The Roles and Functions of Primary Health Organisations

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September 2009

Published in September 2009
by the Health Services Research Centre
Victoria University of Wellington

Additional copies available at www.vuw.ac.nz/hsrc
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Citation details:

Barnett P., Smith J., and Cumming J. (2009) *The Roles and Functions of Primary Health Organisations.* Wellington: Health Services Research Centre.

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ABBREVIATIONS

ACC	Accident Compensation Corporation
CHW	Community health worker
CME	Continuing medical education
CNE	Continuing nurse education
DHB	District health board
GP	General practitioner
IPAC	Independent Practitioners Association Council Of New Zealand
NZMA	New Zealand Medical Association
Ministry	Ministry of Health
MSO	Management service organisation
PHC	Primary health care
PHO	Primary health organisation
RICF	Reducing Inequalities Contingency Funding
RNZCGP	Royal New Zealand College of General Practitioners
SIA	Services to Improve Access
Strategy	Primary health care strategy
UK	United Kingdom

ABSTRACT

This report is one of a series produced by the Primary Health Care Strategy Evaluation. The report aims to understand the way in which PHOs' governing boards have developed and how their composition and work contributes to realising the objectives of the Primary Health Care Strategy. Three methods were used: a postal survey of all PHO board members (191/553 respondents; 34.5%); semi-structured interviews with up to eight informants (board members, GP and nurse, associated DHB manager) from 20 purposively selected PHOs (N=127); and semi-structured interviews and written survey with PHO managers (44/79 respondents; 55.7%).

The research found PHO boards to be diverse in terms of numbers of members, their background, the processes by which they are selected and the remuneration they receive. A diversity of board roles was also recognised, and included the strategic development of primary care. PHO informants endorsed community input into PHO decision-making, but reported mixed experience of its effectiveness. Key areas for PHOs included ensuring access to and the availability of services. Decisions regarding fees were viewed variably, with Access PHOs taking greater responsibility for lowering fees. IPA-based PHOs, while ensuring that subsidies were passed on to patients, saw their role as supporting the viability of general practice as a business. PHOs were ambivalent about their role in relation to the primary care workforce, but some had taken initiatives in this area (eg PHO involvement in facilities management, recruitment of doctors and nurses, development of new roles such as community health workers, training, and promotion of team-work). In the area of service development PHOs were undertaking needs assessment and strategic decision-making, securing resources and infrastructure, advocacy and programme implementation. They reported a range of initiatives, including improved access to services, providing outreach and health promotion. PHOs identified problems of capacity, differences in philosophy and the stress of rapid growth as issues associated with service development. PHO relationships with DHBs and other PHOs were developing well, with PHO alliances helpful in supporting smaller PHOs.

EXECUTIVE SUMMARY

Introduction

The Primary Health Care Strategy (2001) provides a clear direction for the development of primary health care (PHC) in New Zealand. The Strategy identified six key directions: that PHC services work with local communities and enrolled populations; identify and remove health inequalities; offer access to comprehensive services to improve, maintain and restore people's health; co-ordinate care across service areas; develop the PHC workforce; and continuously improve quality using good information. To support the Strategy the government has provided increased funds to reduce patient charges and extend eligibility for government funding to the entire population. It has also encouraged the development of primary health organisations (PHOs), local non-governmental organisations established to serve the PHC needs of their enrolled patients. The Strategy also changes the method of allocating the public share of PHC finance from fee-for-service subsidies at the practitioner level to (largely) capitation funding of PHOs. Implementation of the Strategy proceeded swiftly: large numbers of PHOs were established between 2002 and 2005, with 80 PHOs in existence by mid-2008. This evaluation (2003-) was funded by the Health Research Council of New Zealand, the Ministry of Health (the Ministry), the Accident Compensation Corporation (ACC.)

The main objectives of the *Evaluation* overall are: To describe the implementation of the Strategy; to evaluate the implementation of PHOs against the objectives of the Strategy and other Ministry, DHB and ACC objectives; to analyse the net and costs of the Strategy at the national and the PHO level and the extent to which expenditure changes over time; to identify positive and negative influences on PHO achievement and to identify the critical success factors for delivery of effective, accessible PHC.

The *Evaluation*'s research uses four main methods: key informant interviews; survey questionnaires; and quantitative analyses in support of an economic analysis of the impact of the Strategy. This report uses data from a Second Phase of key informant interviews (127 overall) and from three survey questionnaires, to examine the role of PHOs in the reformed PHC environment. A Third Phase of data collection has taken place in 2008-9.

Functioning of PHO boards

PHO boards have diverse membership, with the majority (66%) of members overall drawn from the community, and 33% from general practice teams. Twenty-one percent of all members were Maori. Thirty-four percent of PHO board members were nominated by the community, with 23% nominated by an independent practitioner association (IPA) or management services organisation (MSO). There is significant variation in levels of remuneration for board members, with IPA-based PHOs generally paying at a higher rate.

In reporting the way they perceived their roles, nearly half of respondent board members indicated that this included ensuring accountability and ensuring clinical quality, with lesser percentages indicating that representing provider interests (44%), ensuring management performance (41%), developing new services (39%), communicating with DHBs (39%) and representing community interests (38%) were of importance. Unsurprisingly, the early history of a PHO appeared to influence the extent to which the board had a clear and agreed view of the PHO's role. Where the PHO had evolved from a community trust or similar organisation, there was a shared perception that people had common goals due to a history of shared local governance, and experience of community and clinical leaders working together. Some informants asserted that where a PHO had grown out of an

IPA and continued to receive management services from there, then the PHO tended to focus on the needs and priorities of GPs. Clearly, in the absence of central guidance, PHOs have been left to work things out locally. Some informants noted the importance of PHO size, with small PHOs able to reach agreement more easily but with less capability to fulfil requirements.

There was mixed experience of community participation in PHO governance, with the difficulties of engaging communities acknowledged by many informants. Among board members, 57% reported that community influence on the PHO was 'about right'. Of the 32% who reported that community influence was 'too weak', the largest group (43%) was from medium-sized, non-Access PHOs. Provider involvement in PHO boards is usually through GPs and practice nurses, with 71% of board member respondents reporting the influence of both GPs and practice nurses was 'about right'.

Scope of decision-making in PHOs

A key area of decision-making for PHOs was to ensure access to sustainable services, through both managing the costs of access and ensuring workforce availability. There were differences in how PHOs saw their role. Most Access-funded PHOs were community owned with a commitment to maintaining the lowest possible fee levels and had policies in place to ensure this, although it had clear implications for sustainability. IPA-based PHOs saw their role as ensuring that subsidy increases were passed on to patients, but also supporting general practice to be a financially sustainable business. In these cases, PHOs rejected any role in the control of fees, but monitored them closely and worked to support practices in discussions with DHBs over fee-setting. PHO informants members recognised the critical importance of workforce but were unsure how they should be involved. In one area a coalition of PHOs had jointly undertaken a workforce survey, but in general PHOs were reactive rather than pro-active. However, PHOs, in the absence of any other agency taking responsibility, had undertaken a range of measures to address workforce matters, including data collection and monitoring, identifying areas of skill shortage, some recruitment and retention of both GPs and nurses, facilities development, developing new workforce roles (eg community health workers), training and development, and the promotion of teamwork.

Developing new services was identified as a key function by 75% of Board member respondents and 89% of PHO managers. This usually involved undertaking a needs assessment of their communities, often using statistical and survey data in combination with community consultation. The importance of enrolment as a basis for needs analysis was noted. Interview informants confirmed the importance of PHO boards for setting strategic direction, characterised as '*the wider vision'* or '*the big picture',* although small PHOs noted the difficulties of lack of capacity to so some of this work. Having a robust infrastructure for the PHO was seen as essential for attracting funding for new services. Advocating for new services for their communities and ensuring that there were adequate resources for practices to implement them were seen as important roles for the PHO board.

Informants reported a wide range of service initiatives, particularly in the areas of improving access to core consultation services, through Services to Improve Access (SIA) funding. These included lower fees, additional nurse consultations, use of interpreters, longer consultations, telephone triage, the extension of practice hours and the involvement of community health workers. Outreach services to improve access (eg clinics for migrants, school-based clinics, marae services) have proved popular, and initiatives to extend or 'add value' to core services have been important (Care Plus, management of mental health conditions). Several informants expressed concern over the sustainability of extended services. Beyond core consultation services, some PHOs have actively developed health promotion projects (particularly in the area of lifestyle management), although at the time of the research these were not widespread.

Despite a strong majority of PHO Board Member Survey respondents (77%) reporting that their board had been able to influence the activities of practices to a desirable extent in introducing new programmes, interview informants indicated two major areas of constraint that provided service development challenges to PHOs: the capacity to do the work at all due to issues such as space or workforce, and the tension between a "general practice" and wider "PHC" view of PHOs.

PHO relationships within the system

Key PHO relationships are with DHBs, other PHOs, management services organisations (MSOs) and other agencies in the community. In the Survey of Board members, 73% reported that communicating with DHBs is an important role for PHO boards. Informants reported initial difficulties but many reported significant and improving relationships, although it was noted that not all DHBs appeared to understand or fully support the Primary Health Care Strategy, or have confidence in PHOs. This diversity of experience is reflected in the responses to the Survey of PHO Managers where DHB performance in relation to promptness of response, clarity of expectations and supportive process were not much above the mid-point of the scale from 'very poor' to 'excellent'. Some PHOs, particularly small ones, reported potential or actual conflict of interest on the part of DHBs as both funders and providers of services. Informants reported on the need for greater autonomy and flexibility in their relationships with the DHB, but some were also concerned because they felt that small PHOs had little credibility with the DHB. In general communication was reported as open, and DHB managers expressed the wish to build linkages with individual PHOs that reflected diversity and local factors. The role of the Ministry of Health was reported by DHB managers as creating difficulties for the DHB-PHO relationship because of lack of consistency or clear directives. Contractual matters, funding and fees were all issues that remained to be worked through by DHBs and PHOs.

PHOs reported that from the early days of implementation relationships had been good between PHOs, despite ideological differences relating to ownership and funding structures. Relationships were nurtured through regular meetings and forums, and chairs and managers maintained close contact. Philosophical differences between community and IPA-led PHOs and differences in funding between Access and other PHOs were a potential source of tension. Nevertheless there were quite early examples of joint delivery of services across PHOs, and the concept of 'lead' PHOs (not always the largest) for mutually agreed service projects was soon developed. Relationships between PHOs and MSOs were reported as good, with many PHOs highly dependent on MSO support. MSO roles were increasingly circumscribed, and related mainly to financial management and IT development and data analysis. Relationship management, professional matters and service development were clearly seen as PHO rather than MSO responsibilities. PHOs that engaged MSOs reported very positively on their performance, particularly in financial and IT areas.

Community relationships operate at multiple levels, some of which have already been noted. Overall, PHO Managers (68%) rated their relationships with community agencies as good. Maori PHOs, in particular, reported very positive community relationships and a number of PHO and DHB informants commented on the strong tradition of community relationships for both Maori and Pacific PHOs. Overall, Board Member Survey respondents reported favourably on the time and effort their PHO management put into such relationships, although they also appreciated MSO involvement. Several managers reported that PHOs were working in partnership with non-government organisations.

Conclusions

At the time of the research eighty PHOs had been successfully established, with community, GP and other provider representation. There are variations in size, composition and methods of selection of PHO board members, and patterns of remuneration. All PHO boards recognise the importance of community representation but clearly this does not guarantee effective participation, although commitment across all PHOs to gaining community involvement is strong. There is, however, a fundamental tension inherent in the PHO board model – the requirement that both community and provider interests be represented.

There are differences in the level of influence of particular groups in DHB decision-making, and concerns that some groups do not have as much influence as others. All PHO boards have a focus on health improvement and the reduction of inequalities. The extent to which they are able to embrace strategies to address these depends on a number of factors, including philosophical position, resource availability and the flexibility with which funds are used. The diversity of PHOs indicates that more work needs to be done on how PHOs interpret their role and on how they enact this through the type of work they fund and carry out. The question of whether high levels of diversity in PHO activity are acceptable, and whether this addresses inequalities appropriately, are questions yet to be answered.

At its narrowest, the scope of PHO activity includes a focus on strengthening practice services. At its broadest, it involves a more strategic and community-wide view of service development. Both can be seen as core activities, but it is not possible from the data gathered at this stage in the *Evaluation* to assess how far individual PHOs are addressing these. There is variety in how specific issues are addressed in PHOs – for example: workforce, patient fees, capacity development, service development – and there are tensions between fee restraint and sustainable practices. Some PHOs are more pro-active in addressing these matters; others consider them either beyond their role or their capacity. Despite constraints, there are many examples of innovation in workforce and service development, and in community outreach and engagement.

The critical relationship between PHOs and DHBs appears to be maturing, although a number of issues remain to be worked through. In some cases PHOs and DHBs are developing parallel services, and it may be valuable to consider opportunities for more joint planning and funding activity. The relationships between PHOs are beginning to emerge as important factors in managing the clinical and financial vulnerability of small PHOs and in ensuring local and regional equity or services.

Small PHOs have multiple issues related to the viability of governance, management and service dimensions. It appears that smaller PHOs find it more difficult to fund governance activity, which raises questions of equity and the adequacy of the management fee. There are indications that PHO alliances and networks are being established and that such moves may mitigate some of the risks experienced by small PHOs. The roles of MSOs are variable and changing. Some PHOs do not rely on MSOs at all; others are highly dependent upon them and gain greatly from their support.

1 INTRODUCTION

In 2001, the New Zealand government introduced its Primary Health Care Strategy (the Strategy), aimed at improving the health of New Zealanders and reducing inequalities in health.

The Strategy provides a clear direction for the development of primary health care (PHC), and states that over a five to ten year period, a new vision will be achieved, where: *"*People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for the population, and actively work to reduce health inequalities between different groups." (Minister of Health 2001, p.vii).

The Strategy identified six key directions for PHC in New Zealand: that PHC services work with local communities and enrolled populations; identify and remove health inequalities; offer access to comprehensive services to improve, maintain and restore people's health; co-ordinate care across service areas; develop the PHC workforce; and continuously improve quality using good information (Minister of Health 2001b).

The government has introduced three major changes as a result of the Strategy. First, it provided a significant increase in tax funding to support PHC, with the aims of reducing the charges that patients pay for services and of extending eligibility for government funding for PHC to the entire population. Second, the government has encouraged the development of primary health organisations (PHOs) as local non-governmental organisations established to serve the PHC needs of their enrolled patients. Third, the Strategy changes the method of allocating the public share of PHC finance from fee-for-service subsidies at the practitioner level to (largely) capitation funding of PHOs. Implementation of the Strategy has proceeded swiftly: large numbers of PHOs were established between 2002 and 2005, with 80 PHOs in existence by mid-2008; and an additional $2.2 billion in funding has been provided since 2001 to support the further development of PHC services.

1.1 The Evaluation

In 2003, the Health Research Council of New Zealand, the Ministry of Health (the Ministry), the Accident Compensation Corporation (ACC) provided funding for an evaluation of the Strategy. A national group of researchers from around New Zealand won the tender, and has been engaged in its *Evaluation* since 2003. Two phases of qualitative data collection have been undertaken to date. Findings from the First Phase of data collection are reported in Cumming, Raymont, Gribben Horsburgh and Kent (2005).

1.2 This Report

This report is one of a series of papers reporting on the *Evaluation*'s Second Phase data collection. Its focus is PHOs – the key organisations which have been established in order to move the Strategy forward. We examine how PHOs have developed, the roles they are undertaking, and how key relationships with other organisations in New Zealand's health care sector are developing.

The report consists of seven chapters. The following chapter sets out the methods used to collect the data presented in this report. The central three chapters focus on our key findings: they examine the functioning of PHO boards; the scope of board decision-making; and the relationships of PHOs to other health sector organisations. The final chapter draws conclusions from our findings.

2 BACKGROUND TO THE STRATEGY

Prior to 2001, PHC funding was largely via a government funded fee-for-service payment for consultations with a general practitioner, and for associated pharmaceutical prescribing and diagnostic tests. By 2001, the co-payment for patients was significant, especially for consultations. During the 1990s most general practices affiliated with independent practitioner associations (IPAs) in order to increase their bargaining power with government and embark on initiatives that would enhance the scope and quality of primary care. However, inequalities in both geographical and financial access persisted, except for those patients enrolled in non-profit primary care trusts.

The Strategy was introduced in February 2001, with the aim of improving the health of New Zealanders and reducing inequalities in health. The government has introduced three major changes as a result of the Strategy.

A first important change has seen a significant increase in the funding provided to support PHC, particularly the consultation fee, in New Zealand. The Strategy notes that there have been longstanding barriers which have made it difficult for some New Zealanders to access PHC services and the government has committed itself to reducing cost barriers in particular by providing additional funding to reduce the cost of access. In practice, this has involved policies which aim to reduce the fees which patients pay when they use PHC services as well as the provision of additional funding to support the development of new PHC services. The Strategy also signals a move away from a targeted approach, where the government only provides funding to support PHC for some groups in the population, to a universal approach, where all New Zealanders are eligible for government funding for PHC.

A second important aspect of the Strategy is the development of Primary Health Organisations (PHOs). PHOs are:

- funded by district health boards (DHBs) for the provision of essential PHC services to an enrolled population[1]
- required to develop services that will be directed towards improving access to first-line services to those who are unwell and to improving and maintaining the health of the population overall
- required to involve their communities in their governing processes and be responsive to community needs
- required to involve all providers and practitioners in influencing decision-making
- required to be not-for-profit
- funded on a capitation basis (Minister of Health 2001).

New Zealanders are encouraged to enrol with PHOs via their usual PHC provider, but they can continue to choose not to enrol and they continue to have a choice over where they receive PHC services. Likewise, practitioners can choose to affiliate with a PHO or not. However, those people or practitioners who remain outside the PHO system cannot access any of the new public funding for PHC; thus there is a strong incentive for both to participate in the new arrangements.

[1] DHBs are purchasers and providers of health and disability support services, with responsibility for overseeing the health and independence of their geographically-based populations. The twenty-one DHBs are governed by majority-elected boards and have annual agreements with the Minister of Health which govern their activities.

A third change is the move to capitation payments for PHOs. One key rationale for moving to capitation is to reduce inequalities by ensuring that PHOs are funded according to the needs of population they are serving, rather than in relation to the number of services being delivered (Minister of Health 2001). A move to capitation is also considered important in encouraging multi-disciplinary, team approaches to care (including developing the role of nurses in PHC), and in promoting a focus on wellness as opposed to sickness (National Advisory Committee on Health and Disability 2000). Although the policy results in PHOs being paid by capitation, how PHOs pay practices and practitioners is left up to PHOs, practice owners and managers and practitioners to decide. With many New Zealanders using PHC services still also paying a contribution to the cost of services through user charges, practices continue to receive funding from both public and private sources, and through a mix of payment types.

Implementation of the Strategy has proceeded rapidly, with PHOs starting to be established from July 2002 onwards. In July 2008 there were 80 PHOs, ranging in size from 3,000 to over 350,000 enrollees.

In order to move towards a universal approach and at the same time to ensure that new funding set aside for the Strategy went to those most in need, the government chose, at first, to create two forms of funding – known as Access and Interim funding.

At first, Access PHOs or practices received a higher per capita rate per enrollee than Interim PHOs or practices.[2] Access PHOs were defined as those where the PHO had more than 50% of its enrolled population identifying as Māori or Pacific, or from lower socio-economic areas (as measured by a New Zealand deprivation index (Crampton, Salmond, Kirkpatrick et al 2004). Funding was targeted towards PHOs with a majority of its enrollees in these population groups on the grounds that they have poorer health status on average and higher health needs than other New Zealanders (Ministry of Health 1999; Ministry of Health 2004; Ministry of Health 2004b)Raymont 2004. The main reason for providing this new funding was to reduce the payments that patients pay when accessing PHC. Access PHOs received their new funding as they became established. The first Access PHOs were established in July 2002.

