Evaluation of the
Primary Health Care Strategy
(for the period 2003-2010):
Final Report

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Jacqueline Cumming

September 2013
<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
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<tr>
<td>ALAC</td>
<td>Alcohol Advisory Council of New Zealand (subsumed by the Health Promotion Agency from 1 July, 2012)</td>
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<td>ASH</td>
<td>Ambulatory Sensitive Hospital Admissions</td>
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<td>CE</td>
<td>Community Education</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<td>CNE</td>
<td>Continuing Nursing Education</td>
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<td>CPI</td>
<td>Consumer Price Index</td>
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<td>CSC</td>
<td>Community Services Card</td>
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<td>DHB</td>
<td>District Health Board</td>
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<td>GMP</td>
<td>General Medical Practices</td>
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<td>GMS</td>
<td>General Medical Services - general medical services provided to service users (does not refer to specific funding stream)</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HE</td>
<td>Health Education</td>
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<td>HNE</td>
<td>Health Needs Analysis</td>
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<td>HP</td>
<td>Health Promotion</td>
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<td>HPV</td>
<td>Human papillomavirus (immunisation programme)</td>
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<td>HUHC</td>
<td>High Use Health Card</td>
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<td>IPA</td>
<td>Independent Practitioner Associations</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MSD</td>
<td>Ministry of Social Development</td>
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<tr>
<td>MSO</td>
<td>Management Services Organisation</td>
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<td>NA</td>
<td>Needs Analysis</td>
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<td>NGO</td>
<td>Non-government Organisation</td>
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<td>NI</td>
<td>Nursing Innovations funding</td>
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<td>NZDep</td>
<td>New Zealand Deprivation Index 2001</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PHCN</td>
<td>Primary Health Care Nurse</td>
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<td>PHCS</td>
<td>Primary Health Care Strategy</td>
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<td>PHN</td>
<td>Primary Health Nurse</td>
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<td>PHO</td>
<td>Primary Health Organisation</td>
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<td>PMS</td>
<td>Patient Management System</td>
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<td>RICF</td>
<td>Reducing Inequalities Contingency Funding</td>
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<td>SIA</td>
<td>Services to Improve Access</td>
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<tr>
<td>Strategy</td>
<td>Primary Health Care Strategy</td>
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<tr>
<td>VLCA</td>
<td>Very Low Cost Access (payment scheme)</td>
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<td>WINZ</td>
<td>Work and Income</td>
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EXECUTIVE SUMMARY

This report sets out the key findings from the Evaluation of the Primary Health Care Strategy (PHCS) undertaken between 2003 and 2010 by the Health Services Research Centre, Victoria University of Wellington and CBG Health Research Limited of Auckland.

The Evaluation was designed to examine the implementation and the impact of the PHCS. The report is based on three phases of evaluative activity from 2003 to 2010, involving key informant interviews, surveys and statistical analyses of fees and consultation data. Our key findings are summarised below.

Throughout the evaluation, we have found strong support expressed for the PHCS and its aims and objectives. Significant progress has been made in implementing the Strategy, facilitated by the provision of significant new funding to support primary health care (PHC) in New Zealand.

Implementation of the Strategy has created a strong organisational framework for PHC in New Zealand. This framework centres upon Primary Health Organisations (PHOs) with which the great majority of the population is enrolled and to which most general practices belong. There is, however, significant variation between PHOs in terms of size, governance and management arrangements and roles and responsibilities. Key roles and responsibilities need to be clearly allocated to PHOs and their structures reviewed to ensure they can fulfil these functions appropriately.

District Health Boards, PHOs, and practices are in the process of actualising many of the goals of the Strategy, including:

- Inclusion of community input into the organisation of PHC
- Provision of a wide range of new services, many provided free of charge to patients with emphasis placed on improving access to services for higher needs populations
- Outreach to the community, via mobile clinics, nurse visiting and community health workers
- An increased role for nurses and improved teamwork
- Co-ordination of primary and secondary health services
- Co-operation with other community services provided by Non-government Organisations (NGOs).
Consultation rates initially increased for most population groups, but there was a drop-off in consultation rates in 2006/07. Consultation rates overall over the entire study period rose for those aged 18 and over, especially amongst the elderly. When the data are broken down by population group, consultation rates were seen to increase over the full study period for those with CSCs in Interim practices and older adults (45+) in Access practices, for Māori (especially those aged 45 and over) and for Asian groups (especially those aged 18-25 and 45+). Worryingly, consultation rates had fallen for Pacific peoples.

Access-funded practices serving vulnerable populations provide care at low cost to enrolled patients and generally meet government targets with respect to fees charged; consultation rates have increased in particular for adults (aged 18 and over) but remain below consultation rates in Interim practices. Access-funded practices appear to have some difficulty attracting and retaining clinical staff.

Interim-funded practices provide care to the majority of the population but despite a drop at the time of increased subsidy, patient charges have risen progressively, while consultation rates have only increased for those with Community Services Cards (CSCs).

There is a concern for people who are not enrolled (or, having moved, are enrolled elsewhere), who face higher costs. People who are time consuming to care for may not easily be able to enrol.

Co-operation and co-ordination of activities between practices and other services have been found to be both variable and tentative, and this is an area where further work is required to improve delivery of services.

There are a number of issues on which decisions need to be made as the PHC sector looks to the future; these relate primarily to funding and role definition and include the following issues.

Given budget constraints, there is a tension between providing universal subsidisation of PHC and high level subsidisation of health care for needy populations. Evidence of lower consultation rates at Access practices; a fall in rates for Pacific people over time; increased consultation rates for those with CSCs at Interim practices (for whom the increase in subsidy has been small); and no consistent increase in rates of consultation for those without CSCs at Interim practices (at the time when the relevant subsidy was increased) suggest that new funding might best be targeted towards needy populations in the first instance in order to improve access to and use of PHC services.

Throughout the health care system there is uncertainty about the correct location of a variety of functions (needs analysis, planning and funding, workforce development) which creates conflict and waste. This should be resolved by assigning task to specific organisations.
In particular, it is uncertain whether PHOs should be seen as networks of providers or whether they should be independent planners, funders and purchasers of community-based services. This issue should be resolved and, if the latter role is chosen, current governance and management structures will need to be reviewed to ensure they provide sufficiently for an independent purchasing function.

If PHOs are to fulfil their potential as planners and funders of community care, they need to have oversight of all community-based health care services including services presently provided by DHBs and services provided by health care professionals not initially covered by the Strategy. Work is well underway to devolve DHB services to PHOs; evaluations of the implementation issues that arise and the cost-effectiveness of devolved service delivery are essential to increasing our understanding of the performance of this aspect of the New Zealand health system.

Accountability and monitoring arrangements have been reported to have imposed a significant burden on providers and PHOs, arising from the separation of funding into different pools with their own accountability requirements. There is a need to simplify these arrangements and ensure that progress towards achieving key outcomes is assessed appropriately.

Co-operation and co-ordination of activities between practices and other services need to be improved. There are a number of ways in which this might occur – for example, through co-location of services, sharing of information, and improved collaboration in working with individual patients through to full integration of funding and service delivery through integrated providers. Clarity is required about the aims and objectives of moves to better integrate services and evaluations of the implementation issues and cost-effectiveness of different approaches will be important to increase our understanding of the advantages and disadvantages of different approaches.

There appears to be a shortage of clinical staff particularly in rural and high health need areas. There needs to be an overall plan to train, recruit and retain clinicians, and to ensure that their distribution matches need. Work is already well underway on this issue.
1 INTRODUCTION

In 2001, New Zealand’s Labour-led coalition government introduced a Primary Health Care Strategy (the Strategy), aimed at improving the health of New Zealanders and reducing inequalities in health (King 2001). The Strategy identified six key directions for Primary Health Care (PHC) in New Zealand: that PHC services: work with local communities and enrolled populations; identify and remove health inequalities; offer access to comprehensive services to improve, maintain and restore people’s health; co-ordinate care across service areas; develop the PHC workforce; and continuously improve quality using good information (King 2001).

The government introduced three major changes through the Strategy. First, it provided a significant increase in funding to support PHC, with the aims of reducing the charges that patients pay for services, extending eligibility for government funding of PHC to the entire population, and expanding the services provided. Second, the government mandated the development of primary health organisations (PHOs) as local non-governmental organisations to serve the PHC needs of their enrolled patients. Third, the Strategy changed the method of allocating the public share of PHC funding from fee-for-service subsidies at the practitioner level to (largely) capitation funding of PHOs.

In 2003, the Health Research Council of New Zealand, the Ministry of Health (the Ministry) and the Accident Compensation Corporation (ACC) provided funding for an evaluation of the implementation of the Strategy. A group of researchers from around New Zealand, led by the Health Services Research Centre of Victoria University and CBG Health Research Limited, has been engaged in this work since then. The Evaluation was designed to examine implementation and the impact of the PHCS as it was rolled out since 2002. The evaluation has involved three major phases between 2003 and 2010, and a mix of methods – including key informant interviews and surveys with key stakeholders and statistical analysis of data from a sample of New Zealand general practices.

This report provides an overview of the findings of the evaluation as a whole. Section 2 briefly sets out the key components of the Strategy, while Section 3 summarises the evaluation design and methods. Section 4 reports our main findings, while Section 5 provides the overall conclusions of the evaluation. The report is supported by a series of Appendices that summarise findings from the various components of the three phases of the evaluation.
2 THE PRIMARY HEALTH CARE STRATEGY

In February 2001, the New Zealand government published the Primary Health Care Strategy (PHCS), aimed at significantly bolstering the delivery of PHC services in New Zealand, in order to improve overall health and reduce inequalities in health.

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

The key priorities set out in the Strategy included:

- Reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health, and to improve access to first-contact services
- Supporting the development of Primary Health Organisations that work with enrolled populations
- Encouraging developments that emphasise multi-disciplinary approaches to services and decision-making
- Supporting the development of services by Māori and Pacific providers
- Facilitating a smooth transition to widespread enrolment of Primary Health organisations through a public information and education campaign to explain enrolment and promote its benefits for communities.

The Strategy began to be implemented in 2002 and involved three major changes: significant increases in funding, in order to reduce the fees that patients pay when they use primary health care services as well as to extend the range of services provided by primary health care providers; the development of Primary Health Organisations (PHOs) as local non-governmental organisations which serve the needs of an enrolled population; and a shift towards capitation funding for PHOs, in order that funding be allocated according to the needs of the populations being served by PHOs. Each of the three changes is discussed in more detail in the paragraphs that follow.

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

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

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

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

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

\(^1\) DHBs are purchasers and providers of health and disability support services, with responsibility for overseeing the health and independence of their geographically-based populations. The twenty-one DHBs are governed by majority-elected boards and have annual agreements with the Minister of Health which govern their activities.
The PHCS signals a move away from a targeted approach where the government only provides funding to support PHC for some New Zealanders to a universal approach where all New Zealanders are eligible for funding for primary health care. Prior to the introduction of the PHCS, the New Zealand government partially subsidised (funded) access to PHC, with different subsidy rates available for different population groups. Access to subsidised care was provided for all children under six years of age, with subsidy rates ($32.50 per visit in 2002) expected to mostly cover the cost of services provided to children, with patients generally expected not to have to pay a patient charge for child visits. For young people aged 6-17, and for adults, subsidised care was available to those families with community services cards (CSCs), a subsidy card available to those on lower incomes, and to those with a high user health card (HUHC), available for people who had an on-going health condition, and who had visited the GP 12 or more times in the previous 12 months. For young people, subsidies of $15 and $20 were available respectively for those without and with subsidy cards; for adults, subsidies of $15 per visit were available for those with cards. In most cases, people with CSCs and HUHCs also paid a fee to the primary health care provider. Adults without a subsidy card paid the full cost of primary health care themselves.

To ensure that new funding set aside for the PHCS went to those most in need, the government chose, at first, to create two forms of funding – known as Access and Interim funding. Access PHOs generally served higher needs population, and were defined as those PHOs where the PHO has more than 50% of its enrolled population as Māori, Pacific, or people from lower socio-economic areas. All other PHOs were Interim PHOs. At first, Access PHOs were funded at higher capitation rates than Interim PHOs. The first Access PHOs were established from July 2002. Since 2003, the government has provided further funding, increasing the capitation payment rates to Interim PHOs to the rates paid for those in Access PHOs, for particular groups in the population. New funding was provided to Interim PHOs for those aged 6-17 years of age (from 1 October 2003), those aged 65 and over (from 1 July 2004), those aged 18-24 (from 1 July 2005), those aged 45-64 (from 1 July 2006), and those aged 25-44 (from 1 July 2007).

Both types of PHOs were also eligible for other new funding, for services to improve access (SIA), management, and health promotion. In addition, all those eligible for the new, higher subsidy levels also became eligible for cheaper pharmaceutical services – with part charges for fully subsidised items falling to $3 per prescription item.

As Access funding was rolled out to PHOs, the government noted that it expected that increased capitation payments should be reflected in low or reduced costs to patients (King 2003). In practice, this policy was implemented through discussions between Ministry of Health officials, DHB staff and PHO staff. These discussions focused on usual fees within specific communities, as well as a view that a ‘low’ fee is generally a zero fee for those aged six years and under; $7-$10 for those aged 6-17; and $15-$20 for adults.
New roll outs of funding for Interim PHOs occurred in October 2003 for those aged 6-17 years of age; in July 2004 for those aged 65 and over; July 2005 for those aged 18-24, July 2006 for those aged 45-64 and July 2007 for those aged 25-44. For the roll out of new funding for those aged 6-17 years of age, there was a signalled desire for fees to be reduced in line with the increase in subsidies. More detailed templates were developed relating to the roll out of funding for those aged 65 years and over in July 2004, where it was expected that PHOs would reduce their charges for those people without subsidy cards by $25 and by $10 for those with subsidy cards (plus $1 adjustments to maintain the value of the subsidies against inflation). It was also noted that there should no longer be a differentiation between fees for those with and without cards. Further guidelines were developed for the roll outs from 1 July 2005 onwards (detailed in Raymont, Cumming and Gribben, 2010).

In October 2006, a further change was made to the funding levels for PHOs, with all those PHOs offering very low fees becoming eligible for even higher levels of subsidies under the Very Low Cost Access (VLCA) payments scheme. At October 2006, this required zero fees for children under 6 years; $10 maximum for children 6-17 years and $15 maximum for all adults 18 years and over. Initial allocations were not adequate to achieve this, and additional funding was provided to these Very Low Cost Access practices from July 2007 with the aim of keeping child visits free, visits for those aged 6-17 at no more than $10.50, and adult fees at a maximum of $15.50 (Ministry of Health 2007).

Further changes in funding were implemented from January 2008, when capitation payments for visits for children were increased by $6 to $45.70 where PHOs and practices do not charge patients for child visits.

