Primary Health Organisations

The first year (July 2002 – June 2003) from the PHO perspective

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Executive Summary

- The Health Services Research Centre/Te Hikuwai Rangahau Hauora was contracted by the Ministry of Health in April 2003, to undertake a small study reviewing the experiences of Primary Health Organisations (PHOs). This study was to be a precursor to a more detailed evaluation of the Primary Health Care Strategy.

- This report is a result of the review, and describes the experiences of PHO implementation from 1 July 2002 to 1 June 2003, from the PHO perspective. Interviews with personnel from 12 selected PHOs were conducted between 16 June and 8 July 2003. Nine out of the remaining 22 PHOs established by 1 April 2003, responded to an emailed questionnaire.

- Strong support was expressed by PHOs for the philosophy of the Primary Health Care Strategy (PHCS). There is goodwill present within the sector despite difficulties with the implementation process, and a willingness to 'make it work' to achieve health gains for all.

- PHO establishment required an enormous investment of time, personnel and resources from the organisations involved. Establishment funding was felt to be inadequate and late, and costs were often masked as much work and time was provided voluntarily (i.e. unreimbursed).

- District Health Boards (DHBs) were noted to be generally supportive of the establishment process, and overall the ongoing relationship with individual DHBs was described as being good.

- Inconsistency and variation in the contracting process was noted. Several different versions of the PHO contract had been signed. Not all PHOs had an agreed contract before going "live".

- It was felt that there was a need for greater clarity and consistency with regard to the implementation of PHOs.

- Clear guidelines and consistent advice were particularly needed around enrolment.

- Poor public awareness of PHOs and an associated lack of understanding by the general public as to the concept and implications of PHO enrolment were felt to be a concern.

- PHO funding being tied to enrolment based on general practice (GP) registers was seen as a disadvantage because: 1) it appears to undermine the potential for a multidisciplinary/holistic approach as envisioned by the PHCS; 2) GPs bear the financial risk in the PHO; 3) non-revenue generating partners may

have an equal role in governance, but their clients are not recognised within the PHO unless registered with a participating general practice.

- Quarterly fluctuations in income as a result of mobile populations and fee-for-service deductions were particularly severe in areas with increasing numbers of PHOs, and were seen to threaten the financial viability of practices and PHOs.

- Overall funding levels were seen to be limited. In particular the funding streams for health promotion and management costs were felt to be inadequate.

- Patient co-payments had decreased in all Access funded practices. Opinions varied with regard to whether reduced fees had made a difference to patient access and utilisation rates.

- Payment processes were noted to be cumbersome. Concern was expressed as to whether Health PAC processes were rigorous enough and whether reports were always accurate. There was dissatisfaction with the adequacy of documentation related to register processing, and delays in returning registers were a problem. Checking information believed to be inaccurate was time consuming and difficult.

- A wide range of new services was being provided or planned under the PHO model.

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Introduction

Primary Health Organisations

Background

On 11 December 2000 Cabinet agreed to a strategy aimed at "improving the health of New Zealanders and reducing health inequalities through a strong primary care system"[1]. In February 2001 the Primary Health Care Strategy was introduced to create "an overall framework for the organisation and delivery of primary health care", and thus provide direction to District Health Boards (DHBs) regarding the provision of primary health care services to their populations [2].

The Primary Health Care Strategy is focused on reaching those not currently well served by primary care, extending primary care provision into population health, and changing modes of service provision. Under the Primary Health Care Strategy there will be a move towards capitation funding and the development of a broader base of primary care providers, involving a range of professionals. There will also be a greater emphasis on the role of the community, particularly community involvement in governance within primary care [2].

The Primary Health Care Strategy outlines a "vision" for primary care, the realisation of which is anticipated to take approximately 8-10 years[2]. The Primary Health Care Strategy has six key directions: "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 primary health care workforce; continuously improve quality using good information"[2].

A key facet of the Strategy is the need to establish Primary Health Organisations (PHOs) - not-for-profit bodies funded on a capitation basis to provide a set of essential services to enrolled populations. The directions of the Strategy will be expressed through PHOs, which will need to provide both "first-line services" and population/preventive health services. They will also need to include both the community and providers in their governing processes. Membership of a PHO will be voluntary for both providers and patients [2].

A provider or provider groups wishing to become a PHO will have to meet certain criteria in order to be formally approved as a PHO, and receive their funding entitlement according to the funding formula for PHOs. There are currently two population based funding formulae - the 'Access formula' and the 'Interim formula'. (A further funding initiative called 'Care Plus' is being trialed. This will be available to both Access and Interim funded PHOs.) Both formulae provide a subsidy for first line general practice services and include additional funding for health promotion services, services to improve access (SIA) and management costs. The Interim formula is based on current subsidy levels while the Access formula provides a higher level of funding. Formal approval for Access funding will be given if the enrolled population is defined as "high need" based on socio-economic status and/or ethnicity.

At present it is expected that 50% of the enrolled population must be either decile 9 and 10, according to the New Zealand Index of Deprivation (NZDep), or be of Māori or Pacific Island ethnicity in order for a PHO to qualify for Access funding [3].

Purpose and Scope

In April 2003, the Ministry of Health (MoH) contracted the Health Services Research Centre/Te Hikuwai Rangahau Hauora to undertake a review of the experiences of New Zealand Primary Health Organisations (PHOs). This report is a result of the review which focuses on the experiences of New Zealand's early PHOs; those established between 1 July 2002 and 1 April 2003. A total of 34 PHOs were established in this period. The first two were established on 1 July 2002; a further four PHOs on 1 October 2002; seven on 1 January 2003; and twenty-one on 1 April 2003. The review was limited to discussions with PHOs; other stakeholders were not included.

This review of PHOs is related to, but is reported separately from, other health systems research that the Centre is currently undertaking. First, a project researching the implementation and impact of the 2001 health reforms - the reforms establishing DHBs - has also looked at a number of issues relating to implementation of the Primary Health Care Strategy in New Zealand. An interim report on initial findings from this project has recently been released [4]. It looks at the experiences of a wide range of stakeholders in implementing the Primary Health Care Strategy, not just the experiences of PHOs. Second, the HSRC leads a consortium of researchers that has recently won a tender from the Health Research Council, MoH and ACC for an evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy. The evaluation, which commenced in October 2003, will draw on the results of this initial review of PHOs. It will focus on a number of the issues that the initial review has considered, work with a wider range of PHOs than has been possible here and look at their experiences over a longer time frame.

Aims

1. To give an overall description of PHOs:
   - organisational structures;
   - establishment processes, including contract negotiation;
   - funding and payment processes;
   - relationships with DHBs and MoH;
   - enrolment processes;
   - services, including SIA;
   - plans to reduce health inequalities for Māori, Pacific and low income groups;
   - community participation.

2. To describe participants' experiences of PHO implementation.

3. To describe participants' perceptions of the strengths and weaknesses of PHOs at this stage of implementation.

Method

Data was sought from 4 sources:

1. Documentation produced by the PHOs, DHBs and MoH;
2. Telephone interviews with personnel from selected PHOs;
3. A mailed questionnaire to PHOs not selected for interview;
4. A review of news articles about PHOs from *New Zealand Doctor* and *GP Weekly* (see Appendix 3).

Sampling Strategy

Thirty-four PHOs were established between 1 July 2002 and 1 April 2003.

All 34 PHOs were asked for documentation relating to the aims of the project.

Due to time and budget constraints twelve PHOs were selected for in-depth interviews. They were chosen to give a broad representation of the range of PHOs – large and small, urban and rural, including Māori and Pacific populations. They also represented early-established PHOs, and those more recently established.

The remaining 22 PHOs were to be sent a questionnaire via email.

Data Collection

On 15 April 2003 a covering letter was sent from the Health Services Research Centre (HSRC) to all 34 PHOs established to date, together with an information sheet about the research, a consent form (requesting consent to participate, agreeing to provide documentation, giving permission for the researchers to access documents from their DHB, and agreeing to take part in either an interview or postal questionnaire), and a list of documents sought by the researchers (see appendix 1).

A letter was also sent from the MoH to PHOs, further explaining and supporting the research (see appendix 1).

It was requested that consent forms be returned to the HSRC by 30 April. All PHOs which had not replied by that date were then contacted by telephone and/or e-mail.

The 12 PHOs selected for interviews were contacted by telephone, and arrangements made to conduct a telephone interview with one or more personnel involved in the PHO.

An interview schedule was developed after reading relevant policy documents. The interview schedule was reviewed by the MoH, and their comments were taken into account in developing the final version.

Between 16 June and 8 July 2003, either or both of the first two authors of the report conducted semi-structured interviews with the 12 selected PHOs. The interviews were tape-recorded and tapes stored in a locked cabinet.

A questionnaire covering the same areas addressed in the interviews was developed for the remaining 22 PHOs. The questionnaire was reviewed by the MoH and their comments were taken into account in developing the final version. This was sent out to PHOs by E-mail on July 8, with a requested return date of July 18 2003. PHOs which had not responded by this date were sent two follow-up e-mails in an attempt to increase the participation rate.

Analysis

After repeated review of the taped interviews, a detailed summary of each interview was made. Relevant verbatim quotes from interviewees were included in the summaries.

Summaries were read repeatedly and data sorted according to broad categories from the interview schedule. Themes arising in the data were then identified within these categories. The summaries were then coded according to these themes. Free text data from the questionnaires were analysed in a similar manner.

The report contains analysis of both interviews and free text data from the questionnaires. Where questionnaire respondents were asked to answer questions using Likert scales, the collated responses to these questions have been included as a table in the report.

Feedback on Draft Report

Some participants expressed a desire to review and comment on the research findings prior to the final report being sent to the MoH. A draft report was sent out to all participants at the completion of the analysis of data from interviews and questionnaires. Participants were asked to return comments within a two-week period; otherwise it would be assumed that they had no objections to the content of the report. Following this two-week period, the same draft report was sent to the MoH for feedback. Comments received from participants and the MoH were taken into account when writing the final report.

