

**Taking the Temperature of
Primary Health Organisations:
A Briefing Paper**

Judith Smith

Jacqueline Cumming

September 2009

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

Additional copies available at www.vuw.ac.nz/hsrc
or through:
Maggy Hope (+64 04 463 6565) maggy.hope@vuw.ac.nz

Citation details:

Smith J., and Cumming J. (2009) *Taking the Temperature of Primary Health Organisations: A Briefing Paper*. Wellington: Health Services Research Centre.

TABLE OF CONTENTS

1	INTRODUCTION	1
2	METHODS	2
3	THE DEMOGRAPHY OF PHOS	3
3.1	Enrolled patient population.....	3
3.2	PHO background.....	4
3.3	Composition of PHOs.....	6
3.4	Management services.....	7
3.5	Governance.....	7
3.5.1	<i>Size of PHO board.....</i>	<i>8</i>
3.5.2	<i>Composition of PHO board.....</i>	<i>8</i>
3.5.3	<i>Method of selection of board members.....</i>	<i>13</i>
3.5.4	<i>Term of appointment of board members.....</i>	<i>14</i>
3.5.5	<i>Frequency of board meetings.....</i>	<i>14</i>
3.5.6	<i>Fees paid to board members and chairs</i>	<i>15</i>
3.6	Conclusion about demography of PHOs.....	17
4	THE ROLE OF PHOS	18
4.1	Managers' views of the role of their PHO	18
4.2	Allocation of first-contact finding by PHOs to general practices.....	21
4.3	Allocation of other primary health care resources by PHOs to practices	23
4.4	Staffing in PHOs	25
5	PHO FUTURE SUSTAINABILITY.....	28
5.1	PHO future goals and directions.....	29
6	DISCUSSION AND POLICY IMPLICATIONS	30
	ACKNOWLEDGEMENTS.....	33
	REFERENCES	34
	APPENDIX 1: PHO SURVEY	36
	Internal structure	36
	Capacity and sustainability	38
	Financial distribution	38
	Questions 7–10 paragraph form.....	39
	Questions 7–10 tabular form.....	40

LIST OF TABLES

Table 1:	Enrolled population of PHOs in July 2008	3
Table 2:	Background of the PHO	5
Table 3:	PHO composition	6
Table 4:	Number of people on the PHO board.....	8
Table 5:	Total number and percentage of PHO board members by representation	9
Table 6:	Composition of PHO boards – number of PHOs by percentage of board member representatives	9
Table 7:	Number of PHOs by percentage of board members who are elected	13
Table 8:	PHO managers’ perceptions of the role of their PHO, ranked	18
Table 9	PHCS budget, 2007/08.....	23
Table 10	Whether PHOs allocate health promotion funding directly to practices.....	23
Table 11	How PHOs that allocate health promotion funding to general practices calculate the amount of funding	24
Table 12	Whether PHOs allocate SIA funding directly to practices	24
Table 13	How PHOs that are allocating SIA funding to general practices calculate the amount of funding.....	24
Table 14	PHO employees – by category of employee and percentage of total employees.....	26
Table 15	Views of PHO managers about the sustainability of their organisation.....	28
Table 16	Views expressed by PHO managers responding ‘other’ to the question about the sustainability of their organisation	28

LIST OF FIGURES

Figure 1:	Enrolled population of PHOs in July 2008	4
Figure 2:	PHO establishment by year, as reported in July 2008.....	4
Figure 3:	Affiliation of PHOs with national organisations.....	5
Figure 4:	PHO composition	7
Figure 5:	Number of people on the PHO board.....	8
Figure 6:	PHO board composition – number of PHOs by percentage of board made up by GPs	9
Figure 7:	PHO board composition – number of PHOs by percentage of board made up by practice nurses.....	10
Figure 8:	Māori representation on PHO boards	10
Figure 9:	Pacific representation on PHO boards	11
Figure 10:	Community representation on PHO boards.....	11
Figure 11:	Other representatives on PHO boards	12
Figure 12:	Number of PHOs by percentage of board members who are elected.....	13
Figure 13:	Term of appointment of PHO board members, by number of PHOs.....	14
Figure 14:	Fees paid to PHO chairs per board meeting, by number of PHOs	15
Figure 15:	Fees paid to PHO members per board meeting, by number of PHOs.....	16
Figure 16:	PHO managers’ perceptions of the role of their PHO	19
Figure 17:	PHO managers’ view of importance of particular roles	20
Figure 18:	PHO employees	26
Figure 19:	PHO employees – by category of employee and percentage of total employees.....	27
Figure 20	Relationship between size of PHO and perceived sustainability.....	29

ABSTRACT

This paper sets out the findings of a survey of managers of primary health organisations (PHOs) in New Zealand. The survey was sent to every PHO in the country (80 in all as at July 2008), and 91% (73 PHOs) responded. The overall aim of the survey was to explore, using a common framework, key issues relating to the organisation and purpose of PHOs. This paper evaluates the state of PHOs in 2008, specifically in terms of the role they perform within the New Zealand health system, and explores their future sustainability.

The paper finds major diversity amongst PHOs, in terms of enrollee numbers; management support arrangements; and the size, composition, remuneration and activity of governance boards. PHOs differ in terms of the providers that they work with. Significantly, they also differ in their expectations of themselves. To give a vivid example, half of the PHOs surveyed thought that a PHO should be a provider of services; the other half disagreed. The manner in which PHOs allocate public funding was another issue arising from the survey. At present, PHOs exert little financial leverage over the largest allocation of funding, for first-contact services. In part, this is a result of central government policy decisions aiming to reduce fees for primary health care services. Finally, the survey data reveals a feeling of vulnerability within the PHO sector: a large proportion of PHOs see themselves as being 'at risk', and fewer than half consider themselves to be 'doing well'.

The paper concludes by noting that if PHOs are to further develop their role as planners and funders of primary health care and to better integrate primary health care using mechanisms such as more devolved budgets and pooled funding streams, there are issues to be worked through in relation to how PHOs relate to their providers, and to their management services organisations. New Zealand has put in place an extensive network of primary health care infrastructure – how to best use that infrastructure is a key policy challenge. It would seem that the time is ripe to revisit the role and expectations of PHOs, along with an assessment of whether they have the capacity to achieve those expectations. The policy challenge now is to clarify the expectations and role of PHOs, and to provide them with the funding and organisational flexibility to enact these expectations and thus support local practices and providers in delivering ever stronger and more extensive primary health care services for local populations.

1 INTRODUCTION

This paper sets out the findings of a survey of managers of primary health organisations (PHOs) in New Zealand. The survey was sent to every PHO in the country (80 in all as at July 2008), and 91% (73 PHOs) responded. The overall aim of the survey was to explore, using a common framework, key issues relating to the organisation and roles of PHOs. This paper therefore evaluates the demography of PHOs in 2008, specifically in terms of the role they perform within the New Zealand health system, and explores issues about PHO sustainability and aspirations.

The survey was developed as part of the evaluation of the Primary Health Care Strategy (PHCS) that is being led by the Health Services Research Centre (HSRC) at Victoria University of Wellington and funded by the Health Research Council of New Zealand, the Ministry of Health and the Accident Compensation Corporation (ACC). The survey was intended to assist the research team in developing an updated profile of PHOs, and to inform the final phase of evaluation fieldwork which took place in early 2009.

Given the high response rate and the richness of the data gathered, the research team has considered it worthwhile to produce this interim briefing paper on the main findings from the survey, with the aim of informing policy debate on the future of PHOs and the further development of primary health care in New Zealand in general.

2 METHODS

As noted above, the overall aim of the survey was to explore, using a common framework, key issues relating to the organisation and roles of PHOs. The research team drafted a survey based on key research questions used in the PHCS evaluation and on further key issues which the team felt should be explored with PHOs, with feedback provided by the funders of the research. Following a small pilot, CBG Health Research Ltd undertook the fieldwork, using a computerised assisted telephone interview (CATI) process.

All PHO managers were approached by telephone to participate in the research; 73 of 80 managers agreed to participate. The CATI interviews took place in July and August 2008. Each interview contained questions relating to the internal structure of the PHO, including staffing and activities; capacity and sustainability; and financial distribution. The survey is attached as Appendix 1.

Quantitative data were analysed using descriptive statistical techniques; qualitative data were analysed using thematic analysis techniques, identifying key themes based on the survey and themes that emerged from the data.

3 THE DEMOGRAPHY OF PHOS

The first set of questions in the survey focused on the internal structure of PHOs. The survey questioned managers on issues such as the enrolled patient population; date of the PHO's establishment; PHO origins; affiliation with national representative organisations; membership by practices and non-governmental organisations (NGOs); provision of management services; and governance arrangements, including board composition, meeting frequency and payment of board members.

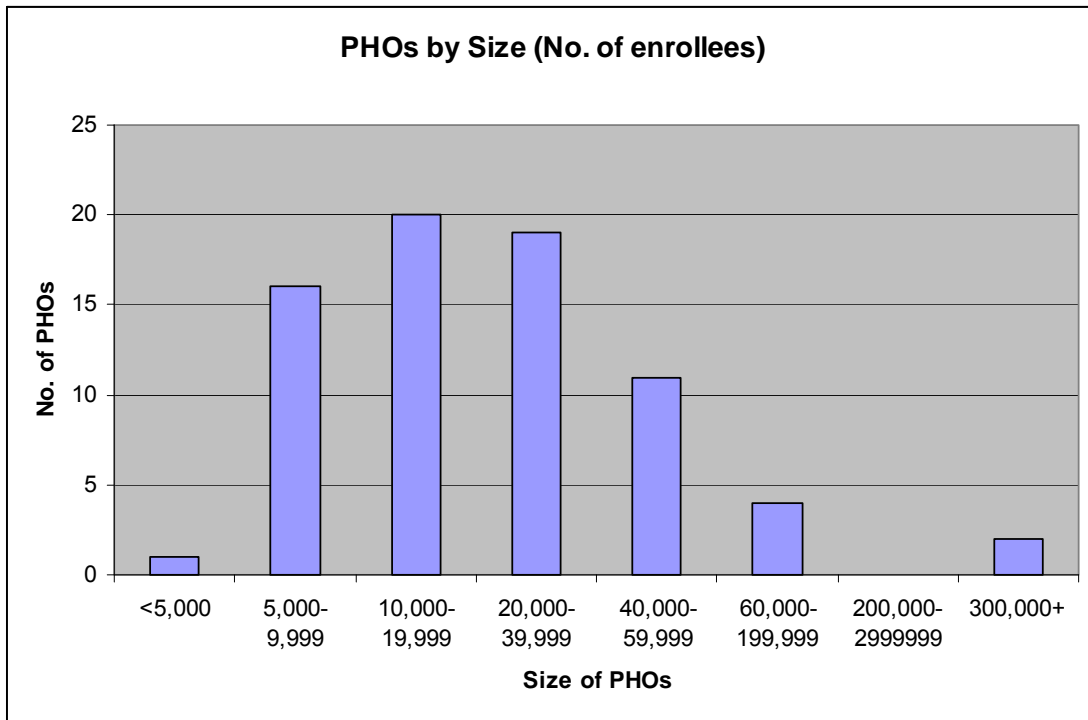
3.1 Enrolled patient population

The survey revealed significant variation in the size of PHOs as measured by the enrolled patient population. PHOs responding to this survey ranged in size from 1536 enrolees to 356,000 enrolees (see Table 1 and Figure 1). Just over half of the PHOs had fewer than 20,000 enrolees (37 or 50.7%), but these PHOs accounted for only 13% of the enrolled population. Just under two-thirds of those enrolled belonged to a large PHO (of 40,000 or more enrolees), with just over 20% of the population enrolled in the two largest PHOs. These findings confirm previous analyses also showing considerable variation in the size of PHOs (Perera, McDonald et al 2003; Cumming, Raymont et al 2005; Gauld and Mays 2006; Gauld 2008). The discussion section of this paper returns to the issue of PHO size, which is of significance in relation to the expected purpose and functions of PHOs in the next phase of development of primary health care in New Zealand.