A number of other funding sources were also made available for PHC in New Zealand. In response to concerns that some New Zealanders with high needs not in Access PHOs might continue to miss out on higher subsidies while the new funding was rolled out, a separate funding arrangement (Care Plus) was established for those with chronic illnesses. Care Plus is targeted towards individuals who need to visit their GP or family nurse often, because of significant chronic illnesses or a terminal illness. Additional funding is also available to support rural practice, and the government has also introduced a performance management programme and funding to support clinical governance and continuous quality improvement in PHC in New Zealand. Some PHOs have also had access to Reducing Inequalities Contingency Funding (RICF), as well as to funding to promote innovations in nursing services and in primary mental health care services\(^2\). (Ministry of Health 2007)

\(^2\) For detailed information on each funding source see www.moh.govt.nz/primaryhealthcare
Overall, the government committed an additional $2.2 billion over seven years from 2002/03 for implementation of the Strategy. This is a significant injection of funding for PHC, providing, by 2008, around $300 million additional new funding per annum on top of an annual spend on general practitioner services of about $337 million in 2002/03. (Ministry of Health 2004a)

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

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3 For details on the capitation rates see www.moh.govt.nz/primaryhealthcare
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<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2002</td>
<td>First Access PHOs established</td>
</tr>
<tr>
<td>October 2003</td>
<td>Enrollees in Interim PHOs aged between 6 and 17 years became eligible for subsidies to lower the cost of doctors’ visits</td>
</tr>
<tr>
<td>1 April 2004</td>
<td>Funding for low cost pharmaceuticals for enrollees in Access-funded PHOs, and 6-17 year olds enrolled in Interim-funded PHOs (maximum charge of $3 per item on subsidised pharmaceuticals)</td>
</tr>
<tr>
<td>1 July 2004</td>
<td>Funding to lower the cost of doctors’ visits and pharmaceutical charges for people aged 65 years and over enrolled in Interim-funded PHOs</td>
</tr>
<tr>
<td>1 July 2005</td>
<td>Funding to lower the cost of doctors’ visits and pharmaceutical charges for people aged 18-24 years enrolled in Interim-funded PHOs</td>
</tr>
<tr>
<td>1 July 2006</td>
<td>Funding to lower the cost of doctors’ visits and pharmaceutical charges for people aged 45-64 years enrolled in Interim-funded PHOs</td>
</tr>
<tr>
<td>1 July 2007</td>
<td>Funding to lower the cost of doctors’ visits and pharmaceutical charges for people aged 25-44 years enrolled in Interim funded PHOs</td>
</tr>
</tbody>
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3 EVALUATION OBJECTIVES AND METHODS

The main objectives of the Evaluation were:

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

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

- To disseminate the results of the Evaluation to government agencies, DHBs, PHOs, and other primary care organisations.

The evaluation proceeded in three main phases. The first phase focused on identifying key issues in implementing the Strategy, and was based on key informant interviews with a wide range of national key stakeholders, PHO Board members and staff, and GPs and practice nurses working in general practices. The second phase involved a statistical analysis of data from a sample of general practices, in order to identify changes over time in the fees patients pay when they use services, and changes in consultation rates; further key informant interviews with a wide range of stakeholders focusing on progress with key aspects of the Strategy; a survey of PHO Board managers, PHO managers and Management Services Organisation (MSO) managers; and a survey of general practice managers, GPs and practice nurses. The third phase involved structured interviews with PHO managers; interviews with DHB PHC managers, PHO staff and practice staff involved with PHOs; further statistical analyses of fees and consultation data from general practices; and a brief survey with practice managers.
Table 3.1. Evaluation of the Primary Health Care Strategy - Publications

<table>
<thead>
<tr>
<th>Phase / Focus/Data source</th>
<th>Methodology</th>
<th>Date</th>
<th>Reference/Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early implementation / Selected PHOs</td>
<td>Interviews/ survey</td>
<td>Mid 2002</td>
<td>(Perera, McDonald et al. 2003)</td>
</tr>
<tr>
<td>I: Implementation / Selected PHOs, Practices, Others</td>
<td>Interviews</td>
<td>Mid 2004</td>
<td>(Cumming, Raymont et al. 2005)</td>
</tr>
<tr>
<td>II. Fees and consultation rates / Sample of practices</td>
<td>Electronic download</td>
<td>2001-2005</td>
<td>(Cumming and Gribben 2007)</td>
</tr>
<tr>
<td>II. Primary Health Care Nursing / Practice nurses and informants</td>
<td>Interviews/ Survey</td>
<td>2006-2007</td>
<td>(Finlayson, Sheridan et al. 2008)</td>
</tr>
<tr>
<td>II. Practice and GP experience / Practices and GPs</td>
<td>Interviews/ Survey</td>
<td>2006-2007</td>
<td>(Raymont and Cumming 2009)</td>
</tr>
<tr>
<td>III. PHO experiences / PHO managers</td>
<td>CATI Interviews</td>
<td>2008</td>
<td>(Smith and Cumming 2009)</td>
</tr>
<tr>
<td>III. Fees and consultation rates / Random sample of practices</td>
<td>Electronic download</td>
<td>2001-2007</td>
<td>(Raymont, Cumming et al. 2010)</td>
</tr>
<tr>
<td>III. DHB experiences / DHB primary care managers</td>
<td>Interviews</td>
<td>2008</td>
<td>This Report – Appendix 1</td>
</tr>
<tr>
<td>III. Practice experiences/ Sample of Practices</td>
<td>Survey</td>
<td>2009</td>
<td>This Report – Appendix 2</td>
</tr>
<tr>
<td>III. PHO, Practice and GP experiences / Selected PHO/practices (Managers/GPs)</td>
<td>Interviews</td>
<td>2009</td>
<td>This Report – Appendices 3,4,5</td>
</tr>
</tbody>
</table>

Note: A summary of reports from Phase III which have not been published separately are presented as Appendices 1-5 of this Report. A summary of reports from Phases I and II are presented in Appendix 6.

**Ethics Approval**

The Multi Region Ethics Committee gave formal ethics approval for the study, including the collection of identifiable information (NHI, ARC45), on 25 April 2005. A memorandum of understanding was signed between the researchers and each participating practice, describing data collection and analysis procedures.
Limitations

In considering the implementation and effects of the Strategy in New Zealand, it is important to note several limitations with this evaluation. First, the evaluation did not include research with people using PHC services and hence their views on the Strategy and how it has changed service delivery are not able to be included in this report. Second, the evaluation reports on the structures that have developed, issues around the funding provided and implementation, changes in fees paid by service users and consultation rates and challenges and future directions, but it has not been able to include analysis of the impact of the Strategy on the length or content of consultations, hospital service utilisation nor on intermediate nor final health outcomes. Additional research on these issues is required to provide an assessment of the full impact of the Strategy and hence to establish whether the Strategy has provided value-for-money.4

4 The HSRC has HRC funding from October 2009 to focus on the relationship between fees and consultation rates, diagnoses, and health status, using New Zealand Health Survey data, and this will fill some of gaps in our knowledge about the impact of the Strategy.
4 OVERALL REVIEW OF EVALUATION FINDINGS

4.1 Introduction

Our findings on the status of PHOs and practices are presented first, followed by an analysis of the impact of the changes on population care. We then consider the role of the District Health Boards (DHBs), as it relates to PHC and PHOs, and come finally to consider progress on the implementation of the Strategy and what changes might profitably be made to further enhance PHC services in New Zealand.

4.2 Overall Findings

Throughout the evaluation, we have found strong support expressed for the PHCS and its aims and objectives. Significant progress has been made in implementing the Strategy. However, while certain requirements were set for PHOs (King 2001), many aspects – including their size, spatial relationships, roles and activities – were not specified in detail. It is likely that the permissive approach adopted has been a positive influence on the rapid implementation of the Strategy, but it has also resulted in significant variation across New Zealand (Smith and Cumming 2009).

While PHC was to offer comprehensive services, many community health services and groups of health professionals were not specifically included in the new arrangements, which were primarily concerned with general medical practices. Co-operation and co-ordination of activities between practices and these other services have been found to be both variable and tentative.

In addition to variability and under-developed co-ordination of services, we have found that, at each organisational level, there are uncertainties related to: the proper location of responsibility; incomplete contractual control; and capacity.

4.2.1 Primary Health Organisations

More than eighty PHOs were created as a result of the Strategy, with the majority formed during 2003 and 2004, and the great majority of the New Zealand population is now enrolled with a PHO.

Achievements – PHOs have achieved much since their creation. When surveyed in 2007 they reported a wide array of activities. In the area of primary health service planning and governance, more than 90% undertook consultation with the community, liaison with other service providers and with the DHB, and provided support to their constituent providers. Most had undertaken needs analysis and half were themselves direct providers of care.
Seventy percent provided education for their clinical staff and 21% employed GPs, 42% employed nurses and 60% were involved in the recruitment of practice staff. A smaller proportion provided locum doctors (32%) and fill-in nurses (25%).

PHOs had also initiated a wide variety of programmes to enhance or supplement services already provided by their constituent practices. These included: new clinical services (38%) and screening programmes (40%); quality initiatives (24%); health education (44%); and arrangements to improve access (31%) or outreach (29%).

PHOs had formed alliances with non-general practice providers, either within the PHO (70%), or outside it (86%). Those outside included community organisations, pharmacies, national organisations concerned with specific diseases (e.g. the Asthma Foundation) and individual professionals and these organisations provided a range of services including health promotion, well-child programmes, screening, patient support, community nursing and other forms of outreach, dispensing and social services. Some PHOs had informal relationships with the Accident Compensation Corporation (ACC), and with Work and Income New Zealand and the Ministry of Social Development. Only 9% of responding PHOs did not report examples of these relationships and services.

**Variation** – PHOs have varied greatly in size, from around 3,500 to 350,000 enrolled members, and a number of differences flow directly from this. Small PHOs have the same responsibilities as large ones but much more limited resources, despite the higher management fee (per enrolee) that they receive. They are less able to provide support for practices, or to purchase or provide other clinical services themselves. Practices that belonged to small PHOs were more likely to say that various support services were not provided or that services which were provided were inadequate. On the other hand, small PHOs consisting of a handful of practices have been found to be more likely to have a close relationship with their constituent practices. All PHOs had community representation on their Boards; small PHOs serving a well-defined population have been more easily able to achieve a relationship with the community.

A second parameter on which PHOs varied was their geographical base. In some cases there is only one PHO in a sub-district, in others, there were several PHOs whose populations overlapped. One problem seen with overlap was the difficulty in planning population approaches: available data on population need applied to the whole population and did not distinguish the population enrolled with the PHO; it was less easy to identify people who were not enrolled with any PHO; and existing or proposed population services could not be easily coordinated across PHOs. There are, however, advantages to multiple PHOs if one is able to provide more appropriate services to a specific sub-section of the population. About half of PHOs responding to the survey in 2007/8, stated that they overlapped with a PHO of the same funding model.
Where several PHOs serve a district, each with its own geographical catchment, they have in some cases formed coalitions able to co-operate in district initiatives and to generate economies of scale by undertaking some functions as a group. It was reported that these benefits could be inhibited if PHOs had different philosophies or business approaches, as well as when they were in competition for practices and patients because they overlapped.

A third key difference between PHOs is in relation to the direct provision of services. About half of all PHOs, serving about half of the New Zealand population, are direct providers of services; the remainder are not (Smith and Cumming 2009). However, many of the latter do report that providers other than general practices are part of the PHO. About three-quarters of PHOs do, therefore, co-ordinate services beyond general medical practices but there is wide variation in the services that are included.

Some PHOs which do provide services indicated that they did so only when a suitable alternative provider was not available. One reason for their reluctance was that they wanted to have a co-operative relationship with other providers and did not want to be seen as taking over all of primary health care. There were reports that other providers were reluctant to form too close a relationship with PHOs which they regarded as dominated by the medical profession. Other reports suggested that some PHOs sought to have services provided by practices even when other, and more appropriate, sources were available.

A final difference between PHOs is their history. Small providers of PHC, set up before the Strategy was implemented to service populations with high health needs and a low average income, already fulfilled many of the requirements of PHOs. They often had a close relationship with the community they served, charged low fees and provided services beyond the scope of traditional practices. In many cases, they were operated by not-for-profit trusts and employed salaried GPs. In general, these providers became PHOs and were already in alignment with the objectives of the Strategy.

Other PHOs, often larger, typically developed from Independent Practitioner Associations (IPAs). They consisted mostly of practices operated as small businesses by their GP owners. While these PHOs have taken on the wider objectives of the Strategy, many of their constituent practices retain a traditional model, caring for those who present themselves at the practice. In particular, the small size of the typical practice makes an expanded role problematic; the mean number of GPs per practice is three and the modal value is one.
Control – The distinctions between types of PHOs described above has affected the extent to which PHOs were able to influence the activities of practices. Small PHOs with few practices, particularly when the GPs were employees of the practice, reported being able to influence practice activities and set fees. Large PHO with many practices, owned and operated by individual GPs, report much less influence. One PHO informant, noting that she spent much of her time developing relationships with GPs, felt that this was a major hindrance in the development of the Strategy.

It was also noted that the ability of the PHO to influence practice activities was reduced if a practice could switch PHOs, a second difficulty related to overlapping PHOs. The essential problem is that much of health care in the community is provided by practices but the responsibility for planning, funding and co-ordinating care lies with the PHO whose contract with the practices is only partial (in the sense that practices are contracted to provide PHC but are free to decide what to include and what priorities be given to different activities).

The interests of practices and PHOs diverge in a number of areas; a particularly obvious example being fee levels. Practices have an interest in higher fees to safeguard the viability of their businesses; PHOs have an interest in lower fees to increase population access (although some PHOs have not sought lower fees in order to maintain the number of practices and practitioners). Other examples of divergent interest reported to the researchers included: the provision of free services by the PHO which duplicated those provided by practices, for whom such services might provide income; and the desire of the PHO to implement a particular programme, for example, Care Plus, when the practice believed that the extra income would not justify the cost and inconvenience, of providing the service.

The diversity of PHO board members sometimes interfered with the development of a clear direction for the PHO. PHO boards have been shown to have strong community, Māori and GP membership, but less Pacific, nursing and other provider membership. Board members sometimes saw themselves as speaking on behalf of the group they represented, rather than as members of a corporate entity. Differences between community and clinician interests were sometimes acted out at the board level and there were reports of discomfort from both sides on this issue.

PHO board members are chosen in a variety of ways, with some PHOs having community advisory groups selected on the basis of geography or ethnicity. In some cases, nominees were put forward by a wide range of community groups. There are, however, wide variations across PHOs in terms of the arrangements that apply to board members in relation to their terms of appointment and also whether they are paid or not to attend meetings.
It was reported that there were sometimes difficulties obtaining community representation; PHOs reported that lack of population awareness of, and knowledge about, PHOs contributed to this problem. Sometimes people with special interests would become board members and their focus on a single issue, perhaps a particular disease or a particular service, could be disruptive. Similarly, there was sometimes conflict when board members were also providers and community representatives found that their influence on the Board was sometimes less than optimal. Sometimes there was difficulty getting GPs to sit on boards.

When Board members were knowledgeable and committed they could be effective. It was reported that one board was able to identify “hidden valleys” of unmet need and to select particular problems that the PHO should address.

**Capacity and Sustainability** – Some doubts were reported about the capacity of PHOs to undertake the functions required of them. Small PHOs did not have the resources to hire many staff and management skills might be relatively scant in some areas. Payments to PHO Chairs and board members were correlated with PHO size. When PHOs were asked to indicate their own health, 16% said that they were “at risk,” however this was not confined to small PHOs.

A particular concern for many PHOs was the work involved in generating reports and analyses. Practice Patient Management Systems (PMSs) were poorly adapted to this function and often incompatible across practices. Further, electronic communication with secondary care was poor in many districts. This was considered an important challenge for the future by many managers and clinicians.

**4.2.2 Management Service Organisations**

Prior to implementation of the Strategy, most IPAs had been providing practices with services including information technology (IT) support, analysis of prescribing and the use of tests, and continuing medical and nursing education (CME and CNE). In many cases the IPAs maintained their existence as MSOs and were contracted by PHOs to provide services, including meeting the reporting obligations of the PHO. A number of new organisations were also created to provide such support services. Some MSOs have expanded beyond the territory of the original IPA; others have lost business as PHOs have become independent or have banded together to form their own MSO.
MSOs had the resources and experience to perform necessary functions for PHOs in the early days of the implementation of the Strategy and several informants indicated that their PHO would have been unable to meet its obligations or to implement new programmes without this assistance. When a survey of PHOs was carried out in 2008, fewer PHOs that outsourced some functions to an MSO also said that they were “at risk” (10% versus 25%). In general, there has been better analysis of process data and programme evaluation among large PHOs and this has mostly been undertaken by a separate MSO.