Findings

Response

The majority of PHOs expressed a willingness to take part in the project when initially contacted. The designated PHO contact person however, did not always have the authority to give consent for participation. In a number of cases, approval had to be sought from the PHO boards. As a result, there was a delay in obtaining consent where boards were not meeting for several weeks.

All 12 PHOs selected for in-depth interviews agreed to participate in the project. Of the remaining 22 PHOs, nine returned a completed questionnaire (details below).

Table 1 Respondents according to establishment date

Establishment Date	Total number of PHOs established on this date	Interview Respondents (N=12)	Questionnaire Respondents (N=9)
1 July 2002	2	2	0
1 October 2002	4	2	1
1 January 2003	7	5	1
1 April 2003	21	3	7

Interviews

Eleven interviews were conducted by telephone (due to budget and time constraints). One face-to-face interview was conducted.

At the beginning of each interview, confirmation was sought from participants that they were willing to have the interview tape recorded. All interviews were tape-recorded.

Interviews lasted on average 1 hour, ranging from a minimum of 40 minutes and a maximum of 1 hour 20 minutes.

Out of the 12 PHO interviews, 4 interviews were conducted with more than one person from the PHO participating in the interview. The interviewees included board members, managers and providers from within the PHOs.

Questionnaires

Out of 22 PHOs, five PHOs declined to participate in response to the original letter. Therefore, 17 questionnaires were sent by email (due to time constraints). Out of these 17, two declined to participate, six failed to respond and nine returned a completed questionnaire. The majority of the questionnaires were answered by management personnel.

Non-respondents were sent a follow up email and/or a phone call and a further email in an effort to increase participation. PHOs which declined to participate cited other pressing priorities and limited resources (both financial and staff time) as reasons for not taking part in the project.

Table 2 Groups of Respondents

Category	Interview Respondents (N=19)*	Questionnaire Respondents (N=9)
Administrator/Manager/CEO	12	8
Board Member/Chair	6	1
Providers	1	0

*4/12 interviews were conducted with more than one participant from the PHO.

Documents

Eleven PHOs supplied sets of documents (six were PHOs that were interviewed, and five were PHOs which responded to the questionnaire). Not all these PHOs supplied complete sets of documents.

Some of the more recently established PHOs commented that their documentation was still being developed, and these PHOs, therefore, were not able to provide a complete set of documents for the project. It was not clear why some of the other sets were incomplete or not supplied.

The table below indicates the types of documents supplied and the number of PHOs (out of a total of 11) that supplied each document.

Table 3 Documents

Documents Supplied By PHOs	Number of documents received*
Registration of Interest Proposal	5
Request for Establishment Funding	1
Business Plan	5
Strategic Plan	3
Contract between PHO and DHB	6
Contract between PHO and Provider	4
Management Services Contract	1
Enrolment Information for Providers	2
Enrolment Information for Patients Developed by PHO	3
SIA Plan	7
Health Promotion Plan	5
Māori Health Plan	1
Service specification	1
Rules of PHO incorporated society	2
Charitable Trust Deed	1
Annual Report	1
'Fact sheets' developed for providers and community during PHO formation	1

*This number refers to how many PHOs (out of a total of 11) supplied this category of document.

Due to time constraints, and incomplete sets of consent forms from all the PHOs within one DHB district, documents were not able to be sought from DHBs.

Characteristics of PHOs in Research Sample

Twenty-one out of 34 PHOs participated in the research.
Tables 3, 4 and 5 below summarise the characteristics of participating PHOs.

Table 4 Organisations Combining to Form a PHO

Organisations combining to form a PHO	Interview Respondents (N=12)	Questionnaire Respondents (N=9)
IPA/private GP practice	4	1
IPA/GP practices + non-GP Māori health promotion/nursing services	5	2
Māori provider organisations including GP services and other services	1	3
Community trust (includes GP services) + partnership with Māori organisation	1	2
Pacific umbrella organisation – includes GP and other services	1	1

Table 5 Size of Enrolled Population of PHO

Number	Enrolled Patients (Interviews, N=12)	Enrolled Patients (Questionnaires, N=9)
<10,000	2	3
10,000-19,999	2	3
20,000-29,999	2	1
30,000-39,999	2	0
40,000-49,999	1	1
50,000-59,999	0	0
60,000-69,999	0	0
70,000-79,999	1	0
80,000-89,999	1	0
90,000-100,000	0	0
>100,000	1	1

Table 6 PHOs Categorised by Funding

Funding	Interviews (N=12)	Questionnaires (N=9)
Interim	1	0
Interim with Access Practices	2	2
Access	9	7

Perceived Advantages and Disadvantages of PHOs

Advantages

Overall, strong support was expressed by PHOs for the philosophy of the Primary Health Care Strategy (PHCS). The main advantages of PHOs expressed by respondents were the potential for collaboration between various professional and provider groups, greater integration of services, and the strengthening of existing partnerships and relationships.

The combining of different paradigms - an individual health approach together with the holistic approach of Māori service providers and a greater emphasis on population health - was also seen as an advantage.

The new PHO structure was felt to offer greater opportunities and increased scope of practice, especially for nursing services.

Added opportunity for community involvement at all levels within a PHO was generally viewed positively.

There was also an expectation of benefits accruing to patients from user fee reductions and the potential for improving access, particularly for those with high health needs and low income. In addition, the potential to offer a greater range of services via a greater range of providers, with the funding not restricted to general practitioners (GPs) generating a general medical services (GMS) claim, was felt to be an advantage. However, this was associated with a realisation that positive outcomes would be visible only in the long term.

Disadvantages

Many of the disadvantages noted by PHOs revolved around funding issues and the "mechanics" of capitation, particularly enrolment and payment processes.

Despite the fact that funding was not to be dependant on the generation of a GMS claim by general practice, in reality, due to the enrolment requirements for PHOs, revenue for PHOs is based on GP registers. This was seen as a major disadvantage for a variety of reasons:

1. From the general practice point of view this meant that GPs bore the financial risk in the PHO.
2. This caused some to question the role of non-revenue generating partners in the PHO, as they did not contribute financially to the PHO, but could have an equally significant role in the governance of the organisation.
3. Conversely, while non-GP provider organisations offered significant health promotion services and community links to the PHO, the populations served by these organisations were not necessarily recognised within the PHO unless they were registered with a participating general practice.

There was also felt to be a potential for fragmentation of funding and services (specifically SIA and health promotion services) between a number of small organisations, particularly in the case of the presence of other PHOs in the same region. The potential destabilising influence of having low cost Access funding practices set up alongside practices on the Interim formula was also noted.

There were additional concerns about whether funding for establishment and ongoing costs was adequate (see under funding). Issues include the sufficiency of continuing funding, financial fluctuations due to register cleansing, unlimited fee-for-service deductions so that an itinerant population would increase the risk of "blowing the budget" and questions around the viability of smaller PHOs due to lack of resources.

It was felt that there was a need for greater clarity and consistency around the application of policy with regard to the implementation of PHOs. Changes to the rules while implementation was underway, mixed messages and differences in application of rules between regions, were a source of considerable frustration and annoyance. There was seen to be a lack of cohesive strategies around implementation and a perceived gulf between the idealism of policy and the reality of its application. It was felt that the lack of a clear toolkit to *"make it happen"* together with the rapid speed of implementation created uncertainty *"as we lurch from phase to phase"*.

It was felt that collaboration, relationship building and strengthening of partnerships in establishing PHOs had been a positive move, but it had also required an enormous investment of time, personnel commitments and resources. It was therefore considered that there was a danger that energy was going into restructuring the primary health care sector, rather than being focused on the reduction of inequalities/improving health outcomes which was the philosophy behind the PHCS.

There was also concern that the new structures might not be reaching those in greatest need, and that there was a comparatively greater reduction in fees for those previously not eligible for subsidised GMS claims. Allied with this was a feeling that DHBs/consumers expected rapid change despite the fact that potential benefits in terms of outcomes would only be realised over a much longer period of time, if at all. There were also concerns about what a change of government might mean for PHOs.

Establishment

A number of documents provide information on the establishment of PHOs. These include The Primary Health Care Strategy [2], Minimum Requirements for Primary Health Organisations [5], A Guide for Establishing Primary Health Organisation [6] and PHO Checklist and Worksheet [7, 8].

The Guide for Establishing Primary Health Organisations notes that the material on establishment

> *"…is intended as a collection of helpful ideas, examples and tools. It does not set further requirements. Since the Minimum Requirements are deliberately permissive of different approaches, DHBs should be careful not to restrict this approach or stifle innovations by setting their own more rigid requirements. Providers are encouraged to approach DHBs with their suggestions, and DHBs should develop their own plans in light of such proposals." [6]*

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The drive behind the initiation of the establishment process varied between PHOs. In some cases the establishment of the PHO was either actively encouraged, or even driven by the District Health Board (DHB). In other instances the impetus for establishment came from the parties interested in forming the PHO.

Reasons for the formation of a PHO ranged from an expectation of advantage through being one of the first established, to fear of a threat to the viability of existing practices due to the presence of other PHOs in the area.

Negotiation was necessary, however, to gain a philosophical agreement between the partners and develop governance arrangements. In addition, general practitioners (GPs) needed to be reassured with regard to the financial/business implications of becoming a PHO. GPs' concerns prior to establishment centred around the fact that capitation payments were estimates only, and they had no ability to verify the final income that would be received under the PHO model. In addition, the advantages of joining with a non-revenue generating partner were queried since the revenue would be dispersed out to the whole organisation.

In some cases, the ideals of the collaborative approach and partnership with Māori provided the impetus for the formation of PHOs. For some organisations such as community-based, Māori providers who brought with them a holistic approach to health, health promotion capabilities and extensive community links, the philosophy of a collaborative approach, particularly as a way of reducing health inequalities, was considered to be more important than any financial gain that might accrue.

For most PHOs, the initial phase of the establishment process involved large amounts of time spent in relationship building and negotiating with potential PHO partners, providers and the community, as well as putting together the necessary legal and organisational structures. All PHOs noted that the establishment process was time consuming, although the stated length varied between PHOs. Availability of management resources (for example, for some Independent Practitioner Association

(IPA) partners) or where a DHB actively facilitated the process, allowed for a quicker establishment phase. It was also noted that although a PHO was formally established on a particular date, the organisation still needed time to *"bed in"*.

