Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy

First Report

May 2005
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Mihi

Ē ngā mana
Ē ngā reo
Rau rangatira mā
Tēna koutou, tēna koutou

Ngā mate, ngā aitūa,
Ō koutou, ō mātou,
Ka tangihia e tātou i tēnei wā,
Haere, haere, haere.

Te hunga ora
Tēna koutou katoa.
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Abbreviations

ACC  Accident Compensation Corporation
AHB  Area Health Board
CHE  Crown Health Enterprise
CSC  Community Services Card
DHB  District Health Board (The Organisation)
GP   General Medical Practitioner
HFA  Health Funding Authority
HHS  Hospital and Health Service
IPA  Independent Practitioners’ Association
IPAC Independent Practitioners’ Association Council
Ministry  Ministry of Health
NGO  Non-Government Organisation
NZDS  New Zealand Disability Strategy
NZHS  New Zealand Health Strategy
NZPHDA New Zealand Public Health and Disability Act
PHCS Primary Health Care Strategy
PN   Practice Nurse
PHO  Primary Health Organisation
RHA  Regional Health Authority
Executive Summary

1 Introduction

In February 2001, the New Zealand government published the Primary Health Care Strategy (King 2001b). The Strategy noted that ‘a strong primary health care system is central to improving the health of New Zealanders and … tackling inequalities in health’ (King 2001b, p. vii). The Strategy envisages a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals in service delivery, and the advantages of funding based on population needs rather than fees for service (King 2001b, p.vii).

Essentially, there are three major organisational and policy changes occurring to implement the Strategy:

- Government funding for primary health care is being increased, so that fees that service users pay can be reduced and so that more people are eligible for government subsidies for primary health care;
- The Government is encouraging the development of Primary Health Organisations (PHOs) as local non-governmental organisations which serve the needs of an enrolled group of people; and
- Public funding of primary care has changed from fee-for-service subsidies at the practitioner level to capitation funding of PHOs.

Implementation of the Strategy is proceeding quite quickly – the two first PHOs were established in July 2002 and as at April 2005, there were 77 PHOs in existence covering almost 3.828 million New Zealanders. There are two main types of PHOs – Access-funded and Interim-funded. An Access-funded PHO has more than 50% of its enrolled population as Māori, Pacific, or people from the lowest (NZDep 9 and 10) socio-economic areas and all those enrolled in Access-funded PHOs have had higher subsidies paid for all enrollees. Those in Interim-funded PHOs have been funded at a lower subsidy rate. However, new funding has been provided to Interim-funded PHOs for those aged 6-18 years of age (from 1 October 2003), and to those aged 65 and over (from 1 July 2004), increasing subsidies and allowing fees for these population groups
to be reduced. The government aims to have all New Zealanders funded at higher rates from 1 July 2007, with those aged 19-24 in PHOs to be covered by higher subsidies from 1 July 2005, those aged 45-64 eligible from 1 July 2006, and the remainder of the population – those aged 25-44 – to be covered from 1 July 2007.

In addition to providing new funding to reduce user charges, there has also been additional funding provided for ‘services to improve access’, for management costs, and for health promotion. A number of other targeted initiatives are also in place. Overall, the government is providing an additional $1.7 billion in funding over the six year period from 2002/03 for implementation of the Strategy.
2 Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy

The Health Research Council, Ministry of Health and Accident Compensation Corporation have funded an Evaluation of the Implementation and Intermediate Outcomes of the Strategy. The Evaluation is formative, and the findings are being disseminated during the research in order to inform policy development as the Strategy is implemented. This report provides an overview of the findings from the first phase of this evaluation.

The research uses four main methods – key informant interviews; a postal questionnaire; quantitative analyses focusing on utilisation and intermediate health outcomes; and quantitative analyses in support of an economic analysis of the impact of the Strategy.

Key informant interviews provide the data used for this report. Overall, 151 interviews in twenty-six PHOs and practices within PHOs, and an additional 15 interviews with policy makers and other stakeholders, were undertaken for this research. Interviews in PHOs, practices, the Ministry of Health and with key stakeholders were undertaken between April and October 2004; interviews with ACC staff took place in March 2005. Semi-structured interview schedules were used to guide interviews. From notes made during the course of the interviews, key messages were identified and quotes pertaining to each were assembled and selected to give the typical flavour of the message.

It should be noted that in analysing the qualitative data, while every effort has been made to avoid emphasising uncommon situations, we have focused on including different view points rather than quantifying the extent to which views are held across participants. A robust study of the frequency of various structures, initiatives and problems, and of their correlation with PHO characteristics, must await the completion of the postal survey later in 2005.
More detailed analyses of the implementation and intermediate outcomes of the Strategy will be undertaken as this Evaluation progresses. The next phases of our research include completing the postal survey and undertaking more detailed quantitative analyses using data from practice management databases.
3 Findings

Reactions to the Goals of the Strategy and its Implementation

Almost all informants had strong positive reactions to the goals of the Strategy. It was generally agreed that fee reductions had improved access to primary care and informants also noted opportunities to improve patient care through more flexible service delivery with a focus on prevention. At the practice level, many practitioners felt their practice would be better resourced, and pointed to the advantages of cooperation with other practices and with others, such as iwi.

However, a number of concerns were expressed about the Strategy. Some GPs were concerned that their role had been inadequately recognised in the Strategy and they were worried about the long-term financial implications for themselves and their practices, and about perceived moves towards greater control of general practice by government. Some practitioners have, however, come to believe that the prospects are positive for their practices in a financial sense and were expressing a more optimistic view of the Strategy and the changes it might engender.

Some informants felt that more resources should have been put into the implementation process, and raised concerns about what they saw as the imprecise targeting of new funding as well as problems with ‘clawbacks’ (loss of funding arising from patients making casual visits to GPs they are not enrolled with).

PHOs

The community appeared to be well represented at board level in PHOs. The most common approach was to have representatives of the community (including representatives of Māori and Pacific peoples) along with clinicians (both medical and nursing) on the PHO board. In some PHOs, however, there was concern about medical dominance and many informants were clear that communication with the community was in its early stages.
There was general agreement that PHO management required a large input of time and money. Small PHOs were struggling with inadequate management resources and large ones were trying to establish and maintain adequate communication with practices.

There was a sense that the hard work of setting up and organising PHOs was nearing completion and focus could soon be directed to improving services and implementing new programmes. The types of new services and programmes discussed are set out in the table below.

**New Services Discussed by Key Informants**

<table>
<thead>
<tr>
<th>Greater accessibility and acceptability</th>
<th>Focused clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended opening hours</td>
<td>Care plus related activities</td>
</tr>
<tr>
<td>Whole family visits</td>
<td>Diabetes and nutrition clinics</td>
</tr>
<tr>
<td>Recruitment of a female practitioner</td>
<td>Asthma nurse clinics</td>
</tr>
<tr>
<td>Home visiting</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td>Medical clinics at schools</td>
<td>One-stop-shop for youth</td>
</tr>
<tr>
<td>Assistance with transport</td>
<td>Free sexual health clinics</td>
</tr>
<tr>
<td>Information for new immigrants</td>
<td>Cervical and breast screening</td>
</tr>
<tr>
<td>24 hour PHO Helplines</td>
<td>Programmes for mental health</td>
</tr>
<tr>
<td>Cultural training</td>
<td>Programmes for disabled persons</td>
</tr>
<tr>
<td>Interpreter services</td>
<td>Extra-practice services</td>
</tr>
<tr>
<td><strong>Secondary care liaison</strong></td>
<td>Radiology</td>
</tr>
<tr>
<td>ED liaison services</td>
<td>Retinal screening</td>
</tr>
<tr>
<td>Acute illness home care</td>
<td>Refraction</td>
</tr>
<tr>
<td>Specialist availability in practice</td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
</tr>
</tbody>
</table>

PHO respondents mentioned examples of positive relationships with other PHOs. There were also a number of examples of PHOs or their member practices working with other community organisations, most commonly district nurses and Plunket.
**Nursing Issues**

The research has indicated that there are many opportunities under the Strategy for enhancement of nursing practice to contribute to health outcomes. Individual practices vary enormously in nursing development, depending mainly on the preferences of the GPs as employers. Nurses feel that the development of a career pathway together with financial recognition for their levels of skill as well as increasing training opportunities would improve opportunities for development of nursing practice.

**The Primary Health Care Workforce**

The Strategy increases the responsibilities of the primary health care team, and there is concern that the medical and nursing workforce may be inadequate to the tasks required by the Strategy. Many key informants saw workforce capacity as a major issue for the immediate future.

**Injury Services**

All respondents felt there would be no change in the management of injuries as a result of the implementation of the Strategy. There was a suggestion that ACC policies should be aligned with the population health and prevention focus of the Strategy, although ACC officials noted that ACC as presently constituted is not able to match some aspects of the Strategy and that ACC already has a strong emphasis on prevention. It was also noted that the incentives for making ACC claims have changed – with ACC co-payments now being higher in some practices than non-ACC co-payments, patients have a disincentive to make claims, while at the same time there are incentives for practices to make ACC claims as these are outside the capitation payments they already receive.
Secondary and Referred Services
Some key informants suggested that there would be an incentive to use hospital services more, although respondents reported that they thought there appeared to be little change in the use of secondary health services to date. Management support for laboratory tests and pharmaceuticals and initiatives to reduce hospital admissions is on-going, and were thought likely to be supported by the PHO performance management project and the incentives it provides. With regard to laboratory use and prescriptions, respondents felt that it was relatively urgent to deal with known under-use of pharmaceuticals and laboratory tests by some populations with high needs.

Looking Ahead to Achieving Sector Goals
There was concern in the sector that the changes generated by the Strategy might stall and it was thought that many key goals had not yet been achieved. These included the delivery of low cost care for all; addressing population health; full community involvement in PHOs; the monitoring of outcomes; the consolidation of community health services within PHOs; and the development of closer ties with agencies involved in the determinants of health.
4 Discussion - Issues Raised by the Research

In the four years since the government published the Primary Health Care Strategy, much has been achieved and there is wide, and strong, support for the goals of the Strategy. Many in the population are registered or enrolled in one of 77 PHOs, and PHOs report that much of the set-up work has been completed and that effort can now be re-directed towards substantive changes in service delivery. For many New Zealanders, there are now lower fees (Ministry of Health 2004g), and there are reports from our key informants that access to services has improved. There are also indications that some general medical practitioners feel there is a greater flexibility in how they use their time. Some have found in the PHO environment a welcome opportunity to co-operate with other practitioners and one went so far as to say that the changes would rejuvenate general practice. Nurses appreciate the opportunities newly available to them to develop their practice.

However, informants have noted a number of issues relating to the Strategy and its implementation. For example, there are on-going concerns over the lack of targeting in the new system and concerns that some New Zealanders may still be missing out on cheaper care. Some GPs feel that the government is seeking a greater degree of control of general practice and that the viability of practices may be threatened. A number of implementation problems have also been noted.

Variations Between PHOs

The issues raised by the research vary across PHOs and we have identified two extreme types of PHOs, each with different concerns. On the one hand, PHOs made up of Access-funded practices already possess many of the qualities and provide many of the services mandated by the Primary Health Care Strategy. However, it would appear from the views of our informants that these organisations, given fewer management resources, are at risk financially and from individual and group ‘burn-out’. On the other hand, PHOs composed of Interim-funded practices may see little need to make changes and some community informants believed that the risk here is that some of the anticipated benefits of the PHO model will not materialise. It should
be noted, however, that the distinction is not rigid and some large Interim-funded PHOs are functioning very well, leading the way in needs analysis, public health and health education initiatives, and in the provision of new clinical services.

**Policy Implications.** A key question arising from this and other related research is whether small PHOs are viable, and whether policies need to be developed to support them. The development of PHO-level initiatives in needs analysis, public health and health education, outreach, and the provision of new clinical services should be monitored and managed to ensure that the changes suggested by the Strategy are being fully realised.

Ensuring meaningful community engagement, encouraging wider participation in PHO decision making, and a wider population understanding of the Strategy, are also key issues for the immediate future. The Ministry of Health and DHBs should work together to identify issues here and to facilitate further development in these areas.

**Managing Referred Services**

Given that PHOs are responsible for the health of their enrolled populations, they may have a *prima facie* case for being involved in the provision of many if not all community health services. In particular, it would also seem advantageous to maximise value by providing GPs with incentives to consider cost-effectiveness in laboratory test ordering and prescribing.

**Policy Implications.** The present policy on the transfer of services from DHBs or the Ministry of Health to PHOs (or to a joint venture) is permissive. A more active approach with DHBs being required to justify inaction might be implemented.
Practitioner Changes

Small Access-funded practices tend to support innovative activities. Private practitioners within large, Interim-funded PHOs, are independent and relatively invisible, and may feel little need to change the way they work.

Policy Implications. Incentives are needed at the practice level to ensure that the goals of the Strategy are achieved and that the government’s investment in primary care generates maximum benefit. Changes include seeking feedback from the practice clientele, making fuller use of nurses (and other providers), and advocating more actively with other service providers. Recognition of practice achievements, inclusion of these issues in the quality programme or monetary reward might be considered. As PHOs settle into their roles, they should be in a better position to influence their member practices in these ways.

Financial Barriers to Care

Removal of financial barriers to care is essential to the success of the Strategy. While fees have been reduced for many and subsidies will be available to all from July 2007, some practices charge substantial co-payments and there is already pressure for further fee increases.

Policy Implications. It has been suggested by PHOs and GPs that the fair cost of providing primary care should be independently established, making due adjustments for population health need and other factors beyond the control of practitioners. Another approach to the control of co-payments, suggested by a DHB informant, would be to arrange for the level of subsidy to reflect agreed co-payments, so that practices with higher fees attracted lower subsidies.
The Primary Care Workforce

The Strategy will generate more work in primary care and concern has been expressed that there are already too few GPs and practice nurses in New Zealand. Sufficient medical and nursing graduates must be attracted to general practice, given appropriate training and retained in practice. Innovative approaches to recruitment and retention are needed to ensure appropriate service delivery.

With medical practitioners, a key issue seems to be ensuring appropriate distribution across populations. With practice nurses, the impact of wage gaps between primary care nursing salaries and other salaried needs to be considered in policy development. Even then, many nurses find that the attitude of their employers - the GPs - can restrict nursing practice.

Policy Implications. The changes in the requirements being made of the primary care workforce should be figured into the assessment of training and workforce requirements. The models for attracting staff developed by community-based practices should be supported and developed. PHOs should also be encouraged to develop the role of nurses.
1 Introduction

In February 2001, the New Zealand government published the Primary Health Care Strategy (King 2001b). The Strategy noted that ‘a strong primary health care system is central to improving the health of New Zealanders and … tackling inequalities in health’ (King 2001b, p. vii). The Strategy provides a clear direction for the development of primary health care, and states that over a five to ten year period, a new vision will be achieved, where:

“People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for the population, and actively work to reduce health inequalities between different groups.” (King 2001b, p.vii).

The Strategy envisages a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals, and funding based on population needs (King 2001b).

Essentially, there are three major organisational and policy changes occurring to implement the Strategy:

- Government funding for primary health care is being increased, so that fees that service users pay can be reduced and so that more people are eligible for government subsidies for primary health care;
- The Government is encouraging the development of Primary Health Organisations (PHOs) as local non-governmental organisations which serve the needs of an enrolled group of people; and
- Public funding of primary care has changed from fee-for-service subsidies at the practitioner level to capitation funding of PHOs.
Overall, it is hoped that the changes will improve access to services, encourage providers to focus services on population as opposed to ‘walk-in’ patient needs and on preventing ill-health and treating illness early. The Strategy is also aimed at enabling the development of services that more appropriately meet the needs of people not well served by traditional models of care such as private general practices. The development of PHOs is designed to encourage practitioners to work together across traditional disciplinary boundaries to improve quality of care. Finally, the changes are supposed to allow local populations to have more input into health care service delivery, creating a more responsive set of services.

The Strategy began to be implemented in July 2002, with the establishment of the first two PHOs from that date. By April 2005, some 3.828 million New Zealanders were enrolled with 77 PHOs. From an estimated $337m spent on GP services annually in 2001/02 (Ministry of Health 2004i), the government has committed an additional $1.7 billion over six years from 2002/03 for implementation of the Strategy (Ministry of Health 2004i).

In early 2003, the Health Research Council of New Zealand (HRC), the Ministry of Health (MoH) and the Accident Compensation Corporation (ACC) tendered for an Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy. A research team made up of researchers from the Health Services Research Centre (Victoria University of Wellington), CBG Health Research Ltd (Auckland) and other organisations submitted a proposal for the evaluation of the implementation of the Strategy. The team was awarded the contract in July 2003. The evaluation spans a three to five year period, and is designed to be a formative evaluation. That is, an important aspect of the research is to report on, and disseminate, findings throughout the research endeavour.
This report is the first report on the research. It covers the period from October 2003 to October 2004, and is focused on findings from interviews with government Ministers and officials, stakeholder organisations, those involved with PHOs and staff in practices that belong to PHOs, as well as those in practices that are not part of PHOs. The report also indicates the types of quantitative analyses that the research team will be undertaking over the next year.

The report begins by discussing the background to the Primary Health Care Strategy and its implementation. The report then outlines the research methodology, themes and methods, and provides a summary of the research undertaken to date and the data sources used in this report. The findings from the research are then presented, followed by an overall assessment of the implementation and performance of the model based on the research undertaken so far. The report concludes with an outline of the next steps in the evaluation process. A number of appendices are included in this report. Appendix 1 provides an overview of the organisation of New Zealand’s health care system, and provides a discussion on issues and recent developments in primary health care in New Zealand. Appendix 2 sets out in some detail the policies and processes surrounding the implementation of the Strategy. Appendix 3 sets out a list of evaluations being undertaken on the Strategy and its implementation. Appendix 4 sets out examples of how quantitative data from practices are being analysed to assess the impact the Strategy on fees and utilisation of services.
2 The Primary Health Care Strategy

The New Zealand health care system has been reformed a number of times in the past 20 years and the details surrounding the reforms and the organisational structure of the New Zealand health care system in 2005 are set out in Appendix 1. The Primary Health Care Strategy was introduced in February 2001. As noted above, it aims to improve the health of New Zealanders and to reduce inequalities. Implementation has involved three major policy changes.

A first important change relates to funding levels to support primary health care in New Zealand. The Strategy notes barriers to accessing care and the government has committed itself to reducing cost barriers to care over time through additional funding to the sector, beginning with those with the highest needs (King 2001b). How this has worked in practice is discussed in more detail below.

A second important aspect of the Strategy is the development of PHOs. PHOs are:

- Funded by district health boards (DHBs) for the provision of essential primary care services to an enrolled population;
- Required to develop services that will be directed towards improving and maintaining the health of the population as well as providing first-line services to those who are unwell;
- Required to involve their communities in their governing processes and be responsive to community needs;
- Required to involve all providers and practitioners in influencing decision-making;
- Required to be not-for-profit;
- Funded on a capitation basis (King 2001b).
Patients are encouraged to enrol with PHOs via their usual primary care provider, but they can continue to choose not to enrol and they continue to have a choice over where they receive primary health care. Likewise, practitioners can choose to affiliate with PHOs or not. However, neither patients nor practitioners who remain outside the PHO system can access any of the new public funding for primary care; thus there is a strong incentive for both to participate in the new arrangements.

A third change is the move to capitation payments for PHOs. One key rationale for moving to capitation is to reduce inequalities by ensuring that primary health organisations are funded according to the needs of population they are serving, rather than to the number of services being delivered (King 2001b). A move to capitation is also considered essential to encouraging multi-disciplinary, team approaches to care, and a focus on wellness as opposed to sickness (National Advisory Committee on Health and Disability 2000). The New Zealand policy aims to pay PHOs by capitation – but how PHOs pay practitioners is left up to PHOs and practitioners to decide. With patient user fees still in place, practices continue to receive funding from both public and private sources, and through a mix of payment types.

The Strategy also seeks to encourage multi-disciplinary approaches to care, support the development of services by Māori and Pacific providers, and facilitate transition to widespread patient enrolment with PHOs through a public information and education campaign (King 2001b).
2.1 Implementation of the Primary Health Care Strategy

2.1.1 The Shift from Targeting to a Universal Approach

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

Access-funded PHOs received a higher per capita rate than Interim PHOs. Access funded PHOs were defined as those where the PHO had more than 50% of its enrolled population as Māori, Pacific, or people from lower socio-economic areas, as measured by a deprivation index (Crampton, Salmond et al. 2004). Funding was targeted towards PHOs with a majority of its enrollees in these groups on the grounds that they have poorer health status on average and higher needs than other New Zealanders (Ministry of Health 1999; Ministry of Health 2004o; Raymont 2004)). All those enrolled in such PHOs had access to lower primary care fees.

Since 2003, the government has provided further funding, and has focused on increasing subsidies for particular groups in the population. As Access-funded PHOs were already funded at a higher level, new funding has allowed Interim-funded PHOs to reduce fees for those aged 6-18 years of age (from 1 October 2003), and to those aged 65 and over (from 1 July 2004). As a result, all New Zealanders in these age groups – regardless of the type of PHO they are in – are now subsidised at a higher level for primary care.
In response to concerns that some New Zealanders with high needs not in Access-funded PHOs might continue to miss out on higher subsidies and lower fees for care, a separate funding arrangement has been established for those with chronic illnesses who are likely to increase costs for specific practices within PHOs. Called Care Plus, this funding is targeted towards individuals who need to visit their GP or family nurse often, due to significant chronic illnesses or a terminal illness. Care Plus is currently running in around 52 PHOs around the country (Ministry of Health 2004f). Further details are provided in Appendix 2.

In addition to providing new funding to reduce charges for service users, all PHOs have received additional funding for ‘services to improve access’, for management costs, and for health promotion. Before receiving the services to improve access and health promotion funding, PHOs must submit proposals as to how the additional funding will be used, and have these approved by their DHB. Many new service initiatives have been reported; 24 are outlined in the recent publication, “A Difference in Communities: What’s Happening in Primary Health Organisations” (Ministry of Health 2005c).

Overall, the government has committed an additional $1.7 billion over six years from 2002/03 for implementation of the Strategy, i.e. around $300 million additional per annum on top of an annual spend on general practitioner services of about $337 million in 2002/03 (Ministry of Health 2004i). The government has now indicated that all New Zealanders will be covered by higher government subsidies for primary health care by July 2007; extra funding for 18-24 year olds will be provided in July 2005, allowing reductions in fees for those in Interim-funded PHOs; those aged 45-64 will gain extra funding in 2006; and the remainder of the population – those aged 25-44 years, benefiting from July 2007 (Ministry of Health 2004k).
2.1.2 Encouraging PHO Development

The first two PHOs were established on 1 July 2002 (Ministry of Health 2004k); by April 2005 there were 77 PHOs. PHOs have enrollee numbers ranging from just over 3,000 to just over 333,000 enrollees. Some 3.828 million New Zealanders are now enrolled with PHOs\(^1\) (Ministry of Health 2004k). The numbers of New Zealanders in PHOs are set out in Figure 2.1 and Table 2.1 below.

**Figure 2.1**

![PHOs and Enrolled Population](image)

Note: Left-hand axis is the Enrolled population in millions (bar graph); Right-hand axis is the number of PHOs (line graph). Source: Ministry of Health

\(^1\) Patients who were registered with a GP and had visited that GP prior to two years before the GP became a part of a PHO are considered enrolled; PHOs have three years in which to confirm enrolment.
Table 2.1
The Number of New Zealanders Enrolled in PHOs, With and Without Low Cost Access as at April 2005

<table>
<thead>
<tr>
<th>PHO Type</th>
<th>Access-Funded PHOs</th>
<th>Interim-Funded PHOs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Need/Age Group</td>
<td>Low cost access</td>
<td>Low cost access</td>
<td>No low cost access</td>
</tr>
<tr>
<td>High need*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18</td>
<td>244,551</td>
<td>141,340</td>
<td>0</td>
</tr>
<tr>
<td>18-64</td>
<td>368,732</td>
<td>0</td>
<td>252,938</td>
</tr>
<tr>
<td>65+</td>
<td>44,702</td>
<td>42,334</td>
<td>0</td>
</tr>
<tr>
<td>High need subtotal</td>
<td>657,985</td>
<td>183,674</td>
<td>252,938</td>
</tr>
<tr>
<td>Lower need</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18</td>
<td>106,392</td>
<td>537,678</td>
<td>0</td>
</tr>
<tr>
<td>18-64</td>
<td>283,817</td>
<td>0</td>
<td>1,416,045</td>
</tr>
<tr>
<td>65+</td>
<td>60,138</td>
<td>329,582</td>
<td>0</td>
</tr>
<tr>
<td>Lower need subtotal</td>
<td>450,347</td>
<td>867,260</td>
<td>1,416,045</td>
</tr>
<tr>
<td>Total</td>
<td>1,108,332</td>
<td>1,050,934</td>
<td>1,668,983</td>
</tr>
</tbody>
</table>

*High need people are those who are Māori, Pacific or low socio-economic status (in NZDep 9 or 10). Low cost access is available to all those in Access-funded PHOs and to those aged <18 and 65+ in Interim-funded PHOs. Source: Ministry of Health.

2.2 Potential Impact of the Strategy

These reforms are of great interest both in New Zealand and internationally. They represent major changes in health care organisation to promote a new approach to primary health care access and service delivery. The focus on primary health care reflects its important role in the health care system, with most formal care provision occurring at this level (Green, Fryer et al. 2001). The changes also reflect the attention being paid to primary health care in international health policy (World Health Organisation 1978; World Health Assembly 2003). Primary health care reform is currently occurring in a number of countries, including the United Kingdom and Canada (Sibbald, Sheaff et al. 2004; Wilson, Shortt et al. 2004).
In general, New Zealand evidence supports the direction in which New Zealand is moving in the primary health care sector. As noted above, New Zealand research shows significant inequities in access to and use of services (Ministry of Health 1999; Ministry of Health 2004o; Raymont 2004)). The latest New Zealand Health Survey, for example, shows a mixed picture in terms of variations in the utilisation of a range of services by age, gender and ethnicity, socio-economic status and health status (Ministry of Health 2004o). Analysis of the health services utilisation data shows a higher number of GP visits for those on low-to-medium incomes than those on medium-high or high incomes, for those in more highly deprived areas, for those who are older, and for those with poorer health status. Those in the more highly deprived areas, those on low-medium incomes, young people and adults under 65 years of age, Māori and Pacific and those in poorer health were more likely than other New Zealanders to forego visits as a result of poor health (Raymont 2004).

Numerous studies have been undertaken looking at differences between Māori and non-Māori in relation to access to care (Davis 1986; Davis 1987; Pomare, Keefe-Ormsby et al. 1995; Davis, Lay-Yee et al. 1997; Salmond and Crampton 2000; Westbrooke, Baxter et al. 2001). The overall picture suggests that in many cases Māori have lower utilisation of primary care than would be expected, particularly once differences in need are taken into account, and given higher rates of reporting of unmet need by Māori (Ministry of Health 1999). In terms of secondary care, Māori often have higher rates of utilisation, but for some services lower rates than would be expected (Statistics New Zealand 1993; Pomare, Keefe-Ormsby et al. 1995; Salmond and Crampton 2000; Westbrooke, Baxter et al. 2001; Ministry of Health 2004o). There is also evidence that disparities in relation to health status may have become worse over time between Māori and non-Māori in New Zealand, resulting from increasing differences in chronic disease mortality in middle age (Ajwani, Blakely et al. 2003).
International research also supports the focus that New Zealand is now taking in relation to primary health care. Starfield for example finds lower costs and better health outcomes that are attributable to primary health care (most notably in infancy and childhood) in countries with stronger primary health care systems (Starfield 1994; Starfield 1998). More recent and technically sophisticated studies, controlling for a range of health and socio-economic factors (Starfield 2004) have confirmed these associations for all cause mortality, life expectancy, infant mortality, potential years of life lost for all causes, pneumonia, influenza, asthma and bronchitis, cerebrovascular disease, heart disease amongst males and for all categories of potential years of life lost for females. The analysis showed the consistency of these relationships over time, from 1970 to 1998 (Macinko, Starfield et al. 2003). There is also evidence that better primary health care resourcing is associated with lower levels of social inequity, although there is very little research on this topic (Starfield 2004).

Economic analyses also provide support for the direction of change in New Zealand in relation to cost sharing, which is one aspect of the Strategy (albeit not the only one). The literature suggests that cost sharing can help to control expenditures by reducing utilisation of services, although the need for cost sharing to control expenditure may differ across settings and countries as some health care systems and organisational forms can manage costs through other policies (Rice and Morrison 1994). However, cost sharing has been shown to discourage the use of appropriate and inappropriate care roughly equally (Lohr, Brook et al. 1986), especially for primary and preventive services as opposed to more costly hospital services, and particularly amongst those on lower incomes (Rice and Morrison 1994).
The literature suggests that it is likely that lower user charges will increase use of services, but the evidence from other universal comprehensive public systems is that use and expenditure are strongly related to poor health status (associated with lower socioeconomic status) while most people make little use of health care (Roos, Forget et al. 2004). Although the impact of lower charges on health status is less clear, there are indications that reduced charges can benefit health status by encouraging visits that enable more preventive checks to be made, for example, for high blood pressure, prevention of communicable diseases, and other disease screening, again especially for those on low incomes (Rice and Morrison 1994).

