

## **A summary of Victoria University Health Services Research Centre's four PHO research reports**

*These reports draw on interviews with staff in Primary Health Organisations, District Health Boards, Management Services Organisations and General Medical Practices and from surveys with PHO board members, general medical practice managers, GPs and practice nurses undertaken between August 2006 and June 2007, and from a survey of Primary Health Organisations undertaken in July/August 2008.*

### **Status and Activities of General Medical Practices**

*Dr Antony Raymont and Dr Jacqueline Cumming*

This report finds clear support amongst practices and individual GPs for the increase in primary health care funding over recent years and for a greater role for nurses.

However, support for specific changes – including the creation of PHOs, the provision of universal low-cost access, the seeking out of patients who do not present for care, and the Care Plus programme (for those with chronic illnesses) – was more muted.

Practices and practice staff in PHOs reported that more consultations were being provided, and that practices had become busier over time. The increase in consultations had been aided by having greater funding and lower fees charged to patients.

Practice and GP views on their PHO varied from enthusiasm to distrust, although PHO influence was judged to be 'about right' by a majority of respondents. Some respondents, however, felt more PHO services would be desirable.

Many respondents, especially individual GPs, were concerned about the sustainability of primary medical practice, citing an ageing workforce and practice vacancies. Respondents felt that recruitment would be aided if practices received better overall support – from the Ministry of Health and DHBs as well as their PHO – and if secondary services were improved.

This report concludes that the implementation of the Primary Health Care Strategy has aided the development of some general medical practices and increased access for some populations, and also notes the considerable variation in practices and practice views around the country. This suggests that further improvements are more likely to be facilitated by working with individual practices, rather than imposing a 'one size fits all' approach to primary health care services.

## **Patient Fees as a Metaphor for So Much More in New Zealand's Primary Health Care System**

*Dr Bronwyn Croxson, Dr Judith Smith and Dr Jacqueline Cumming*

This report considers the implications of recent changes in the funding of primary health care services, with new funding having been provided to reduce the fees that patients pay when they use primary health care services, and to ensure that such fees remain affordable for patients.

The report notes that fees have been seen by government as a metaphor for reducing inequalities, with fee reductions considered an important means of improving access to services, in particular for people who find it difficult to pay for services when they need them. But to GPs, fees represent the freedom to charge patients and are an important symbol of GPs' autonomy and status as trusted independent professionals. In recent reforms, general medical practice fees have therefore become a metaphor for the often fraught relationship between the state and GPs, leading to a focus on fees as a key issue as opposed to how we might further enhance our primary health care services in future.

The report concludes that with the roll-outs of new funding complete, we now need to shift away from this focus on infrastructure and fees towards achieving wider primary care goals such as how to develop extended and better integrated local services. The time is ripe for an exploration of future options about the relationship between the state and general practice, and how the new environment can be further developed to improve the health of New Zealanders.

## **The Roles and Functions of Primary Health Organisations**

*Associate-Professor Pauline Barnett, Dr Judith Smith and Dr Jacqueline Cumming*

This report looks at the way in which PHOs, in particular PHO governing boards, have developed and how they are working to improve primary health care service delivery in New Zealand.

At the time the research was undertaken, 80 PHOs had been successfully established. PHO boards are however diverse in terms of numbers of members, their background, the processes by which they are selected and the remuneration they receive. All PHO boards recognise the importance of community representation, and although this does not guarantee effective participation (with about a third of Board members reporting community influence is too weak), there is a commitment from PHOs to gaining community involvement in their work.

The report also finds diversity in how PHOs think about their roles. Where the PHO had evolved from a community trust or similar organisation, it was seen that a shared perception of common goals due to a shared history of local governance was more readily developed between clinical and community leaders. Some felt, however, that where a PHO had grown out of an IPA, then, initially at least, the PHO retained more focus GP needs and perspectives. For example, some PHOs declared a commitment to maintaining the lowest fees possible while others saw their role as ensuring that increased government funding was passed on to patients. Most PHOs, whatever their origins, were actively balancing the competing goals of achieving lower fees while maintaining sustainable business practices.

Taking a strategic approach was seen as important for PHOs, as was developing new services, and a wide range of service improvements were mentioned throughout the research. There is however variety in how specific issues are addressed in PHOs, for example in relation to workforce issues (which is a major issue for PHOs), patient fees, capacity development and service development, and there are tensions between fee restraint and sustainable practices. Some PHOs are more proactive in addressing these matters, while others see them as beyond their role or capacity. Despite this, there are many examples of innovation in workforce and service development, and in community outreach and engagement.

PHO Board members reported improving relationships with their DHBs, although not all DHBs were seen to understand or fully support the primary health care strategy, or have confidence in PHOs. PHOs were also looking for greater autonomy and flexibility in their relationships with DHBs. There appeared to be some parallel development of services in DHBs and PHOs, suggesting a need for more joint planning and funding.

Small PHOs find it more difficult to fund governance activity, raising questions about the equity and adequacy of the management fee. However, the development of alliances and networks and working with management services organisations may mitigate some of these risks.

**Taking the Temperature of Primary Health Organisations: A Briefing Paper**  
*Dr Judith Smith and Dr Jacqueline Cumming*

This paper also looks at the roles of PHOs in New Zealand, based on a survey of PHOs undertaken in July/August 2008. Once again, the research finds major diversity amongst PHOs, in terms of their enrollee numbers, management support arrangements, and the size, composition and remuneration of governance boards and frequency of meetings. PHOs also differ in terms of the providers that they work with. Most importantly, they differ in terms of what they expect of themselves, in particular over whether they should be a provider of services or not.

The paper also reports on issues relating to the allocation of public funding by PHOs, with little financial leverage exerted by PHOs over the largest allocation of funding, for first contact services. This reflects central government policy aimed at reducing the fees that patients pay when they use services, and appears to have left PHOs with limited financial leverage in respect of how they seek to develop local primary care services.

The survey also shows a degree of vulnerability within PHOs, with a worrying proportion (12 PHOs or 16% of PHOs) of PHOs indicating they are at risk, and fewer than half (30 PHOs or 41%) considering themselves to be doing well. Although some smaller PHOs feel that they are at risk, there does not appear to be a straightforward relationship between organisational size and perceived robustness in the face of future challenges.

The paper concludes that having put in place an extensive primary health care infrastructure, we now need to consider how best to use that infrastructure, in particular by clarifying the roles and expectations of PHOs, along with an assessment of whether or not they have the capacity to achieve these expectations.