NON GOVERNMENT ORGANISATIONS (NGOs)

AND THE

PRIMARY HEALTH CARE STRATEGY

Developing relationships with Primary Health Organizations from an NGO perspective

A Report from the

Health & Disability Sector NGO Working Group

March, 2005

CONTENTS

EXECUTIVE SUMMARY

This study on which this report was based, was researched and written by an independent contractor, Heather Kizito, commissioned by the NGO Working Group. To date, provision of information by Government about health and disability NGO participation in the new primary health care structure has been slight, and only in the context of health promotion. This does not address the wider context of the range of specialist services, holistic care and diverse support offered by the hundreds of health, and disability NGOs.

This study explores the experiences and identifies the key issues of eight NGOs as they seek to develop relationships with primary health organizations (PHOs) and establish their fit within the new primary health care structure. It also draws on statements reflected in the NGO – MOH survey of relationships with DHBs, and more recently with the Ministry of Health.

NGOs that agreed to be interviewed for this study did so on the understanding that any information identifying their agency would be removed from the published report. It has proved more difficult to anonymise some organisations than others, and it is an expectation that this desire for anonymity be respected.

Results showed that that while NGOs were generally supportive of the philosophy behind the Primary Health Care Strategy, particularly as the desire to reduce inequalities has traditionally been a major driver for NGOs, they had significant concerns about:

- their place in the new environment
- the limited PHO responsiveness to NGO attempts to form relationships
- the transaction costs involved in seeking to build relationships
- the lack of equitable opportunities to tender for new projects
- the vulnerability of health promotion within the PHO setting
- Maori provider issues
- the lack of understanding by DHBs and PHOs, about the skills and services provided by NGOs
- the apparent intentions of some DHBs intend to contract with PHOs or even a single PHO rather than NGOs, and
- the possible gradual devolvement of all primary health, and eventually public health funding, to PHOs.

The feedback overall highlighted that, if NGO participation in the new environment is to be effective, there is an urgent need for action by Ministry of Health, DHBs and PHOs to:

- provide clarity and direction in relation to funding for and inclusion of NGOs in the new primary care system, and

- facilitate and enhance participation in line with government policy, by PHOs in the development of NGO – PHO relationships. NGOs are already generally motivated to do this but PHOs need encouragement from the Ministry of Health, DHBs, and their own management, and both groups need contractual frameworks and funding incentives.

Resolution of these issues has major implications for the sustainability of NGOs and the health and wellbeing of their communities.

Furthermore there is a sense that the clients of NGOs do not receive the same benefits, in terms of subsidized care as those of PHOs.

1. BACKGROUND

The Minister of Health launched the Primary Health Care Strategy in February 2001. The strategy offers a new vision where:

- people will be part of local primary health care services that improve their health, keep them well, are easy to access and co-ordinate their ongoing care

- primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

This vision involves greater emphasis on:
- population health and the role of the community
- health promotion and preventive care
- the involvement of a range of professionals
- funding based on population needs rather than fees for service.

To achieve this vision a new system has been set up with Primary Health Organizations (PHOs) at its core. The key points about PHOs are:

- PHOs are funded by district health boards (DHBs) to provide a set of primary health care services to people enrolled with the organization.

- PHOs are required to offer services that improve, maintain and restore people's health.

- PHOs are expected to involve their communities in their governing processes, and be responsive to their communities' needs and priorities.

- PHOs must ensure that all providers and practitioners within the organization have equal influence in decision making, rather than one group being dominant.

- PHOs, as not - for - profit organizations, must be fully and openly accountable for all public funding.

- Although encouraged to join PHOs, membership of primary health care practitioners is voluntary.

Information on, and references to, NGO involvement in the new primary health care environment

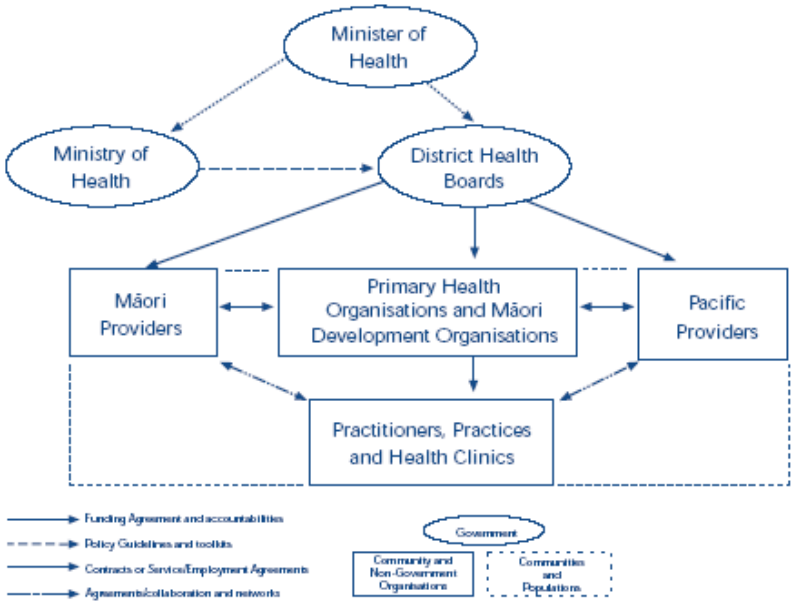
NGO involvement in the new primary health structure is not clear. The Primary Health Care Strategy (Ministry of Health, 2001) merely states that some services, e.g., maternity care, family planning, well-child services may be provided by different groups whose services have developed along parallel paths to more generalist services. While it "recognizes the importance of continuing to provide such alternative choices for people" the Strategy does not offer any insights into how these services would fit into the PHO model. Indeed, the diagram (see over) (refer "The Primary Health Care Strategy", page 5,) outlining the structure of the new primary health care sector omits any NGO involvement.

Later documents make more mention of NGO and provider roles in the new environment. Public Health in a Primary Health Care Setting (Ministry of Health, 2003) identifies public health service providers as:
- public health units attached to DHBs
- a network of NGOs
- Iwi providers
- Pacific Providers
- territorial local providers

The diagram below shows the relationships between Primary Health Organisations, the Ministry of Health, District Health Boards, communities, and other providers.

Existing organisations will need changes to become Primary Health Organisations.

THE NEW PRIMARY HEALTH CARE SECTOR[3]



[3] This diagram reflects the sector as envisaged under this Strategy, however, as noted previously, primary health care practitioners will be free to decide whether or not they join a Primary Health Organisation.

The expectation in the Ministry's document is that providers will work in collaboration, co-operation and co-ordination across the health sector, including with PHOs. There is already evidence from the NGOs in this study that this process is complex. The document has little recognition of the potential challenges, practicalities, funding implications and lack of clarity in some areas posed by this process. Indeed a major finding of this study relates to the challenges in developing NGO – PHO relationships.