Access PHOs also had access to new forms of funding for specific programmes such as Services to Improve Access (SIA), for health promotion services, and for management services. Before receiving the SIA and health promotion funding, PHOs must submit proposals indicating how the additional funding will be used, and have these approved by their DHB. SIA and health promotion funding is also paid on a capitated basis, with higher rates for those individuals enrolled with the PHO who identify as Māori or Pacific, or from lower socio-economic areas. Management fees are also on a capitated basis, with slightly higher rates per enrollee for smaller and medium sized PHOs.

The first Interim PHOs were established in October 2002. At first, they were funded at lower capitation rates than Access PHOs. Since 2003, the government has provided further funding, increasing the capitation payment rates to Interim PHOs to the rates paid for those in Access PHOs.

[2] Although the policies related to both PHOs and practices, this report uses “Access PHOs” and “Interim PHOs” as shorthand for “Access PHOs and their affiliated practices” and “Interim PHOs and their affiliated practices” .

Table 2.1: Roll-out of PHC Funding

October 2003:	Enrollees aged between 6 and 17 years became eligible for subsidies to lower the cost of doctors' visits.
1 April 2004:	Funding for low cost pharmaceuticals for enrollees in Access-funded PHOs, and 6-17 year olds enrolled in Interim-funded PHOs (maximum charge of $3 per item on subsidised pharmaceuticals)
1 July 2004:	Funding to lower the cost of doctors visits and pharmaceutical charges for people aged 65 years and over enrolled in Interim-funded PHOs
1 July 2005:	Funding to lower the cost of doctors visits and pharmaceutical charges for people aged 18-24 years enrolled in Interim-funded PHOs
1 July 2006:	Funding to lower the cost of doctors visits and pharmaceutical charges for people aged 45-64 years enrolled in Interim-funded PHOs
1 July 2007:	Funding to lower the cost of doctors visits and pharmaceutical changes for people age 25-44 years enrolled in Interim funded PHOs

Source: Ministry of Health (http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding).

From 1 July 2007 Interim PHOs were also eligible for the SIA, management, and health promotion funding, funded in the same way (and at the same capitation rates) as Access PHOs.

In addition, all those eligible for the new, higher subsidy levels also became eligible for cheaper pharmaceutical services – with part charges for fully subsidised items falling to $3 per prescription item.

In October 2006, a further change was made to the funding levels for PHOs, with all those PHOs offering very low fees becoming eligible for even higher levels of subsidies under the Very Low Cost Access payments scheme. At October 2006, this required zero fees for children under 6 years; $10 maximum for children 6-17 years and $15 maximum for all adults 18 years and over. Initial allocations were not adequate to achieve this, and additional funding was provided to these Very Low Cost Access practices from July 2007 with the aim of keeping child visits free, visits for those aged 6-17 at no more than $10.50, and adult fees at a maximum of $15.5 (Ministry of Health 2007).

As a result, all New Zealanders enrolled in a PHO – regardless of the type of PHO – are now subsidised at a higher level for primary care than they were in 2001. Since July 2007, differences in the capitation funding between Access and Interim PHOs virtually no longer exist (young people aged under 15 years of age in Access PHOs are paid at a slightly higher capitation rate than those in Interim PHOs). However, higher capitation payments continue to be paid for health promotion and SIA services for people from lower socio-economic areas and for Māori and Pacific populations, as well as for those receiving services from Very Low Cost Access practices[3]. Capitation payments are also now annually adjusted to maintain the value of the subsidies over time.

[3] For details on the capitation rates see www.moh.govt.nz/primaryhealthcare

A number of other funding sources are also available for PHC in New Zealand. In response to concerns that some New Zealanders with high needs not in Access PHOs might continue to miss out on higher subsidies while the new funding was rolled out, a separate funding arrangement (Care Plus) was established for those with chronic illnesses. Care Plus is targeted towards individuals who need to visit their GP or family nurse often, because of significant chronic illnesses or a terminal illness. Additional funding is also available to support rural practice, and the government has also introduced a performance management programme and funding to support clinical governance and continuous quality improvement in PHC in New Zealand. Some PHOs have also had access to Reducing Inequalities Contingency Funding (RICF), as well as to funding to promote innovations in nursing services and in primary mental health care services[4]. (Ministry of Health 2007)

Further changes in funding were implemented from January 2008, when capitation payments for visits for children were increased by $6 to $45.70 where PHOs and practices do not charge patients for child visits. Overall, the government has committed an additional $2.2 billion over seven years from 2002/03 for implementation of the Strategy. This is a significant injection of funding for PHC, providing, by 2008 around $300 million additional new funding per annum on top of an annual spend on general practitioner services of about $337 million in 2002/03.(Ministry of Health 2004a)

[4] For detailed information on each funding source see www.moh.govt.nz/primaryhealthcare

3 METHODS

This chapter provides details of the key sources of data used in this report.

In April 2003, a research team led by the Health Services Research Centre (Wellington) and CBG Health Research (Auckland) submitted a proposal for the "lead*" Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy*. This proposal was developed in response to a brief issued by the Health Research Council of NZ (HRC). The *Evaluation* is funded by the Ministry, ACC and the HRC, and administered by the HRC under their "partnership" programme. The team was awarded the contract in July 2003. The *Evaluation* is independent, and acknowledged to be independent, of government agencies. Through it, the funders are seeking to obtain a credible, independent and scientifically rigorous examination of the Strategy's implementation . The *Evaluation* is to be formative and will inform current and future policy decisions and assist implementation of current policy.

The main objectives of the *Evaluation* overall are:

- To describe the implementation of the Strategy with a specific focus on PHOs, including describing the structural, governance, funding, workforce and contractual issues that impact on the establishment of PHOs.
- To evaluate the implementation of PHOs against the objectives of the Strategy and other Ministry, DHB and ACC objectives, in particular by:
  - reaching an in-depth understanding of the experience and activities of PHOs and their member providers in responding to the Strategy
  - measuring change in programmes, processes and intermediate health outcomes during the adoption and implementation of the Strategy
  - assessing the impact of the Strategy on reducing health inequalities involving Māori, Pacific peoples and the financially disadvantaged.
- To analyse the net costs of the Strategy at the national and the PHO level, and the extent to which expenditure changes over time, by population group and service type.
- To identify positive and negative influences on PHO achievement and to identify the critical success factors for delivery of effective, accessible PHC.
- To disseminate the results of the *Evaluation* to government agencies, DHBs, PHOs, and other primary care organisations.

3.1 Research Methodology

The *Evaluation*'s research uses four main methods: key informant interviews; survey questionnaires; and quantitative analyses in support of an economic analysis of the impact of the Strategy. Earlier reports have focused on key findings from the First Phase of key informant interviews (Cumming et al. 2005) and from a first analysis of general-practice-level quantitative data on fees and consultation rates (Gribben and Cumming 2007). This report uses data from a Second Phase of key informant interviews and from three survey questionnaires, to examine the role of PHOs in the reformed PHC environment. A Third Phase of data collection took place in 2008-9.

3.1.1 Second Phase Qualitative Interviews

These interviews were undertaken with practices, PHOs, district health boards (DHBs) and individuals involved in the management and monitoring of the Strategy's implementation. It was intended to "take the pulse" of the sector during 2006, five years after the Strategy was launched.

Selection of PHOs

A list of the PHOs extant at the end of 2005 was obtained from the Ministry's website. PHOs were seen to differ on the basis of: registered patient numbers (up to 20,000, 20,000 – 100,000, more than 100,000); funding formula (Access, mixed and Interim); previous existence as an IPA (yes/no); and focus (Māori, Pacific and other). There were thus 54 possible types of PHO although not all in fact existed. Seven PHO types were identified (as shown in Table 3.1) on the basis that:

- all large PHOs were IPA-based and had related features
- A Māori or Pacific focus was likely to be a key differentiating factor
- The features of a PHO without either of these characteristics were likely to be determined by size or funding formula.

Table 3.1: PHO Type and Number Selected

PHO type	Total number	Number selected
Large IPA-based	9	5
Māori	15	4
Pacific	3	2
Medium Access	9	2
Medium mixed/Interim	17	2
Small Access	13	2
Small mixed/Interim	15	3
TOTAL	81	20

Seven DHBs were selected for the research – Northland, Waitemata, Auckland, Waikato, the Hutt Valley, Wellington, and Canterbury. This allowed representation of: PHOs with a Māori and Pacific focus; rural, city and metropolitan PHOs; and PHOs from both the North and the South Islands. Twenty PHOs were chosen by purposive sampling, to give recognition to each type of PHO and to provide "over-sampling" of Māori and Pacific PHOs.

Selection of interview informants

It was intended that an average of eight interviews would be undertaken within each PHO. These included: the PHO chair; the PHO manager; Māori, Pacific and community PHO board representatives; a GP and a nurse who were board members; a non-board-member GP and nurse; and a practice manager (in some cases, individuals chosen held two of these roles). On occasion, two or more respondents were interviewed together; but care was taken to ensure that those with potentially opposing views or interests were interviewed separately.

The relevant DHB primary care managers were also interviewed, as were national stakeholders including representatives of the Ministry and PHC organisations (such as the RNZCGP, NZMA, and IPAC).

The interview guide

Each interview was conducted in an open-ended manner, but was based on an interview guide developed by the researchers in conjunction with the Steering Committee. This guide contained the seven major questions shown in Table 3.2; each was supported by a number of "probes" (see Appendix 1 for full text).

Table 3.2: Topics in the Second Phase Interview Guide

1 – Keeping, or bringing, the level of co-payments down
2 – Equalising access to care on the basis of need
3 – Increasing the focus on chronic conditions
4 – Achieving and using community input
5 – Maintaining an efficient health workforce – including teamwork
6 – Functioning of PHO (and MSO)
7 – Relationships with the DHB and Ministry; ACC

Process

Interviews were undertaken by seven researchers. Each telephoned the relevant individuals, made an appointment for an interview, and sent out a copy of the interview schedules with an information sheet on the *Evaluation* project. At the start of the interview, permission was obtained to use a tape recorder and the informant signed a consent form. Informants were generally willing to participate.

Difficulty was experienced in organising interviews with informants in two PHOs, but useful information was obtained in each case from a smaller number of individuals.

In total approximately 150 interviews were completed, 130 with PHO personnel, seven with DHB managers, and nine with national stakeholders.

While each interviewer used the seven major questions to organise their report, each processed the interview material slightly differently. Their approaches included:

- preparation of a summary statement for each PHO, with quotes added
- preparation of notes for each PHO, with quotes added
- preparation of notes on each interview with quotes added
- edited gist of interview exclusively in the words of the interviewer
- transcription of interview intact.

Analysis

The records of the interviews were broken down by subject (from the interview guide) and distributed to authors of this and other *Evaluation* reports. The report authors then undertook a thematic analysis of the material.

By convention, those interviewed are referred to as informants while those who responded to the surveys are referred to as respondents. In reporting from the qualitative interviews, sources are identified where possible; but the *Evaluation*'s commitment to preserving the anonymity of informants precludes more detail being provided.

3.1.2 The Survey

The survey component of the *Evaluation* was intended to quantify the impressions gained through the Second Phase interviews.

Development of the survey questionnaires

The First Phase qualitative interviews were completed in 2004 and a set of survey questionnaires was developed, including two for PHOs (board members and managers) and one for MSOs.

Survey questionnaires were also developed for practices, GPs and practice nurses; but these are not referenced in this report and so are not described here. Details of the Practice, GP, and Practice Nurse Survey Questionnaires can be found in the *Evaluation*'s third report (Raymont and Cumming 2009).

The PHO and MSO Survey Questionnaires were based on information obtained from PHO board members and PHO and MSO managers as part of the First Phase interviews.

All questionnaires were submitted for the consideration of the Steering Committee at the end of 2004. During 2005 there was an extended round of negotiations between the researchers and interested individuals within the Ministry, over the content and form of the questionnaires. This resulted in a refining of the original drafts.

Most questions were closed, with specified responses; but the surveys also contained at least one open-ended question, most commonly an "overview" question about PHC or the Strategy. (The PHO Board Member Survey Questionnaire, the PHO Manager Survey Questionnaire and the MSO Survey Questionnaire are provided as Appendix 2, 3, and 4 respectively.)

Carrying out the surveys

The surveys were conducted between August 2006 and June 2007.

All PHOs and MSOs were approached to participate.

For the MSO survey, each chief executive was contacted by telephone and was asked if they were willing to participate. If they were, they were phoned again later at an agreed time and the *Evaluation's* lead researcher went through the questions with them. This enabled the questionnaire to be tailored to the MSO's specific circumstances.

The chief executive of each PHO was also approached by telephone: they were asked if they were willing to participate personally (by completing the PHO Manager Survey) and to distribute the PHO Board Member Survey Questionnaire to their board members. If they were, they were sent one copy of each questionnaire.

Response to the surveys

The response rates for the PHO Board Member Survey Questionnaire and the PHO Manager Survey Questionnaire can be seen in Table 3.3. (The MSO Survey Questionnaire, which was conducted by telephone on an individual-to-individual basis and had a 100% response rate. This survey was not used in this report and is therefore excluded from the table)

Table 3.3: Survey Response Rates

	Eligible	Received	Response rate %
PHO Manager Survey	79	44	55.7
PHO Board Member Survey	553*	191	34.5

Note: *Estimated from the total number of PHO board members across the country.

Survey analysis

The survey results were analysed using descriptive statistical techniques, using Excel.

4 THE FUNCTIONING OF PHO BOARDS

In this section, an examination is made of how PHO boards are composed, supported and governed. Consideration is given to the ways in which boards operate, with a particular focus on the influence of different stakeholders on decision-making at board level.

4.1 Background

In *The Primary Health Care Strategy* (Minister of Health 2001) it was made clear that DHBs would "work through Primary Health Organisations to achieve the health goals locally" (Minister of Health 2001, p4) and that "[t]he vision and new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary Health Organisations will be the local structures to achieve this" (Ministry of Health 2001a, p5).

Considering the ambition underpinning these assertions, the researchers found it surprising that little detail was set out about how PHOs were going to be put in place, how they would relate to existing structures for the organisation of general practice and PHC, and how they might practically achieve the objectives being set for them. There was, however, a set of "minimum requirements for PHOs" that was intended to "set the parameters within which DHBs and local groups will find their own best answers" (Minister of Health 2003, p3) and that was used as a means of assessing the "fitness" of an organisation or grouping seeking to become a PHO. Of these minimum requirements, the following relate to the role and responsibilities of PHO boards:

- PHOs will aim to improve and maintain the health of their populations and restore people's health when they are unwell. They will provide at least a minimum set of essential population-based and personal first-line services.
- PHOs will be required to work with those groups in their populations (for example Māori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs.
- PHOs must demonstrate that they are working with other providers within their regions to ensure that services are co-ordinated around the needs of their enrolled populations.
- PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community.
- PHOs must demonstrate how all their providers and practitioners can influence the organisation's decision-making.
- PHOs are to be not-for-profit bodies with full and open accountability for the use of public funds and the quality and effectiveness of services.

These minimum requirements are restated here as a benchmark against which to assess the functioning of PHO boards, as revealed in fieldwork carried out for the *Evaluation* in 2006. They point to a policy concern about the following issues:

- that PHOs focus on a population health approach that is concerned about the improvement of people's health status and a reduction in health inequalities
- that PHOs take responsibility for making sure minimum levels of PHC service provision are in place locally
- that PHOs seek to work in partnership with other local providers, including other local PHOs, to ensure effective co-ordination of services for consumers
- that the composition of PHO boards reflect community participation; and that each PHO board foster community participation
- that the composition of PHO boards reflect provider and practitioner participation; and that each PHO board foster provider and practitioner participation

- that PHOs focus on both financial and clinical governance, taking responsibility for quality standards as well as proper use of public funds.

This chapter addresses the final three of these issues: PHO board composition; the participation of community and provider interests within boards (including issues related to influence); and the extent to which boards are performing their governance responsibilities

4.2 The Composition and Remuneration of PHO boards

There was never any specification by the Ministry in relation to how PHO boards should be composed, nor how members should be selected, beyond the "minimum requirements" for community and provider participation. This is in contrast to the establishment of DHBs, which, in the same time period, were subject to a clear directive to hold public elections for a majority of their members, with the Minister of Health having a right of appointment of members to ensure appropriate representation at board level.

4.1.1 PHO Board Membership

PHO boards have more diverse membership than DHBs, both in terms of the number of board members, and the make-up of the board in relation to the background of members and/or the organisation or community to which they are affiliated. From Table 4.1 it can be seen that the majority of all PHO board members are drawn from the community (ie not members of general practice teams) (38%), with general practitioners comprising 29% and Māori 21%

Table 4.1: Background of Board Members

Area of representation	Number (N=189)	As % of all
Local community	72	38
GP	39	21
Independent chair	2	1
Māori (in both Māori and non-Māori PHOs)	40	21
Practice nurse	22	12
NGO	5	2.1
Pacific	5	2.6
Other	2	1
TOTAL	**187**	**98.7**

Source: PHO Board Member Survey Questionnaire Q1.

It is clear that PHOs are not dominated numerically by GPs and that Māori representation is probably high compared with other areas of the health system, such as DHBs, although this also reflects the presence of Māori PHOs.

PHO board selection processes

In the PHO Board Member Survey Questionnaire, respondents were asked to set out the method by which they were selected for board membership.

As can be seen from Table 4.2 below, there was considerable variation in how board members were selected, with nomination by the community [eg local community groups, local authorities) being the most frequently reported method of being recruited onto a PHO board (n=64), followed by nomination by or invitation from the MSO or IPA (n=44), and other (n=41). This suggests that PHOs have operated within the minimum requirements to work closely with community and providers when establishing boards. There is no indication that DHBs were influential in determining the composition of PHO boards.

Table 4.2: Selection to a PHO Board (by Board Member Type)

Type of board member	Nominated or invited by:					TOTAL
	DHB	IPA/MSO	PHO	Community	Other	
Not specified/other	0	1	0	1	3	**5**
Community	1	15	17	27	12	**72**
GP	0	12	8	11	8	**39**
Independent chair	0	0	1	0	1	**2**
Māori	2	8	4	15	11	**40**
Nurse	0	8	5	6	3	**22**
NGO	0	0	0	1	3	**4**
Pacific	0	0	2	3	0	**5**
All board members	**3**	**44**	**37**	**64**	**41**	**189**

Source: PHO Board Member Survey Questionnaire Q2.

Board members responding to the survey questionnaire were asked what sort of community or group they represented on the PHO board. Analysis of responses revealed that GP board members all considered that they represented doctors on the PHO board and similarly, nearly all nurse board members believed that they represented nurses. Māori board members reported that they represented either the Māori community or a Māori organisation, and all community members reported that they represented either a specific geographic community or the community in general. This suggests that PHO boards tend to represent a coming together of different communities of interest, with each of those communities feeling affiliation and responsibility to the particular grouping from which they have been drawn. This indicates a board that is not intended to be "corporate" in the sense that the overriding priority is to develop an entity based on members' skills and experience in order to enable corporate decision-making. Rather, the PHO board is intended first and foremost to enable participation of specific interest groups – community and provider – in the governance and planning of local services. In this way, it is a community participation model of governance, which serves to explain some of the issues highlighted in this paper in relation to how PHO boards appear to operate in practice.

Board meetings

The average frequency of PHO board meetings in the previous year as reported by respondents to the PHO Board Member Survey Questionnaire was 11.27 meetings, with a median of 11 and a range of 5-24. This suggests a usual pattern of monthly board meetings with some boards meeting every other month and some twice a month. There was no significant difference in frequency of board meetings between different types of PHOs.

