships with community, voluntary and iwi/Māori organisations, and recognised the unique and vital role these organisations play in New Zealand society. Government and the community sector depend on each other to achieve shared goals of social participation, social equity and strengthened communities.

NGOs are defined as 'independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market'. (This report focuses on a subset of NGOs – those providing primary and population health services). The Primary Health Care Strategy

describes PHOs as the local structures for organising the delivery of services around the needs of their enrolled populations (Minister of Health 2001).

This definition of an NGO is broad enough so that some PHOs identify themselves as NGOs. In fact NGOs and PHOs are similar in that they are both:

- not-for-profit (although member organisations of many PHOs, such as privately owned medical practices, are for-profit)
- committed to delivering services aimed at reducing inequalities and improving outcomes for their populations.

The main difference between NGOs and PHOs is the basis on which they were formed. NGOs have generally developed in response to specific needs identified in the community while PHOs have been established as an outcome of government policy. Also, all PHOs must meet a set of minimum requirements issued by the Minister of Health, by demonstrating that they:

- actively work with other groups within their regions to ensure services are co-ordinated around the needs of their enrolled populations
- are responsive to their communities' needs and priorities, and involve communities in their governance structures.

There is a wide range of NGOs, and many provide primary health care services but sit outside the PHO structure. The role of NGOs in primary heath care is not explicit in the Primary Health Care Strategy, and many NGOs have expressed concern about the lack of clarity on their future roles in PHOs and the primary health care context.

Sector engagement

A work programme has been developed between the Ministry of Health and District Health Boards (DHBs), which signals the next phase of implementing the Primary Health Care Strategy. Within this work programme, the service development workstream has particular relevance for NGOs and their best fit within the primary health care setting. It has three projects getting under way, which focus on: capabilities required to successfully implement the Primary Health Care Strategy, business models and models of care. While the service development workstream projects were being formed, the Ministry undertook preliminary work to help determine the 'best fit' for NGOs as a contribution to the service development workstream.

A series of meetings was held around the country in July to hear the views of NGOs, PHOs and DHBs on how NGOs can best fit within the primary health care setting. Information was sought on:

- the types of links and relationships that exist between NGOs and PHOs, and any barriers that have prevented relationships from developing
- the role of DHBs in fostering and encouraging relationships
- views on the alignment of funding streams for NGOs and PHOs.

Joanne Hayes was seconded to the Ministry to undertake this consultation and to report on the findings. Joanne is the Chief Executive Officer of Taumata Hauora Trust Māori Development Organisation and PHO, and has worked in both NGO and DHB environments. She was recommended for the secondment by the Health and Disability NGO Working Group, of which she is a member.

The Health and Disability NGO Working Group held regional meetings in the four main centres in May and June 2006. The purpose of these meetings was to collect feedback on the Primary Health Care Strategy Implementation Work Programme and other issues relating to PHOs. Attendees at these meetings raised similar concerns about the clarity of the roles of NGOs in primary heath care. They advised that NGOs would like to be recognised and featured in the work programme as key partners in delivering on the Primary Health Care Strategy alongside PHOs.

The information contained in the following sections is based on the feedback collected at the sector meetings on the best fit for NGOs. More detailed information is included in the summary in the Appendix. Where appropriate, comment is incorporated from the Health and Disability NGO Working Group's feedback on the Primary Health Care Strategy Implementation Work Programme 2006–2010.

2. RELATIONSHIPS BETWEEN NGOS AND PHOS

A variety of relationships have been formed between NGOs and PHOs, with most falling into the following categories.

- The NGO has no relationship and is not sure how to go about forming one, or the PHO has signalled lack of interest in forming a relationship.
- NGOs are represented at the PHO board level but consider representation to be token only.
- Formal memoranda of understanding have been developed between NGOs and PHOs.
- NGOs have had the opportunity to tender for PHO contracts for services provided from Services to Improve Access (SIA) and Health Promotion funding.
- NGOs are included as membership groups alongside practices in PHOs – they are consulted on SIA and Health Promotion plans and are given first opportunity to express an interest in providing the services.
- The DHB has devolved the NGO contract to the PHO.