Thus far, information and documents provided to the NGO sector have largely viewed NGOs as health promotion /public education providers, rather than in a wider context as providers of a range of specialized services and holistic care (e.g., clinical services, social support, alternative therapies, etc). This study shows that providers of clinical services in particular face additional challenges under the new structure. These challenges are outlined in the analysis and summary, and detailed in Appendix 2.

"PHOs are not expected to do all of health promotion in their community. The current health promotion programmes will continue to be delivered by Public Health Units and NGOs. This is an opportunity to contribute to existing health promotion programmes in ways that specifically meet the identified needs of communities…" (A Guide to Developing Health Promotion Programmes in Primary Health Care Settings, Ministry of Health, 2003)

While this vision (above) may seem straightforward enough, it presupposes that NGOs will have defined their fit in the new system, developed partnerships with PHOs and have the confidence of a secure funding stream. In reality, as this study shows, NGOs are struggling with these processes and have described them variously as "exciting," "challenging," "frustrating" and "elusive", and feel that their funding base is less certain than that of PHOs or DHB provider arms.

This study

In the context of the issues outlined above, the NGO sector is currently planning for and responding to the requirements of the new environment. This study explores the progress and experiences of selected NGOs as they seek individually and collectively to develop and define their relationships with PHOs and their involvement in the new primary health care system.

2. METHODOLOGY

Eight NGOs participated in this research. Organisations included national NGOs involved in personal (clinical) and public health roles (A and D), umbrella and NGO membership organizations for disability and mental health (B, C and F), and Maori health (E, G and H). These NGOs covered a range of sizes.

In addition, a short interview with a women's health NGO was undertaken by phone and their feedback incorporated into the main document.

Just prior to the Christmas break, introductory phone calls / voice-mail messages were made to the above NGOs informing them of the project and inviting them to participate. These calls were followed by e-mails offering further information and possible times for phone interviews.

A basic questionnaire was developed. Due to the unavailability of most key informants over the Christmas break, the administering of the questionnaires varied. Most key informants were e-mailed questionnaires in preparation for the interviews, others were asked the questions sight unseen in phone interviews, and two were given the questionnaires to complete. The questionnaire is attached as Appendix 1.

A follow-up round of phone interviews with most NGOs was undertaken in mid January. In addition, two meetings were held with Wellington-based NGOs.

While the first round of phone calls focused on the questionnaire, the second involved an unstructured discussion on further NGO issues with PHOs. The unstructured discussions resulted in a diversity of feedback and an opportunity for information sharing (websites, reports, documents etc).

As an accuracy check, all interview notes taken by the researcher were emailed to the relevant participants to review after each interview. This process often elicited additional comments and information.

Feedback fell into six main categories. These included:

- **The Primary Health Care Strategy: NGO responses, perspectives and experiences**
- **PHO relationships**
- **Access issues, including Maori, youth and high need groups**
- **Maori provider issues**
- **Risks and concerns for NGOs**
- **Other.**

NGO responses are set out in detail in these categories in the Appendix 2, and summarized in the main body of this report.

Some information is also included from relevant sections in the surveys of NGO relationships with DHBs (2003) and the Ministry of Health (draft: 2004) which were carried out by the NGO Working Group.

3. ANALYSIS

3.1 Feedback from NGO Surveys 2003& 2004

In late 2003, 103 NGOs replied to a survey by the NGO Working Group on the NGOs' relationships with DHBs.

This included a question on the Impact of PHO Development.

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Impact of PHO development

(i) Of 26 NGOs 25% of respondents were involved in a PHO.
Some specific comments were made about PHOs, suggesting, for example, that "people who may not have the skills to develop this entity are thrown together and left to try and do the best they can". Others commented that more time should be resourced to help people establish PHOs. Some commented on the administrative demands and high levels of resources required.

Others commented on their NGO's difficulties with:

- isolation in a PHO dominated funding environment
- GP capture
- problems for Maori NGOs
- failed or unrelated collaboration between NGOs and PHOs
- lack of consultation
- a lack of understanding of health promotion
- increasing NGO isolation as the PHOs increasingly dominate the funding and structure, and
- lack of clarity about the role of national NGOs and NGOs in general in a DHB/ PHO environment.

Positive comments included a belief in the "huge potential" for new opportunities for subcontracting, shared resources, lower cost of services (see Appendix 3).

(ii) Likewise the survey of NGO relationships with the Ministry of Health also included a question on PHO involvement and impact (see Appendix 4).

66 people responded; 23 NGOs were involved with a PHO. The 45 responses in relation to PHOs were varied, but give the impression that NGOs feel a medical model of health care dominates PHOs. Some felt PHOs were less engaged with their communities, that they were captured by GPs and essentially a guaranteed income for GPs and overlooked the impact of the socio-economic environment and psychosocial needs of individuals.

There were several positive comments, but others were worried about confusion and competition. Several felt there were potential benefits for clients, while others felt PHOs lacked an understanding of health promotion principles.

Many of the NGOs responding to a question related to the three most important issues facing the health and disability NGO over the next 5 years identified the emergence of PHOs and their impact on their service delivery. (See Appendix 4)

3.2 Feedback from 9 NGOs analyzed under the six categories (refer Section 2).

3.2.1 The Primary Health Care Strategy: NGO responses, perspectives and experiences

All NGOs in the study expressed confidence in their skills, experience and knowledge in their respective fields, and felt they could make a real contribution to the new system. However,

they believed that DHBs & PHOs were largely unaware of what NGOs did, and that some DHBs were replacing NGO contracts with contracts with PHOs. Furthermore, they felt PHOs failed to recognize NGOs' specialist skills and their role in the delivery of community-based, holistic health care.

Most of the NGOs in the study expressed concern over the lack of clarity about the fit of NGOs under the new structure. They felt there was a lack of information, education, advice, support and direction from the Ministry. Indeed, two NGOs asked who they were meant to go to for clarification *("Who is in the control room?").*

They welcomed the new focus on population health, health promotion and wellness. However all but one (F) expressed concern about whether the health promotion would be sufficiently understood, supported, sustained and promoted by PHOs. The biggest threat to health promotion was seen as GP capture of PHOs and the subsequent dominance of the medical model.

Some felt disadvantaged in comparison with the PHOs' funding model, with respect to cost of living increases, increasing access and administration funding.

All NGOs recognized the potential opportunities within the new system for partnerships with PHOs to increase health and disability gains. However, in practice, these opportunities appeared elusive, with five NGOs describing challenges in developing these partnerships. Two NGOs (D and F) recorded significantly more success in this area.

Within NGOs, organizational changes in response to the new environment varied. One had restructured their organization to maximize capacity for developing relationships and partnerships with PHOs and others. Another developed a training programme for senior management to support their performance in the new environment, while other NGOs have developed formal strategic plans or work programmes designed to facilitate relationships with PHOs. All NGOs, to greater or lesser degrees, have begun to re-orient their focus towards working in a PHO environment.