4.1.2 Remuneration of PHO Board Members

Board members were asked to report the annual level of remuneration that they received for attending board meetings and, separately, the remuneration that they received for all other PHO board business. Annual level of remuneration for members for attending board meetings, by PHO type, was as set out in Table 4.3 below:

Table 4.3: Remuneration of PHO Board Members for Attendance at Board Meetings (by PHO Type)

PHO		Remuneration for attendance at board meetings ($)				
Type	**Number**	**Mean**	**Std Dev**	**Minimum**	**Maximum**	**Median**
IPA	13	7408	4343	1000	18000	7200
Māori	11	4123	2536	0	10000	4600
Medium-sized Access	23	3064	1389	1100	8000	2860
Medium-sized Interim	47	3041	2769	200	15000	2665
Pacific	2	7800	2546	6000	9600	7800
Small Access	25	901	877	0	3000	600
Small Interim	43	3783	2840	40	17000	4000
TOTAL	164	3390	3007	0	18000	2750

Source: PHO Board Member Survey Questionnaire Q5.

Overall median remuneration for a PHO board member is shown as $2750 per annum, with a range of $0 to 18,000. This points to significant variation in how PHOs chose to remunerate board members for attending board meetings. It also suggests that IPA-based PHOs pay a higher rate of remuneration to board members, in many cases more than twice the rate offered by other forms of PHOs. Numbers of Pacific board members were too small to be significant in this analysis.

Table 4.4 shows remuneration per annum for attendance at board meetings by the type of board member. It can be seen that there was no significant difference, apart from community members reported as receiving more than GPs (small numbers that lack statistical significance have been removed from the analysis).

Table 4.4: Remuneration per annum of PHO Board Members for Attendance at Board Meetings (by Board Member Type)

Board member		Remuneration for attendance at board meetings ($)				
Type	**Number**	**Mean**	**Std Dev**	**Minimum**	**Maximum**	**Median**
Not specified	3	6933	9617	600	18000	2200
Practice administrator	1	2000	0	2000	2000	2000
Community	65	3986	3567	0	17000	3300
GP	34	2533	1885	0	8000	2400
Independent chair	2	4300	990	3600	5000	4300
Māori	33	3139	1963	0	10000	2665
Nurse	18	2714	1910	200	7500	2400
NGO	4	2100	1619	600	3500	2150
Other	1	2750	0	2750	2750	2750
Pacific	3	5217	4823	50	9600	6000
TOTAL	**164**	**3390**	**3007**	**0**	**18000**	**2750**

Source: PHO Board Member Survey Questionnaire Q5

Table 4.5 and Table 4.6 both show remuneration per annum received for all other PHO board business. There was a range from $0 to $10,000 in board members payments, with the overall median payment being $400 – a small amount in comparison with the median remuneration for attendance at board meetings. As can be seen from Table 4.5, Interim and IPA-based PHOs appear to pay more for other PHO board business than Access or Māori PHOs.

Table 4.5: Remuneration per annum of PHO Board Members for All Other Board Work (by PHO Type)

PHO		Remuneration for all other board work ($)				
Type	**Number**	**Mean**	**Std Dev**	**Minimum**	**Maximum**	**Median**
IPA	10	1431	3060	0	10000	280
Māori	5	320	716	0	1600	0
Medium-sized Access	12	734	826	0	2500	525
Medium-sized Interim	18	1378	2087	0	6000	450
Pacific	2	6800	4525	3600	10000	6800
Small Access	19	315	493	0	1800	100
Small Interim	19	2103	2386	0	10000	2000
Total	**85**	**1283**	**2170**	**0**	**10000**	**400**

Source: PHO Board Member Survey Questionnaire Q6.

Table 4.6: Remuneration of PHO Board Members for All Other Board Work (by Board Member Type)

Board member		Remuneration for all other board work ($)				
Type	**Number**	**Mean**	**Std**	**Minimum**	**Maximum**	**Median**
Not specified	1	160	0	160	160	160
Community	39	1794	2479	0	10000	1000
GP	21	407	664	0	2000	2
Independent chair	2	3900	2970	1800	6000	3900
Māori	9	119	247	0	675	0
Nurse	9	787	776	0	2000	700
NGO	2	400	566	0	800	400
Pacific	2	6800	4525	3600	10000	6800
TOTAL	**85**	**1283**	**2169**	**0**	**10000**	**400**

Source: PHO Board Member Survey Questionnaire Q6

In the Second Phase interviews, the issue of remuneration was raised by some informants as being a problem. Not surprisingly this was in relation to where board members were not receiving remuneration.

> *The difficulty is not with the board rather than with the process of operating a board. The trustees volunteer and have to travel hundreds of kilometres to [and] from their practice and family. (PHO manager)*

What is clear is that the permissive policy environment in which PHOs have been developed has led to significant variation in whether board members are remunerated at all, and if so, how much and what for. The data reported here suggest that IPA-based PHOs appear to pay their board members more than other types of PHOs do; and that Access and Māori PHOs appear less able to remunerate their board members to the same degree.

4.3 The Role of the Board and its Members

The role of the PHO board, as interpreted by the Strategy and the minimum requirements involves: community governance of PHC; reduction of inequalities in health status among the local population; co-ordination and oversight of local PHC services; and development of plans to enhance the local PHC workforce.

When the PHO Board Member Survey respondents were asked how they viewed their role as a board member, they were given the opportunity to identify specific roles from the following list:

- representing community interest
- representing provider interests
- ensuring accountability
- communication with local DHBs
- ensuring management tasks achieved
- ensuring clinical quality
- developing new services
- other.

Table 4.7 sets out responses to this question, by PHO type.

Table 4.7: Roles of PHO Board Members (by PHO Type)

PHO type	Board members' roles (%)*						
	Represent community interest	Represent provider interests	Ensure account-ability	Communicate with local DHBs	Ensure management performance	Ensure clinical quality	Develop new services
IPA	63	75	94	75	94	81	69
Māori	55	55	100	73	82	91	64
Medium Access	79	79	88	75	92	83	75
Medium Interim	71	89	93	71	73	96	71
Pacific	100	100	100	100	100	100	100
Small Access	79	82	100	82	89	100	89
Small Interim	71	84	83	69	67	92	71
ALL PHOs	**71**	**83**	**91**	**74**	**79**	**92**	**74**

Note: Percentage of respondent board members in each PHO type answering "yes" to each of the options in Q17 of the PHO Board Member Survey Questionnaire. .

Informants had earlier revealed a similar range of views about the role of the PHO board. For some, the board was clearly concerned with the setting of strategy and direction for local PHC services and health improvement:

> *The board relates to the management committee and ideas are sent to the board from that committee who decide what should be funded through discussion. (Pacific PHO)*

> *We direct [the MSO]. The PHO board determines which projects are funded and where they want the money to go.* (*IPA-based PHO)*

In this latter example, informants noted that it was the PHO that directed the MSO, because the PHO board strategically planned which projects would receive funding and set direction for the services required by their practices and the population they serve. They explained that the chairman of the PHO was also part of the board from the MSO and acts as a link between the two organisations. This example suggests that some PHO boards have been able to assert themselves as strategic leaders of local PHC planning and funding, considering themselves in a governance and direction role in relation to the PHO's management.

There were, however, other examples where it was asserted by respondents that the PHO board appeared to exist to service the needs of the local provider and GP community, to the detriment of community voice and influence.

> *One PHO is particularly GP dominated. It is difficult, as the majority of the decisions re PHOs at the moment are focused round general practice and GPs. The community voice is therefore often not heard, as it is influenced by the GPs. (DHB manager)*

Because the PHO board is made up of community people but the PHO contract is very much GP driven there is a huge difference....[in the way people perceive].... the whole PHO philosophy. The business is being dictated to by non contributing agents. This is hard to manage and does not make sense. Would like to see all primary health contracts come through the PHO as this would make it easier for the communities to jell and work together. (Manager, Medium PHO)

In other cases, it was not asserted so strongly that provider or GP interests were dominant, but rather that there was an inherent tension in seeking to include both community and clinical input and governance within PHOs.

I would like to improve the "collectiveness" of the PHO in terms of service delivery. We currently try to merge the two groups [community and GP] together and generally do it well, but I must service the GP group as that is where the money is coming from for the enrolled population. (Manager, Medium PHO)

With some PHOs there is a conflict with providers that are on the board, because they can push their barrow rather than seeing the whole health picture […] It's caused some problems particularly around mental health. (Māori board member, small Access PHO)

I think at times, the GP representatives will have a different viewpoint of certain aspects of activity than the community representatives and the same could be said about Māori issues. (Manager; Medium PHO)

It has been a huge learning curve for all. I think that community representatives would like to see more emphasis on other community health providers, rather than what has been seen as a lot of focus on empowering the general practice teams to deliver services. We are moving down that track, it is an evolutionary process. (Manager, Medium PHO)

For these informants, the PHO board appears to be less clear in terms of its overall strategic role, struggling to be a unified entity given the existence within the board of constituencies that may view PHC in different ways. This illustrates a fundamental tension inherent in the PHO board model – the requirement that both community and provider interests be represented.

Just as concern was expressed by some informants about difficulties with PHO boards performing their function in relation to community governance, in some cases, GP board members expressed a sense of isolation within PHOs. Some felt that the board lacked an understanding of what it was to be a PHC provider.

I'm a GP in business, and I don't really think that our PHO protects that. With regards to the dispute over fee-capping, the other provider representatives had no idea how that might affect GPs, so they couldn't understand the issue. A meeting [with] providers since then has clarified this, but if there is only one GP on the board, then it's very difficult. That's the only time I have felt isolated on the board: I was made to feel as if I was holding the PHO to ransom, whereas when I went to talk to the providers they began to understand the issue. (GP board member)

I'm the only GP on the board (there is only one practice in the PHO) and I get frustrated at the lack of understanding of the board and manager of practice issues and things of importance to us and our funding. (GP board member)

Unsurprisingly, the early history of a PHO appeared to influence the extent to which the organisation and its board had a clear and agreed view of the PHO's role. Where the PHO had evolved from a former community trust or similar organisation, there was a shared perception that people were "singing from the same hymn sheet" and had common goals about the organisation's functions and priorities. This was perceived to be due to the long history of shared local governance, and experience of community (and often clinical) leaders working together to plan and deliver services for a community.

It's how we've always been, though: the trust is formed with community representatives. The PHO hasn't actually changed, we thought of ourselves as a natural PHO when the idea came up, [we] thought "this fits us, we already do that". We have been designed by the community, the community got together, [it] thought "this is the organisation we want". We're probably the closest to that model in the country – we are community driven Most PHOs are run by the practitioners but ours is run by the community. (Manager, Māori PHO)

Likewise, where a PHO had grown out of an IPA and continued to receive its management support from the IPA, it was sometimes asserted by informants that the PHO continued to focus on the needs and priorities of GPs. In cases such as this, board members often reflected on how they saw part of their role as being to help to bridge the segregation that could occur where there were separate clinical and community "parties" within the PHO - because as board members they wanted to concentrate the organisation on directing the wider population health and service development activity.

I would characterise the PHO as very IPA/GP driven. We are in the process of distinguishing the two by moving to wider community engagement with the PHO. The IPA will be about growing and sustaining GPs. (Source, please)

The board works quite well. We get quite diverse discussion – which is what you need. It shouldn't be provider dominated, but providers are very important because they are doing the work. (Manager, IPA-based PHO)

This illustrates how PHOs, in the absence of clear guidance from the Ministry about their specific role and functions, have been left to work out at a local level how to balance clinical and community interests – and to determine how both sets of interests can be met, whether by the PHO, the IPA or by some other means. What was clear from interviews was that GPs who had been part of IPAs in the 1990s continued to trust IPAs to look after their interests, and were still learning to be able to trust PHOs in the same way. Similarly, where community governance of PHOs had predated the implementation of the Strategy, it seemed that community trust of, and engagement in, the PHO was often higher than in those cases where the PHO was a newer entity that had been set up specifically to enact the Strategy.

For some informants, the role and function of the PHO board was determined by the size of the PHO. Some informants asserted that smaller PHOs were able to easily reach agreement on issues.

> *If we all had our own pet projects and agendas we would end up like the big PHO – they never got going for a long time. This PHO is small, compact, all the GPs are in easy agreement around the direction of the PHO. That has been one of the strong points: we have a more concerted common interest. (GP chair, Access PHO)*

Others underlined the value of being a smaller PHO, but pointed out that it was taking them some time to prove themselves within the health system, given the level of resources they had.

> *In response to a question about how the board is working] Improving! We started off as a disparate group of people, some […] knew a lot about health services and some did not. So there is a good mixture of backgrounds. We are learning what we can do, and that we can only do a certain amount, we don't have much money but there are some things we can do without much money by organising and communicating better. It will take another couple of years before I am confident that we are an effective governance organisation that is making a difference. We are a significant way towards that point, but as for many small PHOs, the direction from central government has been unclear, as has been the amount of money available. (Chair, medium rural Interim PHO)*

> *We [the PHO board] work as well as we can. The amount of work that's involved is carried by [one person]: he tries to keep up with the play. The board itself, we come together on a monthly basis we discuss issues but really we talk about what we need but there's not a lot of power in it really. (Who, Māori PHO)*

For other smaller PHOs, however, being small represented a challenge for the managers in particular, who expressed some feeling of isolation and being overwhelmed.

> *Everything's left to me, and the board comes along and ratifies everything. And the problem is, as they are such a diverse group of people, they don't really understand the system, the problems of health care. (PHO manager)*

What is clear is that PHOs have embarked upon a journey of development, and the experience of this journey differs for reasons that include the PHO's history in relation to an IPA, community trust, or other background; the size of the organisation; local relationships between general practice and community representatives; and the extent to which the PHO's management has been able to harness both clinical and community interests and participation at board level. This diversity appears to be reflected in the way in which board members view the functions and role of the board, and in how the PHO itself views itself as an entity.

The next sections of this chapter examine in more detail how PHO boards are seeking to ensure the participation of community and provider interests, as prioritised in the minimum requirements for PHOs.

4.4 Board Participation by the Community

A majority of chair and chief executive informants spoke with enthusiasm about how they were seeking to secure community input to the governance of PHO boards, and what this was enabling in terms of board focus, priorities, and achievements. For some, the positive experience was based on the history of the organisation.

> *We had the infrastructure to have true community representation and input. It's always been part of our organisation.[PHO Manager]*

> *[The] structure of the PHO is important. Nine board member: three providers, three Māori (two hapu and one provider), three elected from local communities. Good representation. Two practices are owned and operated by community trusts. The other practices very close to their communities and have deep roots there. Primary care in rural areas is fragile, in terms of getting staff etc, so communities value health services very highly and are very supportive. (PHO chair)*

> *We are very much inclusive of the community. The community in general has a "connectedness" in terms of servicing clients [and] they have the same philosophy in servicing clients. (Manager, Medium PHO).*

For others, community input was something that had evolved as part of Strategy implementation and a move from an IPA towards a model of governance with a greater degree of community input.

> *Projects [on community representation] come to us via the representatives who are part of the advisory groups who consult with the community. They also emerge from our links with NGOs and other health providers. (PHO manager, IPA-based PHO)*

> *We have done a number of things. The setup of the board is unique, and it's been very successful, with representatives elected by local groupings. We have set up focus groups in these areas too, and we have set up a geographical one in [a specific location] too where we are dealing with a rural area where issues are fed into us in a broad area, not just from the GPs. We have set up focus groups with both providers and community representatives, so that the messages go back and forth between community interests and the PHO. That's on trial as a process, but I believe it's been enough of a success to make sure that we are listening "out there". It's hard to get community input in a large PHO so we are hoping that this will provide another avenue of communication between the wider community and our representatives. (PHO chair, IPA-based PHO)*

And for others the involvement had developed as part of the establishment of a new PHO.

> *The PHO board have representatives from Māori, Pacific, doctors, practice nurses … Any community initiative always requires the input of the community reps and also [requires] checking it out with some of our own community providers. For example, the marae-based GP proposal is an initiative [where] the board values the engagement of marae and others. The outcome has been very positive, with the appointment of a project manager to be made very soon. (PHO manager)*

We are open to community views – but whether they are reflected enough round the board table, I'm still not sure. The majority of board members have no inhibitions about raising whatever issues they see as important. This may mean we are getting a broad spectrum of issues in front of us, but it may be that we are only getting a few of the main issues. It's hard to tell. [PHO chair)

There was, however, a sense of mixed experience in enabling participation that was both meaningful and influential on PHO direction and strategy. Non-chair board members or observers such as DHB managers highlighted this, citing reasons such as difficulty in defining a community, the challenge of individuals representing a community, and the differing history of PHOs – some of which had relatively little experience of community governance and participation prior to the Strategy's implementation.

Ah, it's a nightmare. It's hard with a big community and there has been no historical funding over the years to develop community link...We constantly get from community people "go away we are tired, we do not want to talk just around your PHO we have lots of other things to deal with". We have disbanded the community reference group because it became incredibly dysfunctional because of various lobbying members [who were] there for their own issues […] it did not represent the community. We have employed a half-time community liaison person who has been an extremely good investment. She can help link us and talk at all the forums and we have set up a virtual reference group using email with whole numbers of NGO, refugee and migrant people. It continues to be a problem. (Manager, PHO)

Representatives are selected to represent their ethnic group. This community is made up of many different ethnicities; they can't represent the views of everyone so we also invest in public meetings. (PHO Manager)

How can you have one representative for such a large population who can fairly represent that community. These PHOs are dictated by the CEOs, they are still GP driven. (DHB manager)

It's a theory that we get input through the advisory networks but the reality is that there is not much filtering through either way because the public does not understand PHOs, does not know what to expect, or their role in all of this. (PHO Community board member)

There has been good input at the board level although defining a community has been problematic. We have commissioned research into how best to engage with the community and have implemented some of the recommendations .(PHO Manager)

A number of informants talked about the need for increased public awareness of PHC services, and of PHOs as funders and developers of such services. Echoing the original intent within the Strategy that PHOs should be sources of information about the range of local PHC services, and be seen to offer choice of services to those enrolling with them, some informants called for social marketing to be used to "spread the word" about PHOs, and others for PHOs to play a role in setting out the vision for PHC locally.

It's difficult to get the community on board when the majority don't see any difference: [they ask] "what is a PHO?". They don't know what to expect and what to ask for. There needs to be more social marketing around this. (DHB manager)

The job (i.e. community representation) is very difficult because the community does not know what to expect from PHOs. How can they have input into something that they don't understand (PHO Community board member)

It is going to be very important in the future that the public understand PHOs. There has to be a marketing campaign; you can't expect to have good community involvement without a campaign. (PHO manager)

We have needed a vision to give to the community. Something that is meaningful to them and this proposal fits that criteria. They will be interested and they will want to have a say. (PHO community board member)

4.4.1 Community Influence at Board Level

As noted in the following chapter, boards are focusing their attention on issues such as needs assessment, community views on such needs, the development of local PHC services, and optimal use of new sources of funding allocated to (or channelled through) PHOs. There is, however, evidence of differences between PHOs in how far the board itself feels that it is able to influence such activities. There is also evidence of differences, within boards, on how far specific board members or groups of board members perceive themselves as able to shape PHO direction and priorities.

Table 4.8 sets out the responses to a question in the PHO Board Member Survey Questionnaire that asked respondents to rate the influence of different groups on the board. It shows that 108/189 respondents (57%) felt that community influence on the PHB board was "about right", with 60/189 (32%) were of the view that such influence was "too weak". Only two respondents felt that community influence was "too strong". This result – together with the views reported above – suggests that there has been progress in establishing community participation within PHO board activities, even though in many cases people perceive that a greater degree of such involvement needs to be developed. Board members clearly value community participation, and are reflecting on how to further foster this. The overall verdict in 2006 appeared to be "sound progress, but more to be done".