Table 1: Enrolled population of PHOs in July 2008

PHO enrolees	Number of PHOs	Percentage of PHOs	Cumulative percentage of PHOs	Percentage of enrolled population	Cumulative percentage of enrolled population
<5,000	1	1.4%	1.4%	0.1%	0.1%
5,000–9,999	16	21.9%	23.3%	3.7%	3.8%
10,000–19,999	20	27.4%	50.7%	9.2%	13.0%
20,000–39,999	19	26.0%	76.7%	22.1%	35.1%
40,000–59,999	11	15.1%	91.8%	25.1%	60.2%
60,000–199,999	4	5.5%	97.3%	18.2%	78.4%
200,000–299,999	0	0.0%	97.3%	0.0%	78.4%
300,000+	2	2.7%	100.0%	21.6%	100.0%
Total	73	100.0%		100.0%	

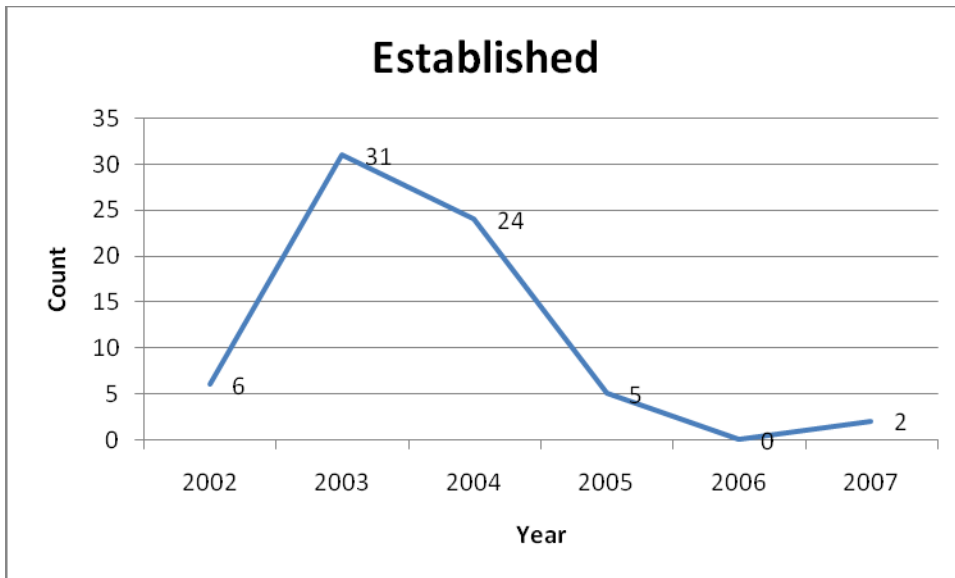
Figure 1: Enrolled population of PHOs in July 2008



3.2 PHO background

As set out in Figure 2 below, the majority of PHOs were established in 2003 and 2004.

Figure 2: PHO establishment by year, as reported in July 2008



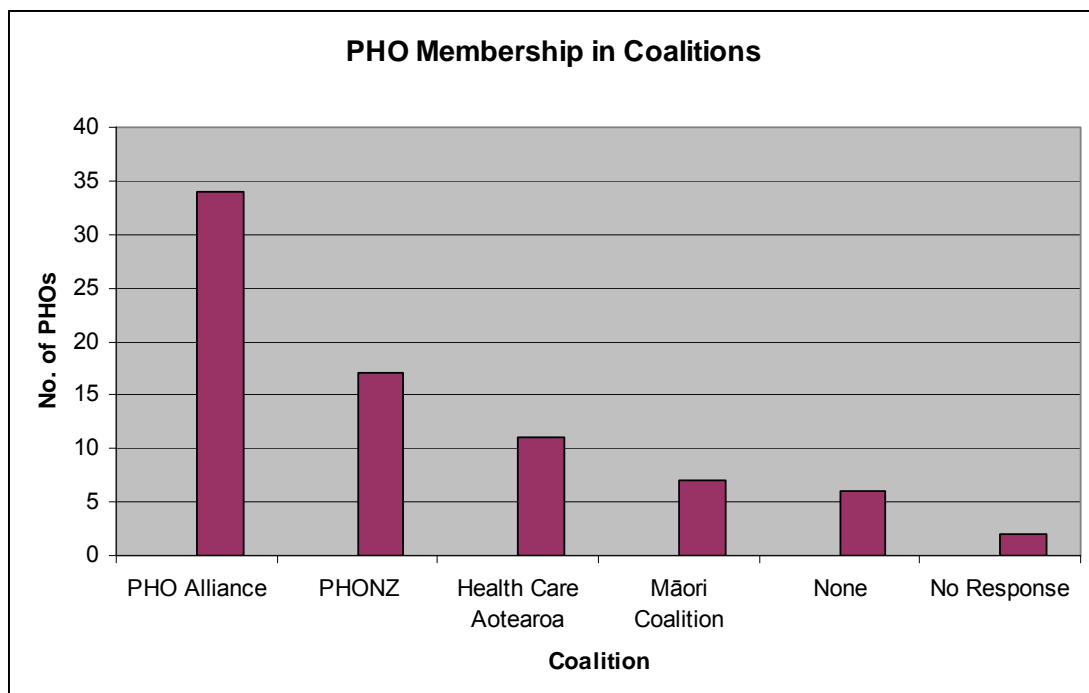
Managers were asked to describe the background of the PHO: namely, its origins prior to being established as a PHO. As indicated in Table 2 below, 32 PHOs (44%) reported having a background as an independent practitioner association (IPA), six (8%) as having developed within the Healthcare Aotearoa network, nine (12%) as having an iwi/Māori background and one (1%) as having a Pacific background. Twenty-four (33%) indicated they had another background. Of these, a community background, or one deemed to be ‘mixed’ (different combinations of community, general practice, iwi and IPA backgrounds), were the most frequently reported. This once again points to the diverse nature of PHOs.

Table 2: Background of the PHO

	Frequency	%
Independent practitioner association	32	44
Healthcare Aotearoa	6	8
Iwi/Māori	9	12
Pacific	1	1
General practice	4	6
Community	10	14
Mixed	10	14
Don't know	1	1
Total	73	100

The continuing impact of these origins is illustrated by the pattern of affiliation of PHOs with national organisations representing or creating networks amongst PHOs. As Figure 3 below shows, PHOs affiliate with national representative organisations in a pattern that broadly mirrors their diverse origins. The survey found four PHOs that were members of more than one of the national organisations identified in Figure 3, and six that did not belong to any organisation.

Figure 3: Affiliation of PHOs with national organisations



3.3 Composition of PHOs

Managers were asked about the composition of their PHO, in relation to general practices, NGO providers and other providers (see Table 3 and Figure 4 below). This question aimed to identify how many service provider organisations were contracted to work with PHOs; however, some managers may have responded with a broader concept of composition in mind (for example, composition of the PHO board, or of organisations which are affiliated with the PHO in some way).

Thirty-seven PHOs (just over half) comprised mostly general practices; that is, between 90 and 100% of the organisations comprising the PHO were general practices. All PHOs comprised at least one general practice, although in 12 PHOs, general practices made up less than 50% of the organisations comprising the PHO.

Forty-one PHOs did not have any NGOs within their composition; 17 PHOs had NGOs making up less than 50% of their composition; and eight PHOs had NGOs making up over 50% of their composition. (Seven PHOs noted that they had NGOs in their composition, but could not provide an estimate of how many: these are recorded in Table 3 in the 'None' category.)

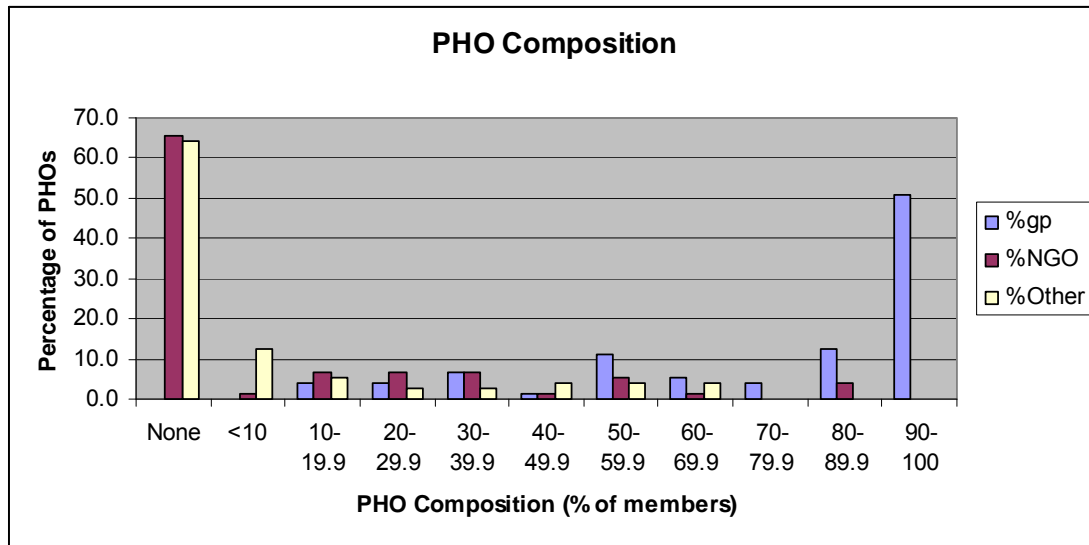
Forty-seven PHOs (two-thirds) comprised no other providers; 20 PHOs had other providers making up less than half of their composition; and six PHOs (8.2%) had other providers making up more than half of their comprising organisations. Other providers included pharmacies, dieticians, mental health providers, disability organisations and Plunket.

Again, these data are an indicator of great diversity amongst PHOs.

Table 3: PHO composition

% PHO composition	GPs	NGOs	Other	% GP	% NGO	% Other
None	0	48	47	0.0	65.8	64.4
<10	0	1	9	0.0	1.4	12.3
10–19.9	3	5	4	4.1	6.8	5.5
20–29.9	3	5	2	4.1	6.8	2.7
30–39.9	5	5	2	6.8	6.8	2.7
40–49.9	1	1	3	1.4	1.4	4.1
50–59.9	8	4	3	11.0	5.5	4.1
60–69.9	4	1	3	5.5	1.4	4.1
70–79.9	3	0	0	4.1	0.0	0.0
80–89.9	9	3	0	12.3	4.1	0.0
90–100	37	0	0	50.7	0.0	0.0
Total	73	73	73	100.0	100.0	100.0

Figure 4: PHO composition



3.4 Management services

Forty-one PHOs (56%) reported that (at least some) management services were outsourced, rather than being directly provided from within the PHO.

Further analysis of providers of outsourced services revealed that 22 PHOs (30%) received management services from current or former IPAs. The remainder obtained such services from private consultancy organisations, PHO shared services agencies and Māori organisations.

Types of services outsourced by PHOs included management of the patient register, financial management and information technology (IT) management. Some PHOs also mentioned the outsourcing of core management (sometimes through direct employment of the PHO management team); responsibility for the PHO quality programme and performance management programme; practice support and networks/liaison; and analysis of activity data.

Once again, this information underlines the diverse nature of PHOs, which vary not only in size, background and composition, but also in their approaches to ensuring that they have the management capacity to carry out their required functions.

3.5 Governance

A key element of the PHCS was for PHOs to involve local communities in their governance arrangements. In this survey, PHO managers were asked about the size of their board, composition of the board (numbers and background/role of members), method of selection or election to the board, term of board appointment, frequency of board meetings and fees paid to board members and chairs.

3.5.1 Size of PHO board

Across the 71 PHOs whose managers answered this question, there was a total of 621 board members: an average of nine members per board (Tables 4 and 5).

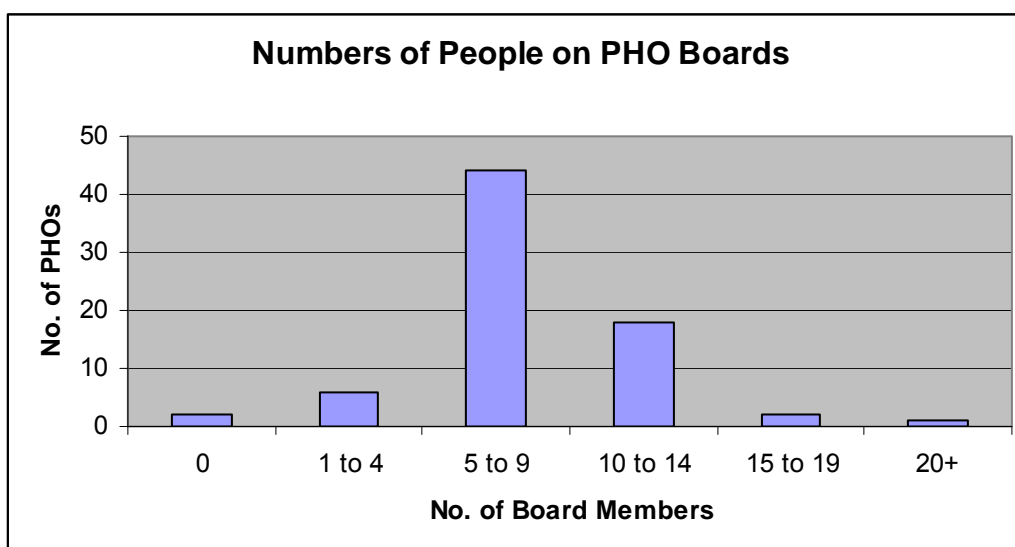
The range in size of PHO boards is set out in Figure 5. This shows that six PHOs had a board of four or fewer people, 44 had five to nine members, 18 had 10 to 14 members and three had 15 or more members (with one PHO board with 20 people on it). The most usual size for a PHO board in New Zealand was therefore five to nine members. This variation is not surprising, given the lack of policy specification about the size and composition of a PHO's board (beyond the requirement for community and provider representation), and the evident diversity of PHOs' size, background and management arrangements.