Many of the above conclusions are based are the findings from cross-sectional studies, and while cross-sectional studies tell us about the possible reasons for differences in access and utilisation, they cannot tell us how access and utilisation change when fees change. Very few studies have been undertaken that inform us as to the impact of changes in fees (Roos, Forget et al. 2004). International studies have shown reductions in demand with the introduction of co-payments (Scitovsky and Sneider 1972; Beck 1974; Scitovsky and McCall 1977; Beck and Horne 1980; Scheffler 1984; Cherkin, Grothaus et al. 1989; Cherkin, Grothaus et al. 1990; Cherkin, Grothaus et al. 1992) – and in some studies it was found that physician office visits fell while hospitalisations increased (Roemer, Hopkins et al. 1975; Helms, Newhouse et al. 1978) – although the findings from some of these studies need to be viewed cautiously due to problems with data (Rice and Morrison 1994). In Saskatchewan, use of medical services fell by around 6-7% when fees were introduced; when free health care was reintroduced in Saskatchewan in 1971, the use of services then returned to its predicted trend value (Richardson 1991). Other studies have shown an increase in the number of visits by the poorest groups, upon the introduction of the United Kingdom National Health Service (Stewart and Enterline 1961), and upon the introduction of Canadian Medicare to Quebec in 1970 (Enterline, Salter et al. 1973). Interestingly, both studies also showed a drop in visits for the relatively well off.
Two New Zealand studies have researched changes in utilisation of services following changes in user charges. The WaiMedCa study enabled researchers to explore changes resulting from the redesign of the user charge regime in New Zealand in 1992, with falls in utilisation of services following reductions in charges for community services card-holding groups – the counterintuitive result arising possibly from the negative publicity associated with the changes, the possibility that fees charged did not in fact fall as far as the subsidy changes might have allowed, access to private health insurance and, more speculatively, from problems in accessing the community services card required to access cheaper care (Davis, Gribben et al. 1994). An evaluation of the introduction of ‘free’ care for the under-sixes introduced in New Zealand in 1997 found that more children under six appeared to consult a GP following the introduction of the scheme, and that this may have reduced hospital use, in particular in relation to acute respiratory illnesses. However the data available were inadequate to evaluate the scheme fully (Dovey and Tilyard n.d.).

2.3 Early Research Findings on the Primary Health Care Strategy

Prior to the commencement of the Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy, two other projects have researched the early experiences of the implementation of the Strategy.

The first is the Health Reforms 2001 Research project. This three year project, funded by the Health Research Council of New Zealand, the Ministry of Health, The Treasury and the State Services Commission, was undertaken to chart the progress of, and evaluate, as they were implemented, the health reforms enacted by the New Zealand Public Health and Disability Act 2000.
In relation to the Primary Health Care Strategy, the research (Cumming, Goodhead et al. 2003) found, amongst those working within the sector, general agreement with the principles and aims of the Strategy. Informants saw the potential for greater integration of services, teamwork and innovation, community involvement, a more social model for health care, and lower costs for patients.

There were, however, concerns over the consultation process undertaken during the development of the strategy and implementation plans, and with aspects of the implementation of the Strategy. Concerns were expressed about issues of equity during the transition to more complete funding, and there were questions about whether there would be sufficient funds to ensure low cost health care for all. Those interviewed also noted the ‘huge commitment of resources and energy’ required for setting up a PHO, and some felt this was exacerbated by demands for information and reporting from the Ministry of Health.

General practitioners raised concerns about the right to charge patient fees (co-payments)\(^2\) and about the potential for a more demanding workload. This was seen as potentially arising from greater concentrations of high needs patients and from other professions taking over some of the more routine tasks. Professional organisations were concerned about the future relative roles of different groups of professionals, and concerns were also expressed by nurses and allied professionals about general practitioners dominating both governance and service delivery.

For the second project, The Health Services Research Centre was contracted by the Ministry of Health in April 2003 (under the auspices of the Health Reforms 2001 Research Project) to undertake a small study reviewing the early experiences of PHOs, as a precursor to the larger evaluation of the Strategy. The research described the experiences of PHO implementation from 1 July 2002 to 1 June 2003, from the PHO perspective.

\(^2\) See Appendix 2 for further details on this issue.
At the time of the research, 34 PHOs were in existence. Findings were based on 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.

The research (Perera, McDonald et al. 2003) again found continued strong support for the philosophy of the Strategy, generally supportive DHBs and good relationships between DHBs and PHOs, and that a wide range of new services were being provided or planned as a result of the Strategy. Those in PHOs noted the enormous investment of time, personnel and resources required for the establishment of PHOs. It was noted that patient co-payments had decreased in all Access-funded practices, although opinions varied as to whether reduced fees had made a difference to patient access and utilisation rates.

Those participating in this research also noted a number of concerns with implementation, including in relation to: inconsistencies and variation in the contracting process; poor public awareness of PHOs and an associated lack of patient understanding about the implications of PHO enrolment; PHO funding being tied to enrolment based on general practice (GP) registers; fluctuations in income as a result of mobile populations and fee-for-service deductions; views that health promotion and management funding were felt to be inadequate; and cumbersome payment processes, requiring time consuming checks.
3 Evaluation of the Implementation and Intermediate Outcomes of the Strategy

The Ministry of Health and other agencies are funding a number of pieces of research on the implementation and outcomes of various aspects of the PHCS (see Appendix 3). These include the ‘lead’ evaluation of which this is a first report. Information on and reports from other evaluations – for example on the implementation and outcomes from the Reducing Inequalities Contingency Fund, Care Plus, and 11 nursing innovation pilots – are available on the Ministry of Health website (www.moh.govt.nz).

This section of this report sets out the key objectives for the lead evaluation, and describes the main methods being used in evaluating the Strategy implementation and intermediate outcomes. Further detail on the methods is included later in this report.


In April 2003, a research team led by the Health Services Research Centre (Wellington) and CBG Health Research (Auckland) submitted a proposal for the ‘lead’ evaluation of the implementation of the Strategy. This proposal was developed in response to a brief issued by the Health Research Council of NZ (HRC). The evaluation is funded by the Ministry of Health (MoH), the Accident Compensation Corporation (ACC) and the HRC, and administered by the HRC under their “partnership” programme. The team was awarded the contract in July 2003. The evaluation is independent, and acknowledged to be independent, of government agencies. Through the evaluation, the funders are seeking to obtain a credible, independent and scientifically rigorous evaluation of the implementation of the PHCS. This evaluation is to be formative and will inform current and future policy decisions and assist implementation of current policy.
3.2 Evaluation Objectives

The main objectives of the evaluation are, with consideration to both health and injury-related services:

- To describe the implementation of Primary Health Care Strategy with a specific focus on PHOs, including describing the structural, governance, funding, workforce and contractual issues that impact on the establishment of PHOs.

- To evaluate the implementation of PHOs against the objectives of the Primary Health Care Strategy, and other Ministry of Health, DHB and ACC objectives, in particular by:
  
  - reaching an in-depth understanding of the experience and activities of Primary Health Organisations (PHOs) and their member providers in responding to the Primary Health Care Strategy (PHCS);
  
  - measuring change in programmes, processes and intermediate health outcomes during the adoption and implementation of the PHCS;
  
  - assessing the impact of the Strategy on reducing health inequalities involving Māori, Pacific peoples and the financially disadvantaged.

- To analyse the net costs of the strategy at the national and the PHO level, and the extent to which expenditure changes over time, by population group and service type.

- To identify positive and negative influences on PHO achievement and to identify the critical success factors for delivery of effective, accessible primary health care.

- To disseminate the results from the evaluation to government agencies, DHBs, PHOs, and other PCOs.
3.3 Research Themes

The research focuses on the following themes, as set out in the Request for Proposal issued by the HRC, MoH and ACC. The research will describe, analyse and assess:

1. The relationship between the Ministry, DHBs, PHOs and PCOs.
2. Governance and internal financial arrangements of PHOs.
3. Changes in the role of consumers and local communities in the development and management of primary health care services.
4. Enrolment processes and efforts to address population care.
5. Efforts to identify and correct inequities in access to health services.
6. The development of new services, other changes in service provision and the achievement of comprehensiveness in primary care.
7. Efforts to improve service quality.
8. Developments in information collection and quality.
9. The impact on primary health care services for Māori.
10. The impact on primary health care services for Pacific peoples.
12. The development of multidisciplinary teams within PHOs particularly the role of nurses.
13. Moves to coordinate services between PHOs and other organisations.
14. How the PHCS has increased access, and reduced inequalities in access, to services.
15. The impact of the PHCS on health status and in reducing health inequalities.
16. The impact of the implementation of the PHCS on injury care provision.
17. Changes in the quality of primary care services (including use of drugs, laboratory tests and referrals).
18. Variations between types of PHOs and other PCOs and identify key factors for success.
19. The economic impact of the PHCS.
20. The new prescribers’ initiative.
3.4 Research Methods – Overview

The research uses four main methods: key informant interviews; a postal questionnaire; quantitative analyses focusing on utilisation and intermediate health outcomes; and quantitative analyses in support of an economic analysis of the impact of the Strategy. These are briefly described below; further details are reported in later sections of the report.

**Key Informant Interviews** – The aim of these interviews is to reach an in-depth understanding of the experience and activities of PHOs, and their member practices in responding to the Strategy. As qualitative research, interviews are designed to give an overview of the views and experiences of those interviewed. The qualitative research is also designed to inform the design of a nationwide postal survey, which will allow us to quantify the extent to which particular views and experiences identified by the qualitative research are held by PHOs, providers and practices.

PHOs are selected to represent the range of sizes, structures, geographical locations and enrolled populations of such organisations nationwide. Separate interviews are held with representatives from governance/management (eg board members, partner organisations, CEO, financial officers), Māori and/or Pacific programme managers, medical services, nursing services and community members. Within the selected providers, separate interviews are held with medical and nursing leaders, Māori and/or Pacific programme managers and community members, as appropriate. These interviews are to be undertaken twice – during the early phases of implementation of the Strategy and again around 18 months later. A sub-project extended the key informant interviews to Ministry of Health staff with responsibility for designing and implementing the PHCS. Separate interviews were also held with senior officials at ACC.
Postal Survey – The postal survey, to be undertaken in mid-2005, and again in early-to-mid 2006, will cover a similar range of themes and topics as the interviews but will enable the evaluation to be widened to cover all PHOs and member practices, and, as noted above, to quantify the extent to which views and experiences found through interviews are found in the wider community. A questionnaire will be developed based on the themes identified above and on information obtained from the key informant interviews. Informants at PHO/non-PHO level are likely to include the CEO and community liaison, clinical leads (medical and nursing) and consumer representation. Descriptive data will be reported on the organisational characteristics and initiatives of the PHOs and provider organisations.

Quantitative Assessment – Utilisation and Intermediate Health Outcomes – This phase of the research will measure the change in activities, processes and outcomes of primary care during the adoption and implementation of the Strategy (Themes 14-17). Data for this phase of the research comes from two main sources – national data sources and practices. This report, in Appendix 4, sets out more detail on the quantitative assessments the research team will undertake to report on the impact of the Strategy in relation to changes in fees and utilisation of services.

Economic Analysis – Economic analysis of the Strategy is complicated because of the number of changes occurring at the same time. This makes it particularly difficult to determine which components of the policy are responsible for identified impacts on costs and benefits. For the economic component of the evaluation, we will undertake two analyses that aim to estimate the (net) costs of the Strategy and the extent to which the distribution of expenditure changes over time, by population group and by service type (Theme 19). We will use both national and practice-level data sources for the economic analysis. It should be noted that our ability to undertake these analyses is highly dependent on the availability of data from national data sets and from PHOs and providers. At the time of writing, an initial data set has been provided to the researchers, and economic analyses have only just commenced. We will report on our findings from these in future reports.
This report focuses on findings from the key informant interviews. The next phases of our research include completing the postal survey and undertaking detailed quantitative analyses using data from practice management databases and national databases. Future reports will include drawing on the findings of the other evaluations undertaken over the next eighteen months, as well as on additional research projects that are currently in the planning stages or underway.

**Combined Analyses** – Data obtained from key informant interviews, the postal survey and the quantitative assessments will be combined to create a complete picture. Thus, informants will share the experience of setting up new programmes, the survey will indicate what new programmes have been set up and the quantitative data will show to what extent these programmes have been effective.

A key goal of the Strategy is to reduce inequalities in health and in access to healthcare. At present, Māori, Pacific peoples and the economically deprived have poorer health and less access to healthcare.

**Assessing Issues for Māori**

Data will be gathered, analysed and interpreted, on:

- Māori representation in governance and management;
- Involvement of the Māori community in health care issues;
- Cultural safety for Māori involved with PHOs/PCOs;
- Understanding and implementation of He Korowai Oranga;
- Efforts to identify Māori /non-Māori health inequalities;
- Public health/health promotion programmes directed at Māori;
- Efforts to attract Māori for health assessment;
- Health programmes directed at Māori;
- Cost of care for Māori;
- Health utilisation by Māori relative to practice roll;
- Quality of care for Māori especially screening and preventative care;
- Changes is secondary care use among Māori;
• Māori admissions sensitive to ambulatory interventions;
• Māori elective admissions;
• Development of Māori providers and workforce;
• Relationship between PHOs/PCOs and Māori providers.

Addressing Issues for Pacific Peoples
Similar data will be sought on the care of Pacific Peoples. More focus will be given here to the care of people un-used to communicating in English. Particular attention will also be paid to the understanding and implementation of the Pacific Health and Disability Action Plan.

Addressing Issues for Those in Lower Socio-economic Status Populations
Similar data will be sought on the care of those with lower socio-economic status. The focus will be primarily on costs involved in accessing care including transportation, family care and co-payments as well as on efforts to identify particular groups and to better meet their needs.

Reducing Inequalities
Information will be sought on PHO/PCO efforts to identify and correct both inequities in access to care, and inequalities in health status:
• Efforts to identify inequities in access to care;
• Programmes to reduce inequities;
• Efforts to identify inequalities in health;
• Programmes to reduce inequalities;
• Information on barriers to identifying and reducing inequities and inequalities;
• Quantitative data analyses, where possible, comparing rates of utilisation across population groups, changes in ambulatory sensitive admissions, secondary care admissions, quality of care performance indicators by population group, and expenditure on key population groups.
Service Teams and Inter-sectoral Co-operation

A second key goal of the PHCS is to widen the services available to registered members of primary care organisations, especially in the area of public health and practice nursing. We will enumerate projects in these areas and assess related workforce changes via survey; understanding of process and outcome changes will be limited by the availability of data e.g. reporting of nurse visits.

Factors for Success

The formative goal of the evaluation requires that the relative success of PHOs and PCOs be assessed and related to local factors. It is recognised that success has multiple components which may not be correlated. Aspects of success (better access, improved quality, healthier population, productive workforce) will be isolated and related to context (community status, organisational history, size and competition) and programmes (community education, cultural acceptability, reduced co-payments, expanded role of nurses). Suggestive relationships will be explored with the data available.

Injury Services – The ACC is a co-funder of the evaluation and is interested in ascertaining the impact of the PHCS on the behaviour of providers and claimants in relation to injury services.

In interviews with senior ACC officials, a number of potential benefits from the PHCS were noted, including the potential for more integrated relationships between different providers of primary health care services, greater use of nurses, a focus on disease-management, and a greater focus on teamwork. However, the PHCS and its implementation may have implications for ACC arising from changing incentives as a result of the changes in funding and funding arrangements brought about by the PHCS.
It was suggested that the following changes may occur, although in practice providers and claimants across PHO types will face different incentives:

- Prior to the introduction of the PHCS, ACC and Vote:Health paid the same per consultation fee for consultations for children under 6 years of age. This was seen to lead to a lower claim rate for those under 6, because claiming ACC requires the provider to complete a separate form (an ACC45 form) and seek approval from ACC for the claim. Subsidies for those under 6 have not changed as a result of the Strategy, but this example indicates that if Vote:Health pays more for consultations than ACC, then there is little incentive (other things being equal) to claim on ACC; however, if ACC pays more for consultations than Health, the incentives shift towards claiming on ACC, with subsequent cost implications for ACC. ACC has increased its subsidies for GP consultations to $32 per adult consultation from 1 April 2005; this may provide an incentive for an increased number of claims to ACC. The respective co-payments set by providers to patients may also influence patients in relation to making a claim; if ACC co-payments are lower than Health co-payments, they may wish to have a claim made to ACC on their behalf.

- The change to capitation payments for PHOs may also influence the incentive on providers to make ACC claims. If providers seek to maximise their incomes, being paid by capitation for health-related services provides an incentive to claim for ACC wherever possible, as ACC is a possible alternative source of revenue.

ACC officials see under-claiming as a potential issue where patients may miss out on appropriate treatment and rehabilitation. They also note that there is the potential for greater cost-shifting from Health. However, as it is necessary for claims to be shown to be accident-related, it was suggested that this may make it harder to shift costs to ACC if there has not been an accident.

ACC has also identified the risk that practitioners focus on setting up PHOs and resolving implementation issues may distract from best practice programmes in the treatment of injury.
It should be noted that ACC, as presently constituted, is prohibited from matching some aspects of the Strategy. For example, ACC may not differentiate the funding of injury care on the basis of citizen income and it cannot fund on a capitation basis since costs must be attributed to “accounts” based on the context of injury.

While changing incentives may disrupt ACC claim rates, there are a number of ways in which the Strategy presents opportunities to improve care of the injured. For example: ACC may be able to work with PHOs in the development of injury prevention programmes; PHOs might be able to coordinate the care of the elderly where a risk of injury and a chronic illness may often co-exist; and PHO practices might extend the primary care team to include physical therapists and coordinate care for the injured.

On this research, both the key informant interviews and the postal survey research will assess provider incentives by identifying PHO payment mechanisms and recording co-payment schedules.

The practice data that will be collected will indicate the relative ratio of ACC to non-ACC consultations. Changes in the ratios of funding source, the incidence of new claims and changes in the number of visits per claim, taking account of changes in demographic variables, will measure changes in provider claiming behaviour. If possible, the changes in patient and provider behaviour will be related to changes in co-payment levels. This is dependent on the willingness of providers to supply this information. We also plan to obtain ACC claims data from the ACC data warehouse by provider and practice. These data will be used to measure shifts in overall ACC claim volumes for PHOs and PCOs. When considering claims volumes and patterns it would be desirable to perform analyses of common conditions (for example low back pain, acute knee injury) to eliminate the confounding effects of changes in case mix.
A wide variety of funding models will be operating over the period of the evaluation, each with different associated financial (and other) incentives. Describing these accurately over time will be an essential component of our analysis in general, and for the analysis of injury care in particular.

### 3.5 Ethics

The research plans were submitted for ethical consideration to the Chair of the Wellington Ethics Committee. The Chair noted that this project did not require formal ethical approval. However, the Research Team agreed with the Chair on stringent adherence to sound ethical research practice. Therefore the following steps were incorporated in relation to qualitative data:

- Potential participants were given the right to decline to take part;
- The consent form committed the researcher to send a transcript of the interview for perusal and possible amendment, unless the interviewee asked to waive this step;
- Participants were given the option of withdrawing their involvement and statements at any time;
- Data is to be stored for 10 years;
- Analysis and reporting protects the identification of individual informants and DHBs;
- Māori and Pacific researchers are used to maintain cultural consistency with culturally sensitive aspects of the research.
3.6 Analyses In this Report

This report presents the findings from the first year of data collection, from key informant interviews. Key informants, including a range of ministers, officials, and those involved with PHOs, PHO practices and some non-aligned practices were interviewed in mid-2004, to gather information on expectations and early experiences of the Strategy. Analysis of data from these interviews is complete and an analysis of data from these interviews is included here. A number of comments apply to this analysis:

- We are reporting on the issues and themes identified by those people we have interviewed. Interviews for this research were undertaken over the April to October 2004 period. Thus, our reporting should not necessarily be considered to be representative of how things are today;

- As qualitative research, it is important to note that we are reporting the views and experiences of those interviewed. Further, as qualitative research, and given some interviews were undertaken specifically in order to elicit issues for follow-up in other streams and phases of the research, it is not appropriate to infer from our report that the issues raised are generalised throughout the sector. However, where possible, analysis has been presented to note consistency between informants and sources of information;

- Later streams and phases of the research will follow-up on issues raised here and will be triangulated across data sources and sites in order to infer both the range of views and the generalisability of those views. In particular, the planned postal survey will identify and quantify the extent to which issues raised in this report are experienced throughout the primary health care sector.

The report sets out key findings from first the qualitative phase of the research, and in Appendix 4 provides an indication of the types of analyses that will be undertaken for the quantitative phase of the research.
4 Findings – Key Informant Interviews

4.1 Detailed Methods and Sample

**Purpose** – The aims of these interviews were to reach an in-depth understanding of the experience and activities of PHOs and their member practices in responding to the Strategy, and to inform the design of a nationwide quantitative survey. This research strategy addresses research themes 1 to 13, 15 and 16 identified above. This phase of the research provides information for the evaluation in its formative role, that is, in identifying issues early on in the implementation of the Strategy and in disseminating findings throughout the research.

**Design** – The qualitative evaluation was based upon an inductive approach to discover, develop and verify ideas through systematic collection and analysis of the data relevant to the 15 themes. Grounded theory techniques, as outlined in the data analysis section below, were used to ensure that emergent ideas were comprehensively reported and reflect the everyday reality of primary health care organisations.

**Sample and Representation** – Twenty-six PHOs were selected to represent the range of sizes, structures, geographical locations and enrolled populations of such organisations nationwide. They were invited to take part in formative qualitative research, by participating in key informant interviews. PHOs were selected from each wave of funding from July 2002 to April 2004 to facilitate capture of data from both set up and development phases. Within each PHO, representatives from an average of two providers (depending on the number of practices within each PHO) were asked to participate in the research. In addition, medical practitioners and nurses in eight non-PHO practices were interviewed during the evaluation period. This strand of the research explored the features of these practices and the choice to remain outside the PHO system, and aimed to understand the changes they undergo with the implementation of the Strategy.
Within each PHO, separate interviews were held with management (CEO or Manager and/or Chair) and with board members including medical, nursing and community representatives. Community representatives included Māori and/or Pacific representatives where these were identified. Within the selected providers, separate interviews were held with medical and nursing representatives. Each interview might involve several people but care was taken not to mix those with possibly conflicting positions.

A total of 151 interviews have been undertaken to date across 23 PHOs. One PHO was not established and another was disestablished; four refused to participate of which three were replaced by PHOs with similar characteristics. In addition, eight interviews have been undertaken in non-PHO practices.

Twelve interviews were undertaken as part of a sub-project aimed to extend the key informant interviews to Ministry of Health staff with responsibility for designing and implementing the PHCS and to others in the primary health care sector with an interest in the process, and to some DHB staff. Data from these interviews are included here. A further three interviews were undertaken with senior ACC officials.

**Data Capture** – Semi-structured interview guides were created to ensure that all relevant research aims were covered during each type of interview. Separate interview schedules were used to guide interviews with PHO representatives, GPs and nurses working in PHO practices, GPs and nurses working in non-PHO practices, and policy makers. Where appropriate, the ethnic character of the organisation/service entity was matched to a researcher from the same ethnic background. In addition, the researcher’s clinical and/or health research background was matched to the specific data collection task. With the permission of the participants, all interviews were recorded. Notes were taken from each interview, and returned to interviewees for checking.
Data Analysis – Each interviewer made notes during the course of the interview. They subsequently reviewed the notes and the tapes of each interview. From the answers to each question one or more messages were identified; these were noted by the interviewer and quotes were transcribed which conveyed different messages. This material was gathered into sections using an iterative process. That is, the initial list of sections was provided by the Research Themes identified in the project plan; this list was amended to match the data obtained from interviews and the final list is represented by the headings reported below (Section 4.2). Quotes pertaining to each section were assembled and reviewed. From this a brief description of each relevant message was generated and quotes were selected to give the detail and flavour of the message.

In the findings presented below the sources of the quotes are identified using the following code: Chair = PHO Board Chair; CRep = PHO Board Community Representative; GP = General Medical Practitioner; Ind = Independent Informant; Manager = PHO Manager; MoH = Ministry of Health Official; MRep = PHO Board Māori Representative; PN = Practice Nurse. Where the informant is a member of a PHO the type of PHO is identified using the following code: M-PHO = Māori-focused PHO; P-PHO = Pacific-focused PHO; A-PHO = Other Access-funded PHO; IPA-PHO = IPA based PHO; PCO = Primary care organisation (other than a PHO); ACC = ACC Official.
4.2 Findings

4.2.1 Positive Reactions to the Strategy Goals

Almost all informants had strong positive reactions to the goals of the Strategy. To quote a community representative and a GP:

“It’s all great - should have happened long before.” (CRep, IPA-PHO)

“I think there will be population health gain because I’m convinced that money going into primary care will have a flow-on advantage to [reduce the need for] secondary care.” (GP, IPA-PHO)

Recognition of the benefits, however, had not necessarily been immediate:

“The PHO was started off in that context of ‘here we go again, another structural change,’ so it took quite a while for us to grasp that there was potential here. It also took a group of people to say ‘the thing is bloody well going to be there, so let’s make it work’.” (GP, M-PHO)

Among GPs there was wariness about how the Strategy would affect them personally and some were more convinced of the benefits than others:

“I thought the strategy had potential and that it was worth moving forward and I saw a lot of potential barbs for general practitioners. I felt it was still quite a risk to jump in without knowing the full implications and I still think that is a fair comment, that we are still not sure of all the implications.” (GP, IPA-PHO)

“There is the ability to co-ordinate primary care, for me this was an incentive and this is a personal view. This is not a universal view among my colleagues, but I think that it’s important. Other GPs don’t have the same view of this and may see involvement with other providers as more of a threat.” (GP, IPA-PHO)
Informants identified a number of benefits that they felt were likely to be, or were already being achieved, as a result of the Strategy, including improved patient care, better identification of the community served and better organisation for practices. Each is discussed in turn below:

**Patient Care**

Informants believed that there was now better access to care as a result of reduced costs to the patient. For example, increased subsidies for those aged 6-18 and over 65 years was described as, “that’s been brilliant” (GP, IPA-PHO). Changes related, by informants, to capitated payment included the opportunity to supervise patients without having to see them in the office, the possibility of providing preventive care and the opportunity to give more time to those patients who needed and valued the extra consultation time.

“I feel the patient care is better in the PHO system. ... I am happy to set up a good plan with the patient during the consultation and institute that plan remotely by discussing by phone etc.” (GP, IPA-PHO)

“What I found was it would certainly benefit my patients from the point of view of preventative health care which we are promoting within the PHO structure.” (GP, P-PHO)

“I said previously because of the different structure that we were working with, one had to service the patients quickly to maintain a certain income stream, but with capitation funding that is not a requirement.” (GP, P-PHO)
More generally:

“It will work, that is reducing inequalities, reducing issues around accessibility, reducing costs.” (MRep, IPA-PHO)

The benefits of the integration of services between and outside practices, particularly with regard to efficiency, were mentioned:

“Our disease management projects, our integration of [other] providers that have not been part of primary care ... brings them in and linking them with practices. It appears that the resources have really grown but what it’s done is bring us all together, it was there already but it actually appears greater than it is. Collaboration is really showing some real gains.” (CRep, P-PHO)

 “[We] expect more coherence across providers from the clustering and PHO development.” (DHB)

In general:

“We expected people to understand that primary care was more than the GP; that the Primary Care Strategy was about improving health and reducing inequalities through population health and accessible care.” (DHB)

“There have been real improvements to [the] level of services [we are] able to offer patients.” (GP, IPA-PHO)
Identification of Community by PHOs

Some informants commented on the enhanced ability to care for people when a practice, or PHO, population had been identified. This was due to enrolment and to the ability to cater for an identified population group. Pacific and Māori people identified the motivating effect of caring for their own:

“[It’s] an incredible advance to have enrolled populations, [to] have a sense of population health strategies, [health] promotion responsibilities, tailoring services. That has been a joy to watch, the providers who were already doing that ... and those who were in mainstream practice [who] have actually been rejuvenated by the opportunity to do things differently and feel a sense of ownership.” (DHB)

“I think [it] is [the] people involved, and people with an interest and Pacific people, not just health but the whole wellbeing of Pacific people and also people who are motivated to do things without any selfish motivations.” (CRep, P-PHO)

Practice Benefits

Many practitioners knew that their practice would be better resourced under the Strategy; with one noting that prior to the Strategy they were forgoing co-payments quite often. Many practitioners also noted the advantages of co-operation with other practices with PHO membership and felt the PHO would give them a stronger voice:

“For our practice there were also financial incentives that when we looked at the numbers it looked as though we would benefit financially from joining the PHO.” (GP, IPA-PHO)

“The NGO sector was politically committed to the direction. With mainstream – on a local level, very savvy – [they] could see advantage of being in early. They’ve all gained by joining and can see the advantages.” (DHB)
“Things are going well, income has improved; previously we were subsidising patients more.” (GP, IPA-PHO)

“We are really just starting, there is a great potential for the PHO to work with practices, we have already developed a locum scheme for the PHO, it has given us the ability to organise beyond individual practices.” (GP, IPA-PHO)

“Why we joined the [IPA and then the PHO] was because being solo I thought threatened by the group down the road who were a big practice.” (GP, IPA-PHO)

In some cases, the possibilities of the Strategy were seen against a concern that general practice was not working well. One practitioner focused on the opportunities for practices to work together and with iwi:

“And I also felt that general practice wasn’t really going anywhere and it would die if we didn’t do something different.” (GP, IPA-PHO)

“The idea of reunifying general practices throughout the [area] really struck a chord [and] the opportunity to actually work meaningfully with iwi was really good because [there has been] a lot of talk about this kind of staff but that’s all it is, often.” (GP, IPA-PHO)
Some practitioners actively wanted to expand the focus of primary health care and improve population health:

“Some GPs just want to get on doing general practice and doing it as well as they can. But if you have a personal bent for more organisational aspects, then you’ll choose to get involved. For me it’s because I want to work with the whole population.” (GP, IPA-PHO)

The Strategy was thought to have had a positive impact on some individual practices. Practitioners from Access-funded practices explained that they had gained more patients because of reduced fees.