Table 4.8: PHO Board Members' Perceptions of the Community's Influence on the Board (by PHO Type)

PHO type	Perception of community's influence					
	Too strong	About right	Too weak	Don't know	Missing data	Total for PHO type
IPA-based	0	9	5	2	0	**16**
Māori	0	8	2	0	1	**11**
Medium-sized Access	0	15	8	1	0	**24**
Medium-sized Interim	0	23	26	4	3	**56**
Pacific	1	1	0	0	0	**2**
Small Access	1	22	4	1	0	**28**
Small Interim	0	30	15	5	2	**52**
ALL PHOs	**2**	**108**	**60**	**13**	**6**	**189**

Source: PHO Board Member Survey Questionnaire Q9.

Progress in developing community participation and involvement was evident in different types of PHO. It was also clear that medium-sized Interim PHOs appeared to have the largest proportion of board members who felt that community influence was too weak. In terms of reasons for weak or inadequate community influence and participation, some clues were provided in answers to questions in interviews:

> *Māori and to a degree the community representatives feel a bit intimidated at times in terms of their ability to debate with, question or even stand up to the GPs in meetings. This is something to work through and manage as the chair. (Chair, IPA-based PHO)*

> *[If you have only] one community rep, then you find that the board is always dominated and driven by the GPs. So it is always GPs needs [that]are a priority rather than [looking] at all aspects of the organisation. (Board member, Pacific PHO)*

> *But it's a huge task. You got no resources to do it. I was lucky that I have a service, that the board is made up of community reps. So I come and report to that board, which is made up of Fiji, Samoan, Tongan, Cook Island and Niuean [representatives] and then they go out to their communities and hopefully pass that message on. But if I was a community rep without any resources behind me, I wouldn't be able to do, apart from my own church to go out there and talk to them, so while the expectation is there. (Board member, Pacific PHO) .*

Involving community representatives at board level appears to be a priority for PHOs. What is less clear is how far community influence is being felt by boards, and there is evidence of tensions between professional/clinical and community interests and influence at board level.

4.5 Board Participation by Providers

As noted earlier, some informants perceived that provider/GP interests were dominant within PHO boards Others (almost always GPs) reported that such interests needed to be better represented at board level, given the centrality of practice services to the business of PHOs.

> *There is always the constant fear that our surgeries could get hijacked by the lay component of the PHO administration … the last thing you want, without a strong GP voice, is the lay component telling you how to run your practice…..*
>
> *They could pass all sorts of things that were not practical in the running of your practice. (GP chair type of PHO)*

The complexity of this issue, in light of the Strategy's assertion that both community and providers should be effectively engaged within PHOs, is evident in the following reflections.

> *The chairman is on the MSO board and it's run almost by doctors for doctors … for the benefit of doctors. Ultimately they have the good of the community at heart [people in the community] are better off than they have ever been. (Community board member, Access PHO)*
>
> *PHOs generally mean well but we need guidance and [now] we are really directed by what the doctors want – and they are very overworked. (Community board member, Access PHO)*

Provider involvement at PHO board level typically takes the form of the presence of GPs, nurses or managers on the board, sometimes with an advisory committee or forum feeding in from particular professional groups.

PHO Board Member Survey respondents' views on the influence of the PHO's GPs members on the board are set out in Table 4.9.

Table 4.9: Board Members' Perceptions of the Influence GP members on the PHO Board (by PHO Type)

PHO type	Perception of GPs' influence					
	Too strong	About right	Too weak	Don't know	Missing data	Total for PHO type
IPA-based	3	12	1	0	0	**16**
Māori	0	9	2	0	0	**11**
Medium-sized Access	2	22	0	0	0	**24**
Medium-sized mixed/Interim	8	36	8	2	2	**56**
Pacific	1	1	0	0	0	**2**
Small Access	3	23	2	0	0	**28**
Small Interim	13	31	5	1	2	**52**
All PHOs	**30**	**134**	**18**	**3**	**4**	**189**

Source: PHO Board Member Survey Questionnaire Q9 .

These data provide an interesting contrast to respondents' views about community influence on PHO boards. When asked about the influence of GPs, 134/189 (71%) felt the influence was "about right"; 30/189 (16%) suggested it was "too strong" and 18/189 (10%) perceived it to be "too weak". This suggests that there is less work to be done in relation to GP input into and influence on PHO boards (compared with what needs to be done in the area of community influence). The data here indicate a majority of board members feel that doctors have an appropriate degree of influence, whereas almost a third of them felt that community influence needed to be increased.

The same question was also asked in relation to nurses' influence. The results are set out in Table 4.10.

Table 4.10: Board Members' Perceptions of the Influence of PHO Nurse members on the PHO Board

PHO type	Perception of nurses' influence					
	Too strong	About right	Too weak	Don't know	Missing data	Total for PHO type
IPA-based	1	12	3	0	0	**16**
Māori	0	7	4	0	0	**11**
Medium-sized Access	0	15	9	0	0	**24**
Medium-sized mixed/Interim	0	43	9	3	1	**56**
Pacific	1	1	0	0	0	**2**
Small Access	1	17	6	4	0	**28**
Small Interim	0	39	7	3	3	**52**
All PHOs	**3**	**134**	**38**	**10**	**4**	**189**

Source: PHO Board Member Survey Questionnaire Q9.

The results shown in Table 4.10 indicate that nurses were considered by 134/189 (71%) respondents to have about the right amount of influence on PHO boards. While their influence (like that of the community) was perceived as "too weak" by 38/189 (20%) of respondents, they are hardly ever considered to have "too much" influence.

This suggests that PHO boards are still in a state of development whereby they are working to engage community, GP, nurse and other provider views at both board and operational level. It is hardly surprising that this is proving to be challenging for PHOs and that progress appears to vary, with acknowledged need for more to be done to engage groups that traditionally struggle to have an influence within health policy and management (namely nurses and community representatives).

> *It has been a huge learning curve for all. I think that community representatives would like to see more emphasis on other (non-GP] community health providers, rather than what has been seen as a lot of focus on empowering the general practice teams to deliver services. We are moving down that track; it is an evolutionary process. (Manager, Medium PHO)*

4.6 Overall Board Performance

Barnett et al (2001) drew on the work of Shortell and Kaluzny (1993) to define governance as the function that "holds management and organisation accountable … helps provide management with overall strategic direction" and maintains viability and effectiveness (Weiner and Alexander 1993). In the context of PHOs in New Zealand, the governance of the organisation is clearly vested first and foremost in the PHO board as the accountable body charges with directing the organisation towards improving health and reducing inequalities in health status among people registered with the PHO (Minister of Health 2001).

The analysis in this chapter indicates that boards perceive themselves to be responsible for ensuring accountability and clinical quality as well as representing provider interests and ensuring management performance. Slightly fewer Board Member Survey respondents noted communicating with DHBs, developing new services and representing the community as part of their role. Clearly further analysis according to background of members is required to understand this better. This ambiguity of PHO function is referred to earlier in this paper, and in other commentary on the Strategy's implementation (such as Gauld 2008; Mays and Blick 2008; Smith 2009), and reflects the expressed desire in the Strategy not to impose a central model of PHO, rather to allow local and organic evolution of the approach.

To further emphasise the diversity of interpretation of the PHO role, data from the PHO Board Member Survey Questionnaire illustrates board members' varying views about their scope of influence (see Table 4.11). For example, in respect of the board's ability to influence the activities of practices to a desirable extent on specific issues, key messages were as follows, reflecting multiple responses from among 189 respondents:

Table 4.11: Board Members' Views on Their Ability to Influence the Activities of Practices (by Area of Practice)

Area of practice	Can the board influence practice in these areas?			
	Yes	No	Not board's role	Total no. of responses
Clinical governance/quality	110 (63%)	26 (15%)	39 (22%)	175
Responsiveness to community	114 (65%)	44 (25%)	17 (10%)	175
Practice organisation	62 (36%)	44 (26%)	66 (38%)	172
Setting level of fees	62 (36%)	36 (21%)	74 (43%)	172
Developing new programmes	145 (83%)	22 (13%)	7 (0.04%)	174

Source: PHO Board Member Survey Questionnaire Q12.

These data suggests that PHOs are firmly focused on developing new programmes, presumably with additional resources such as SIA, Care Plus and health promotion funds. PHOs clearly seek to be responsive to the community, and also to have influence on quality of care and clinical governance. There is also a sense of ambivalence about seeking to influence the organisation of practices. In relation to fee setting, a third of PHO Board Member Survey respondents felt that the board had some influence, although 39% felt it was not a PHO role.

4.7 Summary

As a result of the permissive policy environment, PHO boards are quire diverse in terms of numbers of members, their background, the communities from which they are drawn, the processes by which they are selected and the remuneration they receive. A diversity of board roles was also recognised, including the strategic development of primary care and various representational and special interests.

Community input into PHOs was endorsed by chairs and managers, but there was a mixed experience of its effectiveness. A majority of respondent board members reported community influence to be 'about right'. Overall PHOs are firmly focused on developing new programmes, on being responsive to the community and having an influence on the quality of care and clinical governance, but more ambivalent about seeking to influence the organisation of practices or setting fees.

5 SCOPE OF DECISION-MAKING IN PHOS

The Governance Guide for PHOs (Ministry of Health 2007) sets out the expectations of PHOs in terms of their processes and areas of decision-making. Although this document was not available at the time when the *Evaluation* was designed, we have framed this discussion around key topics identified in the Guide. The areas of decision-making for PHO boards can be identified as three broad topics:

- access to sustainable primary care services
  - costs of access
  - workforce availability and development
- service development to improve population health and reduce inequalities
- service quality and clinical governance.

Information is available on the first two of these topics from both survey questionnaires to PHO managers and board members and interviews with PHO personnel and other stakeholders. The surveys provided limited data on the third topic and it is not discussed in this section.

5.1 Access to Sustainable Services

Access to sustainable services requires minimising cost barriers for the community while ensuring the availability of providers.

5.1.1 Costs of Access

The *Evaluation*'s research was undertaken in 2006 and early 2007, prior to the full implementation of the fee review process. All PHOs interviewed expressed a commitment to reducing fees for patients wherever possible. In the PHO Board Member Survey, 84% of respondents indicated that they were "officially aware of practice charges". Many interview respondents spoke of the difficulties for PHOs in balancing the competing forces of reducing cost barriers to access and ensuring financial sustainability of providers. PHOs took somewhat different positions on how this is to be achieved, depending on their funding and ownership structures. For example, in the survey of PHOs, nearly 60% of Access PHOs (10/17) reported discussing fees with practices, compared with only 48% (13/27) of other PHOs. In terms of board decision-making, 42% of the PHO Board Member Survey respondents overall from Access, Māori and Pacific PHOs reported that their boards are able to influence practices to a desirable extent in fee setting, compared with 28% from other PHOs.

Access PHOs

Most of the Access-funded PHOs surveyed were community owned, some with salaried practitioners. Interview reports suggest that most saw their role as to maintain the lowest possible fee levels, and had taken the decision to set or recommend a consultation fee. If a PHO adopted a "low-fee" or "no-fee" policy, this had implications for sustainability. Two PHOs, for example, acknowledged that free care could not be made available to non-enrolled patients, including visiting whanau. Another medium-sized Access PHO reported that the recommended fee was unsustainable. These and other PHOs emphasised the importance of maintaining the enrolment register as a basis for maximising funding, with "low-fee" or "no-fee" policies being a strong incentive for people to enrol. One Access PHO reported that practice fees charged were sometimes higher than the PHO had agreed, but that it was not the task of the PHO to regulate private business exchanges:

We are not the capitation police. We try to enforce the $10-$15 but we have to trust the practitioner. Many high needs [people] pay nothing ... no one fee fits all situations. (Manager Pacific PHO)

Most Access PHOs had strategies in place to support low or no fees. In some cases negotiations with the DHB had enabled more funds to be made available and the Very Low Access fee policy has been in place since October 2006. A number of PHOs reported using other primary care funding streams, such as SIA, CarePlus or health promotion funds to support the "no-fee" policy. This approach was reported by one PHO to be no longer available.

Part of Services to Improve Access was to support co-payments, but that was taken out. The criteria seem to be changed. (Māori PHO Board member)

Another reported that funding early in PHO development had helped address inequalities but that this was "no longer available".

Some PHOs had used charitable funds or had "systems to support Māori and Pacific families". Others reported that even low ($10-15) fees are beyond the reach of some families.

IPA-based PHOs

Interview reports suggest that PHOs with a strong IPA history and IPA-based MSO see their role in ensuring access and sustainable services somewhat differently. They saw their role as two-fold: ensuring that any increase in subsidy is passed on to patients, thereby minimising financial barriers to access, but also supporting general practice to be financially sustainable as a business.

In general, IPA-based PHOs reported that they saw no role for themselves in setting a consultation fee.

Our docs will pass on the $27 to the patients, but they will resist having their fees controlled. GPs are concerned; they do not want government controlling their business. They are independent businesses. (Manager, IPA-based PHO)

Exceptions occurred in the case of very small IPA-based PHOs, where there were instances of all practitioners able to agree on, for example, maintaining free care for the "Under 6s".

We will continue, as we do now, to subsidise the under 6s. I am talking with the partners as to how we see the "overs and unders" so the more vulnerable groups will pay less. (Manager, small IPA-based PHO)

Generally, IPA-based PHOs reported their role to be supporting practices to ensure that subsidies are passed on and any increases in co-payments could be justified in terms of additional costs and practice sustainability.

The variation in fees is about different practices with different overheads serving different communities, different consultation types for different people and problems. (Manager, IPA-based PHO)

Generally these PHOs rejected any role in the control over fees but had a good knowledge of the local fee structure and monitored them closely. They saw their role as working with practices to ensure that fees were realistic, but not excessive. They also saw their role as to support practices in their discussions with DHBs, particularly in relation to fee-setting, and make decisions that support sustainable general practice. This includes, for some PHOs, "top-slicing" to support after hours services and casual patient "clawback".

5.1.2 Workforce Availability and Development

Developing the PHO role in relation to workforce

In the first few years of their existence, PHOs clearly felt some ambivalence about their roles in relation to workforce matters. Most PHO Board Member Survey respondents recognised that workforce issues were critical to the success of the PHO, but they were unsure how they could best address these. The few PHOs that expressed extreme reluctance to be involved in workforce issues were small ones. One of these PHOs indicated that workforce was a practice-level issue; another reported being too small to be directly involved in workforce issues.

> *We're basically in survival mode which means that you can't be as creative and amazing as an organisation can be. (Manager Māori PHO)*

Despite this, the PHO in question recognised problems of retention, recruitment and workforce stress, and welcomed the idea of a coalition of PHOs to work on this. An example of such a collaboration was mentioned by several PHOs who noted the positive implications of an area-wide workforce survey.

> *They [several PHOs]are putting action together to address the issues. (Board member, small Access PHO)*

A more typical response from PHOs was acceptance of their role in workforce, both because it was important and because there appeared to be no-one else accepting responsibility. This position was characteristic of PHOs of all sizes, with some responding in an ad hoc, reactive way, and others presenting a more strategic or comprehensive approach. The more limited approach is characterised by the approaches to recruitment and retention activity reported by one large PHO:

> *We have been involved in this, but we don't want to be seen as the agency that's recruiting workers for general practice, that's not our role. But our role is to step up when they [the board] see a gap or an issue and find a way through it. (Manager, IPA-based PHO)*

And by a small PHO:

> *[We do] recruitment and retention because there is no other body to do it. (Manager, small Interim PHO)*

The PHOs which took a more pro-active approach had varying ways of engaging with workforce issues. PHOs that had a relationship with an IPA may contract with the IPA to manage a range of workforce activities; other PHOs saw their own positioning and role on workforce matters as critical.

If a PHO is supportive of providers and recognises their importance it will be easier to recruit staff, rather than a PHO that is going in a different direction to its providers. (Who, small Interim PHO)

Examples of a more pro-active approach to workforce was given by some PHOs.

It's taking that role on, which is expected [of] a PHO. As it works more efficiently it becomes more aware of the global positioning of doctors and nurses. It was all a bit piecemeal before and no one actually cared about it. Now it's a team, the management of the PHO is now aware if its practices are doing well – and I think increasingly it will fall on a good PHO's shoulders to manage its workforce. (Manager, Interim PHO)

Currently, the PHO is investigating the feasibility of PHO family medical centres, with salaried GPs and nurse[s]. The team anticipates that GPs entering practice and those about to exit (being near retirement age) will welcome the idea. (Manager, IPA-based PHO)

PHOs have taken differing approaches to determining their appropriate level and type of involvement in workforce, determined largely by local needs. However, the way in which these new responsibilities have been undertaken can be explored through an analysis of their reported actions. Activity has occurred in two broad areas: analysis of problems and risks, and strategies for workforce development.

Analysis of problems and risks

Data collection and monitoring: An important first step in addressing workforce issues is to have a good understanding of the size and scope of the problems facing PHOs. Given their many other responsibilities this has proved a considerable challenge, with some reporting that they did not have the capacity to undertake such analyses. Regionally-based PHOs indicate that working together gives them greater capacity to do such work.

Skill shortages: PHOs identified specific areas of skill shortage that prevented the provision of a fully accessible primary car service. For example, The most important shortages were reported by Māori and Pacific PHOs, expressing a need for Māori and Pacific staff, particularly nurses and managers.

No doubt about it, that when we are delivering services to Māori in a marae-based setting and there is a Māori nurse there, we are more successful. (Manager, Māori PHO)

There are some Māori staff but we need some succession planning to see them start to move into management. (Māori board member, small Interim PHO)

PHOs serving migrant communities need interpreters and health promotion skills in both practices and the PHOs

The development of new services, or new types of activities (such as health promotion, management of continuing care) sometimes involved new sets of responsibilities for which staff may have been unprepared. While most discussion centred on the development of nursing, a few PHOs also acknowledged, the lack of preparation for the widening roles of general practitioners.

Lack of capacity: PHOs indicated that the amount of work generated through increased enrolment, new programmes and additional paperwork was difficult to be managed with current resource levels. For example, one PHO reported an increase in enrolment of 10,000 people, but no increase in the number of doctors and, despite increases in nursing personnel, still not enough nurses for the work to be done.

> *The biggest problem is the fact that utilisation has gone up what was a busy place is now a place resembling a train wreck. From a personal point of view work has got substantially more stressful we're always just holding our head up I can't see that improving anyway quickly because of problems with workforce retention. (Manager, medium-sized Interim PHO)*

> *But [there are] not enough nurses, and [we] can't take advantage of the opportunities that the PHO is offering [for nurses]. (Manager, small Interim PHO).*

PHOs also expressed concern at lack of capacity in traditional general practice premises to deal with increased service activity, particularly expanding nursing roles:

> *The premises weren't designed for more comprehensive approaches to primary health care. Some practices have rebuilt to deal with this, with nurse consulting room. (Manager, small urban Interim PHO)*

Recruitment and retention of GPs and nurses: Several PHOs commented on the ageing of the general practitioner workforce and the difficulties of recruiting in "high need" areas, both urban and rural. This created the prospect of closing registers or leaving communities without services. There were examples of this in urban areas, but most concern was expressed about the difficulties in rural areas where PHOs reported additional issues, such as the needs of families of practice staff, the wide scope of practice and uncertainty about "on call" responsibilities, as barriers to recruitment. Only a minority of PHOs (9/44) reported providing locum doctors although a further six were assisted in this by their MSO and eleven expressed an intention to become involved at some point. Slightly fewer PHOs reported either current or planned involvement with nursing workforce management than reported involvement with arranging locum GPs.