These findings confirm those found in a recent survey of PHOs by *New Zealand Doctor*, which also found an average of nine board members per PHO, and which noted the importance of the board in ensuring high levels of performance, and the benefits of a board comprising members from a range of backgrounds (Cameron 2008).

Table 4: Number of people on the PHO board

Board members	0	1 to 4	5 to 9	10 to 14	15 to 19	20+	Total
No. of PHOs	2	6	44	18	2	1	73
% of PHOs	3%	8%	60%	25%	3%	1%	100%

Figure 5: Number of people on the PHO board



3.5.2 Composition of PHO board

As Table 5 shows, the highest proportion of PHO board members comprises Māori and community representatives, there being 151 members (24%) in each of these categories across the country. General practitioners (GPs) are the next largest group, with 122 GPs on PHO boards making up 20% of members nationwide. Practice nurses and Pacific members make up less than 10% of total board membership.

Table 5: Total number and percentage of PHO board members by representation

Manager	GPs	PNs	Māori	Pacific	CRep	Other	Chair	Total
20	122	53	151	37	151	62	25	621
3%	20%	9%	24%	6%	24%	10%	4%	100%

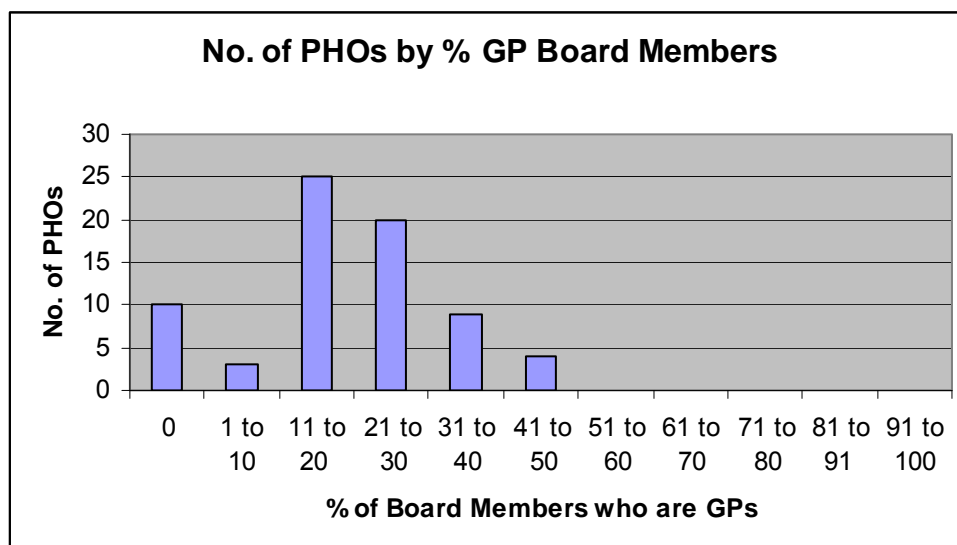
Another way of looking at the data is to assess how individual PHO boards are made up. The series of tables and figures below indicate the percentage of different community and provider groups represented on PHO boards, and the numbers of PHOs with each pattern of composition.

Table 6: Composition of PHO boards – number of PHOs by percentage of board member representatives

	0	1–10	11–20	21–30	31–40	41–50	51–60	61–70	71–80	81–91	91–100	Total
Manager	56	3	9	3	0	0	0	0	0	0	0	71
GPs	10	3	25	20	9	4	0	0	0	0	0	71
PNs	31	12	24	3	0	1	0	0	0	0	0	71
Māori	11	3	17	23	9	3	2	0	2	1	0	71
Pacific	50	3	10	5	1	2	0	0	0	0	0	71
CRep	13	1	15	17	14	9	1	1	0	0	0	71
Other	42	5	12	4	4	1	1	0	0	0	2	71
Chair	48	8	14	1	0	0	0	0	0	0	0	71

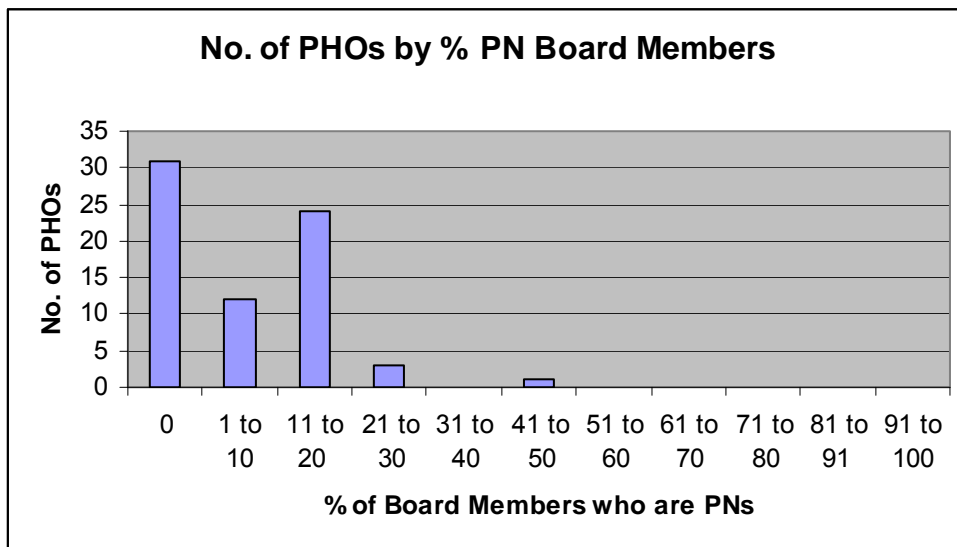
Table 5 shows that, collectively, there were 122 GPs serving on PHO boards, making up 20% of the total number of PHO board members. In terms of the proportion of GPs on each PHO board (Table 6 and Figure 6), the survey found that 10 PHOs had no GP members on their board; in three PHOs 1–10% of board members were GPs; in 25 PHOs 11–20% of board members were GPs; in 20 PHOs 21–30% were GPs; in nine PHOs 31–40% were GPs, and in four PHOs GPs made up 41–50% of board members. In no PHO boards did GPs make up more than 50% of board members. In only five PHOs were GPs the largest proportion of members.

Figure 6: PHO board composition – number of PHOs by percentage of board made up by GPs



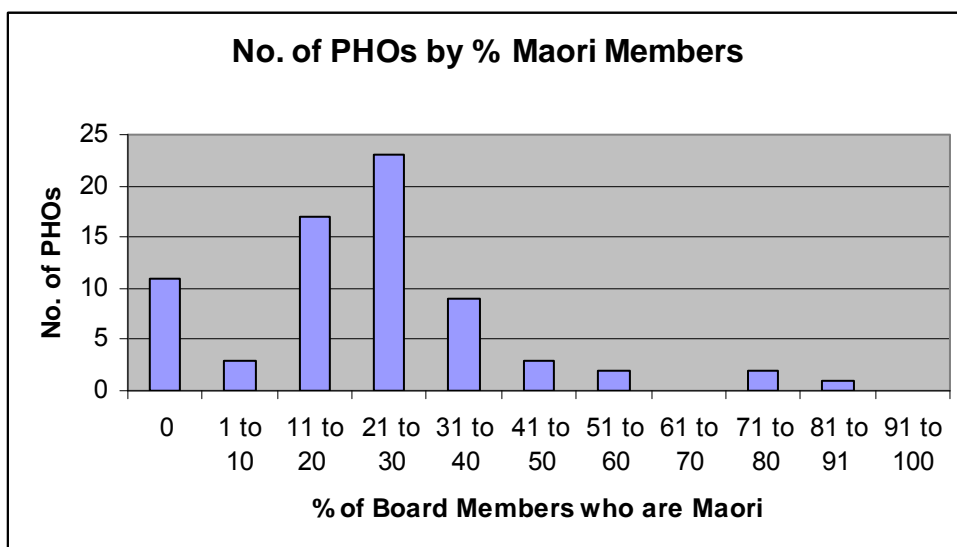
Collectively, there were 53 practice nurses serving on PHO boards, making up 9% of the total number of PHO board members (Table 5). In terms of the proportion of practice nurses on each PHO board (Table 6 and Figure 7), the survey found that 31 PHOs had no practice nurse members on their board; in 12 PHOs 1–10% of board members were practice nurses; in 24 PHOs 11–20% of board members were practice nurses; in three PHOs 21–30% of board members were practice nurses; and one PHO had a board made up of 41–50% practice nurses.

Figure 7: PHO board composition – number of PHOs by percentage of board made up by practice nurses



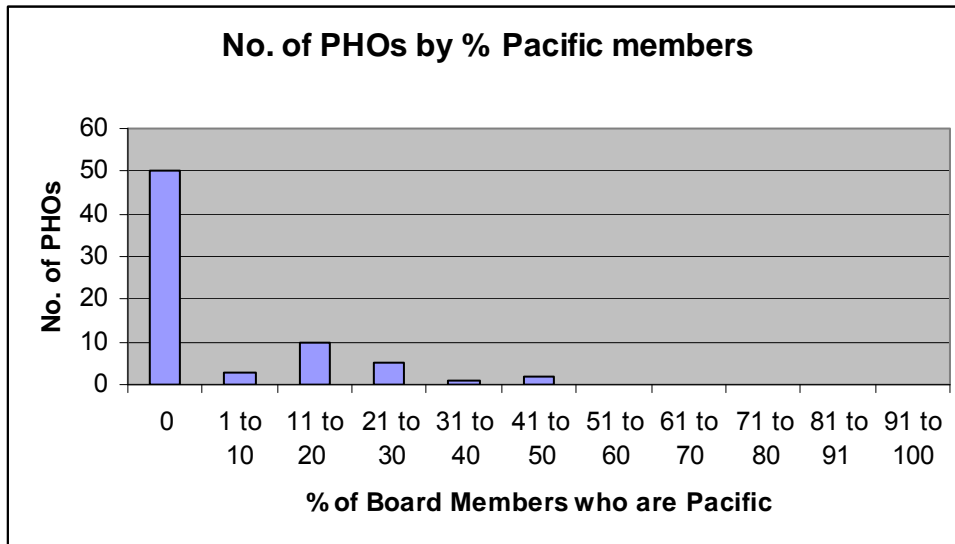
There were 151 Māori representatives serving on PHO boards across the country, making up 24% of the total number of PHO board members (Table 5). In terms of the proportion of Māori on each PHO board (Table 6 and Figure 8), the survey found that 11 PHOs had no Māori on their board; in three PHOs 1–10% of board members were Māori; in 17 PHOs 11–20% were Māori; in 23 PHOs 21–30% were Māori; in nine PHOs 31–40% were Māori; in three PHOs 41–50% were Māori; in two PHOs 51–60% were Māori and in another two 71–80% were Māori; and in one PHO Māori made up 81–90% of the board.

Figure 8: Māori representation on PHO boards



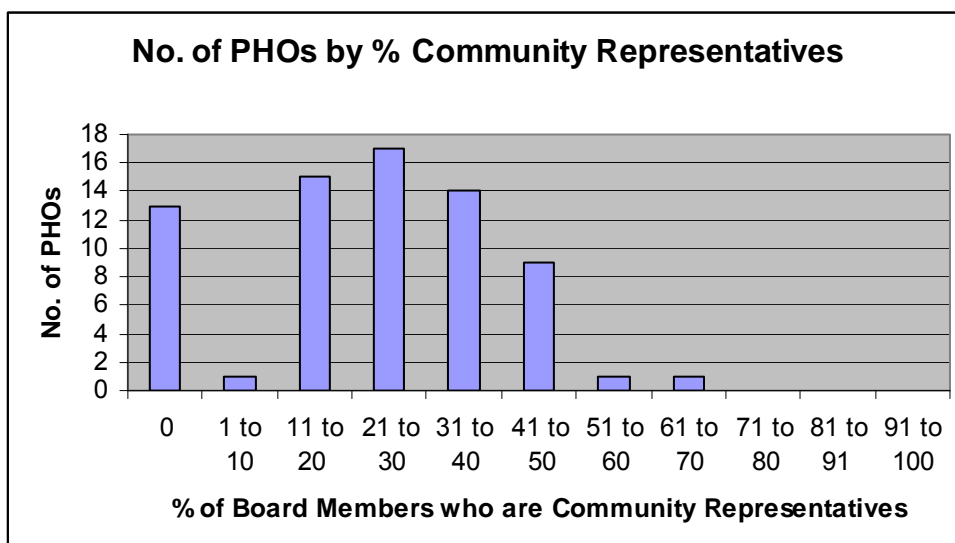
There were 37 Pacific representatives serving on PHO boards, making up 6% of the total number of PHO board members (Table 5). In terms of the proportion of Pacific representatives on each PHO board (Table 6 and Figure 9), the survey found that 50 PHOs had no Pacific people on their board; in three PHOs 1–10% of board members were Pacific; in 10 PHOs 11–20% were Pacific; in five PHOs 21–30% were Pacific; one PHO had a 31–40% Pacific board; and two PHOs had a board in which Pacific peoples made up 41–50%.