**In Summary** – Almost all informants had strong positive reactions to the goals of the Strategy. They identified a number of benefits they felt would be achieved, or already had been achieved. In relation to patient care, informants believed there was now better access to care as a result of reduced costs to the patient, and some practitioners felt that capitation allowed opportunities to improve patient care, for example, through the ability to supervise patients without having to see them in the office, the possibility of providing preventive care and the opportunity to give more time to those who needed and valued the extra consultation time. Informants also mentioned the potential benefits of integration of services, both between and outside of practices. Some informants felt there was improved ability to care for people when a population was identified. At the practice level, many practitioners felt their practice would be better resourced, and pointed to the advantages of co-operation with other practices and with others, such as *iwi.*
4.2.2 Concerns about the Strategy

While the goals of the Strategy were supported by almost all informants, the chosen mechanisms, including the creation of PHOs, capitation and community involvement, were not welcomed by a substantial number of general medical practitioners. These views were strongly held by practitioners who had remained independent:

“The first thing that struck me was that there was considerable resistance amongst the GPs ... we sat back to see how the water would turn out, we felt that the process needed a lot refining and that was one of the reasons we weren’t keen to go ahead with it.” (GP, PCO)

Further, some also felt that the Strategy de-emphasised the role of general practitioners:

“Our major reservation at the time was that it de-emphasised the role of General Practice. If you go to the Strategy you will notice that the words general and practice are hardly mentioned.” (GP, IPA-PHO)

This negativity was partly related to “bad press,” some from the IPA movement. However, IPAs were also credited with facilitating progress:

“A lot of bad press that [GPs] have picked up from around the country, a lot of negativity that was picked up initially particularly through the IPA movement.” (CRep, A-PHO)

“Without IPA organisations being able to lead [GPs] forward the uptake would have been nothing like what it was.” (GP, IPA-PHO)

Some GPs believed that they had been put in a position where they were effectively forced to join a PHO. One IPA already working under a capitation funding arrangement was given to understand that the old contract would not be updated:

“There was no other long-term option, so it was about 40% coercion.” (GP, IPA-PHO)
“There was not a lot of option, it was tied into the funding model; there would be no benefit to us or our patients unless we took part.” (GP, IPA-PHO)

There was concern that the new structure would not deliver any advantages while generating extra organisational work:

“It’s just another layer of people telling us what to do and when [and] how to do it and we are still struggling day to day.” (GP, A-PHO)

“Underlying, I had the suspicion that PHOs were going to generate a huge amount of administrative cost which could be better put into the existing system, fine tuning the existing system targeting those at need.” (GP, IPA-PHO)

“I feel my satisfaction would reduce if I was part of a PHO as I would spend so much time demonstrating compliance rather than practising medicine.” (Indep. GP)

Some GPs thought that the Ministry had a hidden agenda of controlling their practices and many commented on a high level of mistrust of the Government. Some felt that it was intended to move towards the British NHS model:

“The increased control, there will be restriction of prescribing, on lab testing, restrictions on most things. You will have to justify everything that you do and all that does not give much time left to practice medicine.” (Indep. GP)

“There was, and perhaps there still is, an overwhelming feeling of mistrust about what the Ministry and the Government were doing because of what has gone on before.” (GP, IPA-PHO)
“Doctors will become salaried, it’s going to be [like] the NHS in a few years and I do not want to be a part of that.” (Indep. GP)

“This scheme will lead to ‘bread and butter’ - six minute consultations - like the UK.” (Indep. GP)

Some GPs felt that the Ministry did not, in any case, understand the functioning of general medical practices as a business:

“[There is a] general sense that Ministry does not understand general practice and that the financial and business position of GPs leads them to expect at least a little latitude in decision making over fees.” (GP, IPA-PHO)

“If they are going to interfere with the way [the GPs] practice and, most importantly, in their ability to make a living ... I think most of them accept that there will be some short-term gain but the sinking lid policy is all too familiar to doctors. The Government’s [linking of the capitation fee to] the CPI which has unfortunately gone unnoticed by most doctors is a hugely significant thing.” (Manager, IPA-PHO)

“Subsidies, GMS, immunisation and midwifery have not kept up with the pace of inflation. Cheap or free treatment for all - what that really means is that it is coming out of the GP’s pockets.” (Indep. GP)

The fundamental concern of GPs was that their incomes would be reduced or that the practice as a business would cease to be viable. There was a sense that the government wanted to control the practices but to leave the business risk with the doctors:

“The fiscal risks of this new model were required to be borne by the GP and the Ministry lacked, and still lacks, the capacity to provide GPs with the information about that risk, or to show an adequate audit trail.” (GP, IPA-PHO)
“I felt we should either become fully nationalised and let the government take the risk of running the business … or we shouldn’t have any interference altogether … [perhaps there could be] a patient owned subsidy.” (GP, PCO)

Some practitioners indicated that while fees to patients had been reduced, access funding did not compensate for lost revenue:

“We were better [with] our PCO funding and charg[ing] people more because the increase in the amount that we get as low access … has not compensated us.” (GP, A-PHO)

In addition to government interference, there was a concern that, if PHOs were controlled by a board with significant community representation, decisions could be taken for the benefit of the population but damaging to the financial sustainability of the practices. One community representative felt significant hostility from clinicians:

“The reason for this is that there was a lot of mistrust between the parties - doctors don't trust the community and vice versa.” (CRep, IPA-PHO)

“GPs came into a 50:50 relationship, like how are we going to work with these Māoris [sic], what’s going to happen, are they going to steam-roller us? As the relationship settled they started to [say] well gee these Māoris [sic] aren’t what we thought they would be, they are not here to take away our incomes … so that alone has created huge changes in the way the board operates.” (CRep, M-PHO)

“Now I have to sit on the PHO with some GPs who think I am the Anti-Christ. Someone said ‘Oh! look, they’ve left their broomsticks at the bottom of the stairs’ … we’re bad because we were going to destroy not only their private business but their standing.” (CRep, IPA-PHO)
The resistance to the Strategy may have been based on misunderstanding and some commentators felt that general practitioners did not understand the goals of the Strategy:

“The biggest problem is the mind-set and the patch protection and the lack of information and that’s community and providers.” (CRep, IPA-PHO)

“I don’t think many GPs understand the model.” (CRep, IPA-PHO)

The most negative view was expressed by a GP working in a small practice and still struggling with PHO set up:

“It falls on my [partner] and myself, because we do not have a practice manager. This actually makes us very keen to get out, [it has] just made you even more determined to leave and that’s probably the main affect for us, we just don’t want to continue, not worth the stress and the changes, there are other ways to live.” (GP, A-PHO)

There is some evidence that practitioners, particularly in Access-funded practices, are now less worried and more supportive of the Strategy:

“So we've done some recent surveys which show most of our GPs are happier now [than] they were a year ago.” (CRep, IPA-PHO)

“The income of my practice is reasonably stable and the advantages of [PHO membership] is [sic] seeing less patients and able to spend time with them.” (GP, IPA-PHO)

It should be noted that GP informants tended to focus on financial issues and provided little material on other aspects of the Strategy such as an expanded role for nurses and community input into governance. Two community representatives confirmed this focus and felt it was hindering the general development of the strategy:
“The key inhibiting factor] would be the focus on fees as the main thing about PHOs and the main thing about the strategy, yeh get doctors fees down and that’s it.” (CRep, IPA-PHO)

“What the GPs were told was that it was a new funding [model] ... what we were telling people was that it was about population health ... a way of participating in health and the two are so different.” (CRep, IPA-PHO)

**In Summary** – While GPs were pleased that public resources for primary care were being increased, some were concerned that their role had been inadequately recognised in the Strategy. They felt their participation was unavoidable (that is, that they had to participate in order to have access to the new funding being provided, given that those practices not in PHOs are not eligible for new funding), but they were worried about the long-term financial implications for themselves and their practices, and about perceived moves towards greater control of general practice by government. Some informants were also concerned that administrative changes would occur without realisation of the intended benefits. The attention being paid to fees was seen by some to be preventing a focus on other issues, and hence was hindering the general development of the Strategy, in particular a population-based approach to health. In spite of these concerns, some practitioners have come to believe that the prospects are positive for their practices in a financial sense and were expressing a more optimistic view of the Strategy and the changes it might engender.
4.2.3 PHO Governance

Board Composition and Selection

The Strategy requires that PHOs involve the community in their governance. They have found a variety of ways to do this, but, according to our informants, the commonest is to have representatives of the community, including representatives of, Māori and Pacific peoples, along with clinicians, both medical and nursing, on the PHO board.

The details of community participation in the Ministry’s “Minimum Requirements for PHOs” were permissive but at least one DHB developed tighter definitions:

“Our [DHB] Board did something quite unusual compared to other Boards to deal with the issue of community participation ... we developed explicit bottom lines against the minimum requirements. Proposals were measured against these criteria and had to be signed off by the Board.” (DHB)

The process of PHO board member selection varied. Often nominations were called for, either from the community-at-large or from community groups; sometimes subsequent selection was on the basis of the skills needed:

“The DHB called for applications and the people had to have knowledge of the primary health care strategy, community development, links back into the communities and community organisations, a broad understanding of access issues and barriers.” (CRep, IPA-PHO)

“The PHO went through a completely open nominations process for their board, then appointed on a competency basis with the result they got some really good people on their board.” (DHB)
In some cases a more corporate model was followed with specified groups having a shareholding in the PHO:

“There are two shareholders ... one is ... all the doctors and the practice nurses ... the other ... is another company set up exclusively for the purpose and is made ... of six Māori organisations. ... [Each] appoints three members and ... they went out to a wider community consultation to get two others from the community as a whole.” (CRep, M-PHO)

Many PHOs have a formal process whereby community groups - pre-existing or formed for the purpose - provide input to the board, in some cases, by direct representation:

“They set up three management groups, for the three geographically distinct areas. In each they have set up community advisory Boards, who then select one person to be on the PHO Board. [It] has worked quite well, and is a good solution given their geographical layout.” (DHB)

“We have a community advisory group. ... There was a fairly wide-ranging community consultation ... to bring forth members from the community or from NGOs or from different organisations to actually reflect some of the communities’ pulse to the board. ... The board has given them the prime authority to look at all the SIA proposals. ... The board are trying to give this community group some teeth ... and they are blooming good.” (CRep, IPA-PHO)

“The PHO asked the rural health trusts for representatives to the interim board.” (CRep, IPA-PHO)
There is some concern that the PHO boards are dominated by medical professionals or by IPAs as their representatives, and further, that this is preventing the full realisation of the potential benefits of the Strategy. However, the value of IPAs is also acknowledged and medical dominance is seen as related to the present funding arrangements (as only GPs lists qualify for capitation funding). One informant felt that the IPA moderated the influence of general practitioners:

“We have gone through a process to set up governance structures that are inclusive and bring the community in, but what is happening around the table is that those community people ... are deferring to those professionals who know the most or have the longest history, and that is usually an IPA representative.” (DHB)

“There is a very powerful and influential sub committee which we called the board clinical committee; there [are] eight people on that, three of them are nurses, so they look at clinical projects and ... anything to do with ethics.” (Manager, IPA-PHO)

“Within the IPA-based PHOs, the old IPA structure is alive and well and really stopping the PHOs from realising their true potential.” (DHB)

“The IPA has definitely got a place there; they have got some excellent systems and experience, some of them quite sophisticated. They were very good at what they did. But they should be doing that and not dominating PHO boards. The vision and strategy of the PHO should be quite different from the vision and strategy of the IPA. They have got fundamentally different drivers.” (DHB)
There’s an advantage if you have the IPA infrastructure, the potential downside is that ... some of our partners think the process is provider dominated ... that’s the nature of PHOs at the moment, there are only GP contracts and there is not a lot of funding for anyone else and it is difficult to keep the vision alive of a PHO for the other stakeholders when the resourcing is so heavily structured towards GPs.” (Manager, IPA-PHO)

One community representative described an effort to avoid a business focus for the PHO Board:

“The other people [who came forward] I understand were business people; but the community group was large enough and vocal enough and had enough contacts into the newspaper that it was not in the DHB’s best interest not to listen to us.” (CRep, IPA-PHO)

**PHO Board Processes**

A number of key informants discussed PHO Board decision-making processes. They indicated that boards make decisions on a consensus basis. In one case specific processes were established so that groups with a particular interest in an issue could veto a decision.

“Decisions are made by consensus, there is never a vote at such, but it’s always by consensus. But with contentious issues we always put [it] aside and may discuss [it] later.” (CRep, P-PHO)

“We have two different mechanisms which force a consensus approach. [First] we aimed to set the trust up as a 50/50 [between community and providers] with no casting vote ... and second ... we also had caucuses which had a veto vote ... on an issue in which they have a material interest ... we believed that if you were really serious about partnership that that would force a discipline on the board and the management organisation.” (Manager, IPA-PHO)
“We make decisions as a board, but a lot of work is done in working groups ... That process means that once it’s reported back it’s likely to go through without too much trouble. We have worked together long enough to trust each other’s judgement.” (CRep, IPA-PHO)

As might be expected some individuals carry more weight than others. As one nurse said:

“Most strategy to date has been driven by GPs”. (PN, IPA-PHO)

“We are making decisions largely by consensus, it’s recognised that people have their own area of expertise and they get listened to. Our decision-making arrangements are informal and it seems to work well so far.” (GP, IPA-PHO)

This was defended by one practitioner:

“I think the involvement of clinicians ... is crucial because when you just run the paper part of it without knowing what’s happening to the person it doesn’t make sense. It’s got to go together and that input makes a big difference.” (GP, M-PHO)

**Interaction with the Community**

In many cases, interaction between PHO boards and the general community involved community groups. The following quotes come from board members from the same PHO:

“[The group] meets monthly and the people who are part of that come from health, welfare, the council, Māori providers, public health, health promotion ... the idea is they bring what’s happening in their organisations to the meeting and they help [us] make decisions about what’s happening at the PHO.” (CRep, IPA-PHO)
“We have a monthly forum, I give a report [and] it goes out to a wider group of people. The forums are advertised locally in the paper and the community link group have a huge database of people and they send it to them.” (MRep, IPA-PHO)

In other cases community representatives on the board had strong personal links into the relevant community:

“I have good links into the community, being on the Health Trust and having children at school and pre-school and I am involved in running things for kids.” (CRep, IPA-PHO)

“Sometimes I ring up the radio, to find out community meetings on what dates, then I go to those meetings and relay some information about the PHO and projects, for instance the meningococcal project.” (CRep, P-PHO)

“We did some radio programmes in different languages way before, about the PHO and the enrolment process, so they were well aware of it.” (CRep, P-PHO)

Some PHOs adopted stronger means to communicate. In one case, a letter drop was employed giving notice of the services available and in another case, the PHO wrote to all patients explaining the goals and objectives of the PHO, the benefits for the community and the processes for enrolling.
Connection appeared to be easier with small, or tightly defined, communities:

“Our community is quite small, a close knit community, so they will ring me and ask me or I talk to them through these ... groups.” (CRep, P-PHO)

“Compared to Māori and Pacific groups ... we have not finalised our community group ... we have a core group but we are still wanting someone from immigrants and youth.” (CRep, IPA-PHO)

In many districts, both urban and rural, Māori organisations were in a position to provide strong representation and seemed to be leading efforts to make community participation a reality:

“Getting three Māori onto the PHO is quite unique but we fought for that, we fought for three months, we were well aware that if we did not get a favourable position for Māori in the PHO environment we would be disempowered in the long term. So the conflicts with doctors particularly were quite heavy.” (MRep, IPA-PHO)

“The other groups weren’t quite into an empowering mode - with having a fifty/fifty split with the doctors - the Pacific people were aghast ‘these Māoris are fighting the GPs’ but I hope over the next little while they can do it for themselves.” (MRep, IPA-PHO)

Some Māori saw their involvement as implementing Article Three Treaty rights and expected some resistance:

“We are talking about Article Three Treaty rights, that is, the rights of British Subjects to taxpayer services.” (MRep, IPA-PHO)

“While things look progressive, there’s still going to be a battle in front. The doctors have to buy into the Treaty.” (MRep, IPA-PHO)
“I feel some resistance - why Māori health? Why Māori? That comes through loud and clear. You find yourself not only trying to get a [Māori health] plan together and some good process, but also justifying your position.” (MRep, IPA-PHO)

There was acknowledgement that some parts of the population are easier to reach than others and that only a select group is willing to attend public meetings:

“It helps that the patients are well informed – indeed many of them are MoH employees! On the other hand it’s harder to understand for the older part of the population – what’s the difference between enrolment and registration? Older people are also scared of big brother, particularly given that information can be shared.” (GP, IPA-PHO)

“Busy, poorer families or those that don’t really understand ... they don’t have the time to get involved.” (CRep, IPA-PHO)

“There are so many people in that community who do not know how to, are too frightened to, not confident enough to have a voice.” (CRep, IPA-PHO)

“The biggest concern for me is getting the community people to participate ... everyone is busy these days and their time is precious. They all go to lots of meetings and it is the same people who go to lots of meetings.” (CRep, IPA-PHO)
Many informants were clear that communication with the community was in its early stages. The public in general was relatively unaware of developments in primary care and some questioned their need to improve their knowledge particularly in the absence of any incentive to remain with a single practice:

“There is very little communication so far with the community, but a media strategy will be part of the overall strategic plan. All this comes with time and capability, but there is a clear intention to be open and ‘walk the talk’.” (CRep, IPA-PHO)

“They care about how much it costs, where to access. They care about the quality not the structure.” (PN, IPA-PHO)

“There is nothing in it for the patient. Why would they change behaviour and stop doctor shopping? That’s the bit that is missing.” (PN, IPA-PHO)

“Māori community groups do not understand PHCS; jargon turns them off. They want to know, ‘what are you going to do for us?’” (MRep, IPA-PHO)

**In Summary** – The community appeared to be well represented at board level in PHOs. The most common approach was to have representatives of the community (including representatives of Māori and Pacific peoples) along with clinicians (both medical and nursing) on the PHO board. The process by which PHO board members were selected varied; often nominations were requested from the community-at-large or from community groups. In some cases a more corporate model was followed with specified groups having a shareholding in the PHO.

Many PHOs have a formal process whereby community groups provide input to the board, in some cases, by direct representation. In some PHOs, however, there was concern about medical dominance.
Interaction with the general community was handled by multiple informal and formal mechanisms, including various types of community groups and the use of personal links into the relevant community. In many districts, both urban and rural, Māori organisations were in a position to provide strong representation and seemed to be leading efforts to make community participation a reality. Some Māori saw their involvement as implementing Article Three Treaty Rights and expected some resistance to their participation on PHO Boards.

Many informants were clear that communication with the community was in its early stages. Many board members and practitioners considered that the general community was relatively unaware of developments in primary care, and that some sub-populations were hard to reach.

### 4.2.4 The Implementation Process

**General**

Many in the sector thought that the Ministry of Health had put insufficient resources into implementing the Strategy:

“Everyone supports the policy but the implementation of the policy has been difficult and I think that’s mainly [because the Ministry] has taken on a role which previously sat with the HFA ... they do not have enough people with operational nous ... things like contracting and negotiating and operationalising policy ... they do not have it and I do not think they particularly appreciate that they need some help.” (Manager, IPA-PHO)
There were calls for an implementation plan with appropriate performance indicators although it was recognised that until the later phases of funding were confirmed some goals could not have been set:

“We had lengthy debates about the need for an implementation plan ... there was scepticism about whether the funding would follow and I am pleased to be able to say that the government delivered on that ... the Minister has done a great job.” (DHB)

There were a number of areas, in addition to an implementation plan, where it was felt that it would have been helpful to promulgate more definite guidelines. One such area was the issue of the size and extent of PHOs:

“This DHB took a very permissive approach [to small PHOs] ... its fair to say that that is going to buy us some troubles over the next few years ... overlapping, size issues around viability, capacity issues, particularly about communities of interest and this overlap that occurs.” (DHB)

“[We] do very well thank you very much because it has a critical mass. I’ve estimated that 50,000 is probably break even.” (CRep, IPA-PHO)

However, it was recognised that local factors might require ‘one-off’ solutions:

“We would have preferred only two [PHOs]. The northern one has only 6,500 population, and for economies of scale, we would have thought one more appropriate. However the Māori providers concerned had a strong dream of ‘for Māori, by Māori’ and the DHB eventually conceded.” (DHB)

A related issue was a sense that the rules had changed during the implementation process:

“[The DHB] said that the business rules had changed [and] they were no longer able to support funding of a capital cost in a building which ... they had already done [elsewhere].” (MRep, A-PHO)
“[In the early days] we were always told that a whole group of GPs could not set up and become a PHO. ... But since then GPs have set up been encouraged to set up PHOs.” (MRep, A-PHO)

“Because this is new and developmental, the Ministry themselves are always changing the rules. Given we were the first PHO to start up in this area and its been two years ... there have been a huge changes in the intent of PHOs and what they were set up to do. There will always be a tension until the rules are consolidated and the goal posts stop shifting.” (MRep, A-PHO)

**Accuracy of Targeting**

Perhaps the most substantive criticism of implementation decisions was that the extra funding passing into primary health care benefited many able to pay for their own care and only some of those in need. There were a number of aspects to this problem. First, fees, while lower, remain high in many interim practices:

“The issue of the fees is the single biggest failure of the Strategy. It has been poorly managed. It has been a huge opportunity lost, $700$ million in and we still have people able to charge $40.” (DHB)

“[As a DHB] we have negotiated within the parameters imposed on us by the Ministry$^4$ [but] we haven’t managed to get co-payments anywhere near $20 for most providers.” (DHB)

Among Access-funded providers, charges are still seen as a significant barrier for some:

“Access practices are more affordable but there is a range from those offering no or very low cost services, to those charging $20.” (DHB)

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3 As noted earlier, the government is providing an additional $1.7 billion over six years from 2002/03 to implement the Strategy.

4 This decision was made by Government rather than the Ministry of Health.
Second, a significant proportion of the new money is going to those with adequate personal resources:

“Now, we worked out that if we have to charge a uniform flat rate for all over 65s\(^5\) that it will be $28 – so that’s a $2 reduction for CSC [or] high needs [patient], but a $25 reduction for people who could previously afford to pay.” (PN, IPA-PHO)

“As an area with Access funding, my impression is that the well-to-do, ‘worried well’ are getting to see the doctor more often, as it is cheaper, and they are really happy. Those who previously had community service cards, are paying the same or even slightly more.” (CRep, IPA-PHO)

“Why should the rich get the extra support just because they happen to be part of a particular practice?” (GP, IPA-PHO)

One doctor recalled telling his older patients that they would be charged less:

“That’s good, they said, but don’t forget to give me a receipt for Southern Cross.” (GP, IPA-PHO).

The same doctor pointed out that many poor patients are already being subsidised by Work and Income New Zealand or ACC and that the increased funding was simply cross-subsidising other arms of government.

Many respondents thought that the decision to direct extra funding to practices serving high needs populations was regrettable. Practices without Access funding were concerned about losing business and those with it were worried about getting swamped:

“You need to individually target to deliver services to those who really need it. That is targeting the individual, not a suburb. That’s a clumsy way of dealing.” (GP, IPA-PHO)

\(^5\) The changes apply to those aged 65 and over.
“Naughty [patients], no loyalty, just go to the cheapest. They are usually the wealthier ones.” (Indep. GP)

“We are incredibly cheap, we charge $5, so more and more people want to access us. We get the really sick, we get patients from other practices and the workload for us is astronomical.” (GP, M-PHO)

“A hospital script costs $15 to fill and people want it put on my letterhead so that it’s only $3! Similarly we have this community radiology – private specialists cannot access it and send private patients back to me to save costs and delay.” (GP, IPA-PHO)

Discussion with Ministry informants indicated that the choice of targeting mechanisms represented a compromise between many that had been suggested. Thus, the continuing use of the CSC is an example of targeting on the basis of individual economic need and Care Plus of targeting individual healthcare need.

“The first question is to decide if you want low cost for all, or not. If low cost for all is the aim, then inevitably those with the smallest subsidies under the previous regime will get the biggest gain ... All these [methods of targeting] are actually in use! Effectively a compromise on the way to universal coverage.” (MoH)

**Mobile Populations**

Many of those involved with PHOs complained that the process for dealing with patients who made casual visits at practices where they were not enrolled or where patients changed doctor were unsatisfactory. It resulted in “clawbacks” which could exceed the capitation sum originally received for the individual patient and lead to uncertainty about practice income. However, the impact of this varied. Some PHOs found that the issue had relatively little impact:
“We have about the right number of doctors ... so we don’t have practices battling for market share ... that also limits the ability of patients to shop around quite as much ... and ... we have spent time over the years cleaning registers and we have a good handle on overlap.” (Manager, IPA-PHO)

One rural PHO decided not to implement the clawback process, related to after-hours work:

“[They] have decided not to clawback within their on-call areas. Initial data suggests that there may be winners and losers (between 2-6%) but they plan to let it run and monitor the impact over time.” (GP, IPA-PHO)

The general feeling was that HealthPAC was inadequately prepared to manage capitation payments, the calculation of clawbacks and dealing with patients who moved practices:

“HealthPAC looked at its own systems ... but did not look at the complete system from the GP’s desk. We ended up with lots of errors most of them sitting within PMS systems or at PHO level ... that for a while threatened the whole implementation ... in retrospect ... they were all predictable and preventable and should have been planned for.” (DHB)

It was of particular concern that validating HealthPAC decisions proved difficult and many suspected that some of HealthPAC’s data were inaccurate:

“We think that ... a proportion of patients ... are enrolled [with us] but then we are told that they are enrolled elsewhere. The unfortunate thing is that this is done at Government, HealthPAC, level. We have no way of knowing if this is true or otherwise.” (GP, IPA-PHO)

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6 It was noted by the Ministry of Health that this is not a HealthPAC responsibility and the Ministry has subsequently contributed to the cost of practice management system software development.
“It’s inaccurate [and] we can’t influence it. HealthPAC\(^7\) has not earned trust, they need defensible evidence for some of the decisions that they make.” (GP, IPA-PHO)

HealthPAC was required to develop systems rapidly even as policy was being refined and business rules hammered out:

“We have been doing is implementing policy in parallel with implementation. ... If you look at the sequencing of policy decisions, there have been a lot of policy decisions made in the last few years that have had operation implications.” (MoH)

As one manager reflected:

“The intentions were good but it’s almost like the whole thing was introduced live before they even thought it through.” (Chair, IPA-PHO)

However, again, some PHOs found that there was little effect on the overall amount of money received and that errors for a particular practice could be mitigated by the PHO:

“[At one practice] they were only funded as if they had about 40 card-holders instead of 400\(^8\). It made a significant difference [and] was a potential nightmare for the practice. What we did about it ... we were lucky enough with our critical mass to have enough cashflow to fix it.” (Manager, IPA-PHO)

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\(^7\) It should be noted that the decision not to release data on clawbacks and changes in enrolment was made at the policy level and the issue is currently being considered by the Privacy Commissioner.

\(^8\) This disparity was corrected and it should be noted that loss of this type of data could occur at any of three levels – practice management system, PHO or HealthPAC; or be an issue of compatibility between systems.
Populations with unmet health needs, such as Māori and Pacific people, were often mobile. The resulting changes in enrolment were problematic for PHOs serving these groups and provided a perverse incentive for the PHO not to enrol them.

“[There are] issues around geo-coding and register changes because [it] is a transient population going where the māhi is, people from [X] spinning out and coming here for a bit of R & R.” (CRep, M-PHO)

The Ministry of Health programme of television advertisements was criticised by a number of interviewees, for increasing expectations of reduced fees without giving helpful information about enrolment.