PHOs reported that some areas had difficulties in recruiting and retaining practice nurses. While nurses were encouraged by recent pay rises and new roles, some PHOs experienced difficulties because of local workforce shortages or because of the still more attractive hospital salaries. One PHO specifically commented on the lack of experience of some nurses, indicating that this was a special issue for primary care:

> *[Practices] are overwhelmed about what it means to have to try to get a novice into their practice and having to orientate them from the start. And they have to deal with high turnover because nurses now have so many choices. (Nurse board member, IPA-based PHO)*

Strategies for workforce development

Recruitment initiatives: Through the interviews only a minority of PHOs reported being actively involved in the recruitment of doctors and nurses, indicating that this was a practice responsibility. However, in the survey 26/44 reported some involvement in recruitment activity of some kind, with specific examples given:

> *We went to the UK Expo and we advertise internationally. [We] don't poach locally. If you start campaigning in New Zealand you're stealing from each other. (Manager, IPA-based PHO)*

> *The PHO has become involved in supporting overseas doctors to become registered and then work in PHO practices. (Manager, small Access PHO)*

One PHO reported an increase in trainee nurses wanting to experience work in the community, and the importance of promoting primary care in the nurse training setting and providing information on the opportunities of working in the community.

> *The last two elective placements have seen 30% of nurses seeking [community] placement, whereas it's usually 5% wanting community placements. Not sure how to explain it, but we have worked very hard at promoting primary care nursing and the organisation to students, really selling the community as a exciting career choice with opportunities for new roles in the future. (Nurse board member, IPA-based PHO)*

> *We have a primary care internship programme for new graduate nurses – and more recently a programme for nurses wanting to move from hospital or other areas into primary care. The practices that are short of nurses do not have the time and capacity to take on people who are new to primary care. You cannot take on people with minimal training and drop them into practices like that where nurses have a lot of responsibility. Everywhere we can train someone we do. (Nurse board member, IPA-based PHO)*

PHO management of workforce issues

Being generally supportive of practice personnel was seen as a valuable stance to take by PHOs, instilling confidence in the PHO on the part of practices, as opposed to *"a PHO going in a different direction from its providers"* (Manager, small IPA-based PHO)

PHO involvement in facilities' ownership and employment: Among PHOs that were engaged in workforce initiatives, a few reported efforts to create a satisfactory work environment as a method of supporting recruitment and retention, with some indicating willingness to own facilities and employ staff, including GPs, directly. In the survey only 9/44 PHOs reported directly employing doctors in clinical positions. One PHO reported that previous difficulties in recruiting Pacific doctors and nurses had been resolved because new personnel were "attracted to the salary option". Another PHO reported investigating the feasibility of PHO family medical centres, with salaried GPs and nurses.

> *Salary options could be attractive to new doctors coming into practice and those looking towards retirement. We need to hang on to the GPs that we have and give them some semi-retirement options. (Board member, IPA-based PHO)*

The option of practice nurses being employed directly by the PHO rather than by individual practices was also raised, with arguments presented both for and against this. In the survey, 18/44 PHOs reported directly employing nurses in clinical positions (although this may not have been as practice nurses). In the interviews, one PHO reported that a possible option was direct employment of nurses to undertake work in the community that local GPs were not interested in being involved in:

> *We can try and change these attitudes and if it doesn't work we need to think about employing nurses through the PHO to do some of these things in the community. (Manager, small PHO)*

The provision of practice premises was also reported as assisting with recruitment and retention, particularly in rural areas. However, most PHOs were clearly reluctant to become involved in the provision of facilities. Others, particularly in rural areas, were more willing or saw themselves as in a "brokering" role, encouraging local authorities to make premises available (Manager, medium-sized PHO)

PHO facilitation of workforce changes: There are new and specific roles that some PHOs are undertaking because of their responsibility to ensure access for their enrolled populations. For example, if a practice closes, a PHO might recognise the need to find a systematic way of ensuring that the patients from that practice are enrolled elsewhere. One example was cited:

> *We had a practice that closed down recently, the doctor couldn't sell and had to close the doors. There were a large number of patients but the neighbouring practices were already full. It's an indication of the type of pressure points on primary health care. In the next couple of years there could be as many as 5[or] 6 practices in the city close down, and there are some practices with the capacity to pick up people, but it will mean making better use of practice nurses and other nurses to make sure everything gets covered and to make sure that doctors will be able to stay in the system. (Manager, IPA-based PHO)*

Managing the nursing workforce: One PHO reported maintaining a register of nurses so that practices could fill both short and long-term staffing needs more expeditiously. Another PHO reported a regional approach to nursing issues through a regional committee:

> *There is a regional nursing committee which covers all our PHOs and a workforce development manager who has just started. [The committee] develops nurses already on-board in their roles and helps them communicate back with other nurses – and to give advice to the PHO boards from a nursing perspective. (Nurse board member, IPA-based PHO)*

If the option of directly employing nurses is developed, the PHOs will clearly widen their scope of workforce activity.

Development of the community health worker (CHW) role: There is strong support across many PHOs for the development of CHWs. Already they were being characterised as *"now seen as part of the structure"* and working closely with practices, part of the PHC team and not on an independent basis. Informants were not explicit about employment arrangements, but a model whereby CHWs were employed by PHOs or MSOs and either assigned or sub-contracted to practices was mentioned.

CHWs were already undertaking important roles in support of existing practice efforts or in developing new areas. The most important area of work was supporting efforts to improve access. They were characterised as *"connecting with "missing out" patients", "bringing people in"* and *"working alongside practices"*. CHWs work primarily in high need neighbourhoods, but there was no indication that they were working independently of practices, or that there was any effort to "*draw a line between health and social work"* as one DHB was reported as wanting. Overall PHOs reported CHW's to be "and important part of our structure".

Besides services to improve access, areas where CHWs were already or could potentially be involved included the development of integrated care, facilitating work with midwives and supporting clinical nurse educators. One PHO had specific plans for CHWs to be involved in healthy eating/healthy activity programmes.

The acceptance and involvement of community health workers reflects a broader approach to primary care that extends the idea of teamwork beyond the practice team to include other local resources.

Training and development

Nurse training and development: Many PHOs identified the development of the nursing workforce as critical for addressing the widening scope of primary care, and for taking the opportunities offered by new funding streams. In the Survey of PHO Managers, 32/40 PHOs reported undertaking continuing nurse education (CNE) activities for nurses. Some smaller PHOs reported that they can gain access to training through larger PHOs in their region. Historically, IPAs have played a large role in the continuing education of nurses – and PHOs associated with IPAs are building on this, with MSOs and IPAs continuing this role on behalf of the PHO.

> *We do send our nurses on all the courses that are available The MSO provides them for nothing; we pick up [the time] at this end. We have six nurses: they do not do it in their own time. And we pay for some courses. (Manager, IPA-based PHO)*

> *Up to now it's the IPA that has taken on the responsibility for the development of nursing. I hope the PHO will be able to continue with this. (Nurse board member, IPA-based PHO)*

One PHO recognised that while the role of nurses was widening in the PHO environment, there was a need for nurses to develop *"bigger picture thinking".*

> *Would like, however, to see nurses become more proactive and confident in the way they practice. For too long the now, the nurses have become dependent on the GP around them…In the PHO, initiatives such as nurse vaccinators are small steps but can be seen as giant steps, as now we are able to go out to our client group who are not bringing their babies for vaccination. Another vision is to see the development of nurse practitioners within the PHO, and the mentoring process for them to have prescribing rights. (Manager, small Access PHO)*

Another PHO reported that the introduction of the nurse practitioner role could be important but indicated that the current model needs more flexible implementation and recognition of accumulated experience in practice, issues to be addressed at a national level. Some PHOs have offered scholarships for nurse training, with this seen as part of a wider effort to develop local the local workforce.

Promotion of teamwork: Some practitioner/manager informants saw teamwork in a relatively narrow way. This reflected a quite limited view of teamwork, confined to the functioning of the practice team, particularly the working together of nurses and doctors. Within this the development of the nursing role was seen as an *"extension of what we are already doing".*

> *The PHO is on a journey, and an enhanced role for nurses is the way ahead. (Manager, IPA-based PHO)*

While there was broad agreement over the importance of developing nursing roles, many nurse and doctor informants reported a broader or more critical view of teamwork.

> *To me it is the most appropriate person doing the job, utilising the capabilities of each member of the team … complementary rather than substitution. (Nurse board member, IPA-based PHO)*

This perspective was extended further by board-member informants, who generally had a strategic view of what teamwork meant: they agreed that it was an important component of the Strategy and that it could make an important contribution to the work of the PHO, in both clinical and non-clinical areas.

In the case of clinical practice, board-member informants saw teamwork as extending beyond simple working together within a practice setting. For example, they saw it as involving specialisation of roles where practices were large enough to allow this.

> *It's the bigger practices that are making most changes. It's easier when there are enough people to be able to specialise. (Manager, IPA-based PHO)*

It was noted that some practices had not moved away from a limited model of teamwork either because of shortage of resources or conservative attitudes. Despite varying views on teamwork, in the survey, 42/44 PHOs reported being involved in promoting teamwork and improving practice processes, largely on their own account (35) but with seven working through their MSO.

Teamwork was seen as being able to maximise the value of existing resources. One DHB manager commented that historically highest levels of teamwork had been among Māori and rural providers, compensating for the shortage of GPs in those areas.

> *Māori providers have fewer GPs and thus they have been more innovative about teamwork. (DHB manager)*

One Māori PHO reported that, with increased workload and growth, nurses had become more specialised.

Board-member informants also saw the team as extending beyond the practice with involvement with NGOs, district nurses and other primary care providers, such a pharmacists and midwives.

> *Within the general practice setting we have social workers, whanau workers, community health workers, and also expertise sitting outside (e.g. drug and alcohol unit, mental health promotion, domestic violence provider). The skills and team-based work styles are there, but there is much more we can do to improve in this area. (Manager, IPA-based PHO)*

The importance of collaboration across, as well as within, practices was mentioned by a number of informants. One urban PHO reported considering the development of "virtual" teams, relying on IT to facilitate working across practices and sharing skills across the whole population.

The significance of teamwork for non-clinical aspects of the PHO was also commented upon. In rural areas, for example, an emphasis on teamwork was seen to "*make the lives on individuals much easier, prevents isolation and support for rural GPs".* Where PHOs serve high needs populations it was reported that stress on staff can be alleviated by teamwork. Governance itself was also seen as a fruitful area for the development of teams, bringing together management, clinical and Māori perspectives. (Board member, Māori PHO)

5.2 Service Development

5.2.1 PHO Role in Service Development

A strong majority (75%) of PHO Board Member Survey respondents acknowledged that one of their main roles was the development of new services, and that they personally appreciated the opportunity to be involved in this work. Most respondents to the PHO Managers' Survey (39/44; 89%) reported developing new programmes within the PHO itself, with two using the MSO for this purpose and three having the intention to become involved in service development in the future. PHOs, through their boards and management, have important roles in relation to service development, including understanding the needs of the community, strategic decision-making/planning; securing resources and infrastructure, service advocacy and programme implementation.

5.2.2 Understanding the Needs of the Community

PHO boards in general recognise the importance of good information in understanding community needs. A majority of PHOs, through the PHO Manager Survey (30/44; 68%), reported being involved in needs assessment on their own account, with a few assisted by their MSO. Board members surveyed rated the performance of both PHOs and MSOs highly in terms of undertaking needs analysis (on a five-point scale, 1=poor; 5=good, as 3.7 and 3.3 respectively). Of the respondents to the PHO Board Member Survey, 86% reported that needs analysis reports were one way in which they obtained information about community needs, with other methods (such as informal contact, community meetings, DHB reports) reported less frequently.

The PHO Manager Survey elaborated on the approaches to needs analysis, with 28/44 (64%) reporting that they compared their own population with the census, with 31/44 (70%) reporting community or iwi involvement. Smaller numbers reported undertaking community surveys (11) or formal focus groups (16), with 7 reporting other mechanisms, particularly the use of hospital data.

Reports from interviews indicated that complete enrolment is recognised as essential to providing a community profile based on age, sex, ethnicity and deprivation, with the proportion of people for Māori, Pacific and migrant communities being particularly important. For example One PHO reported surprise at the high proportion of Asian people on its enrolment register and expressed an intention to address the needs of that group.

In terms of other information for service development, PHO informants expressed disappointment over the limited data available on services and outcomes. As new programmes, such as Diabetes Get Checked and Care Plus develop the information associated with these was expected to be of more value. One PHO, however, reported comprehensive data capture by its MSO on both cardiovascular disease and diabetes.

Besides relying on the collection of routine data, several PHOs reported on the importance of getting ideas directly from the community, either via public meetings or hui, or from representatives on the board.

> *Community reps generate new views leading to some changes. … Yes, it has been [to have community reps]; you certainly get a different point of view, which is great. (Chair, IPA-based PHO)*

> *The idea emerged in our Pacific community and came to us through our Pacific representative. The board has supported it. (Manager, IPA-based PHO)*

In addition to "getting ideas" several informants noted the importance of Māori and Pacific board members in encouraging cultural awareness:

> *It's got to happen from the board down and if it challenges a few people in their philosophy, well, so be it. We have to get our own house in order first. (Chair, IPA-based PHO)*

5.2.3 Strategic Decision-Making and Planning

Most PHO Board Member Survey respondents felt well served by their PHO or MSO in the development of plans, rating them on average 4 and 3.6 respectively on a five-point scale (1=poor performance, 5= good performance). Interview informants generally recognised the role of PHO boards in setting direction and determining how resources are allocated. Some PHOs were more specific with two small PHOs, for example, indicating that the board *"sets targets for population health",* and may *"guide and steer the PHO"* or *"test proposals against strategic direction.*

PHO boards were seen as being able to develop and maintain what was characterised as "*the wider vision"* or *"big picture management"*, an example being the important link between health promotion and chronic care management. PHOs were also reported as having the vision and standing to collaborate with other PHOs, with NGOs or specialist services.

Some notes of caution were expressed by interview informants and PHO Managers concerning the role of boards in strategic decisions. One small PHO reported a limited role for the board, citing few resources and overstretched individuals, and indicated that the board was seeking support from an MSO. Several boards reported a need not to take on too much early on and to be aware of any "strings" attached by funders.

In another instance a non-board GP expressed concerns about "lay high-jacking" of PHO boards:

> *There is always the constant fear that our surgeries could get hijacked by the lay component of the PHO administration. The last thing you want, without a strong GP voice, is the lay component telling you how to run your practice. (GP board member, IPA-based PHO)*

5.2.4 Securing Resources and Infrastructure

Some board members and managers indicated that PHOs had an important role in ensuring both infrastructure and resources for services. One informant noted that if the governance structure was robust, then this would be more attractive to DHB as funders.

> *For the first time with PHOs and the structure and organisation of primary care, there is the ability to put additional resources in for service development. [This] wasn't there before because there was no structure. (Manager, small IPA-based PHO)*

In terms of acquiring resources for development, a number of informants pointed out the importance of accurate and updated registers with Māori and Pacific enrollees carefully identified, because of the impact on funding. There was a suggestion that some difficulties arise because the mechanism for generating additional funding (practice-based enrolment profiles) were not necessarily reflected in the way that PHOs actually disbursed funds. This was identified as a possible source of tension between PHOs and practices.

The rapid growth of activity in PHOs was seen by many interview informants to pose a risk to the stability of the infrastructure.

> *We need adequate administration and reporting support to do the high-level collaborative stuff. The whole organisational structure has to be resourced appropriately. (Manager, Māori PHO)*

5.2.5 Advocacy

PHO boards and individual members were seen as having an important role in advocating for community needs. Māori and Pacific members were identified as having particular roles, but all board members were seen as needing to "stand up for" identified needs. A wider advocacy role was noted where PHOs perceived flaws in services or policies that required DHB or national intervention. For example, one informant reported that the PHO needed to advocate with the Ministry for changes to maternity services.

5.2.6 Programme Implementation

PHOs were identified as important contributors to the successful implementation of programmes. There was a need to ensure that practices had the tools for implementation, particularly in complex programmes such as chronic care management, including access to electronic templates, and the PREDICT and asthma assessment decision tools. Some PHOs noted the importance of their MSO in ensuring the availability of training, support and infrastructure, and evaluation.

Several informants reported the importance of "bringing the practitioners along" and that PHO boards had a role in *"getting GPs and the rest of the organisation working as one."*

5.2.7 Service Development Initiatives

Improving access to core consultation services

Improving access to practice services*:* Services to improve access (SIA) has been the funding mechanism designed to bring improved access to core consultation services. Through the interviews PHOs reported a variety of strategies suited to local needs, including lower fees, additional nurse consultations, use of interpreters, longer consultations, telephone triage, the extension of practice hours and the involvement of community health workers. One rural PHO had funded after-hours nursing triage to support after-hours GP cover.

Some PHOs or practices have concentrated on specific target groups, such as Māori or Pacific people, by developing the appropriate workforce. Increased rates of enrolment, consultations and increased workload overall have been reported by some PHOs. Improvements in access are not always dependent on additional funding, but are associated with improved understanding and a more receptive environment.

> *Although we have a small Māori and Pacific and disadvantaged community it is something we have to give voice to and action to. They have distinct needs which we may not be meeting. One GP) said "I treat all patients the same". I said "we cannot treat all patients equally until they are equal", which gave him pause for thought. An outcome has been that we are having a cultural awareness training day next month … I have told the receptionists [in the PHO's practices] that if a Māori person asks for an appointment they have reached out to us and we must meet that need so if there are no appointments you may need to double book…. It's positive discrimination. If the new Zealand public had even a whiff of the reasons for these severe and worsening inequalities they would never have torpedoed the "closing the gaps" initiative. It's an area which is occupying a lot of my time and a lot of the board's time. (Manager, Small Interim PHO)*

Outreach services*:* Some PHOs and practices have moved beyond improving access to services only at the practice, and now provide a range of alternative venues and opportunities. Generally these services are characterised as "outreach", for example, clinics for migrants, school-based clinics, marae services, free-health checks. Other aspects of improved services involve additional components, such as the co-ordination of nursing, a "wellness" office, a "Pacific Village nursing services and a variety of other ways of making access to core consultation services easier and more attractive to particular segments of the community.

"Adding value" to core consultation services

PHOs are expected to develop a more comprehensive range of programmes, particularly to prevent or manage chronic conditions as part of the Strategy. There is strong support for these goals and many practice teams are undertaking additional roles and more complex cases. The main areas have been the management of chronic conditions and addressing mental health problems in the community.

The Care Plus programme has provided significant additional resources and a framework for practices to provide more complex care. One PHO board member commented that Care Plus had made individual providers more aware of their responsibilities to this population and that it had been *"excellent"* and *"led the way."*

Not all informants were equally enthusiastic about Care Plus. Some reported it as bureaucratic and administratively cumbersome, with inadequate resources for the task. Some DHB informants confirmed general concerns on the part of PHOs over the capacity and resources available to sustain the advancement of chronic care management projects.

While scepticism was expressed by a number of PHOs about the sustainability of Care Plus, one PHO informant made a more general point about the problem of making decisions to take up funds for new programmes:

> *Any new programme/initiative that is introduced by government often requires a [cost-]benefit analysis to confirm benefits to the recipients of the services with the confidence from all participating stakeholders that there is real value in the product. Therefore such schemes may at times require testing the waters to confirm [their] worth and value. (Manager, IPA-based PHO)*

Health promotion: At the time of this research, health promotion was not well developed in many PHOs. It was acknowledged by a number of informants as a new area for primary care, with the limitations on resources, including available skills, a major challenge.

In terms of health promotion programmes, there was a clear recognition by some PHOs or practices of the importance of health promotion for addressing inequalities and for the management of chronic conditions such as heart disease and diabetes through lifestyle change. Smoking cessation therefore became an important focus for several PHOs, along with fitness initiatives

It was clear that some PHOs were taking a strong community approach to health promotion, working via existing structures such as Pacific churches and other local organisations, including NGOs. PHOs recognised the need to be pro-active in health promotion, despite the limitations imposed by shortages of resources and skills. Working with other PHOs, in both rural and urban areas, was noted as an effective way of maximising returns.

Challenges and limitations

Despite a strong majority of PHO Board Member Survey respondents (77%) reporting that their board had been able to influence the activities of practices to a desirable extent in introducing new programmes, interview informants indicated two major areas of constraints that provided service development challenges to PHOs: the capacity to do the work at all due to issues such as space or workforce, and the tension between a "general practice" and wider "PHC" view of PHOs.