Some PHO informants have suggested that their MSO had inhibited aspects of the implementation of the Strategy. A centralised service was said to have less awareness of local issues and an MSO that appointed only a part-time manager for each PHO did not facilitate the development of a community of interest between the PHO, practices and the enrolled population. The manager of a PHO that had signed up with an MSO to provide backroom functions said that, while she appreciated the help and collegial support, the PHO had become less “nimble” in their decision making. Other informants said that an MSO, owned by GPs, only thought to distribute funding for new services to practices and were reluctant to include other service providers.

4.2.3 General Practices

During the implementation of the Strategy, practices reported they had made many practice changes, including a greater development of teamwork, the uptake of programmes such as Care Plus and various out-reach initiatives. They also reported, in some cases, that the PHO had enhanced co-operation among practices; in one case a shared management systems had been developed. Some noted that having an enrolled population allowed pro-active approaches, such as outreach to non-attenders, which had not been possible before.

However, there was significant variation, with some practices remaining untouched by newly available opportunities. Few practices said that the adoption of capitation funding, providing the possibility of greater flexibility in meeting patient needs, had altered their mode of operation.
Most practices said that they had become busier since the implementation of the Strategy. The number of GPs in the practices that responded to the final practice survey had increased by 3.9% but many new doctors were employees or associates and the number of practice owners or partners had decreased by 3.8%. The number of Primary Health Care Nurses (PHCNs) had increased 14.3%; overall and in most practices there were an equal numbers of GPs and PHCNs.

Many practices were working at capacity and 21% said they were too busy; however, some practices, particularly large ones, indicated that they could undertake more work. Overall, practices indicated that they were working at 95% of capacity. Despite this, there was concern that the workforce might be unable to cope with future demands; many practices had vacancies for doctors (15.6%) or nurses (13.3%), instances of practices closing were cited, and doctors indicated that, on average, they were two-thirds of the way through their career in general practice. Capacity problems were most marked in rural practices and those serving disadvantaged populations.

In many practices there were limitations on space that made expansion problematic; some owners were reluctant to invest in new buildings in what they saw as an unstable policy environment.

It was noted from all levels of the system that practice staff members were often overwhelmed by work demands and that this prevented them from adopting new programmes or improving existing processes. One source of overload was the reporting requirements associated with the implementation of many small programmes. Many informants felt that such programmes generated unfortunate divisions in care and that both funding and reporting should be simplified.

4.2.4 General Practitioners

GPs welcomed the increased focus on PHC implied by the Strategy and indicated that the increased funding would be beneficial. They noted that their personal incomes had increased initially but some said that this increase had been negated by increasing expenses. On average, GPs indicated that they had a good level of work satisfaction (score 3.5 out of 5).

\[\text{The term primary health care nurse is used in preference to the more familiar practice nurse as it recognises the expanding role of nurses in primary health care.}\]
GPs recognised that there is a conflict between making PHC inexpensive for all and subsidising those with less available financial resource. A majority favoured a system providing “affordable low-cost access” to one providing “universal low-cost access.”

GPs were less enthusiastic about the formation of PHOs; indeed some were antagonistic to their activities. They felt that PHOs used resources that could be better employed for clinical care and some suggested that PHOs provided services of little value or duplicated services already provided by the practice.

However, GPs valued services which assisted them in their work, for example, readily available counselling or social assistance for patients. Some also felt that the PHO was useful in advocating for them with the DHB, co-ordinating community services and addressing determinants of health.

In the first survey (2006-7), both practices and GPs were asked about the influence of the PHO. Most respondents indicated that the influence was “about right” but a significant minority was concerned about the PHO influence on fees (it should be noted that this survey was undertaken during the introduction of a fee review process by DHBs).

Sources of GPs’ dissatisfaction included a sense that they were not appreciated and that there was poor support from secondary services – more than a third rated the availability of local elective services as poor. In general, many GPs feared that the implementation of the Strategy threatened their status as independent professionals and business people. In particular, the control of fees generated alarm; while planners see low fees as a metaphor for better access, for GPs it is metaphor for loss of independence (Croxson, Smith et al. 2009).

Many GPs felt burdened by the obligation to provide care after-hours; however, some noted contradictions in the policies of hospital Emergency Departments (EDs). Care at the ED was free and allowed instant access to hospital investigations. If such investigations were available to GPs and the incentive of free care was removed, many patients now seen in EDs could be cared for by GPs at a fraction of the cost (to the system) and with better continuity of care. Other specialist functions could also be undertaken in practices if this was funded and if it was supported by the specialists themselves.

GPs were aware of health services used by their patients that operated quite separately from practices. These included the professions of midwifery, pharmacy and physiotherapy, and community nursing specialties, particularly district nursing.
4.2.5 Primary Health Care Nurses

Under the Strategy, the role of PHCNs in practices has developed, continuing a process that has been underway for some time, particularly in practices serving more vulnerable populations. The development has been aided by specific funding for nursing innovations and by funding available under the Services to Improve Access (SIA) and the Reducing Inequalities Contingency Funding (RICF) programmes, as well as the Care Plus programme.

In many practices, PHCNs are responsible for triage, undertake consultations, perform immunisations and smear tests, and are responsible for the practice Care Plus programme. Many serve on PHO boards where they make up 9% of members. Among those who responded to our PHO survey, only 31% of boards had no nurse representation; however, PHOs with more than 20,000 enrollees rarely had nurses on the board (Smith and Cumming 2009).

In general, respondent GPs welcomed the increased role for nurses and considered that nursing and medical clinicians worked as a team. Our analyses of PMS data from 2001/02 to 2004/05 showed a significant increase in the number of consultations undertaken by nurses (Cumming and Gribben 2007); nevertheless, we have concluded that the participation of nurses in PHC could be developed further. Barriers include: lack of recognition by GPs and the general public of the capability of nurses to operate independently; the cost and time of additional training; a poorly developed educational structure for PHCNs; and nurses’ lack of confidence in going beyond traditional practice nurse activities (Finlayson, Sheridan et al. 2008). Further development is also hindered by structural issues including the employer/employee relationship and the exclusive right of medical practices to enrol patients under the Strategy.

Further development of the PHC nursing role is represented by the nurse practitioner (NP), a profession brought into being in New Zealand in 2001. The potential of this role has been limited by the lack of NP positions in practice, especially since NPs who work independently cannot access the subsidies available under the Strategy.

Nursing informants stressed that progression of the nurses’ role was dependent on their representation at the governance level and that, to fulfil this function well, nurses needed appropriate education and mentoring. Many management positions in both PHOs and the primary health care division of DHBs are filled by nurses. Some GP informants reported concern about the “nursing agenda” expressed as an emphasis on nursing roles under the PHCS and in the appointment of nurses to management functions within PHOs.
4.2.6 Population access to Primary Health Care

A key goal of the Strategy was to increase access to PHC, particularly through the reduction of patient fees.

Fees (Raymont, Cumming et al. 2010) – The latest report generated with data from practice Patient Management Systems shows that, between 2001 and 2007, the fees charged have generally fallen for those aged between 18 and 64. At Access practices fees have fallen modestly but progressively and they are significantly lower than at Interim practices. With the new funding, the government aimed, at Access practices, to have zero fees for children; fees of between $7-$10 for those aged 6-17 and fees of $15-$20 for adults. According to our analyses, other than for children under six, this is being achieved.

At Interim practices, fees fell with the introduction of the subsidy, mainly for those previously not funded (without Community Services Cards (CSC) or High User Health Cards (HUHC)). The government was seeking falls in schedule fees of around $25 for those without cards and of $10 for those with cards; our data show that falls were substantially less than this on average. Further, what falls there were, have been against a background of progressive increase in fee levels. For those at Interim practices, aged over 64, whose invoiced fees were lower at the start of the period, the fall with the increase in funding has been overtaken by the background inflation in fees. Fee reductions over the whole period were experienced mainly by those without CSC.

An estimate of average fees showed that Access practices set fees at 59% of those advertised by Interim practices and practices that were members of community-owned PHOs (a sub-set of Access practices) set them at 42%. When actual fees, recorded in the PMS, were compared in the same way, Access practice charges were 55% of those at interim practices.

Average fees are also rising for children at both Access and Interim practices; however, they remain very low. This is explained by the fact that children have not benefited from higher capitation rates as new funding has been rolled out through the Strategy, other than through adjustments in 2002 for the general level of inflation between 1997 and 2002 and through annual adjustments since 2002 to maintain the value of the subsidies.

Fees for ACC services, for which there has been no change in subsidy, have increased. The increase has been much greater in the older age groups and at Interim practices.
Access (Raymont and Cumming 2009) – There is some evidence that access to PHC has improved. Responding to the practice survey (2006-7) GPs at Access funded practices reported a decrease in late presentations as well as an increase in patient presentations judged unnecessary. Some practices reported a lowering of patient debt levels. Informants noted that a number of additional services were provided without charge and felt that these increased access for particular populations; such services included sexual and mental health clinics. Some practices also found other ways to improve access, including fully-subsidised visits, easy-payment plans and assistance with transportation.

However, informants suggested that the increased subsidy had benefitted people who were easily able to pay for GP visits and cautioned that increased utilisation could not always be equated with more appropriate access.

There is significant variation in ease of enrolment across districts. In some districts, a patient could enrol at any practice; in one, no practices had open books and the DHB funded, at an Accident and Medical Clinic, the care of those unable to enrol. Overall, nine percent of practices had closed books but 36% of the remainder had qualifications as to who they would enrol. Some informants indicated that they would be unwilling to enrol people who were likely to be “difficult” patients. The move to capitation funding increases the disincentive to accept such patients; when a standard fee is paid for the care of patients (in a particular age and gender category), relatively healthy, socially agreeable patients generate more income per hour worked, especially if the practice income related to patient co-payments is low or uncertain.

At a more general level, several informants felt that the capitation system was unfair and that it did not make sufficient allowance for the increased needs of the vulnerable. Some said that they should be paid “for what we do” and not on the basis of a capitation formula. Others thought that capitation encouraged practices to enrol more patients than they were able to look after.

Of particular concern is access for transients, who may be are enrolled elsewhere, or not enrolled anywhere, and who cannot not take advantage of reduced fees. Our data suggest that they may also face difficulty obtaining appointments; 23% of practices indicated that they would not see new casual patients. Similarly, those who could not find a convenient Access or VLCA practice might be denied the related benefits and, as mentioned, the differential in cost was considerable.
Rates of consultation (Raymont, Cumming et al. 2010) – Consultation rates initially increased for most population groups, but there was a drop-off in consultation rates in 2006/07. Consultation rates overall over the entire study period rose for those aged 18 and over, especially amongst the elderly. When the data are broken down by population group, consultation rates were seen to increase over the full study period for those with CSCs in Interim practices and older adults (45+) in Access practices, for Māori (especially those aged 45 and over) and for Asian groups (especially those aged 18-25 and 45+). Worryingly, consultation rates had fallen for Pacific peoples. Consultation rates are lower at Access practices than at Interim practices; 34% lower for younger people (0-18) and 19% lower for adults (18-65+). This is of concern as this group is likely to have poorer health and higher health needs. Of particular concern is the falling of Pacific peoples’ consultation rates and this warrants further investigation.

Reduced fees do not seem to have always been associated with increased rates of consultation. Access practices with on-going lower fees have not achieved consistently greater growth in consultation rates than Interim practices; and those without CSCs who have experienced the biggest reduction in fees have shown no consistent growth in utilisation. It is likely that outreach and other activities (such as provision of transport) aimed at attracting those who tend to under-use services have been successful in also increasing rates of consultations. Lower than desirable consultation rates for Pacific populations, those in Access practices and those from more deprived areas (especially among children) suggest we have some way to go to ensure equitable consultation rates.

4.2.7 District Health Boards

As part of the third phase of this research, the primary health care managers of all the DHBs were interviewed by telephone late in 2008 and provided an informed view of the progress of the implementation of the Strategy.

In general, relationships between the DHBs and the PHOs have developed in a positive direction, aided by the passage of time and increasing understanding of issues of mutual concern. Sometimes this has been jeopardised by rapid turn-over of DHB managers. Managers provided information about the multiple functions of DHBs and PHOs in PHC; each is considered in turn.

Needs Analysis (NA) – This was seen as a function shared by both the DHB and the PHO. NA was undertaken by the DHB as part of its statutory function and related to the population of the district as a whole; NA was undertaken by the PHO relating to its enrolled population, often to justify proposed projects which would attract additional funding.
Managers felt that NA should, in the future, be a joint DHB/PHO activity. At present, progress was inhibited by: interest in different populations; limited DHB and PHO capacity; weak PHO-level population data; and incompatible IT systems.

Examples were given of improved services resulting from NA; these included: a new population awareness and improved motivation at the practice level; identification of unexpected issues such as a high prevalence of sexual health problems and of diabetes in an Asian population; improved targeting of immunisation; and improved after-hours care.

**Primary Health Care Service Planning** – Planning of primary health services was also seen as a joint DHB/PHO responsibility and many examples were given of PHO or practice staff sitting on DHB committees or participating in joint projects. Some national projects, for example, pre-school checks, were specified in detail by the Ministry and it was felt that these might not fit local conditions. Other programmes, for example, community mental health programmes, were able to be tailored to suit local conditions with better results.

Many examples were given of service improvement resulting from the joint planning process; these included: appointment of additional primary care health workers, especially nurses; co-operation with Māori providers of health care and social services; chronic illness initiatives; provision of hospital services in the home; anti-smoking programmes; funding of minor surgery in practices; and resolution of after-hour service problems.

A number of problems were noted in the planning of services; these included:

- Uncertainty about the role of PHOs
- DHB/PHO conflict, often based on past differences
- Multiple and overlapping PHOs, sometimes with different approaches
- Inability of the PHO to influence practices, especially when initiatives were seen to undermine the sustainability of practices
- Inability of PHOs to work with other community organisations and distrust of PHOs by those organisations.

Of particular concern was the need to ensure that PHC services had adequate capacity and were available at reasonable cost. DHBs and PHOs had worked to attract new GPs and had funded GP trainees and summer studentships. Training for PHCNs was also provided and, in one case, the salaries of newly appointed nurses were subsidised. One DHB has been working to attract people, from populations often excluded from health care occupations, into training courses and to mentor them once there.
A key problem for both DHBs and PHOs was the inability to influence where new practices were set up or new staff employed. In some districts, DHBs, noting inadequate services in particular areas, had bought or set up practices or nurse-led clinics.

**Other Community Services** – There is a bewildering array of community health-related services which may be divided up by provider type (e.g. DHBs and NGOs), professional group (e.g. nurses, midwives, pharmacists, counsellors), by situation (e.g. post-discharge care, acute care, palliation), by disease state (e.g. diabetes, sexual health, mental health) or by function performed (e.g. immunisation). Managers indicated that there is often poor co-ordination between these services and large variations in their availability.

Devolution of some services from the DHBs had been considered (and, at the time of writing, is being encouraged by the National Party-led Government). Such services would include community nursing functions and some diagnostic services, and might include specialist activities, such as first-specialist-assessments and minor surgery. Within their role as co-ordinators of community health services, PHOs might take on the management of these additional services or work to co-ordinate general medical practice, DHB services and health related NGOs.