“Well the bad advertising form the Ministry of Health has generated more expectations and less understanding.” (GP, P-PHO)

“I do not think the ads on TV are doing much to promote [the Strategy]. People wonder what they mean and I do not think it carries the right message at all. There is huge lack of understanding about what a PHO is and I think there should be a lot more done in that area.” (CRep, P-PHO)

**Miscellaneous Issues**

There was a general feeling among community representatives and DHB officials that GPs and their organisations (IPAs, IPAC, NZMA, RNZCGP) had taken an unexpectedly high profile in implementation. This was seen to have resulted in the use of a corporate model and a focus on financial issues:

“I would argue that the implementation has been far more provider-based and provider-biased than any of us would have envisaged. There was a very strong move to separate IPAs and providers in general from PHOs, hence the name change ... but it was not supposed to be just a shift sideways.” (DHB)
“My biggest frustration is that the government should never have allowed the IPAs to set up PHOs in the first place because it took a community model and put it into a corporate, private sector.” (CRep, IPA-PHO)

“The GPs were told ... that it was a new funding [model]...what we were telling people was that it was about population health ... a way of participating in health and the two are so different.” (CRep, IPA-PHO)

Services to Improve Access (SIA) money goes straight to the PHOs and DHBs felt that this reduced their power to influence its use:

“[We have] less of a lever than if we were saying you can sign that off and here is the money to do it ... it would have made more sense to devolve that money to the DHBs. It might have allowed a bit more innovation around shared learning and working together than we have seen.” (DHB)

The enrolment process was considered to have been run from the practices and it was felt that patient-driven enrolment, which would have required greater public understanding of the Strategy, would have been preferable:

“This whole question of enrolment that is supposed to be a patient driven strategy is practice driven strategy ie they engage them rather than the patient saying, ‘I wish to be enrolled’.” (CRep, IPA-PHO)

**In Summary** – It was felt by many informants that more resources should have been put into the implementation process. Some key informants suggested a need for more definitive guidelines relating to, for example, PHO size. Others, however, recognised the need for there to be local solutions to local issues. Some informants also noted that business rules had changed during implementation, generating uncertainty and, in some cases, dismay.
Many informants thought that targeting of the increased funding had been imprecise and that money had been ‘wasted’ on those who could afford to pay while – among those groups for whom funding had not been increased – affordable care was not available to many.

Many of those involved with PHOs complained that the process for dealing with patients who made casual visits at practices where they were not enrolled, or where patients changed doctor, were unsatisfactory. Casual visits resulted in ‘clawbacks’ (loss of funding) which could exceed the capitation sum originally received for the individual patient, leading to uncertainty about practice income. However, the impact of clawbacks varied. Some PHOs found that the issue had relatively little impact; some found that there was little effect on the overall amount of money received and that errors for a particular practice could be mitigated by the PHO.

With regard to situations where patients changed doctor, populations with unmet health needs, such as Māori and Pacific people, were often mobile and the resulting changes in enrolment were problematic for PHOs serving these groups and provided a perverse incentive for the PHO not to enrol them. Informants also raised concerns over the lack of information made available to practices and PHOs on these clawbacks and enrolment changes.
4.2.5 PHO Management

Workload
There was general agreement that PHO management required large outlays in time and money, but the problems were different for different types of PHOs:

“For the mainstream providers [there was] a lot of work cleaning up registers because they were not capitated. [They] had the infrastructure though to do it [and] to manage their members to get them to buy in. They had [to deal with] the politics and fee for service registers. The capitated providers, the Māori, low income and Pacific, had the opposite problem – they had the political will, they had the capitated, clean registers but they didn’t have the infrastructure. They have run on a single manager [and] they have never had the opportunity to make savings, they have never had IT investment or capital investment. So you have the IPA with a building, [many] employees [including] analysts and you have the [Māori] clinic with a volunteer receptionist. ... [This is] still a problem with each new roll out of policy; we haven’t dealt with that deficit. They still do it, they achieve it, the small PHOs in our area were the first to put in the utilisation reporting, where the so-called sophisticated ones haven’t but it is done out of peoples’ voluntary time and they really need the infrastructural development to allow them to participate.” (DHB)

“[It takes an] enormous amount of effort to really engage with the community and our stakeholders. It’s taking us day and night and all of us here are working around the clock just to really engage.” (CRep, IPA-PHO)
One small PHO noted that meeting IT requirements and cleaning registers almost exhausted an establishment grant and that there had been no funds to hire a manager. Each practice had to share the organisational burden and it had taken an unexpectedly long time to get started and communications between diverse practices had been problematic:

“We only have [one] fulltime employee actually and ... a lot of the demands ... are shared out with the managers [of the providers].”
(Manager, A-PHO)

“There has been a problem not having a project manager and management has been bitsy. There is, however, goodwill.” (PN, IPA-PHO)

PHO representatives noted that new programmes would require an expansion of managerial capacity and felt that it was easy to take on too much:

“There are other programmes like chronic care that they will be bringing in; as these programmes [are] introduced then we need to expand, both in professional and IT management.” (CRep, P-PHO)

“I think perhaps that they might be taking on a bit too much at the moment ... perhaps a bit much all at once, a little bit confusing to us.” (CRep, P-PHO)

Most informants were confident of the capacity of the PHO to meet these needs but, in some regions, noted a shortage of skilled people:

“Of course, I have full confidence in the PHO to meet these new challenges.” (GP, P-PHO)
The changes were a significant burden at practice level as well:

“The huge workload, the huge burden, on all the providers who have decided to do it. In a short time there is a big expectation in terms of IT and admin.” (DHB)

“There is a huge amount of unpaid work to get everything up and running ... In fact the previous practice manager left because she was so fed-up with the constant demands of being in a PHO. Employees can do that, but doctors can't just walk away!” (GP, IPA-PHO)

One practitioner from a four person practice estimated that the manager spent a day per week on PHO business and indicated that this would have been much more if they had not already established appropriate IT systems. Practice managers, amongst other activities, had to understand the PHO system and teach everyone else; send data to the PHO, deal with error reports and teething problems; improve the integrity of the register; produce “endless spreadsheets” and deal with practitioner anxieties.

**Funding**

Current management fees appeared adequate for large PHOs but did not cover the amount of work needed for small ones:

“Very poor, the management fees are not adequate for what we are doing.” (CRep, P-PHO)

“If the Ministry wanted a thousand flowers to bloom and wanted smaller PHOs which are more responsive to their community, I do not think the management fee addresses that.” (DHB)
Small PHOs noted they had marginal financial positions but large ones had significant positive cash balance because programmes had been funded but the time taken to implement them meant that expenditure lagged:

“It’s probably the richest its ever going to be in its life ... because we had funding from day one and ... it takes a while to get anything going.”

(Manager, IPA-PHO)

Most informants felt that practices were better off under the new funding arrangements; this was partly due to the provision of more services or increases in enrolment:

“I think [income] is about 10% better but at a cost of having to open on Sat and Sun to provide better patient care.”

(GP, P-PHO)

“We reduced fees and we deal with many [more] walk-ins than before because patients have easy access to doctors.”

(GP, P-PHO)

Distribution of capitation funds to practices appears to be done on the basis of their enrolled population as a ‘straight-across’ process. There was talk of PHOs taking a percentage of the capitation to be used to fund after-hours care or other programmes. At least one PHO planned to distribute Care Plus monies on the basis of work done with the GPs billing the PHO.

In general, distribution of practice income to individual practitioners was based on the number of consultations undertaken. It was noted that different doctors worked at different rates, apparently without difference in quality, and that payment by output was therefore essential:

“The work rate of the GPs varies enormously [by 100%] ... so it’s hard to come up with another disbursement mechanism. Some people are putting through twice as many people, ... you can give them the most complicated cases and they will deal with it more quickly than another doctor.”

(GP, IPA-PHO)
The major exception was the practices where GPs, like nurses, were on salary. It was noted that such practitioners were more relaxed about the financial implications of the new funding mechanisms and requirements.

**Focus**

Most PHOs noted that they had been so concerned with the setting-up process that other activities had had to be delayed:

“[So far we have been] forming the trust, shifting the funding system to capitation, register development. I call this the ‘ugly phase’ of PHOs, very little to do with health.” (MRep, IPA-PHO)

“The next six months for us really is just going to be sorting out the infrastructure to deliver on all the projects we want to do ... and I think it is going to take us 12 months to get those systems up and running.” (CRep, M-PHO)

“[The PHO has] worked pretty hard on trying to pull together the GPs and their practices and pull them into the network and implement the new funding regime for the GPs so that has taken quite a bit of time – now they are starting to grapple with ‘how do we affect specific health issues in our area’. That is starting to make a difference.” (CRep, P-PHO)

**PHO/Practice Relationships**

In general a good relationship between practices and PHOs was described. A sense of support and belonging was mentioned by one GP who praised the PHO for its presence in, and understanding of, the community in the area.

Issues of co-ordination are decided at the PHO but decisions on services are considered by individual practices:

“The PHO is a co-ordinating body, co-ordinating mechanism for GPs and nurses, to make sure what programmes are delivered, that everybody within the PHO knows what is happening.” (CRep, P-PHO)
“It’s more an individual thing, the decisions in terms of services will have to be made by individual practices and we do have some consensus if there is particular matter about the PHO, then we talk about it in our [PHO] clinical meeting.” (GP, P-PHO)

PHOs were seen to support the administration of member practices. Some indicated that they provided (or were about to provide) advice on cultural matters and others gave incentives, for example, to increase breast-screening rates:

“[The PHO supports] administration and management functions, adding value and capacity to their practices, [it gives free] cultural [advice] … and we provide petrol vouchers for them for after-hours meetings.” (CRep, P-PHO)

“The other thing that our PHO does was to … give incentives to our providers to do the work.” (CRep, P-PHO)

One PHO mentioned the development of guidelines as a means of influencing practitioner behaviour, noting the variability between individuals:

“The key issue is the breadth of philosophy and understanding – no two practices are the same. You’d have a group of doctors here that espouse [the Strategy] and really move enthusiastically [and] you’ve got [those] that could be quite resistant. ... So what we are doing is going where there is most enthusiasm and moving [with] it rather than hitting the hard edge first. [We] just recognise the diversity of our docs and practices and [we are] actually trying to build a relationship with them.” (CRep, M-PHO)
Communication could be difficult in both large and small PHOs. A GP whose practice was a member of a large PHO noted that he was not connected to board decisions but they did keep him informed “to a degree”:

“It concerns me a little bit that these projects were put forward and agreed to go ahead without anyone [but the board] knowing about it.”

(GP, IPA-PHO)

A GP from a small PHO noted that communication suffered from a lack of human and financial resources. This applied to both PHO/practice and practice/practice communication. Improvement was expected:

“They have also very recently set up a committee not just for GPs and nurses [but also receptionists] to come together and share ideas and bounce ideas off the PHO representatives.” (GP, M-PHO)

Difference or competition between practices in a single PHO provided other communication issues and entrenched ways of working could generate difficulties:

“I am not sure that this local PHO is aware of the needs of a rural practice which we are because they are different to the urban area, because a lot of staff, people on those boards are urban people where a rural practice we do have different problems.” (PN, IPA-PHO)

“But it is difficult when you belong to an organisation and then you come in expecting to be part of a PHO, because no one is prepared to give up their identity or the way they work, or their autonomy and the decision making for there organisation.” (Manager. A-PHO)
Another informant noted that practitioners were “still coming to terms with collaborative vs competitive modes” of operating (CRep, IPA-PHO).

In one case where an IPA had recently initiated a PHO, doctors and nurses felt that their relationship was essentially with the former. They anticipated that the IPA would continue to provide clinical and management support services and would represent them to the PHO. A nurse noted that there was no nurse on the PHO board although the IPA had been very supportive of the nursing role.

Other Issues
One PHO wished to recruit practices with a similar philosophy and consisted of several practices widely dispersed. This exacerbated the difficulty and expense of communication and meetings.

In Summary – There was general agreement that PHO management required a large input of time and money. Small PHOs were struggling with inadequate management resources while large ones were trying to establish and maintain adequate communication with practices. It was also felt that new programmes would require an expansion of managerial capacity, and that it was easy to take on too much. Some smaller PHOs felt their financial state was marginal, while some large ones had significant positive cash balances. However, most informants felt that practices were better off under the new funding arrangements. There was a sense that the hard work of setting up and organising PHOs was nearing completion and focus could soon be directed to improving services and implementing new programmes. Relationships within PHOs were generally positive, and PHOs were seen to support practices well.
4.2.6 Access

There was general agreement that reduced fees had reduced barriers to access. This applied to all patients of Access-funded practices, to those eligible for Care Plus and people aged 6-18 or over 65:

“The patients do not have that fear of not being able to visit a doctor because they can’t pay their fees.” (PN, IPA-PHO)

“Cost is [one barrier], a big leap ahead with that one because we are an access PHO we provide cheaper visits and prescriptions.” (PN, IPA-PHO)

“You find a lot of whanau members bringing the other member and saying, ‘we suspect [he’s] got this’. They know that there is access so that they can get out and go and get help.” (GP, M-PHO)

“It would appear that a lot more people are taking up their scripts, there were a lot of unfulfilled scripts here, I’m only getting that from chemists anecdotally.” (GP, M-PHO)

In a PHO where nurse visits were established, increased funding allowed patients to see the doctor more easily both directly and as a referral from the nurse:

“In some way it has made it easier [for patients] to see the doctor when in the past they might have tried to just see the nurse because it was cheaper but they needed to see a doctor.” (PN, IPA-PHO)
A number of limitations to fee reduction benefits were mentioned. There was concern, as mentioned above, that costs were still similar, or even increased, for some in the 19-64 age group than before the Strategy was implemented:

“It probably has improved access, but there is this big group in the middle that isn’t any better off, just above the community services card cut-off you have probably been detrimentally affected by the PHO process ... the medium-to-low-income people are still left hanging out there.” (GP, IPA-PHO)

Given that co-payments were limited, some informants suggested it was uneconomic to allow long visits and there was an incentive to see people for shorter periods:

“The Ministry is obsessed with the fees people pay, they are not really interested in how good the service is ... or the needs of the patient. [There are] people who don’t want to come once a month, bang, bang, which would satisfy the Ministry fantastically; they want to come for half an hour and get it all sorted out. We could offer free visits but they would only be two minutes.” (GP, IPA-PHO)

“We had stories of GPs saying ‘for your $20 you get 10 minutes and the next 20 minutes I’ll charge you another $20’ you know which wasn’t really in the spirit of the exercise.” (GP, IPA-PHO)

A word of caution was sounded concerning the degree to which reducing financial barriers would improve access:

“You can make it free but that does not motivate those who need most help, that takes more resources and it’s those resources they don’t have.” (GP, IPA-PHO)
In Summary – It was generally agreed that fee reductions had improved access to primary care. This applied to all patients of Access-funded practices, to those eligible for Care Plus and people aged 6-18 or 65 and over. Some informants expressed concerns that people aged 19-64 just unable to qualify for a Community Services Card were experiencing continued, and sometimes increasing (where fees were rising), financial barriers to care. Concerns were also expressed by some over the ability to provide longer visits with limited co-payments, although others suggested that the shift from fee-for-service to capitation had enabled them to have longer visits.

4.2.7 Population Health

In general, population health projects were in the planning phase and many PHOs were unclear about the best approach to this new activity:

“At one stage we were flummoxed because we had to write a plan for the health promotion position because none of us had any experience in that before and that was difficult.” (RN, IPA-PHO)

“I think they have really struggled with [public health initiatives] as they have never had to do it before, and didn’t know where to start. But I think the NIR [national immunisation register] and the meningococcal vaccine strategy will tune them in better to public health.” (GP, P-PHO)

One PHO that was of moderate size and served a deprived population had begun to work with other agencies to address the determinants of health:

“We are endeavouring to [influence] the determinants of health. So we have been putting a lot of work into housing, poor housing, youth, employment, - recreational facilities, lifestyle, the district council. If you had to say what the difference between us and the IPA, which looked after the clinical side, we've moved a lot into the actual ... determinants.” (CRep, M-PHO)
“I'm particularly excited that we can look at the determinants of poor health and not just the symptoms at the end and have some ability to address those.” (GP, M-PHO)

Registration of patients allowed identification of communities with low levels of utilisation when a PHO was the sole provider in a defined area. In some cases these areas had been targeted by providing free visits, funding out-reach nurses and by co-operation with schools, food banks, Plunket and midwives:

“When you look at the registers against the census population ... you can see a missing population. It’s the same for Māori, it’s there crystal clear; we have never had the resource before to go find them. And that is where you target the work of the outreach.” (Manager, IPA-PHO)

**In Summary** – Population health issues were just beginning to be addressed, with innovative programmes related to changing health determinants and identifying populations with low use of services. Improved enrolment data were seen to allow better estimation of population health need and to facilitate targeting of services on the basis of need.
4.2.8 Quality and Information

Quality

General practitioners in an Access-funded practice noted that, free from the constraints of the fee-for-service subsidy, they were able to spend longer with patients and felt that this had increased the quality of care provided. They reported being able to focus on education and prevention:

“The thing is, with our PHO, we are able to discuss those cultural, economic, social issues much better, because we are able to spend more time with patients.” (GP, P-PHO)

“Well as I said, the focus is more on preventative care and patient education and, the referral patterns to the hospitals have in my opinion decreased.” (GP, IPA-PHO)

PHOs were working with clinicians to set and monitor quality targets:

“Quality targets had been established, these targets had been set with the mutual discussion in our clinical meetings by the various practices and the board.” (GP, M-PHO)

Table 4.1 lists topics that were mentioned as subject to goals or audit.

Table 4.1
Topics Subject to Goals and/or Monitoring

<table>
<thead>
<tr>
<th>Prevention and Screening</th>
<th>Patterns of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisation</td>
<td>Patterns of prescribing</td>
</tr>
<tr>
<td>Influenza immunisation</td>
<td>Patterns of testing</td>
</tr>
<tr>
<td>Cervical smear</td>
<td><strong>Management</strong></td>
</tr>
<tr>
<td>Breast screening</td>
<td>Ethnicity data</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>Read coding</td>
</tr>
<tr>
<td><strong>Disease management</strong></td>
<td>NHI input</td>
</tr>
<tr>
<td>Asthma plans</td>
<td>Correct addresses</td>
</tr>
<tr>
<td>CORD action plans</td>
<td></td>
</tr>
</tbody>
</table>
Practices that had been members of IPAs or members of Health Care Aotearoa indicated that there had always been a strong focus on quality and that there had been few innovations since moving to the PHO. Some even suggested that quality issues had been eclipsed by the work necessary in the transition although there had been some targets related to that process:

“If anything the throttle has been taken off because the throttle was firmly on the quality aspects prior to PHOs being established ... it’s all lapsed there is no referred services contract now ....” (GP, IPA-PHO)

“We have done things like cervical screening audits. ... They were IPA contractual requirements; we had a whole quality schedule with all sorts of activities. The PHO contract does not have anything like that at the moment. We are not going to run those audits this year, the practices just would not cope, with everything else that’s going on, our management staff would not cope.” (GP, IPA-PHO)

Practices that had not been associated with IPAs anticipated a greater effect from the introduction of quality targets:

“We do not have the IPA experience of being aware of pharmaceutical budgets and management. So [funding for quality targets] will be a major impact for us. We will have to have a greater input [from a] pharmaceutical facilitator and clinical advice to management; we also need administrative support which we do not have in place.” (Manager, A-PHO)
It was noted that for small practices, possible incentive payments related to the quality framework were relatively small and were therefore likely to be ineffective. Few informants mentioned the quality framework spontaneously and some seemed unaware of it:

“The government has no idea what quality of medicine is being given out for their dollar, they have no idea and some of it is crap value and some of it is good value ... it’s about time there were some performance indicators attached to the funding.” (GP, IPA-PHO)

**Information**

Many informants noted the need to upgrade data recording and information technology in order to meet PHO requirements. Some indicated that previous investment, often supported by IPA involvement, had enabled PHO IT needs to be more easily met. Improvements included: more structured record keeping; co-ordination and standardisation; and collection of data on disease risk factors.

A beneficial side effect of this process was improved population, ‘denominator’, data which was of value for needs assessment:

“Our understanding of population health is far better than it ever was, we have a better idea of who people are, where they are, their disease codes.”

(GP, IPA-PHO)

“Because of capitation funding, we have superb data for needs analysis. We have excellent information on the population.” (GP, IPA-PHO)
In Summary – Freedom from fee-for-service funding was reported to allow some practitioners in Access-funded practices to spend longer with patients, allowing a greater focus on education and prevention. Some informants suggested that IPAs and Health Care Aotearoa had always had a strong focus on quality, with few innovations since moving to the PHO. Practices that had not been associated with IPAs anticipated a greater effect from the introduction of quality targets. It was noted that for small practices, possible incentive payments related to the quality framework were relatively small and were therefore likely to be ineffective.

Many informants noted the need to upgrade data and information technology; while some noted that a beneficial side-effect of this process was improved population data, of value for needs assessment. Practices that had not been associated with IPAs anticipated a greater effect from the introduction of quality targets.

4.2.9 New Services

A large number of types of new services were mentioned and many more were in the planning stages. Table 4.2 summarises the types of service mentioned.

<table>
<thead>
<tr>
<th>Table 4.2</th>
<th>New Services</th>
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</thead>
<tbody>
<tr>
<td><strong>Greater accessibility and acceptability</strong></td>
<td><strong>Focused clinics</strong></td>
</tr>
<tr>
<td>Extended opening hours</td>
<td>Care Plus related activities</td>
</tr>
<tr>
<td>Whole family visits</td>
<td>Diabetes and nutrition clinics</td>
</tr>
<tr>
<td>Recruitment of a female practitioner</td>
<td>Asthma nurse clinics</td>
</tr>
<tr>
<td>Home visiting</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td>Medical clinics at schools</td>
<td>One-stop-shop for youth</td>
</tr>
<tr>
<td>Assistance with transport</td>
<td>Free sexual health clinics</td>
</tr>
<tr>
<td>Information for new immigrants</td>
<td>Cervical and breast screening</td>
</tr>
<tr>
<td>24 hour PHO helplines</td>
<td>Programmes for mental health</td>
</tr>
<tr>
<td>Cultural training</td>
<td>Programmes for disabled persons</td>
</tr>
<tr>
<td>Interpreter services</td>
<td><strong>Extra-practice services</strong></td>
</tr>
<tr>
<td><strong>Secondary care liaison</strong></td>
<td>Radiology</td>
</tr>
<tr>
<td>ED liaison services</td>
<td>Retinal screening</td>
</tr>
<tr>
<td>Acute illness home care</td>
<td>Refraction</td>
</tr>
<tr>
<td>Specialist availability in practice</td>
<td>Podiatry</td>
</tr>
</tbody>
</table>
Many proposed new services were dependent on the availability of resources:

“We have not done any outreach initiatives; that will be later on, and depending upon the resources and the staffing level.” (PN, M-PHO)

In some areas, new programmes had not yet been started. Sometimes this was related to the short history of the PHO and some mentioned the desire to choose activities that were of the highest priority and met an acknowledged community need:

“We’ve said that we wouldn’t look at any proposals until we had a grip on what the community looks like, what the priorities were, and then we would match up funding proposals with those priorities.” (CRep, IPA-PHO)

The creation of new services was affected by the history and situation of the practice. Forward-looking practices and IPAs had sometimes initiated new programmes prior to conversion to PHO status:

“The IPA was functional, doing all the community work previously, perfectly adequately before the PHO came along.” (GP, IPA-PHO)

Newly created, small, Access-funded, PHOs often saw opportunities to respond to the particular needs of their practice populations including lower levels of existing service provision:

“[Re weekend opening] there was a demand from ... our practice population as they find it easier to visit us on Sat and Sun because of transport requirements.” (GP, P-PHO)

There was significant variation between practices, even within a PHO, in the provision of new services. At the time of the interviews Care Plus was being initiated but there were differences in the level of enthusiasm. A degree of caution prevailed and small practices noted the limited financial benefit relative to set-up costs:
“I feel quite positive about [Care-Plus] really ... there are some people who need someone to step back from the routine appointments that they come in for, to have a look at where things fall down for them when they do end up in A&E or hospital admissions.” (PN, IPA-PHO)

“We feel it is something we want to go slowly with and get confident with before we take it on in a large way.” (GP, IPA-PHO)

“[My initial reaction was] there is no way I am going to do that for $100. But we are advertising ourselves as a PHO practice and people will expect it.” (GP, IPA-PHO)

**In Summary** – Many informants noted that new services were in the planning stage or that there was a need for work on community needs and priorities before they could be introduced. However, in some cases, new services had already been initiated prior to the PHO being established. In general, informants suggested that new service developments would depend on the resources available.

### 4.2.10 Nursing Issues

**Opportunities for Nursing**

There was general agreement that the Strategy had generated opportunities and incentives for nurses to expand their contribution to primary health care. The informants indicated that the adoption of capitated public funding reduces the need for patients to be seen by the doctor in order to access the fee-for-service subsidy. Where practices had been capitated previously such changes had already occurred. Many activities can now be undertaken by nurses, nurses are seen as cost-effective and some nursing activities are outside the usual scope of GP interest. Where this process has advanced, doctors and nurses are reported to have taken on a more collegial relationship:
“There is much more scope for nurses to do one-on-one work with the patients under the new system once it’s all happening properly.” (PN, IPA-PHO)

“[Are you undertaking more activities now that the practice has joined a PHO?] Only to the point that I’m able to see more patients that don’t have to see the GP too to get GMS. So, often I see people for minor things. [Previously] I would have had to call the GP in so it was like a dual consultation and it wasn’t actually necessary and that’s still the case with ACC. It is a significant change and I am really happy about it.” (PN, IPA-PHO)

“This practice has always been a capitation practice, we always had a very proactive role in education, triaging, -so really I don’t think my role has vastly changed.” (PN, P PHO)

“The new funding impacts on nursing from the point of view that practices are capitated which means that doctors and nurses can actually take on different roles. Nurses can take on the teaching and well being.” (PN, IPA-PHO)

“It’s more cost effective if the patient sees a nurse four times and only sees the doctor twice.” (PN, IPA-PHO)

“PHOs have started to involve nurses more in health care. They are concerned with population health and health promotion, and it is dawning that GPs can’t meet those needs.” (DHB)

“[In] the old days you have your doctor up here and the nurses down here, within this PHO we work on the same level, [with] a lot of discussion [about] our clients.’’ (PN, P-PHO)
A fuller use of nurses requires education of the public:

“[The] general public have to have confidence that they don’t have to see a doctor for things. Confidence that nurses do have knowledge; that they do know what they are talking about.” (PN, IPA-PHO)

In particular, it was reported that areas with too few doctors can easily increase the role of the nurse and the roll-out of Care Plus will generate much nursing work:

“I think there is the potential to achieve [the expanded role], and it is happening particularly in the rural areas where there are not enough GPs to provide services.” (PN, IPA-PHO)

“Care Plus came in with the PHO and it has given me back some job satisfaction. You can implement your knowledge and your skills in the consultation. Care Plus is great.” (PN, IPA-PHO)

However, the process of expansion of the nurses’ role may be uncertain:

“[Nurses] are really struggling at the moment to see how they fit in to the whole structure. Some of them have embraced the idea then been knocked back by the PHOs who are really GP dominated.” (CRep, IPA-PHO)

And the involvement of nurses was remarkably variable:

“I am embarrassed I know nothing about this PHO; it does not change anything for me as a nurse, it did not help me to develop as a nurse and if I want to do anything that will develop my skills I just go and do it.” (PN, A-PHO)
Activities

The role of practice nurses is highly variable across practices. Since the implementation of the Strategy the role has expanded and is said to be in the process of expanding further. Table 4.3 summarises the practice nurse activities mentioned by our respondents. There was also a feeling that the nurses’ major contribution was less definable but that they often held the practice together:

“It really depends on what kind of role you play in the practice. I think the nurses are the main ones that keep the clinic running.” (PN, P-PHO)

Table 4.3
The Range of Practice Nurse Activities

<table>
<thead>
<tr>
<th>General</th>
<th>Health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunistic discussions*</td>
<td>Recalls (e.g., for screening)</td>
</tr>
<tr>
<td><strong>Management of Acute Illness</strong></td>
<td><strong>Management of Chronic Illness / Risks</strong></td>
</tr>
<tr>
<td>Emergency care</td>
<td>Diabetic clinic</td>
</tr>
<tr>
<td>Phone consultations/advice</td>
<td>Asthma management</td>
</tr>
<tr>
<td>Triage of walk-ins</td>
<td>Dietary advice/Weight loss</td>
</tr>
<tr>
<td>General consultations</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td>Sexual health</td>
<td></td>
</tr>
<tr>
<td>Injury assessment</td>
<td><strong>Social Activities</strong></td>
</tr>
<tr>
<td>Wound care</td>
<td>Spanning cultural and language barriers</td>
</tr>
<tr>
<td><strong>Prevention and Screening</strong></td>
<td>Community visits (schools, churches)</td>
</tr>
<tr>
<td>Immunisation</td>
<td><strong>Non-patient contact</strong></td>
</tr>
<tr>
<td>Cervical screening</td>
<td>PHO Board membership</td>
</tr>
<tr>
<td>Blood taking</td>
<td>Practice management</td>
</tr>
<tr>
<td>Health education</td>
<td>Practice co-ordination</td>
</tr>
<tr>
<td></td>
<td>Nursing education</td>
</tr>
</tbody>
</table>

*One nurse noted that she might intercept a patient who emerged from consulting the general practitioner looking unhappy and deal with residual issues.