Capacity: As noted above, PHOs had reported on the stresses the implementation of programmes had created. Small PHOs reported a need for greater resourcing and support and sometimes this was provided by the local DHB or other larger PHOs. Working across PHOs is becoming an increasing feature of service development. While only two of the 44 respondents to the PHO Manager Survey reported that their PHOs were considering uniting with another, 21 (48%) reported considering sharing services with other PHOs and 12 (27%) were considering engaging an MSO. Larger PHOs with a supportive IPA infrastructure also expressed concern over lack of capacity.

It's lack of capacity that stops us from doing more. Everyone is really, really busy and often we have unrealistic expectations. We [the PHO] get really excited about something but then have to be realistic about our ability to deliver this on top of what's already being done. The day-to-day work doesn't go away; and it's not just about money, but about getting more skills and capacity in the workforce. (Manager, IPA-based PHO)

We need adequate administration and reporting support to do the high level collaborative stuff. The whole organisational structure has to be resourced adequately to support [access initiatives]. (Manager, Māori PHO)

The PHO has taken on so much in such a short period of time - e.g. SIA, RICF, health promotion, performance management, enhanced management, Care Plus, MenzB immunisation. We are expected to pick up and run with it all and have systems that accommodate that. (Manager, Māori PHO)

Population and other approaches: A number of informants referred to the speed with which PHOs had been implemented, the important tasks that had to be done to ensure proper enrolment, and the lack of time to prepare general practice teams for the philosophical shift to a more inclusive and population-based approach.

While many informants acknowledged the progress made in this area, and the importance of both SIA and health promotion funding in "broadening the horizons of practice teams", there were indications that there were some tensions between the more narrow general practice and wider PHC perspectives.

There will always be a tension until GPs see the potential of [the Strategy] and accept it wholeheartedly, rather than having it forced upon them. There has to be a sea change in both GPs and clients to embrace the wellness model. (Manager, IPA-based PHO)

One GP board member expressed it thus:

There is always a constraint that our surgeries could be hijacked by the lay component of the PHO administration. The last thing you want is the lay component telling you how to run your practice. They could pass all sorts of things that were not practical in running your practice. (GP board member, IPA-based PHO)

The issue is well summarised by a DHB manager:

We need to acknowledge that PHOs have to pace themselves in order to take GPs along with them – we have not paid enough attention to process.

5.3 Summary

Key areas for decision-making in PHOs relate to ensuring access and the availability of suitable workforce. Decisions regarding fees were viewed differently by PHOs, with Access PHOs taking a more active role to ensure low fees. IPA-based PHOs, however, while ensuring that increasing subsidies were passed on to patients, also saw their responsibilities as supporting general practice as a viable business.

PHOs were ambivalent about their role in relation to the primary care workforce, with many reluctant to become involved, but recognising that there were important issues to be addressed. PHOs identified specific issues (eg. workforce monitoring, skill shortages) and a number reported initiatives already under way (eg PHO involvement in facilities management, development of new roles such as community health workers, training, and promotion of team-work).

In the area of service development PHOs identified their role as including needs assessment and strategic decision-making, securing resources and infrastructure, advocacy and programme implementation. They reported a range of initiatives, including improved access to services, providing outreach and health promotion. They identified problems of capacity, differences in philosophy and the stress of rapid growth as issues associated with service development.

6 PHO RELATIONSHIPS WITHIN THE HEALTH SYSTEM

The Strategy established PHOs as new institutions within the health system, with collaborative relationships with other parts of the sector. The key relationships are with DHBs, other PHOs, with MSOs and with other agencies in the community.

6.1 Relationships with DHBs

In the early stages of PHO formation the role of the DHB was limited and the first *Evaluation* report (Cumming et al. 2005) did not comment on this. More recently from the data collected in 2006, PHO managers, board members and a variety of PHO interview informants reported on issues relating to relationships with their local DHBs. In fact, 73% of respondents to the PHO Board Member Survey indicated that communicating with the DHB is an important role for boards. Informants described some initial struggles in PHO-DHB relationships but many reported significant and continuing improvements. Generally, relationships were categorised as maturing and developing, as the PHOs and DHBs gained more understanding of their respective roles and the levels of interaction with each other increased.

6.1.1 General Working Relationships

Ninety-one percent (40/44) of the PHO Manager Survey respondents reported that the PHO itself undertook all necessary liaison with DHBs, with only four delegating this task to the MSO. PHO views were highly polarised when commenting on their relationships with DHBs. Interview informants identified and acknowledged the presence of many constructive and supportive PHO/DHB relationships and avenues for advancing and nurturing these; others were critical of DHBs' management of the relationship.

On a positive note, one IPA-based PHO detailed how its relationship with the DHB had significantly improved in the previous 18 months as the two parties developed more understanding of each other through a PHO/DHB strategic group, which united both parties in the interests of achieving better health outcomes:

> *We now complement each other in what we are trying to achieve with regard to health outcomes. (Manager, IPA-based PHO)*

A Pacific PHO reported an excellent relationship with the DHB, and expressed admiration for its support and encouragement. Informants described taking part in regular monthly meetings with the DHB to discuss new projects and emergent issues. They also detailed receiving DHB support to establish systems to implement new projects.

> *The relationship between us (DHB and PHO) is good. We usually have a monthly meeting and look at new programmes coming up, any issues arising. (Manager, Pacific PHO)*

Managers in both an IPA-based and a Māori PHO described positive and solid relationships with their respective DHBs:

There is a pretty good relationship with the DHB. There is a lot of dialogue, so that is very positive. (Manager, IPA-based PHO)

We have absolutely solid working relationships with the DHB. (Manager, Māori PHO)

DHB informants confirmed that they had worked hard to develop harmonious and respectful relationships with their respective PHO community and that compromises had been made to ensure this.

We have a good working relationship … and we try and work in a respectful way, to their issues. We do not always agree but can discuss. (DHB manager)

The DHB team works really hard to form relationships with the providers. [You} cannot manage contracts and get good outcomes without harmonious relationships. Compromises have to be made to maintain the relationships. (DHB manager)

Despite the evolving and improving relationships between DHBs and PHOs, a number of other interview informants advised that there was some lack of understanding and support of the Strategy by DHBs. Further it was noted that when that understanding did exist, there was a lack of focus on the Strategy, with the perception of a continuing emphasis on secondary care. It was suggested that this arose because of different political and philosophical standpoints. One PHO felt it was imperative that the funding body was clear about the national direction and always acted in pursuit of that course. Another advised that better understanding and support of the Strategy would improve PHO/DHB relationships and drive the Strategy.

They [all the PHOs] are driven by different political and philosophical standpoints. The DHB have little understanding of the [Strategy's] direction so often no one is driving the Strategy. (Manager, IPA-based PHO)

Other IPA-based PHOs also reported that the DHB appeared to have a limited interest in or understanding of the primary care configuration, and little trust in PHOs.

They [the DHB] don't understand the sector and more importantly, they don't think they need to understand. We have a tight PHO group and a DHB that can't always relate to us or manage primary care effectively. (Manager, IPA-based PHO)

I don't think that the DHB boards understand what we do, but maybe they don't have to and a little bit of trust is what's required. (Chair, IPA-based PHO)

6.1.2 Relationship Processes

Support and collaboration

A number of interview informants with direct experience of DHB relationships categorised these as being supportive, constructive, flexible and collaborative, but some also acknowledged that the experience of other PHOs may not be as positive. For example:

Generally they [the DHB] are very supportive, knowing the problems that have occurred [elsewhere]. (Manager, IPA-based PHO)

We have a constructive relationship with DHB, one of the better in the country. Largely about people, long history of organised general practice, ….. other PHO managers in the DHB area also been around a while. We understand their issues. (Manager- based PHO).

PHOs need to work collaboratively with DHBs. We do here, but this is not the case all around the county and I hear some horrendous stories. (Chair, IPA-based PHO)

We are one of the lucky areas in terms of the interest and support we get from our local DHB. (Chair, small PHO)

This diversity of experience is reflected in responses from the PHO Manager Survey. On the scale from 1 (very poor) to 5 (excellent), the average rating that managers assigned to their DHB's performance on clarity of expectations (3.19), promptness of response (3.19) and supportive process (2.95) were not much above the mid-point (2.5) – and there was a wide variety of individual ratings. This is similar to the reported perceptions of respondents in the PHO Board Member Survey, who on average rated the degree of support that their PHO had received from its DHB at 2.96 on a scale of 1-5 (again with a wide range of individual ratings).

Formal contacts

Informants reported regular contact and relationship building between the DHB and PHOs by various means, including regular joint meetings, PHO/DHB strategic groups, and joint forums. Some DHBs reported on their early leadership role in these initiatives:

We run a PHO forum every month. You don't want them all doing different things; you want co-operation. They also have a PHO forum without the DHB – there is dialogue. This board has a very good primary care person; but the provider arm is not that flush. (DHB manager)

We have a PHO advisory group, with [the] DHB CEO chairing, meeting every 2-3 months. We have decided to have a whole-day meeting to agree strategic priorities for next 3 year phase. We work with each board at least once a year before we move into the next contracting round [and] we meet with the management to complete that. (DHB manager)

DHB from the start brought the PHOs together. All meet each month with DHB, hash out stuff. So PHOs work together, and sit around in an equal relationship. (Chief executive, large IPA-based PHO)

Contact with DHB planning and funding

Among informants PHO chairs specifically acknowledged the importance of "high level" governance and management interaction between PHOs and DHBs.

[We] have a high level of contact at officer level and at chair level. Therefore [we] have access to appropriate level of people in the DHB to discuss issues and concerns. Very helpful and accessible generally. (Chair, small PHO)

Senior DHB staff member to attend next PHO board meeting to talk issues through. (Manager, small PHO)

While governance-level contact was considered important, most day-to-day contact was reported to be at management level.

We have a good working relationship with the DHB planning and funding arm. (Manager, small PHO)

It's my job to deal with the DHB, to get on with planning and funding [personnel in DHB] … to talk to them honestly. And we raised lots of things. (Manager, small Interim PHO)

Have plenty of contact; [the DHB] contract manager attends [our] meetings. She has reporting requirements further up and when we are a bit slow she will rattle our cage. We couldn't function without them, but they do require a lot of reporting. (Community board member, medium-sized PHO)

The CEO communicates with the DHB on behalf of the PHO, and [the DHB portfolio manager] is extremely helpful and very open. During the establishment process we had (name), and that, too, was all very, very well done. (GP board member, medium-sized PHO)

Many PHO informants reported the importance of contacts with the planning and funding arm of the DHB. But some also mentioned building working relationships with other areas of DHBs:

The PHO is doing a lot of work to try and build relationships with a number of core business areas within the DHB. (Manager, small Māori PHO)

The manager in a small rural DHB also reported that its PHO had begun to build a working relationship with the secondary care rural mental health teams who had been supportive of the PHO mental health demonstration model.

Conflicts of interest

Suggestions of conflicts of interest were more likely to be reported by small PHOs. For example, informants in a small Access PHO and a Māori PHO were concerned about the potential for the DHB to have conflict of interest in its role both as funder and provider of services. They reported that the PHO primary care services were in competition with the other DHB primary care services. Concern was expressed that this could lead to funding packages for PHC being open to vested interests. It was felt that not only would the PHO be in competition with DHB funded primary care services, but also with the DHB secondary care service priorities.

Informants considered that a way to transform this potential conflict of interest into a positive situation would be for DHBs to consider and use integrated approaches to PHC provision. It was suggested that by using its funding and provider capability and capacity across the primary/secondary interface, the DHB could do more..... to integrate GP and primary care services.

Recognising and valuing "difference"

Informants highlighted the importance of the DHB valuing "differences" between the PHOs in terms of their potential. DHB understanding of the PHOs, the PHC sector generally and the direction of the Strategy were also deemed essential in promoting collaborative PHO/DHB relationships.

Informants from a Māori PHO outlined how they felt the DHB lacked understanding of how their PHO functioned and that this was reflected in their funding situation. They considered their funding reflected neither the needs of the PHO nor its longer-term capabilities to deliver innovative primary care initiatives such as a nationally acclaimed family care programme.

> *Part of our problem is that we are different and they don't really understand how we function and they don't bother to come and find out. We have to get our funding through them but they want to fund us on what they think we should have rather then what we need for what we do. (Manager, Māori PHO)*

Informants from a small Access PHO also reported that they had had few expectations of the DHB supporting them and recognising the value of their contribution to health care. They explained that it was difficult for the PHO to reveal any difficulties in meeting contract requirements to the DHB for fear that such revelations might affect their chances of receiving future funding.

> *We talk with the DHB about contracts, we enforce our funding agreements with them.. Do they understand us? The struggles? Probably not. They are the funder: that is the relationship. (Manager,, small Access PHO)*

A contrary opinion was expressed, however, by two PHOs which specifically acknowledged that the DHB understood their unique character as PHOs. A small Māori PHO detailed that the DHB was very understanding of the "limitations" of a small PHO and that DHB personnel were very accommodating in working with them. They also felt that their Māori perspective was valued. One chair also reported that:

> *They [DHB personnel] understand we are different and do our best for us and they chide us when we don't do things on time, but on the whole it's very good. (Chair, medium-sized Interim PHO)*

The impact of PHO size on relationships with the DHB

Some interview informants reported differing views on the attitudes of DHBs to PHOs of varying sizes. Issues were identified, for example, by both a large and a small PHO. An IPA-based PHO reported that they perceived the DHB acted to support the largest PHO in the area, even when this direction was, in the PHO's opinion, contrary to the direction of the Strategy. To support this view, they reported that a large PHO had recently been funded to deliver a supposedly innovative service, but in fact the PHO proposed a GP focused service delivery model and requested a third of the funds be devoted to managing the service:

> *Our relationship with the DHB is tenuous. This proposal did not include any other services; it was purely dollars to GPs and 33% of the monies going to the PHO to run it. We cannot agree to that but the DHB has signed the contract. (Manager, IPA-based PHO)*

The PHO informants considered that this decision reflected a poor understanding by the DHB of the Strategy. They considered that conflicts such as this arose because of different political and philosophical standpoints. Therefore it was imperative that the funding body was clear about the national direction and always acted in pursuit of that course.

A contrary opinion was expressed by another IPA-based PHO which considered that their DHB had favoured a small Access PHO:

> *One problem we have as a large Interim PHO is the constant favouring of the small Access PHO to the point of obsession… favouring in numerous ways… it's intensely frustrating. (Manager, IPA-based PHO)*

Informants also emphasised the size-related pressure on small PHOs. One small PHO noted there was pressure on the smaller PHOs to demonstrate capacity and capability because many believed that smaller PHOs would not survive. This pressure itself created tension in the PHO/DHB relationship. Another small Access PHO, however, perceived that the DHB was very supportive of the smaller PHOs' continuance.

> *{We] have a very good relationship with the DHB, especially through the work of the PHO manager. This is a critical relationship. [We] feel very supported by the DHB as a very small PHO and that the DHB wants the PHO to continue. (Manager, small Access PHO)*

6.1.3 Strategic Decision-Making

Autonomy in decisions

Informants commented about the need for greater autonomy and flexibility in their relationships with the DHB.

> *If they want us to be a community-based organisation they have to give us more autonomy. DHB community services could well be provided through the PHO. (Chair, small PHO)*

The chair of another small PHO considered that PHO money came with "many strings attached" and that this situation *"smells of not wanting the PHO to be a sovereign organisation and represent the community".*

A GP board member in a large-IPA based PHO considered that its DHB was administering PHC largely in a manner prescribed by the Ministry and that often the rules lacked "flexibility and sensibility". This board member felt that, rather than the PHO and DHB acting in partnership, the DHB was seeking to impose a form of health service that reflected policy removed from the "coalface" where the service is delivered.

It was acknowledged, however, that generally this DHB was more responsive and supportive of GPs than was believed to be the case in other areas – where it was reported that direct consultation with GPs had largely disappeared and had been replaced by consultation with the PHO.

A community board member from an Access PHO articulated a concern that the PHO was being dominated by the DHB and the MSO as its agent. There was a concern that the PHO was simply "rubber stamping" decisions which had already been made by the DHB. It was reported that the PHO had not been involved in the strategic planning process and that the PHO was responding to a direction decided by the DHB/MSO. There was concern that the PHO in question had moved away from an initial health promotion/public health approach for which it received central government accolades, by requirements of the DHB.

The chair of a small Interim PHO also highlighted concerns about the decision-making capacity of the PHO board in its relationship with both the DHB and its own manager. The chair considered that manager might be unduly influenced by the DHB with the PHO sometimes being "short circuited" as the manager brought "fait accompli" decisions to the board. It was suggested that the PHO itself should engage with planning and funding at a senior level on strategic issues.

Consultation and information exchange

Consultation and information exchange was managed differently in individual DHBs, but in general communication was reported as open. One DHB manager indicated that the DHB would like to build linkages with individual PHOs in different ways to take account of their different structures and staffing levels. This, however, would have major capacity issues for an already stretched DHB planning and funding. The future intention of this DHB was to maintain and enhance "partnership relationships" with PHOs whilst maintaining some flexibility.

Sometimes relationships were more difficult. Informants from a small rural PHO noted the need for timely information exchange and consultation by the DHB to enhance decision-making. They reported frustration over the response time that the DHB took to turn round and "sign off" on PHO health promotion and SIA plans. The level of DHB critique was also considered "nit-picking" at times.

Comment was made that not enough time was given for reflection and considered feedback, thus compromising PHO decision-making and undermining PHO/DHB partnership relationships.

Influence of the Ministry

Some DHB informants emphasised that DHB/PHO relationships could be compromised because of lack of consistent directives from the Ministry to DHBs: often DHBs obtained differing guidance on important issues such as whether a proposed PHO fee structure was acceptable. The informants outlined the need for clear and consistent directives to help DHBs manage PHOs.

> *The answer cannot depend on who you ask. We need consistency in the directives. (DHB manager)*

The role of the Ministry was also seen as a constraint on DHBs.

> *The intention is to implement [the Strategy] as well as possible in the area and this is part of the reason for the IPA changes, as part of that long-term vision. Really difficult for individual DHBs to make radical changes, when many things are done at a national level. (DHB manager)*

When a DHB was reported as taking excessive time to answer queries both in writing and through dialogue, one informant (a PHO chair) suspected that this was partly because the DHB had to refer to the Ministry "as their masters". This was seen as a mechanism for the Ministry to have input into the detail of PHO plans.

6.1.4 Operational Matters

PHO informants detailed specific areas of relationship engagement on operational matters with the DHB. Two examples include contractual issues and fee-setting.

Contractual issues

Several informants categorised their relationship with the DHB as being one of a predominately contractual nature. A small PHO reported that its relationship with the DHB was largely concerned with contract negotiations – and that it had few expectations beyond this "funder" relationship.

Issues relating to PHO/DHB funding and contracting relationships were identified by informants. The Manager and chair of a small Interim PHO detailed a situation where the DHB wished to change the proven community laboratory provider, to a provider outside the local community. This situation was currently causing conflict and possible damage to PHO/DHB relationships because of a perceived lack of consultation, and poor decision-making:

> *[For example] the GPs and the local community are incandescent with rage about getting rid of [a] proven provider which has served the district well. No GP was consulted and most of the committee was from the neighbouring district. If they get it wrong they will damage the relationship between the DHB and the PHOs in a big way and it will torpedo the warming relationship between the GPs and the DHB. It will be very difficult for the DHB. (Manager, small Interim PHO)*

There was also a perception that in making this decision the DHB was being less than straightforward:

> *We have this thing at the moment … the DHB wants to send the laboratory out of the community, so the relationship is not that good at the moment. They [the DHB] keep on hiding behind commercial sensitivity issues. (Chair, small Interim PHO)*

Funding and fees

Informants commented on the funding and fee setting situation. A GP board member of a small Interim PHO considered that a recent funding transfer could have been done better, with advance warning of potential issues. Instead the transfer led to problems in maintaining health promotion programmes – and these problems could have been avoided. Informants also said it was disappointing that good nurse-led programmes came to an end because of poor planning, and that this had put strain on PHO/DHB relationships.