Figure 9: Pacific representation on PHO boards



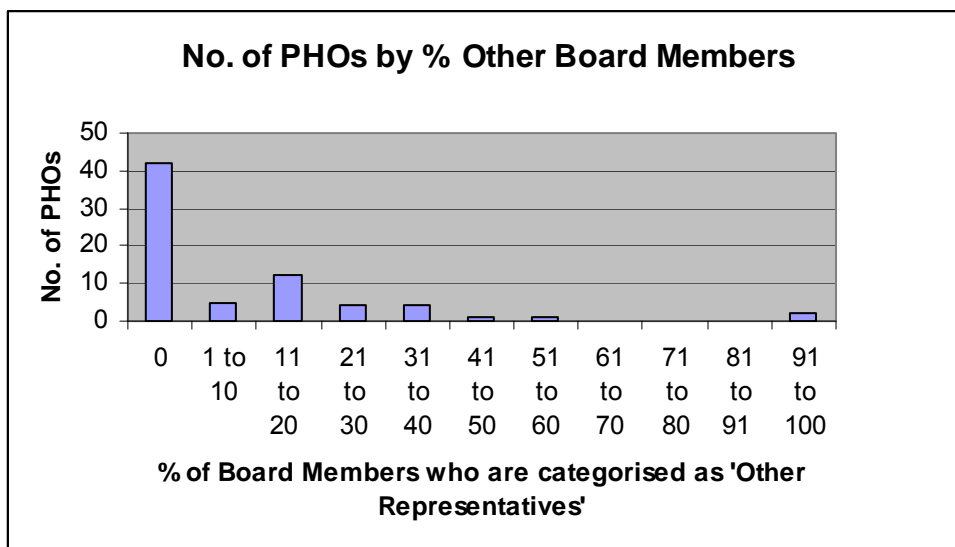
There were 151 community representatives serving on PHO boards, making up 24% of the total number of PHO board members (Table 5). In terms of the proportion of community representatives on each PHO board (Table 6 and Figure 10), the survey found that 13 PHOs had no community representatives on their board; in one PHO 1–10% of board members were community representatives; in 15 PHOs 11–20% were community representatives; in 17 PHOs 21–30% were community representatives; in 14 PHOs 31–40% were community representatives; in nine PHOs 41–50% were community representatives; in one PHO 51–60% were community representatives; and in one PHO 61–70% of board members represented their communities.

Figure 10: Community representation on PHO boards



'Other' providers reported included podiatrists, pharmacists, staff from the PHO or IPA, financial advisors, and city council and university representatives. Collectively, there were 62 'other' board members on PHO boards, representing 10% of all board members (Table 5). In terms of the make-up of individual PHO boards (Table 6 and Figure 11), the survey shows that that 42 PHOs had no other members on their board; in five PHOs 1–10% of board members were other representatives; in 12 PHOs 11–20% were other representatives; in four PHOs 21–30% and in another four 31–40% were other representatives; in one PHO 41–50% were other representatives; in one PHO 51–60% were other representatives; and in two PHOs other representatives made up 91–100% of board members.

Figure 11: Other representatives on PHO boards



Once again, there is great diversity amongst PHOs in terms of their composition. A few PHOs had no representation from GPs (10 PHOs or 14% of those surveyed), and although no PHO board had more than a 50% GP membership, the majority of PHOs had a board with a GP membership of between 11 and 30%. Few PHOs did not have Māori representatives (11 PHOs or 15% of those surveyed). The majority of PHO boards had a Māori membership of between 11 and 30%, while the boards of some PHOs were predominantly Māori. A number of PHOs had a relatively high proportion of community representatives on their boards, while others had none at all.

In some areas the survey data showed less diversity in the composition of PHO boards. Almost half of the PHOs surveyed had no practice nurse representatives, and those that did tended to have a proportion of practice nurses of less than 20%. Over two-thirds (70%) of PHO boards had no Pacific representative. Fewer than half of the PHOs had representatives from 'other' groups.

3.5.3 Method of selection of board members

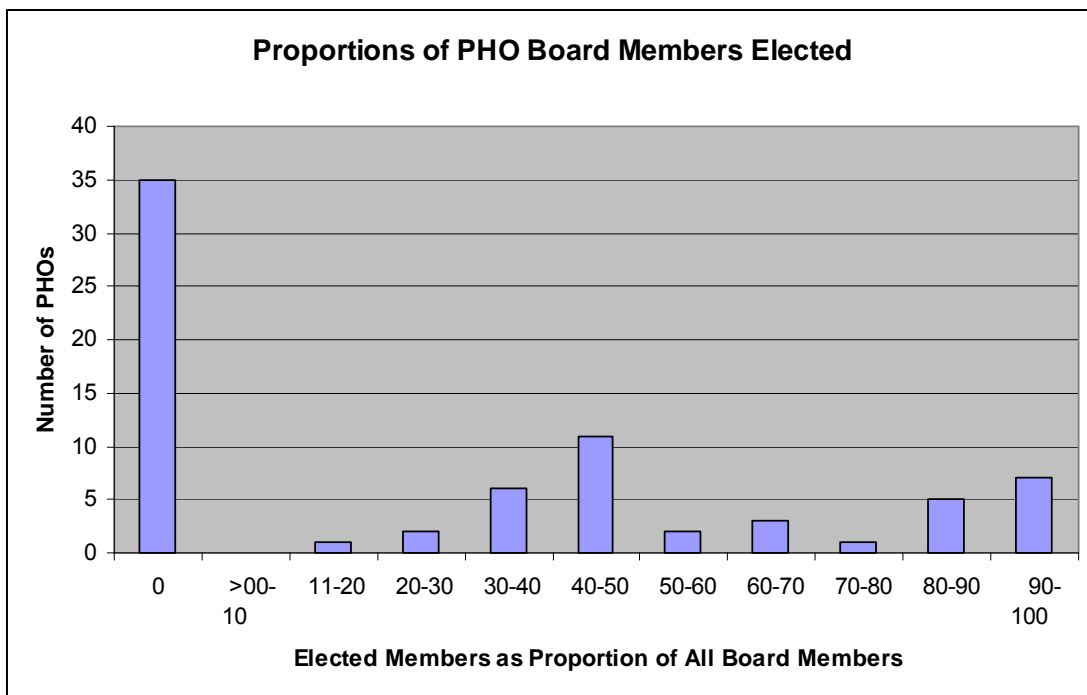
Managers were asked about the number of board members that were elected as opposed to appointed. The findings from this question are set out in Table 7 and Figure 12 below. These data show that in 35 PHOs (48%), none of the board members were elected, a finding which might be considered surprising in a system intended to promote strong community participation. This contrasts with the situation in district health boards, where a majority of board members are elected. Unlike for PHOs, however, election of district health board members is a legislative requirement, and is able to be carried out at the same time as local body elections, significantly reducing the costs of the process.

Six PHOs (8%) reported that all their board members were elected (that is, none were appointed), and the remaining PHOs reported a mixture of election and appointment for their membership. This indicates a diverse pattern of selection and election of PHO board members across New Zealand.

Table 7: Number of PHOs by percentage of board members who are elected

Proportion of board members elected	0	>1-10	11-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100
Number of PHOs	35	0	1	2	6	11	2	3	1	5	7

Figure 12: Number of PHOs by percentage of board members who are elected

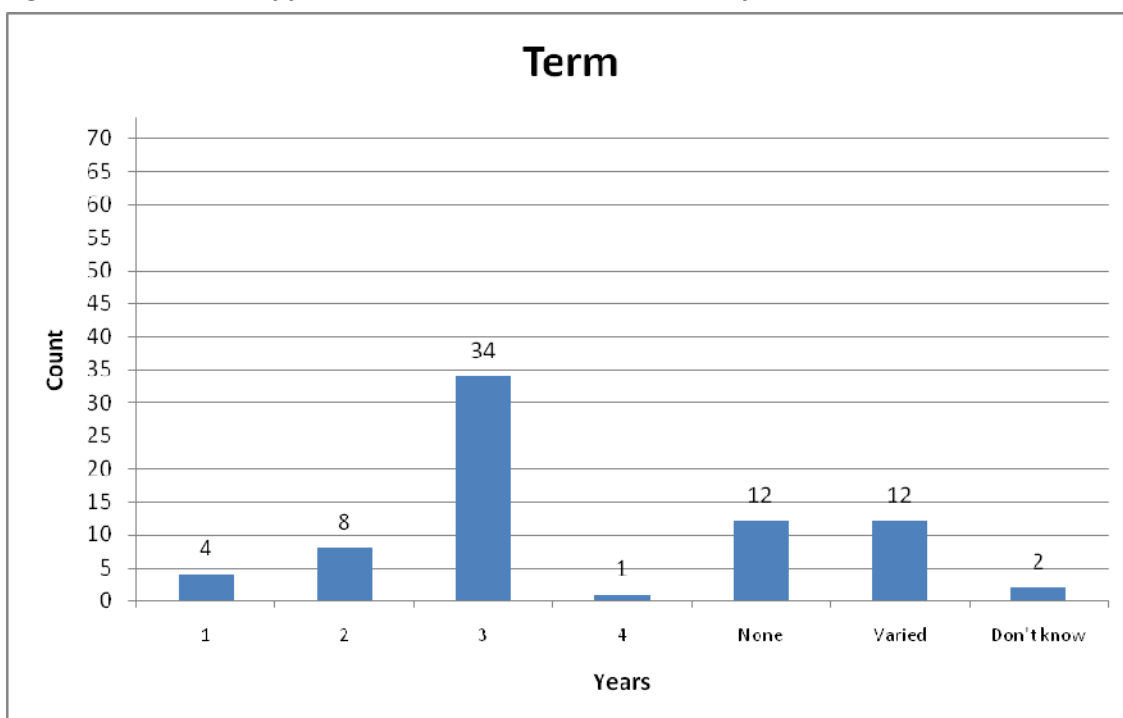


3.5.4 Term of appointment of board members

Term of appointment to a PHO board also varied greatly across PHOs, as set out in Figure 13 below. While three years was the board term reported by 34 (47%) PHOs, 12 PHOs (16%) did not have a specified term of appointment, and the same number reported a 'varied' term. Commentary suggested that some PHOs had terms that varied across board members; sometimes (as reported by seven PHOs) according to the category of board member. Some mentioned that board members could continue in their roles beyond their initial terms.

While variation in term of appointment per se is not a concern in relation to governance, to have 12 PHOs where there is no specified term of board membership suggests a lack of clarity that might be considered an important indicator of a lack of attention to good process and or poor governance. This could be of concern in the future, if there are moves towards a greater degree of delegation of public funding to PHOs for the further development of primary health care provision.

Figure 13: Term of appointment of PHO board members, by number of PHOs



3.5.5 Frequency of board meetings

When asked about the frequency of PHO board meetings, 58 managers (79%) reported that in their PHO, meetings were held on a monthly basis. In a further 12 PHOs (16%), meetings were held every two months, and in one PHO meetings were held on a quarterly basis. Two managers did not know the frequency of board meetings.