One, as a provider of clinical services run on similar lines as a clinical practice, faced a unique set of circumstances that posed a risk to its viability as an organization. These circumstances related to it being ineligible for benefits under the PHO interim / access funding formulae and the subsequent risk of increased competition from GPs, which in turn could impact on clients' choice of provider for specific services.

It was perceived by all NGOs that differences in PHOs throughout the country (size, shape, access/interim, Maori, mainstream etc) meant that different interfaces and relationships between NGOs and PHOs would need to take place. One NGO (D) pointed out that this runs the risk of fragmentation of services, which in turn results in management challenges.

Most NGOs expressed concern about the lack of certainty over contracts and funding flows. In addition they were concerned over the amount of funding allocated to PHOs (and continuing to be allocated), whether PHOs would eventually be charged with control for all primary health funding and whether DHBs intended to replace numerous NGO contracts with contracts with one or two PHOs. However, NGO D felt that PHO control of funding would keep budgets closer ("and safer") to the NGO sector.

3.2.2 PHO relationships

As mentioned above, developing relationships with PHOs proved a largely challenging, frustrating and disappointing experience for most NGOs in this study.

Developing relationships with PHOs is viewed by many NGOs as "one way traffic." All NGOs in the study made the initial overtures and contacts with PHOs. With two (D and F), relationships developed more successfully than with the other NGOs. One of these has a few contracts with some PHOs and has developed memoranda of understanding with others. The

other has contracts with some smaller NGOs. One was on the Board of a larger PHO; others had nominated organizational representation for Boards.

With the other NGOs initial contacts and visits often proved to be one-offs, or if more than one visit was involved this was usually due to the efforts of the NGO. In most cases contacts were not reciprocated, or there was sparse contact that did not develop further, or only for the AGM to demonstrate community involvement. Most NGOs complained that they were "left out of the loop" by PHOs, and that their skills and expertise were not sought. (A) is a member of two PHOs but funding limitations, on both sides, prevent joint ventures. (B) had an initial meeting with a PHO but the relationship went no further. One NGO commented they had to "beg" to get a meeting with a PHO. One had been approached by a PHO to deliver services but neither party was able to fund the initiative, although relevant to reducing inequalities.

A number of NGOs mentioned they had no budgets to cover the resources, visiting, consulting and developing relationships with PHOs. In spite of this, all NGOs were committed to working with PHOs and intended to continue in this vein.

The main barriers to partnerships and participation in the new system were identified as:

- lack of response by PHOs to NGO attempts to develop relationships
- limited understanding by PHOs about what NGOs "actually do" and what skills they have
- in some cases NGOs being perceived as potential competition
- lack of information about the new system, primary care funding and policies. Both Maori and mainstream organizations are struggling to understand where they fit in the new system and the benefits of developing relationships with PHOs
- in the case of Maori, the potential for tokenism in a relationship with a PHO
- The risk of losing hard-earned tino rangitiratanga if Maori providers form partnerships with PHOs.

3.2.3 Access issues, including Maori, youth and high need groups

NGOs were generally supportive of the initiatives to improve access, including the move toward cheaper fees, a population health focus for increased equity, collaboration with Maori and Pacific providers, increased consultation with communities, and integration of health care to improve access and reach in hard-to-reach, high-need groups. However, NGOs believed they needed to be included in the solutions to improve access, since they could offer the community networks, specialized skills / support, and a holistic approach, all of which impact on removing barriers and enhancing access.

There were concerns, however, about access issues. Unlike PHOs, NGOs with clinical services will not be funded under the PHO access or interim formulae, and therefore will not receive patient subsidies. This impacts on access in the following ways:

- high-need clients will not receive the benefit of fee reductions
- some clients may then decide on a provider only on the basis of fees
- due to sensitivity, these clients may not wish to access services such as sexual and reproductive health services from their family GP and will therefore miss out on important health care.

Mental health NGOs commented that people with mental health issues may be disinclined to access PHOs services as they do not provide recovery and wellness support, and are less informed about the issues for mental health patients in the community. Furthermore, PHOs do not offer alternative therapies that people with mental health issues often wish to access.

Mental health NGOs are keen to develop partnerships with PHOs to improve access and health care for mental health consumers.

Maori NGOs commented that while Maori generally prefer to access Iwi providers who are responsive to cultural needs and who may provide cheaper services, some consumers will inevitably access mainstream PHO facilities because of the wider range of services on offer. However, lack of culturally sensitive services and higher costs within a PHO may be a barrier for some, who may therefore miss out on important health care.

3.2.4 Maori provider issues

The new environment also provides opportunities for collaborative relationships between Maori providers and general practices. There are currently 78 PHOs; seven are Maori-led with a further five Maori / general access PHOs.

The Maori provider NGOs interviewed felt that in many cases Maori providers do not yet have the capacity to form Maori PHOs, nor for many is it currently a priority, as they are more concerned with other immediate issues (such as funding and accreditation). In addition, like many providers, Maori are still trying to understand the complexities of the new system.

There is also a perception amongst some providers that involvement with PHOs may compromise their hard-earned tino rangitiratanga. Maori providers also recognize the potential for tokenism in developing relationships with PHOs.

3.2.5 Risks and concerns for NGOs

The following risks and concerns were identified:

3.2.5.1 Lack of DHB and PHO recognition and utilization of NGO skills and services

All NGOs in the study believed that DHBs and PHOs had limited understanding of the specialist/ specialized skills, experience and knowledge built up by NGOs over the years. In particular, PHOs were deemed to have little insight into the importance of holistic care and the range of NGO community services crucial for recovery and maintaining wellness, or providing specialized services in specific areas of expertise.

There was also a sense that DHBs often did not consider NGOs alongside PHOs when calling for programme proposals, and did not fully understand NGOs, and would prefer to minimize the number of contract partners. In some cases DHBs must seek to ensure the viability of their own provider arm and this prevents funding being passed out to NGOs.

3.2.5.2 Lack of support for health promotion

NGOs felt that health promotion within PHOs was at risk due to:

- the potential for capture from GPs and the subsequent dominance of the medical model
- the “flow through” of the treatment model from business-oriented IPAs and group practices into PHOs
- lack of collaboration with NGOs and other groups who have a health promotion approach
- limited understanding of health promotion by clinicians

3.2.5.3 Funding devolved to PHOs

NGOs expressed concern that all public health funding could be devolved to PHOs to control. This would be likely to negatively impact on primary health funding and eventually all funding support for some NGOs, particularly since some PHOs have a limited understanding of what NGOs offer, and therefore impact negatively on communities.

Another cause for concern was the recent announcement (Dominion Post, 10 January 2005) that GP fees have increased by a third ($20 Million), fuelling fears that the system is weighed down by bureaucracy, and that health money is being poured into "the black hole of PHOs."

{See also Dominion Post – Monday March 14}

3.5.2.4 The impact of the funding formulae on some NGOs

NGOs, which offer specialized clinical services, are not included in the interim and access funding formulae and therefore their clients miss out on the benefits of the increased funding for primary care, including reduced charges. This poses a major threat to NGOs which provide clinical services, not only in terms of client accessibility and affordability, but also in terms of financial viability.