Recent legislative changes have made prescribing by appropriately trained nurses legal. Several practice nurses suggested that this increase in the nursing role did not justify the necessary training:

“As for prescribing, it’s very difficult, you have to do a Masters and no one wants to do that, I think we are quite happy for the doctors to take that responsibility.” (PN, P-PHO)
“Prescribing - you have got to do a masters, which is quite an expense, and basically what you prescribe is over-the-counter stuff at the chemist. At the moment I can’t see value in it.” (RN, IPA-PHO)

**Employment Conditions**

Nurses are employed by practitioners or practices and do not share business risk. This employment relationship was seen to hinder the development of the nurses’ role:

“It is inhibiting if you want the person who pays your salary to change things.” (PN, IPA-PHO)

“It depends also on the attitude of the GPs, and the nurse-doctor employment arrangement is often a barrier.” (PN, IPA-PHO)

“[It] depends on the openness of the GP to change and to allowing nurses to develop [the] role and use initiative. Nurses need the confidence to be assertive here. Capitation is already making a difference where GPs are open and nurses confident.” (PN, IPA-PHO)

“Nurses [are seen as] taking away from the doctor ... the doctors haven’t quite made the leap of the primary health strategy. Nurses have grasped the strategy and want to run with it but are tied back....” (PN, IPA-PHO)

“I’m fine but I know from speaking with a lot of practice nurses that they don’t get the encouragement because the GPs feel that there isn’t the role for practice nurses that the primary health care strategy envisages.” (PN, IPA-PHO)
Some practices had embraced the expanded use of nurses and discovered advantages in a more flexible structure:

“We have four nurses on; two on the phones, one in the acute room (includes “triage”) and one in the practice room. If we want to spend longer dealing with a problem, the nurses on the phone can look after new people coming in. The phone work includes triaging, giving advice, supporting people and getting people in for reviews.” (PN, IPA-PHO)

Other GPs, and some nurses, preferred the traditional hierarchical relationship. Some doctors were reputed to be worried about their legal liability for nurses’ work. One nurse indicated that the nursing role would not expand with “this generation of doctors”:

“We acknowledge that nurses are responsible practitioners in their own right. It’s good in theory but it’s not there in practice. A lot of GPs think that they are responsible for the nurses, that they are liable for the nurse, they are not actually giving that professionalism any [recognition].” (PN, IPA-PHO)

“There are going to be some nurses who, for their own reasons, don’t want to progress beyond the handmaiden scenario.” (PN, IPA-PHO)

One nurse, although trained to do so, did not do cervical smears “because doctor doesn’t require that” and referred women who want to have a female do cervical smears to an independent nursing practice.
Nursing Career Framework

Many nurses, like their employers, work in small practices without internal opportunities for advancement. Even in large practices where a nurse manages the nursing team, the role involves co-ordination rather than supervision. Thus, there is minimal career structure although there is increasingly an opportunity to gain skills and expand the scope of practice. As the informants indicated, in secondary care nursing there is a framework offering support and providing possibility for advancement:

“In the hospitals you have senior clinical nurses, nurse educators and some charge nurses who are behind you, that you can go and ask for help if you are stuck.” (PN, P-PHO)

Under the PHO structure there are nurses who work across practices in an educational and management role and at least one PHO provided a relief ‘capacity’ nurse. Some DHBs have appointed primary health care nurse managers who have oversight of public health, district and practice nurses:

“I am the leader of the practice nurses [in the PHO], my job is to ... to upgrade and update the skills [of our practice nurses].” (PN, P-PHO)

“We have a nursing integration leader within the PHO, she’s the one we refer to if we are not sure about things or if we want to bounce an idea off her, very supportive person actually.” (PN, P-PHO)

Nurses, especially in small practices, often feel isolated and organisational divisions separate each group of nurses working in the community:

“The nurses are very fragmented. We have 22 practices and nurses do not feel that they are part of a wider group. Then you’ve got your iwi nurses, your public health nurses, your district nurses, your Plunket nurses, you know, all silos. So [it is] a very disempowered work force and so this bringing together with the nursing innovations thing that we have got going [is] giving that strength.” (PN, M-PHO)
“It’s like seeing through a glass darkly, there some things that are coming a bit more clear but when we are working as practice nurses ... in smallish practices I can’t see that there is a lot more that I can do. If we were a large practice there would be a lot more scope to either go out to the community or to run courses or do health promotion in a group situation.” (PN, IPA-PHO)

Some PHOs are considering the possibility of employing nurses directly and nurses note that they would be in a stronger position if they had their own funding stream:

“For that to change we are looking as a PHO ... at having nurses paid by the PHO.” (PN, IPA-PHO)

“I am aware that some PHOs are considering employing nurses directly. This would have a huge impact and would make it possible to train new graduates more easily. ... Nurses need to get over thinking of themselves as employees of the doctor and value their role as a nurse, this is where post-graduate education is essential.” (PN, IPA-PHO)

“The biggest thing is to have our own funding stream. The primary health care strategy asks nurses to get out there and do all these things but we are still depending on our employer and we are still funded by them and I think we should get out of that and be funded by the PHO.” (PN, IPA-PHO)

Practice nurses are paid relatively poorly and some feel that up-skilling is not worth the effort. Some PHOs are considering better incentives, closer to the hospital model:

“All practice nurses [are at] one level. In the [hospital] you go off and complete further education and it leads to a pay increase.” (PN, IPA-PHO)
“For that to change we are looking, as a PHO, to develop a framework for practice nurse development so that nurses can enter into a grade that recognises their skills.” (PN, IPA-PHO)

“[The local hospital] as an organisation has got a clinical career pathway programme in place and they have been the first to start that and from all accounts I understand that it is the best.” (PN, IPA-PHO)

Hospital nurses have recently had a pay increase; the financial impact on primary health care of matching hospital pay for nurses was seen by some to be great:

“Nurse equity is a huge issue with the pay jolt that has been given to nurses in the secondary sector.” (DHB)

**Nursing Education**

Education is available to practice nurses at several levels, including: mentoring within the practice; visits by specialist nurse experts; PHO nurse groups; short courses; and formal degrees. Many nurses spoke highly of the educational opportunities provided by the PHO and, in some cases, by the IPA before:

“We have a nurse from the PHO that comes and visit and provide education for diabetes and help us run our clinic.” (PN, P-PHO)

“We have meetings once a month with all the nurses, they provide some education for the nurses and we discuss any issues to do with our work within our practices.” (PN, P-PHO)

“Since we've done the PHO thing there has been what I’d call networking which didn’t really happen in a huge way before.” (PN, M-PHO)

“We can access further training, like the CPR training, they paid for all the nurses to do that.” (PN, P-PHO)
“The IPA [now a PHO] is very nurse focused. We have good CME and CNE as we nurses are invited to attend CME as well. There is at least one session per week and often there is more. We have a lot of access to ongoing education.” (PN, IPA-PHO)

Attendance at short courses may or may not be supported by the practice or the PHO and both costs and work substitution need to be covered. This contrasts with nurses working in secondary institutions where training time is treated as work time. Distance may also be a problem for nurses working outside the major centres:

“In any other [parts of the] sector nurses’ on-going education is done as part of their daily work. For example, public health nurses, if they have to learn about a new immunisation that’s coming out, it’s during the day or they are paid to go to particular seminars. Practices nurses for years have had to do it at night in their own time, usually not paid and I’d really like to see that change.” (PN, M-PHO)

“Barriers are always funding [and] local availability of further training. ... People have to go away to Auckland or to AUT which runs a lot of the postgraduate nursing courses. Plunket runs its Tamariki Ora training in Wellington.” (PN, IPA-PHO)

Formal diplomas or post-graduate degrees are not supported by employers and require nurses to invest their own time and resources:

“So I went and enrolled at AUT, just completed my first paper, but I am stressed out of my brain, and there are other training [courses] as well but we do not have the time and we have families too, and also attending all the after hours meetings.” (PN, IPA-PHO)
New practice nurses, despite years of hospital experience, find that practice nursing requires new skills. While there are some relevant general courses, they are not easily available and mentorship, also thought to be important, is only available in bigger practices:

“I came to the practice with 15 years hospital experience but still experienced a sharp and ongoing learning curve.” (PN, IPA-PHO)

“It would be a huge job coming into practice nursing new.” (PN, IPA-PHO)

“There is one practice nurse course, it covers what we do every day; something like that, at the PHO level, would be excellent.” (PN, IPA-PHO)

“The problem is that there is no standard introduction to practice nursing anywhere. There is a need for one but at the end of the day ... nurses need to be mentored so that they can up-skill.” (PN, IPA-PHO)

Nurses indicated that, in addition to technical skills such as immunisation or smear taking which can be easily learnt, practice nurses required less tangible abilities in counselling and education, and an awareness of local community resources:

“They need also to learn what is out in the community, what other health providers provide in terms of services. ... I do not think that staying in the hospital, the experience in the hospital, is that relevant.” (PN, P-PHO)

“I think understanding how to access things, like how you get a wheelchair for a patients - I mean they are simple things but its quite difficult, and how the community services put together.” (PN, IPA-PHO)
There was a general perception that the mean age of practice nurses is increasing and that new graduates were not attracted to primary health care. Exposure of students to general practice, better mentoring arrangements for new nurses, development of a more autonomous style of practice nursing, and better pay, were all mentioned in connection with improving recruitment.

**Qualifications**

At present there is no requirement for a special training for practice nurses, although accreditation is available through the College of Practice Nurses. One nurse advised that:

“The College is talking with the Council of Nurses to align the new competency based practicing certification with practice nurse accreditation [through the College of Practice Nurses]. With the competency based certificates aligned with accreditation you [would] have one standard throughout New Zealand.” (PN, IPA-PHO)

The requirements made of practice nurses vary:

“At the moment we have a system which allows nurses to function at different levels within general practice, very much dependent on the employer.” (PN, IPA-PHO)

One PHO, building on the work of a predecessor IPA, was reported to have developed a ‘novice to expert’ structure, recognising widening areas of competence. Progression towards ‘expert’ might also lead to pay differentials and providing an incentive to up-skill:

“There should be a structure that recognises skills, accepts that there is [sic] senior staff. There must be incentives to up-skill, nurses should be rewarded.” (PN, IPA-PHO)
In Summary –There are many opportunities under the Strategy to enhance the contribution of nursing practice to better health outcomes. These include expanding the activities undertaken by nurses within traditional general practice and taking on new tasks required under the Strategy. Individual practices vary enormously in the degree of nursing development, depending mainly on the preferences of the GPs as employers. Busy GPs are more likely to welcome the opportunity to delegate, to nurses, tasks that they are accustomed to undertaking themselves.

Nurses felt that the development of a career pathway would improve the attractiveness of primary health care nursing. This would involve recognition, including financial recognition, of different levels of skill and experience. It was recommended that appropriate training be made available, that practical barriers to education be reduced and that nationally recognised and accredited standards for practice nurses be agreed.

4.2.11 The Primary Health Care Workforce

The Strategy increases the responsibilities of the primary health care team and adequate numbers of people with the necessary skills need to be recruited and retained to discharge them; many commentators saw workforce capacity as a major issue for the immediate future:

“What we have identified as the key issue we are facing is workforce capacity and the need for more nurses and more GPs.” (DHB)

“My biggest area of concern would be around workforce capacity, so, to me, funding is not so much of a barrier any more ... it’s more around having enough workforce around to do the work.” (DHB)
“I have a real fear that within five years we will be facing a massive crisis with our primary care workforce. We have already a real problem in the rural areas. I believe thirty-five rural towns are looking for a GP at the moment. It’s not that much better in the provincial towns either.” (DHB)

“Retention and recruitment is a major issue.” (MRep, IPA-PHO)

Low GP morale is likely to reduce recruitment and lower retention, and a number of doctors considered morale to be low. They indicated that they were no longer able to practice as they thought they should and that their remuneration compared poorly with many of their peers in specialist practice or management careers:

“[Morale is low] largely due to the fact that a lot of us are not now doing, or able to do, what we believed we were going to do when we went into general practice. People who know less about our job than we do, are putting out barriers and constraints to stop us doing what we know needs to be done - such as prescribing certain drugs [and] delivering maternity care. A lot of us went to a lot of trouble to train ourselves up to provide maternity care ... but I got the feeling I wasn’t wanted.” (GP, IPA-PHO)

“It would help the morale greatly if we were remunerated to the same level as our hospital colleagues, especially when we see ourselves taking just as much responsibility as they do and having to run our own businesses ... without the time and support staff which they have at the hospital.” (GP, IPA-PHO)
On the other hand, there was also a feeling that new approaches, possible under the Strategy, were raising morale:

“It has completely rejuvenated general practice. [It has] raised the morale of GPs who believe in the real primary care model. [It is] now like GP used to be 20 years ago when they worked with district nurses, communities.... Over time the Strategy is bringing GPs into a shared vision.” (GP, IPA-PHO)

“Our GPs say they belong a lot more to the PHO than they did to the IPA.” (CRep, M-PHO)

“It is now more like one big family. We are much more relevant to the practices.” (GP, P-PHO)

One practitioner mentioned that he felt secure in general practice given the support of the population and the direction of government policy:

“The patient perception of general practice is so strong that I can’t see it but being a robust entity. ... And that’s supported by the government because they think that a primary care led system is cheaper.” (GP, IPA-PHO)

These divergent views may be related to divergent reactions to perceived changes in the content and style of general practice. A general practitioner may see teamwork in a negative light, as people taking away the easy bits, or in a positive one, as being able to give time to the more difficult problems. One practitioner, mentioning maternity care, self-referral to physiotherapists and chiropractors, smears and immunisation done by nurses and minor injuries going to accident and emergency centres, noted that:

“I see it being fragmented which is going to leave us with Care Plus patients basically; all you see is poly-pharmacy and 75% of the patients are over 65.” (GP, IPA-PHO)
“[Given] the strong entrenched medical model and the strong entrenched ... GP at the centre of primary health care [it is hard] for the GPs to refer to some of these other people.” (CRep, IPA-PHO)

“Certainly it has become more satisfying clinically, because there is not that much pressure [to see every patient].” (GP, IPA-PHO)

“The way I see it [is] that by changing the funding structures we will be able hopefully to free up the way I deliver health care ... and have a much less fee for services based style of medicine so people can access me more freely. I hope that I will then be able to improve the way I run my weekly hours and ... we will then interact much more as a team.” (GP, IPA-PHO)

Some practitioners welcomed a simultaneous move to take up more functions presently undertaken by specialists:

“With chronic disease programmes, nurses will be completing a lot of the work. GPs will be more specialised, involved in acute care and co-morbidity management.” (GP, IPA-PHO)

“I see a change to more specialist general practice.” (GP, IPA-PHO)

“There may be a blurring of the line between secondary and primary care.” (GP, IPA-PHO)

Many of these changes in primary health care are easier in large practices where there is greater flexibility:

“We are looking at herding GPs into bigger centres. Doubling the nursing workforce.” (CRep, IPA-PHO)
Some practitioners believe that attitudes to a career in primary health care are changing. One issue is the extent to which GPs will make themselves available for after-hours care (which is part of the PHO contract). This is becoming a concern in several parts of the country:

“We are also starting to see the difference between the baby boomers and the generation X. The baby boomers to quite a degree still have a community focus and wear woolly jumpers and the generation Xs are saying ‘well actually, my family and my lifestyle are more important to me, than being available to do 24/7 care.’ We are getting quite a push back that ‘we don’t want to do that anymore, we don’t want to do after hours care, we don’t want to be this stressed we don’t want to have all these responsibilities,’ and that is quite difficult for us to manage.” (GP, IPA-PHO)

“Since then we have had one practice withdraw ... the two doctors did not want to take part in the roster. ... They are unlikely to rejoin. All others are in PHOs.” (GP, IPA-PHO)

“After-hours is going to be vexed issue here because some GPs are saying they won’t sign the PHO contract if AH is not taken off their responsibility list.” (GP, IPA-PHO)

More generally:

“I just wondered if there are two different types of general practitioners around – the committed ones who went into general practice as a full time vocation and the ... other ones who ... [provide] sessional assistance ... and don’t want to do the after hours care. ... I feel the full time GPs should receive more remuneration than here-to-day gone-tomorrow sessional GPs.” (GP, IPA-PHO)
Another issue is the desire to avoid the responsibilities of running a small business:

“Having said that, there are some excellent opportunities for people to change the way they practice; for GPs to get out of running a business which they don’t want to do and to go back to being a doctor full time.” (CRep, IPA-PHO)

“Many registrars are going into salaried positions and may stay that way. They may prefer the lower stress of not running the business.” (GP, IPA-PHO)

There is some evidence that many recent medical graduates are attracted to primary health care but that limited training opportunities are deterring them. Existing practitioners have peer group education and mentoring provided by some PHOs, especially where IPA activity was strong:

“That they have three times as many applicants as there are places on the GP vocational training scheme means we are not churning out the health professionals to do the work and that really needs to be addressed.” (DHB)

As ever, many practitioners indicated that the workload was onerous and commented especially on the flood of new information and paperwork:

“It’s difficult to believe that one can earn more filling out HUHC forms than seeing patients!” (GP, IPA-PHO)

However, there was also recognition that the expanded role for nurses might compensate for any increase in workload related to better access. Indeed, it was suggested that in areas with more doctors, a wider use of nurses might be less apparent because:

“If we delegated work to the nurses the doctors would be unemployed; we’re meeting the needs now.” (GP, IPA-PHO)
“I don’t necessarily see the workload increasing so much, we won’t necessarily have to see the blood pressure people every three months as we have had to up till now because that’s the way we’ve been paid. If the person is well controlled, the nurse takes it and I really don’t have to see them more than once or twice a year.” (GP, IPA-PHO)

There were also initiatives planned, where clinicians were particularly busy, to remove some of the administrative work:

“We are looking at taking away some of the paperwork that chews time, that back office stuff.” (Manager, IPA-PHO)

Perhaps the most balanced view, drawing attention to the time needed to implement reform, was:

“I am hopeful in the long term that doctors will become excited and they will earn more money and the younger doctors will want to come in because they will see that this is the way forward, but that takes a while ... the unfortunate message that we are getting at the moment is that it’s all becoming too complicated and too hard because of the bureaucracy around it... I can see an opportunity for a practice management system to move in and say ‘you just come in 9 to 5 and do your thing and we will do the rest’. Some of those who have got those establishments do have complicated pay structures for their doctors. They are paid on an hourly rate with all sorts of incentives.” (DHB)
**In Summary** – The Strategy increases the responsibilities of the primary health care team, and there is concern that there may be insufficient medical and nursing workforce to undertake the tasks required by the Strategy. Many key informants saw workforce capacity as a major issue for the immediate future. Some informants felt that GP morale is low, with some mentioning they are no longer able to practice as they feel they should and that their remuneration compares poorly with many of their peers in specialist practice or in non-medical careers. Other informants felt that new approaches, possible under the Strategy, were raising morale. In this context, individual key informants mentioned a shared vision, a sense of belonging, the support of the population, and the direction of government policy in thinking a primary health care led system is cheaper.

These divergent views may be related to different reactions to perceived changes in the content and style of general practice. For example, some informants saw increased teamwork as an opportunity by being able to give more time to difficult problems, while others saw that other practitioners might take on the easy parts of the practice, leaving them with only complex problems and a more difficult workload. Some believe that GP attitudes to a career in primary health care are changing, with GPs no longer automatically making themselves available for after-hours care and with many interested in a salaried position rather than taking on the responsibility of running a small business. Some suggested that such changes may well attract recent medical graduates to primary health care.

Issues of workload and paperwork were also noted as concerns. An expanded role for nurses was seen by some as potentially compensating for an increase in workload related to better access, and some key informants mentioned initiatives, where clinicians were busy, to remove some of the administrative work.
4.2.12 Injury Services

All respondents felt that there would be no change in the management of injuries as a result of the implementation of the Strategy. However, several informants felt that ACC policies should be aligned with the Strategy:

“There is a bit of a mis-match there between primary care services and what ACC are trying to do.” (GP, IPA-PHO)

“There needs to be a shift in the way that ACC is funded. It’s quite separate.” (GP, IPA-PHO)

For example, one informant suggested PHOs merge injury services into the PHCS, and that this would lead to better prevention strategies, utilisation of services and improved well-being. The focus by ACC on fee-for-service was contrasted with attempts to move to a focus on wellbeing, with the emphasis on prevention.

At least one PHO has a major focus on preventing injury via a SIA-funded project aimed at safe driving among the young. Another was considering seeking ACC funding for such a project.

Possible changes in relation to ACC claiming were identified by a number of informants. Changes could go in either direction. For example, it has been alleged that (in the past) patients with musculo-skeletal problems tend to attribute these to injury so that ACC subsidies can be claimed. Informants indicated that this was no longer in the patient’s interest, especially in Access-funded practices (with low co-payments):

“[With regard to claiming in marginal cases] there is no advantage now to claiming ACC because the co-payments are similar.” (PN, IPA-PHO)

“The ACC co-payments are already out of line with our co-payments.” (PN, IPA-PHO)
ACC informants had identified this issue and felt that reduced claiming might lead to under-reporting and possible delays in seeking treatment or rehabilitation:

There remains however some incentive for the practitioner to make an ACC claim, and this too was noted by informants:

“If people come in with two issues ... I am already paid for the GMS side of things so it is in my interest to put it on ACC. What we know is that what happens is determined by the income stream - so there will be a trend that way.” (GP, IPA-PHO)

ACC had also identified this issue and the attendant financial risk, but had noticed no changes at the time of the interview.

Divergent opinions were expressed on specific ACC policies:

“The [ACC] rural contract is much better than the old one; it’s brilliant for us.” (PN, IPA-PHO)

“GPs are almost more critical of ACC than the Ministry, if that’s possible.” (GP, IPA-PHO)

One GP expressed concern about the impact of new medical misadventure rules on ACC’s liabilities:

“If they are removing the threshold of severity ... then I am going to claim from ACC [in every case of complications] and that is a major risk.” (GP, DHB)
Those who experience injury may benefit from physiotherapy, osteopathy or chiropractic, or acupuncture. ACC was interested in teamwork between GPs and these professionals but noted that there had been little focus in this area:

“I don’t see that all providers are ever going to be under PHOs, but it would be nice if a community ... of providers understood more each other’s roles in the continuum of rehabilitation for ACC.” (ACC)

In Summary – All respondents felt there would be no change in the management of injuries as a result of the implementation of the Strategy. There was a suggestion that ACC policies should be aligned with the population health and prevention focus of the Strategy, for example by merging injury services into the PHCS, thereby encouraging better prevention strategies, more efficient utilisation of services and improved well-being. The focus by ACC on fee-for-services was contrasted with attempts to move to a focus on well-being, with the emphasis on prevention.

ACC officials noted that although ACC as presently constituted is not able to match some aspects of the Strategy, there are a number of potential benefits for injury care in the context of the PHCS. ACC has a strong emphasis on injury prevention with its investment in public safety and workplace programmes and leading the New Zealand Injury Prevention Strategy.

It was noted that the incentives for making ACC claims have changed – with ACC co-payments now being higher in some practices than non-ACC co-payments, patients have a disincentive to make claims; however, there are incentives for practices to make ACC claims as these are outside the capitation payments they already receive.
4.2.13 Secondary and Referred Services

In general, under the Strategy relatively little has changed in the management of secondary services although planning of management support for laboratory tests and pharmaceuticals and initiatives to reduce hospital admissions is on-going. Significant attention was given to the appropriate use of laboratory tests and best practice in prescribing under the IPAs. It is acknowledged that this will continue under PHOs and be supported by the Quality Framework and the incentives it provides. There is some concern that existing support structures may not be able to be maintained while awaiting roll-out of the framework and of budgets for tests and drugs:

“Referred services management it’s called and that’s when we work with doctors and look at their prescribing behaviour and trying to meet national and local targets in terms of prescribing, that’s huge money and so there will be incentives in that.” (DHB)

“I believe the PHOs should have some responsibility for managing the referring for labs and pharmaceuticals, but that some of that will be done in part through the PHO performance framework.” (DHB)

“Eventually there will be changes in referred services when we move into budget holding. I like to think that we are doing things now, on a good clinical basis, and that that will still be the case.” (DHB)

“[The] pressure [is] now on to address this at PHO level since four pharmacists are currently unfunded [and we may need] to lay them off.” (Manager, IPA-PHO)

DHB informants were aware that pharmaceuticals and laboratory tests had been shown to be under-used by populations with high health needs and thought that this should be addressed with some urgency. The role of the PHO was acknowledged:
“[There is] supposed to be a feedback loop, to change historical distribution, but it hasn’t happened and delay favours the status quo. ... It needs to be analysed and reviewed before distributing referred services money. Even small shifts there would make a huge difference.” (DHB)

“It would appear that ... we have quite a suppressed demand, we refer for labs and pharms less than other DHBs. So we need to make sure we are using those appropriately, that we are giving the right level of care. The quality review, the peer review, may be a better way of doing things than to try and keep referral levels artificially down.” (DHB)

It was acknowledged that there would be an incentive to use hospital services more but it was unclear how significant this would be:

“Theoretically one would think that as capitation became a larger proportion of one’s income there would be a greater incentive to refer and I think that will probably occur.” (GP, IPA-PHO)

Data on outpatient use, including NHI and referring doctor, (beyond aggregate numbers as available to date) would enable this to be monitored:

“The other thing ... is the work the Ministry has started, looking into collecting outpatient data. Historically we have only collected inpatient data. Included in the proposal is recording where the referral has come from.” (DHB)

The use of Hospital Emergency Departments (EDs) for after-hours care was thought to be a more immediate issue but one emergence department which had monitored volumes had seen no difference:

“We had heard of cases where [going to ED] was being promoted as a way of managing PHO demand ... interestingly we have not seen an increase. [With] after-hours care there is a risk of that, we may have seen more use in the evening.” (DHB)
“When [we] become a PHO [after-hours care] will incur a clawback so there’s the inclination to say ‘just go up to the hospital’.” (GP, IPA-PHO)

In Summary – Some key informants suggested that there would be an incentive to use hospital services more, as a result of the shift to capitation and with secondary care services being funded separately. However, respondents reported that they thought there appeared to be little change in the use of secondary health services to date. It was suggested that the use of emergency departments for after-hours care should be monitored.

Management support for the use of laboratory tests and pharmaceuticals and initiatives to reduce hospital admissions is on-going, and were thought likely to be supported by the PHO performance management project and the incentives it provides. With regard to laboratory use and prescriptions, respondents felt that it was relatively urgent to deal with known under-use of pharmaceuticals and laboratory tests by some populations with high needs.
4.2.14 Relationships Between Organisations

PHO respondents mentioned examples of positive relationships with each other:

“We have a working and growing relationships with other the four PHOs in the [district] ... just for sharing knowledge and understanding and also to form a lobby with DHB.” (Manager, IPA-PHO)

One Pacific PHO had developed a memorandum of understanding with a local Māori PHO. Two large Interim-funded PHOs had developed a good practical relationship with small access-funded PHOs but one noted that there were ideological differences:

“We are starting a dialogue now with the Māori PHOs to try and make sure we do not overlap but work together on additional services.” (Chair, IPA-PHO)

“With the regional contracts that we managed, [they] always took a pragmatic line ... and we’re quite happy to participate in [the] service.” (Manager, IPA-PHO)

“On the ground our providers and our staff work constructively together; we have both been interested in establishing some clinics in secondary schools.” (Manager, IPA-PHO)

“There is a clear philosophical divide between the practices that now make up [the Access-funded PHO] being community owned and operated and the practices that tend to be part of the IPA which are privately owned.” (Manager, IPA-PHO)

There were also a number of examples of PHOs or their member practices working with other community organisations, most commonly district nurses and Plunket.
**In Summary** – PHO respondents mentioned examples of positive relationships with other PHOs. One key informant noted that there were ideological differences between the community owned and operated practices and the practices which are privately owned. There were also a number of examples of PHOs or their member practices working with other community organisations, most commonly district nurses and Plunket.

**4.2.15 Looking Ahead to Achieving Sector Goals**

There was concern in the sector that the changes generated by the Strategy might stall and it was thought that many key goals had not yet been achieved:

“But also my concern is we still have this ten year vision. We [said] that if you are just doing this to reconfigure general practice you are wasting your time and money, it needs to be a bigger more audacious goal than that and that is about bringing in other services [and functions].” (DHB)

A first key goal is the delivery of low cost care:

“If you put in $700 million\(^9\) and you still don’t have affordable care I think there is a problem. They should make low cost care one of the quality indicators. At the moment there is absolutely no recognition for those providers that do provide low cost care, they just get inundated with people wanting to join their service – no reward, no reinforcement and yet that is supposed to be a key part of the strategy.” (DHB)

“The best we could achieve for one practice was [co-payments of] $40 - nowhere near low cost care.” (DHB)

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\(^9\) As noted earlier, around $1.7 billion over six years from 2002/03 is being provided to support the implementation of the Strategy.
A second key goal is to move to population health (while retaining the capacity to deliver acute care):

“We are still based on an acute need paradigm, that shift needs to occur.”

(DHB)

A third key goal is to move beyond tokenism in community involvement in PHOs and a fourth is to monitor outcomes:

‘[A key goal for the future] is getting the key players such as the board, staff and the DHBs to understand what the primary health strategy is trying to achieve. And from our point of view it’s about trying to mobilise communities, to have an understanding and appreciation of their own health need and what they can do about it.” (Manager, IPA-PHO)

Two other major goals still to be achieved are the consolidation of community health services within PHOs and the development of closer ties with agencies involved in the determinants of health. Table 4.4 lists professional groups that might become part of PHOs and community agencies with whom links might be formed, as mentioned by informants.