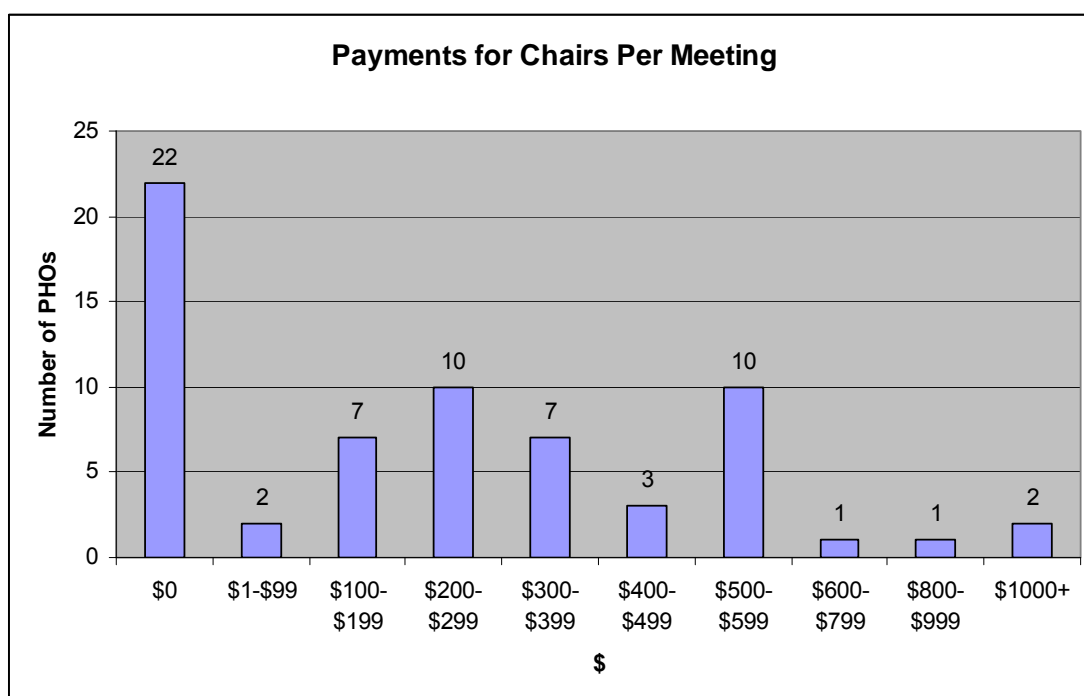
3.5.6 Fees paid to board members and chairs

In 53 PHOs (73%) board members were paid a sitting fee. In 13 PHOs (18%) they were not, and in seven PHOs (10%) the manager did not know whether board members were paid.

This is yet another example of diversity within the governance and organisational arrangements of PHOs. It is surprising to find that 10% of PHO managers did not know whether or not board members were paid a sitting fee.

The range of fees paid to PHO chairs per board meeting is set out in Figure 14 below, which illustrates a range from no fee through to a fee in excess of \$1000. (This excludes honoraria, which were also paid to PHO chairs in some cases.)

Figure 14: Fees paid to PHO chairs per board meeting, by number of PHOs



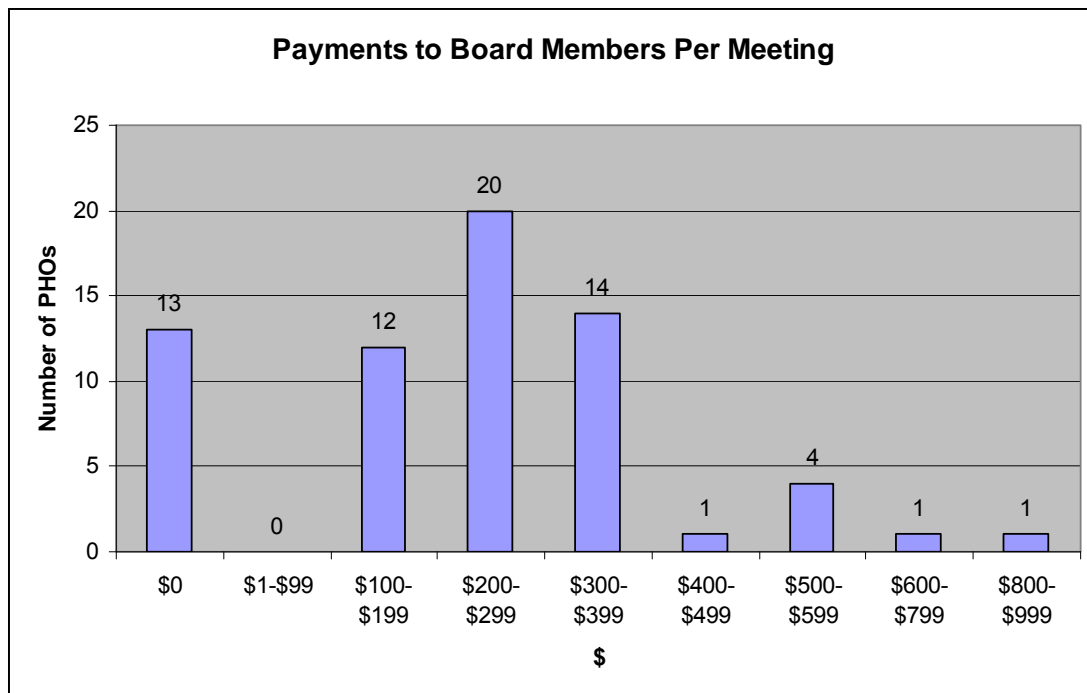
The survey found significant variation in the monetary value PHOs placed on the contribution of their board members. Fees paid to PHO board members other than the chair are set out in Figure 15. Although board member fees varied to a lesser extent than those paid to chairs (46 PHOs (63%) paid members between \$100 and \$399 per meeting), six PHOs were paying members \$500 or more, and 13 were not making any payment at all.

The diversity in fees paid to board members was also noted in the *New Zealand Doctor* survey referred to earlier in this paper, as was the average fee of \$273 per board member per meeting and \$459 per board chair per meeting (Cameron 2008).

The *New Zealand Doctor* report commented on a recent Institute of Directors review of South Island PHOs which suggested that the duties of PHO board members were ‘onerous’ and that all PHO board members should be paid an annual salary of around \$15,000 and all board chairs \$37,500. The Institute of Directors report found that South Island PHO board members spent a median of 121 hours per year on board duties, while board chairs spent around 300 hours per year. Not everyone spoken to by *New Zealand Doctor*, however, agreed that PHO board members should be paid more. Some commentators pointed to the need to ensure that board members were genuinely interested in undertaking socially useful work. The report also noted that no one spoken to considered that paying board members more would attract *better* people to their boards, although they agreed more money would indeed attract *more* people (Cameron 2008).

New Zealand’s Department of Prime Minister and Cabinet sets out guidance on fees for chairs and members of a range of different bodies, varying according to the role of the body and the level of turnover or assets it is responsible for. Under the category ‘All other committees and other bodies’, which would include PHOs, fees per meeting for chairs range from \$190–\$240 for low-level bodies to \$330–\$435 for mid-level bodies and \$600–\$970 for high-level bodies. For members, the respective fee ranges are \$140–\$180, \$250–\$325 and \$450–\$730 (Cabinet Office 2006). Thus, the fees paid to PHO board members are generally in alignment with those suggested by the Cabinet Office, albeit that a number of members and chairs are not paid at all.

Figure 15: Fees paid to PHO members per board meeting, by number of PHOs



3.6 Conclusion about demography of PHOs

PHOs are clearly a diverse group of organisations within the New Zealand health system. This diversity reflects the permissive policy context within which PHOs were introduced, in which a set of limited 'minimum requirements' were imposed to guide their development, which made no specific guidance about organisational size, board remuneration, method of board appointment, frequency of board meetings and so forth.

The discussion section of this paper examines the implications of diversity in relation to the next phase of development of PHOs.

4 THE ROLE OF PHOS

This section explores PHO managers' views of the role of their individual PHO, and specifically its allocation of resources to providers. This part of the report builds on the data set out above by providing an analysis of managers' concepts of the role of the PHO. This information forms a prerequisite to an examination of the future sustainability of PHOs, and to an overall exploration of what these survey findings might mean for the future purpose and shape of PHOs in New Zealand.

4.1 Managers' views of the role of their PHO

Managers were asked their views on the role of the PHO, being asked 'Do you see your role as...', with a number of response options, of which they could tick as many as they felt applied to their PHO. They were also asked to rate the relative importance of each role they had ticked, on a scale of 1–5 in which 1 indicated 'not important' and 5 indicated 'very important'. The results of this question are set out in Table 8 below.

Table 8: PHO managers' perceptions of the role of their PHO, ranked

			Importance													
	Yes		No		1		2		3		4		5		DK	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Direct provider of services	35	48	38	52	2	6	4	11	6	17	4	11	19	54		
Strategic planner of primary health care	72	99	1	1					2	3	16	22	54	73		
Provider development	70	96	3	4			4	6	11	16	23	33	32	46		
Community development	71	97	2	3	1	1	5	7	14	20	14	20	37	52		
Funder of primary health care	71	97	2	3	2	3	1	1	6	8	6	8	56	79		
Inter-sectoral work	70	96	3	4			4	6	16	23	25	36	25	36		
General practice support	72	99	1	1	1	1	2	3	8	11	16	22	45	63		
Other	27	37	46	63							5	19	15	56	7	10

Note: The first four columns of this table report those responding 'Yes' and 'No' to the question, 'Do you see your role as ...?'. Only those responding 'Yes' then rated the importance of that role, using a 1–5 Likert scale.

Figure 16: PHO managers' perceptions of the role of their PHO

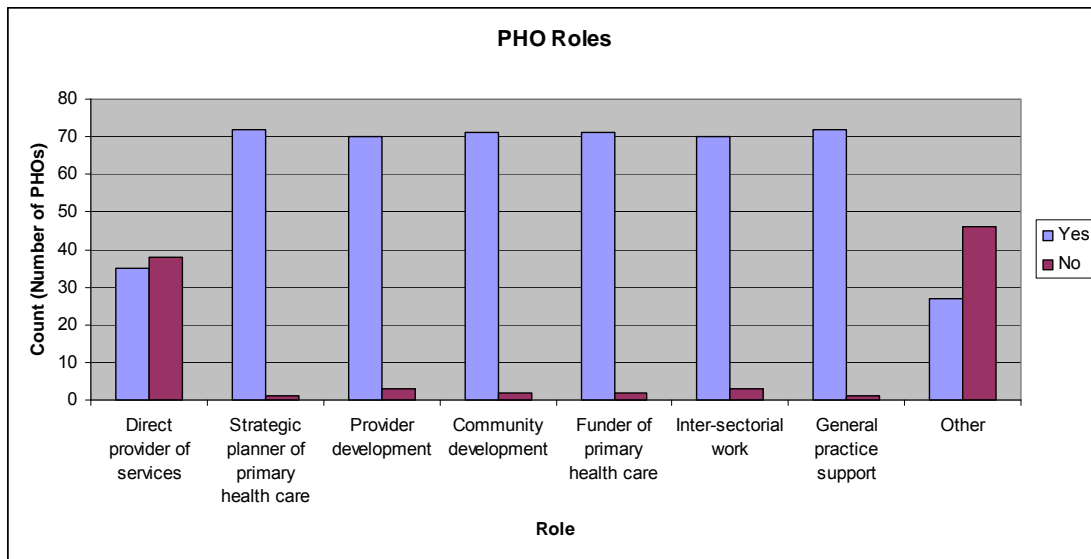


Table 8 and Figure 16 show that almost all PHOs concur with the view that their role is to:

- carry out strategic planning of primary health care
- develop primary care provision
- undertake community development
- fund primary health care
- undertake inter-sectorial work, and
- provide support to general practice.

'Other' roles identified by the PHOs included community liaison; standards, IT and workforce development; population health; Māori health development; advocacy; and involvement in social policy development.

While 35 PHOs (48%) saw their role as one of directly providing primary care services, 38 PHOs (52%) did not. This represents a fundamental difference in interpretation of the role of a PHO. These differences could be attributable to the different backgrounds and histories of respondent PHOs, some having grown out of provider organisations such as community-governed trusts and IPAs that provided a range of services under contracts to funders, and others having been formed specifically to allocate new primary health care funding made available as part of the implementation of the PHCS.