Often, NGOs do not receive cost of living increases, access or administrative funding, experience regional price variations and often have only one-year contracts.

3.5.2.5 Perceived competition and Client Choice

Competition between NGOs and PHOs for the provision of some services exists where one offers free services owing to subsidies and the other cannot, but this may result in the loss of access to comprehensive specialized services to high risk groups. Some PHOs may feel they can replicate these services but the quality may differ in some cases, and although they can offer the services at lower charges because of subsidies they may not necessarily be the client's provider of choice.

3.5.2.6 Equality of Opportunities

NGOs which provide primary care services would like the same opportunities as PHOs to tender for relevant projects or to be encouraged to tender jointly.

3.5.2.7 Recruitment of NGO-trained staff

Many NGOs have worked hard to develop a competent and well trained workforce often in the face of a competitive health environment, where the public health provider can afford to pay higher wages. Concern was expressed by two NGOs about the potential for PHOs to recruit highly trained staff from NGOs, rather than explore ways of working collaboratively. This would have significant consequences for the NGO workforce, in terms of training investment and operational capacity, particularly in the environment of recent increased nurses pay awards.

3.5.2.8 Barriers to Maori involvement

The lack of clarity about PHOs and how the new system will function is partly responsible for the slow response by providers in developing partnerships with PHOs. NGOs also recognize that PHOs have had to focus on setting up new organizational structures, etc, with relatively little time to develop new partnerships in the early stages, but hope this will now change.

Maori providers have achieved a sense of control (tino rangitiratanga o te hauora) in the provision of health care by Maori for Maori, and may be reluctant to accept a partnership due to perceived tokenism or risks to tino rangitiratanga.

Any modifications to NGO services as a result of the new structure may impact negatively on Maori (and others) and therefore on the goal to reduce health inequalities between different groups.

4. SUMMARY

- NGOs are generally supportive of the philosophy behind the new primary health care strategy, especially its population-based focus and the emphasis on improving, maintaining and restoring health.

- There is a lack of clarity about the NGO role in the new system and whether their funding will continue, and who the funder will be; there is also a lack of responsiveness to requests by NGOs for more information.

- PHOs appear largely unresponsive to attempts by NGOs to develop relationships with them.

- There is a need for PHOs to recognize the range of specialized skills, knowledge and experience that the NGO sector offers, and to form partnerships with them to provide holistic, integrated care or take advantage of areas of expertise.

- NGOs are concerned about the potential for medical model dominance within PHOs. It is crucial that health promotion, holistic care, wellness and recovery approaches are encouraged, supported and promoted by PHOs.

- Some NGOs providing clinical services may be disadvantaged by the PHO system (e.g., funding and competition issues) to the point where their specialized services may no longer be viable.

- Some Maori providers need appropriately targeted information about PHOs and the new system to assist in their understanding of and decision making around PHO issues.

- Some Maori providers are concerned that partnerships with PHOs may be tokenistic, or may undermine tino rangitiratanga.

- NGOs are concerned that all primary health funding and eventually public health funding may be devolved to PHOs and that NGOs and their clients and communities may be adversely affected by DHBs transferring their contracts to PHOs, which appears to already have happened in some cases.

- Some NGOs expressed concern about the potential for PHOs to recruit highly trained staff from NGOs thereby undermining NGO investment and capacity.

- Access, equity and health gains can be maximized for all when treatment, recovery and wellness services are integrated, supported and delivered through partnerships between PHOs and NGOs.

- There is a need for funding frameworks to reflect service delivery, and also encourage collaboration between PHOs and NGOs.

- There is a need for equal opportunities by DHBs ensuring PHOs & NGOs have equal opportunities to tender for appropriate projects.

5. CONCLUSIONS

The NGO health sector is complex and diverse, employing many thousands of people and delivering millions of dollars of health service. This study highlights the willingness and commitment of NGOs to form partnerships with PHOs for the delivery of integrated holistic health care to the populations they serve, and the need for more responsiveness from PHOs in developing these relationships.

It signals that if the vision for improving, maintaining and restoring health and reducing inequalities is to be realized, there is an **urgent** need for action by the Ministry of Health, DHBs and PHOs to:

- provide clarity and direction in relation to funding for, and inclusion of, NGOs in the new system, in line with government policy
- facilitate and enhance participation by PHOs in the development of NGO – PHO relationships. NGOs are already generally motivated to do this but PHOs need encouragement from the Ministry of Health, DHBs and their own management, and both need contractual frameworks and funding incentives.

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NGO Survey on Relationships with the Ministry of Health (draft: 2004)

APPENDIX 1

NGO Working Group Research: QUESTIONS FOR PHONE INTERVIEWS WITH NGOs

1. Any positives happening in relation to working with PHOs? (Working well? Examples? Any contracts?)

2. How do you rate your relationship with / approaches to PHOs thus far? (Effective? fragmented? etc)

3. Any concerns or possible issues that have arisen - or might arise in the future? (Examples?)

4 What impact might the new system have on your clients / consumers? (e.g., in terms of services, access? needs of Maori, other groups?)

5. Have you any insight into how PHO development is affecting Maori or Pacific health providers?

6. Any views on funding issues for your organization in the new structure?

7. How would you rate the potential for overlapping, duplication (or nonsupport) of your services in the new system?

8. With the advent of PHOs, what changes have occurred (or are likely to occur) in the way you currently operate?

9. PHO responsiveness to your NGO: Are you kept in the loop? Is your expertise acknowledged/sought, etc?

10. Do you have any other issues / comments that could be included in the report?

11. Did your organization make a submission on *"Emerging Issues in Public Health*?" If so, any discussion in your submission to do with your organization's view of working relationships with PHOs would be very useful to me.

APPENDIX 2 NGO RESPONSES

Note: The responses below have been offered by one key informant from each participating NGO. It has become apparent during this study that different workers within the same NGO may have differing perceptions and experiences in relation to the new primary health care structure.

1 (A) is a nation wide service providing a range of services including clinical services, and health promotion.

The Primary Health Care Strategy: responses, perspectives and experiences

(A) recognizes that the new environment offers opportunities for NGOs to form relationships and partnerships with PHOs. In practice, however, they have found the process of developing relationships with PHOs both challenging and disappointing.

To better meet the needs of the new environment, the organization restructured and a national strategy was developed focusing on developing relationships and partnerships with PHOs.

PHO relationships

- The NGO is a member of two PHOs and had early involvement in setting them up. It continues to support and commit to the development of these PHOs and it believes it has benefited in terms of relationship building and an understanding of PHO development but unfortunately joint projects with these PHOs have not eventuated owing to funding limitations on both sides.