DHBs also saw that relations with the PHOs had become more difficult as the next round of funding negotiations got closer:

> *There is so much tension around the fees situation. The July situation [roll-out of the next stage of capitation changes] will not help our relationship with them I fear. (DHB manager)*

6.2 Relationships with Other PHOs

In the First Phase interviews, PHO informants mentioned examples of positive relationships with other PHOs – such as the development of a memorandum of understanding between two PHOs, and the development of practical and supportive relationships between PHOs in a particular DHB area. One informant noted the ideological differences between PHOs with different practice-ownership structures (community owned vs privately owned).

In the Second Phase interviews there were no specific questions about PHO-PHO relationships; nor were there such questions in the PHO Manager Survey and the PHO Board Member Survey. So systematic coverage of the topic is not possible. However, as part of the discussion on other topics, some informants made reference to PHO relationships; this section draws on such comments.

6.2.1 Trends in Relationships

Both PHO and DHB informants reported that relationships between PHOs were evolving and maturing. Relationships were being nurtured through regular meetings and forums, particularly of chairs and managers. In many cases these were initiated by the DHB, but PHOs indicated that they themselves were also taking the initiative. Informants were generally positive about the development of further relationships and collaborative projects.

6.2.2 Sources of Tension

Some sources of tensions between PHOs were identified. Philosophical differences between PHOs that were community owned or for-profit appeared to persist.

> *At one end of the spectrum you have got the not-for-profit, do anything for the patients. At the other, you have the more profit-orientated ones. They are driving the anxiety about the July funding and what it means to general practice. (DHB manager)*

Different funding levels were also perceived to have created tensions between Access and Interim funded PHOs, with the anticipated removal of these differences likely to improve working relationships. The removal was also seen as creating opportunities for some smaller PHOs to merge with each other to improve viability and reduce management costs.

> *Once they roll out the next lot of monies, there will be no advantage in being Access funded, then I think we will see the[PHOs with] less than 30 to 40,000 [merging with] each other. (DHB manager)*

> *The way to protect yourself is to go from 30,000 to 120,000. (DHB manager)*

6.2.3 Collaboration

Informants cited examples of joint venture service delivery initiatives across PHOs such as the Healthy Eating, Healthy Action programme. There was support amongst both the PHO and DHB informants of the concept of “lead” PHOs for mutually agreed areas of service delivery – where one PHO would be identified as having the capability and willingness to take the lead in developing and providing a service for the collective of PHOs in a certain geographical area. Examples of lead services identified by informants included diabetes pre-checks, mental health development training, immunisation co-ordination, and pandemic planning.

PHO working parties for the development of new services were cited as a demonstration of the intention to maximise the viability and sustainability of services across the DHB area. The additional possibility of forging strategic alliances with PHOs beyond the DHB area, to promote the interests of rural health, was raised by the manager of a small rural PHO.

6.3 Relationships with MSOs

In the early stages of formation a number of PHOs retained an MSO to provide a variety of administrative services that the PHO was not yet set up for. Some MSOs were IPAs that had worked with general practices over several years, while others were new organisations set up specifically to serve PHOs.

6.3.1 Importance of Good Management Support

Many PHO board members and DHB managers reported that good management support was essential to good PHO performance in all areas. A large PHO indicated that, without the MSO, it could not deliver on contract. One small PHO which had had its own manager was considering contracting with an MSO in order to maximise resources.

> *Contracting with a larger organisation will help a lot. There is no point in us recreating these systems, and the marginal cost for the larger organisation is not very high. We are not in competition and it works well. (Chair, small rural PHO)*

Another small PHO was examining how it could avoid duplication of activity at practice level by engaging an MSO. At the other end of the spectrum, some PHOs had decided either to have their own management team or to work with others to provide the essential management support.

6.3.2 Scope of MSO Activity

PHOs overall did not necessarily see an MSO as essential to ensure good management. Furthermore, responses from the PHO Practice Managers Survey Questionnaire indicated a relatively circumscribed role for MSOs (see Table 6.1).

Table 6.1: PHO Managers' Indications of Activities Undertaken by PHOs or MSOs

Activity	Currently managed by:	
	MSO	PHO
Liaison with community	2	42
Support of general practices and providers	6	37
Provision of locum doctors	6	9
Provision of fill-in or support nurses	3	8
Promotion of teamwork and improvements in practice processes	7	35
Quality initiatives	5	37
Management of relationship with other community health providers	1	41
Management of relationship with non-health community services	1	41
Needs analysis	7	30
Development of new programmes	2	39
Direct provision of services	10	20
Management of relationship with MoH/HPAC	10	33
Liaison with DHB	3	30
Financial management, income distribution	15	26
IT/data development and analysis	25	17

Note: Number of responses = 44

Source: PHO Manager Survey Questionnaire Q18, 19.

Table 6.1 indicates that MSOs played a minor role in most areas of PHO activity, other than IT/data development and analysis (for 25/42 (57%) PHOs) and financial management (for 15/41 (34%)). These areas were regarded as vitally important by PHOs – but even here some PHOs had alternative arrangements.

> *[A certain] PHO does the register management [for other PHOs in the area] which is a very complex piece of work, and they send it off to Wellington and HealthPac and do a whole lot of processing on behalf of all the PHOs. (Manager, Māori PHO)*

An MSO is involved often provides a comprehensive range of services.

> *[We need the PHO] to do all the administrative side, meet all the requirements and inform the board, be mindful of risk to the board, chase up new initiatives and funding streams, work with GP teams on education, financials and IT components, and contract management [and] take direction from the board. (Manager, small PHO)*

6.3.3 MSO Performance

PHO Board Member Survey respondents whose PHO did engage an MSO reported positively on the support provided by the MSO (average rating of 4 on a scale of 1-5, when 5=lots of support). Board members can also be seen as giving a positive rating to the performance of MSOs, in various areas of activity (see Table 6.2).

Table 6.2: Board Members' Ratings of MSO Performance

	Number of respondents N=	Mean rating*	Standard deviation
Provision of information	79	3.9	1
Development of plans	74	3.6	1
Financial management	78	3.9	1.1
Quality initiatives	77	3.6	1.1
Needs analysis	75	3.3	1
Development of new programmes	72	3.4	1.1
Community relationships	73	2.9	1.2

Note: *1=poor; 5=good.
Source: PHO Board Member Survey Questionnaire Q11.

The interviews revealed similar levels of satisfaction with the performance of MSOs.

> *It's been really important. We couldn't have done that capitation thing without a[nother] body running the whole thing. (Nurse, medium-sized Access PHO)*

> *We have the support infrastructure through the management of services to take any project forward and implement it well. All of the projects have targets and they are all evaluated against them. (Who, IPA-based PHO)*

On the other hand, informants also recognised the risk to the PHO of a MSO that was strongly GP-oriented:

> *I would characterise the PHO as very IPA/GP driven. We are in the process of distinguishing the two by [the PHO] moving to wider community engagement […] The IPA will be about growing and sustaining GPs. (Manager, IPA-based PHO)*

6.3.4 Relationship between PHOs and MSOs

The relationships between MSOs and PHOs are highly variable. Clearly there is potential for tension and conflict of interest, especially when an IPA is involved and regards the PHO as a "usurper" in the role of providing leadership and making decisions in primary care. In general most PHO informants felt the MSO/PHO relationship was good, largely because attention was paid to the accountability relationships.

> *There is potential for conflict. But we have the lines pretty clear, and it [the relationship] works really well. Part of this is that we have a clear sense of direction as a PHO. If you are not sure what you are doing then you are vulnerable to the Management Services Company just rolling along. The PHO drives it and there is clear accountability. (Manager, IPA-based PHO)*

> *We direct the MSO. The PHO board determines what projects are funded and where they want the money to go. (Board member, IPA-based PHO)*

6.4 Relationships with the Community

Relationships with the community operate at multiple levels: board representation; community input into PHO decisions; and community partnerships in PHO services. While these relationships have been discussed at various points in this report, there remains the need to look at PHO relationships with the community overall. The two surveys (of PHO board member and managers0 and the interviews with PHO informants provided useful information; but particularly valuable insights came from DHB managers, because of their independent overview of developments.

Overall, the PHO managers rated "relationships with community organisations" as within the scope of the PHO's role, with 40/44 respondents reporting that they had such relationships (see Table 6.3). Table 6.3 also shows that 30/44 (68%) of these respondents reported their "relationships with other community health services" to be good; and a range of experiences was reported in "relationships with non-provider community groups".

Several DHB managers commented that relationships between PHOs and the community had developed more slowly among IPA-based PHOs.

> *They were slow and carried on managing in much the same way that they had been as an IPA. They came under pressure from some of the more proactive community groups themselves and us. (DHB Manager)*

> *The pressure that they came under from the community groups meant that they had to involve them. (DHB Manager)*

Relationships were particularly strong between Māori PHOs and other community organisations. Interviews provided further examples of the ways in which such relationships had been fostered. For example, one informant noted: "*community involvement has been a component to their operation for a number of years prior to PHO establishment*".

Table 6.3: How PHO Managers View Their PHO's Relationships with Community Organisations

	'Respondent managers' views on their PHO's relationships with community organisations					
Community organisation	**Poor**	**Fair**	**Good**	**Not our role**	**No response**	**Total number of responses**
Māori groups	3	2	39 (88%)			44
Pacific groups	13	2	21 (48%)	4		44
Other community groups	2	1	40 (90%)	1		44
Disease groups	10	3	29 (66%)	1	1	43
Territorial local authority	9		33 (75%)	2		44

Source: PHO Manager Survey Questionnaire Q9

Board members also reported on relationships with community organisations. Across all organisations they reported a "good" relationship less often than did the PHO managers, with the most marked differences being in the rating of "relationships with other community groups" (managers reported 90% of relationships as "good"; board members reported 66%) and territorial local authorities (managers reported 75% as "good"; board members reported 42%).

Clearly there has been a significant investment in working with community organisations. PHO Board Member Survey Respondents reported spending an average of 16 hours per year in liaison with community groups, with Māori board members (across all types of PHO) reporting an average of 27.5 hours – which was consistent with reports from informants during the Second Phase interviews

A number of informants from both DHBs and PHOs commented on Māori and Pacific groups' strong (pre-PHO) tradition of community relationships, which was carried forward into the PHO environment.

The time and effort put into working with other organisations seems to be reflected in the degree of support for the PHO that board members respondents reported from different types of organisations. On a scale of 1-5 (1=no support; 5=lots of support), the rating for iwi/tauiwi groups was 3.21 (above the mid-point); others were rated between 2.05 and 2.73. Several DHB managers also reported that PHOs in their areas were working in alliance with the voluntary sector on a range of projects and with a variety of funding arrangements.

Overall, PHO Board Member Survey respondents (Question 10) appreciated the role of PHO management in maintaining these community relationships, giving an approval rating of 3.63 on the 1-5 scale (5=good). However, MSOs that were involved in PHO-community relationships were not rated quite so highly (2.89).

6.5 Summary

PHOs reported that their relationships with DHBs were maturing and developing. Most PHOs undertook their own liaison with DHBs, only a few delegating it to MSOs. There was a great diversity of experience. Some PHOs reported a lack of understanding of and support for the Primary Health Care Strategy by DHBs, others reported high levels of support and flexibility on the part of DHBs. PHOs reported a need for greater autonomy in strategic decision-making and less influence by the Ministry of Health which was felt to constrain DHB flexibility. Informants reported positive relationships with other PHOs. Some philosophical differences between community and privately owned PHOs persisted although numerous examples of collaboration were cited. MSOs provided some PHOs with essential infrastructure and management support, but undertook relatively limited roles in areas other than IT and financial management. MSO performance was reported positively, although some PHOs reported tensions in some instances arising from former IPA-roles of some MSOs. PHO relationships with the community operated at multiple levels, including service partnerships and input into governance. Relationships were particularly strong between Maori PHOs and their communities.

7 CONCLUSIONS

In view of a the relative permissiveness of the Strategy and the uncertainty about what has been expected of PHOs, it is difficult to make firm judgements about how well they are faring in their governance roles. The following points can be made:

1 At the time of the research eighty PHOs had been successfully established, with community, GP and other provider representation. There are variations in size, composition and methods of selection of PHO board members, and patterns of remuneration.

2 All PHO boards recognise the importance of community representation but clearly this does not guarantee effective participation. While some PHO boards recognise that they have not always been as successful as they would wish, the commitment across all PHOs to gaining community involvement is strong. There is, however, a fundamental tension inherent in the PHO board model – the requirement that both community and provider interests be represented. This is a tension that has been reported in other studies of primary care organisation governance in the UK and Australia (such as Mays, Wylie, Malbon and Goodwin 2001; Dowling and Glendinning 2003; Smith and Goodwin 2006; Smith and Sibthorpe 2007).

3 There are differences in the level of influence of particular groups in DHB decision-making, and concerns that some groups do not have as much influence as others. The implications of this have yet to be fully addressed.

4 All PHO boards have a focus on health improvement and the reduction of inequalities. The extent to which they are able to embrace strategies to address these depends on a number of factors, including philosophical position, resource availability and the flexibility with which funds are used. A key question that arises from this is the extent to which public health and health promotion interventions are managed through general practices or are developed as parallel initiatives by PHOs.

The diversity of PHOs indicates that more work needs to be done on how PHOs interpret their role and on how they enact this through the type of work they fund and carry out. The question of whether high levels of diversity in PHO activity are acceptable, and whether this addresses inequalities appropriately, are questions yet to be addressed.

5 There is a high degree of variability in the way boards see the scope of their PHOs:

At its narrowest, the scope of PHO activity includes a focus on strengthening practice services. At its broadest, it involves a more strategic and community-wide view of service development. Both can be seen as core activities, but it is not possible from the data gathered at this stage in the *Evaluation* to assess how far individual PHOs are addressing these.

There is variety in how specific issues are addressed in PHOs – for example: workforce, patient fees, capacity development, service development – and there are tensions between fee restraint and sustainable practices. Some PHOs are more pro-active in addressing these matters; others consider them either beyond their role or their capacity. Despite constraints, there are many examples of innovation in workforce and service development, and in community outreach and engagement.

6 The development of external relationships has been a key activity of PHOs:

The critical relationship between PHOs and DHBs appears to be maturing, although a number of issues remain to be worked through. In some cases PHOs and DHBs are developing parallel services, and it may be valuable to consider opportunities for more joint planning and funding activity.

The relationships between PHOs are beginning to emerge as important factors in managing the clinical and financial vulnerability of small PHOs and in ensuring local and regional equity or services.

7 The extent of a PHO's role in clinical governance is not clear. However, as PHOs are allocators of the largest element of new government funding for PHC (the capitation funding for first-contact care), it seems appropriate that they be given the means to hold their contracted providers to account for both financial and service/clinical governance. The existence of partial (as opposed to full) contracts between PHOs and providers/practices fundamentally compromises the governance role of PHOs (Croxson, Smith, and Cumming 2009).

8 Small PHOs have multiple issues related to the viability of governance, management and service dimensions. It appears that smaller PHOs find it more difficult to fund governance activity, which raises questions of equity and the adequacy of the management fee. There are indications that PHO alliances and networks are being established and that such moves may mitigate some of the risks experienced by small PHOs.

9 The roles of MSOs are variable and changing. Some PHOs do not rely on MSOs at all; others are highly dependent upon them and gain greatly from their support. The implications of these different situations require further exploration.

APPENDIX 1: PHC STRATEGY SECOND PHASE INTERVIEWS – PHO AND PRACTICE INTERVIEW GUIDE

Issue 1 – Keeping, or bringing, the level of co-payments down

Do you have good data on the fees that are being charged?
How would you summarise the present fee situation?

Why do fees vary and what does fee variation achieve?

What role does the PHO have in reducing fees?
What has been done to reduce fees?
What hinders achieving lower fees?
What could be done to maintain a low fees environment?

How can funding arrangements be improved?

Do Māori or Pacific providers have particular issues with fees/fee setting?

Issue 2 – Equalising access to care on the basis of need

Do you have good data on access to care (utilisation and meeting need*)?
How would you describe the present equity of access?

What is your role in improving access?
What has been done to increase access?
What helps achieve more equal access (e.g. SIA, RICF, health promotion funds)?
What hinders achieving more equal access?
How have low-users been attracted?

Do the answers vary across Māori/Pacific/low SES/high SES practices?

Issue 3 – Increasing the focus on chronic conditions

Do you have data on services for chronic conditions?
To what extent have practices increased their focus on chronic conditions?
What chronic conditions do you recognise; which of these have you addressed

What is the role of your organisation in increasing focus on chronic conditions?
Has Care Plus been a useful model?
What other programmes are emerging to deal with chronic conditions?

Do Māori or Pacific providers have particular issues with chronic conditions?

Issue 4 – Achieving and using community input

What has the PHO done to obtain and use community input?

Has community input from PHO boards been useful?
Is there effective community input at the practice level?
How could community input be better sought and used?
Where does the voluntary sector fit in?

Have the DHB, PHO and practices worked together to improve community information, generate community input and foster health education?

How is information about health shared across the community?

Do Māori or Pacific providers have particular issues with community input?

Issue 5 – Maintaining an efficient health workforce – including teamwork

What data do you have on workforce recruitment and retention?
Are there difficulties in your area in recruiting doctors or nurses?

What problems do personnel face?

Is the role of nurses increasing?
Does the focus on chronic conditions lead to a wider role for nurses?

What does teamwork mean to you?
Do you think it an important part of primary care reform? Why?
Are personnel adopting team-based work styles?
When does this work and why?

What is the role of your organisation in managing workforce issues and what has been done?

Do Māori or Pacific providers have distinguishable approaches to workforce issues or teamwork?

What role is played by, or foreseen in the future for, community health workers?

Issue 6 – Functioning of PHO (and MSO)

What role does the management service organisation play (if applicable)?

How well is the PHO board working?

Are there any difficulties in the relationship between GPs, other providers and the community representatives on the PHO board (and generally)?

What is the role of the PHO in developing services?
How does the PHO influence service development at the practice level?

Is PHO management of funding and other resources adequate?

What opportunities and problems do you foresee for the future?

How will the performance management regime affect the PHO and its member practices?

Do Māori or Pacific providers have particular issues with PHO/MSO functioning?

Issue 7 – Relationships with the DHB and Ministry; ACC

What issues are there in the relationships with the Ministry?
How could these relationships be improved?

What issues are there in the relationships with the DHB?
How could these relationships be improved?

Have any services moved from the DHB to the PHO?
    If so, has this worked well?
Are there any services that should move from the DHB to the PHO?
What assists or inhibits service transfer or co-management?

Are there any implications for ACC in the implementation of the Strategy?