Costs incurred by PHOs during the establishment phase included resourcing the development of legal structures, consultation, development of plans, bringing together of providers, IT costs, indemnity/professional insurance and the cost of governance. The costs in terms of staff time were noted to be *"huge"* and included the opportunity cost of what was not being done at the same time, both by managers and practice administration staff.

Establishment funding was noted to be inadequate, and often arrived after establishment, or in some instances had still not arrived several months post-establishment. PHOs said that they had *"pooled, borrowed and begged"* to meet costs. It was suggested that many of the costs incurred during the establishment process were *"masked"* because they were often borne (i.e. absorbed) by the organisations involved, including IPAs and practices; PHOs worked with existing staff or in some cases used staff provided by the DHBs; and much work and time was provided voluntarily (i.e.unreimbursed) including provider time for attending meetings, which were often numerous.

Documentation

The types of documents produced by PHOs include 'Registration of Interest', 'Request for Establishment Funding', 'Business Plan', 'Strategic Plan', Services to Improve Access Plan', 'Health Promotion Plan' and 'Māori Health Plan' (See Table 3).

There were differences between PHOs with regard to how easy or difficult the required documentation was to produce. Insufficient documents were received to be able to assess whether there were different standards of documentation between PHOs (e.g. large or small), or variations between DHB areas.

Documentation was noted to be easy to produce in those PHOs where there was internal philosophical agreement, or where existing material such as IPA templates were available to be converted into required PHO documents. Some PHOs commented that the templates provided by the Ministry were useful and support from DHB staff also facilitated the provision of documentation.

Those PHOs that noted that the documentation was difficult to provide cited issues such as legal complexity, difficulties with reaching internal agreement, the lack of experience of the personnel involved in producing the documentation and inadequate management fees to cover costs including staff time to produce the required documents. In addition, several noted that trying to produce the documentation prior to the establishment of the PHO was *"putting the cart before the horse"*.

Assistance from District Health Boards

The majority of PHOs found their DHBs were supportive of the PHO establishment process, often providing very practical support in terms of staff time and sometimes

financial resources. In addition, some DHBs facilitated co-ordination with other PHOs and project managers.

Many commented however, that often the DHBs were on the same learning curve as the PHOs, and a lack of knowledge within the DHB made things difficult. A few mentioned that the level of support from the DHB depended on the individual staff member at the DHB. In one instance it was noted that the DHB had *"actively made things more difficult"*.

Overall, the ongoing relationship with DHBs was noted to be good. However, in a few instances, despite the DHB being very supportive in the early phase of establishing the PHO, support had dropped off as they moved to set up other PHOs in the region, and early *"promises and dreams [were] not realised"*.

The two PHOs that straddled DHB boundaries commented that the overlap was handled at the DHB level and was done in a satisfactory manner. The PHO therefore only needed to deal with one DHB on a regular basis.

Assistance from the Ministry of Health

Overall, PHOs felt that there had been little or no contact or assistance from the MoH apart from some support in terms of advice, and meetings to troubleshoot problematic processes. *"Nothing other than hollow words of encouragement"* and *"encouraging but lives on another planet"* were some comments.

It was noted that uncertainty and lack of direction from the DHB and MoH at the initial stages of establishment meant a lot of extra work for PHOs, and demands for information from both the DHB and MoH were at times challenging during the establishment phase.

Better communication at the initial stages of implementation, clearer explanation and guidelines for key priorities, appropriate tools for data collection, timely and adequate funding, clarification of the rules regarding qualification for funding, and consistent advice were suggestions for improvement.

Contracts

Inconsistency and variation in the contracting process were noted. For example, some DHBs had indicated that a PHO could not go 'live' until their contract was signed. However, several PHOs had gone 'live' without having signed a final contract. In addition, variations were described between PHOs in different DHB regions as to whether other contracts currently held by providers who were joining the PHO had to be brought into the PHO contract, or could be retained outside the PHO. There was also variation between DHBs as to whether SIA contracts had to be for totally new services, or could be an expansion of services already delivered by one or more providers prior to joining the PHO (see SIA funding section).

Problems with specific clauses were cited as difficulties for some PHOs, specifically problems with agreement over 'section J' (the organisation specific clause) and the absence of reference to the Treaty of Waitangi in version 16 of the contract. GPs also expressed concerns regarding signing a contract while there was uncertainty about the amount of capitation payment likely to be received.

Some noted they had agreed to a contract without being completely happy with it, trusting that things could be changed later.

Version 16 was the most common version of the contract that had been signed, with others noting that they were either in the process of discussing version 17 or 18, or the contract was pending. Eleven out of 21 PHOs had not signed a contract at the time of data collection. (See Table 7.)

Table 7 Contracts Signed by PHOs

Contracts	N=21
signed version unknown	4
signed version 15	1
signed version 16	4
signed version 17	0
signed version 18	0
not signed	11
Unknown	1

All PHOs were aware of discussions around the development of a national contract, and most were represented in some way at these discussions either directly, via individual IPAs or by The IPA Council of New Zealand or HealthCare Aotearoa.

Public Perception[1]

All PHOs considered that in general, public awareness of PHOs was poor. They noted that the majority of people either had no idea about PHOs or were confused as to what it meant.

> *"People only know what they've read in the media which isn't much and which talks about what PHOs can achieve – conceptual stuff, but what does it mean at grass roots level?"*

Most PHOs were critical about the lack of dissemination of information *"from above"* to the public regarding PHOs, and felt that too large a part of the burden of responsibility had been placed on the individual organisations with regard to informing the public. PHOs noted that it involved a big educational process for patients, particularly populations that were hard to engage due to literacy, language and cultural issues. It was felt that most patients had little understanding of the structural issues behind the development of PHOs, and that the idea of PHOs was rather meaningless to most people who already felt they were getting good care or *"just want to see the doctor today"*. It was felt that in general people were economically driven i.e. looking for a cheap service, rather than being interested in its philosophy, and that the *"key thing that matters to people is what it costs to go to the doctor"*. This created some problems for Interim PHOs which were unable to provide lower fees for patients.

The means used by PHOs to inform their community and the general public about PHOs varied considerably. This ranged from extensive community consultation prior to the establishment of the PHO, to the use of provider newsletters and media releases in community magazines and newspapers at the time of establishment. One PHO was hoping to develop a website.

It was felt that a public information campaign regarding enrolment/registration was necessary, and should be driven by the MoH, as in general, PHOs did not have the financial or staff resources for marketing PHOs to the public.

[1] PHOs were asked about their perspectives on the public's perceptions of PHOs. Information was not gained directly from the public.

Enrolment

The *Minimum Requirements for Primary Health Organisations* state that

> " PHOs will use a national enrolment system to enrol people through primary providers" [5].

Enrolment determines a PHO's capitation funding, and will allow a PHO to define the populations they cover and therefore plan and deliver population health services to meet their needs [6].

Initially, patients registered with a GP practice within a PHO will be considered to be enrolled with that PHO. Within three years, the provider must inform patients of the benefits and implications of PHO enrolment, so they can choose whether or not to remain enrolled. People can only be enrolled with one PHO at a time [9].

Enrolment processes and rules are detailed in the Enrolment Manual for Primary Health Organisations [10].

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Enrolment Processes

The lack of understanding by the general public as to the concept and implications of enrolling with a PHO was considered to be a big hurdle, and it was suggested by one informant that *"patient behaviour around enrolment could see the downfall of PHOs"*.

Many PHOs commented on having done considerable work internally to ensure that the enrolment process was as smooth as possible, and all PHOs noted the enrolment processes involved a large amount of ongoing extra work for practices. This mainly involved time and effort spent in training staff on enrolment procedures, in explaining enrolment to patients, in entering data and in establishing payment processes. Many PHOs noted that front line staff saw the enrolment process as *"an imposition on top of everything else they do"*, but acknowledged the need to put time and effort into it because it *"drives the revenue"*.

The number of changes that needed to be made by organisations to accommodate enrolment requirements varied between PHOs. Some PHOs noted that *"huge changes"* had been required, both at an individual practice and PHO organisational level. Others, however, particularly those with practices that were already capitated, suggested that changes had been minor and mostly centred around the efforts to ensure that people's details were collected accurately. The most common changes made were to information technology (IT) systems, and administrative and accounting procedures.

All PHOs noted that patients were enrolled opportunistically as they presented to a practice. The means of enrolment varied between PHOs. Some PHOs commented

that the forms and information packs provided by the MoH were used. Others thought these were not useful and developed their own enrolment forms and information packs.

The type of information that needed to be provided to patients involved explaining the rules of enrolment (for example, enrolling with only one provider), the benefits of enrolling with one provider (and not simply re-enrolling somewhere else for the sake of a cheaper visit on the day), the implications of changing practices and so on.

A number of problems with enrolment procedures were described, including the practicalities of communicating information in situations where English was poor (the MoH brochures were noted to be only in English); the difficulties of trying to keep the language simple despite *"…a lot of legal jargon which gets people suspicious"*; difficulties noted by Pacific providers *"…because the policy requires people to choose one provider when traditionally in this community people have several providers depending on where they are"*; mobile populations; and simply the difficulty of explaining the concept of PHOs to people who are ill.

Changes to the Enrolled Population

Most PHOs had experienced changes to the numbers of their enrolled population since establishment. Some PHOs had increased their enrolled populations since establishment through active enrolment efforts and when new practices joined the PHO. In other PHOs, however, the enrolled population had declined when a practice(s) left the PHO.