- It has initiated contact with other PHOs around the country but this has proved to be a one way process and as a result relationships remain largely undeveloped. In several cases PHOs have responded with requests for the NGO to deliver services, often in areas of deprivation among Maori populations but the PHO has not been able/willing to provide the funding and the NGO has similarly been unable to find the service from its existing contract.
- The NGO is sometimes invited to PHO consultation meetings which are generally information sharing forums. One of the largest PHOs in New Zealand invited them to a meeting to nominate representatives to the interim governance board. They heard nothing more from them until a year later when at another meeting they were again asked to elect members to their board. (The first meeting was attended by around 50 people, the second by 11 people representing only six organizations.)

Access issues, including Maori, youth and high need groups

- Clients of the NGO will not receive the benefit of the fee reductions that PHOs can offer under access and interim funding formulae, since the NGO is not funded under these formulae. This will act as a barrier to some clients.

- Underutilization of the NGO services may have serious results. Research has shown that when such services close, youth and marginalized people do not usually revert to local GP services.

As in many communities clients and their families are well known to GPs, and some clients will, therefore, not seek information or advice at all.

- In terms of commitment to Maori, the NGO, at their own expense, are in the process of working with a Maori NGO to implement training and protocols. However, the NGO receives no funding that is specifically targeted for Maori, or for increasing access.

Risks and concerns

- There is very real potential for PHOs to duplicate NGO services in the new environment, rather than collaborate, but this is not necessarily what clients want, nor always at the same level of expertise.

    - The NGO is a specialized service working with youth and marginalized people. Some PHO members do not have the same level of specialized knowledge and expertise to work with these clients.

    - In the sensitive areas of health, people need choices. In many communities clients and their families are well known to GPs and clients my wish to access the sexual/reproductive health services of an alternative provider.

The following funding issues highlight the vulnerability of the NGO under the new Primary Health Care Strategy, and seriously impact on its viability as a provider.

- The NGO does not have the certainty of an agreed funding model as PHOs do which incorporates development costs or costs of increasing access in order to reduce inequalities and deliver Government's objectives. Nor does it receive specific funding, as do PHOs, for governance and management, administration, IT project management and data collection. (In the NGO these functions are funded through clinic income.)

- Unlike PHOs, the NGO does not have the certainty and continuity of a future funding track for 2004-2007, but a one-year contract. Furthermore it is unclear at this point whether either the Ministry of DHBs will budget to fund it for 2005 – 2007.

- Unlike interim PHOs, the NGO have not been permitted to charge co--payments for every subsidized client and philosophically would prefer not to as its mission is to increase access.

- It has not been indicated whether the incremental subsidies offered to PHOs for clients aged 22-65 over the next 3 years will be offered to the NGO. This will impact severely on their fee income and overall budget.

- The impact on recruitment and retention of staff from major DHB pay agreements with nurses and doctors have been further factors in the NGO seriously considering its sustainability.

Other

This is one of the few NGOs which employ doctors and nurses with all clinical services purchased through primary health. Their services are run in the same way as GP services, the only difference being that it provides specialized services and not the full range of GP care.

The new funding for subsidized GP visits that is being introduced over the next 2-3 years will have a huge impact. GPs will be able to offer services at a much cheaper price because of the subsidies, and most will still charge co-payments which the NGO cannot do.

- With the current system of all primary care funding being attached to PHOs and GP services the NGO is very disadvantaged. Many GPs see the NGO as their competitor and would not consider contracting with them to provide services.
- the NGO visits DHBs they are often enthusiastic about what it could provide but are extremely worried that they may upset their GPs if they contract any services with the NGO. *"DHBs then go off and consult their PHO (made up of the GPs) and we never hear from them again."*

- Often the NGO, like other NGOs, is not offered the same opportunities to tender for new initiatives. While tenders may involve sexual and reproductive health projects, the

NGO may not know about them *"and yet we may be able to carry out such projects more effectively and at better prices."*

- The NGO's Strategic Framework is based on collaboration but this is proving more difficult than expected.

2 (B) is a charitable trust formed from a group of trusts focusing on intellectual disability services and mental health services

B contracts with both the Ministry of Health and DHBs to provide community support for people with intellectual disabilities and those recovering from a mental illness.

Primary Health Care Strategy: Responses, perspectives, experiences

The NGO supports the new focus on wellness and health promotion within PHOs but has some concerns over whether this approach will be supported and sustained.

The NGO feels that PHOs may never be able to replicate the knowledge and expertise that NGOs have built up over the years. They stress that the new structure needs to recognize and utilize this knowledge and work in partnership with NGOs for population health and disability gains.

In response to the new environment, they have developed a strategic plan which involves developing relationships with PHOs.
"They need to know our specialist depth of knowledge and experience in community mental health services."

PHO relationships

- "Our relationships with PHOs are nonexistent." However, this may change over time.

- A 'one off' approach to a PHO – at the request of a mental health co-coordinator– failed to develop further.

- Relationships between the NGO and PHOs may evolve as the NGO implements its Strategic Plan
- *"The people we support will access PHOs, but the PHOs cannot provide what we can. That is why we need to develop relationships with PHOs so that they know what we do, and together we can provide integrated holistic care.*

Access issues, including Maori and high need groups

- The NGO's clients may not necessarily experience improved outcomes under a PHO system because the most obvious benefit, that is, lower or nonexistent fees have not yet eventuated.
  "We need to keep the focus on the recovery model which isn't yet embraced, or indeed understood by, PHOs."

Risks and concerns

- It may be easier for the DHBs to devolve all funding, including NGO funding, to PHOs, rather than maintaining funding contracts with a range of NGOs. This poses the risk of under-funding or omitting funding for NGOs.

- NGOs work in a way that diminished the medicalization of disabilities. Under PHOs, medicalization of disabilities may be increased.

- Although there is no direct competition with PHOs, there may be some overlap between PHOs and the NGO in the provision of services, e.g., where PHOs decide to start providing non-clinical support to people with mental health issues on a long term basis.

Other

- There may be too many PHOs. Some contract back to IPAs for management services which may mean that their emphasis remains on clinical services rather than extending their focus onto working with other community providers. It may also result in IPAs becoming even more powerful than they already are.

- The many tasks to be undertaken by PHOs – from community consultations to health promotion and treatment services - may be too numerous to be done effectively

3 (C) is an umbrella NGO membership organization ,and (H) is a registered charitable company offering services throughout the health sector

(C) and (H) were interviewed together. Their joint responses are recorded below.)

Primary Health Care Strategy: Responses, perspectives, experiences

Both NGOs are supportive of the PHO philosophy focusing on improving, maintaining and restoring health, particularly in the areas of wellness and health promotion. They are continually looking for ways of working together with PHOs to provide health and wellness options for people.

However they expressed the following reservations.

- PHOs are unaware of the work, skills, knowledge and experience of NGOs. While GPs are generalists, NGOs are specialists in their fields and provide a holistic approach to health and wellness. They know how to engage with service users, communities and local agencies such as housing, employment and counseling. PHOs would benefit from this expertise and from a clearer understanding of the complexity of the NGO sector.