### Table 4.4
Potential Contributors to, and Functions of, PHOs

<table>
<thead>
<tr>
<th>Medical Specialties In-the-Community</th>
<th>Other services</th>
<th>Other agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrinology</td>
<td>Pharmacists</td>
<td>Housing New Zealand</td>
</tr>
<tr>
<td>General paediatrics</td>
<td>Physiotherapy</td>
<td>Police and Justice</td>
</tr>
<tr>
<td>Other medical specialties</td>
<td>Social workers</td>
<td>Local councils</td>
</tr>
<tr>
<td>Sexual health clinics</td>
<td>Speech and language therapists</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Surgical specialties</td>
<td></td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td><strong>Nursing roles</strong></td>
<td></td>
<td>(inc. Work and Income)</td>
</tr>
<tr>
<td>District nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School nurse educators</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other professional groups</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental hygienists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td></td>
<td></td>
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<tr>
<td>Dietitians</td>
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<tr>
<td>Midwifery</td>
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<tr>
<td>Occupational therapy</td>
<td></td>
<td></td>
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<tr>
<td>Opticians</td>
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</tbody>
</table>
In addition to these goals, acknowledged in the Strategy, informants mentioned other desirable changes which had emerged during the implementation process. One was the advantage of development of larger practice organisations; another, the need to provide care in areas presently un-serviced:

“I can see that the future lies with big practices.” (GP, IPA-PHO)

“There is the view that if we are struggling to get service provision in high needs areas and we cannot attract GPs there and PHOs are not interested then ... it might be that DHB provision is one option but our preferred pathway is to encourage that through a PHO. Perhaps we should salary GPs?” (DHB)

In Summary – There was concern in the sector that the changes generated by the Strategy might stall and it was thought that many key goals had not yet been achieved. A first key goal is the delivery of low cost care, which, it was felt by some, has yet to be achieved for all patients. It was noted by one informant that practices do not get rewarded for offering low cost care. A second key goal is to address population health, and some informants suggested that there is some way to go yet to achieve this vision. A third goal is the need to move beyond tokenism in community involvement in PHOs; and a fourth is the need to monitor outcomes. Other goals still to be achieved are the consolidation of community health services within PHOs and the development of closer ties with agencies involved in the determinants of health. Others noted that the future seemed to lie with larger practices, while concerns were also expressed over how to ensure service provision in rural areas.
5. Analysis and Policy Implications

The findings presented above come directly from the interviews with key informants. In this section, we discuss the findings, in light of our own knowledge of the sector, academic material and information available on the Strategy and its implementation from the Ministry of Health and other sources. We have focused on key topics where problems are being encountered and on possible resolutions to these problems.

5.1 Implementation of the Strategy

In the four years since the government published the Primary Health Care Strategy, much has been achieved and there is wide, and strong, support for the goals of the Strategy. More than 90% of the population are registered or enrolled in one of 77 PHOs, an uptake considerably faster than originally anticipated. PHOs report that much of the set-up work has been completed and that effort can now be re-directed towards substantive changes in service delivery.

For many New Zealanders, there are now lower fees (Ministry of Health 2004g), and there are reports from our key informants that access to services has improved. PHOs indicate that they are better able to identify and meet the needs of a known, enrolled, population. Community representation on PHOs boards appears to have been achieved and many service development initiatives are underway.

Some general medical practitioners, freed to some extent from the incentives of a fee-for-service subsidy, have noted a greater flexibility in how they use their time. Some have found in the PHO environment a welcome opportunity to co-operate with other practitioners and one went so far as to say that the changes would rejuvenate general practice. Nurses appreciate the opportunities newly available to them to develop their practice.
However, informants have noted a number of issues relating to the Strategy and its implementation. For example, there are on-going concerns over the lack of targeting in the new system and concerns that some New Zealanders may still be missing out on cheaper care. Some GPs feel that the government is seeking a greater degree of control of general practice and that the viability of practices may be threatened. A number of implementation problems have also been noted.

5.2 Variations Between PHOs

There is great variation between PHOs in terms of size, structure, age and context. Our familiarity with the interview material suggests that there are two broad types of PHOs. Table 5.1 presents the key characteristics of these PHOs and the discussion following develops further these characteristics further.

One of the key differences across PHOs relates to size. Of 77 PHOs, 37 are small with less than 20,000 people enrolled, and while these PHOs made up 48% of PHOs, they work with only 10% of the total enrolled population. Small PHOs face most of the compliance costs of large ones, and while their management fees are set at a higher amount per enrollee, they tend to have difficulty meeting external reporting requirements and supplying management input within their organisations. Small PHOs are more likely to be made up of Access-funded practices (62% of small PHOs are Access-funded) while large ones are more commonly Interim-funded or have mixed funding (70% of large PHOs are Interim-funded or have mixed funding).
Table 5.1
Characteristics of PHOs (simplified)

<table>
<thead>
<tr>
<th>Small (&lt; 20,000 enrollees)</th>
<th>Large (&gt;20,000 enrollees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate management resources</td>
<td>Well resourced, efficiently managed</td>
</tr>
<tr>
<td>Access-funded</td>
<td>Interim-funded</td>
</tr>
<tr>
<td>History – Previous NGO, capitated</td>
<td>History – Previous IPA, fee-for-service</td>
</tr>
<tr>
<td>Low investment in IT, premises</td>
<td>Established IT, premises etc</td>
</tr>
<tr>
<td>Salaried doctors</td>
<td>Doctor’s own practice</td>
</tr>
<tr>
<td>Low co-payments</td>
<td>Higher co-payments</td>
</tr>
<tr>
<td>Full/increasing use of nurses</td>
<td>Use of nurses dependent on workload</td>
</tr>
<tr>
<td>Established community governance</td>
<td>Establishing community governance</td>
</tr>
<tr>
<td>Māori and Pacific focus</td>
<td>General population focus</td>
</tr>
</tbody>
</table>

Many Access-funded practices serve populations that, historically, have been poorly provided with health care by private practice. Such populations usually have low incomes, have a high proportion of Māori or Pacific people, and may live in remote locations. In the past, their health care has often been provided by community-owned and governed primary health care organisations, commonly related to union, Māori or Pacific organisations. These health organisations have traditionally been bulk funded, initially as ‘special medical areas’ and more recently under individualised capitation-based contracts. They have had low co-payments and have been unable to make large investments in premises or infrastructure. They have employed doctors, along with nurses, on salary, and have encouraged a team approach. The team has often involved additional workers including midwives, dentists and community health workers along with the doctors and nurses. Because of the needs of the population, this team has spent additional time liaising with other parts of the health service, particularly secondary care services and other agencies such as Work and Income New Zealand, the police and Justice. Needs analysis, outreach efforts, analysis of the determinants of health, and health education and public health initiatives, have often been undertaken by these practices.
It would be fair to say that PHOs made up of such Access-funded practices already possess many of the qualities and provide many of the services mandated by the Primary Health Care Strategy. However, it would appear from the views of our informants that these organisations, given fewer management resources, are at risk financially and from individual and group ‘burn-out’.

Interim-funded practices are invariably privately owned; co-payments are generally higher (Ministry of Health 2004g) and practice infra-structure is often well established. Such practices join a PHO as independent entities and may see little need to make changes beyond compliance with the reporting needed for remuneration. Some community informants believed that the risk here is that the anticipated benefits of the PHO model will not fully materialise.

It should be noted, however, that some large Interim-funded PHOs are functioning very well, leading the way in needs analysis, public health and health education initiatives, and in the provision of new clinical services.

In our research, in addition to the broad characteristics of PHOs noted above, we have also noted that the issue of ‘overlap’ may be an important determinant of experiences under the Strategy. Overlap occurs where more than one PHO services the same population. PHOs vary in the extent to which the population they serve is distinguished geographically or culturally. Where the target population is poorly defined, the PHO is likely to experience difficulties with enrollees moving between practices. Under such circumstances, the PHO may not be so easily able to understand the particular needs of that population or to identify individuals or sub-groups that are under-serviced. Overlap also increases competition between PHOs for staff and patients.

Finally, it should be noted that more recently-founded PHOs have had less time to undertake key tasks, such as needs analysis, and to put in place services specific to the needs of their enrolled population.
**Policy Implications.** A key question arising from this and related research is whether small PHOs are viable, and whether policies need to be developed to support them. A review of management services in PHOs (Capital Strategy Ltd 2004) has recently been released acknowledging the importance of small PHOs and suggesting appropriate measures to support them. Extra funds have been set aside for the management costs of PHOs with less than 20,000 enrollees (Poutasi 2005) and the Ministry of Health is investigating the potential of shared service arrangements.

In our postal survey and in later phases of this research, we aim to follow-up on the implications of size. Further, two of our principal investigators, Judith Smith and Jackie Cumming, are now undertaking a separate project which will identify the issues that need to be considered in relation to size of PHOs. This will focus on the tension between critical mass/management capacity on the one hand and sensitivity/community and practitioner engagement on the other.

The development of PHO-level initiatives in needs analysis, public health and health education, outreach, and the provision of new clinical services should be monitored and managed to ensure that the changes suggested by the Strategy are being fully realised by all types of PHOs. In our future research, we aim to evaluate the extent and success of these innovations on the bases of the size and other characteristics of each PHO.

Where PHOs overlap without a clearly defined population to be served (for example, an ethnic group), consideration should be given to amalgamation or co-operation in some functions (for example, needs analysis). DHBs may play a crucial role in supporting PHOs here.

Ensuring meaningful community engagement, encouraging wider participation in PHO decision making, and a wider population understanding of the Strategy, are also key issues for the immediate future. The Ministry of Health and DHBs should work together to identify issues here and to facilitate further development in these areas.
5.3 Managing Referred Services

A key issue that arises from this research is how PHOs and practices refer and link to other services that are provided in community settings. The cost of general practice services is a relatively small portion of the total government budget for community-based health services. The total cost of laboratory tests and prescription medications to the government is greater than that of GPs (Ministry of Health 2002d). Other community-based health services – funded by the DHB or by the Ministry of Health directly – include radiology, retinal screening, midwifery, district and public health nurses, the school dental services and mental health services. To this list could be added hospital services, such as outpatient clinics, provided to non-admitted patients.

GPs often claim that secondary service managers do not understand the community or how to service it. Given that PHOs are responsible for the health of their enrolled populations, they may have a *prima facie* case for being involved in the provision of many community health services. Historically, secondary care providers have been reluctant to let go of services. They cite a number of reasons for this, such as the difficulty of paying for hospital and other overheads from a smaller budget when funding is devolved, and the perceived need for some services - for example, post-operative home nursing care - to be under specialist control. On the other hand, secondary service providers may have a positive incentive to transfer under-funded functions.

**Policy Implications.** The present policy is that management of services can be transferred from DHBs to PHOs when a case can be made in terms of effectiveness and efficiency. While such a permissive approach is understandable, it seems likely that, in all but the most obvious examples, budgetary and power issues may overwhelm the appeal of such gains.
One approach to this issue would be to construct a list of services which could be devolved to the PHO or to a DHB/PHO joint venture, to list additional principles (for example that the PHO involved provides a majority of the primary care in an area), and to require that inaction be justified.

A case in point is the provision of laboratory services and subsidisation of medication. In the recent past IPAs have held budgets for these services and have been allowed to use savings to provide additional services. GPs are responsible for ordering tests and prescribing medication and programmes are available to help them target the resources used in this area more effectively. It would seem advantageous to maximise value in this area by providing GPs with incentives to consider cost-effectiveness. The new PHO Performance Management Project will include payments for meeting some targets relating to prescribing, and the effects of this should be carefully evaluated once the project is in place. It may however be necessary to develop further measures. If budgets were assigned on the basis of population need, expenditure in over-serviced areas would be reduced and extra funds made available to under-serviced ones (see below).

5.4 Practice Level Changes

With small Access-funded PHOs, especially those originating in community-owned services, there is little division between PHO and practice management, and practice clinicians support innovative activities from belief or as employees. On the other hand, private practitioners within large, interim-funded PHOs, are independent and relatively invisible, and may feel little need to change the way they work.

However, it is at the practice level that the development of a team approach, with an expansion of the categories of people included in the team, takes effect. Similarly, advocacy for individual patients, either with secondary health services or with other agencies, originates with the discovery of need during a consultation. And the consultation is the starting point for individual approaches to prevention and lifestyle
change. Furthermore, such need exists among the patients of all practices and the Strategy implies that it should be met at whatever practice people choose to attend.

**Policy Implications.** Incentives are needed at the practice level to ensure that the goals of the Strategy are achieved and that the government’s investment in primary care generates maximum benefit. Community-owned practices indicate that the involvement of community representatives in the management of the actual practice has generated many beneficial changes. Private practices might be encouraged to seek feedback from their clientele, to make fuller use of nurses (and other providers), and to advocate for their patients, through a range of incentives, including simple recognition of their practice achievements, measurement through indicators in the quality programme or by monetary reward. As PHOs settle into their roles, they should be in a better position to influence their member practices in these ways.

### 5.5 **Financial Barriers to Care**

Removal of financial barriers to care is essential to the success of the Strategy. New funding has been provided to reduce fees for over 2 million New Zealanders (see Table 1, above). In general, those in Access-funded PHOs or practices are paying lower fees than people in Interim-funded practices; available data show that fees for younger people aged 6-17 are lower than adult fees, and Interim-funded practices reduced fees following the introduction of higher subsidies for older people aged 65 and over in July 2004 (Ministry of Health 2004g). While subsidies will be available to all from July 2007, some practices charge substantial co-payments even to those in receipt of a subsidy and there is already pressure for fee increases.
However, self-employed practitioners are fiercely attached to the right to set fees, seeing it as their only real protection against income loss or lack of practice viability. At present, most capitation funding for first contact services is passed through to practices based on their enrolled population\(^{10}\); should some of this income be needed to provide other services – for example, after-hours care – the pressure to increase fees could accelerate.

Another factor contributing to the upward pressure on fees could be the uneven distribution of GPs. Where there is a higher concentration of GPs, each enrolling a smaller population, practitioners may perceive a need to increase co-payments and service patients more intensively in order to maintain income levels.

**Policy Implications.** It has been suggested by PHOs and GPs that the fair cost of providing primary care should be independently established, making due adjustments for population health need and other factors beyond the control of practitioners, such as living costs (since neither the surgery nor the clinician’s residence will cost as much in a small town as in a metropolitan area). We believe that this suggestion has merit and such research would provide evidence against which subsidies and co-payments could be negotiated.

Another approach to the control of co-payments, suggested by a DHB informant, would be to arrange for the level of subsidy to reflect agreed co-payments, so that practices with higher fees attracted lower subsidies. Practices would then have to increase fees more to achieve the same increase in income and, if they lowered fees, would lose disproportionately less income while becoming more attractive to cost-conscious patients. The subsidy would have to be high enough to adequately reward practitioners who provided low co-payment care. The appropriate policy setting might be found by considering the fair cost of providing care, as noted above.

\(^{10}\) However, Services to Improve Access, health promotion and management services funding is retained by PHOs for collective use.
5.6  The Primary Care Workforce

The Strategy will generate more work in primary care and concern has been expressed that there are already too few GPs and practice nurses in New Zealand. There is no international agreement on the proper number of GPs needed to serve a population and the number would be affected by factors such as the health needs of the population, the functions fulfilled by the practitioners in a particular country and the degree to which work was shared with nurses and other members of the primary care team. Nevertheless, sufficient medical and nursing graduates must be attracted to general practice, given appropriate training and retained in practice

There is evidence that less desirable areas are less easily able to recruit GPs and the effects of uneven distribution of GPs have been mentioned above. Practitioners may be reluctant to work in remote or deprived areas, with patients who seem difficult to care for or where remuneration is low. On the other hand, there may be practitioners who are attracted to work with people with more severe health needs, especially when supported by an appropriate team. In these circumstances, practitioners may prefer a guaranteed salary to an uncertain profit margin. Innovative approaches to recruitment and retention are needed to ensure appropriate service delivery. As an example, one Māori health provider operating in a relatively remote district has been successful in recruiting practitioners from overseas by offering a time limited contract, by providing good support and by mentoring graduates as they adjust to practice in New Zealand. Similarly, practices serving immigrant communities have been able to present their work in a positive light as socially valuable and interesting by providing team support and translation services. In general graduates will be attracted to high quality, high morale, workplaces.

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11 New Zealand’s Health Workforce Advisory Committee is developing workforce recommendations through a sustained programme of research and policy development. See www.hwac.govt.nz
Under the Strategy, nurses are being called upon to take on a larger share of primary care work. Many are enthusiastically taking up this challenge but, among practice nurses, there are those who do not wish to extend their role and, more generally, a significant number of nurses who choose not to work in nursing. Significant wage gaps can exist between primary care nursing, hospital nursing, and other non-nursing roles in New Zealand and the impact of these needs to be considered in policy development.\footnote{Recently, negotiations between unions and DHBs have settled on significant pay increases for hospital nurses. There are fears that primary care nursing will become less attractive as a result (NZPA 2005)}.

As with GPs, nurses need appropriate incentives to enter, and remain in, practice nursing. As discussed in the body of this report, many nurses interviewed find that the attitude of their employers – the GPs – can restrict nursing practice. Some GPs encourage nurses to expand their role and develop their independence; others wish to undertake all clinical activities themselves. Further, the costs of up-skilling may be prohibitive, particularly in view of the lack of financial recognition of increasing levels of skill.

As mentioned above, it is also apparent from our research that capacity is also likely to be an issue in relation to management, analysis and service development functions in PHOs. There is a question mark at present as to whether PHOs – particularly the smaller ones – will have the resources available to adequately undertake these tasks in order that the Strategy achieves its objectives. DHBs will also have a crucial role to play in working with and supporting PHOs and they too must develop the capacity to work towards achieving the goals of the Strategy.

**Policy Implications.** The changes in the requirements being made of the primary care workforce must be figured into the assessment of training and workforce requirements. The models for attracting staff developed by community-based practices should be supported and developed. PHOs should also be encouraged to develop the role of nurses. Availability and access to management, analysis and service development training is also an issue for future consideration. The distribution of primary health service personnel may also need to be addressed.
Appendix 1  Background

A1.1  Overview of the Organisation of the New Zealand Health Care Sector

The organisation of funding for the health care system in New Zealand has remained more or less unchanged since the introduction of free hospital care in the late 1930s. That is, hospital care and public health services are provided free of charge to all New Zealanders. Primary care is subsidised by government, particularly for those on lower incomes. All users pay some charges for primary care, but those on higher incomes pay the full cost of much primary health care. Disability support services (DSS) were brought into the health sector funding in the early 1990s. Here, needs are assessed at an individual level and there are income and asset tests to determine eligibility for publicly-funded care. A parallel private health insurance system offers those who can afford it faster access to, and private facilities for, elective care, as well as insurance coverage for user charges. There is separate social insurance funding for accident-related prevention, care and rehabilitation through ACC.

The structure of the New Zealand health system of purchasing and delivery has undergone a number of reforms:

- The amalgamations of small hospital boards into larger units prior to the 1970s;

- The formation of 14 area health boards, through amalgamations of 27 publicly-owned hospital boards with 18 public health units (regional offices of the Department of Health) throughout 1980s (Gauld 2001). AHBs were responsible for taking a ‘population’ approach, focusing on the health of their populations, and the planning and meeting of health and health care needs for those populations;
• The introduction of a ‘quasi-market’ through the splitting of purchasing and provision functions in 1993. Four regionally-based purchasers (Regional Health Authorities or RHAs) were established to plan and purchase a wide range of services – public health, personal health and disability support services – and the government turned the provider-arms of the 14 AHBs into 23 Crown Health Enterprises (CHEs). CHEs were established under a business model, required to make a profit, and to compete with a wide range of other service providers for contracts with the four purchasers. Purchasers could contract with CHEs, privately-owned medical and surgical and residential hospitals, and privately-owned for-profit and not-for-profit primary and community care providers;

• An amalgamation of the RHAs into a single, national purchaser (the Health Funding Authority or HFA) in 1997 and the gradual move away from a competitive model towards a more co-operative model. CHEs became Hospital and Health Services (HHSs) in the same year, and were no longer required to earn a profit but expected to remain within budget. Contracting between purchasing and providing agencies remained throughout the period;

• The establishment from January 2001 of a district model, through 21 District Health Boards (DHBs) which purchase and provide or arrange for the provision of services for geographically defined populations. Funding for health services is devolved to these Boards, which are responsible for purchasing and provision of hospital care and for funding/contracting with community and primary care providers. There is upwards accountability directly to the Minister of Health, with the Ministry of Health acting as the Minister’s agent, (hereafter referred to respectively as the Minister and the Ministry). Emphasis is placed on local, cooperative, collaborative arrangements.
A1.2 Accident Compensation and Rehabilitation

As noted above, there is a separate social insurance scheme for accident-related prevention, care and rehabilitation. Legislation establishing the accident compensation scheme was passed in 1972, and the scheme now provides accident cover for all New Zealanders. The scheme provides a no-fault entitlement to compensation. In establishing this no-fault entitlement the governing legislation extinguishes an individual’s right to sue for indemnity through the legal system. The scheme is currently governed by the Injury Prevention, Rehabilitation, and Compensation Act 2001.

The Accident Compensation Corporation (ACC) administers New Zealand’s accident compensation scheme. It is a Crown entity, and was established in 1974.

ACC is responsible for:
- Preventing injury;
- Collecting personal injury cover levies;
- Determining whether claims for injury are covered by the scheme and providing entitlements to those who are eligible;
- Paying compensation;
- Buying health and disability support services to treat, care for and rehabilitate injured people;
- Advising the government.

Accident compensation and rehabilitation costs around $1.4 billion per annum. Funding for the scheme is through a series of premiums, paid by employers, employees and the self-employed (based on income), by the government (to cover those not employed) and through a tariff on petrol (see www.acc.co.nz for further details).
The ACC scheme covers the cost of assessment, treatment and rehabilitation following injury. A claim is made to ACC, and, if accepted, leads to payment by ACC. In relation to community-based care, payment is made to providers on a fee-for-service basis and can include care provided by general practitioners and practice nurses, as well as from physiotherapists, chiropractors and osteopaths, and acupuncturists. Most of these professionals require a co-payment at the time of the service; this is determined by the provider.

Acute hospital-based care requires no application and is not billed to ACC. However, ACC makes a lump sum payment to cover acute hospital care, transferring funds to Vote: Health. Subsequent, elective care required as a result of injury, is funded on a fee-for-service basis by ACC and, depending on a number of factors, may take place in a public or a private hospital.

A major part of ACC’s responsibilities concern support for people permanently or temporarily disabled. This support includes lump-sum compensation, income replacement, home-help, and the provision of equipment.

A1.3 New Zealand’s Primary Health Care Sector

Primary health care in New Zealand has traditionally been organised around general practices that provide first contact care, from which people have then been referred into the separately funded and organised wider system of care (covering laboratory and pharmaceutical services, community-based services for mental health and disability support, and secondary and tertiary care provided by hospitals) (Coster and Gribben 1999). General practice services have largely been based on a single or small group practice model, but, unlike in other countries, without patient enrolment.
Traditionally, GPs have been funded through government subsidies paid on a fee-for-service basis, along with fee-for-service charges paid by service users who are free to use any general practice. Since the 1970s, practice nurse subsidies have also been paid to allow practices to recruit nurses to provide administrative support along with preventive and chronic disease management services.

Originally, the fee paid to GPs represented about 75% of the doctor’s total fee, and all New Zealanders paid the same fee. By the mid-1980s, different subsidy amounts were paid to different groups of patients, and the subsidy represented on average around 20-30% of the doctor’s total fee (Health Benefits Review 1986). In 1992, the government introduced an income-related Community Services Card (CSC) system in order to target the existing subsidy money more sharply on the least well off. Low-income adults, and those with at least 12 GP visits in the previous year, received a government subsidy for GP care. Until recently, this was $15 per visit; leaving around $20-$25 to pay out-of-pocket for most New Zealanders, depending on the level of fee charged by the doctor. For pharmaceuticals, those with CSCs have been paying a $3 per item charge up to 20 items per family per annum. The rest of the adult population has been receiving no subsidies for GP care (paying between $35 and $50 per visit depending on market conditions locally), but is entitled to subsidised pharmaceuticals (paying up to $15 per item for up to 20 items per family per annum). In July 1997, ‘free’ GP care for all children under six years old was introduced, with the government paying GPs $32.50 per child consultation. Actual fees charged by some GPs have been higher, with the result that some part-charges have continued to be payable.
This approach based on fee-for-service government subsidies coupled with patients paying unregulated fees has been criticised for many years on the grounds that it contributes to:

- Poor access to care for some groups in the population, arising from financial, as well as cultural and other barriers to care (Health Benefits Review 1986; Coster and Gribben 1999; Crampton 1999; Crengle 1999; Cumming and Mays 1999; Tukiotonga 1999). Surveys undertaken by the Commonwealth Fund in 1998 and 2001, for example, found 20% of New Zealanders reported financial barriers to getting medical care, with statistically significantly higher rates for those on below-average incomes (Schoen, Davis et al. 2000; Schoen and Doty 2004);

- Little incentive for practices to promote health or prevent disease under a fee-for-service system based on patient-initiated demand;

- A poorly distributed workforce in relation to population needs, given the importance of practices locating where the market will support private practices (Malcolm and Clayton 1988; Malcolm 1993; Malcolm 1996; Malcolm 1998);

- An inability for the government to fund according to population health needs. This arises because the fee-for-service system directs funding to those using the most services. These may not always be the people with the highest health needs, who may not be accessing services at all;

- A bias towards GP care, with the fee-for-service system meaning that patients having to visit the GP for GPs to receive government subsidies. This has been seen to lead to inappropriate and inefficient pattern of primary health care, and under-development of wider primary health care team provision.
Some alternative approaches to funding and delivering primary care have sat alongside the fee-for-service system (Health Benefits Review 1986), but these have been limited, mostly to a few isolated areas of the country or in areas with low incomes. During the late 1980s, more alternative arrangements developed, with union clinics introduced to provide affordable high quality care to union members, the clinics recognising the access problems that had developed from high service user fees in the primary health care sector (Crampton 1999).

Unexpectedly, as a result of the 1990s quasi-market reforms, primary health care service delivery in New Zealand underwent significant change. GPs increasingly joined independent practitioner associations (IPAs) or other networks, fearing that, otherwise, they would be at a disadvantage in contract negotiations with the RHA purchasers (Malcolm, Wright et al. 1999). The 1990s also saw the further development of “third-sector”, community-governed, not-for-profit provider groups where GPs work alongside a range of health professionals to deliver care. These included the previously mentioned union-based clinics, as well as other community and iwi (tribal)-based organisations networked with Health Care Aotearoa (Crampton 1999). There has also been a rapid increase in the number of ‘by-Māori, for-Māori’ providers, and increased interest in developing Pacific providers (Crengle 1999; Tukiotonga 1999). The overall result from the reforms of the 1990s was therefore a more diverse range of providers in primary care.

Some new payment arrangements were also introduced during the 1990s. There was an increase in the use of capitation formulae; along with the development of some general practice budget-holding for pharmaceuticals and laboratories; some service-specific funding to develop new services for a range of new providers; and the use of financial incentives to achieve specific aims, eg to reduce acute hospital admissions (Malcolm, Wright et al. 1999).
ACC is also a funder of primary health care in New Zealand. The scheme covers the cost of assessment, treatment and rehabilitation following injury, and hence provides funding for primary health care in New Zealand. A claim is made to ACC, and, if accepted, leads to payment by ACC. In relation to community-based care, payment is made to providers on a fee-for-service basis and can include care provided by general practitioners and practice nurses, as well as from physiotherapists, chiropractors and osteopaths, and acupuncturists. Most of these professionals require a co-payment at the time of the service; this is determined by the provider.

A1.4 Nursing and Primary Health Care

The term primary health care nursing refers to the practice of registered nurses who provide care in the community and outside the hospital in a variety of settings, including general practice, public health, Plunket, community based clinics and in people’s homes. Therefore, primary health care nurses include public health nurses, Plunket nurses, practice nurses, district nurses, rural nurses, nurses providing care to specific groups (for example, respiratory and diabetic patients), nurses in accident and medical clinics and nurses working in Māori and Pacific health provider organisations (Ministry of Health 2003e; Ministry of Health 2003b). The activities that these nurses undertake may be quite narrowly focused, while others will have broad roles encompassing health promotion, preventative and surveillance activities, home based care, disease management and wellness care (Carryer, Dignam et al. 1999).

Since 1970 a Government subsidy has been provided to general practitioners to enable them to employ practice nurses. A review in 1997 found that the numbers of practice nurses employed by general practitioners had significantly increased since the introduction of the subsidy; however there was little evidence of any subsequent health benefits to the population (Michel 1997).
A similar picture was found in the UK when in 1990, the general practitioner contract boosted nurses’ involvement in primary health care with additional funding. Increases in numbers of practice nurses resulted (Atkin, Hirst et al. 1994; Atkin and Lunt 1996).

While practice nurses are employees of general practitioners in the predominant general practice small business model the employment approach differs with nurses salaried employees in the community-based groups such as Health Care Aotearoa and Māori providers. These groups have since 1980 developed services which extend the role of primary health care nurses. The intent is that nursing skills within these groups are comprehensively used. It still needs to be shown, however, that nurses do use a broad range of skills or have expanded roles with these providers.