Several PHOs noted that *"significant"* unexpected losses occurred as a result of the 'cleansing' of registers by HealthPAC. In this process, 'duplicates' (patients considered to be already enrolled with another PHO) are removed from a PHO's enrolled population and not counted in the capitation assessment. For some PHOs this has resulted in initial losses of up to 12% - a *"huge shock"* for the PHO.[2]

In addition, quarterly population fluctuations were noted. One PHO noted changes in every quarter of up to 23%. Five other PHOs notes losses without giving percentages, though one described them as *"significant"* and another said, *"decreased dramatically"*. Reasons given include *"…business rules that allowed other practices to claim regular patients of ours on the basis of them having made a visit to them sometime in the last 3 years,"* and the effect of a mobile population in some areas - *"20% of [our] population move every year - informing the GP of their movement is not high on the list of priorities!!"*. [2]

The impact of 'duplicates' was felt particularly strongly in areas where there were several PHOs, causing some to question the number of PHOs allowed to proliferate in the same area:

[2] Financial implications of this are discussed under Funding Fluctations.

> *"Patients don't care less about PHOs, business rules, governance systems or how the health system works. They just want to see the Dr when they are sick and quite happily move around signing enrolment forms with different PHOs depending on what is convenient or economic from day to day".*

It was strongly felt that there needed to be both clarification and tightening of the rules of enrolment. Various PHOs also commented on discovering 'loopholes' in the enrolment rules, for example, practices being incentivised to casualise all low-funded capitation patients and those that enrol after the quarter has started, and just enrol Māori, Pacific HUHC, CSC holders and children.

> *"What incentive is there to enrol an A3 patient for a capitation payment of 5 – 10 dollars per year, when this dilutes the practice register in qualifying for Access funding?"*

> *"When someone enrols just after the start of a quarter, the PHO will not get any funding for them till the next quarter and so this patient should count as a 'casual' until then".*

Conversely competition and aggressive recruiting by organisations was compared to *"…putting a bounty on the heads of the poor"*.

> *"Practices that previously didn't want to know our patients have suddenly fallen in love with them."*

PHOs also cited examples of A&E clinics enrolling patients who call in casually without the intention of being a permanent patient of the practice, and non-PHO providers registering patients in order to have the most recent date of enrolment if and when they do form a PHO. It was suggested that *"[E]nrolment and selective enrolment is looming as the next big crisis in PHO development".*

Respondents commented that they were aware of a review of enrolment processes taking place in Counties Manukau.

[Note: A registration/enrolment review of the four PHOs existing in Counties Manukau at 1 January 2003, was commissioned by Counties Manukau DHB and carried out by HealthPAC Audit & Compliance [11]. Its purpose was to review "the whole PHO enrolment process and Business Rules with a focus on the higher than expected duplicate patient entries identified by HealthPAC in the register submissions", and also "to establish whether the HealthPAC systems were working appropriately". "Following this review, a joint project involving the MoH (including HealthPAC), Counties Manukau DHB (CMDHB) and all Counties Manukau PHOs was established in June 2003 to consider opportunities for process improvement with regard to the enrolment business rules, their application, and the way in which the rules are made operational by PHOs and their practices, the practice management systems providers and the MoH (HealthPAC)" [12]. Readers are referred to these reports for details of their findings.]

A PHO forum was also to be established in another region for common understanding of enrolment rules.

PHO Funding

The Government has made available significant new funding for primary health care in New Zealand. There has also been a major shift to needs-based capitation funding for primary health care services provided through PHOs (recognising that about one third of GMS and practice nurse subsidy payments were already made to organisations on a capitation basis) [3].

Two capitation-based funding formulae have been developed to fund PHOs. The Access formula takes into account the age, gender, ethnicity, deprivation and High User Health Card status of the enrolled population. Access funding is initially available to PHOs serving high need populations. It is intended that over the next 8-10 years, all PHOs will be funded under this formula. In the meanwhile, PHOs which do not meet Access funding criteria will be funded under the Interim formula, which uses the same variables as the Access formula, with the additional factor of Community Service Card status. The Interim formula uses existing GMS rates, which differentiate on the basis of CSC status [3].

The numbers of Access, Interim and 'mixed' funded PHOs in this research sample are given in Table 6.

Under both capitation based funding formulae, four funding streams are available to PHOs. These are:
1) first contact services funding - the base capitation rate for delivering minimum services to the enrolled population, including first contact general practice services;
2) services to improve access funding - additional funding that is intended to be used for services to provide care to high need groups and reduce inequalities. PHOs need to define and gain approval for these services from their DHB before this funding component is available to them;
3) health promotion funding - PHOs must gain approval from their DHBs before this funding is released;
4) management services funding - calculated on a per capita basis for the enrolled population[3].

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Overview of PHO Funding

The philosophy of the PHO model and the benefits of collaboration were motivating factors to form a PHO for many organisations. The financial advantages of becoming a PHO, particularly for Interim practices, however, were noted to be largely intangible. *"We wouldn't be in it for the funding".*

Overall, funding levels were seen to be limited and the majority of PHOs felt that funding levels were inadequate, particularly for small PHOs. Several noted that they were receiving significantly less funding than expected, and some were even losing money due to casual visits and fee-for-service deductions (see later).

> *"Practices are really freaking about the fact that they are losing money; some of them, even on an Access formula, have lost quite a bit of income."*

Despite the fact that for some PHOs the capitation funding represented an increase in funding for primary care services for their populations, it was considered debatable whether the funding was adequate to provide services to very highly-deprived populations.

It was felt that the rules governing qualification for funding were not as clearly defined as they could have been. There were also variations between PHOs regarding the ease of data collection to qualify for Access funding. Some PHOs found it easy to demonstrate they qualified for Access funding. Others noted that even with good data collection, it may be difficult to meet the Access criteria. For example, one respondent believed the deprivation index was not a suitable mechanism to base funding on, as only some of the poor live in concentrated areas of poor people.

> *"Many of the poor who live in wealthier suburbs travel to free practices like ours for treatment. But we are denied the ability to benefit from funding supposed to meet their needs because of their address. In one of our practices, over 80% of patients have a community services card, but we are only 19% deprivation level 5."*

Table 8 Questionnaire responses re funding levels (N=8)*

"Please indicate how adequate you consider PHO funding levels were for the following."

		Please put an x in the appropriate box					
		Inadequate				Adequate	Don't Know
		1	**2**	**3**	**4**	**5**	**DK**
4.1	Provision of 1st level health services (e.g. general practice/nursing/ immunisation etc)	3	1	2		1	1
4.2	Services to increase access	3	3			1	1
4.3	Health promotion	6				2	
4.4	Management	7				1	

*8/9 respondents answered this question. One respondent considered it 'a nonsense question', querying the measure used to assess adequacy.

Funding Streams

First Contact Services Funding

There were variations between PHOs as to the adequacy of the base capitation funding. Some PHOs commented that the funding was insufficient and they were struggling to provide basic services. Others, however, were satisfied with the level of capitation funding *"as long as it continues to rise with inflation."*

Other concerns expressed by PHOs were:

1) Negative incentives were present with respect to the capitation funding,

> *"If we encourage appropriate increased access by patients, this will decrease the overall payment per patient under capitation."*

This is because the annual per capita funding for a PHO's enrolled population is determined by the existing national average general practice utilisation rates [3]. Therefore if patients increased their utilisation of general practice services as a result of improved access under PHOs, the 'value' of the per capita payment was correspondingly reduced.

2) Established PHOs were concerned about the effects of losing patients in register cleansing as more PHOs form and come 'on line'.

> *"Each quarter we get less money through capitation but the workload remains the same or is rising. All in all, this is putting a significant financial stress* [on practices]*…and the ability for the practice to continue to operate is in doubt…"*

All PHOs reported paying the capitation funding directly back to providers according to their registers. As a result it was suggested that, from the point of view of the PHO, the funding was *"Teflon coated"* i.e. *"it slides in and slides out"* with no margin or deductions available for the PHO.

Services to Improve Access Funding

In general, interviewees from PHOs that had received SIA funding at the time of data collection, felt that the level of funding was *"fair"*. However most also felt that there would still be unmet needs, and more SIA funding could easily be spent. Questionnaire respondents were more definite in considering the level of SIA funding to be inadequate (see Table 8).

The difficulty of preparing SIA proposals at the same time that the PHO was being established was noted. Time was needed for consultation with providers and the community, and for adequate data collection in order to plan new services that would *"really impact the community rather than just be token gestures"*. Some felt that the proposals for SIA funding had needed to be rushed through to meet funding timelines. One PHO which had not yet received any SIA funding had *"money currently sitting with the DHB"* until programmes were established. Another *"gave it away"* for the

first quarter to enable consultation and relationship building to occur around the proposals.

It was suggested that *"leadership from the Ministry of Health"* with regard to developing new services such as *"some templates we could use and documents to help us get underway"* would have been of use.

Programmes established with SIA funding were likely to be long-term projects, and would therefore need ongoing funding. It was felt this would use up all the available SIA money very quickly, and thus reduce the opportunity to invest in new projects in the future.

There was some confusion as to whether SIA funding could be used to expand existing services. Three PHOs mentioned some of their SIA projects involved enhancing or extending existing services, including expanding services currently contracted to a particular provider(s) to now cover the whole PHO. Another PHO, however, reported receiving conflicting advice from its DHB as to whether a provider contract that had been brought into the PHO could then be developed under an SIA proposal or not. One PHO noted that their SIA projects would try to replicate some services for the whole PHO so that when individual contracts ran out, patients would not experience any discontinuity of service.

There was also concern that if SIA funding was used for pre-existing contracts held by providers, once services presently covered by existing contracts were paid for, there would not be a lot of money left over.

> *"…so is this funding just a re-jigging of existing funding streams rather than new money?"*

There was variation as to whether the development of SIA plans could be done using the SIA funding. One PHO had received a quarter's funding to develop SIA plans, then had funding stopped because the plan was not yet finalised. Funding was reinstated in the third quarter and the PHO given more time to do data collection and develop their proposal. On the other hand, a PHO which had understood it could receive SIA funding immediately and then develop a proposal to use it, found they had to have a project 'ready to run' before it would be funded. One PHO also reported it had to use management funding, which it already considered inadequate, for SIA and health promotion planning.

There was concern that SIA funding may also be insufficient to meet raised community expectations for additional services.

SIA funding was paid out to providers against specific contracts.