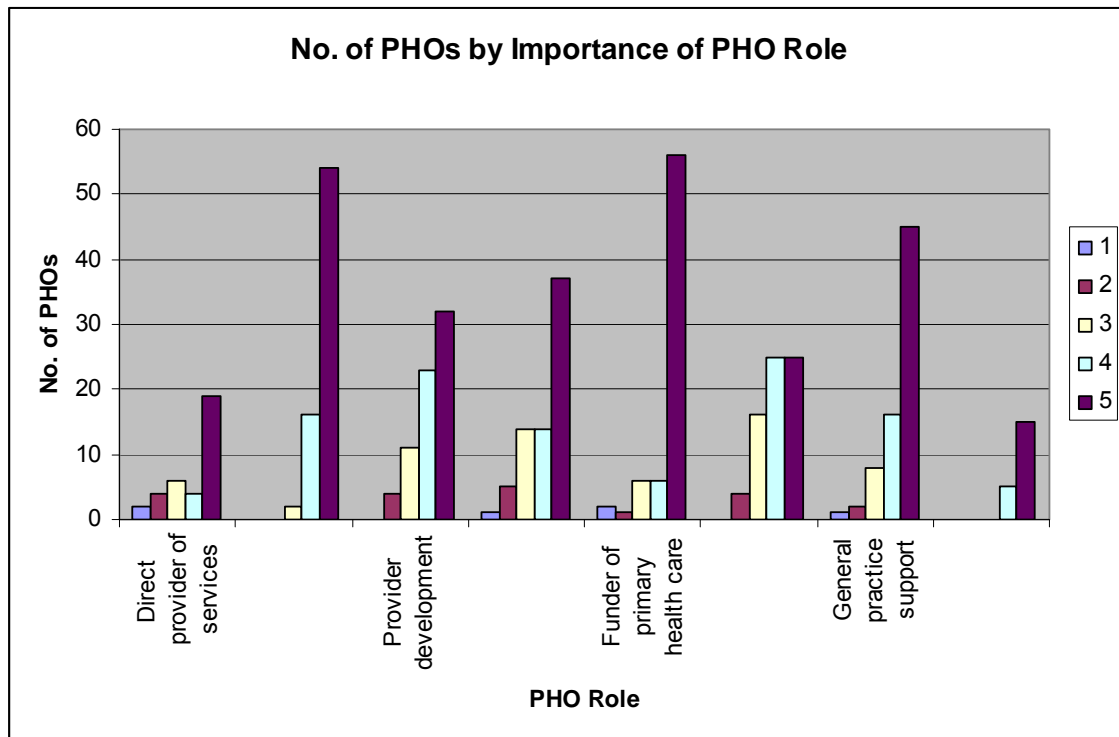
Figure 18 shows the ranking managers placed on the various roles (where category 5 indicates functions that were seen as very important). Overall, the roles presented ranked as follows (in order of most important to least important):

1. Strategic planner of primary health care
2. Funder of primary health care
3. General practice support
4. Provider development
5. Community development
6. Inter-sectorial work
7. Direct provider of services.

In the first four of these categories, over 75% of respondents agreeing that it was a role they ascribed to their PHO went on to describe the role as 'important' or 'very important'. Actual provision of services was seen as important or very important by only 23 of the 35 PHOs (66%) who ticked 'yes' for this role.

The focus on strategic planning and funding is not surprising when considering how PHCS implementation focused on PHOs as conduits for new government funding intended to reduce the cost of access to first-contact primary health care services. It may also be a result of the growth of many PHOs out of organisations set up to provide support to general practice services, rather than to deliver services themselves, and may reflect a concern that PHOs ought not to compete with the service providers they comprise.

Figure 17: PHO managers' view of importance of particular roles



Note: Only those responding 'yes' in relation to what they saw as a PHO's role answered the question relating to importance. The figures reported here relating to importance represent the percentage of those responding 'yes' to the first question. 1= not important; 5=very important.

The original intention in the PHCS was that PHOs should become increasingly important providers of integrated primary and community services for local populations (King 2001). However, the results above would appear to support suggestions (Cumming, Raymont et al 2005; Gauld 2008; Smith 2009) that, amongst PHOs, PHCS implementation has focused on population health issues such as reducing the cost of access to care and allocating new sources of funding for initiatives such as health promotion and chronic disease management, rather than becoming more active and extensive providers of primary health care services.

It is interesting to note that almost all PHO managers considered general practice support and provider development as the PHO's role, and many saw it as an 'important' or 'very important' role. Another interesting point is that despite the fact that PHCS implementation centres largely on population health issues, community development did not feature highly on the list of 'important' or 'very important' roles.

It is clear that, almost universally, funding and planning primary health care services are seen as core roles for PHOs. Likewise, support and development of general practice and other primary care services were central to PHO concerns. What is much less uniform is the extent to which PHOs consider they should have a role in direct provision of primary health care services, the data showing an almost even split between agreement and disagreement. Even amongst those who agreed, provision of services was not universally seen as an important or very important role. This suggests that in debate about next steps for PHOs, there needs to be discussion about whether PHOs should provide, as well as plan and fund, services.

4.2 Allocation of first-contact funding by PHOs to general practices

Managers were asked a number of questions about how they allocated first-contact funding to general practices. The term 'first-contact funding' covers the delivery of core general practice services.

When asked if they disbursed all first-contact funding to practices, 71 of the 73 PHOs (97%) said yes, with just two PHOs (3%) reporting that they top-sliced, or used part of the funding for specific PHO initiatives. This information seems to corroborate past criticism of PHOs having a tendency to be 'post boxes' through which government money has flowed, leaving them with few resources of their own and without financial leverage to contract specific services or developments with public funding (Primary Health Care Nurse Innovation Evaluation Team 2006; Mays and Blick 2008; Croxson, Smith and Cumming 2009; Smith 2009).

When a follow-up question asked managers:

'Do you ever use first contact funding to leverage change in general practices' clinical practice or service provision? (For example, in addition to the PHO Performance Management Programme, do you ever withhold first contact funding to penalise, or use payments to reward, specific activity?)'

only two PHOs responded in the affirmative.

The government may never have intended first-contact funding processes as a means to facilitate systematic change. It may have originally seen first-contact funding merely as a means of redirecting money previously used to subsidise general practice visits for people on low to middle incomes into universal subsidies for that purpose. The fact that government policy focused on applying increases in first-contact funding towards reducing fees for services also significantly diminished PHOs' ability to use such funding to support PHO services and to leverage change. However, it would be paradoxical for PHOs to at once declare themselves to be planners, funders and developers of primary health care and at the same time feel they have almost no financial leverage over the funding that they allocate. It is important to note that the first-contact funding allocated through PHOs represents by far the largest element of government funding for primary health care (see Table 9 below), and in terms of leveraging change through financial means, PHOs apparently focus much of their funding and planning activity on smaller ticket items such as health promotion and services to improve access funding.

In terms of *how* the level of this first-contact funding was allocated to practices, 67 PHOs (92%) reported that they were using the Ministry of Health's weighted capitation formula, rather than measures related to practice activity. This suggests that while PHOs may feel they lack the 'clout' to top-slice such funding and contract in a more complete manner for its use, they do now feel able to allocate the money to general practices in a way that reflects population characteristics, rather than activity within general practice.

However, although PHOs generally are using a capitation formula to allocate funding to practices, practices may not necessarily be using the same approach in their allocation of funding to staff and practice owners. In an accompanying survey of 99 general practices, 82% of non-owners in practices reportedly received their income via a fixed payment (for example a salary), but around a third of non-owners were receiving at least some income based on the number of patients seen or fees earned. Amongst practice owners, the list size affected payments for 52% of respondents, and payments made according to patients seen (59%) and fees earned (69%) were even more prevalent for this group. In this survey, multiple responses were possible, and proportions of income coming from particular sources were not specified, but the results suggest that at least some income is still being paid to general practice staff and owners on a fee-for-service basis in New Zealand.¹

Thus, there appears to have been a partial move towards a capitated primary health care system in New Zealand. Initially such a regime was seen as an important lever in steering primary health care service delivery in New Zealand away from episodic services towards more preventive services, and in encouraging the involvement of a wider team of service providers. However, the continuing use of fee-for-service arrangements amongst practice staff and owners, along with the levying of patient co-payments, undermines the extent to which the benefits of capitation are optimised in New Zealand. In addition, the incomplete nature of contracting between PHOs and practices compromises the extent to which PHOs can require specific developments or activity from practices in return for the funding they allocate. This situation was foretold by commentators at the time of the drafting of the PHCS (Coster and Gribben 1999; Cumming 1999), and the current situation has been analysed in detail in an accompanying paper (Croxson, Smith et al 2009).

¹ ACC payments are also paid to practices on a fee-for-service basis.

Table 9 PHCS budget, 2007/08²

	Funding stream	\$ million	Percent of total budget
Capitation-based funding [\$730.0 million or 89%]	First contact	520.5	63.6
	Pharmaceutical subsidy	126.3	15.4
	Services to improve access	39.1	4.8
	Health promotion	9.1	1.1
	Management fee	31.8	3.9
	Laboratory subsidy	3.2	0.4
Other PHCS initiatives [\$88.8 million or 11%]	Care Plus	30.2	3.7
	Performance payments	29.2	3.6
	Rural health	12.6	1.5
	Mental health	7.3	0.9
	Other items	9.5	1.2
Total budget 2007/08		818.8	100.0

4.3 Allocation of other primary health care resources by PHOs to practices

Managers were also asked about how they allocate health promotion and services to improve access (SIA) funding to their general practices. Tables 10 and 11 indicate that, in contrast with the way they handle first-contact funding, two-thirds of PHOs retain health promotion funding rather than allocate it to practices or to other providers, and that where money is passed to practices, it is typically applied to specific agreed initiatives. This finding is unsurprising, given the national requirement for specific project plans and district health board approvals for health promotion funding, and that many NGO providers have a focus on health promotion activities and see this as a key part of their role in primary health care.

Table 10 Whether PHOs allocate health promotion funding directly to practices

	Frequency	%
No	48	66
Yes	25	34
Total	73	100

² Adapted from the Ministry of Health website, <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding>, and first used in Mays and Blick 2008, 'How can primary health care contribute better to health system sustainability? Working Paper'.

Table 11 How PHOs that allocate health promotion funding to general practices calculate the amount of funding

	Frequency	%
According to the cost of specific initiatives / agreed budgets for specific initiatives	18	25
By capitation, or weighted capitation, using an alternative formula based on practice population	2	3
By weighted capitation, using the Ministry of Health formula	2	3
Other	1	1
Using a measure related to practice activity, such as the number of consultations	2	3
Total	25	34

A different picture emerged from responses of PHO managers as to whether their organisation made direct allocations of SIA funding to practices, and, if so, how this was calculated. As Tables 12 and 13 show, almost two-thirds of PHOs allocated SIA funding to general practices, on the basis of specific initiatives with agreed budgets. In this way, it appears that PHOs are contracting with their practices to deliver SIA projects, yet are tending to run health promotion projects from the PHO itself or through other providers, albeit that individual projects may involve and engage general practices.

Table 12 Whether PHOs allocate SIA funding directly to practices

	Frequency	%
No	28	38
Yes	45	62
Total	73	100

Table 13 How PHOs that are allocating SIA funding to general practices calculate the amount of funding

	Frequency	%
According to the cost of specific initiatives / agreed budgets for specific initiatives	31	42
By capitation, or weighted capitation, using an alternative formula based on practice population	5	7
By weighted capitation, using the Ministry of Health formula	2	3
Other	2	3
Using a measure related to practice activity, such as the number of consultations	5	7
Total	45	62

These responses suggest that PHO behaviour is profoundly shaped by the way in which arrangements for allocating government funding are designed at a national level. The 'passing-on' of first-contact care funding by PHOs is a logical consequence of how the roll-out of this funding was enacted in national policy, resulting from the government's focus on reducing fees for services. The incomplete nature of the contract between government and general practice for this funding (Croxson, Smith et al 2009) is similarly attributable to a process of national negotiation between government and general practice that resulted in a contract between DHBs and PHOs, rather than directly with general practices.

PHOs have, however, taken a different path in allocating health promotion and SIA funding, developing specific initiatives for its use and channelling funds to practices as and when the PHO deems it appropriate. This again reflects the national policy framework, under which these funding streams require project plans, district health board approval and national reporting processes.

The survey findings suggest that PHOs focus more effort on specific funding streams in which they perceive that they have some direct influence, albeit that these streams are very much a small proportion of the overall primary health care funding handled by PHOs. PHOs exert little or no leverage over allocation of funding for first-contact care, the largest component of funding handled by PHOs, and all but two felt unable or unwilling to withhold any funding in this area in order to lever change in service provision.

4.4 Staffing in PHOs

The survey asked managers how many staff (and how many full-time equivalents (FTEs)) they employed, and the main role of these staff members (Figure 18 and Table 14). The focus here was on staff employed by the PHO itself, as opposed to staff employed by a management services organisation (MSO), although not all respondents may have interpreted the question in this way. The survey found that 15 PHOs had no staff; and amongst those with staff, numbers ranged from 0.5 to 41 staff. There was a total of 379 employees across PHOs, which on average employed 6.54 people (amongst those with employees). The most common patterns were 1–2, 2–3 and 4–5 employees.