The perceived quality of the relationship between NGOs and PHOs is also varied. The most positive relationships had often existed before the formation of PHOs, and where the parties shared a similar philosophical base. While a number of NGOs stated they had found it easier to form relationships with 'smaller, community development focused' PHOs, there were a few examples of positive relationships with large PHOs.

NGOs vary greatly in size and service focus. They provide health promotion, clinical services, and community/family/whānau home and social support for a wide variety of health conditions. Some NGOs focus on specific issues (eg, cancer), particular populations (eg, children) or particular communities (eg, many Māori providers).

Some NGOs consider they have a 'better fit' in the primary health care context than others. Single-issue NGOs whose focus is both narrower than PHOs but at the same time extended further across the service continuum than primary health care (vertically integrated organisations) advised they found it difficult to engage with PHOs in a meaningful way. PHOs are essentially horizontally integrated organisations, focused on improving primary health outcomes for their enrolled populations.

Although national NGO service providers recognised the need for greater collaboration with PHOs, and one national NGO provider had developed memoranda of understanding with several PHOs, the high transaction costs of attempting to develop explicit relationships with potentially up to 81 PHOs were extremely daunting.

NGOs also made the following comments on relationships, either as feedback on the Primary Health Care Strategy Implementation Work Programme or during the meetings to discuss 'best fit'.

- NGOs want to be seen as ‘valuable partners that can work alongside PHOs in delivering services for the benefit of the community’. PHOs need to be encouraged to form better links with NGOs, which are often the ‘existing experienced service providers of client-focused services’ and ‘can offer PHOs much relevant experience in how to achieve this efficiently and effectively’.

- The diversity of NGOs and PHOs means a one-size-fits-all approach to NGO–PHO relationships and service links will not work.

- Both NGOs and PHOs need to see the benefits of forging a relationship. Coercing NGOs to join with PHOs or devolving their contracts to PHOs against their will is disempowering and potentially destructive for relationships.

- It would be easier for NGOs to work across PHOs if PHOs worked more collaboratively with one another to improve population health. PHOs in some DHB areas are pooling a portion of SIA or Health Promotion funding and providing opportunities for NGOs to tender for district-wide service provision. This could be encouraged in other areas to achieve both efficiency and improved population health objectives.

3. FUNDING OPTIONS

Current NGO–PHO funding issues

Nearly all new primary health care funding is being channelled through PHOs. Currently, most PHO funding is in the form of first-contact capitation funding and flows directly to general practices. PHOs pointed out that many NGOs overestimate the amount of funding PHOs have available to apply to providers other than their general practices for first-level services.

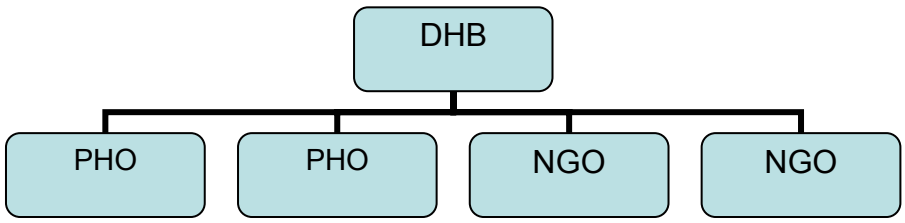
SIA and Health Promotion funding (which together make up only 8.6 percent of the total PHO capitation funding) present the best opportunity for developing positive PHO–NGO relationships. Some PHOs use their SIA funding to work with existing NGO providers, or openly tender for services so that NGOs have the opportunity to compete for this extra funding. Other PHOs retain the funding to build up their own infrastructures by employing additional people to deliver services. NGOs complain that this latter approach leads in some cases to PHOs duplicating existing services and failing to make the most of the expertise the existing NGO provider can offer.

Future funding options

There are two broad options for the future funding of PHOs and NGOs for primary health care and population health services. It is important that whichever strategic direction a DHB favours, care is taken to encourage collaboration among the key stakeholders to improve population health outcomes and reduce inequalities, rather than promoting competition for resources.

One option, which is similar to current funding models, is for the DHB to fund PHOs and NGOs separately. DHBs would be responsible for ensuring there was no service duplication and would be accountable for primary health care outcomes.

Figure 1: Option 1– separate funding



The main advantage of Option 1 is that it aligns closely with the Health and Disability NGO Working Group's desire for working in partnership, and may therefore achieve better collaboration between PHOs and NGO service providers.