Health Promotion Funding

The greatest amount of dissatisfaction was expressed over the funding available for health promotion. Two dollars per head of Health Promotion (HP) funding was described as *"pitiful"*, and it was felt that little could be achieved with this level of funding, particularly for a small PHO. A number of PHOs were therefore looking at pooling resources and planning health promotion activities on a regional basis. Several PHOs reported working with the public health unit of their DHB (which had more money, regional involvement and existing projects) to determine the needs of their community and best approaches to health promotion.

Several PHOs had not yet received HP funding at the time of data collection, as they were still either developing proposals or awaiting DHB approval. One PHO was also waiting while its DHB determined a process to decide how HP money could be spent.

Potential health promotion methods ranged from a *'big bang'* approach, to an aim to work through general practices and thus gain access to extended families and communities via individual patients.

Management Fees

All PHOs, except one questionnaire respondent, felt that the management fee available under capitation was *"pretty useless"* and *"totally inadequate"*, and that the level of management funding *"cripples any sensible planning, and the robustness of the organisation"*.

Costs needing to be met from the management fee included paying the Board of the PHO; training Board Directors; indemnity insurance for both Board members and professional indemnity insurance for the PHO; management salaries; IT; and rent.

Most PHOs commented that the funding levels were well below what business plans or benchmark studies had predicted for a good infrastructure and corresponding management fees. For example, one PHO had a DHB-approved business plan allowing for management costs three times more than they actually received. Another had done a benchmark study before becoming a PHO which suggested a baseline of $600,000 was necessary for management costs. Again, this was considerably more than the PHO received.

It was felt that DHBs expected the move to the PHO model could be done by streamlining existing systems, without appreciating that there were additional requirements to be met for a PHO. The PHO infrastructure demanded an investment in terms of personnel for governance as well as additional documentation, planning and reporting requirements. It was felt that in the light of these requirements, better management resources were needed.

Small PHOs which had the same minimum requirements as large PHOs noted having to rely on infrastructure that spanned a number of PHOs, for example using existing Primary Care Organisation (PCO) structures. Others commented that they were

relying on the goodwill of individuals such as their Board of Directors, who were accepting less remuneration than they could expect for their role.

For some PHOs, once basic management functions were met there was little money left.

> *"We subcontract the 'management functions'…and that costs us 75% of the management fee. What can you do with the remaining 25%? Very little. It will not even support half a worker and no office".*
>
> *"Once directors' fees and insurance are paid, there's nothing left".*

Other Contracts and Other Sources of Funding

As well as the capitation-based funding all PHOs were entitled to, some were also receiving additional funding.

A number of PHOs had providers who held other contracts outside the PHO, including funding for rural practice, A&E services, and diabetes checks. These remained the subject of discussion between providers and the PHO, and between the PHO and their DHB as to whether they would eventually come under the PHO's contract. There was also some confusion over the level of funding for providing these services under existing contracts if they were brought into the PHO; i.e. would the funding remain the same as before, or increase to reflect the larger PHO population?

Other funding that PHOs were sourcing included support from the Ministry of Social Development and local district council. This was seen as taking a holistic approach to health, and so using other resources to address the total well-being of the community.[3]

Funding Fluctuations

Funding on a capitation basis is tied to enrolled population numbers, which may increase or decrease in each funding quarter. Fluctuations in the enrolled population may be caused by a mobile population, patients being de-registered because they were considered to be a "duplicate" (i.e. they had enrolled with another PHO elsewhere), or fee-for-service deductions being made for casual visits by an enrolled patient to a provider who was part of another PHO. These would result in fluctuations in a PHO's income on a quarterly basis.

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Two PHOs felt their funding had been stable, while the remainder had experienced fluctuations in their quarterly income. Register cleansing and fee-for-service deductions were noted to be the main reason for the fluctuations, but some concern was also expressed with regard to whether HealthPAC information was accurate (see further detail under 'Payment Processes').

[3] Other sources of funding may also be available to PHOs.

Fluctuations in income destabilised the financial viability of both the practices and the PHO: *"…trying to manage a business when you only know your income for 3 months"* was noted to be *"extremely challenging"*. This constrained long term planning of projects, so PHOs were limited to either spending money on *"one-offs"* or using pre-existing resources. Planning staff levels was also difficult.

Financial fluctuations also affected the relationship between the PHO and providers.

> *"[It] puts a strain on good working relationships without best information and analysis to provide explanations as to why there have been fluctuations in funds due to fee for service deductions"*.

One solution offered was for the MoH to consider whether they could 'buffer' PHOs so that if register numbers, and therefore funding, decreased, there was a financial threshold below which the PHO would not drop. Otherwise, it was felt that the impact on the viability of individual practices would mean that smaller PHOs particularly, would need to combine, or *"face perishing"*.

The impact of funding fluctuations was particularly noticeable in areas with an increasing number of PHOs.

Patient Co-payments

An aim of the increased funding for primary health care is low co-payments for patients, which will also improve access for patients to the health services they need [3].

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Co-payment range

All Access funded practices had reduced their patient co-payments in response to the additional funding they were receiving. Under 6s were free. For children aged 6-18, co-payments ranged from free to $10, and adults were charged $10-$22.

Practices funded under the Interim formula, which is based on pre-existing subsidy levels, have not been expected to reduce their fees.

Patient reaction

Respondents reported that patient reaction to the effect of PHOs and the impact on fees had been mixed. Some patients had expressed pleasure at the drop in fees at Access funded practices.

Other practices had already offered subsidised services before moving to the PHO model, and thus were only able to offer a minor fee reduction. These practices had noted some dissatisfaction from patients who had expected a larger drop in fees under

the PHO. Conversely in other situations, some patients who could afford to pay had expressed surprise at their eligibility for lower fees in Access practices, and had wondered why they were entitled to them.

Some PHOs contain both Access and Interim funded practices. This has caused confusion for patients, who thought that if they were enrolled with the PHO, they could expect lower fees from all practices within the PHO. This was not the case if they visited an Interim funded practice.

Process of setting co-payments

The setting of co-payments involved two stages of negotiation.

The first stage involved provider negotiations within the PHO. For example, in one case, fees were set by discussion and agreement between the initial practices to form the PHO, and others then choosing to join did so on the basis of what had already been agreed.

In the second stage, negotiations were conducted between the PHO and its DHB. Two PHOs reported difficult negotiations with their DHBs over co-payment levels, because the maximum co-payment level that the DHB would accept was considered by practices to be too low, thus potentially affecting their future viability.

Impact on access

Opinions varied between PHOs with regard to whether reduced fees had made a difference to access and utilisation rates. Some felt it was too early to say, or that as charges had been low already, patients would not have noticed a big change. Others were definite that they were seeing an increase in usage, and/or patients accessing services earlier.

However it was also noted that cost was not the only factor to affect access to first level services – patient education, information and attitudes, and transport were other factors cited. Prescription costs were also seen as a possible barrier for patients, even if they could now afford to see a GP.

Payment Processes

The new capitation-based funding system requires PHOs to collect specific data on their enrolled population and transmit this information electronically to HealthPAC, where it is analysed, verified and the capitation payment calculated. The processed patient information and various other reports are then returned from HealthPAC to the PHO, and payment is made. This cycle is repeated three-monthly[13].

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Information Technology Requirements

Changes required to Information Technology (IT) systems by the new payment processes, and the extent of those changes, varied between practices and PHOs. For some, existing systems were able to be used, with changes mainly centred around upgrading software used by practices within the PHO. For other PHOs *"very substantial changes"* had to be made, with resultant extra workload and cost. In general, large changes were necessitated in situations where practices within the PHO were running a variety of different software systems.

HealthPAC

Payment processes were described as being *"cumbersome"*, and the necessity of a once-a-quarter 'event' was queried when it was possible to be done on an ongoing basis. Overall, it was noted that major resources needed to be committed to the data management process and that there was a need to simplify the processes used. There was also recognition of the increased demands being made of HealthPAC, and concern whether HealthPAC itself had adequate resources to cope with the new workload generated by PHOs.

The majority of PHOs expressed distrust about the HealthPAC processes, and were in general unconvinced that these were rigorous enough. Apart from two interviewees, questions were raised by PHOs as to whether HealthPAC reports were always accurate.

Dissatisfaction was expressed about the inadequacy of documentation related to register processing. Concern was expressed as to whether information from HealthPAC was accurate with regard to details such as duplicates, fee-for-service deductions, and Community Services Card details.

In addition, delays in returning registers meant that GPs did not know who was on the register and who was not. "*Unfriendly"* reports made it difficult for clinics to track payments and unravel errors.

> *"HealthPAC are not returning register files submitted one month out from the start of the quarter till maybe the night before the quarter starts. This is totally unacceptable and makes it impossible for PHOs and practices to upload the*

register for that quarter on time. It has funding implications and also compliance implications for HealthPAC audit. If the up-to-date register is not loaded at practice level they have no idea who is a legitimately enrolled patient…and will claim fee-for-service for that person…only to find later they were on the register all along".

PHOs noted that it was time consuming and difficult to check information they believed was inaccurate. Deductions and register cleansing often had to be accepted as PHOs did not have the time to query them, and the cost of doing so could offset any gain. Conversely, even a small percentage error could result in large financial implications for a PHO, and others therefore considered it necessary to monitor and challenge data received from HealthPAC.

Different interpretations of the business rules of enrolment, and privacy issues prevented PHOs from verifying why individual patients had been removed from their register.

Out of nine questionnaire respondents, only one 'strongly agreed' that payments had been received on time (see Table 9). Two questionnaire respondents added specific comments that they had experienced late payments.

Deductions

The capitation funding is calculated to include all services a typical patient is expected to receive in a given year, including casual visits to other providers outside the PHO they are enrolled with [3]. As a result, PHOs have monthly deductions made for such casual visits which are paid to the treating provider.

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Deductions were a major source of concern to PHOs and providers. Two respondents specified deductions of 10-11%; eight others mentioned deductions without giving a percentage, but included comments such as *"surprisingly high"*, *"unpleasant"* and *"a struggle"*. As a result of deductions, a practice could end up being 'cash negative' for a patient on its register, if they had made a number of 'casual' visits outside the PHO.