The capacity of PHOs to undertake this co-ordination or extra management role was variable and informants were unclear if they were required to do so. If several PHOs covered the same area, co-operation might be difficult to achieve. Further, there were differences of philosophical approach between the groups (for example, between doctors, nurses and midwives) and concern that one might take work from another.

Limited attempts to improve co-ordination were reported. For example, some district nurses were co-located with practices and some PHOs employed community liaison nurses.

In summary, DHB managers were clear that there was the potential for health, equality and efficiency gains in the provision of community health services. In general, they would favour moving towards partnership arrangements but major problems were anticipated in integrating disparate services.

**Primary/Secondary Liaison** – Co-ordination is also desirable between primary and secondary health care services and this was a well-developed function within most districts. It took two forms, GP liaison positions and participation in joint committees. A number of successes in the appropriate management of patients crossing the primary-secondary divide had been achieved. These included: better sharing of information; delivery of specialist services in practices; up-skilling of GPs to undertake some specialist functions; and access for GPs to “hospital” investigations.
The focus of GP liaison was on clinical issues, particularly elective surgery and discharge planning, but managers felt that attention should be widened to consider more general issues, for example, the difficulties in communicating with GPs because of their dispersal across many small practices. Electronic communication has the potential, realized much more in some DHBs than others, to improve primary/secondary integration and reduce repetition in patient work-up. At present, diagnostic tests may be repeated at the hospital even though they have been done (sometimes by the same laboratory) immediately before referral.

**Provider Development** – General practice provider development was seen as a PHO function with the DHB playing a supportive role of variable intensity. The impact of the PHO on provider development was limited by PHO capacity, and by practice autonomy and overwork. Within many practices, there was little energy available for change, particularly when new programmes were administratively work intensive, or could not easily be supported by existing PMSs. There was little incentive to adopt new approaches and the most traditional (unchanged) practices were said to be the most profitable. There were, nevertheless, a large number of programmes in place seeking to expand practice services and improve PHC provider service quality, management and approach to care. These included CME and CNE, feedback of practice statistics, quality audits such as Cornerstone and Te Wana, and the PHO Performance Programme. GPs were enthusiastic about improving clinical quality but uptake of changes related to a population approach was variable.

With regard to provider change, there was significant variation between PHOs and even more between practices. Large practices had more capacity to make changes but practices attached to a business model were less likely to adopt a population approach.

Other functions Health education (HE) is undertaken at each level of the health care system from the Ministry to the individual clinician, and a wide range of communication methods are used. Co-ordinated efforts tend to be made around specific issues, often after-hours care. DHB managers felt that HE is under-developed and patchy. Social marketing of PHO services is hindered by lack of population awareness, with many people being ignorant of the existence of PHOs.

Community development interventions have been initiated or supported by DHBs and PHOs. Relatively little resource had been put into this area and there were sometimes difficulties in defining and representing the community.
4.3 Progress on the Six Key Directions of the Strategy

Here we summarise progress on the six key directions for PHC identified in the Strategy with a particular focus on successful models.

**Work with community and enrolled populations** – PHO boards have been successfully established and include good representation from the communities they serve, including from Māori, community representatives and GPs. There is less representation from Pacific populations, nurses and other providers. There are some difficulties in finding people able to represent the community and sometimes community representatives find their influence on the board less than optimal.

Community representation does not of course guarantee community engagement and we have not been able, in this evaluation, to examine each PHO’s community engagement processes and successes. One issue we do note is that while some surveys of enrollee were undertaken by PHOs, this means of identifying unmet need and service deficiencies appeared to be relatively underused. In addition, practice awareness of community input appeared to be minimal except in small community-owned PHOs where the relationship between the PHO board and practice was particularly close.

Given the tensions between practice and community interests, it is arguable that PHO boards should take on a more independent corporate community-focused role and receive advice from advisory boards representing provider interests separately.

**Identify and remedy health inequalities** – The new funding arrangements for PHOs – via capitation rather than fee-for-service – supports equity goals as funding now is available to support all communities and individuals, regardless of whether or not they are actually using services. This enables organisations to put in place new or expanded services in order to improve access to care and increase the use of services by those who previously may have not used as many services as they might need. However, although the move from a targeted to a universal funding model may make it easier for those who have higher needs or lower incomes to access services without having to worry about their eligibility (through cards such as the CSC), much of the new funding is now supporting people who it could be argued can afford to pay for primary health care services themselves. Many GPs in particular argue that universal funding should be replaced by more targeted funding to increase the support available for lower income and higher need New Zealanders.
Our research suggests that the fees being charged to New Zealanders when they use services continue to reflect differences in ability to pay and degree of need, with those enrolled in Access practices charged lower fees, and lower fees continuing for Māori and Pacific patients. However, although consultation rates for Māori are higher than for the “Other” ethnic group and have increased at a faster rate, consultation rates for Pacific have fallen over time. This and the fact that those in Access practices and those from lower socio-economic areas – who are likely to have higher health needs – have lower consultation rates than those in Interim practices and from higher socio-economic areas suggests a need for greater attention to be paid to these more disadvantaged groups. A key mechanism for this may be the VLCA funding provided to practices who keep fees low.

Some larger PHOs, or the MSOs which supported them, had undertaken studies of the incidence of disease by ethnicity or by economic level (NZDep) and some had analysed ambulatory sensitive hospital admissions (ASHs). The researchers are not aware of any surveys of enrolees to assess unmet need and differences in local health status and the technical problems of undertaking these should not be underestimated; in particular, because those with unmet need may be least likely to respond to a survey and those not enrolled will not be reached. Nevertheless, it is possible that population studies could better identify health inequalities and better focus efforts to remedy them.

In spite of this, many PHOs had developed programmes which could have the effect of reducing health inequalities; these have included: Māori initiatives; new or mobile clinics in underserved areas; community liaison by nurses or community health workers (CHWs); and increased subsidisation of visits by the economically vulnerable. We have not monitored the impact of these initiatives on Māori health outcomes, but this should be monitored over time.

**Provide comprehensive services** – It a strength of the New Zealand primary health care system that the practice covers most health care needs with the exception of major emergencies. Practices are set up to “improve, maintain and restore” health in most of its aspects.

There are, however, a number of areas in which the care provided by practices is incomplete. As mentioned above, there are a number of professions and health care functions not initially covered by the Strategy. This might be remedied if the role of coordinating other community health services with each other and with practices were to be assigned to the PHOs.
A first issue of particular interest is the management of illness and trauma which occurs out-of-hours but is sufficiently serious to require prompt attention. There are several interlocked issues. First, GPs are reluctant to undertake after-hours work since it is disruptive of both day-time work and home life. This might be ameliorated if remuneration was adequate to compensate for lost day-time earnings and to attract doctors willing to specialise in provision of after-hours care. Some PHOs have “top-sliced” capitation funding to pay for after-hours care.

Second, patient care at hospital Emergency Departments is free and allows prompt access to hospital services; for many patients these advantages compensate for delays longer than those experienced at the local GP after-hours service. Access to X-Ray examinations, GP up-skilling in relevant areas and increased funding might resolve these issues and save on ED costs.

Third, communication between providers of after-hours services and people’s individual GPs should to be improved so that follow-up in practices is aided. There is no reason in principle that emergency discharge notes should not be electronically available to practices within minutes.

It should be noted that after-hours care issues are gradually being solved in many districts. Solutions differ depending on geography and population characteristics. In some districts, care after 10pm is routinely undertaken in the ED to increase efficiency by maximising the use of available personnel.

A further issue of interest is the fact that the pressure of work may encourage GPs to address only the presenting problem and discourage them from taking a more holistic view of the patient or undertaking screening activities. One PHO manager mentioned the advantages that could be obtained if each patient seen at the practice were to be screened for health problems distinct from the presenting illness (this is distinct from the Care Plus programme which provides long visits for those with established illnesses).

It is possible that there could be incentives, perhaps included in an expanded version of the PHO Performance Programme, to overcome this problem. Payments could be related to longer review consultations. GPs and PHCNs are ideally placed to undertake such work especially when they have established a long-term relationship with an individual and his or her family/whānau.

Co-ordinate health services – Given that practices are commonly the first source of care for each new problem, they are well place to co-ordinate care. This function is well established with secondary care and supported by the liaison activities mentioned above. Improvements in the flow of information between primary and secondary services can still be made.
Communication between practices and community services, including the services of other professionals, DHB community services and NGOs, is much less well developed. This could be addressed if PHOs were to manage or coordinate these services or if services could be co-located.

**Workforce development** – As mentioned above, PHOs and DHBs have a number of projects to address workforce issues, although one of the issues we have identified here is a need to clarify where responsibility for workforce issues lies. It appears that the adequacy of the current workforce in practices varies significantly from place to place but that the population of GPs and PHCNs is aging, indicating that recruitment has not kept pace with demand. This problem applies all across the specialities of medicine and nursing; it is proposed to increase the number of medical students in our medical schools but we are unaware of any similar increase in nursing. A significant number of New Zealand medical and nursing graduates work overseas and the health system is dependent on graduates from other countries.

In this context, the proportion of graduates who choose to work in primary health care, and where they choose to work once in primary health care, becomes critical. Some approaches to attracting them are mentioned above. GP informants indicated that their income and conditions of service compared unfavourably with hospital specialists. In addition, they tend to feel unappreciated and under-supported by secondary care services. It is possible that more would be attracted to primary care, not only if income was higher, but also if secondary support was improved.

Shortages of GPs may disproportionately affect practices serving disadvantaged people. Such GPs, who responded to the first survey, had experienced less increase in salary and were less satisfied with their income, although there may be some compensation for them in shorter hours and salaried positions with no financial risk. A disproportionate number of rural practices indicated vacancies for doctors; rural doctors areas tended to have a heavier work load and to work more frequently after-hours.

A key issue for the health system is the inability to control where doctors set up practice. There is significant variation across districts in the ratio between the number of GP and the size of population. It is unlikely that this will change unless appropriate incentives are found to draw GPs to under-served and rural areas. While the capitation system of funding matches the government subsidy to population size and patient need, GPs in areas with more doctors can increase their income by charging higher fees thus offsetting lower numbers of patients per doctor.
Similarly, there are indications of shortages of people wanting to work as PHCNs and this is exacerbated by the collective salary agreement which pays more to hospital nurses than to those in practices. While traditional practice suits some nurses, it is possible that others will be attracted to the expanded role that seems to be developing; there were fewer vacancies for nurses in Māori PHO practices that characteristically have made greater use of nurses.

**Quality and information** – The Strategy intended to increase primary health care quality based on improved information. The Performance Management Programme rewards practices that meet certain quality criteria, and DHB informants indicated that practices were keen to improve clinical quality. Some DHBs have fielded successful programmes designed to improve some parameters of practice, particularly the choice of investigations and the selection of medications.

Some initiatives have received formal evaluation and some PHOs produce regular quality-related reports. However, more could be done in this area. Difficulties include: PMS systems that are poorly suited to report production; and the cost of collecting data on enrolled populations rather than on those attending the surgery. Significant improvement in data collection and analysis might be obtained with suitable incentives.

One example of improved data collection is the recently published results from the Performance Management Programme (see www.dhbnz.org.nz). These data show improvements over time and achievement of national targets in relation to: prescribing of inhaled corticosteroids; laboratory and pharmaceutical expenditure; and doctor and nurse utilisation by high need populations. There have also been improvements in other indicators even though national targets have not yet been achieved (e.g. vaccination and screening). These results also show considerable variation across PHOs. Further analyses of the data in terms of the types of PHOs more likely to be succeeding in achieving positive change would also be useful in determining the future direction of PHOs.

### 4.4 The Future of Primary Health Care in New Zealand

This section first considers issues for the future of PHOs and providers of PHC; it then moves on to a more general discussion of issues for the health system as applicable to primary health care in New Zealand.

#### 4.4.1 Primary Health Care Organisations

Essentially PHOs may have four characteristics each with its own issues; these characteristics are: large size; small size; overlap; and “distant function” (when PHO functions are performed elsewhere and the PHO consists of a visiting manager and a board).
As discussed above, large PHOs have significant resources and have been the leaders in providing a large number of services both to practices and to the enrolled population. They tend to have relatively distant relationships with both providers and the community they serve. In the future it may be desirable to subdivide (perhaps internally) these PHOs so that they correspond to an enrolled population which, itself, has some sense of cohesion. However, this may well not be meaningful in large cities with relatively homogeneous populations, and will raise concerns if it results in overall higher administrative costs and loss of economies of scale.

Small PHOs often correspond to a well-defined population, such as a small town, a particular ethnic community or a relatively deprived group or neighbourhood. In general, such PHOs relate well to their enrolled population and community. They may struggle to meet their reporting obligations and tend to experience limits on the services they can provide to their constituent providers. They, or their practices, often experience difficulties in recruiting and retaining medical staff, because of the lack of city amenities in rural or deprived areas combined with an inability to provide sufficient financial incentive. Those that serve a deprived population have, sometimes by accessing funding outside the Strategy, often been able to provide a wide range of services beyond traditional practices.

Small PHOs typically serve populations with high need and should be supported. They already receive an increased management fee and many receive higher subsidisation through the VLCA Scheme. Non-financial support may be equally important; this includes, or could in the future include, provision of back office functions and mentoring of local staff. The use of MSOs has already gone some way in this direction.

“Distant function” PHOs are those that have few or no local staff either in management or clinical roles. While the board may embody community interest it has a reduced ability to create and maintain local initiatives meeting local needs. In recognition of such problems the West Coast PHO separated from its distant MSO, hired a local manager and staff and contracted a new organisation to undertake back-office functions and to mentor the new managers. Southland PHOs also went through a similar process including the formation of a district MSO. It seems likely that such changes should be encouraged wherever applicable.

Overlapping PHOs generate a number of problems, including difficulty defining the population served and co-ordinating services, and a reduced ability to influence practices. These issues are exacerbated if the formation of different PHOs has resulted from differences of attitude amongst the providers. It would seem desirable to combine, at least some functions, under a single PHO; however, groups of practices with different philosophies, for example those supportive of and with VLCA funding, might be retained.
In general, it was reported that PHO boards functioned reasonably well with some conflicts related to the different interests of members who represented the community and those who represented providers.

There were wide differences in the levels of support available to providers and in the services provided to the community. There is no question that less active PHOs should be encouraged to emulate the more active ones in order to live up to their mandate. Problems specific to small PHOs have been mentioned above. It seems likely that progress will result from joint action between the DHB and the PHO.

### 4.4.2 General Practices

Practices and the clinicians who work within them are required to provide high quality services; the Strategy also calls upon them to increase their focus on prevention and the care of those with chronic illness. Although clinicians differ in their interests, there seems little doubt that they are in accord with these directions.

The Strategy requirement that inequalities in health be identified and remedied implies that providers should seek out individuals whose health care needs are not being met. Some of these will be seen when in need of acute care and others may be identified as non-attenders from the enrolled population. Some clinicians are reluctant to exploit these means of extending the reach of PHC and one PHO manager indicated that he would like doctors to be more reliable in probing for unmet needs or undeclared problems. This reluctance is hardly surprising given that: clinicians do not like to be intrusive; previous attempts to explore may have been rebuffed; time is likely to be limited; and “drumming-up” business is contrary to the ethos of a health professional. As a GP informant said, “getting people into the doctor should be someone else’s business.” Several PHOs have contracted community health workers or nurses to fill this function, an activity which should be encouraged where there is unmet need. People who are not enrolled anywhere or who are enrolled elsewhere may require special attention.

Several informants felt that there were categories of patient who were insufficiently subsidised and there are certainly people whose care is uneconomically time consuming. There is an incentive not to enrol these people, particularly if they unable to pay fees for atypically frequent or prolonged visits. It is possible that the DHB could keep a register of such people and ensure that they have adequate access to PHC and that those who care for them are adequately rewarded.