There are two main disadvantages with Option 1.

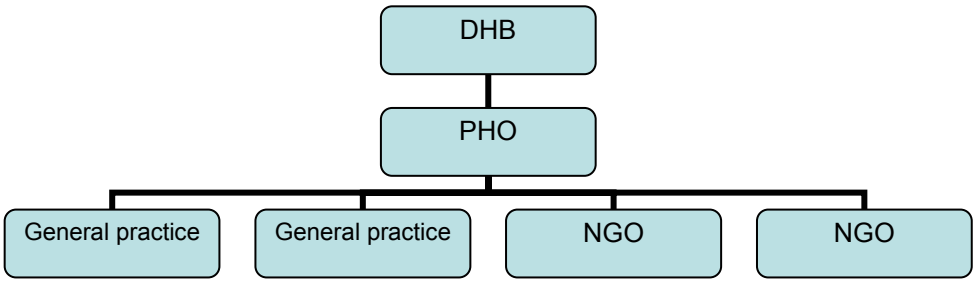
- It could encourage too much competition for funding between PHOs and NGOs, which may work against DHB attempts to create better service links. PHOs are

accountable for the population health outcomes for their enrolled population. Therefore, if an external provider is responsible for providing some key primary health services to their enrollees, the PHO service and the NGO service provider need to collaborate to ensure their services are well joined-up.

- It could limit the opportunities for some PHOs to build a focus on community development and reducing inequalities.

The second broad option involves NGOs being encouraged to affiliate and contract with PHOs. NGOs (as well as general practice and other key stakeholders) would be represented on the governance of the PHO. The DHB would need to ensure there were effective mechanisms for dealing with conflicts of interest, and a transparent and equitable process for allocating any new funding for service provision.

Figure 2: Option 2 – funding via PHOs



The potential advantages of Option 2 are:

- improvements in local service management and links
- a broadening of PHO governance to include NGOs, which may enhance a community focus
- a broadening of PHO responsibilities and focus consistent with the Primary Health Care Strategy, particularly its focus on improving population health outcomes and reducing health inequalities.

However, there are also a number of risks associated with Option 2 for both NGOs and PHOs, particularly if this approach proceeded too quickly.

- If extended too far, it could lead to a perception that the PHO is taking over the DHB's funding allocation responsibilities and create another layer of bureaucracy.
- NGO service providers and general practice providers could be encouraged to compete for new funding, rather than collaborating to achieve joined-up services and improved population outcomes. However, they may both develop their own niche services where the competition is limited to overlapping services only.
- PHOs are still in their development phase and many do not have the infrastructure in place to manage NGO contracts effectively.
- Relationships between most PHOs and NGOs have not developed sufficiently for NGOs to trust PHOs to pass on their existing funding or offer equitable opportunities to access new funding.

The option chosen is likely to reflect local circumstances and needs. Both options potentially promote collaboration and neither option avoids competition for resources or duplication of services. Nor are the two options mutually exclusive. Under Option 1, some NGOs and PHOs that see mutual benefit in doing so could form contractual relationships, and under Option 2 exceptions could be made for DHBs to contract directly with some NGOs. Over time, the strategic approach adopted could move from Option 1 to Option 2 as the risks identified for Option 2 were actively managed.

There are other issues for national NGO service providers operating within a decentralised health system, including:

- services would be fragmented if funding and contracts were devolved to all 81 PHOs, with very large transaction costs
- it would be difficult to achieve national service consistency, because different DHBs have different processes and priorities.

NGO concerns about the possible devolution of NGO contracts to PHOs (Option 2)

The Primary Health Care Strategy Implementation Work Programme signalled that by the year 2010 DHBs will have 'devolved more funding/contracts to PHOs as PHOs demonstrate performance against the high-performing PHO continuum'. This produced a mixed response at the best fit sector meetings, with the clear message that the Ministry and DHBs should be very cautious about proceeding towards any further devolution of funding to PHOs. NGOs were firmly of the view that joining a PHO should be optional, not mandatory.

It was reported that a small number of DHBs have told NGOs that all future primary health care funding will be going directly through PHOs. One NGO that had agreed to its contract being devolved to the PHO experienced mixed results. On the one hand it considered its philosophies had been compromised by having to accommodate a new client group to fit within the PHO model; on the other hand, joining the PHO did provide it with the opportunity to access additional resources through SIA funding.