"People are very transient in this area. Some providers are actually paying to have people on their register. If a person goes elsewhere more than four times in a quarter, all their capitation funding is lost".

One respondent therefore suggested that a 'deduction floor' was essential, to safeguard against major reductions in income due to a transient or mobile patient population.

The difficulty of anticipating deductions accurately also impacted on a PHO's financial planning.

It was believed that there was a need for more patient and community education so that people understood the implications of enrolment. However one respondent noted that patients were unlikely to consider the financial implications for providers when they sought care from other GPs. Rather, they would choose the services they thought they needed when they were sick. Another commented that patients might be willing to change their enrolment when making a 'casual' visit in order to avoid higher co-payments.

Deductions for casual patients were less of a problem where there were no surrounding or overlapping PHOs, particularly in rural areas.

Table 9 Questionnaire responses re PHO payment processes (N=9)

"Please indicate the extent to which you agree with the statements below with regard to your experience of the PHO payment process."

		Please put an x in the appropriate box					
		Strongly Disagree				**Strongly Agree**	**Don't Know**
		1	**2**	**3**	**4**	**5**	**DK**
5.1	Our existing Information Technology (IT) systems met requirements.	2	2	4	1		
5.2	The process of submitting registers to HealthPAC is straightforward.	4	1	3		1	
5.3	The numbers of our registered patients tallied with HealthPAC reports.	4		3		2	
5.4	We are satisfied that HealthPAC reports are accurate.	5	2	2			
5.5	We have received payments on time.	2	2	1	3	1	

Services

The Primary Health Care Strategy requires that PHOs provide at least a minimum set of essential first-line services, to improve and maintain the health of their populations and restore people's health when they are unwell. In addition, PHOs are to work specifically to address the needs of those in their population with poor health or who are missing out on services to address their needs [2]. Some of the latter services will be provided with Services to Improve Access funding.

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All PHOs reported their providers met first level service requirements. As well as general practice services, other services already provided included terminal care visits; sexual health project; dietary consultations; diabetes 'get checked' programmes; social services; disability services; mobile retinal screening; antenatal smoking cessation programme; meningitis awareness programme; dental services; whanau ora and tamariki ora.

A wide range of new services were being provided or planned under the PHO system.

New services include:
School-based clinics;
Interpreting services;
Refugee & migrant health services;
Mental health project;
CarePlus (part of National Pilot);
The provision of more services out into the community using multidisciplinary teams (e.g. Doctor, tamariki ora worker, nurse, health promotion worker);
Diabetes screening via random screening, referral and monitoring;
Rehabilitation of ACC recipients via 6-week work preparation and therapy;
Whanau Violence reduction delivered via counselling and whanau support;
Extension of Access Project initiatives to practices funded on the Interim formula targeting high health need, CSC card holders, Māori and Pacific patients;
Subsidised script fees for all HUHC holders and those families registered with two Māori services;
Discharge planning;
Feasibility and service design work for new primary care services for Pacific and Māori populations;
New community health workers;
An additional 500 diabetes checks in an effort to improve penetration of these checks amongst Māori;
An additional 5000 free flu vaccinations to cover 18-44 year olds who are not covered by either the MoH or DHB programmes;
Sexual health project where consultations are free for under 25s, Māori and Pacific Islanders (and others at GP discretion), and which will later include IUDs and vasectomies;
Palliative care project to allow patients who wish to, to die at home;

Extended mental health programme to cover referrals to psychologists' service without cost to patient;
Extended service hours of particular existing services.

New services being planned or considered include:
Cardiovascular initiative;
Diabetes retinal screening;
Primary/secondary integrated diabetes service;
New clinics;
New Māori health 'wrap around services';
Contribution to palliative care shortfall;
Registered nurses in the community to work alongside the doctors and follow up on identified clients, monitor clients at risk in the community and the chronically ill;
Adult dental service in urban area; child dental education and promotion in rural area;
Transport subsidy;
Primary mental health;
By Pacific for Pacific GP/nurse service;
Mobile services in targeted settings;
Subsidising medications/assistance with prescription costs;
Integrated diabetes services;
Financial assistance for those accessing second level services/specialist services (such as travel and other associated costs);
Screening Māori men aged 35-60+ for cardiovascular disease;
Developing a mobile nursing service;
Purchase of tympanometers to provide ear services for children;
Coordination of youth health;
Looking at making GP visits free of charge for under 17s in business hours so that people get into being pro-active rather than delaying accessing services;
Working with Kohanga and early childhood services to improve immunisation rates;
Increasing sexual health clinics, hopefully at low or no cost;
A nurse coordinator to coordinate all the different nursing services in the area and avoid duplication;
Rural oral health programme for children under 5;
Rehabilitation outreach (pulmonary rehabilitation programmes in rural communities);
Healthy lifestyle coordination (rural areas; reduce harm from tobacco);
Palliative care home visits in rural areas;
Marae and mobile GP services;
Child health educators (to coordinate services provided to rural children enrolled with the PHO);
More accessible services for refugee and migrant health.

Community Participation

The Minimum Requirements for Primary Health Organisations state that PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community [5].

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There was variation between PHOs as to the nature and extent of community participation in the PHO. At this stage of implementation the extent of community involvement was largely dependant on existing community participation in the organisations which formed the PHO. Some already had extensive community links while a few PHOs were still in the process of formulating networks and ways of engaging with the community. The majority of PHOs however, had either formed, or were in the process of forming, a community advisory group; had a mixture of centralised governance and community representation; or had a community governance structure for the PHO board with the majority of the PHO Board or Trustees of the PHO being from the community.

All PHOs acknowledged the importance of community involvement. A few, however, questioned whether community representation on the PHO board was actually the best way to represent the community.

"The idea that people generally are, or should be, particularly interested in the mechanisms of healthcare delivery needs to be challenged. Likewise the idea that setting up artificial organisations with token representation from all over…is community development or participation needs some careful examination."

Reduction of Inequalities

A key direction of the Primary Health Care Strategy is to identify and remove health inequalities, recognising there are significant inequalities in the health of different groups of New Zealanders[2]. Consequently, 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 [5].

****

There is a great commitment by PHOs to the philosophy of reducing inequalities. Despite this, there was some concern as to whether this is possible under the current funding levels. Some PHOs felt that there was little understanding of the degree of assistance required particularly for those *"starting from scratch"* at an organisational level. Capacity building, especially with regard to the workforce, was needed, as well as addressing issues surrounding scoping and developing projects.

It was also questioned whether health inequalities could be tackled without at the same time addressing underlying socio-economic determinants of health.

PHOs noted that the development of services to reduce inequalities was identified in SIA and HP plans. Many Access funded PHOs in particular suggested that as their client base was largely Māori and Pacific Island, all PHO programmes would have an impact on the health inequalities of their population. Most PHOs had identified and/or were developing services that could reach their target groups. Many, however, were considered to be long term projects, the results of which were unlikely to be evident in the short term. Reduced fees were felt to be the most tangible impact for patients in the meantime.

Evaluation of the effectiveness of programmes for reducing inequalities was considered to be essential, but likely to be difficult. PHOs noted that implemented projects would have an evaluation component, and that in many instances, feedback from the community was an essential part of indicating whether projects were meeting expectations. However concern was also expressed about the difficulties of evaluation, particularly in the collection and interpretation of data. Most PHOs had developed, or were in the process of developing, various means of evaluation which ranged from appointing a community medicine specialist in conjunction with the DHB to look at this area, to developing organisational and project specific key performance indicators within the PHO, or stating that they would evaluate against contracted outcomes.

Governance

Three key points relating to the governance of PHOs are set out in The Primary Health Care Strategy:

> "Primary Health Organisations will be expected to involve their communities in their governing processes. They must also be able to show that they are responsive to communities' priorities and needs.
>
> Primary Health Organisations must be able to demonstrate that all their providers and practitioners can influence the organisation's decision-making, rather than one group being dominant.
>
> Primary Health Organisations will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive" [2].

****

At least three legal forms are open to PHOs: non-profit companies, incorporated societies, and trusts [6]. There were PHOs in the study using each of these structures.

Governance arrangements and ways of involving community and providers varied.

Changing Roles of Health Care Practitioners

The Primary Health Care Strategy "…will have significant implications for the number, mix, distribution and education of the primary health care workforce", and in particular, "the move towards greater population focus and emphasis on a wider range of services will increase the need for well-trained primary health care nurses" [2].

****

Increased collaboration and a 'team approach' were anticipated to develop under the PHO model, involving changes to staff roles.

Several interviewees reported that while nurses already had expanded roles in their provider services, the advent of the PHO gave further opportunity to develop and extend this. A team approach was seen to be an important part of PHOs, involving not only practice nurses, but also community nurses and nurses associated with, for example, Māori partner organisations. For some, new roles had not yet developed, but there was an expectation this would occur over time. Two PHOs reported appointing new nurse coordinators, and another was planning to employ new nurses for a mobile community nursing service.

Some doctors were also reported to have had changing roles for some time, and there was recognition that new clinical projects could involve an increased workload for doctors, not only in clinical work, but also in data collection. It was also believed that although the PHO model had allowed increased collaboration and a greater community focus, it would take time for a 'cultural' change to develop.

Apart from doctors and nurses, PHOs did not report involving other practitioners, because there were no funding streams for them. However some PHOs were undertaking discussions with other health and related services with a view to ongoing development of links between them and the PHO.

Limitations

This project was conducted within a limited timeframe and resources. This constrained the sample size and the design of the research. The design of the study was therefore aimed at gaining an overview of the implementation process with regard to PHOs from their perspective. The study was not intended to describe differences between PHOs of, for example, different size, funding type, or location.

Variation between PHOs became apparent, however, during the course of the research. The pattern of these variations was not able to be defined given the small sample size since the inconsistency in variations between PHO types was not anticipated when the research was designed.

The upcoming evaluation of the PHCS will draw on results from this initial review of PHOs and further explore issues that have been highlighted.

Conclusion

There was great variability between PHOs with regard to many of the processes involved in establishing and maintaining a PHO. Much of this variability depended on the types of organisations which combined to form the PHO, their populations and the resources they had access to in terms of existing infrastructure, IT systems, experienced staff (both managerial and at a governance level) and finances.