DHBs need to ensure that there are an adequate number of VLCA practices with the capacity to serve those who find the cost of PHC difficult to meet.

The excessive load of administrative work discussed above is frequently reported by practices. Every effort should be made to simplify and automate this.
4.4.3 General Practitioners

Some GPs feel that the Strategy was poorly conceived and has had undesirable consequences. Complaints include: time consuming management and governance duties; unreasonable demands on the practice, both to meet administrative requirements and to implement new services; and the take-over of potentially profitable practice activities by PHOs. These difficulties should be seen against a background of disaffection based on: poor pay and conditions in relation to specialists; lack of respect from secondary services; and a perceived history of government “interference” in primary care. The relationship between the Ministry and GPs displays a mutual lack of trust as exemplified by the “fees metaphor” mentioned above (Croxson, Smith et al. 2009).

A concerted effort is needed to reframe this relationship. The Ministry and DHBs should acknowledge the indispensable part played by GPs in the New Zealand health care system. Secondary services should improve the service to GPs, particularly around non-urgent care; despite limitations of resources, they should respond promptly to GP queries. PHOs should be sensitive to the impact that any services they plan will have on practices. Finally, GPs’ income potential and conditions of service must be attractive. An improved approach to GPs is important, given that the workforce is ageing and that new graduates can go into specialty practice or emigrate. Medical graduates must be attracted to general practice.

There are already shortages in less popular areas. Two actions are suggested. First, differentials in the subsidy might be adjusted so that GPs earnings and conditions of service compensate for loss of other amenities; this is already occurring to some extent with the rural subsidy. And, second, GPs in well-doctored areas might be prevented from increasing their fees to compensate for serving fewer people; the new fee review process provides a mechanism to support this.

At the same time the performance of GPs should be monitored and most GPs welcome this, especially if the transaction costs are kept low and the measures used seem relevant to them.

4.4.4 Primary Health Care Nurses

Nurses have experienced increasing employment opportunities under the Strategy, including the number of jobs available and the range of responsibilities that they undertake. If PHC is to reach its full potential this trend should be encouraged. As outlined in the reference above this requires provision for more independent work, matching educational opportunities and mentoring in management and governance roles.
4.4.5 Other Community Services

The implementation of the Strategy has been focussed on practices but PHOs were required to co-ordinate the care of those enrolled with the constituent practices. Primary/secondary care liaison is well advanced but co-ordination with other community health agencies is at an early stage. Some PHOs include, or contract work from, various NGOs, but other groups of health professionals and DHB services work independently with little inter-group communication. Levels of service provision vary markedly and quality information is scanty.

There is great potential to improve effectiveness by generating co-operation between these disparate agencies and equalising levels of care across districts. Two processes might be undertaken: first, the merging of DHB management groups responsible for community-based health services (to allow within-DHB coordination and reduced overhead costs); and second, a merging of those responsible for planning, contracting and monitoring community services across PHOs and the DHB. An initial step might be the formation of joint working groups; this might be followed by creation of joint ventures and, ultimately, the unification of management structures.

4.5 General Issues for the Community Health Care System

Significant progress has been made in the implementation of the Strategy. This has been based on the gradual development of relationships and the increase in mutual understanding between the participants. PHO structures and relationships, and the means found to resolve problems, have varied across districts based on history and the local situation. There is a significant danger that further structural change in the primary health care system, including an attempt to standardise arrangements on a national basis, would undermine what has been achieved and reduce our ability to respond to local needs appropriately.

We therefore believe it is desirable to adopt a progressive, rather, than an abrupt, process to continue the development of PHC. Districts should be allowed to move forward in ways that reflect their present situation and potential. If bodies, at present distinct, were initially to form joint working groups that ultimately were transformed into formal organisations, the loss of skilled individuals, established relationships and organisational knowledge, could be minimised.

Funding – A first major issue that currently needs attention relates to the overall funding of primary health care. We have moved to a universal funding arrangement and have redistributed funding through needs-based capitation payments, ensuring that all New Zealanders have access to subsidised primary health care and that funding is provided regardless of the use of services, thereby enabling the development of initiatives to meet the needs of those who have made less use of PHC.
The current capitation formula provides only a modest additional subsidisation for higher needs groups. The issues we have raised regarding lower than desirable rates of consultations for such groups suggests a need for new funding to be targeted towards them. The VLCA scheme, targeted at practices serving high-needs populations, goes some way in this direction. It should be noted that universal funding is not supported by all.

However, the practices that choose not to participate in the scheme may also serve some people with high needs and limited financial resources. It is these people – those with CSCs at Interim-funded practices - who have shown an increase in consultation rates over the period for which we have data; this suggests a level of unmet need. It is possible that there needs to be recognition of these people in the structure of the subsidy, particularly in areas where there is no VLCA practice.

We need additional research to examine the actual impact that changes in fees have on consultation rates. We also need to estimate the desirable intensity of primary care for different population groups. Data on the number of visits per year is available and has been used in this research as a proxy but we may find that there are other and better measures of this intensity. The lack of an increase in consultations among those without CSC suggests that they already consider that care is adequate.

We conclude that it is likely that fees for practice visits at Interim practices will continue to rise if no additional funding is provided and that this may undo recent achievements in slowing the rate of growth of patient fees. Although controversial in some circles, the new fees review process does provide the government with new mechanisms to manage this growth over time.

We also conclude that outreach may be as or more important than fee levels in ensuring that people receive a level of care that will meet their needs and reduces the societal costs off illness.

**Roles** – A second key issue relates to the respective roles of the multiplicity of organisations in our health care system – the Ministry of Health, DHBs, PHOs, MSOs, practices and NGOs – and how they work together and co-ordinate services.

Each organisation tends to see the level above as unreasonably proscriptive, while seeing that below as resistant to change and unwilling to be accountable. Thus, for example we have seen concerns expressed over the role of the Ministry of Health and, in turn, the DHBs in specifying too closely the scheme to ensure that pre-school children receive health checks. This suggests the need for attention to be paid to clarifying roles in policy development and implementation early on and ensuring key organisations have the capacity and capability to undertake these roles.
A further source of stress and conflict between levels of the hierarchy is the work associated with change. In general, there has been little funding to support change management and informants noted that programme development and organisational change often appeared unrewarding. This was in addition to inadequate funding for activities such as community consultation and compliance activities. The problem could be compounded if a programme was too successful and attracted more demand than expected, or if funding was not renewed.

Table 4.1, below, lists the most obvious functions in the planning and funding of PHC, from the high level direction setting, at the Ministry, to provision of services by individual clinicians. Setting goals, monitoring progress, data analysis (including health needs analysis), and workforce development are all assigned to three levels. The responsibility for each should be better defined and aligned.

This hierarchy, with up to eight levels, is associated with uncertainty about both the appropriate location of responsibility and an inability for an actor on one level to influence other, especially more distant, levels.

Of relevance to this report, there is confusion between DHBs and PHOs about the location of responsibility for strategic planning for PHC and for data gathering and analysis, including health needs analysis. Given variable capacity in the relevant organisations, it might be most effective for each organisation to specify what it will do and what is expected of those organisations with which it contracts. Data and other specifications should be standardised so that those completing different aspects of a task work efficiently together.

There is the possibility that the number of levels might be reduced to diminish duplication and save cost. A guide to this might be the alignment of organisations and functions with the most appropriate level. The Ministry has the clear responsibility for the overall direction, planning and performance of health care at a national level, while the DHBs manage planning at the district level (with coalitions of DHBs managing some regional services).

6 The Minister; the Ministry; DHBs; MSOs; PHOs; subcontracted NGOs; individual clinicians; and patients. The creation in 2009 of the National Health Board potentially adds a further level.

7 With the creation of the National Health Board similar issues arise as to the demarcation between the role of the Ministry and the Board.
Table 4.1. Location of Functions Relative to Primary Health Care

<table>
<thead>
<tr>
<th>Function</th>
<th>Responsibility now</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Direction of PHC, including funding</td>
<td>Minister</td>
<td></td>
</tr>
<tr>
<td>Setting goals/monitoring progress</td>
<td>Minister, DHBs/PHOs</td>
<td>Simplify</td>
</tr>
<tr>
<td>Data gathering</td>
<td>DHBs, Services</td>
<td>Standardise and simplify</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Ministry, DHBs/PHOs</td>
<td>Divide/clarify responsibility</td>
</tr>
<tr>
<td>Health needs analysis</td>
<td>Ministry, DHBs/PHOs</td>
<td>Divide/clarify responsibility</td>
</tr>
<tr>
<td>Service co-ordination - district</td>
<td>DHBs</td>
<td></td>
</tr>
<tr>
<td>Service co-ordination - small area</td>
<td>PHOs</td>
<td>Needs defined population</td>
</tr>
<tr>
<td>Service co-ordination - primary/secondary</td>
<td>DHBs/PHOs</td>
<td></td>
</tr>
<tr>
<td>Workforce development</td>
<td>Ministry, DHBs/PHOs, Services</td>
<td></td>
</tr>
<tr>
<td>Ensuring service capacity</td>
<td>DHBs/PHOs</td>
<td></td>
</tr>
<tr>
<td>Ensuring practice service quality</td>
<td>PHOs (MSOs)</td>
<td></td>
</tr>
<tr>
<td>Ensuring other service quality</td>
<td>Professional, Organisation</td>
<td>See note</td>
</tr>
<tr>
<td>Individual health care</td>
<td>Clinicians/practices</td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>Professionals/management</td>
<td>See note</td>
</tr>
<tr>
<td>Community development</td>
<td>DHB</td>
<td></td>
</tr>
</tbody>
</table>

Note – Includes a wide range of disparate services including: independent professionals (midwives, pharmacists, counsellors); NGOs (health education, mental health, addiction, social support); and DHB services (district nursing, retinal screening, etc.).

A number of factors suggest that ensuring service co-ordination and service capacity would be best undertaken at a district level by DHBs. These factors include: the limited capacity and non-geographic basis of some PHOs; the problems of PHO overlap; and the fact that many community services are currently provided, or contracted, by the DHBs.
The major issue identified in this report relates to the roles of PHOs themselves. We have seen differences of views in what the PHOs’ key roles are, but fundamentally the issue that needs resolving is whether PHOs are networks of communities and providers working together to develop primary health care services locally, or whether we expect them to develop a stronger purchasing role. If the former, then the current arrangements could well work reasonably well, with DHBs working with PHOs to deliver a range of services to their enrolled populations. If the latter role is desired, then the governance arrangements for PHOs need to be examined more closely (to exclude, for example, potential conflicts of interest).

Either way, the scope of their roles needs to be clarified, particularly with regard to their relationship with a range of services that might be devolved from DHBs and the wide range of health services providers who currently deliver services in the community outside of PHOs. Their capacity to deliver the functions that are assigned to them also needs to be assessed. We need to be clear about where choice is provided – for both providers in terms of the PHOs they work with and for patients in terms of where they access their care.

At present, MSOs undertake back-office functions for some PHOs and provide education for practice professionals (nurses, doctors and managers); this seems to work well, given economies of scale, at a district level. In some cases, MSOs also hire the PHO manager and PHO clinical staff, and convene community advisory groups, effectively functioning as the PHO, responsible only to the PHO Board. In such cases the organisation chart seems to connect the DHB, MSO and providers, with the PHO board off to the side. It would seem that, if organisations are to correspond with communities of interest, the chart should connect the DHB, PHO and providers with the MSO off to one side. This would free the PHO to create a community of interest between its enrolled population and providers.

The National Party-led government in 2009 has sought further development of the Strategy through requests for proposals to enable “Better, Sooner, More Convenient Primary Health Care” through the development of “Integrated Family Health Centres.” These represent a logical direction for primary health care in New Zealand, following on from the development of IPAs and then PHOs which has so far enabled us to enhance our primary health care organisation and services. The current plans would appear to favour greater co-operation between, and amalgamations of, PHOs in some parts of the country, and the current process the government is using is to encourage local organisations (DHBs and PHOs) to identify the best way forward for their districts, albeit with the understanding that more collaboration and amalgamations are required.
Fewer PHOs may make it easier overall for the DHBs to plan services and may reduce governance and administration costs, but we also need to be clear about the ability of larger PHOs to successfully engage with their communities and to effect change amongst providers where change is desired. Some small PHOs based on a single practice or a small group of practices, perhaps owned by a community trust, have been seen to be some of the most creative and their ways of working need to be protected if further development of PHC is to be encouraged.

We need to ensure, too, that our national policy settings – for example in relation to the funding formula, the need for clarity in relation to the roles and responsibilities of different organisations, and an understanding of the likely future direction of PHC policy (for example, in relation to purchasing roles, provider and patient choice) – support these local initiatives. This might involve devolving responsibility for primary health care more clearly to DHBs who can then develop their own local arrangements; or be clear about what alternatives are preferred, perhaps by enabling a small number of alternative forms and responsibilities for PHOs, with clear funding and responsibilities laid out for the different types of PHOs.

**Accountability and Monitoring** – In general, accountability and monitoring of PHC are seen to impose a significant burden on providers and their managers. The extra work generated by the separation of funding into different pools each with their own accountability requirements was an issue constantly mentioned throughout this evaluation. There is an opportunity now to simplify requirements. The highest practical level of information should be used, with outcomes preferred to inputs, and funding and reporting on different programmes combined where possible. The collection of some statistics might be automated. Thus, PMS systems could be set up to report standard practice parameters.⁸

Some informants noted that what they had to report was relatively unimportant while critical issues like good clinician-patient relationships or accurate diagnosis were not monitored. This is reflected in an analysis of PHC quality indicators which found that most related to prevention and chronic illness, or prescribing and test-ordering, where inputs could be easily counted.

Given a lack of complete contracts, accountability remains problematic. Health professionals, especially those operating independent business, have been responsible for their own activities with discipline the responsibility of professional bodies, reinforced since 1994 by the Health and Disability Commissioner. Independent review has only been initiated when complainants have been sufficiently distressed to contact such bodies; they also needed to have the skill to negotiate the required process.

⁸ This is already being done for some aspects of practice data.
Doctors, for example, work independently and, most commonly, do not relate to a practice or a PHO as employers. Similarly, PHOs themselves, as representatives of their constituent parts (providers and community), act as independent agents within the ground rules laid down by DHBs and the government.

In response to this type of relationship, DHBs or the Ministry have required activity reports for additional funding, as, for example, in the case of the Care Plus programme. This ensures that activities are undertaken but has made the programme less attractive to providers and GPs have been at liberty not to adopt it. Many maintain that their patients are already receiving all desirable care.

In general, informants have suggested that goals should be set and that those responsible for the care should be free to adopt whatever means they believe work in the particular situation. It is suggested that programmes should be designed to allow as much freedom as possible to those responsible for their execution. In the case of Care Plus, the Ministry might, for example, set a goal of reducing ambulatory sensitive admissions for complications of diabetes. The DHB would be able to decide whether to run a primary/secondary case management programme, to incentivise PHOs to reduce admissions, or to adopt some other process. PHOs in turn might pay GPs to undertake reviews or to hire a diabetes nurse to service the PHO population.

Where the pay-off for some activity is distant, however, some goals would have to be defined in terms of inputs. Thus, the Ministry might have specified that all children should have a pre-school check with a certain content and the DHBs been allowed to implement this as it saw fit.