NGOs were concerned that if their existing contracts are devolved to PHOs they will lose their autonomy and individual identity, which could negatively impact on their fund-raising activities; that PHOs would 'top slice' their funding for contract management; and that it would create a new set of complexities and contractual obligations, taking more time away from their core business.

The Health and Disability NGO Working Group response expressed greater concern, citing the following problems with PHOs having a greater funding role.

- The transaction costs of building relationships and contracting with multiple PHOs would be 'enormous and beyond the resources and capacity of most NGOs'.
- Their experience with PHOs had been that most PHOs prefer to keep any funding they receive for their own provider structure and offer few, if any, opportunities for NGOs to tender for services.

- They were concerned at how a ‘high-performing PHO’ would be defined and hoped this would include adequate consideration of a PHO’s ability to engage with their community – meaning the NGOs in their community.

NGOs delivered a clear message that they do not want to be forced into joining PHOs. The Primary Health Care Strategy states: ‘while primary health care practitioners will be encouraged to join primary health organisations, membership will be voluntary’ (Minister of Health 2001). Although NGOs are not explicitly mentioned in this context, an even-handed approach to providers should apply. This means that if NGOs are to be encouraged to join PHOs, there needs to be clear mutual benefits for both the NGO and the PHO, and the risks need to be minimised.

There also appears to be a perception among a number of NGOs that, in the future, funding for all community services will be distributed through PHOs. Hon. Pete Hodgson, Minister of Health, has confirmed that there is no national policy for funding for all community services to be distributed through PHOs.

4. CONCLUSIONS AND KEY MESSAGES

Key policy planks concerning NGOs and PHOs

The following key policy planks concerning NGOs and PHOs have been confirmed by Hon Pete Hodgson, Minister of Health, so that policy settings are clearer, particularly with regard to NGO contracts for primary and population health services.

- In order for the Primary Health Care Strategy's vision of better population health outcomes and reduced health inequalities to be fully realised:
  - all key stakeholders, including PHOs and NGO service providers, need to be fully engaged, working collaboratively and 'fit for purpose'
  - the Ministry of Health and DHBs need to ensure that their strategic approach promotes collaboration among key stakeholders to realise the vision, rather than competition for resources.
- NGO service providers should be encouraged to affiliate and contract with PHOs, however this remains voluntary for NGOs, as is the case for health practitioners.
- PHOs are expected to work with other providers within their regions to ensure that services are co-ordinated around the needs of their enrolled populations and services are more joined up. However, this does not necessarily require a contractual relationship between PHOs and other service providers.
- If NGO service providers are to be encouraged to affiliate with and contract with PHOs and agree to their service contract being transferred to a PHO, mutual benefits for PHOs and NGOs will need to be identified.
- NGO service providers can be reassured that there is no national policy for funding for all community services to be distributed through PHOs.
- Given the diversity of NGO service providers and PHOs, and the relationships between them and local needs, a flexible approach is required – a one-size-fits-all approach will not work.
- With the exception of national NGO service providers, NGO–PHO engagement will be locally rather than centrally driven.
- Because national NGO service providers face a different set of issues in relation to devolving primary health care funding, any decisions about their contracts will be made following service reviews.

Key messages and further work incorporated into service development workstream

The co-sponsors of the service development workstream of the Primary Health Care Strategy Implementation Work Programme (Sarah Turner, Ministry of Health, and Dr Alan Moffitt, DHBs) have agreed to incorporate within the service development workstream further work on NGO issues and opportunities and their best fit within the primary health care context. They agree that the main focus for further work will be within the business models project. In addition to this, where required, NGO

expertise will be sought for the capabilities project and the service delivery project areas of the service development workstream.

An NGO-specific project would be counter-productive, because it is important to tease out the relationships between PHOs, NGOs and general practice and realise the opportunities presented by NGOs in assisting PHOs to become more fit for purpose and better able to deliver on their objectives of improving health outcomes and reducing inequalities.

The co-sponsors of the service development workstream will see that work on how best to achieve effective collaboration among all key stakeholders, including PHOs and NGOs, and their full engagement and 'fitness for purpose' to fully realise the vision of the Primary Health Care Strategy, is firmly embedded in each of the three project areas.