Agreement with the philosophy behind the formation of PHOs was widespread, despite the fact that the overwhelming workload and frequently un-reimbursed time required by those involved at any level within the PHO often placed an increased burden on struggling organisations. PHOs' expectations of the primary health care 'vision' were often at odds with the reality of implementing it.

Dissatisfaction was expressed over many of the processes involved with implementation of PHOs, especially with regard to funding and payment processes. Concern was expressed that funding was inadequate, particularly for management and health promotion. Greater definition and clarity around the rules pertaining to qualification for funding was also felt to be required. Streamlining of payment processes, greater accuracy and appropriateness of reports, and timely payments, were believed to be a necessity.

Lack of knowledge by the general public about enrolment processes was felt to be a major hurdle. Tightening the rules of enrolment, particularly in regions which had more than one PHO in close proximity, was also considered important. There was great concern over the viability of some practices due to fluctuating income from register cleansing and deductions, and a 'deduction floor' was mentioned as a means of safeguarding this.

However there is still goodwill present within the sector, despite difficulties with the implementation process (hampered by delays in documentation regarding requirements); confusion and inconsistency in application of rules; and inadequate funding streams. There is also a willingness to 'make it work' for the longer term benefits to patients and the community, and to achieve overall health gains for the wider population. This is despite some concern that unless certain implementation difficulties are addressed, there is a danger that the restructuring of the primary care sector will not be viable in the long term.

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Appendices.

Appendix 1: Material sent to PHOs

Appendix 2: Interview schedule and Questionnaire

Appendix 3: Media Analysis

Appendix 1 Material sent to PHOs

a) Letter from Ministry of Health

b) Letter from the Health Services Research Centre to the 12 PHOs to be interviewed

c) Letter from the Health Services Research Centre to questionnaire participants

d) Information sheet about the project

e) List of requested documents

f) Consent form for the 12 PHOs to be interviewed

g) Consent form for questionnaire participants

16 April 2003

[Address]

Dear

The Government is interested in receiving information on how the first year of implementing the Primary Health Care Strategy (PHCS) has proceeded, and the strengths and opportunities of the process. I am writing this letter to recommend that your PHO take part in a stocktake of the development Primary Health Organisations (PHOs) in 2002/03. This stocktake will inform the report we prepare.

At the same time the Health Research Council, ACC and the Ministry of Health are joint funding a three year process and intermediate outcomes evaluation of the implementation of the Strategy. The joint venture partners will be choosing a provider in June this year and they will be beginning work in July 2003.

This evaluation will address many features including the development of new providers and services, management and governance, relationships with the community, the impact that Primary Health Organisations have on reducing health inequalities, intermediate health outcomes and an economic analysis. The evaluation will have a strong formative component and provide input for informing decisions by PHOs, District Health Boards (DHBs) and the Government.

When the research team has been chosen we will be notifying the sector of who is undertaking the evaluation and the main themes they will be addressing. We expect to notify this through our electronic newsletter *Primarily* some time in July of August.

Of course, by that time many PHOs will have been in place for some time. It is important that their experience is recorded and analysed at this time to inform the evaluation. We have therefore contracted with the Heath Services Research Centre (HSRC) to carry out a “stocktake” of progress in the first twelve months.

This will include collecting some information from all PHOs established up until March 2003 and more in depth review of progress in 12 PHOs that cover the range of new PHOs. A list of the 12 PHOs is attached.[4]

The following topics will be addressed:

1. The structure of each PHO;
2. The planned procedures for informing patients, communities and providers about PHOs;
3. The programmes established by each PHO;
4. The enrolment processes and the IT/data management systems for each PHO;
5. Changes to charging systems as a result of the introduction of PHOs;
6. The costs of establishing PHOs;
7. Changes to staff and procedures as a result of the introduction of PHOs;
8. PHOs' relationships with the Ministry of Health;
9. PHOs' relationships with its DHB;
10. Initial feelings within PHOs for the strengths and weaknesses of the implementation of PHOs;
11. Perceptions of strengths and weaknesses of the process of developing PHOs.
12. Perception of changes (positive and negative) as a result of the introduction of PHOs
13 Public perception of PHOs

The researchers appreciate that staff in PHOs and DHBs are busy people. They will ensure that the time commitment of the people contacted is kept to a reasonable level.

HSRC will be contacting PHOs soon to ask for your cooperation. This project is an important part of the ongoing evaluation and I recommend you take part in this. If you have any queries about whether you should take part please contact Dr John Marwick, Principal Clinical Adviser, Primary Health Team at the Ministry of Health (Ph 04 496 2052 john_marwick@moh.govt.nz).

A copy of this letter has been sent to the primary care team in your DHB.

Yours sincerely

[4] This list has been removed to retain the confidentiality of participants' responses.

Colin Feek
Deputy Director-General
Clinical Service Directorate

15 April 2003

[Address]

Dear

Please find enclosed an information sheet from Dr Roshan Perera explaining a research project on Primary Health Organisations which we have been contracted to carry out for the Ministry of Health. You will have already received a letter from Dr Colin Feek of the Ministry of Health explaining the research.

Also enclosed is a form which we ask you to sign to confirm your willingness to participate in the project and a list of the documentation we ask you to provide. If you have any additional documents you think would be useful for the research please include them. If it would be easier to send these documents electronically please email them to roshan.perera@vuw.ac.nz.

We have selected your PHO as one of the organisations we would like to investigate in more depth. The 12 that have been selected were chosen so we would have a range of PHO with different characteristics. We have chosen a both big and small organisations, some rural, some urban and some provincial PHOs as well as some serving Māori and Pacific populations.

Either Roshan or Janet McDonald will get in touch with you to arrange a suitable time to carry out a phone interview.

We urge you to participate in the research project – it will not take a lot of your time. The cooperation of all PHOs will mean that we will be able to provide the Ministry of Health with a comprehensive report of the status of PHOs at the present time.

Please return the enclosed consent form by 30 April (small prepaid envelope included) A second copy of the form has been included for your files.

We would be grateful to receive documentation by 7 May (large prepaid envelope included).

I realise that these are fairly tight deadlines but we have very little time to do this work. We would appreciate it if you could give this matter your urgent attention.

Please note that we are independent of the Ministry.

Thank you for your help.

Yours sincerely

Celia Murphy
Project Manager
Health Services Research Centre
Victoria University
Rutherford House, 23 Lambton Quay
PO Box 600
WELLINGTON
DDI: 04 463 6592
Email: celia.murphy.vuw.ac.nz

15 April 2003

[Address]

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Please return the enclosed consent form by 30 April. (small prepaid envelope included) A second copy of the form has been included for your files.

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Please note that we are independent of the Ministry.

Thank you for your help.

Yours sincerely

Celia Murphy
Project Manager
Health Services Research Centre
Victoria University
PO Box 600
WELLINGTON
DDI 04 463 6592 Email: celia.murphy.vuw.ac.nz

07/04/03

Primary Health Organisations – Stocktake of the first year (July 2002 – July 2003)

I am writing to you to request the participation of your DHB/PHO in a "stocktake" of Primary Health Organisations (PHOs). The project is funded by the Ministry of Health and is being conducted by the Health Services Research Centre, Victoria University of Wellington.

It is anticipated that in mid 2003 the Ministry will conduct a process evaluation of the implementation of the Primary Health Care Strategy. The first Primary Health Organisation (PHO) however, began operation in July 2002, with further PHOs being established in October 2002, January 2003 and April 2003. In order to inform the Ministry's evaluation of the implementation of the Primary Health Care Strategy, a stocktake of PHOs is being undertaken.

The stocktake will provide a description of the structure, processes and programmes established by the PHO, and changes to existing structures required as a result of the introduction of the PHO model. A description of the strengths and weaknesses of the implementation processes, the relationships established and the perception, both positive and negative, of the changes required as a result of the introduction of PHOs will also be produced.

If you would be willing to participate in this project, I would be grateful if you would indicate this on the form provided.

A document analysis of the documentation produced by the Ministry of Health, DHBs and PHOs forms part of the stocktake, and we would be grateful if you would provide us with copies of any documentation relevant to the establishment and maintenance of the PHO. (see attached list). A postage paid envelope is enclosed.

A mailed questionnaire will also be sent within the next few months.

12 of the 34 PHOs have been selected for in-depth analysis. PHOs were selected to achieve maximum variation. Phone interviews with key personnel in each of the 12 PHOs will also be conducted. Interviews will be approximately 1 hour. We would like to tape the interviews. Taped material will be securely stored. Only the research team will have access to the tapes. Summaries of the interviews will be coded. A draft report will be sent to each PHO to check and amend as necessary.

If you have any queries or require any further information about the project, please contact Roshan Perera of the Health Services Research Centre: phone 04 4636575 or email roshan.perera@vuw.ac.nz.

Thank you for your time and consideration of our request.

Primary Health Organisation Stocktake Research Project

Documents Requested

Contracts (DHB and providers)
Māori Health Plan
Health Promotion Proposal
Proposal to improve access to services

Documents relating to

- organisational structure of the PHO
- establishment of the PHO (including tendering documents)
- programmes established by your PHO
- enrolment processes
- planning - eg strategic and annual plans
- business plans
- fees and charging structures]
- procedures for informing patients, communities and providers about your PHO

Primary Health Organisations Stocktake Project.

PHO

1 …….. Primary Health Organisation agrees to participate in this stocktake research project.

2 I agree to provide the documentation requested by the research team.

3 I give permission for the research team at the Health Services Research Centre to access documents pertaining to ……PHO which are held by the Ministry of Health and the District Health Board.

4 I agree to complete and return the postal survey.[5]

5 I agree to allow key staff in the PHO to be interviewed by the research team.

Signed ……..

Name ……..

Position ……..

Date ……

[5] Interviewees were not required to fill out the postal survey.

Primary Health Organisations Stocktake Project.

PHO

1 …….. Primary Health Organisation agrees to participate in this stocktake research project.

2 I agree to provide the documentation requested by the research team.

3 I give permission for the research team at the Health Services Research Centre to access documents pertaining to ……PHO which are held by the Ministry of Health and the District Health Board.