- There is a lack of clarity in relation to NGO involvement and function under the new primary health care strategy / PHO system is a concern.

- There is no reference to the NGO role in the Primary Health Care Strategy. Indeed, NGOs have been left out of the diagram of the primary health care sector.

- NGOs have been told that DHBs will be managing contracts with NGOs, but DHBs are indicating that PHOs will be doing the contracting

- When asked for some clarity around the NGO situation, the Minister of Health commented that NGOs “have always been innovative and can find their own way.” However NGOs are funded for deliverables, not for innovation in seeking solutions

PHO relationships

H commented that at present there was a "search phase" in the health sector with organizations searching for suitable partners – a complex process given the myriad NGOs and the many developing PHOs. As well as organizations exploring business synergies they are also exploring interpersonal fit. In PHO-NGO relationships this appears to be enhanced where NGO representatives are on PHO boards.

- NGOs are expected to – and are keen to - build partnerships and networks with the PHOs although they are not funded for this.

- With commitment from both NGOs and PHOs, partnerships can be developed. An example of this occurred in early 2004 when - in response to a Ministry of Health request - NGOs and PHOs collaborated on proposals exploring options for Mental Health Integration and Innovation in PHOs. (To date there has been no response by the Ministry to any of these proposals.)

- The differences between PHOs (e.g., in size, philosophy, geographical location, enrolled populations etc) means that there are also differences in PHO responsiveness to NGOs. For this reason:
    - NGOs require different strategies for interfacing with different PHOs around the country
    - some branches of an NGO feel more confident / valued / involved with a PHO than other branches of the same organization. Therefore, staff working within the same NGO may have very different perceptions about the way in which their organization functions in the new environment

Access issues, including Maori and high-need groups

- Mental health consumers are often keen to access a range of therapies such as reflexology, massage etc. These therapies cannot be accessed in a PHO clinical set up.

- Mental health NGOs provide community support services around client recovery and wellness. Clients cannot access this type of support in a PHO.

Risks and concerns

- PHOs may decide to recruit skilled workers from NGOs, rather than contracting with or working with NGOs. Mental health NGOs train community support social workers to a high degree and PHO recruitment of these workers would seriously undermine NGO capacity and investment in training. In addition, the many benefits of working with a range of diverse holistic community organizations would be lost to the PHO.

- There was concern about the status of health promotion in some PHOs. Situations could arise where:

    - there is GP / bureaucrat capture of PHOs, resulting in domination by the medical model
    - the "drama" of medicine takes precedence over the "unsexiness" of wellness.

Other

It was suggested that GPs could seek competencies in alternative therapies (eg, a GP with qualifications in medicine and acupuncture) as this could expand the PHO into more holistic areas. In addition, they could seek alliances with alternative practitioners to enhance the range of health choices available to PHO populations.

C and H drew attention to the potential conflict between the PHO's not-for-profit philosophy and the IPA / GP business focus and felt there was much talking to be done to reconcile the two stances. (GPs can still increase their co-payment charges.) If this difference in philosophy is not resolved, the PHO will not achieve its goals of better access and improved health.

The two NGOs also made the following points.

- Government is employing a "hands off"/ risk-averse approach by charging communities to set up their own PHOs and systems. This approach means that Government has diminished responsibility for any outcomes.
- In early 2004, The Ministry of Health, in a "consulting" exercise, asked NGOs to present proposals looking at innovative ways to include mental health care within PHOs. In spite of very tight timelines, a number of PHOs in collaboration with NGOs quickly submitted their proposals. Thus far there has been no response from the Ministry except to say there was a delay and the papers will be reviewed. The NGOs involved feel they have been cut adrift and have lost a year's worth of progress.
- There appears to be no one in the control room. *"Who do we talk to – who do we discuss our issues with? Who is in charge?"*

4 (D): A provider of child and family health services.

Primary Health Care Strategy: Responses, perspectives, experiences

(D) is very positive about the new primary health care environment and the opportunities for partnering with PHOs in delivering well child services. From an early stage the NGO has been proactive in visiting as many PHOs as possible, offering solutions and strategies for working together.

PHO relationships

- The NGO is well down the track of initiating relationships and building trust with PHOs. Relationships are now beginning to be reciprocated at the local level. However these vary around the country due to differences in PHOs.
- They have only a "smattering "of contracts with PHOs, but as they hold a national contract with MOH, contracting with PHOs not a priority at this point. Contracts will be a more natural follow-on once relationships are established. They are currently focusing more on developing relationships and partnerships with PHOs.
- They have currently developed memoranda of understanding with some PHOs.
- They will bring their expertise and knowledge to partnerships with PHOs. For example they have information that can be useful to PHOs, e.g., health related data through its links with the community.

Access issues, including Maori and high need groups

- PHOs and the NGO will be caring for the same children and families, so communication and good relationships are crucial in providing access, integrated health care and maximizing health gains.

- The NGO believes it will largely be 'business as usual' for their clients in the new structure. However there is potential to improve health outcomes through better information sharing between the NGO and PHOs and clients.

Risks and concerns

- Concerns revolve around the national management of relationships with PHOs. All relationships will be different around the country and the NGO is not keen for fragmentation of services, where for example, one PHO may want to essentially change a specific area in their work with the NGO while others may want to change something else.

Other

Much research and energy has gone into developing a model which is national, consistent and acceptable. The NGO wants partnerships that acknowledge their hard earned expertise and which don't create a 'mish-mash' of dreamt up programmes.
"*This is why it is important to explain and sell what is good about what we do, and how we can work together to meet mutual goals."*

5 (E) A Maori Health umbrella agency

Primary Health Care Strategy: Responses, perspectives, experiences

Like other NGOs, it welcomes the new emphasis on community focused health care, wellness and health promotion in the Primary Health Care Strategy but has reservations about its priority within PHOs, and the management which controls all the funding of the local PHOs.

The NGO believes there is a disconnection between PHO strategy and PHO implementation whereby the strategy encompasses a broad primary healthcare focus, but in reality there is a focus on primary treatment services.

"If we start off from a wrong premise in the beginning, it will continue to be off track in the future."

In addition there is a perception that the *" PHO should not be a provider, but a system."*

PHO relationships

"At present there are no positives, and no contracts!"

- The NGO attempted to develop a partnership relationship with a view to becoming a PHO. This was blocked another PHO being set up in the region.

- The NGO has Maori representatives on PHO boards in the region.

- The NGO believes it is not being kept in the loop by PHOs, nor is its expertise acknowledged or utilized by local PHOs.

"Although we have the skills we have to beg for any response."

Access issues, including Maori and high need groups

Within PHOs' strategies for improving access, nurses are being recruited to facilitate access for Maori and Pacific people. This service is still treatment-based and is making money for PHOs. It is not keeping populations well and is not delivering health promotion.