Work that can be usefully undertaken to support service development workstream projects includes:

- a review of recent international literature on NGOs (and related terms such as 'social enterprise models' and 'third sector') in the primary health care context
- research and collection of examples of innovative community projects developed in partnership between NGOs and PHOs that demonstrate best practice at governance, planning and service development levels. This could include a review of the impact of comparative PHO approaches to NGO involvement in services provided with Services to Improve Access and Health Promotion funding.

Meanwhile the following points need to be taken on board by those involved in promoting changes in PHO/NGO relationships, whether through the service development workstream or at individual DHB level:

- Considerable work is required to develop and strengthen relationships between DHBs, PHOs and NGOs before any decisions are made about the further devolution of NGO contracts to PHOs. A cautious approach is indicated.
- Where it is decided to encourage NGO primary and population health service providers to affiliate with and contract with PHOs as PHOs demonstrate they have the required capabilities to deliver on the outcomes of the Primary Health Care Strategy, the following needs to occur.
  - Evidence of engagement with NGOs should be one of the key capabilities required of PHOs, in addition to community participation at all levels of activity, including governance, planning and service development.
  - Robust and transparent processes should be in place for the approval of programmes and distribution of funding such as Services to Improve Access and Health Promotion funding (in line with the *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown* (The Treasury) and the recent *Principles to Underpin Management by Public Entities of Funding to Non-government organisations* (Office of Auditor-General).

- The DHB needs to be satisfied that collaboration among service providers is supported to achieve well joined-up services and to avoid service duplication.
- The DHB needs to be satisfied that the PHO has the capacity to take on the contract.
- Benefits are maximised for the community served as well as for the PHOs and NGO providers.

APPENDIX: SUMMARY OF SECTOR FEEDBACK ON THE BEST FIT FOR NGOS

Sector feedback on the 'best fit' for NGOs in primary health care was obtained from NGO providers of primary and population health services, PHOs and DHBs during July 2006. The comments below are those expressed through face-to-face meetings, telephone discussions and written submissions and should not be taken as reflecting the views of the Ministry of Health. These views did contribute to the identification of policy planks that required confirmation and key messages that need to be incorporated into Primary Health Care Strategy Implementation Work Programme, particularly the service development workstream outlined in this report.

Otago, Canterbury, South Canterbury, and Nelson–Marlborough DHB regions[1]

Meetings

Relationships

- NGOs would like to meet with PHOs to discuss each other's roles and how they could work more collaboratively. Mental health providers see synergies between themselves and PHOs and want to engage more with PHOs.
- NGOs have mixed relationships with PHOs, ranging from informal mutual agreements, to formal memoranda of understanding, to contractual agreements.
- NGOs reported that:
  - some have had difficulty engaging with PHOs
  - some have felt they are being played off against one another
  - NGOs are represented on PHO governance boards, but in some cases believe this to be token only.
- There is conflict between the role of PHOs and the role of Māori development organisations.
- Disability support services have yet to find their fit within PHOs.
- Some PHOs hold monthly meetings and invite the public and community groups, but some NGOs are unaware of this.
- Some NGOs focus too much on the financial aspects of potential relationships rather than community health outcomes.

Funding / service provision

- NGOs are frustrated that service duplication occurs in some areas.
- Some PHOs said they work closely with NGOs and are careful not to duplicate services that already exist. Instead, when specific gaps are identified, the PHOs work with NGOs to provide additional services.
- SIA and Health Promotion funding are tendered out to NGOs in most instances. Tenders are evaluated by sub-committees.

[1] People from Southland and West Coast DHB regions were unable to attend the sector meeting.

Other

- There needs to be a higher profile of the role of PHOs, and this should be communicated to NGOs and the community.
- PHOs are in varying stages of development.
- PHOs acknowledged that all NGOs are different and some may require more support than others in terms of infrastructure, capacity and capability.
- PHOs see their role as assisting in the future development and support of NGOs and are sometimes able to lobby on behalf of NGOs to apply for increased funding, or to access funding from other sources.
- Both PHOs and NGOs advised: 'Don't make changes for change's sake.
- Some PHOs have been developed out of the Independent Practitioners Association (IPA) model, but are moving towards a more community-development-focused model.