4 I agree to complete and return the postal survey.

Signed ……..

Name ……..

Position ……..

Date ……

Appendix 2 Interview Schedule and Questionnaire

a) Interview schedule
b) Questionnaire

Interview Schedule Stocktake

Questions	Probes
Overview - can you give us an overall description of your organisation?	Establishment date, provider groups, Population (enrolled no's and % high needs groups), Governance structure, type of funding (ac/int)
Overall, what do you see as the advantages/disadvantages of becoming a PHO?	What were your expectations? Have these been met? If not, why not?
Can you tell us what processes you had to go through to establish your PHO? - Negotiation (internal – providers) - Contracts (internal/external) - legal (rules of the organisation); - documents - service requirements/SIA - enrolment - IT Overall, what were you impressions of the establishment process? What was easy? Why? What was hard? Why? Is there anything that would help facilitate the enrolment process?	What was the timeframe involved? E.g. from discussions to establishment?
Do you have any concerns about your contract with the DHB? If so, what? Has your PHO signed a contract with its DHB? - If yes, which version? - If no, why not? - What has the contract discussion process been like? Are you aware of discussions about a national PHO contract? Are you represented in those discussions? - If yes, who by? - If no (or don't know), would you want to be – and by whom	Ask about the standard clauses and locally specific clauses
What costs did you incur during the establishment process? What were the demands on the existing staff of the establishment process?	? need for extra staff
Which DHB/s are you part of? What support did you/or didn't you get from - DHB/s? - Ministry? (financial support, other types of support) How would you describe that support?	Could anything be improved? If so, what would this be?

If you relate to more than 1 DHB, what issues does this raise? Is there any other help you would like to have received from the DHB or MoH? Did financial and/or other support (or lack of it) have an impact on the speed at which you became a PHO?	
How would you describe your relationship with - your DHB - the Ministry	
• How have you, or how are you planning to inform your patients/community about the formation of the PHO? • Enrolment - have you had to make any changes to accommodate enrolment requirements; - are there any problems – currently/envisaged for the future - Has your enrolled population increased or decreased, and if so, why? - Overall how would you describe your experience of the enrolment process? - Is there anything you think could be improved about the enrolment process? • Services - have you had to make any changes to meet the minimum requirements in terms of o services offered; o coordination of services; o impact on workforce (no's/type of staff/training) • Are you offering or proposing to offer any new services (eg Māori health; health promotion; innovative modes of practice) - Are they for SIA? - Are there any barriers to achieving these extra services? (particularly wrt staff, skill mix, potential increased workload for the member practices) - Impact on workforce (no's/type of staff/training) • Has the role of nurses changed with the formation of your PHO? (Governance level; additional services; innovative services) • Has the role of doctors changed? If so how • What about other practitioners	
How do you intend to reduce health inequalities for Māori/Pacific/low income people in your PHO? How will you know you are achieving your aim?	

What are your views on the funding of PHOs? Describe the components of funding your organisation receives. Describe how your organisation pays various providers (e.g. capitation, fee for service, salary – GPs, nurses, other providers, PHO non-clinical staff) How would you describe the funding levels for: • Essential 'first level' (GP and practice nurse) services • New services (SIA & Health promotion) – comments on the process for agreeing on services and funding? • Administration • What other contracts you have and how they have been affected by the set up of the PHO How is the payment process working for your PHO? • IT requirements/enrolment/cleaning of registers • Impact of de-duplication • Impact of the causal patient payment arrangements - mobile patient population/casual visits elsewhere - after hours arrangements - charge back systems	Meeting of expectations Impact on financial status of the PHO
What, if any, changes have you or your providers made to patient charges? - Do you think this has made an impact on people's ability to access services? - What process was used to decide any change in fees? - What, if any, difference will the recently agreed fees framework make to your PHO or your providers?	- what level were fees before? - role of GPs, PHO, DHB, Ministry - ?any plan to review fees?
For Māori/Pacific providers within the PHO - what are the advantages of becoming a PHO - are there any disadvantages of becoming a PHO/do you have any concerns For Māori/Pacific board members/managers/nursing staff/other staff etc - how much input do you have into governance decisions, direction of PHO, services etc. - how much influence are you able to exert?	?assimilation into the mainstream/loss of identity/ ?what expectations do you have with regard to decreasing health inequalities?
In what ways are you encouraging community participation in the PHO?	

What level of community participation do you have? How are Māori and Pacific people participating?	
What do you think is the public perception of your PHO? What are people's expectations of PHO's?	PHOs in general
What do you think are the main strengths of PHOs and why? Do you think there are any weaknesses of PHOs, and why?	
Is there anything else you would like to add?	
Is there anyone else in the organisation that you think we should talk to?	

Ref: 000

PHO Stocktake Project Questionnaire

He mihi tēnei ki a koutou katoa ngā iwi o ngā hau e whā. Kia koutou e ngākau nui nei ki te tautoko ki te manaaki i tēnei kaupapa nunui. Tēna koutou, tēna koutou, tēna koutou katoa.

Greetings to you from around the country.
To those of you participating in this project, tēna koutou, tēna koutou, tēna koutou katoa.

- Thank you for taking part in this important study.
- Identifying information will be removed, and the information supplied will be combined with other responses in the report to the Ministry of Health. Your individual response will not be identifiable.
- Please complete every item in the questionnaire by **marking an x in the space provided** corresponding to the number on the scale that most closely reflects your opinion or situation, or **writing your opinion** as requested.
- The questionnaire can be completed electronically.

Please return the questionnaire by Friday 18th July 2003.

The questionnaire may be returned by email to janet.mcdonald@vuw.ac.nz

Or post to:

PHO Stocktake Project
Health Services Research Centre
Victoria University of Wellington
PO Box 600
Wellington

For further information contact: Janet McDonald Ph: (04) 463 6582

Question 1

Description of PHO

Question	Answer
1. What was the establishment date of your PHO?	**1.**
2. What organisations and/or provider groups combined to form the PHO? Please describe briefly what type of services each organisation provides e.g. gp/mental health/health promotion	**2.**
3. What are the governance arrangements for your PHO?	**3.**
4. What was the total number of enrolled patients at establishment? (The number of registered patients initially accepted by HealthPAC.)	**4.**
5. What was the percentage of "high need" patients at establishment? (enrolled Māori, Pacific Island and decile 9 and 10)	**5.**
6. What type of funding is your PHO eligible for? I.e Access/Interim/Access with Interim practices.	**6**
7. Have you signed a contract with the DHB? If yes: which version have you signed?	**7.**

If no: why not? When do you expect to sign a contract?	

Question 2

PHO Establishment

Please indicate the extent to which you agree with the statements below with regard to your experience of the PHO establishment process.

		Please put an x in the appropriate box					
		Strongly Disagree				Strongly Agree	Don't Know
		1	2	3	4	5	DK
2.1	Overall the establishment process was straightforward.						
2.2	The establishment funding from the DHB covered our establishment costs.						
2.3	PHO member organisations spent a lot of non-reimbursed time on establishment processes.						
2.4	We had sufficient staff capacity within PHO member organisations to undertake the establishment process.						
2.5	The documentation required by the DHB for establishment was easy to provide.						
2.6	The time frames for establishment were adequate.						

2.7.1: What assistance did you receive from the Ministry of Health during the establishment process?

2.7.2: Is there any other form of help that you would like to have received from the Ministry of Health during the establishment process? Please explain.

2.8.1: What assistance did you receive from your District Health Board during the establishment process?

2.8.2: Is there any other form of help that you would like to have received from your District Health Board during the establishment process? Please explain.

2.9: Please add any OTHER comments you have about the establishment process.

Question 3

PHO Enrolment Process

3.1: Please describe how you are enrolling patients in your PHO.

3.2: Did you need to make any changes to existing procedures to accommodate PHO enrolment requirements? Please explain.

3.3: Has your enrolled population increased, decreased or remained the same since establishment? Please explain.

3.4: Please add any OTHER comments you have about the enrolment process.

Question 4

PHO Funding Levels

Please indicate how adequate you consider PHO funding levels were for the following.

		Please put an x in the appropriate box					
		Inadequate				Adequate	Don't Know
		1	2	3	4	5	DK
4.1	Provision of 1st level health services (e.g. general practice/nursing/ immunisation etc)						
4.2	Services to increase access						
4.3	Health promotion						
4.4	Management						

4.5: Has your funding remained stable or fluctuated between payment periods?
Please explain why.

4.6: What impact, if any, does the above have on your PHO?

4.7: Please add any OTHER comments you have about funding levels.

Question 5

Payment processes

Please indicate the extent to which you agree with the statements below with regard to your experience of the PHO payment process.

		Please put an x in the appropriate box					
		Strongly Disagree				Strongly Agree	Don't Know
		1	2	3	4	5	DK
5.1	Our existing Information Technology (IT) systems met requirements.						
5.2	The process of submitting registers to HealthPAC is straightforward.						
5.3	The numbers of our registered patients tallied with HealthPAC reports.						
5.4	We are satisfied that HealthPAC reports are accurate.						
5.5	We have received payments on time.						

5.6: Please add any OTHER comments you have about the payment process.

Question 6

Services

6.1: Please list the services you offered at the time of PHO establishment.

6.2: Please list any new services, if any, you have implemented since PHO establishment. Please describe briefly who the services are for, and how they are delivered.

6.3: Are you planning to implement any new services? If yes, please list. Please describe briefly who the services are for, and how they are to be delivered.

Question 7

Reduction of health inequalities

7.1: Please describe how you intend to reduce health inequalities for Māori, Pacific and low income people in your PHO.

7.2: Please describe how you will evaluate your measures for reducing inequalities.

Question 8

Community Participation

8.1: Please describe the arrangements for community participation in your PHO (during the establishment process, and ongoing).

8.2: Please describe how Māori and Pacific people are participating in the above processes.

Question 9

Other Comments

9.1: Please add any other comments you have.

9.2: Please describe your position and role in your PHO.

Thank you again for taking part in the research.

Appendix 3 Media Review