Figure 18: PHO employees

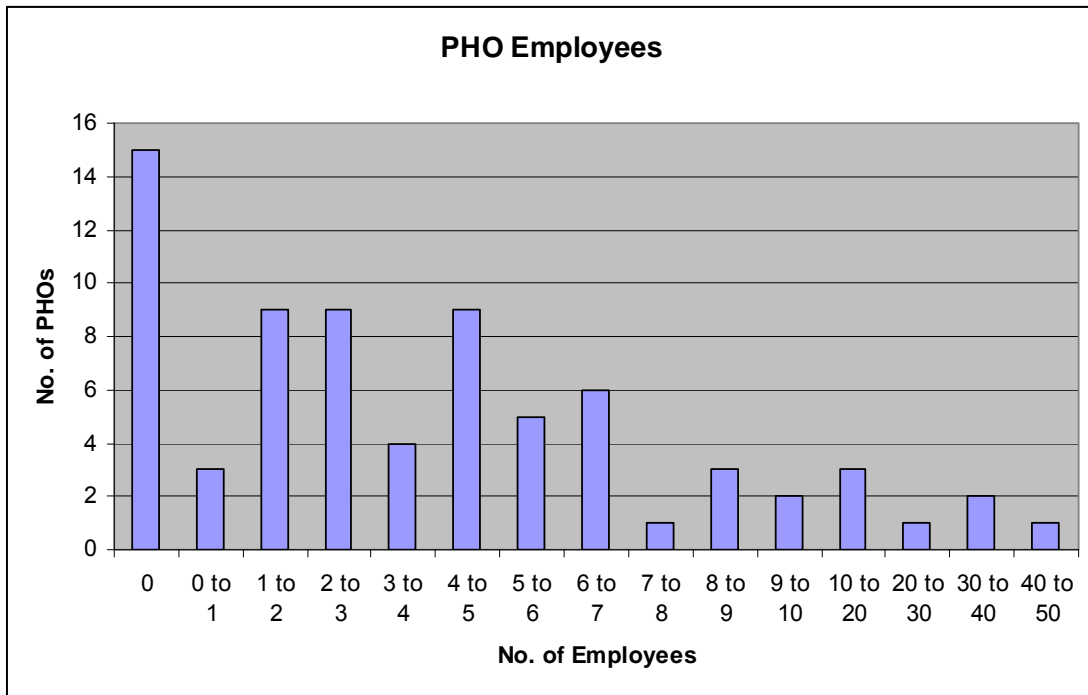
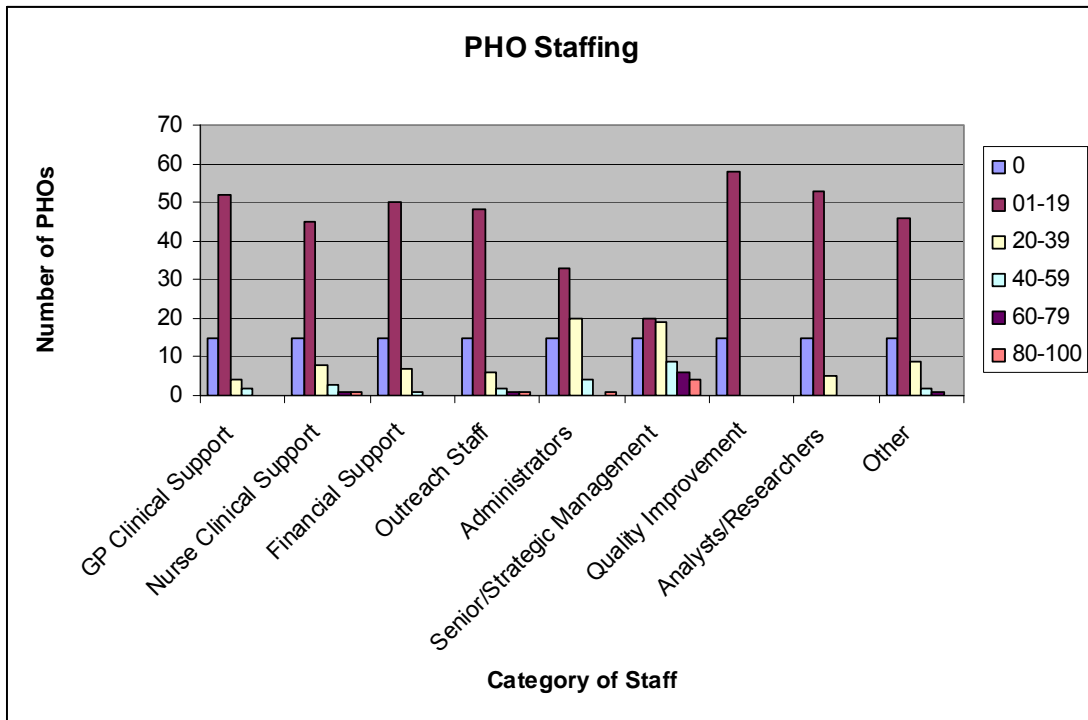


Table 14 PHO employees – by category of employee and percentage of total employees

	0	1–19	20–39	40–59	60–79	80–100
GP clinical support	15	52	4	2	0	0
Nurse clinical support	15	45	8	3	1	1
Financial support	15	50	7	1	0	0
Outreach staff	15	48	6	2	1	1
Administrators	15	33	20	4	0	1
Senior/strategic management	15	20	19	9	6	4
Quality improvement	15	58	0	0	0	0
Analysts/researchers	15	53	5	0	0	0
Other	15	46	9	2	1	0

Figure 19: PHO employees – by category of employee and percentage of total employees



Fifteen PHOs reported that they employed no staff (in which case, staff may have been employed by a MSO). Most PHOs employed a range of staff, especially clinical staff, with each category of staff comprising up to 20% of the total employed. Senior/strategic management and administration staff made up a higher proportion of total employees in some PHOs. However, these data need to be interpreted with caution, as the survey did not ask about employment by MSOs, and PHOs and MSOs, in many cases, provide complementary services.

5 PHO SUSTAINABILITY AND FUTURE GOALS AND DIRECTIONS

The survey asked managers to assess the sustainability of their PHO, in terms of the following categories: 'doing well'; 'holding its own'; 'at risk'; 'don't know'; and 'other'.

The responses given are summarised in Tables 15 and 16 below. It is of note that in written responses the four 'other' responses indicate a degree of vulnerability and perceived risk, rather than a sense of 'doing well'. If these responses are included in the 'at risk' category, 12 PHOs (16%) can be deemed to have perceived themselves at risk or with an element of risk. That only 30 PHOs (41%) consider that they are 'doing well' and between eight and 12 consider themselves to be 'at risk' presents a picture of a rather vulnerable group of organisations, especially considering the fact that most have been in existence for at least four years.

International evidence on the development of primary health care organisations suggests that the first two to three years of establishment entail significant capacity-building and organisational development, and after that, the organisation can expect to make significant progress (Mays, Wyke et al 2001; Dowling and Glendinning 2003; Smith and Goodwin 2006). It is concerning that PHOs, most of which were established during 2003 and 2004, did not present a more confident sense of organisational stability in mid-2008.

Table 15 Views of PHO managers about the sustainability of their organisation

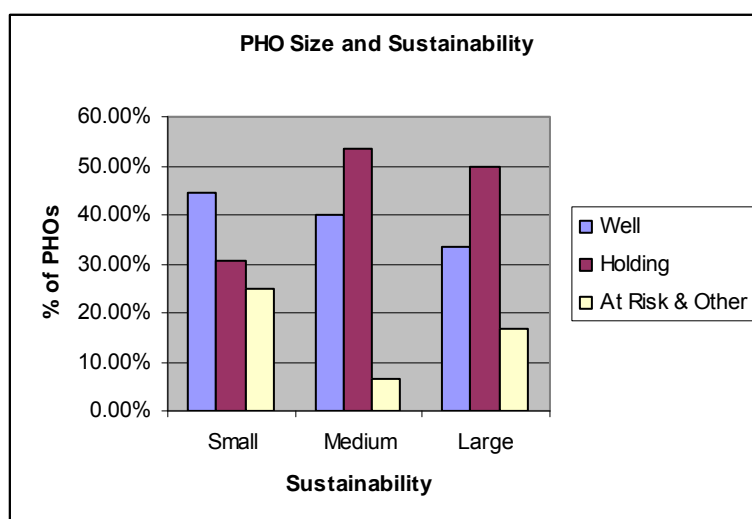
	Frequency	%
At risk	8	11
Holding its own	30	41
Doing well	30	41
Don't know	1	1
Other	4	5
Total	73	100

Table 16 Views expressed by PHO managers responding 'other' to the question about the sustainability of their organisation

Between at risk and holding own	1
Struggling to meet resource and funding requirements in number of areas	1
There are some services at risk, but not the PHO	1
Vulnerable because very small	1

When these data are analysed in relation to the size of individual PHOs, it can be seen from Figure 20 that a higher proportion of small PHOs (having fewer than 20,000 enrolees) see themselves at risk than medium (20,000–60,000 enrolees) and large (more than 60,000 enrolees) PHOs. However, a slightly higher proportion of small PHOs also see themselves as doing well when compared with medium-sized and large PHOs. This analysis suggests that although some smaller PHOs feel that they are at risk in relation to sustainability, there is not a straightforward relationship between organisational size and perceived robustness in the face of future challenges.

Figure 20 Relationship between size of PHO and perceived sustainability



5.1 PHO future goals and directions

At the end of the survey, managers were asked about the three key goals for their PHO for the next three years. The survey found the most common responses related to (in descending order of the frequency with which issues were reported):

1. Sustainability (11 PHOs) – to continue to viably exist, maintaining the financial sustainability of primary health care funding.
2. Workforce issues – eight PHOs aimed to increase their workforce; invest in training/improving the staff skill base; or focus on recruitment and retention.
3. Community engagement – a number of PHOs wanted to focus on engaging and informing whānau and iwi communities at all levels, communicating with enrolled patients and increasing their population’s understanding of health services.
4. Service development or service improvement – PHOs made specific mention of a number of areas they wished to develop, including chronic care management, dental services, GP services, mammography services, services embedded within a practice, new integrated models of primary health care beyond general practice services (including dental services, pharmacists, physiotherapists, occupational therapists and clinical psychologists), oral health and youth health.
5. Reducing inequalities, especially for Māori.
6. Improving health and wellness, and improving access.

These responses suggest that, overall, PHOs felt some vulnerability as they faced the future in July 2008, as responses to the question specifically dealing with organisational sustainability had already indicated. The goals cited are very much in line with the aims of the PHCS: for example, the desire to focus on workforce, primary health care service development, reducing inequalities and improving access.

6 DISCUSSION AND POLICY IMPLICATIONS

The analysis set out in this paper represents a snapshot of the demography of PHOs in New Zealand in July 2008, and summarises the perceptions of individual PHO managers of the role, sustainability and aspirations of their organisations.

This analysis shows significant structural diversity in respect of enrollee numbers; management support arrangements; and the size, composition, remuneration and meeting frequency of governance boards. PHOs differ significantly, particularly in terms of the populations they serve: half of all PHOs serve populations of less than 20,000 enrollees, but most New Zealanders are catered for by larger PHOs. This raises an important policy question about the extent to which such diversity is desirable within a publicly-funded health system, and whether all PHOs have an equal chance to achieve what is expected of them.

Although general practices comprise the majority in just over half of the country's PHOs, composition is generally diverse. Two-thirds of PHOs do not include NGOs or providers other than general practices (although they may have other types of relationships with such organisations).

The analysis of PHO board composition shows a range of representation on PHO boards, and appears to challenge anecdotal evidence of PHOs being 'dominated by GPs'. This survey reveals that in no PHO board are GPs in the majority: in almost all cases GPs represent a third or less of board members. PHO boards appear to have ample levels of Māori and community representatives, but very little representation from practice nurses and Pacific peoples.

Keeping in mind that the PHCS is relatively unspecific about the role of PHOs, managers placed varying interpretations on the role of a PHO, the most vivid example being in relation to the question of whether a PHO should be a provider of services (half replied in the affirmative; the other half disagreed). Although varying interpretations may be acceptable, it makes sense for PHOs collectively to work towards the aims of the PHCS. In the current funding and organisational context it is unclear whether certain types of PHO will ever be able to achieve some of the PHCS's aims, such as those related to primary health care provider development and support, which evaluation evidence suggests has been a relatively under-developed area within PHCS implementation to date (Cumming, Raymont et al 2005; Smith 2009). The fact that many PHOs do not see themselves as providers of services may reflect their different origins. Some may take the view that it is unwise or unnecessary to compete with the service providers they comprise, including those involved in the governance of the PHO.

That PHOs are planners and funders of primary health care seems to be universally accepted, along with their role in supporting general practice and seeking to develop local primary health care provision. This raises the issue as to whether the PHO role complements or duplicates that of the district health board, and exactly what part the PHO should play in planning, funding and developing primary health care at a local level.

PHOs tend to focus on using their financial leverage to effect change through the allocation of relatively minor elements of funding (for example SIA and health promotion). They are not generally in a position to significantly influence allocation of funding for first-contact care, the largest proportion of funding for which PHOs are responsible. It is unsurprising that PHOs tend to pass on this funding without any attempt to shape its allocation or use, given that the policy priority in the past few years has been for first-contact funding to go towards lowering patient fees.