Monitoring the quality of health care provision is also problematic, as is influencing the priorities given by providers to different activities. Care Plus may increase the attention given to people with chronic diseases but it may reduce attention to some other problem which is not monitored. Professional informants made the case that they should be allowed to exercise their own judgment (“no one comes to work in the morning to do a bad job”). It may be that education and a data feed-back is more effective in generating quality and well balanced care than incentives and multiple funding streams and there are examples of improved prescribing and test selection based on these.
5 CONCLUSIONS

There is international evidence that suggests that a strong primary health care system is associated with lower overall costs, improved health and reduced inequalities in health (Starfield, Shi et al. 2005). These benefits are obtained where: there are more primary health care physicians; people have primary health care physicians as their regular source of care; and the key characteristics of primary health care services are stronger. These key characteristics include: first-contact care; person-focused care over time; comprehensive care; co-ordinated care; family- and community-oriented care. In general, New Zealand PHC has possessed all but the last of these characteristics; with the implementation of the Strategy community-oriented care is being developed. The reasons for these relationships relate to:

- greater access to needed services
- having a regular source of care which provides access into the wider health system
- the impact of primary health care on prevention
- the impact of primary health care on early management of health problems
- the ability of primary health care to provide appropriate quality care
- the focus on the person rather than the disease or condition
- the role of primary health care in reducing unnecessary or inappropriate specialist care.

Starfield also comments on the importance of:

- equitable distribution of health services (according to need)
- low or no co-payments
- professional earning of primary care physicians similar to those of medical specialists
- universal or near-universal financial coverage through public arrangements
- a high percentage of physicians being engaged in primary care.

The PHCS has improved our arrangements in relation to the first two and second last of these characteristics.

Table 5.1 summarises the six key directions and the five key priorities given in New Zealand’s Primary Health Care Strategy with comments on their achievement. As shown in this evaluation, significant progress has been made in implementing the Primary Health Care Strategy in terms of these goals. For several categories achievement is considered limited mainly because the Strategy did not fully embrace community services beyond general medical practice.
In summary, having put in place an extensive primary care infrastructure, we now need to consider how best to use that infrastructure along with an assessment of whether the organisations have the capacity to deliver on the tasks expected of them.

Table 5.1. Progress on the Key Directions/Priorities of the Primary Health Care Strategy

<table>
<thead>
<tr>
<th>Six key directions</th>
<th>Now a mainstream activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with local communities and enrolled populations</td>
<td>Now a mainstream activity</td>
</tr>
<tr>
<td>Identify and remove health inequalities</td>
<td>In process</td>
</tr>
<tr>
<td>Offer access to comprehensive services to improve, maintain and restore people’s health</td>
<td>In place for general practice services; liaison with some other services</td>
</tr>
<tr>
<td>Co-ordinate care across service areas</td>
<td>In place for general services; liaison with some other services</td>
</tr>
<tr>
<td>Develop the primary health care workforce</td>
<td>In process</td>
</tr>
<tr>
<td>Continuously improve quality using good information</td>
<td>In process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Five key priorities</th>
<th>Significant progress especially with Access-funded practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health, and to improve access to first-contact services</td>
<td>Significant progress especially with Access-funded practices</td>
</tr>
<tr>
<td>Supporting the development of Primary Health Organisations that work with enrolled populations</td>
<td>PHOs developed and working with variable intensity with enrolled populations</td>
</tr>
<tr>
<td>Encouraging developments that emphasize multi-disciplinary approaches to services and decision-making</td>
<td>GP and PHCN teamwork well developed; other disciplines included in some places</td>
</tr>
<tr>
<td>Supporting the development of services by Māori and Pacific providers</td>
<td>Many such services - some financially insecure</td>
</tr>
<tr>
<td>Facilitating a smooth transition to widespread enrolment of Primary Health organisations through a public information and education campaign to explain enrolment and promote its benefits for communities</td>
<td>Enrolment complete for most New Zealanders; public awareness of changes superficial</td>
</tr>
</tbody>
</table>
It is suggested issues need to be resolved in the four following areas.

**Funding** - The future direction of funding policies to support PHC is currently unclear, and clarity is required about whether universal funding will continue and how future increases in funding will be allocated to further strengthen PHC. A review of current funding formula needs to be undertaken to assess whether higher funding levels are required to meet the needs of more vulnerable groups and to address any concerns there are over financial disincentives to enrol those with complex social or medical problems.

**Role of PHOs** - There is an urgent need to streamline the allocation of key roles within PHC, as within the health sector more generally. We need to clarify where the PHO role is heading – either as an independent purchasing role or as a network of providers contracted to DHBs, and ensure that organisations have the capability and capacity to undertake these roles to a high standard.

We also need to reconsider how the range of services currently delivered through DHBs might be devolved to PHC and how those community health providers currently outside of PHOs will work with PHC services in future.

The issues associated with PHO size and overlap also need to be clarified so that PHOs can work with a definable population.

**Capacity** - An adequate supply of doctors, nurses and other health professionals needs to be ensured. Issues of sub-optimal distribution should also be addressed.

Clinicians need to be attracted to and retained in primary health care roles. For doctors this will require improving the support of primary medical care by secondary services and improving the distrustful relationships between general practitioners and planners/managers as well as issues of remuneration. For nurses, appropriate training and mentoring will be required. Both should be encouraged to provide leadership in health service management.

**Accountability** - Accountability and reporting requirements should be simplified through the use of higher level goals and the use of fewer separate funding pools with individual reporting requirements. Further development of electronic systems for reporting and interaction across services is required.
6 REFERENCES


APPENDIX 1

INTERVIEWS WITH DISTRICT HEALTH BOARD PRIMARY CARE MANAGERS (2008)

A1.1 Executive Summary

A telephone survey of all primary health care managers was undertaken in 2008. In summary, we find from these interviews, the following:

- Significant progress has been made in implementing the Primary Health Care Strategy and there are many useful and innovative programmes among PHOs.

- There is significant variation in the activities of PHOs across the country.

- Large PHOs are well resourced and provide many services to their constituent practices and to their enrolled populations. Member practices tend to retain a traditional approach.

- Small PHOs lack resources. Those serving vulnerable populations have been sympathetic to the principles of the Strategy including adoption of a population approach; such PHOs need to be protected if their gains are to be retained.

- Overlap of PHOs generates problems in identifying and understanding the population being served.

- Distribution of general medical practices and GPs, outside of DHB/PHO control, is an impediment to rational service planning.

- Managers were asked to describe activities undertaken to fulfil a variety of functions:
  - Needs analysis by both DHBs and PHOs had produced a number of improvements in PHC. Needs analysis would be strengthened by becoming a joint DHB/PHO activity.
  - PHC service development was seen as a PHO responsibility but worked best as a cooperative endeavour.
PHC provider development was seen as a PHO responsibility. Most practices were keen to improve clinical management but few were interested in changing their model of care by, for example, expanding nursing responsibility or taking on a population approach.

A wide variety of community health services are available. Many of these were not included in the Strategy and PHOs had not been in a position to act as a coordinator. This was recognised as an area where major gains in efficiency, accountability and effectiveness might be made.

Primary/secondary liaison was well established. It was made more difficult by the multiplicity of PHC providers. In some, but not all districts, electronic communication had improved efficiency and effectiveness.

Health education and community development were concerns for both the DHB and the PHOs. They were relatively undeveloped and had been used mainly to address specific problems, for example, appropriate use of after-hours care.

- The hierarchical structure of the health system generates some conflict and uncertainty as to the location of responsibilities. Clarification of the responsibilities of the Ministry, DHBs and PHOs is desirable.
- DHB managers see cooperative action with joint ventures between the DHB and PHO as the way forward.
- Key functions of the Strategy, namely removal of inequalities in access to care and co-ordination of services, would sit better with the PHO than with individual practices.
- Improved data and data sharing would assist progress planning and in the efficient delivery of health care.

A1.2 Methodology

Contact was made by telephone with the managers of primary care at each of the District Health Boards. The managers were asked to participate in an interview with the researchers; a time was agreed and the interview guide (see below) and a description of the research project were sent by email. Permission to record the interview was obtained.

All managers agreed to be interviewed. A single interview was conducted with a manager in Dunedin covering both Otago and Southland districts. A report was prepared covering each DHB comprising a description of the information obtained.
illuminated by appropriate quotes. The report was structured to follow the questions in the interview guide. These reports were reviewed and, for each question, a description of the findings for the whole country was written.

The following report presents the findings and follows the interview guide, reporting on a series of “functions” related to the planning and implementation of improvement in primary health care. The functions are: Analysis of population needs; Service planning; Community health service provision; Primary/secondary care liaison; Provider development; Community education; Community interventions; Community development; and a general category related to overall health system function.

A1.3 Findings

A1.3.1 Analysis of Population Needs

All DHBs noted that population needs analysis (PNA) was a mandated DHB function. The PNA covered all services needed for the whole population but several primary health care managers (PHCM) mentioned the monitoring of issues specifically related to primary care. Some managers also mentioned Māori-specific health needs analysis that their DHB had undertaken. Some managers felt that PNA should be strengthened.

“I think we are light in this area (referring to PNA); information is not as readily available as it could be or as robust as it could be.”

In most cases a DHB staff member, often a data analyst and sometimes an epidemiologist, undertook the production of the district PNA. In some cases, including both small DHBs and a consortium of all South Island DHBs, the function was undertaken by an external agency such as an accounting firm or a Medical Service Organisation (MSO). DHBs felt that, in the future, the function should be undertaken with the Primary Health Organisations (PHOs) but indicated that, at present, only a few PHOs were full partners in the project. The PNA was available to the PHO to make use of as they wished.

“In the future I would hope that the DHB works closely with each of its PHOs to determine information that they need and we can help them glean.”

“We would want to see it as a joint function. A theme for me is how we... work together to work towards the common outcomes... if we can find a way to do it together I think we will do it better... a work in progress...”

One DHB manager noted that a PHO which served a vulnerable population in the district had undertaken an independent needs analysis. The PHO found that they were limited by poor availability of data, particularly that relating to the health needs of enrollees who did not consult often. However, they found that the exercise had many positive
results, including: new population awareness among clinicians; an increase in motivation to improve service statistics; and the identification of the operation of the “inverse care law” among their enrollees.

“They did a practice report... [based] on a set of MedTek queries... we were astounded by the lack of data literacy by the group... the clinical team was not used to looking at data in that way and then evaluating a model of care... and very quickly that changed... it was very motivating to have the numbers, for example with ‘flu shots... to see the evidence visually... I think this is about a population health approach and understanding the inverse care law... what we end up doing is what is easiest and missing out the people who are harder to reach.”

More generally, many PHOs, and some other NGOS, had undertaken needs analysis to justify projects undertaken with Services to Improve Access (SIA) or Nursing Innovations (NI) funds. Apart from this, many PHOs were said to be reluctant to allocate scarce management resources for HNA although this was seen one of their key functions.

“We have had our struggles here with the PHO evolution... its infra-structure precludes [a small PHO undertaking] proactive activities [like HNA]... they might be looking at [needs analysis] around SIA funding and we have had some innovative projects... but they have not done any comprehensive needs analysis...”

“My view is that it is a critical part of the role of the PHO in terms of knowing and understanding its population... in order to target what little discretionary funding [they] had... While the Ministry would like everybody to be doing the same thing... it just is not going to work like that... every community [is different] and you cannot impose a successful model from one part of the country and expect it to work in others.’

“I do not think PHOs have been too active in that area...”
A number of difficulties were identified in developing combined PHO/DHB needs analysis. These included:

1. DHBs and PHOs are interested in different population with the DHB responsible for the whole population of the district but the PHO interested only in those enrolled with it.

“The other things around population needs analysis ... from DHB you are looking at the needs of its resident population. From the PHO it’s your enrolled population and they are not necessarily the same thing.”

We would like to see the PHOs as more involved... They would see their roles as looking after the needs of their enrolled population... we find it hard to get them to think of the population that isn’t on their books...

2. Lack of data at the PHO level.

3. Lack of data on health need as distinct from health service utilisation.

4. Incompatibility between PHO and DHB IT systems.

5. Some PHOs were reluctant to share data fearing that the DHB would use it to assess their performance or that it might weaken their competitiveness with neighbouring PHOs.

“[PHOs] fear the DHB is trying to access data to have a view of PHO performance.”

“PHO development over the years means that they see themselves as business entities and they see themselves as being responsible for their enrolled population and they sometimes see DHB as paternalistic and driven by its own needs.”

“There is definitely an issue about who owns what” (disclosed in relation to the PHO sharing population need information with the DHB).

“There are tensions between the PHOs here; they get along over some things but [over] others they do not.”

“How do PHOs work together to help a population when essentially they are fighting for that population in order to have the numbers to survive?”

Despite these difficulties, some DHBs noted that they had formalised data sharing arrangements with some PHOs and others were moving in that direction.
“The PHOs’ clinical governance group is looking at what population health information should be available to them and at the practice level.”

“We are working together to improve connectivity...we are talking about being able to share information more easily.”

“...DHB and PHO and Ministry have had a joint meeting and we are working on a plan about how best to capture [district] population data using practice data.”

It was generally noted that development of PNA was hampered by lack of data, particularly for individual PHOs or practices. Efforts to address these problems were mentioned.

“The biggest hindrance has been access to high quality data at regional or sub-regional level... immunization coverage data was only available based on a survey for the whole of the Southern Region... so it was difficult to understand at a DHB level, let alone for an individual PHO... so you ended up with a blended view... “

“We use it (referring to the HNA) heaps but we would use it even more if it was better. It needs to be more up to date, it’s about how timely it is, and we need more information on particular cohorts.”

DHBs noted that there was a fundamental problem with PNA if there was a large transient population in the district. Two further problems of a structural nature were the apparent confusion over the division of responsibility between DHB and PHO, as well as the competition between PHOs.

HNAs had identified issues specific to particular districts including:

1. Lack of availability of primary care services
2. Identification of high levels of diabetes in South Asian populations
3. High levels of sexual health problems
4. Poor targeting of immunisation programmes.
5. Poor primary/secondary communication.

“We have had an extensive consultation with our community... time and time again it came up that primary and secondary do not talk together... ‘When I go the hospital I have to tell the story over again... if I could have one health record it would be fantastic...’“
Examples were given of primary care initiatives that had been developed as a result. These included improvements to after-hours services, development of chronic care management and sexual health services, improved targeting of immunisation recruitment and progress towards an electronic record.

“We have a much better awareness and understanding of diabetes population.”

Mention was made of specific Māori health needs analysis and of co-operation in developing these.

“We have a Māori Monitoring Report that monitors Māori progress and [the] sexual health [programme] came out of that... that was identified as a key area of focus for us... the report was used intensively to inform the business case... we have identified long term conditions as a key focus for this DHB...”

“At the moment the DHB does [HNA]... but recently the Māori health needs assessment... [the DHB], the PHO and public health worked on that... so that’s what we are planning to do [in the future]...”

**In summary**, examples were given of useful findings and improved programmes that had emerged from health needs analysis at both the PHO and DHB level. However DHB managers felt that the function should be strengthened and that it should become a joint DHB/PHO activity. Needs analysis at the PHO level was seen as desirable but was hindered by poor data and limited resources. Additional difficulties were noted relating to PHO overlap and competition, and un-enrolled populations.

**A1.3.2 Service Planning**

New services could be planned by PHOs, DHBs or the Ministry. Managers felt that the most desirable mechanism was to have joint planning involving the DHB and PHOs and reported a variety of forms that this could take. Some had regular meetings between DHB and PHO managers; clinicians attended in some cases. Other words used were consultation, collaboration and joint-sponsorship or joint-planning.

“We work closely with our PHOs to get PHO involvement at the front end...PHOs will sit in the DHB senior management team.”

“We have committees [for service planning] that have both DHB and PHO representation.”