Written submissions

DHBs

- Areas covered in a paper written by a DHB in March 2003 included:
  - promotion of a wellness model
  - improved access to primary care
  - multidisciplinary primary health care providers
  - incentives to influence referred services
  - integration of primary and secondary services
  - sustainable primary health care.
- The paper also provided an outline of the desirable features of a PHO structure and organisation, including some key principles.

NGOs

- NGOs have a good relationship with the largest PHO in the region but limited relationships with other PHOs. Some found it difficult to meet with smaller PHOs.
- NGOs are involved with chronic care management plans and health promotion.
- NGOs mainly have links with the DHB.

Telephone

- One NGO was concerned about not knowing what the priorities for the PHO are.

MidCentral, Hawke's Bay, Whanganui, Capital and Coast and Hutt Valley DHB regions[2]

Meetings

Relationships

- There are a variety of relationships between NGOs and PHOs.
  - Some NGOs have an active working relationship with their PHOs, especially in the area of health promotion.
  - Some NGOs have multiple provider affiliates, and some PHOs have multiple NGO affiliates.
- Mental health providers have reported difficulties working with NGOs.
- A community hospital has two direct contracts with the local PHO. It has good relationships with the PHO but would not want to commit to having all of its funding go through it.
- A Māori NGO has relationships through iwi representatives on the PHO board, but has no formal memorandum of understanding with the PHO.
- Small, community-focused PHOs work closely with NGOs and community groups. Some PHOs were developed out of IPAs and maintain that focus.
- Some PHOs said they have contractual relationships with many providers.

Funding / service provision

- PHOs are not supposed to be duplicating existing services.
- NGOs said they do not want their funding to come through PHOs, particularly when they have to work across multiple PHOs. They are concerned about losing autonomy and identity.
- PHOs need to have confidence that NGOs are providing quality services before they can be considered for funding. They need to prove they have good governance and are accountable.

Other

- NGOs need an incentive to work with PHOs.
- NGOs were given a clear message that PHOs need time to develop themselves.
- Developing a Māori-led PHO is a topic that is being discussed at the moment.

[2] People from Wairarapa DHB region were unable to attend the sector meeting.

Written submissions

- There is a lack of recognition of what NGOs have done and continue to do, with very little thought about how the NGO and PHO sector can work together in partnership to build on health gains.
- Some PHOs are still IPA-driven.
- There needs to be recognition of NGOs' current client lists and existing partnerships.
- One NGO has representation at governance level on the local PHO and has instigated a memorandum of understanding with the PHO. The relationship proposed was an operational one, with both parties being autonomous and independent of each other. This NGO does not believe it should be subsumed by the PHO.
- A rural Māori NGO said there are two PHOs in the area and they have a formal relationship with the smaller PHO and a mutual relationship with the larger PHO. The Māori PHO is small and lacks funding for all its Māori NGO affiliates, while the larger PHO has GPs in the area that the whānau of the Māori NGOs frequent. The rural Māori NGO said that the large PHO needs to look outside of its GP services for investing its primary health care funds. There has been no assistance from the DHB to address relationship strategies for either PHO.
- Future funding should be through the Māori development organisation and/or Māori development PHO for iwi providers.

DHBs

- A paper was submitted titled *Migration of Primary Health Care Contracts to PHOs*. The paper provided some insights into a planned approach for the migration of NGO contracts into PHOs. The DHB has gone so far as to include migration clauses into NGO contracts that would direct the contract towards the PHO contract, thereby delegating the day-to-day management responsibilities of the NGO to the PHOs.
- Risks outlined in the paper included: increased financial expenditure on fee-for-service contracts, and that any under-spend found by PHOs would be directed back to the DHB. Other risks included the ability of the PHO to absorb the increased work that an NGO contract would place on the PHO management.
- The paper describes the process for contract transfers and the transfer of primary health care services funding from secondary care to primary care. Māori providers oppose this move, citing that their relationship is with the Crown and a PHO is not the Crown. Contract transfer for Māori providers would be assessed in terms of an overarching aim of the health and disability sector, which is the improvement of Māori health outcomes and reduction of Māori health inequalities.
- A set of principles for contract transfers have been included in the paper. The paper also points out that future contract transfers to PHOs would need to be staggered.