Maori provider issues

- The mood amongst Maori providers is 'what is happening?'
- Only very few providers are currently receiving any benefit from the new structure. Many providers are still struggling and running on the smell of an oily rag
- Some Maori are invited into PHOs as token representatives. This does not help 'ownership' (tino rangitiratanga) for Maori.
- Some Maori consumers will go to mainstream facilities because of the choice of services available, not because they believe non-Maori services are any better.

Risks and concerns

- Health promotion may not be given much status or priority within PHOs because clinicians do not understand it or how it fits into health care.
- NGOs may be nervous about the fact that every bit of money goes to PHOs.

6 (F): is a major national provider of specialist community health and support services.

Primary Health Care Strategy: Responses, perspectives, experiences

The NGO believes there are enormous possibilities within the PHO model, and already partnerships are beginning to form. In relation to funding, they envisage no real problems under PHOs – only "opportunities."

In response to the new primary health care structure, F has developed an education strategy for their senior mangers based on developing relationships with PHOs over the coming year.

The NGO recognizes that PHOs are a mixed bag – some are revamped IPAs, others very large and comprehensive, some may be too small to be viable. However they are confident they can create partnerships with the different PHOs.

They have no real concerns or issues with the PHO system at this point.
"PHOs have not yet reached a level of interference with what we do"

PHO relationships

- The NGO is already initiating discussions with PHOs and are excited by the partnerships that are starting to develop.
- The NGO has contracts to provide consultancy with some smaller PHOs.
- Within 5 years PHOs may hold the bulk of mental health funding so partnerships between the NGO and PHOs are important.

- While most contact with PHOs has been initiated by the NGO, two smaller PHOs have approached them.

- It seems that most PHOs are talking with GPs, nurses, pharmacists etc, rather than with NGOs.

Maori provider issues

The NGO's views were that:

- most PHOs were endeavoring to meet the needs of Maori, Pacific and other groups

- it was a little premature to comment on how PHO development is affecting Maori providers

- there were many health providers (not just Maori) who were still unfamiliar with the PHO model.

Risks and concerns

- PHOs and other funders need to be constantly kept up to date with NGO capacity. *"The NGO sector is still seen by many as a voluntaristic, not-very-skilled sector doing what we believe in our hearts is right! With the increases of funding over the past decade some NGOs have become major players in an evidence-based health market and are very competent indeed at what they do. We have an absolute responsibility to appropriately market our services otherwise they really will be overlooked. "*

Other

- PHOs have little idea about the amount of funding the NGO sector controls – which currently amounts to one third the amount of New Zealand's entire mental health budget.

7 (G) Maori Health Service support agency

The NGO is currently contracted to support Maori health providers.

Primary Health Care Strategy: Responses, perspectives, experiences

The NGO recognizes the benefits associated with increased emphasis on population health and health promotion in the new environment. However Maori providers are aware that the new primary health care system has been set up to save money – *"it is not about providing quality health care as the statistics for Maori continue to tell us."*

The NGO is currently working with 12 provider groups – most of them large organizations. One of the groups has joined a PHO. The other 11 providers, like other Maori providers, are still struggling to understand the benefits or otherwise of joining a PHO.

PHO relationships

- Many providers are still struggling with funding issues and meeting accreditation, and PHO relationships are not a priority.

- Only one of the 12 providers has become part of a PHO. This partnership is a 50-50 relationship - "*as it should be*" - and is working well.

Access issues, including Maori and high need groups

- Maori people are often still charged less by Iwi providers than they are by PHOs.

- Many Maori still prefer to access services where their own culture is affirmed and understood.

Maori provider issues

- While joining a PHO may be safer option for new providers, too little is known about PHOs. Lack of promotion and education about PHOs is partly responsible.

- A lot of providers are sticking with Maori Development Organizations (MDOs). One exception is Taumata Hauora (Wanganui) which has now become a PHO.

- Iwi geography can get in the way of establishing PHOs who hold the power.

Risks and concerns

- Some providers who have worked hard to take control of their own health services fear that joining a PHO will put their tino rangitiratanga at risk.
  "They have taken a long time to become independent and stand tall, and they do not want to be pushed into bed with a PHO as seems the case now."

Other

"In light of all the issues, Maori need to be stepped through the benefits that a PHO environment will bring."

APPENDIX 3 Comments from NGO Survey on relationships with DHBs (2003)

Impact of PHOs

More work involved

- We have the resource to assist in the prevention focus of PHOs but labour intensive to build multiple relationships. Duplication could easily occur if NGOs are excluded.
- Better funding for GP clinic, enormous amounts of work that seems so repetitive
- Considerable time invested in relationships internally and with the DHB
- Greater and more complex administrative procedures to cope with new requirements.
- We get fewer resources and have more work to do at a management level
- Time consuming to try and understand the PHO process and what each can offer our organization
- Confusion and disarray
- Marked increase in extra workload despite not attracting any funding also increased expectation on our services without funding attached.
- Funding the same but more unstable huge work with register submission and establishment
- Health promotion is not well understood by health care providers NGOs work at a health promotion level and have integral plans with communities there is a concern that PHOs will attempt to reinvent services with little understanding of community needs

Negative impacts associated with funding

- Too early to tell- very unlikely that funding for community residential disability will go to DHBs or to PHOs
- PHOs play significant roles in determining how responsive primary health services GP etc are to disabled people in the community. This is an area which will not be top priority for PHOs and is an area disability provider and national organizations such as NRID can play a role in avocation for
- PHOs will direct how structured in the future and possibly how funded in the future
- The collaboration we hoped for is unlikely- Can it survive
- The impact on our organization has been devastating both financially and on our relationships within our local community – we have become isolated
- There are no financial incentives for GPs to form PHOs
- PHOs in order to capture as much funding as they can will try to provide as many services as possible even though they do not have the expertise to do this
- Poor promotions and advertising members are confused by what the role of PHOs is
- Unhealthy competition
- Concerned with GP capture
- Confusing they appear to want to be funders with all contracts channeled through the PHO that are currently directly contracted with MOH

Little Impact

- Will depend on a number of factors such as community v GP control catchments population needs levels of funding, effectiveness of lobbying
- Concern about the intended direction of the primary care strategy v the reality
- Limited or no additional Maori provider service department as initially indicated
- Not involved yet
- Very little as yet
- There is not a PHO developed in Hamilton at present and will not be until 2004 or later
- There has been no impact at all
- The promise of community governorship of PHOs has not been realized at this point
- Not know as yet
- Unsure as yet have not been impressed to date over lack of consultation by local pacific PHO in particular their developments in primary healthcare delivery in mental health