“We have actually got our PHOs to nominate one of the CEOs to be a joint sponsor so it will be DHB and PHO joint sponsorship.”
The initiative to start a new service, or redesign an existing one, could come from an analysis of population needs by the DHBs or from the identification of a service deficiency by the PHO. Many managers felt that on-going meetings provided the best arena to develop such new ideas. It was noted that capacity to investigate new ideas was limited by resources at both the DHB and at the PHO level.

“Recognising that the position of PHOs is reasonably untenable... they either have to do more population health or have less aspirations... there are really high expectations about what PHOs are going to do but they don’t have the resources to do it at all…”

A number of new programmes had been initiated by the Ministry and rolled-out nationally. In such cases there was usually little option for variation and both the DHB and the PHOs had to accept the programme as designed. An exception was the Community Mental Health programme which allowed adjustment to suite local circumstances and this was thought to have been a more effective process.

“[National projects] comes to us already packaged and we struggle with it because the service design is already done.”

“Over the last six months few [national] projects have needed planning. The design of those programmes is pretty much prescribed but we ask the PHOs for feedback.”

“[The national mental health initiative] was an opportunity to work with each PHO and seeing what would best suit their structure and capacity and population and being creative.”

DHBs and PHO might also be constricted by national targets.

“The PHO may know what is needed locally but they may not be what the health targets say, so we do come up against that…”

A number of factors, beyond resource limitation and national designs, were identified which lead to difficulties in joint DHB/PHO service planning and implementation. These included:

1. Lack of clarity about the role of the PHOs.

“There is no clear distinction of role from the Ministry... we had a conversation yesterday, what is the role of the PHO? Is it a provider? Is it a conduit?”
2. Poor DHB/PHO relationships, often based on historical conflicts or philosophical differences.

“The tension is still there and the DHB is seen as something of a behemoth by the PHOs...”

“We rub with the big PHO quite a lot because we think they are doing the GPs' bidding and not being inclusive enough... they would say that we are getting in the road of them developing their business... they are pushing for devolution of the money and us having less say in how they do their business... it peeves them that they have to be answerable to us... “

“Initially it [the work plan] was seen as ‘this is what the DHB wants to achieve, not taking into account primary care priorities.’ We got to a place where good honest engagement can happen.”

3. Presence of multiple, overlapping and competitive PHOs.

“Our strong relations with the PHOs and their geographical [separation] means that they are open to working collectively.”

4. Differences in approaches between PHO.

“We had four IPAs with slightly different models of care... they have not let go of those differences when coming under the PHO... [especially the difference between] salaried GPs and independent businesses.”

“We had a group break away from the PHO because they thought it could not get its head around the needs of high-needs population... they saw them as very interested in just keeping the status quo... delivering the GPs services for the costs they always had done... “

5. Limited development of PHOs, sometimes related to the on-going influence of IPA based MSOs.

6. Inability of PHOs to influence practice behaviour, particularly when several PHOs were competing for practices. Under these circumstances, practices could “hold the PHO to ransom” and PHOs were only able to “cajole” them into participation.

“Often what comes back from the PHOs is that they are not able to get the general practices to [implement service plans] and they don’t want to rock the boat in terms of their GP relations”
7. Inability of PHOs, based on general medical practices, to work with other organisations such as community nursing, allied health services, or Māori NGOs.

“We are looking at how we would do things differently, given that there is no more money... [one thing is] to utilize nursing more, allied health more... even the relationship with the Māori health providers... in order to get more to more people [to visit them]... but there are not many general practice providers who are looking at that at this point... most of it is ‘they have to see the doctor’”

“Our NGO sector has little connectivity partly because we have so many PHOs in our district.”

8. Conflict between practice business model and the demands of the PHCS.

“The business models in the primary sector are not well aligned to the primary health care strategy... I think that is a huge issue in making the strategy work... some people see the answer as salaried GPs but [...] the productivity goes down...”

9. Reluctance of NGOs to work with the PHO

“We talked to other NGOs about moving their contracts towards PHOs so they would have some overall influence on primary health care... but the [NGOs] were not at all keen... they said the PHOs are not doing what they were set up to do... they hog resources and suck everything into themselves... they don’t liaise properly... “

“The PHO is very keen to be involved in anything but there is some resistance from some of the smaller NGOs.”

A smaller DHB noted the advantage gained from a close relationship with a smaller number of providers.
Examples of new services mentioned in the course of the interviews, included:

1. Allied health services
2. Māori health initiatives
3. Chronic disease management including population screening.

   “We have started our vascular risk assessment tool... and that is intended to screen all patients who come through a GP practice... we have funded the PHO to risk assess... so that we will have access to that data... we are paying for data... we will widen it to all conditions... and we intend to target all the population not just those at risk... it’s a huge project... it’s an extension of the Care Plus programme...”

4. A GP-run service providing minor skin surgery.
5. New initiatives in after-hours care.
6. A programme to reduce ambulatory sensitive admissions.
7. A smoking cessation programme

A1.3.3 Ensuring Service Capacity

Most DHBs monitored primary health care service capacity. Some stated that they believed that people had no problem finding a practice with which to enrol; others mentioned closed practices, “pockets of deprivation” involving, particularly, Māori, and one maintained a list of people unable to enrol.

   “We don’t hear about people not being able to see a GP.”

   “We are getting regular calls from the community saying ‘I can’t find a GP at a cost that I can afford’

   “In rural areas it is a struggle to keep up to the number of GPs you are supposed to have... we do have a few pockets where patients are finding it difficult to register because the practices are full.”
Even where capacity was adequate, managers indicated that most VLCA practices were over-subscribed and expressed fear that this resulted in health “ghettos.”

“There is a perception that [VLCA] practices have more complex [patients]... these practices are bearing the brunt of those people who cannot afford to pay... particularly from a mental health perspective... especially with the pressure to avoid hospitalization and for people to be discharged much earlier... in a much more complex state... with a less than adequate report.”

There were also issues with itinerant populations.

“... it’s complicated because we have quite a large itinerant population there... that puts stress on the ED department when they can’t have access to a GP because many of the GPs in [the area] have closed their books to new patients...”

Examples of efforts to deal with capacity problems included:

1. Encouragement of practices to take GP trainees and offer summer studentships.

“We have a primary care strategy group which facilitates year two and three GP Registrars coming here and joining practices... we [will] pick up one tenth of the training cost... We also go to [the medical school] and talk to year four students about coming here... and we are running summer studentships [for medical students].”

2. Practice nurse and general practitioner post-graduate training.

“We have a primary care nurse graduate programme... funded through the nursing development unit... they are placed in practices who have expressed interest and we oversee their study...”

 “[The nursing programme] has a workforce component so if they come on at advanced nurse level they can study to become nurse practitioners... they are locally grown nurses so they are not likely to leave the area so you have got the retention...”

3. New graduate salary support.

“We pay [part of] the [graduate nurses'] salary...”
4. Employment of staff in primary health care.

“The DHB has put a huge amount of extra resource into the [primary care] sector… we have added about 70 FTEs [of which] about 40 [are] in the PHOs… most are nursing positions and some allied health… we have those teams in every PHO now… lots of programmes... most of the positions are in PHOs... that is not what we really expected but that is just the way it’s gone...”

5. Funding of nurse-led clinics in under-serviced areas; some were independent, some in GP practices and some adopted a Kaupapa Māori approach.

“There has been a whole development of nurse led clinics and extended primary care to [serve] the high need populations... identified by the PHO as a priority... and funded by them through SIA...”

“Most of the nurses are in practices but some are independent... they are risk assessment clinics mainly, around diabetes and cardio-vascular disease.”

“We have just implemented a nurse lead kaupapa Māori service with nurse practitioners.”

6. Practices within a PHO distributing new patients to practices with more capacity.

“The PHOs assist the practices to juggle their registers around so that everybody manages to fit in...”

7. DHB or PHO take over, or foundation, of practices with the employment of salaried staff. Managers commented that although this removed financial risk from clinicians there were still difficulties with recruitment. Further, the coexistence of DHB and PHO practices created tensions.

“I think we are the only DHB that has developed a brand new general practice...”

“It’s quite ad hoc how [the DHB has developed its primary care service]... mostly in the rural areas as providers have pulled out...”

“We look at capacity in our own practices and with the PHO [for their practices]... it’s an on-going issue for the DHB and the practices [to attract enough staff, particularly GPs]... the GP ratio is higher with the DHB practices than it is with the private practices [because of the MECA arrangement] and that gives better conditions for the DHB practitioners. There can be some problems with the DHB owning most of the practices... the DHB practices are better resourced and the DHB has to make up any deficit...”
“In the long run the PHOs may need to be the owner of some of the practices... and become employers of general practitioners... there may be a role for the DHB to enable the financial security to allow the PHOs to take on some of those investments...”

Of particular concern was the provision of after-hours primary care which GPs are said to be reluctant to provide.

“GPs are not willing to cover after-hours care... they are looking to confine their activities to daytime... they are testing the funder’s framework... [It puts pressure on the ED].”

After-hours care was often expensive for patients and this resulted in increased ED attendance. Some managers indicated that night-time health care was provided by the hospital ED. One DHB top-slices PHO payments to fund after-hours care and makes additional payments for un-enrolled patients seen in the GP after-hours clinic.

“Our PHO is top-sliced to provide after-hours care and we have an arrangement [and we pay extra] based on the number of un-enrolled people... “

Ultimately, the power of DHBs to ensure capacity is threatened by their inability to determine where clinicians locate.

“As a DHB we don’t have much control over where new practices spring up.”

“It’s a private business and our control over where and who is limited by that.”

“The GPs are not appropriately distributed; particularly in the rural areas they are very sparse.”

**A1.3.4 Ensuring Provider Affordability, Acceptability and Convenience**

DHB managers mentioned the fee approval process and indicated that most practices were staying within guidelines. They expressed concern that if practice sustainability was undermined, there might be recruitment problems in the future.

“We are still getting challenged by fee increases... some practices embrace the low fees environment and are philosophically attached to that... but we still have a group of GPs that are really pissed off, excuse my French, that their ability to set fees has been challenged and they will continue to press the boundary there...”

“General practice does not like to rock the boat so they are staying within the recommended (referring to fee charges). If general practice is not being adequately supported it could be a long term risk.”
One DHB created VLCA practices.

“I think that [acceptability and affordability] is an issue... we have pockets of real deprivation... and in those areas we picked up the cost of accessing services... we have one or two low cost access clinics and we are looking at a few more in the future at certain strategic sites...”

In summary, DHBs saw the best way to develop new services was by cooperation with PHOs. Innovation was limited by resource constraints and had recently been focussed on national programmes mandated by the Ministry. Difficulties were also encountered related to uncertainties around the roles of PHOs and DHBs, philosophical differences between PHOs and the DHB and competition when PHOs overlapped.

Few PHOs worked with local NGOs.

Most DHBs felt that the degree to which the PHOs could influence the behaviour of practices was limited; this was especially the case if they were in competition with another PHO for practices.

DHBs watched issues of capacity; some reported no shortage while one maintained a list of people unable to enrol with a GP. VLCA practices tended to be over-worked. Several DHBs worked to increase the recruitment of primary care clinicians and there were several examples of DHB/PHO cooperation in the provision of after-hours carer. DHBs felt that cooperation with PHOs was important in this area but noted their inability to prevent additional GPs starting work in areas already well provided with doctors.

The affordability, acceptability and convenience of primary care services were seen as the responsibility of the PHO but the DHB provided an overview, particularly in the matter of fees which they were responsible for reviewing.

A1.3.5 Community Services - Nursing

Nurses undertake a large number of roles in the community. The two largest groups are District Nurses who provide care to people at home and Public Health Nurses who are most concerned with well-child care. The District Nurses are most often employed by the provider arm of the DHB but the service is sometimes contracted out to private organisations. Public Health Nurses are employed either by the DHB or by Regional Public Health Units.
The work of these nurses is overlapped by a wide variety of nursing roles which are undertaken out of DHBs, a variety of NGOs, including community trusts based in small hospitals, MSOs, PHOs and practices. These roles include: health education; immunization; chronic care management; and community-based acute care. In turn, some of the roles may be undertaken by Practice Nurses or Community Health Workers, although the latter undertake social support rather than professional health care. The funding for this wide range of community nursing and related work comes directly from the Ministry, from the DHB as provider and from the DHB via individual contracts and PHO funding (first contact services, SIA and other contracts).

“District health nursing and public health nursing are going through the provider arm at the moment... out-reach services are going through PHO-land...”

“There are other types of community nurses out there who are attached to primary care.”

“Each PHO has an out-reach nurse funded out of SIA... they have community workers... working with WINZ and Housing.”

“We also have services through [the] MSO... cardio, continuing care, diabetes action, the diabetes annual “Get Checked”, sterilization, skin lesions...”

Most managers felt that the present ad hoc arrangements allowed variation in service provision and poor co-ordination between services.

“There are quite a number of NGOs and we work to get them to work alongside the PHO... it is in its infancy and there is an awful long way to go...”

“The public health nursing service is run out of the provider arm. We do wonder if that is the right way to do it... and we feel that there is not enough partnership between public health nursing and our PHOs and we would like to figure out a way to bring them together...”

Many mentioned that devolution of nursing care from the DHB to community organisations had been considered and the general feeling was that some sort of partnership should be formed. The need to rationalise services was thought likely to become greater with the on-going development of chronic care management and programmes to provide acute care at home.

“My opinion is that [district nursing] can fit comfortably out with PHOs. DNs would definitely like to see the disconnect with GPs resolved... conversations are being had...”
“I am of the view that a number of services run out of the provider arm should be [run] out of PHOs... [e.g.] clinical nurse specialists, they should be based in PHO-land... “

“We have one staff member who is looking at how we build community nursing within primary care.”

DHB views varied on the capacity of PHOs to take on these community health services, and other problems were identified with their devolution to PHOs or practices. These included:

1. The uncertain status of PHOs and the limited management capacity of some of them.

   “Where it should be... it comes back to the fundamental question – what is the role of the PHO? And until we get that clear and sorted we will continue this conversation.”

2. Lack of co-operations between PHOs when several covered the same geographical area. Some noted improvement in this area.

   “The only risk is that [these activities] are for the whole population not just parts of it... “

   “Two or three years ago you wouldn’t have had the [two PHOs] talking together but they are and they are looking at joint services.”

3. The need for some services to have many workers so as to have access to a wide range of skills.

   “A single district nurse seconded to a practice did not have the expertise to deal with the range of problems... “

4. Differences between medical and nursing approaches (in one case District Nurses refused to consider becoming part of a PHO).

   “Community nursing is all provided by [the DHB]... when I suggested that district nurses, public health nurses and specialist outreach nurses should be provided by PHOs I got shouted down by those nurses... there is an issue between who owns the services and where they are provided... they should be co-located with general practice...”
A1.3.6 Other Community Services

Managers mentioned a wide range of situation specific services, including: sexual health; mental health; chronic disease management; acute care in the community; and palliative services. Many aspects of these services were provided by nurses as indicated above and some by medical practitioners. In addition, there are a wide range of allied health services available in the community, including: midwifery; pathology; radiology; pharmacy; physiotherapy; counselling; and alternative approaches to health care.

These health care functions were being made available in a variety of different ways. Informants indicated that sexual health services, for example, were provided by: the local hospital; DHB medical employees in community health centres; public health; general practitioners; and various NGOs, including Family Planning and youth oriented organisations.

“Sexual health services are a bit fragmented... we have three providers... we are trying to align the services and there is more clarity about who does what... “

Similarly, mental health services are provided by the DHB, MSOs, PHOs and general practitioners, NGOs and individual counsellors. One manager mentioned cooperation with projects initiated by the Ministry of Social Development and by the Justice Department.