In 2002 an Expert Advisory Group on primary health care nursing was established (Expert Advisory Group on Primary Health Care Nursing 2003). A vision, goals and objectives for the development of the primary health care nursing workforce was developed. The ‘advisory group’ recognised the need to develop innovative models of primary health care nursing that would improve access to primary health care and contribute to improved health outcomes and reduced health inequalities for individuals, families/whānau and communities/iwi. Associated goals include aligning nursing practice with community need and developing funding streams, employment arrangements and service delivery patterns that will support nurses to adopt an integrated approach to practice and incorporate population and personal health strategies into service delivery. Nurses should be supported to provide integrated comprehensive care to individuals and population groups in New Zealand primary health care settings in order to strengthen and enhance the primary health care team. The ‘advisory group’ also recommends that there should be positive discrimination to enable nursing participation in primary health care management and governance.
Other developments in nursing occurring at this time included the development of the Nurse Practitioner role. The Nursing Council of New Zealand, the body responsible for ensuring safe and competent care from nurses, developed competencies and standards for a new level of nurse in New Zealand, that of Nurse Practitioner. Nurse practitioners have expanded roles which may include the independent prescribing of medicines. The scope of practice for Nurse Practitioners is defined under the Health Practitioner Competence Act 2003 (HPCA), effective September 18, 2004 and nurses wishing to use the title Nurse Practitioner must meet the requirements for registration as a Nurse Practitioner with the Nursing Council of New Zealand.

Nurse Practitioners are described as working within a nursing framework and practising as part of a team, leading specialty focused clinics in communities or offering independent primary health care that complements the roles of other health professionals. The Nurse Practitioner role is focused on patient and population needs and improving health outcomes. Fourteen Nurse Practitioners are now registered in New Zealand. Their areas of practice are diverse and include child health, mental health, diabetes management and wound care. The Expert Advisory Group recommend that Nurse Practitioner roles should be established in primary health care services, positioning nursing to align with community need and to directly deliver enhanced nursing services to the public.

The expansion of the nursing role in primary health care is intended to enhance the effectiveness and efficiency of health care in improving health outcomes. The international evidence for this suggests however that expanded nurse roles are under evaluated particularly in terms of cost-effectiveness. Evidence is minimal about the overall cost-effectiveness of expanding nurses’ role in primary health care.
Sibbald, Shen and McBride (Sibbald, Shen et al. 2004) provide a framework for considering changing roles of nurses, i.e. as substitution of the doctor role; delegation of doctors disinvesting in those activities that can be delegated and instead giving their time to activities which only they can perform; and enhancement where nurses add value to services and improve the quality of care for patients.

Whilst the evidence is limited, nurses acting as doctor substitutes in the management of patients have been shown to have more effective interpersonal skills and achieve as good health care outcomes as doctors (Brown and Grimes 1995; McKenna 1995; Venning, Durie et al. 2000; Horrocks, Anderson et al. 2002). In terms of activities, however, there is some evidence to suggest that, when compared to doctors, nurses have longer consultation times, order more tests and investigations and may recall patients more often (McKenna 1995; Venning, Durie et al. 2000).

The literature on enhancement of services to improve the quality of patient care such as nurses taking an extended role in health promotion is more comprehensive. For example, nurses may be responsible for carrying out well-patient checks and providing lifestyle and other interventions (Atkin, Hirst et al. 1994). In chronic disease management, where care is structured and protocol driven, treatment delivered by nurses has been shown to be effective and to improve the quality of patient care (McKenna 1995). Renders et al (Renders, Valk et al. 2004) in a systematic review of interventions to improve diabetes mellitus care in primary settings found that organisational interventions by nurses to regularly contact patients can improve diabetes management and that nurses play an important role in patient oriented interventions, through education or facilitating adherence to treatment.
A study by Wright et al (Wright, Wiles et al. 2001) found that further training was needed for nurses in discussing patients’ understanding of heart disease and related medication, although practice nurses were effective in history taking and offering reassurance and dietary advice. Other studies conclude that while nurses are able to deliver high quality care, the benefits to patients do not outweigh the costs (Family Heart Study Group 1994; OXCHECK Study Group 1995). Evaluative studies of the many initiatives to expand the nurse role in New Zealand primary health care settings are awaited.

**A1.5 Expanded Prescribing**

The issue of extending limited prescribing rights to nurses and other health professionals in addition to medical practitioners, dentists, midwives and veterinary surgeons has been discussed for a number of years. In 1994 The Ministry of Health commissioned a discussion paper on the principle of extending limited prescribing rights to health professionals (Shaw 1994). The professional groups identified as those to which extended prescribing could be extended were nurses, chiropractors, dental therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and medical assistants in the defence forces.

It was clear that any extension of prescribing rights could only succeed in an environment of cooperation between the various providers and health professionals. The MoH decided it would be most appropriate to consider the issues profession by profession and determined that nurses as the group where the largest benefits from extending prescribing might be obtained would be considered first. In 1997 the Minister of Health established a working group to advice on the safety, education and other relevant issues to be addressed before limited prescribing rights could be extended to nurses.
The working group concluded that nurse prescribing should be restricted to specific areas of practice. Nurses practising in these areas would need to demonstrate advanced clinical knowledge and skills with demonstrated competence in their identified specialty, and have completed an appropriate postgraduate educational program. Legislation changes would be needed to either amend the Medicines Act 1981 and the Medicines Regulations 1984 to enable nurses to prescribe and to schedule those medicines available to nurses to prescribe, or to introduce and pass the Therapeutics Products Bill.

In April 2000 Cabinet considered a paper to allow regulations to be made under the Medicines Act 1981 to allow nurses practising in aged care and child and family health to prescribe a specified list of prescription medicines (Minister of Health 2000). These areas of practice were chosen because of the potential benefits likely to result from nurses prescribing in these areas, particularly in relation to improved flexibility in the delivery of health and disability services for children and their families and older people, together with improved access for treatment for these groups in provincial and rural areas. The definitions of aged care and child health, scopes of practice and schedules of generic classes of medicines had been developed by two expert working groups (Ministry of Health 1998). It was estimated that approximately 105 nurse prescribers would graduate each year from 2001 onwards, with up to seven providers offering 15 training places a year (Minister of Health 2000).

In 2001 the Minister established the ‘New Prescribers’ Advisory Committee’ (NPAC) to provide advice to the Minister on extending prescribing rights to other health professionals (for example optometrists, podiatrists and pharmacists) and on further nursing scopes of practice. Generic criteria which any health professional group must meet in preparing an application for prescribing rights were to be established and the Committee would assess applications and provide recommendations to the Minister. It was noted that work had begun on proposals to implement nurse prescribing in sexual/reproductive health, mental health, palliative care and occupational health. Regulations to allow nurse prescribing in aged care and child health were subsequently enacted in 2001.
Since the establishment of the NPAC applications to extend prescribing rights have been considered from the optometry profession and for a sexual health nursing scope of practice.

The process of defining and then maintaining schedules of medicines in respect of defined scopes of practice became the subject of ongoing discussion and review and in September 2003 the MoH consulted the sector on amending the regulatory framework for designated prescribers. The intent was to bring into force amendments to the regulatory framework to provide designated prescribers with legal authority to prescribe all prescription medicines, pharmacy-only medicines and restricted medicines listed in the schedules to the Medicines Regulations 1984, on 18 September 2004, when the final parts of the Health Practitioners Competence Assurance Act 2003 became law. Restrictions would be placed on their prescribing by their registration authorities, which would develop clinical guidelines and lists of generic medicines and exclusions for each scope of practice and audit and monitor prescribing practice.

Designated prescribers would only be able to prescribe medicines that fell within their designated scopes of practice, with restrictions set by the registration authorities as opposed to being determined by a list in regulations. NPAC would continue to consider applications for prescribing rights from registration authorities. Scrutiny by NPAC would include an assessment of the appropriateness of the scope of practice, the medicines to be prescribed, the education, training and competencies and audit and monitoring arrangements the registration authority would have in place.

Cabinet agreed to amend the regulatory framework for designated prescribers in April 2004, however subsequently the MoH received advice from Parliamentary Counsel that there were some legal issues to resolve with these proposed changes. Key components of the proposed framework could not be implemented without amending the Medicines Act 1981 to broaden the regulation making powers of registration authorities. A regulation that purported to authorise a designated prescriber to prescribe ‘all prescription
medicines’ would be *ultra vires* the Governor-General’s regulation making powers under the Medicines Act 1981. A regulation could authorise all prescription medicines of a particular class or description already specified in the Medicines Regulations, but not simply all prescription medicines. Towards the end of 2004 the MoH determined to move forward with a short term solution to implement the proposed framework under current regulations. This would involve, in accord with Crown law advice, not sub-delegating responsibility for maintaining lists of medicines to registration authorities but rather for registration authorities to use descriptions of medicines, by reference to the use or purpose of medicines or other generic features. The long term solution will be the introduction of the Therapeutics Products Bill which will update the Medicines Act, planned for introduction in 2006.

At the time of writing the regulations for aged care and child and family health care nurses remain as the only areas of practice within which nurses can prescribe medicines. The Nursing Council of New Zealand has, however, within the framework of the Health Practitioners Assurance Act (effective 18 September 2004) incorporated the scope of practice Nurse Practitioner, including, “Nurse Practitioners may choose to prescribe medicines within their specific area of practice.” The Nursing Council plans to have NPAC assess an application for this to have effect in 2005.

Currently there is one registered Nurse Practitioner who is also an approved prescriber working in the area of child and family health nursing with legal authority for prescribing under existing regulations. In 2004 there were approximately 40 registered nurses enrolled in, or who have completed, education programmes preparing them for prescribing medicines; specifically completing a practicum module of a master’s degree during which they are supervised in the diagnosis of conditions and management of clients requiring prescription of medicines. These nurses are from diverse areas of practice such as management of diabetes, mental health, neonatal intensive care, primary health care and ophthalmology. Recommendation to Cabinet to make regulations under the Medicines Act 1981 for independent prescribing by optometrists is currently in process.
Appendix 2   PHO Policy Development

A2.1   Introduction: The Primary Health Care Strategy

The Primary Health Care Strategy was released by the Honourable Annette King, Minister of Health, in February 2001, aiming to achieve a new vision over five to ten years in which “people will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care” and which “will focus on better health for a population and actively work to reduce health inequalities between different groups” (King 2001b). Six key directions support the vision: 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; and continuously improve quality using good information (King 2001b).

The Strategy required a re-structuring of the primary health care system, with a move to organising services for a defined group of people, and funding these services on a capitation basis rather than fee-for-service. “Primary Health Organisations” (PHOs) were the local structures that would do this. Six key points about PHOs were given:

- Primary Health Organisations will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled;
- At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people’s health when they are unwell;
- 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;

While primary health care practitioners will be encouraged to join Primary Health Organisations, membership will be voluntary (King 2001b).

The implementation of the Primary Health Care Strategy was expected to be evolutionary and to build on existing strengths, so the “Minimum Requirements for Primary Health Organisations”, which were published in November 2001, do not give a lot of detail, but rather, “set the parameters within which DHBs and local groups will find their own best answers” (King 2001a). In April 2002, a “collection of helpful ideas, examples and tools” were published as “A Guide for Establishing Primary Health Organisations” (Ministry of Health 2002c). It was again noted, “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” (Ministry of Health 2002c). Establishment Service Specifications for Essential Primary Health Care Services provided by Primary Health Organisations came out in September 2002, shortly before the establishment of the first two PHOs, and the Enrolment Manual for Primary Health Organisations in December 2002 (Ministry of Health 2002a; Ministry of Health 2002b).

The first two PHOs were established in July 2002 (Te Kupenga o Hoturoa and Ta Pasefika, both in Counties Manukau District Health Board). There were 34 in existence at the end of June 2003. By April 2005, a further 45 had been formed, and two (Middlemore and Te Kupenga a Kahu) disestablished, for a total of 77, including complete coverage of the South Island.

This section of this report follows policy development and changes in the PHO environment from 2001 to April 2005.
**A2.2 Funding Policies**

In March 2002, Health Minister Annette King announced funding to implement the Primary Health Care Strategy. $410 million was allocated for the first three years of the Strategy: $50 million for the 2002/3 year, $165 million for 2003/4 and $195 million in 2004/5 (King 2002a). Top priority for the new funding were Primary Health Organisations covering high-need populations in order to allow them to have low fees for all their patients. The GMS subsidy for children under 6 years old was also to be adjusted for inflation since 1997. As more funding became available in subsequent years, low-cost access would be extended to other groups, beginning with school age children and followed by the elderly and others with high health needs (King 2002c). In an October 2002 letter to all general practitioners, Annette King recognised a concern that public funding had not kept pace with costs in the past, and promised, “The funding for PHOs will be regularly reviewed to keep pace with inflation” (King 2002b). Annual funding adjustments, in line with the consumer price index, have been made for PHOs in July 2003 and July 2004.

Further funding specifically for reducing inequalities was announced in March 2002. The Reducing Inequalities Contingency Funding “is intended to improve access and support innovative services to reduce inequalities and will be targeted exclusively to providers serving a population group with known poor health status and high unmet health need” (McGrath 2002). Additional criteria included delivering accessible services using a range of providers; working towards forming or being part of a PHO; and committing to low cost access for all enrolled patients (McGrath 2002). $2.8 million was available for the first two years of Reducing Inequalities funding, and $2.4 million for each subsequent year.
$3-$4 million spread over 2002/3–2004/5 was to be made available for PHO establishment. This was “to assist DHBs and providers with one-off costs for the establishment of viable PHOs”, with priority being given to PHOs serving high need populations (McGrath 2002).

Additional funding of $32 million over three years for primary health care in rural areas was announced in May 2002. There were two components: additional funding to support primary health care workers to stay in rural areas, and a ‘reasonable roster’ allowance (King 2002d). From July 2004, the funding was combined to form the rural primary healthcare premium, and the money devolved to PHOs (once agreement was reached with their District Health Board [DHB] on priority uses). DHBs would continue to make this funding available to rural providers who were not part of a PHO (LTK 2004). In October 2004, it was announced that there would be continued funding of $10.9 million annually for the rural primary healthcare premium (O'Connor 2004).

While waiting for details of new funding formulae for PHOs to be announced, doctors raised a number of concerns about proposals for two levels of funding. The New Zealand Medical Association issued a ‘Red Letter’ on 2 July, 2002 warning that the funding proposals “have the potential to seriously destabilise general practice, and to cause new and serious inequities in respect of New Zealanders’ access to general practice services” (Adams and Briscoe 2002). There were fears that patients would move to lower cost doctors, affecting the viability of other practices. It was also considered unfair that patients would receive different funding depending on where they lived rather than related to their individual need.

The Independent Practitioners’ Association Council (IPAC) therefore proposed an alternative funding model called the ‘priority patient formula’ which aimed to individually target patients with particular high health needs.
The new funding arrangements for PHOs were set out in an October 2002 paper (Ministry of Health 2002f). Two capitation-based funding formulae had been developed, taking into account the age, gender, ethnicity, deprivation and High User Health Card status of the enrolled population. The Access formula was initially available to PHOs, or practices within PHOs, serving ‘high need’ populations, which were generally defined as those with 50% or more of their enrolled population being Māori Pacific Island, and people living in decile 9 or 10 areas according to the New Zealand deprivation index. Northland, Tairawhiti and Lakes DHB areas were included for coverage by the Access formula, as were the parts of South Auckland and the East Coast that met the high need threshold (Ministry of Health 2002f). The Government intended that over 8-10 years, all PHOs would be funded at Access formula levels, but in the meanwhile, a second ‘Interim’ formula would apply. This formula included the use of Community Services Card status both for determining funding and for setting co-payments, and rates were based on existing GMS subsidies. Both the Access and Interim formulae include four funding streams: first contact services funding (the base capitation funding); services to improve access funding (to provide additional services for high need groups and reduce inequalities); health promotion funding; and management funding. Before receiving the services to improve access and health promotion funding, PHOs must submit proposals as to how the additional funding will be used, and have these approved by their DHB. Many new service initiatives have been reported; 24 are outlined in the recent publication, “A Difference in Communities: What’s Happening in Primary Health Organisations” (Ministry of Health 2005c).
Higher patient subsidies were available under the Access formula, with the expectation that this would be reflected in lower patient fees. General Practitioners were concerned early on that their fees would be fixed (Adams and Briscoe 2002), but the Minister of Health assured, “I will not fix doctors’ fees nor remove the right to set a fee” (King 2002b). After on-going discussion between IPAC and the Ministry of Health about fee levels and fee setting, it was announced in May 2003 that agreement on a fees framework had been reached. The framework “meets Government objectives to provide access to low or reduced cost visits to GPs, ensures a fair deal for GPs, and also allows local variations negotiated by District Health Boards and PHOs” (King 2002b).

While the Access/Interim funding formulae went ahead, discussion about the IPAC priority patient formula also continued, with its eventual development into the ‘Care Plus’ proposal. Doctors’ concerns about the effects of ‘pepper-potting’ of Access practices, and worries about possible restrictions on co-payments received ongoing media coverage through 2002-3 (eg, (Briscoe 2002; Stuart 2002; Kumar 2003c). In July 2003, the Royal New Zealand College of General Practitioners made a number of recommendations to the Minister of Health, the first of which was that “The sector needs to have a rapid, full roll out of primary health care funding to address: management, implementation and infrastructure costs; inequities in funding resulting in major boundary and viability issues for Primary Health Organisations and general practice; fragmentation of the Primary Health Care Sector” (Austin 2003). The Minister of Health responded by taking a paper to Cabinet and gaining approval to bring forward funding for those 65 and over in Interim PHOs from 2005/6 to July 2004 (King 2003a; King 2003b); additional funding for 6-18 year olds was already planned, and came into effect in October 2003. In addition, a maximum prescription fee of $3 was introduced in April 2004 covering all patients in Access PHOs and those aged 6-17 in Interim PHOs (extended to include over those 65 and over from July that year). This had originally been planned for October 2003, but was delayed to avoid coinciding with the introduction of stat dispensing, which also occurred on that date. The reduced prescription fee applies only to scripts from a patient’s usual practice within a PHO.
In July 2004, Annette King announced further increased funding for PHOs so that all could be funded at the Access formula rate from July 2007. This is earlier than the 8-10 years it was originally expected to take to achieve the aim of low cost primary health care for all New Zealanders. There is to be increased funding for 18-24 year olds from 1 July 2005; 45-64 year olds from 1 July 2006, and for the remaining group of 25-44 year olds from 1 July 2007 (King 2004c).

The level of management fees was of considerable concern to PHOs early on, in particular, for smaller PHOs (Perera, McDonald et al. 2003). In response to these concerns, there was a management fee restructure which took effect on 1 January 2004. For PHOs with over 75,000 enrolled persons, the rates did not change, but for smaller PHOs, there was a 50% increase in the management fee for the first 20,000 enrolled persons, with a 20% decrease in the rate for between 20,001 and 75,000 enrolments (Kumar 2003a). The Ministry of Health also announced it would commission an overall review of PHO management costs in early 2004; the ensuing report, “Review of Primary Health Organisation Management Services” (Capital Strategy Ltd 2004) released by the Ministry of Health in March 2005. The report found management services requirements were not well defined in the PHO contract, and financial information from PHOs as to the cost of providing those services was inconsistent and incomplete. However from the available data, it was found that larger PHOs (>75,000 enrollees) could generally deliver management services for $4-6 per enrolled person per annum; medium PHOs (20,000-75,000 enrollees) for $6-29; and small PHOs (<20,000 enrollees) for $7-38. “It was particularly apparent that the MSF [Management Services Fee] was inadequate for small PHOs, and also for the smaller medium sized PHOs, and that as a result a range of areas in the contract were not being adequately performed” (Capital Strategy Ltd 2004). Two options for changing the management services fee were offered, and it was suggested the Ministry of Health consider defining a minimum size for PHOs.
In response to the report, the Ministry noted, “the importance of small PHOs to the Primary Health Care Strategy and the community”, and that it did not prescribe a minimum (or maximum) size for PHOs (Ministry of Health 2005d). Additional funding of up to $3 million in 2005/6 was announced to support small PHOs. The Ministry was also to fund a feasibility study on establishing shared service arrangements for small PHOs (Ministry of Health 2005d).

PHOs raised a number of concerns about payment processes early on (Perera, McDonald et al. 2003). The number of enrolled patients a PHO has is critical to calculating its capitation funding entitlement. When a PHO is first formed, its aggregate register undergoes a ‘capitation information cleansing’ (CIC) process to correct data errors. Then when registers are submitted to HealthPAC quarterly for payment, the system checks for duplicate patients and assigns them to only one PHO according to a set of capitation based funding business rules (Ministry of Health 2004b; Ministry of Health 2004c). PHOs could thus experience significant changes to their register numbers, and consequently funding fluctuations. In addition, fee-for-service deductions are made when a patient makes a casual visit to another provider outside their PHO. These ‘clawbacks’ were another issue for PHOs, with concerns that casual deductions could exceed the capitation payment received for a patient.

In response to such concerns, two reviews of enrolment and payment processes were carried out in 2003. The first was commissioned by Counties Manukau DHB and carried out by HealthPAC Audit and Compliance (HealthPAC Audit & Compliance 2003). 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 of the four existing PHOs in Counties Manukau as at 1 January 2003. It also sought to establish whether the HealthPAC systems were working appropriately. It found the higher than expected duplicates could be attributed to three factors: Practice Management System software problems; practice interpretation of patient status (registered, enrolled, casual or regular); and lack of patient understanding about enrolment.
A number of recommendations were made concerning enrolment processes and the way PHO registers were submitted to HealthPAC. Subsequently a joint project between the Ministry of Health (including HealthPAC), Counties Manukau DHB and all Counties Manukau PHOs began 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)” (Ministry of Health/CMDHB/PHO Working Group 2003). The report, released in October 2003, made 33 recommendations, some for implementation in the Counties Manukau region only and some for national implementation. A number of the latter recommendations required further national consultation before being implemented, and this included submission to the recently-formed PHO Service Agreement Amendment Protocol Group. Following the report, the Ministry of Health announced a 12-month ‘funding floor’ initiative. This was to support Access-funded PHOs/practices which had experienced a reduction in income since becoming part of a PHO. In addition, the number of fee for service deductions that could be claimed against a practice was capped at three per month for any individual patient (Ministry of Health 2003d).

A July 2004 memorandum to Cabinet by the Minister of Health signalled her intent to increase funding for influenza vaccinations from $11 to $18 from 1 January 2005. This would bring it into line with the payment for childhood immunisations. The increase would be available to all primary providers, whether or not they were part of a PHO, but for those in PHOs at least, the subsidy would also be adjusted for inflation annually along with the rest of PHO funding (King 2004a).

A key aim of the Primary Health Care Strategy is to reduce barriers, including financial ones, to accessing services. A summary of five reports on GP fees (Ministry of Health 2004h) found fees charged by Access PHO practices were lower than those charged by Interim funded PHO practices. This was true even for those age groups for which Interim PHOs received the same level of capitation funding as Access PHOs. However most of the additional funding being received by Interim PHOs was being passed on to patients
through lower fees. The October 2003 funding increase for 6-17 year olds in Interim PHOs was increased to a rate based on $25 per expected consultation, and the February 2004 National GP Fee Survey (CBG Health Research Limited 2004b) showed fees for 6-17 year olds without Community Services Cards (CSC) were, on average, about $22 less than non-CSC adults, while the 6-17 year olds who were CSC holders paid on average almost $24.50 less than non-CSC adults. The 1 July 2004 increase in capitation funding for people aged 65 years and over was also being reflected in fee reductions, averaging $23.40 for non-CSC holders. The remaining patient co-payment averaged $24.65, although this varied between DHBs, with fees highest in the urban areas of Auckland and Wellington (Ministry of Health 2004j).

In response to these findings, the Ministry report noted that as further funding increases are rolled out in the future, “DHBs, supported by the Ministry, will continue to work with PHOs to achieve reductions in GP fees” (Ministry of Health 2004g). DHBs will also report to the Ministry of Health quarterly on any increased fees that have been notified by their PHOs. According to the Ministry of Health, the lower fees in Access practices “supports the Government’s decision to start implementing the Primary Health Care Strategy by making sure extra funding goes first to those PHOs who serve populations of people facing the greatest financial barriers to care” (Ministry of Health 2004t).

Concerns have continued to be raised by the public, DHBs, the Ministry of Health and the Minister that GP fees are too high, or they are not passing on the full increased subsidies to their patients eg (King 2005; Macdonald 2005; Smith 2005). Doctors and PHOs have responded by noting patients do not always understand the differences between Access and Interim funded practices, and that the latter cannot reduce all fees as much as Access practices can. Doctors also defend their right to review costs and income and adjust fees accordingly, and point to the fact that individual patient fees may be discounted eg (Kumar 2004; Kumar 2005; Wilson 2005).
In February 2005, Consumers’ Institute conducted a survey of 800 general practices’ fees, and found Interim practices were often charging more than Access practices for patient services attracting the same subsidy. Individual practice results were published on the Consumer website (www.consumer.org.nz). A number of doctors questioned the accuracy of the figures, and again noted they may discount patient fees rather than charge all patients the ‘blackboard’ fees quoted in the survey. At the time of writing, Consumer had withdrawn the individual practice fees which were being ‘updated’.

The October 2004 meeting of the PHO Service Agreement Amendment Protocol group was reported to have agreed that there is a need to review funding formulae rates. The sector expected this would be done within twelve months, once data is available about patient utilisation of services in the PHO environment (Ministry of Health 2004p).

### A2.3 Care Plus

The Care Plus project developed from a proposal by IPAC in 2002 to replace the planned Access and Interim funding formulae with a way of targeting individual priority patients (Ministry of Health 2004e). While the population funding model for PHOs went ahead, the Ministry of Health continued to work with IPAC on such a formula, which became known as Care Plus, for service delivery and funding that was targeted at a small group of high needs patients.

The 2003/4 Budget included $11.2 million for the Care Plus initiative, which was to be piloted that year and was originally intended to be rolled out for all PHOs in January 2004 (SH 2003c). There were a number of reported concerns as the trials were being developed: provider expectation that Care Plus patients would make up about 5% of their patients over and above their High Use Health Card (HUHC) holders, whereas the Ministry of Health included HUHC users in those who would be eligible for Care Plus, which was capped at 5%; and differences between the Ministry and General
Practitioners’ views on what the level of co-payments for Care Plus visits should be (Hill 2004a). There had also been some expectation that Care Plus would only be available to Interim practices, to recognise the lower level of funding they received compared to Access practices, but in fact all PHOs were to be eligible for Care Plus funding (Hill 2003f).

Care Plus was piloted from August 2003 in three PHOs and the pilots were independently evaluated by CBG Health Research Limited (CBG Health Research Limited 2003; CBG Health Research Limited 2004a). In addition, a Care Plus reference group was established in October 2003 with membership from PHOs, DHBNZ, RNZCGP, IPAs, First Health, Care Net and Health Care Aotearoa to advise on service specifications, the funding formula and the process for a national roll-out (Ministry of Health 2004e).

The start date for national implementation was delayed until July 2004; according to Dr Jim Primrose of the Ministry of Health, “It has become clear that allowing adequate time for the PHO to prepare for Care Plus is essential. ... In addition, the funding and specification of the service need to be revised in the light of these [pilot] experiences” (Anonymous 2004a). Six Ministry-led regional workshops were held during March 2004 to help PHOs and DHBs prepare for Care Plus. By 1 July, 43 out of the then 73 PHOs were being funded at some stage of Care Plus development (Ministry of Health 2004e), and by October 40 PHOs would be implementing the package, and a further 12 would be in the preparatory phase (Ministry of Health 2004p).

The aims of Care Plus are improved management of chronic conditions; reduced inequalities; improved teamwork within PHOs; and lower-cost services for high-need primary health users. The criteria for eligibility are set out in service specifications between DHBs and PHOs.
Care Plus services may be offered to an enrolled person who:

a) “Is assessed by a Practitioner who usually delivers their First Level Services as being expected to benefit from ‘intensive clinical management in primary health care’ (at least two hours of care from one or more members of the primary health care team) over the following six months; and either

b) Has two or more chronic health conditions ...; or

c) Has a terminal illness ...; or

d) Has had two acute medical or mental health related admissions in the past twelve months (excluding surgical admissions); or

e) Has had a total of six First Level Service and/or casual general practice consultations and/or emergency department visits within the last twelve months; or

f) Is on active review for elective health services.” (Ministry of Health 2004n).

The funding for Care Plus allows for 5% of a PHO population to be covered (including HUHC users) (Ministry of Health 2004e). Actual numbers are calculated quarterly from the PHO register, considering age, gender, ethnicity and deprivation categories (Ministry of Health 2004n). Depending on the make-up of a PHO’s population, it is therefore recognised that individual PHOs may have more or less than 5% of their enrolled population as Care Plus patients (Ministry of Health 2004d).