Teleconference – Māori providers

- The Ministry's publication *Whakatātaka Tuarua* (Ministry of Health 2006) discusses IT development and data collection for Māori providers. If successful, this could lead to better collaboration between NGOs and PHOs.
- Māori providers lack confidence in the PHO. Māori providers have been operating for 11 years compared to the PHO, which has been operating for only three years. By 2005 most Māori NGOs had achieved accreditation, with some having international accreditation, whereas PHOs have no accreditation.
- The profile of PHOs and their role are unclear. There is a lack of transparency and accountability to the community by the PHOs.
- There are fears that DHBs do not recognise NGOs and PHOs as being equal, and that funding must be equitable between NGOs and PHOs.
- There is lack of recognition of Māori health professionals and the continuum of care they deliver.
- There is a fear that if all funding goes through PHOs, then funding decisions will rest solely with the PHO. This could have negative affects on NGO contracts and could lead to PHOs investing in themselves, thereby placing the community at risk by limiting the amount of community services they have been able to access.

Northland, Waitemata, Auckland and Counties Manukau DHB regions

Meetings

Relationships

- Relationships between NGOs and PHOs vary. Some NGOs have difficulty engaging with PHOs, and some are too busy to engage with PHOs.
- There is a huge expectation of PHOs. Some have no time to engage with NGOs and it is unlikely there will be engagement given capacity issues. Many PHOs and NGOs reported capacity problems and said they do not have time to actively engage with each other.
- NGOs have both formal and informal agreements with the PHOs. Some have memoranda of understanding and/or service-level agreements, and others have informal agreements and are represented at the PHO board level.
- The Māori providers are an integral player in PHO–NGO and DHB relationships.
- Some national NGO organisations said that the PHOs do not know where NGOs fit. They have approached some PHOs, but the response has been very poor. In other regions their offices report good relationships with PHOs.
- Mental health NGOs do not know where they fit with PHOs, and neither do the PHOs.
- Two new PHOs were established in one region recently and this has challenged the NGO and community relationships.

- Some PHOs are trying to establish NGO forums and spend time building the relationships or links with NGOs.
- One DHB has brokered a relationship between NGOs and a PHO with synergies.
- There are a large number of PHOs in Auckland, and working across multiple PHOs is not easy for single-issue or small NGOs.

Funding / services provision

- One Māori provider is both an NGO and a PHO, but only a third of its contracts are through the PHO.
- One Māori mental health NGO warned to proceed with caution concerning the future contracting and relationships with NGOs and PHOs.
- There is variation among PHOs in contracting services: some employ people to deliver services where gaps have been identified, and others look to engage existing services.
- NGOs have access to SIA funding and take ideas to the PHOs. Two PHOs use a tendering process.
- NGOs and iwi providers need to retain their identities and autonomy – there is concern among NGOs that they will be taken over by PHOs, and that they will have an extra layer to deal with. However, they still acknowledge the importance of making links with PHOs.
- There are good opportunities for PHOs and NGOs to work together, but if all funding is to come under PHOs this needs to proceed with caution. Clear and open communications are needed, and reducing inequalities needs to be the central focus.
- Some NGOs may be enhanced by the potential extra funding PHOs may be able to offer, whereas some may be taken over and lose contracts to the PHOs.
- There will be a huge difference for national organisations that have been in existence for a long time compared with small NGOs that have regionally based contracts.
- A provider of maternity services originally had a contract with the Ministry before it was devolved to three DHBs. Two of the three DHBs picked up the contracts but the third didn't. This issue has had an impact on the un-contracted region. There is fear that this example may be replicated if NGOs' contracts came under multiple PHOs.

Other

- A DHB acknowledged the concerns about NGO contracts coming through PHOs. The DHB also said that NGOs do not always recognise their own needs, and that there could be huge benefits for NGOs in working more closely with PHOs.
- There was an emphasis on PHOs and NGOs communicating their roles more widely.
- There is conflict in NGOs coming on board with PHOs: 'they could be the saving grace of NGOs, or they could be their demise'.

- PHOs questioned whether they were NGOs, and whether there is any distinction between PHOs and other NGOs. It was suggested that the distinction is that PHOs are established through government policy and legislation, whereas NGOs have generally developed out of community groups responding to a specific need that has been identified, and NGOs have their own distinct philosophies.