It is of note, however, that New Zealand government policy appears to put significant faith in a capitation system of funding for first-contact care, as a means by which to shift the model of primary health care from one focusing on episodic treatment towards one that is more health-promoting and preventative (National Health Committee 2000; King 2001). This flies in the face of evidence from international research literature about the limited potential of capitation funding approaches to achieve changes in service delivery on its own (Seddon, Reinken et al 1985; Scott and Hall 1995; Rice and Smith 2001; Robinson 2001). Such concerns have also been raised in New Zealand, where patient co-payments remain a significant element of physicians' income, and where there contracts between funders and providers are often incomplete (Cumming 1999; Cumming 2002; Croxson, Smith et al 2009). The role and purpose of PHOs over and above the 'passing-on' of funding to practices needs to be addressed.

Currently, PHOs effectively use certain minor funding streams to develop care locally. Future discussion needs to address ways in which they can move to the next stage of development, and play a role in planning, funding and incentivising wider-scale change, in order to bring about extended, sustainable and better integrated primary care. This appears to be widely accepted as the next major challenge for New Zealand's primary health care sector. A new approach may require a system of tighter contracts between PHOs and providers enabling greater specificity and accountability in terms of changes planned in service delivery. The government will also need to consider how to balance the provision of funding for changes in service delivery against the need to keep fees for primary health care services affordable.

The key question in this respect is whether, within the current funding and policy framework, expectations of PHOs are realistic in terms of their role in the development of primary health care. Their infrastructure appears to focus on planning, needs assessment and the allocation of specific minority funding streams, despite the PHCS setting out a much bolder and more extensive role for them in relation to primary health care services at a local level.

This survey asked questions about the role and activities of PHOs. It did not address the role and activities of MSOs and IPAs, which necessarily means that only a partial picture of the spectrum of activity being carried out under the auspices of PHOs can be gained. A question for the next phase of development of PHOs would seem to be: what is the role of the PHO as compared with its MSO and/or IPA?

Currently, there are issues pertaining to PHOs' relationships with their providers and MSOs that need to be worked through if PHOs are to further develop as planners and funders of primary health care. Mechanisms such as devolved budgets and pooled funding streams will ultimately result in better integrated primary health care. New Zealand has put in place an extensive network of primary health care infrastructure – putting it to efficient use in the next phase of development is a key policy challenge.

Analysis of these survey data has revealed a degree of vulnerability within the PHO sector that had not been anticipated at the time of designing this research. With 16% of PHOs feeling that they are 'at risk', and only 41% considering themselves to be 'doing well', it would seem that the time is ripe to revisit the role of PHOs within the health system and to comprehensively assess whether they have the capacity to achieve what the policy expects of them. Indeed, 'sustainability' was the most commonly cited goal identified by PHO managers.

Overall, this research gives the sense of a relatively fragile and complex set of organisations, facing significant challenges in relation to the next phase of implementation of the PHCS. While PHOs vary in their size, governance arrangements and background, they are united in a desire to be active planners and funders of primary care, supporters of general practice and developers of primary care services. The policy challenge in the next phase is to clarify the role of PHOs within the system, and to provide them with the funding and organisational flexibility to carry out what is expected of them, thereby supporting local practices and providers in delivering ever stronger and more extensive primary health care services to local populations.

ACKNOWLEDGEMENTS

We would like to thank the funders of this research – the Health Research Council of New Zealand, the Ministry of Health and ACC – for their support. We would also like to thank CBG Health Research Ltd for undertaking the CATI survey of PHOs, and to Antony Raymont and Dean Papa for their help in analysing the survey data quantitatively. Particular thanks are due to the managers of the PHOs for participating in this survey – we would very much like to thank them for the time they took in answering our questions and providing us with such detailed information.

REFERENCES

- Cabinet Office (2006). Fees Framework for Members of Statutory and Other Bodies appointed by the Crown. URL: <http://www.dpmc.govt.nz/cabinet/circulars/co06/8.html>
- Cameron, A. (2008). "On board PHOs: More of a tea trolley than a gravy train." *New Zealand Doctor* 3 December: 6, 8.
- Coster G. and Gribben B. (1999). Primary care models for delivering population based health outcomes: Discussion paper for the National Health Committee.
- Croxson B., Smith J., and Cumming J. (2009). Patient fees as a metaphor for so much more in New Zealand's primary health care system. Wellington: Health Services Research Centre.
- Cumming, J. (1999). "Funding Population-Based Primary Health Care in New Zealand." *Discussion Papers on Primary Health Care*. Wellington: Health Services Research Centre.
- Cumming, J. (2002). "Population-based funding and primary health care in New Zealand: What changes can we expect?" *Healthcare Review Online* 6(1).
- Cumming J., Raymont A., Gribben B., Horsburgh M., Kent B., McDonald J., Mays N. and Smith J. (2005). *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy. First Report*. Wellington: Health Services Research Centre.
- Dowling B. and Glendinning C. (2003). *The New Primary Care. Modern, Dependable, Successful?* Buckingham: Open University Press.
- Gauld R. and Mays N. (2006). "Are New Zealand's new primary health organisations fit for purpose?" *British Medical Journal* 333 (9 December): 1216–1218.
- Gauld R. (2008). "The Unintended Consequences of New Zealand's Primary Health Care Reforms." *Journal of Health Politics, Policy and Law* 33(1): 93–115.
- King A. (2001). *The Primary Health Care Strategy*. Wellington: Ministry of Health.
- Mays N. and Blick G. (2008). *How can primary health care contribute better to health system sustainability? Working Paper*. Wellington, The Treasury.
- Mays N., Wyke S., Malbon G. and Goodwin N., eds. (2001). *The Purchasing of Health Care by Primary Care Organisations: An Evaluation and Guide to Future Policy*. Buckingham: Open University Press.
- National Health Committee. (2000). *Improving Health for New Zealanders by Investing in Primary Health Care*. Wellington: National Health Committee.
- Perera R., McDonald J., Cumming J. and Goodhead A. (2003). *Primary Health Organisations: The first year (July 2002–June 2003) from the PHO perspective*. Wellington: Health Services Research Centre, School of Government, Victoria University of Wellington.

- Primary Health Care Nurse Innovation Evaluation Team. (2006). *Report of the Evaluation of the Eleven Primary Health Care Nursing Innovation Projects*. Wellington: Ministry of Health.
- Rice P.L. and Smith D.L. (2001). "Capitation and risk adjustment in health care financing: an international progress report." *The Milbank Quarterly* 79(1): 81–113.
- Robinson J. (2001). "Theory and practice in the design of physician payment incentives." *The Milbank Quarterly* 79(2): 149–177.
- Scott A. and Hall J. (1995). "Evaluating the effects of GP remuneration: problems and prospects." *Health Policy* 31(2): 183–195.
- Seddon T.D.S., Reinken J.A. and Daldy B.M. (1985). *Capitation Funding of a New Zealand General Practice*. Wellington: Department of Health.
- Smith J. (2009). Critical analysis of the Primary Health Care Strategy and framing of issues for the next phase. Wellington: Ministry of Health.
- Smith J. and Goodwin N. (2006). *Towards Managed Primary Care: The role and experience of primary care organisations*. Aldershot: Ashgate Publishing.

APPENDIX 1: PHO SURVEY

Internal structure

The following information will be taken from HealthPac and previous survey records but will be checked, and adjusted if necessary, at the start of the interview:

1. Enrolled patient population is (including Māori and Pacific)
2. Date of establishment is
3. Number of VLC practices
4. PHO management services are Not out sourced/Outsourced to [name]
5. The governance board comprise member
6. Board members are Elected / Appointed?
7. The term of appointment is years
8. The board meets every months
9. The board is paid a sitting fee? Yes/No \$ Chair \$ Member per meeting
10. Please indicate the make up of the board (primary role only, ie no doubling up).

Role	Number
Manager/Executives	
General practitioners	
Practice nurses	
Māori representative	
Pacific representative	
Community representatives	
Other	

11. What is the background of the PHO?
IPA background HCA background Other (specify)

12. What does the PHO comprise?

Provider type	Number
General practice	
Non-government organisations (NGOs)	
Other providers (such as pharmacies)	

13. How many staff does the PHO employ and who are they?

Role	FTE	No. of people
GP clinical support		
Nurse clinical support		
Financial support (accountant, clerks)		
Outreach staff (CHW, nurses)		
Administrators		
Senior/strategic management		
Quality improvement		
Analysts/researchers		
Locums		
Other (please specify)		

14. What activities are undertaken by the PHO?

	Yes	No
CNE for nurses		
CNE for doctors		
Direct employment of nurses in clinical positions		
Direct employment of doctors in clinical positions		
Recruitment initiatives		
Other (please specify)		

15. Do you see your role as? (Tick as many as apply)

Role	No	Yes	If Yes Please assign a score (1–5) where 1= Not important – 5= Very important
Direct provider of services			
Strategic planner of primary health care			
Provider development			
Community development			
Funder of primary health care			
Inter-sectoral work (eg, with local government, education)			
General practice support			

16. Is the PHO a member of any the following?

Organisation	Membership (Yes/No)
PHO Alliance	
PHONZ	
Healthcare Aotearoa	
Māori Coalition	

2. Do you use the same basic method to calculate how much **First Contact Funding** to allocate to each practice?
 - a. Yes
 - b. No
 - c. Unsure

3. Which of the following methods do you use to calculate how much **First Contact Funding** to allocate to each practice? *Please tick all that apply.*
 - a. Weighted capitation, using the Ministry of Health formula.
 - b. Capitation, or weighted capitation, using an alternative formula based on practice population.
 - c. A fixed, agreed amount.
 - d. A measure related to practice activity, such as the number of consultations.
 - e. Other
 - f. Unsure

4. If you allocate First Contact Funding to practices using some form of capitation, how do you calculate each practice's registered population?
 - a. Using information updated quarterly.
 - b. Using information updated annually.
 - c. Using information from the date when the practice joined the PHO.
 - d. Other
 - e. Unsure

5. Do you ever use **First Contact Funding** to leverage change in general practices' clinical practice or service provision? (For example, in addition to the PHO Performance Programme, do you ever withhold **First Contact Funding** to penalise, or use payments to reward, specific activity?)
 - a. Yes, routinely.
 - b. Yes, occasionally.
 - c. No
 - d. Unsure

Questions 7–10 paragraph form

Questions 7–10 address the way in which the PHO allocates **Health Promotion** and **Services to Improve Access** funding to its own general practices.

7. Do you allocate any **Health Promotion** funding directly to general practices?
 - a. Yes
 - b. No
 - c. Unsure

8. *If yes to Q7, how do you calculate the amount of **Health Promotion** funding to allocate to individual practices? Please tick all that apply.*
- a. According to the cost of specific initiatives / agreed budgets for specific initiatives.
 - b. By weighted capitation, using the Ministry of Health formula.
 - c. By capitation, or weighted capitation, using an alternative formula based on practice population.
 - d. Using a measure related to practice activity, such as the number of consultations.
 - e. Other
 - f. Unsure
9. Do you allocate any **Services to Improve Access** funding directly to general practices? *Please tick all that apply.*
- a. Yes
 - b. No
 - c. Unsure
10. *If yes to Q9, how do you calculate the amount of **Services to Improve Access** funding to allocate to individual practices? Tick all that apply.*
- a. According to the cost of specific initiatives / agreed budgets for specific initiatives.
 - b. By weighted capitation, using the Ministry of Health formula.
 - c. By capitation, or weighted capitation, using an alternative formula based on practice population.
 - d. Using a measure related to practice activity, such as the number of consultations.
 - e. Other
 - f. Unsure

Questions 7–10 tabular form

7. Questions 7 and 8 address the way in which the PHO allocates **Health Promotion** and **Services to Improve Access** funding to its own general practices.

	Services to Improve Access	Health Promotion
a.	Yes	
b.	No	
c.	Unsure	

8. How do you calculate the amount of funding to allocate to individual practices? *Please tick all that apply.*

	Services to Improve Access	Health Promotion
a.	According to the cost of specific initiatives / agreed budgets for specific initiatives	
b.	By weighted capitation, using the Ministry of Health formula	
c.	By capitation, or weighted capitation, using an alternative formula based on practice population	
d.	Using a measure related to practice activity, such as the number of consultations	
e.	Other	
f.	Unsure	

What are the three key goals for your PHO for the next three years?

- 1.
- 2.
- 3.

Has your PHO developed specific services or programmes that you consider to be innovative in relation to enabling better integrated primary health care for consumers or in relation to long-term conditions management?

- 1.
- 2.
- 3.