Payment rates are $211.75 (plus GST) per year for patients in Interim practices, and $199.51 (plus GST) per year for patients in Access practices (less the amount due for HUHC users), the difference recognising that Access practices already receive higher overall funding. Initially PHOs receive 50% of their full funding because of the expected higher costs of first Care Plus patient visits; once 50% of the expected total Care Plus patients are enrolled, funding increases to 65%, and so on until PHOs are receiving 100% of their funding entitlement. The increased payments to health providers for Care Plus patients are expected to be reflected “in low or reduced costs to patients and that those fees are fair to the Contracted Providers and reasonable for Care Plus Patients” (Ministry of Health 2004n).
A further $26 million was allocated in the 2004/5 Budget to fund Care Plus (GM 2004). Annette King also proposed reducing prescription costs for Care Plus patients to a maximum of $3 per item from 1 April 2005 at the latest so that some HUHC holders would not be disadvantaged if they moved to Care Plus (King 2004b).

There are plans to monitor, evaluate and review the implementation of Care Plus over its first year of implementation (between July 2004 and July 2005) (Ministry of Health 2004p).

**A2.4 Referred Services Management and Performance Indicators**

The Referred Services Management (RSM) project began in September 2003 as a joint project between the Ministry of Health and District Health Boards New Zealand (DHBNZ), building on earlier reports on referred services management produced in 2002 (Ministry of Health 2004q). The objectives were to provide a national formula for RSM (community-prescribed pharmaceuticals and laboratory services) for PHOs, and a 3-5 year transition plan to guide the sector’s movement towards managing referred services under the new framework (Ministry of Health 2004q). The rationale behind the project is the observation that there has been considerable variation between practitioners and populations around New Zealand with regard to their use of community pharmaceuticals and laboratory services, and that this does not appear to be related to patient need. The intent is that the RSM model will improve the quality of utilisation of referred services within the funds available (Ministry of Health 2004p).
In a second project, the Clinical Performance Indicator (CPI) Advisory Group was working to define and develop clinical performance indicators for PHOs. Performance indicators and performance payments are seen as a means of encouraging and rewarding improved RSM use in line with evidence-based guidelines; measuring and rewarding progress in reducing health inequalities by including a focus on high-need populations; and promoting the more equitable use of RSM resources (Ministry of Health 2004p).

In August 2002, the Ministry of Health convened a meeting of sector experts to discuss clinical quality indicators for PHOs (Ministry of Health 2002e). Subsequently the Ministry developed 15 indicators for further consultation, with an assurance that “the Ministry will work to ensure they don’t impose onerous data collection on PHOs” (Ministry of Health 2002e). Further feedback on 16 proposed indicators was then gained through a modified Delphi process, and another set of 14 indicators (9 clinical plus 5 administrative) was recommended (Delphi Group 2003). The indicators were seen as an interim set for use in the short/medium term, with the possibility of change as more information became available and as data collection and analysis capacity improved (Delphi Group 2003; Ministry of Health 2003a). It was also explicit that the set was to be considered a minimum requirement of PHOs, and that DHBs and PHOs would be able to add other indicators relevant to their situation (Delphi Group 2003). Further development and definition of the indicators was done by a CPI Advisory Group (Anonymous 2003; Expert Steering Group of the MoH/DHBNZ Referred Services Management Project 2004), and the final list of was expanded to include some laboratory and pharmaceutical indicators (Meylan 2004b).

In May 2004, the two projects (RSM and CPIs) were merged into the PHO Performance Management Project. “A Draft Operational Framework for PHO Performance Management” has been produced and a transition plan is being developed (Expert Steering Group of the MoH/DHBNZ Referred Services Management Project 2004).
Sector feedback on the project was sought in May 2004 through a ‘road show’ presentation in six centres aimed at DHB PHO managers and PHO management (Ministry of Health 2004p). The presentation included information on the framework; performance indicators (clinical, process and financial); targets, performance assessments and performance payments; and the transition process (Ministry of Health and District Health Boards New Zealand 2004). According to the Ministry of Health, “Realistic performance targets will be set and agreed between PHOs and DHBs. These will be sensitive to the different starting points of PHOs, and achievement of these targets will result in additional payments to the PHO” (Ministry of Health 2004p). The maximum performance payment will be $6 per enrolled person (Ministry of Health and District Health Boards New Zealand 2004), which the PHO can choose how to spend.

The model was to go to the PHO Services Agreement Amendment Protocol group as part of ongoing national PHO contract negotiations (Meylan 2004b). A RSM/CPI Advisory Group, with membership from PHOs, DHBs, the Ministry, PHARMAC and technical experts, was also to be formed, with the roles of supporting improvement in data quality, updating and reviewing indicators, informing on best practice, developing associated educational materials, and developing target-setting methodologies (Ministry of Health and District Health Boards New Zealand 2004).

Additional resources and funding for Referred Services Management are to be made available. The costs to PHOs (eg developing the mandatory referred services management plan, and undertaking review and feedback of practitioners’ referred services utilisation) are to be met from the PHO management fee, and this was to be considered in the management fee review (Expert Steering Group of the MoH/DHBNZ Referred Services Management Project 2004; Ministry of Health and District Health Boards New Zealand 2004).
Performance payments will come from Ministry primary health care funding, which may in later years be devolved to DHBs (Expert Steering Group of the MoH/DHBNZ Referred Services Management Project 2004). Both the Ministry and DHBs will be involved in measurement of PHO performance and data analysis (Expert Steering Group of the MoH/DHBNZ Referred Services Management Project 2004), and a national programme manager will be employed by DHBNZ (Meylan 2004a).

The move to implementing the performance framework was expected to occur gradually from the second half of 2004, with PHOs beginning when they met prerequisites. Indicators, targets and incentive payments would be available from January 2005, and it is hoped all PHOs will be working under the framework by January 2006 (Ministry of Health and District Health Boards New Zealand 2004).

A2.5 Contracts

The DHB-PHO contract was initially drafted by DHBs with Ministry of Health input. From early on, there were concerns expressed by the sector and calls for further negotiation (SH 2003a; SH 2003b; SH 2003d). One early version (version 15) was described by an IPAC spokesperson as “completely one-sided, allowing the DHBs to unilaterally introduce obligations and reporting requirements and other elements that PHOs cannot argue with” (SH 2003d). Version 16 (January 2003) included a clause on updating the agreement, in which both parties acknowledged “this Agreement is an interim standard PHO service agreement and is subject to development and negotiation between the Ministry of Health, DHBs and representatives of the primary health provider sector. We both acknowledge that this negotiation is expected to reach mutual agreement on a standard PHO service agreement” (the “Standard PHO Agreement”) (2003a; 2003b).
After further negotiations between the Ministry of Health and sector groups, version 16.1 came out in August 2003 (2003c) and was supported by IPAC, First Health and CareNet, though with reservations about continuing unresolved issues. They considered this contract contained a number of improvements, including new limitations on the obligations of general practices and PHOs, principles to guide the interpretation of the contract, and an agreed fees policy (Hill 2003b; Kumar 2003d).

A PHO Service Agreement Amendment Protocol group (PSAP) was established in August 2003 to continue contract negotiations between the sector and the Ministry. Its membership consists of representatives of PHOs, DHBs, the Ministry of Health and the PHO Māori reference group (Ministry of Health 2004u).

Three further variations to contract 16.1 have subsequently been produced (Ministry of Health 2003c; Ministry of Health 2004m; Ministry of Health 2004n).

- Variation 1 (December 2003) included rate increases for children aged 6-17 and for management fees. There are also amendments to enrolment policies and how duplicates are to be dealt with.
- Variation 2 (April 2004) includes the payment schedule for immunisation services, including the Group B Meningococcal Immunisation Programme, and PHO Coverage Quality Payments for that programme. There is also a schedule for Care Plus preparatory services.
- Variation 3 (July 2004) sets out capitation payment increases for those 65 and over and for other Consumer Price Index adjustments. Care Plus services are defined and their payment schedule is set out.

Version 17, a consolidation of the PHO service agreements for DHBs and PHOs became available in February 2005.
In August 2004, 18 PHOs had signed all three variations; six had not even signed the head agreement; and the remainder were on either variation one or two of contract version 16.1 (Hill 2003b). The Deputy Director-General of Health, Colin Feek, was reported to have sent a letter to DHBs giving a time line for them to have contracts signed as a prerequisite for receiving extra funding for programmes such as Care Plus and Referred Services Management (Hill 2003b).

In addition to the DHB-PHO contracts, a “back-to-back” contract between GPs and PHOs has been developed by NZMA and IPAC, setting out the different obligations of individual general practices, and of PHOs (NZMA and IPAC 2003).

A2.6 Publicity Campaign

Early in the development of PHOs, there was criticism of the lack of a Ministry of Health publicity campaign to inform the public of the changes (Hill 2003c; SH 2003e; Sheddan 2003). In particular, PHOs felt a public information campaign regarding enrolment was necessary, and should be carried out by the Ministry of Health as PHOs did not have the financial or staff resources for marketing PHOs to the public (Perera, McDonald et al. 2003).

The Ministry’s initial response was that it had published material for distribution in the areas where PHOs were established, but it did not want to raise public expectations in places where there were no PHOs, or only Interim-funded PHOs (Hill 2003e). However as the number of PHOs increased, a national publicity campaign was planned.
Market research was carried out in March-May 2004 (Wyllie 2004) which showed 44% of respondents were aware of PHOs (lower for Māori and Pacific respondents). Reduced fees/cheaper health care was the most mentioned benefit of PHOs, although it was still only mentioned by 19% of the 44% who were aware of PHOs (Wyllie 2004). There were low levels of advertising recall (5% unprompted, rising to 12% prompted), thought to be consistent with the low levels of advertising expenditure prior to the survey being carried out.

An advertising campaign began on national television in March 2004, and also involved billboard, cinema and local, ʻiwi and Pacific radio (Hill 2003d; Ministry of Health 2004p). The publicity included reference to an 0800 call centre number which had begun in January. Other national resources such as posters and leaflets continued to be developed by the Ministry and became available in more languages.

Successive quarterly publicity campaigns have coincided with the start dates of new PHOs, and also with the introduction of new policies such as reduced fees for those 65 and over enrolled in PHOs (Ministry of Health 2004p). A telephone survey of 750 New Zealanders carried out in September 2004 revealed 50% had seen or heard of advertising about PHOs in the last three months, and 73% were aware of PHOs, a 30% increase from the previous November (Ministry of Health 2004p).
A2.7 After Hours Services

Provision of and payment for after hours services has become an important issue in the PHO environment. The DHB-PHO contract requires PHOs to provide or arrange access to First Level Services on a 24-hour per day, 7 day a week basis for 52 weeks a year for all service users (2003c). After hours centres do not have an enrolled population with which to form a PHO, and are not eligible for funding to reduce patient fees. PHOs face the disincentive of ‘clawbacks’ if their patients use other service providers, and discouraging patients from doing this may also be affecting the financial viability of private after hours or accident and medical services.

While the Ministry of Health says capitation funding for PHOs is calculated to include all the services a patient accesses, General Practitioners say the funding is not sufficient to cover the costs of after hours services (Hill 2004b). One consequence may be increased charges for patients after hours. A second is that arrangements for after hours general practice services to be provided through hospital A&E departments, at least between midnight and 8am, have been happening in a number of centres, including Dunedin, Palmerston North and Wellington.

Key after hours issues were identified by a Ministry stocktake of DHBs, PHOs, national organisations and after hours service providers in August 2004 (Ministry of Health 2005a). In October 2004, the Ministry of Health announced a working party would be established to look at after-hours services (Ministry of Health 2004l).
The terms of reference state the purpose of the project is “to develop and recommend a national policy framework as it relates to after hours primary health care that:

- Provides clarity to practitioners, PHOs, DHBs and the Ministry of Health about their respective responsibilities for the provision of after hours primary health care; and
- Creates an environment that promotes locally developed solutions to the provision of services over night.” (Ministry of Health 2004a).

Three meetings of the working party had been held by March 2005, and a survey undertaken of different after hours service models around New Zealand (Ministry of Health 2005b). It expected to give a timeframe for reporting following its next meeting.

**A2.8 Mental Health**

In 2002, Janice Wilson, Deputy Director-General Mental Health Directorate, wrote, “Up until now there has been little policy emphasis on the development of mental health services in the primary sector. The Primary Health Care Strategy presents a significant opportunity to improve services to people experiencing mental illness ... In primary mental health, such opportunity lies in prevention and early intervention activities, workforce development and building effective linkages.” (Chiplin 2002).

In June 2003, the Ministry of Health announced it would be seeking input on developing primary mental health services guidelines for PHOs and DHBs which would, “assist in guiding and shaping PHO mental health initiatives, that encompass best practice and meet the needs of their enrolled population” (Ministry of Health 2003d). Consultation took place in late 2003, and the “Primary Health Organisations: Service development toolkit for mental health services in primary health care” was published in May 2004 (Ministry of Health 2004r). With the toolkit’s release came a “Request for Proposals (“RFP”) Mental Health Initiatives and Innovation in Primary Health Organisations” (Ministry of
Health 2004s), funding for which is part of the overall primary health care strategy funding stream. “The aim of this funding is to assist PHOs in:

- Developing activities to reduce the prevalence and impact of mental health problems on their enrolled population, specifically education, prevention, early intervention and treatment activities;
- Developing the skill mix of primary health care practitioners and their ability to effectively respond to the majority of mental health problems that can be managed in primary health settings;
- Building effective linkages with other providers of mental health care, including secondary services, so that the care of those with chronic and/or long-term mental health problems is effectively co-ordinated.” (Ministry of Health 2005e).

Twenty-one initiatives were approved by March 2005, although it was expected up to 36 would be approved by June. An evaluation of these projects is to be carried out between April 2005 and June 2007.

A2.9 The Role of Nurses

The Primary Health Care Strategy envisages an increased role for nurses; indeed, “Primary health care nursing will be crucial to the implementation of the Strategy” (King 2001b). The Strategy recommended, “The Ministry of Health will facilitate the development of a national approach to primary health care nursing that will address capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements.” Accordingly the Ministry established the Expert Advisory Group on Primary Health Care Nursing in June 2001. The group has prepared a report called “Investing in Health: Whakatohutia te Oranga Tangata: A framework for activating primary health care nursing in New Zealand” (Expert Advisory Group on Primary Health Care Nursing 2003), informed by a survey of the primary health care and community nursing workforce.
The report “provides advice and recommendations to the Ministry of Health, District Health Boards and primary health organisations on a framework for primary health care nursing in New Zealand in line with the Government’s Strategy”. The vision of the primary health care nursing framework is “To create the environment that enables nurses to provide integrated comprehensive nursing care to individuals and population groups in New Zealand primary health care settings, and that strengthens the primary health care team towards improving health for all”. There are five goals: “to align nursing practice with community needs; to develop innovative models of nursing practice; and to achieve governance, leadership, and education and career development for primary health care nurses”.

Other current work being done by the Primary Health Care Nursing Expert Advisory Group includes advising on each major work stream or project in the Ministry of Health which has relevance to primary health care, and collecting data to investigate the funding processes of PHOs with a view to determining the most effective manner of deploying nursing services within a PHO (College of Nurses Aotearoa NZ Inc.).

In June 2002, Annette King announced funding of $8.1 million over five years to support primary health care nursing (Hughes 2003). $7.1 million was for innovative models of primary health care nursing, which drew 139 proposals, 11 of which were eventually funded (Hughes 2003). These projects will be evaluated over three years, and are expected to provide new ways for nurses in their communities to work collaboratively to address and make a difference for specific health needs (Hughes 2003). The funding package also included money for postgraduate study scholarships for primary health care nurses, including rural nurse practitioners (Hughes 2003).

Despite the Primary Health Care Strategy’s intentions and the hopes of nurses to see expanded nursing roles, there are some concerns being expressed that this is not happening as much as it could. The website of the College of Nurses Aotearoa (NZ) Incorporated includes a ‘Position paper on current PHO development’ (Carreyer 2003). At that point in time (May 2003), “Around the country nurses are reporting that PHO
development is not generally supporting any real change in the structure and utilisation of nursing services”. Concern was expressed that employment relationships and funding arrangements were inhibiting greater nursing involvement. Four essential goals for primary health care nursing were stated: the establishment of Nurse Practitioner roles in primary health care services; positioning nursing to align with community need and directly deliver nursing services to the public; facilitating the direct transfer of new graduates into primary health care positions; and positive discrimination to develop nursing participation in primary health care management and governance (Carryer 2003). The College of Practice Nurses was also reported to have called for a separate nursing funding stream for PHOs because the anticipated expanded role for nurses was not occurring (St John 2003). More recently, the New Zealand Nurses Organisation has been encouraging the establishment of network groups around the country to bring together nurses working in primary health care (Anonymous 2004b). For example a Southland group had been seeking more representation on sector groups in its region, and had recently been invited to have representatives on Southland DHB’s Community and Public Health Advisory Committee and rural advisory committee. It was also aiming to become an advisory group for primary healthcare in Southland (Anonymous 2004b).

A2.10 Sector and Community Input

Concerns about PHO implementation problems led the Royal New Zealand College of General Practitioners to lobby the Minister and Ministry of Health in 2003 to form a PHO taskforce (Hill 2003a; Kumar 2003b). The “Primary Health Care Strategy and Primary Health Organisation Development Taskforce” was subsequently established, its purpose being, “to provide strategic advice to the Deputy Director-General (Clinical Services) to assist with implementation of the Primary Health Care Strategy and with the development of primary health organisations. The Taskforce will provide this advice in the context of the parameters of Government policy.” (Ministry of Health). The Taskforce met for the first time in February 2004 with membership including representatives of PHOs, DHBs, the Ministry, practitioner organisations, and Māori and Pacific interests.
A Community Council comprising of 12 community representatives on PHO Boards was being formed at the end of 2004 (Ministry of Health 2004p). The Council will “advise Deputy Director General (Clinical Services) Colin Feek on how to ensure communities have a say in the development of PHOs and the further implementation of the Primary Health Care Strategy” (Ministry of Health 2004p).

A2.11 Future Development of PHOs

In a July 2004 Cabinet paper (King 2004b), Annette King noted that establishing PHOs was not the end of implementing the Primary Health Care Strategy, and areas of future development of PHOs currently under discussion included:

- Encouraging teamwork in PHOs;
- Broadening the scope of PHO services;
- Ensuring participation by providers service high need populations;
- Developing PHO management and governance capability;
- Developing PHO infrastructure;
- Building on other initiatives (eg integrated care or chronic disease management initiatives piloted in the past, or already in place in different parts of the country).

Annette King was also reported that month as saying she would eventually like to see maternity care, dentists and pharmacists brought into PHOs, though this is not expected in the short term (SH 2004). The Minister’s opening speech at the March 2005 “Primary Focus 2” conference reiterated her desire to see a broader range of health professionals participating in PHOs (King 2005). Clearly PHOs may be expected to continue to evolve over the coming years.
Appendix 3  Evaluations and Research Relating to the Primary Health Care Strategy

Other evaluations with particular relevance to the Strategy which are currently underway include:

- Monitoring and evaluation of initiatives to increase access funded through the Reducing Inequalities Contingency Fund. These initiatives were in many ways the precursors of Services to Improve Access. The evaluation will be completed this calendar year;

- A qualitative study of the experience and attitudes of users of primary health care services. The data was gathered at an early stage of the implementation of the Strategy and will act as a benchmark for changes in attitudes to health services;

- Evaluating the implementation of Care Plus. The evaluation is in its second and final year;

- An evaluation of eleven primary health care nursing initiatives. These initiatives are specific nurse led projects. The evaluation is in its second year;

- Evaluation of initiatives to provide primary mental health care services, which will begin soon;

- Analysing data collected through the New Zealand Health Survey to establish the relationships between utilisation of primary health care and health status over time.

Each of these evaluations and research projects focus on specific elements of the Strategy. At a later period it is expected that each will provide insight and data for the others and the overall picture of the success of the Strategy. Further information is available from the Ministry of Health (www.moh.govt.nz).
Appendix 4  Quantitative Analyses

The analysis of the key informant interviews presented in this Report provides some understanding of the range of activities and experiences generated in the sector as a result of the Strategy. This information will be refined and quantified by a survey of PHOs and practices but certain important aspects of the implementation of the Strategy, particularly changes in the utilisation of primary care and in intermediate health outcomes, require quantitative analyses, using data from electronic databases. This quantitative strand of the evaluation is underway and is described in this Annexe.

A4.1 Analytical Plan

Our plan is to undertake a longitudinal analysis of the health care experiences of clients of PHOs. Data from before and after each PHO was founded will be compared; changes in utilisation and other measures of performance will be reported; and these changes will also be related to stages in the implementation of the Strategy.

It should, however, be noted that establishing causal relationships between policy changes and health system parameters is problematic. The Strategy itself includes many components and these have received different emphases in different parts of the country. In addition, the current policy environment remains very fluid, and further changes in funding and policies are likely in the timeframe during which this evaluation takes place. Further, a wide range of primary health care initiatives were being implemented by providers and provider organisations prior to the initiation of the Strategy. For example, some IPAs had accumulated significant funds from savings made on budgets for referred services (pharmaceuticals and laboratory tests), which were used to subsidise (or develop) specific additional primary care services.
The introduction of general practitioner accreditation requirements and an increased emphasis on quality throughout the sector have also been a feature of recent changes in primary care independent of the Strategy. The data reported on here may well incorporate outcomes from earlier phases of reform; these will be difficult to distinguish from changes which do result from the Strategy.

Care needs to be taken to understand the context in which data are collected and to link qualitative and quantitative data sources to provide an overall assessment of the impact of the Strategy. At this stage we have not been able to control for such factors; however, later phases of this research will attempt to undertake micro-analyses to isolate the effect of different inputs.

Our original research design was to regard the myriad different components of the Strategy as comprising a single ‘intervention’ delivered by PHOs. A range of practices that did not belong to PHOs were to have been taken as a control group against which this impact was to have been assessed. However the establishment of PHOs has proceeded at a rapid pace, and, at the time of data collection (October 2004) 3.7 million (90%) of the population were enrolled in a PHO. As a result any control group would have been a very significantly biased sample and features other than membership of a PHO would have been likely to have determined the results of the comparison.
Quantitative Research Questions

The research themes, relevant to this quantitative research, set out in the Research Plan, are as follows:

- How the PHCS has increased access, and reduced inequalities in access, to services? (#14);
- What has been the impact of the PHCS on health status and in reducing health inequalities? (#15);
- What has been the impact of the implementation of the PHCS on injury care provision? (#16);
- What changes have there been in the quality of primary care services (including use of drugs, laboratory tests and referrals)? (#17).

From these themes, the following research questions have been developed:

- How have fees changed over time? (#14);
- How has utilisation of primary health care services change over time? (includes GP and nursing services, ACC claims and injury services) (#14);
- What has been the impact on rates of injury care provision? (#16);
- Have admission rates for ambulatory care sensitive conditions changed (intermediate outcomes)? (#15);
- Has quality of care being delivered changed? (#17).
A4.2 Data Sources

A. National datasets
   1. PHO registers

Every PHO submits registers of patients to HealthPAC every quarter for the purpose of determining the capitation payment they should receive. The registers provide a record of the PHO with which a person is registered and the date of registration. If a person is registered with two PHOs, the most recent registration is used to allocate the individual to a PHO. The date of the last visit is also recorded.

The payment also depends on the applicable practice funding formula (‘Access’ or ‘Interim’) and the demographic profile of the registered population. Deductions are made when a registered person has consulted another service provider.

The data from PHO registers allows us to allocate any individual a “start date”, when they formally entered a PHO. After discussion, we decided to use the first date a person enrolled with a PHO to determine the type of the PHO that would be associated with this person in future analyses. Of course, a person may change PHO. The Health Services Research Centre and the Ministry of Health are conducting a project analysing ‘patient continuity’ by estimating the number of people who change PHOs. Preliminary data indicate that 15.7% of the population appeared on the registers of two or more PHOs between April 2003 and March 2004 (personal communication, J Foley). For a proportion of these people, the funding they are then accessing may change also; however, maintaining a history of each individual’s PHO affiliations is not a viable computational procedure when analysing data for 3.7 million patients.

In summary, the registers provide an individual’s date of registration and the type of PHO. The PHO register data also enables us to describe the age, gender, ethnicity and NZDep quintile of residence of registered populations.
2. National Minimum Data Set (NMDS)

The NMDS records information on all hospital discharges in New Zealand. From these ICD9/10 diagnostic codes will be abstracted to establish a discharge diagnosis. This will be used to establish whether the discharge was “ambulatory sensitive” or whether asthma or diabetes was involved.

The hospital discharge data, linked to first date of registration with a PHO, will generate a table giving discharge rates before and after joining a PHO, by PHO type and population age, gender, ethnicity and NZDep01 Quintile.

It should be noted that the linkage of registered patient and NMDS data depends on use of an encrypted version of the National Health Index (NHI). Thus, all data are reported anonymously to the researchers.

3. PHO Utilisation Data

As the Strategy is implemented, a number of other reports are being required from PHOs. The first of these is a utilisation upload, the first of which was due on 1 October 2004. This describes the number of consultations made by patients of different demographic groups, and whether the consultation was with a nurse or a doctor. Over time these will become a valuable monitoring tool, but as of writing this data set is incomplete.

4. Clinical Performance Indicators

A further source of data that will be available at a national level is a set of clinical performance indicators including measures of laboratory test utilisation and prescribing, and a selection of specific measures of clinical performance, such as immunisation rates and rates of recording of clinical data. These are currently under development and testing; when the infrastructure for reporting these is established, we will incorporate these indicators into the evaluation.
Table A4.1
Use of Administrative Data Sets for Assessing the Impact of the Strategy

<table>
<thead>
<tr>
<th>Theme 14*</th>
<th>How has access changed for different population groups?</th>
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<tbody>
<tr>
<td>• Practice registers (from all PHOs) used to examine change in profile of enrolled populations over 3 years of study, including by ethnicity and NZDep score</td>
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<tr>
<td>• Practice utilisation rates used to assess increased or decreased use by patient group, especially changes for groups with low levels of service at present</td>
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<tr>
<td>• Gathering of fee schedules from PHOs and PCOs if agreed</td>
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<th>Theme 15</th>
<th>How have health status outcomes changed over research period?</th>
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<tr>
<td>• Number of admissions as a function of enrolment, for asthma, diabetes, pneumonia, skin infection, and other ambulatory care sensitive conditions, by age, gender, ethnicity</td>
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<tr>
<th>Theme 16</th>
<th>What has been the impact on injury care provision?</th>
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<tr>
<td>• Relative frequency of ACC claims by patient category, variation across providers and association with funding mechanism and co-payments</td>
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<tr>
<td>• Changes in incidence of new claims and service frequency per claim</td>
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<tr>
<td>• Gathering of fee schedules including ACC co-payments from PHOs and PCOs if agreed by that organization</td>
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<tr>
<th>Theme 17</th>
<th>Has the quality of care being delivered changed?</th>
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<tr>
<td>• Calculate Ministry of Health quality of care indicators whenever possible (eg, childhood and &gt;65 flu immunisation rates, diabetes mellitus detection rates, prescribing indicators, appropriate treatment of microalbuminuria in diabetes mellitus, cervical screening %, breast screening, smoking rates, ambulatory sensitive hospitalisations)</td>
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<tr>
<td>• Use prescribing and lab claims data to calculate data quality score</td>
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<tr>
<td>• Chronic disease d/c rates by PHO over time (should decrease or trend lower than pooled data), using NHIs from PHO register, tracked via NMDS.</td>
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</table>

*Research Theme reference as set out on page 18 above.
B. Practice Level Data Sets

The second source of data is the Practice Management Systems (PMS) of each practice. The motivation for using this data is to examine questions that cannot be investigated using national data sources. Software has been developed to interrogate all common PMS systems; the following data is requested from participating practices:

- Demographic data (age, gender, ethnicity);
- The date of any consultations since 1/1/2000;
- The role (doctor / nurse) of the person seen;
- The funding source for the consultation;
- The level of any co-payments charged.

To undertake an analysis of the features of patients who can generate fee-for-service deductions for a practice, the NHI was also collected when available. The data was supplied to NZHIS for encryption and the anonymised dataset returned to the researchers.

A4.3 Specific Analyses

The following analyses will be undertaken when the data are available:

**Register and NMDS data**

Rates of admission for ambulatory sensitive conditions, diabetes and asthma:

- By age, gender, ethnicity and NZDep of residence;
- By time and PHO characteristics.

**PHO Utilisation data**

Utilisation data:

- By age, gender, ethnicity and NZDep of residence;
- By time and PHO characteristics.

**Clinical Performance Indicators**

Quality measures by time and PHO characteristics.
Practice Level Data Sets

Average GMS co-payment  2000 to 2004/05 by quarter
  • By age group and by PHO affiliation (Access, Interim and none)

Average ACC co-payment  2000 to 2004/05 by quarter
  • By age group and by PHO affiliation (Access, Interim and none)

Consultation rate by PHO affiliation (Access, Interim and none)
  • For second year before, first year before and since joining PHO

Per cent of encounters with nurse by PHO affiliation (Access, Interim and none)
  • For second year before, first year before and since joining PHO

Per cent of claims which are from ACC by month relative to joining PHO.
References


Lohr, K. N., R. H. Brook, et al. (1986). "Use of medical care in the RAND Health Insurance Experiment: Diagnosis- and service-specific analyses in a randomized controlled trial." Medical Care 24(Supplement): S1-S87.