Positive improved funding and services

- May have contact in rural areas
- Can only be beneficial as we both work towards better health improvement for the people of the Kapiti Coast
- Positive improved services for our clients
- Our organization has received more funding; it is too early to tell what other impact the PHO development has had on our organization
- Our service acknowledged our interest several months ago but have not received any further correspondence
- Creation of strong Network within like minded organizations
- All new primary health funding is through DHBs to PHO hard to see where national NGOs fits
- Greater collaboration between the member groups greater community development much greater capacity for doing things to improve people's health
- There are difficulties to become an established PHO
- Very positive as we initiated the PHO and are excited by the prospects of service development
- Hopefully will work lack of consultation by leaders of PHOs prior to their vision of being established
- In line with our philosophy and has enhanced our relationship with other providers in PHO
- A reduction in our funding but an increase in health promotion and services to improve access so seen as positive in the long term
- We can now subtract work for a PHO
- At present PHOs perception appears to be that they are only concerned with general practices. As they become more established and develop services there is a risk of NGOs being sidelined as the PHO establishes new services without the knowledge of services provided by NGOs and therefore risk duplicating services and risking the viability of the NGO
- Shared resources / knowledge / skill base with other iwi providers
- Ability to provide no cost general practitioner services
- Potential is huger to benefit PHO desire to improve access to primary health needs
- Positive thus far however the resource required are high
- I would be beneficial to liaise more involvement to a local PHO as we do use their services and our unique location means PHO would also advocate with us in our isolation when dealing with DHBs
- Some beginning this could be an effective way forward for our service delivery as part of what we do

Appendix 4 Comments from NGOs on Survey of relationships with Ministry of Health (draft 2004)[1]

PHOs

Question 13b

Question 13b asked, *Is your NGO involved in a PHO? And, If 'yes' how many?* 66 people responded to this question. 23 NGOs are involved with a PHO (34.8%). Of those, 1 organization said they are involved with all of the PHO s. The average number of involvement was 3 PHOs, and the most common (the mode) answer was 1 PHO.

Question 13c

Question 13c invited people to comment on the question, *What do you believe is the impact of PHO development on your organization?* There were 45 responses to this question (not 45 respondents because some didn't answer and others made from 1 to 3 comments). The responses were analyzed qualitatively and organized themes. In general, there was quite a wide range of opinions about PHOs.

Medical paradigm

The responses give the impression that NGOs feel the medical model of health care dominates PHOs. That is, PHOs may focus on people once they become sick whereas NGOs are helping people to stay well and offer a more holistic approach. For instance, one NGO offered this opinion about PHOs:
"Their focus on a medical model overlooks the impact of the socio-economic environment and psychosocial needs of individuals"

Further, some NGOs feel that PHOs are not as familiar with or as engaged with the communities as NGOs are. For instance, "*Not many PHOs operate as community based organizations, with wide community involvement."* One respondent expressed concern that PHOs "*…have been captured by the medical professional …"* and another holds the view that "*PHO is essentially a guaranteed income for GPs."* There were also a couple of positive comments in this area, with some hoping that PHOs can act as a potential bridge between NGO services and GPs.

Competition, confusion and cost

Some NGOs are worried that there will be competition for contracts and funding because of the PHOs. One respondent commented that PHO development "*obscures where the funding goes and how can it be accessed."* Another claim it has "*introduced a competitive environment with our neighbours."* There was a comment from one NGO that believes it will introduce confusion in the community about where people should refer their clients for services.

There were a small number of comments about the cost of going to see GPs, therefore they won't be able to access PHOs either. They feel that PHOs represent "*increased medical costs to clients."*

[1] [1] The results of this survey will be available in April 2005. The full report will be provided to the Director General of Health. A summary report will be sent to the Minister of Health, NGOs, PHOs and DHBs. Each Ministry of Health Directorate will receive a copy of the survey comments pertinent to their Directorate and be invited to meet with the NGO Working Group to discuss the results.

Benefits, potential and concern

Some NGOs commented that they play a supportive role to PHOs by providing their services to them. One organization claims, "*We can be of assistance to them through our programmes."* I n terms of NGOs benefiting PHOs, some made positive comments about how it could help their clients. For instance, "*All that has occurred for patients is the increase in services to them"* is the opinion of one respondent. Another respondent commented on some direct benefits of working with PHOs by saying, "*PHOs have enabled us to instigate training partnerships, community health initiatives and primary health service capacity building. This has enabled us to address inequalities with greater efficiency".*
One also noted, however, that PHOs don't have a good understanding of health promotion principles and it will take years to develop the same kind of community buy –in that many NGOs already have.

Quite a few respondents commented that although they don't currently work with PHOs they look forward to forging relationships and exploring possibilities in the future. For instance, one respondent said that its " *very hard to gauge at this stage as they have been set formidable tasks. Hopefully in the future we can develop constructive working relationships with them but time will tell."* Others are more cautious about their future role with PHOs. Some feel that being involved with PHOs just represents more relationships to manage when their operating capacity is already stretched so thin.

PHOs overall

It is difficult to give one overall impression about the opinions because they are very wide ranging. There were very few extremely positive comments and equally few extremely negative ones. Mostly, NGOs seem cautiously optimistic about their relationships with PHOs and would like to feel that their services could continue and be valued within the PHO context.

Question 16

The question asked, *"What do you consider the <u>three</u> most important issues facing the health and disability NGOs over the next 5 years?"* The responses have been analyzed qualitatively and organized into themes. There were a total of 192 comments on question 16.

Funding, contracting and reporting

Funding was by far the most common response to this question. Some elaborated that they needed more funding to keep up with the growing demands placed on their businesses. One respondent said, *Government trying to fund an increasing business size without increasing the funds."* In general, people simply responded *" funding"* or *funding issues".* Several respondents also mentioned contracting. Contract length was a common theme, for example, "*Being appropriately contracted with long term contracts".*

"Compliance costs " was another theme in the responses. This is tied in with the responses for increased funding because there is a sense that the NGOs feel as though they need more money in order to keep up with compliance and reporting requirements. One respondent replied, "*Compliance of contracts and capacity to manage it ".*

Workforce development and meeting clients needs

Workforce recruitment, development and retention of both paid and voluntary staff members were common themes in the response. One organization said, "*Shortage of volunteers or ability to attract them"* and another *"Maintaining qualified staffing levels – how do we compete with public sector…"* Other themes included issues of up-skilling current staff as well as maintaining the quality of staff members.

The NGOs who responded are concerned with meeting the needs of the communities in which they work. There is a sense that some organizations would like to provide a quality service but

because of lack of funding, workforce shortages and increased reporting requirements it is becoming increasingly difficult to do so. For instance, one organization said, "*Growth in non-productive, non-client-related activities"* and another said, "*Balancing time needed to spend on output delivery with reporting and accountability requirements".* Some NGOs feel that the increased time spent on non-client-related activities threatens not only the service delivery to the clients but the reputation of the wider NGO sector in general. As one respondent said "…*the implications of those issues (complex reporting and compliance processes and workforce retention) not being addressed is seriously impacting the continuation of flexibility, innovation and adaptability for which the NGO sector is well known*

PHOs

Many respondents expressed concern about how the emergence of PHOs would impact upon their service delivery and they are wondering how they will integrate and build relationships with PHOs. There is a sense that NGOs feel PHOs may not provide the same level of service. One NGO commented, "*Devolution of contracts to area / PHO level and associated fragmentation of specialist services"*