APPENDIX 2: PHO BOARD MEMBER SURVEY QUESTIONNAIRE

PHO Board Member Questionnaire

1. What sort of community/group do you primarily represent?

   a. A specific geographic community 1[ ]
   b. The community in general 2[ ]
   c. A specific Māori organisation 3[ ]
   d. The Māori community in general 4[ ]
   e. A specific Pacific organisation 5[ ]
   f. The Pacific community in general 6[ ]
   g. Medical practitioners 7[ ]
   h. Practice nurses 8[ ]
   i. Other 9[ ] Specify _____

2. How were you selected to be on the PHO board?

   a. Invited/nominated by DHB 1[ ]
   b. Invited/nominated by PHO 2[ ]
   c. Invited/nominated by IPA 3[ ]
   d. Invited/nominated by other Management Organisation 4[ ]
   e. Nominated by community above 5[ ]
   f. Other 6[ ]

   If other, please describe:

3. How often did the board meet in the last year? _____

4. In the last year, how many hours did you spend on the following activities (please estimate)?

   a. Preparation for meeting _____
   b. Board and sub-committee meetings _____
   c. Communication/liaison with practices/practitioners _____
   d. Communication/liaison with community groups _____
   e. Undergoing training (for board membership) _____
   f. Membership of national (health related) committees _____
   g. Other (please indicate)

5. Please indicate the annual level of remuneration for attending board meetings $_____

6. Please indicate the annual level of remuneration for all other board business $_____

7. How do you personally communicate with the community you represent?
(tick all applicable boxes)

Formal meetings	1[ ]
Newsletter	2[ ]
Local newspaper	3[ ]
Informal networks	4[ ]
Other	5[ ]

If other, please describe:

8. Please indicate the degree of support that the PHO board has received from the following (DK=don't know)?

a. District Health Board (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
b. The Ministry of Health (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
c. The Management Org. (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
d. PHO practitioners (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
e. Iwi/tauiwi groups (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
f. Pacific community (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
g. General community (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
h. Disease support groups (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9
i. Local TLA (none)1 – 2 - 3 - 4 – 5(lots), DK[ ]9

Comment on support issues, if you wish:

9. How would you rate the influence of the following groups on the board?

	Too strong	**About right**	**Too weak**	**Don't know**
Management				
PHO doctors				
PHO nurses				
Other workers				
Community				

10. How would you rate the performance of PHO management on:

    a. Provision of information to board poor1 – 2 – 3 – 4 – 5 good
    b. Development of plans etc poor1 – 2 – 3 – 4 – 5 good
    c. Financial management poor1 – 2 – 3 – 4 – 5 good
    d. Quality initiatives poor1 – 2 – 3 – 4 – 5 good
    e. Needs analysis poor1 – 2 – 3 – 4 – 5 good
    f. Developing new programmes poor1 – 2 – 3 – 4 – 5 good
    g. Community relationships poor1 – 2 – 3 – 4 – 5 good

11. If there is a separate Management Organisation (if not, skip this question) how would you rate their performance on the same services:

    a. Provision of information to board poor1 – 2 – 3 – 4 – 5 good
    b. Development of plans etc poor1 – 2 – 3 – 4 – 5 good
    c. Financial management poor1 – 2 – 3 – 4 – 5 good
    d. Quality initiatives poor1 – 2 – 3 – 4 – 5 good
    e. Needs analysis poor1 – 2 – 3 – 4 – 5 good
    f. Developing new programmes poor1 – 2 – 3 – 4 – 5 good
    g. Community relationships poor1 – 2 – 3 – 4 – 5 good

12. Is the board able to influence the activities of the practices to a desirable extent on the following issues?

    a. Clinical governance/quality yes[ ], no[ ], not our role [ ]
    b. Responsiveness to community yes[ ], no[ ], not our role [ ]
    c. Practice organisation yes[ ], no[ ], not our role [ ]
    d. Setting level of fees yes[ ], no[ ], not our role [ ]
    e. Developing new programmes yes[ ], no[ ], not our role [ ]

13. Is the board officially aware of practice charges (co-payments)?
    yes[ ], no[ ],

14. How would you rate the relationship of the PHO with the following (NOR=not our role):

    a. Māori community groups good[ ], poor[ ], NOR [ ]
    b. Pacific groups good[ ], poor[ ], NOR [ ]
    c. Other community groups good[ ], poor[ ], NOR [ ]
    d. Disease support groups good[ ], poor[ ], NOR [ ]
    e. Local territorial associations good[ ], poor[ ], NOR [ ]

f. Other community health services
(eg Family Planning, Plunket) good[ ], poor[ ], NOR [ ]

15. How does the board obtain information on community wishes? Tick all those that apply:

a. Informal contact with community ____
b. Needs analysis reports ____
c. Reports from DHB ____
d. Surveys ____
e. Meetings with community reps. ____
f. Community meetings ____
g. Other (specify) ____

16. Please indicate how well the primary health services meet the needs of the community or group that you represent:

(poorly) 1 – 2 - 3 - 4 – 5 (well), Don't know [ ] 9

17. What do you see as the main roles of board members? [tick all that apply]

a. Representing community interest ___
b. Representing provider interests ___
c. Ensuring accountability ___
d. Communication with local DHBs ___
e. Ensuring management tasks achieved ___
f. Ensuring clinical quality ___
g. Developing new services ___
h. Other (please specify) ____

18. Would the board as currently constituted benefit from training in any of the following areas? (Please tick any that apply)

Governance [ ], Finance [ ], Industrial relations [ ], Communication skills [ ] Clinical issues [ ]. Mention any other areas –

19. Please indicate which of the following you personally appreciate relative to PHO board membership (tick those that apply):

a. Improving health services for community ____
b. Personal income ____
c. Personal development ____
d. Other (specify)

20. Please indicate which of the following you personally consider drawbacks of PHO board membership (tick those that apply):

    a. Time requirement
    b. Loss of income
    c. Frustration with management
    d. Frustration with providers
    e. Frustration with DHB/MoH
    f. Lack of appropriate training
    g. Other (specify)

21. If you were asked to remain on the board at the end of your current term would you do so? Yes[ ], No[ ], Not sure[ ]

22. What would you like to achieve as a board member?

23. Please mention any changes that you would like to see in primary health care in New Zealand:

24. Personal Details

Age_____ Male 1[ ] Female 2[ ] Ethnicity _____

25. Please indicate any special function you have on the PHO board:

Chair 1[ ] Deputy chair 2[ ] Other 3[ ]
If other, please specify _____

26. Please indicate your main area of experience/expertise (tick all that apply or write in):

Previous community involvement	0[ ]
Medical	1[ ]
Nursing	2[ ]
Other clinical	3[ ]
Business/commercial	4[ ]
Government/public sector	5[ ]
Social services	6[ ]
Education/research	7[ ]
Directorship/governance	8[ ]

APPENDIX 3: PHO MANAGER SURVEY QUESTIONNAIRE

PHO Manager Questionnaire

PHO staffing and workload

1. Does the PHO have services provided by a separate Management Organisation?

   Yes[ ]1, No[ ]2

2. How many people (as full time equivalents) are employed by the PHO in the following categories? (*Exclude people employed by any Management Organisation as they will be surveyed separately. If individuals spend time on practice activities, only the time spent on PHO business should be counted*).

Manager/executive	a#	Replacement nurse*	i#
Analyst/planner	b#	Clinical nurse**	j#
IT/IT support	c#	Community worker	k#
Reception/secretarial	d#	Pharmacist support	l#
Clinical director	e#	Other medical support	m#
Locum GPs	f#	Other (specify)	n#
Nurse manager	g#		
Nurse educator	h#		

* replaces nurses as required; **fills an ongoing clinical role

3. Who is responsible for selecting people for these roles (tick all that apply)?

   The PHO board or executive [ ] 1, Management Organisation [ ] 3, Other [ ] 4 – specify_____

4. Given current levels of management funding, would you describe the PHO as:

   Thriving [ ] 1, Getting by [ ] 2, Unable to survive long-term [ ] 3.

5. Are you considering:

   Uniting with another PHO? Yes [ ] 1, No [ ] 2.

   Dividing into two, or more, PHOs? Yes [ ] 1, No [ ] 2.

   Sharing services with another PHO? Yes [ ] 1, No [ ] 2.

   Engaging an existing management services organisation? Yes [ ] 1, No [ ] 2.

6. Please list any initiatives being planned to improve PHO sustainability:

Community representation

7. Please indicate the make-up of your board, give numbers of people –

Manager/executive	a#	General community reps	f#
General practitioners	b#	Other (please specify)	
Practice nurses	c#		g#
Māori community reps	d#	Chair (if not included above)	h#
Pacific community reps	e#	TOTAL MEMBERSHIP	i#

8. Are there arrangements outside the board by which the community can influence the PHO?
   Yes [ ] 1, No [ ] 2.

   If yes, do these include regular meetings with:
   general public (a) [ ], community groups (b) [ ]
   disease support groups (c) [ ], Other (d) [ ], If other, please specify:

9. How would you rate the relationship of the PHO with the following (NOR=not our role):

   a. Māori community groups — good [ ], poor [ ], NOR [ ]
   b. Pacific groups — good [ ], poor [ ], NOR [ ]
   c. Other community groups — good [ ], poor [ ], NOR [ ]
   d. Disease support groups — good [ ], poor [ ], NOR [ ]
   e. Local territorial associations — good [ ], poor [ ], NOR [ ]
   f. Other community health services (eg Family Planning, Plunket) — good [ ], poor [ ], NOR [ ]

Relationship with DHB and Ministry of Health

10. Please rate the performance of your DHB over the last year, on the following qualities:
    Clarity of expectation — a. (low) 1 – 2 – 3 – 4 – 5 (high)
    Prompt responses — b. (low) 1 – 2 – 3 – 4 – 5 (high)
    Supportive process — c. (low) 1 – 2 – 3 – 4 – 5 (high)

    Please comment and indicate what sort of support you would like:

11. Please rate the performance of the Ministry of Health over the last year, on the following qualities (DNA = does not apply):
    Clarity of expectation — a. (low) 1 – 2 – 3 – 4 – 5 (high) DNA
    Prompt responses — b. (low) 1 – 2 – 3 – 4 – 5 (high) DNA
    Supportive process — c. (low) 1 – 2 – 3 – 4 – 5 (high) DNA

12. Please list any programmes or activities currently purchased or provided by the DHB, or purchased by the Ministry of Health directly, which the PHO believes would be better purchased or managed by the PHO. Please indicate why you believe the service should be transferred.
(Programmes or activities previously purchased or provided by the DHB, or purchased by the Ministry of Health directly, and now provided by the PHO, should be listed below (Q27 et seq).

Service	Reason	Date

Other organisations

13. Please list any non-general-practice health providers within the PHO, with the services they provide:

Provider	Services

14. Please list health providers outside the PHO, with the services they provide, with whom the PHO or its Management Organisation has an ongoing (non-business) relationship (beyond calls about specific patients) – eg Plunket, nursing services, kaitiaki groups, pharmacy.

Provider	Services

15. Please list non-health social service agencies with whom the PHO or its Management Organisation has an ongoing (non-business) relationship (beyond calls about specific patients) – eg WINZ, Justice, Police, Council, Housing Corp.

Agency

Overlap and competition

16. Are there Access-funded practices belonging to another PHO within the areas served by your member practices? Yes [ ] 1, No [ ] 2

17. Are there Interim-funded practices belonging to another PHO within the areas served by your member practices? Yes [ ] 1, No [ ] 2

PHO activities (include activities of Management Organisation if separate)

18. If the PHO undertakes this activity at present, please tick column 1.

19. If the activities are undertaken by a Management Organisation (MO) on behalf of the PHO, please tick column 2.

20. If the PHO is planning to undertake this role in future (either itself or through the MO), please tick column 3.

21. If you personally think that this should be a priority role for the PHO please tick Column 4

    (if you are not sure about any of these please enter N/S)

Tick as many columns as necessary	**1 Does**	**2 MO**	**3 Future**	**4 Priority**
Liaison with the community served (a)				
Support general practices and other providers (b)				
Provide locum doctors (c)				
Provide fill-in or support nurses (d)				
Promotion of teamwork and improvements in practice processes (e)				
Support and develop quality initiatives (f)				
Liaison with secondary care providers (g)				
Relationships with other community health providers (h)				
Relationship with non-health community services (i)				
Needs analysis (j)				
Development of new programmes (k)				
Direct provision of services (l)				
Relationship with MoH/HealthPAC (m)				
Liaison (meetings, reports) with DHB (n)				
Financial management; income distrib. etc. (o)				
IT and data development/analysis (p)				
Please describe any other major activity not listed above (q)				

22. How does the PHO communicate with the community?

    Newsletters [ ] 1, Local newspaper [ ], Regular meetings [ ] 2,
    Issue-focused meetings [ ], Surveys [ ] 3, Other[ ]
    If other, please describe:

23. How does the PHO communicate with practices and other member providers?

    Newsletters [ ]1, Cell groups[ ] 2, Other [ ] 3
    If other, please describe:

24. Does the PHO have a role in setting practice fees?

Not at all [ ] 1, Discusses fee issues with practices [ ] 2,
Encourages policy conformity [ ] 3, Determines fees [ ] 4.

Needs analysis

25. In assessing the needs of its population, has the PHO undertaken a needs analysis? Yes [ ] 1, No [ ] 2
If yes, which of the following approaches has been used?

a. Comparison of registered population with Census population? Yes[ ] 1, No[ ] 2, NA[ ]3.
b. Community and/or Iwi consultation Yes [ ] 1, No [ ] 2.
c. Formal community survey Yes [ ] 1, No [ ] 2.
d. Formal community focus groups Yes [ ] 1, No [ ] 2.
e. Other Yes[ ]1, No[ ]2 – if yes please specify:

Workforce issues

26. Please indicate if the following activities are undertaken by the PHO?

a. CNE for Nurses: Yes [ ] 1, No [ ] 2.
b. CME for Doctors: Yes [ ] 1, No [ ] 2.
c. Direct employment of Nurses in clinical positions: Yes [ ] 1, No[ ]2.
d. Direct employment of Doctors in clinical positions: Yes [ ] 1, No[ ]2.
e. Recruitment initiatives: Yes [ ] 1, No[ ] 2.

Desired changes in Strategy

27. Please mention any changes that you would like to see in relation to the Primary Health Care Strategy and its implementation:

28. Please list any challenges facing the PHO at present (eg staff recruitment, costs, competition, etc.):

New initiatives and services

Please list programmes or activities undertaken by the PHO to maintain or improve the health of the population it serves. Include any initiated prior to creation of the PHO. Please indicate in each case: who is doing it (MO, PHO, practices, other provider; when the programme/activity was started; the approximate annual budget; and the source of funding (eg PHO=general PHO income/DHB, MoH,

RICF, SIA, PH). Please classify each by putting it in the appropriate row – non-health services, education, outreach etc.

Should you already have a printed list of your programmes and activities please append it (if convenient), but please indicate when each started and the approximate annual budget, the source of funding and how it should be classified.

Service	PHO/MO/ practices/ other etc	Start date	Annual budget	Funding source
29. **Non-health services -** eg home insulation, advocacy with WINZ				
30. **Health education -** eg media, courses, exercise programmes				
31. **Outreach to the disenfranchised -** eg door-knocking, approaches through community organisations, whanau or immigrant groups				
32. **Improve access -** eg mobile clinics, buses, taxi, extended hours				
33. **Screening -** eg recruitment initiatives, screening in the community				
34. **New clinical service -** eg chronic illness management, clinical pharm., mental health, podiatry, retinal screening				

35. **Secondary liaison -** eg community specialists, telephone referrals, discharge planning				
36. **Quality programmes -** eg input or training on prescribing, investigations, patient relations, cultural issues				
37. **Direct employment of practice staff –** eg doctors, nurses, admin staff or locum staff				
38. **Other –** please add				

APPENDIX 4: MSO SURVEY QUESTIONNAIRE

Management Services Organisation Questionnaire

1. Please list the PHOs for whom you provide services:

2. What is the make up of your board?

3. Who owns the PHOs?

4. What is the structure (partnership/company/etc.) of the MSO?
   Which of the following services do you provide for each PHO?

	PHO 1
Liaison with the community served (a)	
Support general practices and other providers (b)	
Provide locum doctors (c)	
Provide fill-in or support nurses (d)	
Promotion of teamwork and improvements in practice processes (e)	
Support and develop quality initiatives (f)	
Liaison with secondary care providers (g)	
Relationships with other community health providers (h)	
Relationship with non-health community services (i)	
Needs analysis (j)	
Development of new programmes (k)	
Direct provision of services (l)	
Relationship with MoH / HealthPAC (m)	
Liaison (meetings, reports) with DHB, (n)	
Financial management; income distrib. etc. (o)	
IT and data development/analysis (p)	
Please describe any other major activity not listed above (q)	

5. How many people (FTE) are employed or contracted by the organisation in the following categories?

Manager/executive IT/IT support Reception/secretarial Nursing manager Nursing project worker SIA projects			

6. Please indicate your sources of income:

   PHO management fee[ ]1, Contracts with the MoH/DHB[ ]2,
   Other business activities[ ]3? (SIA)

7. Does the MSO have a role in setting practice fees?

   Not at all[ ]1, Encourage policy conformity[ ]2, Determine fees[ ]3.

8. Please comment on the achievements of your organisation and the difficulties it has faced implementing the Primary Health Care Strategy

REFERENCE LIST

Barnett, P., Perkins, R. and Powell, M. (2001) On a hiding to nothing? Assessing the corporate governance of health and hospital services in New Zealand, 1992-1998. *International Journal of Health Planning and Management*, 16:139-154

Crampton P, Salmond C. and Kirkpatrick R. (2004) *Degrees of Deprivation in New Zealand: Atlas of Socioeconomic difference*. 2nd edition. Auckland: David Bateman.

Cumming J., Raymont A., Gribben B., Horsburgh M., Kent B., McDonald, J., Mays, N. and Smith, J. (2005) *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy: First Report*. Wellington: Health Services Research Centre.

Croxson B., Smith J., and Cumming J. (2009) *Patient Fees as a Metaphor for so much more in New Zealand's Primary Health Care System*. Wellington: Health Services Research Centre.

Dowling B. and Glendinning, B. (2003) *The New Primary Care: Modern, Dependable, Successful?* Maidenhead: Open University Press.

Gauld R. (2008) "The Unintended Consequences of New Zealand's Primary Health Care Reforms" *Journal of Health Politics, Policy and Law* 33(1), 93-115.

Gribben B., and Cumming J. (2007) *Evaluation of the Primary Health Strategy: Practice Data Analysis 2001-2005*. Wellington: Health Services Research Centre.

Mays N. and Blick G. (2008) *How can primary health care contribute better to health system sustainability? A Treasury perspective*. Wellington: Health Section, State Sector Performance Group, The Treasury.

Mays N., Wylie S., Malbon G., and Goodwin N. (2001) *The Purchasing of primary care organisations: An Evaluation and Guide to the Future*. Maidenhead: Open University Press.

Minister of Health (2001) *The New Zealand Primary Health Care Strategy.* Wellington

Minister of Health (2003) *Minimum Requirements for PHOs.* Wellington, Ministry of Health

Ministry of Health (1999). *Our Health, Our Future: Hauora Pakari, Koiora Roa*. Wellington, Ministry of Health.

Ministry of Health (2004a). *Health Expenditure Trends in New Zealand 1990-2002*. Wellington, Ministry of Health.

Ministry of Health (2004b). *A Portrait of Health: Key Results of the 2002/03 New Zealand Health Survey*. Wellington, Ministry of Health

Ministry of Health (2007a). Very Low Cost Access Payments. http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding-lowcost

Ministry of Health (2007b). Zero Fees for Under Sixes. http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding-lowcost-under6s

Raymont, A. (2004). *Cost Barriers to Health Care: Provisional Analysis from the New Zealand Health Survey 2002/03*. Wellington, Ministry of Health.

Raymont A. and Cumming J. (2009) *Status and Activities of General Medical Practices*. Wellington: Health Services Research Centre.

Shortell S. and Kaluzny A. (1993) *Health Care Management: Organization Design and Behaviour.* 3rd ed. New York: Delmar.

Smith J.A. (2009) *Critical analysis of the implementation of the Primary Health Care Strategy and framing of issues for the next phase.* Wellington: Ministry of Health.

Smith J, and Goodwin N. (2006*) Towards Managed Primary Care: The Role and Experience of Primary Health Organisations.* Aldershot, Ashgate Press.

Smith J. and Sibthorpe B. (2007) Divisions of general Practice in Australia: How do they measure up in the international context? *Australia and New Zealand Health Policy,* 4 (15) http://www.anzhealthpolicy.com/

Weiner B. and Alexander J. (1993) "Corporate and philanthropic models of hospital governance: a taxonomic evaluation" *Health Services Research* 28(3) pp325-355.