DHB questions

- What benefits are there to the populations the NGOs and PHOs are serving?
- How would national NGOs achieve consistency across the country and the individual PHOs?
- NGOs are serving specific needs rather than the Primary Health Care Strategy – is there a strategic alignment?
- NGOs are ideologically based, and some will not want to move to a more 'bureaucratic' funding model.

Bay of Plenty, Waikato and Tairawhiti DHB regions[3]

Meetings

Relationships

- NGOs are willing to link to PHOs but acknowledge the different types of PHOs.
- Some NGOs have relationships with a Māori PHO, and see opportunities to work more collaboratively towards a common goal. The relationship with the PHO is generally good, although there is a 'big brother' mentality and it is sometimes easier to work directly with the DHB or the Ministry.
- The Māori mental health provider says it would like to work with PHOs around funding and contracting. The provider is not sure how to establish relationships and does not know what the benefits would be.

Funding / services provision

- There are different processes for each PHO, but some NGOs are getting opportunities to tender for services. One national NGO was not aware of any funding available in the Bay of Plenty region.
- Some PHOs do not put contracts out – instead they are using funding to build their own infrastructure and hire people to do the job when there is already expertise out there.

[3] People from Lakes and Taranaki DHB regions were unable to attend the sector meeting.

Other

- Concern was expressed as to where large national organisations fit across the large number of PHOs. It may not be appropriate to be part of the PHO, but could be possible to link in with them as appropriate.
- Some NGOs are seen to be in competition with the PHOs. NGOs agree with the Primary Health Care Strategy and want to establish links, but due to perceived competition find this difficult.
- There is concern about how the Strategy has evolved at a local level and the dominance of one group in the PHO.

Written submissions

- NGOs carry out work across the primary health care spectrum. This could be attributed to existing relationships prior to becoming a PHO. These relationships are described as 'works in progress' because the PHO is clear that its role is to focus on identifying small pieces of work that will bring about a greater understanding to the primary health care sector about NGOs and what they do.
- The DHB has not assisted in brokering the relationships.
- Midlands has had capitation for over 10 years and it has taken time to settle down.
- Transparency of process is required, with sufficient time for the sector to absorb and reflect on it. There needs to be flexibility with altering the model.
- Ring-fencing of funding needs to be highlighted, including what happens if expectations are breached. Mental health ring-fencing has had a partial impact on getting the money spent on mental health. DHBs are often criticised for not being able to manoeuvre around the ring-fence requirements. Māori health is an area that needs to be ring-fenced.
- If PHOs were required to take a greater level of responsibility for planning and funding, this should be reflected in an increase in the management fee.
- The DHB established advisory groups for NGOs and PHOs and facilitated special groups for 'hot topic' discussions.
- The Ministry and DHBs could facilitate meetings between national NGOs and primary health care sector groups like PHONZ.
- PHOs could outline in their annual reports the level of interaction they have had with NGOs over the past year and in what capacity this has occurred.
- PHOs could consider what interaction with specific NGOs is required to assist in the development of shared information and programme development.

Community representative

- It would be advantageous to have a database of all NGOs and what they do within a PHO's geographic area.
- It makes sense to have health funding from one entity. This would help to co-ordinate health care delivery and allow outside organisations like the Ministry of

Health and Ministry of Social Development to be involved. It's a big topic with exciting possibilities.

Relationships with DHBs

- PHOs generally have good relationships with the DHBs.
- The small PHOs say they have few resources and struggle to survive and meet requirements. They are all different in how they deliver services and engage their communities.
- The large PHO appears to be well structured and community focused.
- The small PHOs work well together but there is reluctance from them to work with the large PHO.

Telephone

PHOs

- One large PHO employs only five staff and does not view its future development as becoming a bureaucracy like a DHB. Rather, it sees its principal role as ensuring that primary health care funding received is invested back into the community.
- They have 80 SIA projects, which are predominantly delivered by NGOs. The development of a chronic care framework is well under way, with a planned launch in 2007.
- The PHO can see synergies in working together with other PHOs and NGOs.

REFERENCES

Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health.

Ministry of Health. 2006. *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011: Discussion document*. Wellington: Ministry of Health.

Office of the Auditor-General. *Principles to Underpin Management by Public Entities of Funding to Non-government organisations*.

The Treasury. *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown*. Wellington: The Treasury.