“For mental health we have funding that comes through the primary mental health funding stream...and there are lots of new initiatives...many are nurse led.”

“We have been establishing a number of primary mental health services... with the PHO... it’s being done mainly through GPs but also other NGOs... the intent is that they should be networking with other NGO providers but how effectively that is being done at the moment is questionable.”

“The DHB funds the IPA [sic] to provide a substantive primary mental health brief intervention service. The PHO has been slow to take up any community health services.”

“Our immunization coordination services sit within a PHO but [not] outreach immunization and our National Immunisation Register... we are thinking can we bring them under our PHO.”

There are examples of improved collaboration and the DHBs are making efforts to plan community nursing services with other agencies. Some nurses are already attached to PHOs for a limited period or because the DHB cannot serve locations distant from base.
“The MSD project [for mild to moderate mental health] with the DHB, MSD and the PHOs working quite well collaboratively together... improved collaboration between the GPs and case managers... that was great.”

“The NGO and the PHO have community nurses, a disease state management nurse and primary care nurses... they have a plan to align their services much more closely with general practice... for example referral management between GP and nurses.”

“We try to get the PHOs to be involved in any services that are in the community, for example, every time we develop something we say can we do this through a PHO?”

“In terms of planning it is very much a joint exercise... having everyone round the table saying, ‘Who is best placed to do this?’ In the future a whole heap of them should be in primary care...”

“On occasion, PHNs are attached to the PHOs for the purpose of completing projects.”

It is also clear that, beyond issues of accessibility of services, client satisfaction and service assessment is problematic. A DHB that provided packages of acute care in the home noted that there had been no fall in ED presentations and that uptake levels had varied widely between practices.

“We have an acute demand agreement... with a tripartite agreement between a PHO, an MSO and [the district nurse service]... that’s one place where we have absolute collaboration going on. We have acute nursing services, packages of care, observation services in the 24hr surgery... a whole suite of services that people can get if they are acutely ill... we will fund just about anything if we can keep people at home appropriately.... it’s very flexible... it’s funded on a case by case basis... we would like to see reduced ED presentations and hospital admissions and we are not seeing that... there are some practices who refer to the acute demand service frequently and some who hardly use it at all...”

In summary, there is a bewildering array of community health-related services which may be divided up by provider type (e.g. NGOs), professional group (e.g. nurses), by situation (e.g. post-discharge care), by disease state (e.g. diabetes) or by function performed (e.g. immunisation). Managers did not know how these should be reorganised but they were clear that there is often poor coordination between services; in general they would favour moving towards partnership arrangements.
The capacity of PHOs to undertake these roles was variable and it was unclear if they were required to do so. If several PHOs covered the same area cooperation might be difficult to achieve. Further, non-medical staff needed the support of their own organisation and their might be conflicts between different professional groups.

**A1.3.7 Primary/Secondary Liaison**

Primary-secondary liaison was a well-developed function within most DHBs and took two forms: GP liaison positions and participation in joint committees.

DHBs, and in some cases PHOs, employed GPs to improve function between primary and secondary care. The focus was on clinical issues, particularly elective surgery and discharge planning, but also management processes related to specific conditions. Managers felt that GP liaison people should widen their sphere of concern towards more general population health issues; some felt that GP liaison people had focused too strongly on the needs of secondary care and of the hospital.

“The role has been very much focused on trying to get things sorted in secondary care I suppose.”

“That is something that we constantly talk about but it is not about the primary/secondary interface at all... it’s mainly around electives... discharge planning. It tends to be issues based... for example renal. With long term conditions we have created an opportunity for primary and secondary teams to interact.”

There were some difficulties noted in relating to primary medical care given its division into small units.

“You can’t have just one or two GPs representing all GPs... they are so unconnected... and they do not see PHOs as representing them...”

DHBs had also appointed primary care advisors and one mentioned guidance from a professor of integrated care. They had appointed primary care nursing directors or advisors and some nurses were employed in a liaison role.

With regard to joint committees, the following variations were mentioned: PHO CEOs sitting on the DHB senior management team; joint SMO/GP and joint SMO/GP/manager forums; primary care reference groups; and PHO representatives on steering groups, working parties and DHB executive committees.

Some difficulties were noted with interesting SMOs in strategic questions, as were conflicts of interest related to the public-private split of some SMOs’ work.
These integrative activities had produced a number of positive outcomes, including:

1. Improved sharing of information, including provision of test results on-line, electronic discharge summaries and shared patient-held records (for diabetics). One DHB noted that there were still major issues in this area, with no shared access to test results and inadequate discharge summaries.

   “Within IT, we have primary care ability to access our patient information systems in hospital. Electronic discharges go from the hospital to primary care and there are shared diagnostics and results.”

   “It (referring to a liaison project) will further enhance the IT and linking at discharge and getting electronic discharges to primary care and there is talk about GP direct referrals from the hospital to PHOs.”

2. One DHB had noted problems with musculo-skeletal illnesses and lower level gynaecological problems both of which could be problematic for GPs but were of low priority for secondary services. New clinics dealing with musculo-skeletal problems were created, GPs were encouraged to develop a special interest in the relevant issues and GP to GP referrals were facilitated by arranging for payment.

   “We have a referrals project which focuses on the interface with primary/secondary care... and were trying to pull out of secondary care those services which could be delivered in a community setting... that was kicked off between our Planning and Funding Division and our largest PHO... we have been getting interested specialists and GPs together... and identifying things that need to change... for example in muscular skeletal medicine, there are quite a significant number of referrals coming into the DHB where general practice [finds cases] are outside their levels of expertise... the DHB says [that they are] low priority. We funded a couple of pilot clinics with [specialists] and GPs with a muscular-skeletal qualification... and started to build a service framework... for some conditions there is a need for GP to GP referral process... and we support that as new activity.”

Expectations about pre-referral investigations were developed in gynaecology.

   “Similar things have been happening in gynaecology... around ten common reasons for referral... and [specifying] investigations that should be done before [specialist] referral... we are attempting to use some [new] money... saying if we can invest in primary care we can restrict the growth in our hospital setting... it’s critical transformational stuff... recognizing that generalists are having to do more in the future...”
3. Other types of GP up-skilling included:
   
   a. SMO working in practices or supporting GP services:
      
      “There is a review committee for skin lesions with secondary participation…”
   
   b. Training-up of interested GPs to do “first specialist assessments;”
   
   c. Expanding GPs range of activities (including: minor surgery and thrombolysis);
   
   d. Improvement of GPs’ active review of patients unable to be seen at the hospital.

4. Improved referral patterns and a reduction in the number of avoidable admissions.

   We have GP liaison and there are regular discussions around appropriateness of referrals to elective services and... I think it is fair to say that the liaison between primary and secondary, GP to specialist, is not bad in this area... and referral patterns are appropriate...

5. GP access to diagnostic services.

   We also have a pilot, it was funded by the Ministry but we have put a lot more funding into it, for GP access to diagnostics, to reduce pressure on First Specialist Assessment...


   In summary, primary-secondary liaison was a well-established function in most districts and had achieved a number of successes in the appropriate management of patients crossing the primary-secondary divide. It was noted that there were difficulties communicating with GPs because of the separation between practices. Electronic communication has the potential, realised much more in some DHBs than others, to aid discharge processes and reduce repetition in patient work-up.

   **A1.3.8 Provider Development**

   DHB managers saw the responsibility for the development of primary health care providers as situated largely with the PHOs; the DHB offered various sorts of encouragement, particularly within the area of clinical quality and the development of a population approach.

   “I think there is a role for us if they asked us to get involved but this something that they do autonomously...That goes on at the moment.”
With regard to **clinical quality**, several managers mentioned joint DHB/PHO forums and one mentioned a plan to create a consensus-based development programme. In some cases, DHB and PHO representatives sat on each other’s clinical executive bodies and this was seen as a promising direction for the future.

> “Clinical quality officially comes under the PHOs... the PHOs have their own clinical advisory committees...”

> “PHO has its own clinical governance group and the DHB are about to be represented on it.”

> “This would be someone who would sit on the clinical governance for each of the PHOs to get consistency between them.”

PHOs or MSOs operated a variety of educational activities, including: CME and CNE; use of BPAC and clinical facilitators; and feed-back of clinical statistics. The National Performance Management Programme assists in improving quality and several DHB managers mentioned the use of the Cornerstone programme in provider development. Some PHOs had quality plans in place with practice incentives for improved performance; others had appointed clinical quality advisors. One DHB manager mentioned the need to educate new practitioners and felt that this was done poorly.

> “The PHO hosts CME sessions twice a week...”

> “We have the performance management programme as well as BPAC (which looks at pharmaceutical usage and diagnostic patterns)... there is a lot more work that we could be doing around that... to support our general practices...”

> “There are clinical quality positions in many PHOs now... it depends on the person... the performance management programme has focused people a little... and [it depends] on the capability and capacity of the PHO... this is where size does matter... [you have] to get people to standardise Reid codes and how they put data into the system...”

> “All the PHOs have clinical governance boards... they are all participating in the performance [programme]... We have CME through the IPA... and pharmacy facilitators through [the MSO].”

> “[Our] PHOs are quite different, since [one] is under the MSO umbrella they have a pharmacist and GP, an annual quality plan... incentivised for the doctors... they have a pretty good structure...”
“The three PHOs have a clinical lead... and they all three have a nursing director as well – so they take a leadership role around the training and the development of processes and around the exception stuff... we don’t generally get involved with it at a PHO level. Individual things are addressed on a case by case level...”

“[With regard to practice process] most of them are now looking at the Cornerstone accreditation process... most of the [local] practices are going through it or have gone through it and the PHOs have quality plans in place...”  

Some PHOs are doing well in this area but there is significant variation.

“They are pretty on to it and take it very seriously... they [look at quality indicators] and we use target setting to incentivize that with the PHOs... they are getting regular reporting on diagnostic usage and screening uptake and that is fed back out to them... Each PHO does it slightly differently but they keep [the practices] on their toes... and if they have a practice that is not performing they address it...”

The DHBs encouraged the PHO in these activities and some managers mentioned reviewing audits, for example, of prescribing, laboratory testing data, Care Plus and Get Checked uptake. One DHB mentioned supporting a reference group; another had a consultation and clinical review process relating to chronic care management; another contracted a change management specialist to help practice change. It was felt that these activities would strengthen as more DHB provider arm services were devolved to primary care.

“We (referring to the DHB) are driving it through the combined forum (referring to the PHO CEO and clinical leaders’ group). We have just completed a confidential audit of what quality activities are in place in PHOs and practices.”

“We have a laboratory review group and we feed some of that information on...”

“[the DHB] have a lab and pharms reference group that looks at data and feeds back out to the sector...”

“We have District Management Groups in, for example, cancer and for each of the priority groups... they do not have much effect on the practice level... That issue about... how you change the way general practice is behaving... is key for us... it’s quite hard work... the main thing we are doing is just interaction... We do, for example, an audit of the percentage of malignancy for the skin surgery.”

“Information comes through [to the DHB] through the audits...”
“The DHB knows about [e.g.] Care Plus and it is variable… some practices are doing incredibly well and some do not appear to be interested… I think health targets help… they give the DHB a mandate to work with practices…”

“A few months ago we contracted a change management specialist to work with PHOs on good practice for change management.”

With regard to expansion of the **population approach** in primary care, this was working better in some areas than others and seemed to be a PHO, rather than a practice, focus. This was also an area in which DHBs attempted to support PHOs. One mentioned a population approach team at the DHB; this focussed particularly on HPV immunisation and the implementation of the HEHA scheme. One DHB mentioned that it would advantageous to include the Public Health Unit in this area.

“The population approach is happening more at a management level in the PHO, rather than within the practices… some GPs are beginning to understand more than others…”

“Certainly PHOs see things at the population level. I don’t know if GPs see things at the population level… Population approach, our expectation is that we have contracted for that approach.”

“We have set up a population health team that is attached to planning and funding. They head up HPV, tobacco and HEHA.”

“If we had the Public Health Unit in the DHB, it would improve things.”

“All our PHOs have really creative health promotion programmes… the SIA is really a population approach within each PHO… and we have some really creative stuff… some of it is about trying to capture people who are not enrolled… one PHO is developing a [mobile general practice team] and they go to marae and shearing sheds offering health checks and also using the opportunity to enrol people who are not enrolled in a PHO…”

Provider development including **better management, improved efficiency, and the development of teamwork** were seen as largely a PHO responsibility; where there was an MSO, it often played a role. DHBs might intervene if a particular problem was identified.

“The practices and PHO look after practice efficiency… if there is a major problem the DHB does go in and mediate…”

“[With regard to management] one PHO has facilitators… who go out to the practices and walk alongside them...”
“One of the PHOs does quite a bit of work with the practices showing them how a multi-disciplinary team can work and the advantages of the funding streams... Care Plus etcetera... some [PHOs] are better than others...”

While some PHOs had improved the functionality of primary care providers, DHB managers tended to see PHO efforts to change practices as ineffective. They suggested that practice change had been minimal and some alluded to conflict between PHO and GPs. Many informants recognised the capacity limitations of PHOs in obtaining change and the difficulty practices faced when making changes given that they were already working at capacity.

“Primary care in [this area] was dreadful... there was fighting between practices and it was probably not marvellous clinically... [Now] in terms of the current indicators of PHO performance they are one of the best in the country... they are responsive and they move very fast.”

“Theoretically the PHOs have a clinical governance board... they are not doing much at the present time... except in [one area]...”

“[Getting PHOs to do these things] is not a problem in terms of enthusiasm but it is a problem in terms of capacity... there is only so much they can do... we have people who are working like galley slaves... there is no shortage of enthusiasm...”

“I still feel that they do what they have always done... in terms of doing something new and innovative I think the PHOs would really struggle if they tried to do anything without really good buy-in from the practices.”

“It’s difficult to get good teamwork if the general practice principles are still operating... freeing up the nurses to do the pro-active stuff... when they are busy doing the stuff how they have always done it, both GPs and practice nurses... and they are barely coping with what is walking through the door... to change that is going to be difficult because it is going to require some headspace and they don’t have time to book that into their day...”

Large practices were seen as able to respond more easily but many were attached to a business model. Practices serving more needy populations were seen as more responsive to the goals of the PHCS and it was felt that practices were, in general, responsive to business opportunities.

“Our paper about the sustainability of general practice and general practice infrastructure... we said “Look the corner dairy model is not going to work...” you need larger practices so you can have professional management... plans and strategies... [otherwise] they do not know how to do it... you need more resources...”
“GPs... they would have a chance with some of the small practices... some of the bigger practices are organized around business models, it’s much harder to infiltrate into those organizations... if they are open to opportunities it is financial opportunities.”

“One of the most efficient practices is a solo practice. He uses his nurses extensively in a whole range of areas...”

Some DHBs had put resources into improving PHO governance and some mentioned the Māori and Pacific Provider Development funds in this context. Māori Development Organisations played a role in provider development in some districts.

“The MDO, which works alongside the PHO, oversees career training for all the NGOs...”

“We encourage the PHO to change [some] GP attitudes... [this] is a fairly conservative area when it comes to practice... there is that view ‘we know what we are doing, leave us alone to get on with it.’”

“[The population approach] is all things to all people... the PHOs are all looking at a population approach... it’s the degree... [with regard to GPs] it’s how business focused they are... they see population health initiatives as a cost not as a benefit...”

Managers noted a lack of GP enthusiasm for some aspects of the PHCS and stated that change could be limited given that practices remained autonomous private businesses.

“The PHO manager was recruited from the hospital... there has been some knowledge transfer.”

“I think the whole notion of what the capitated funding is for is problematic... the practices are clear that that is only about reduced costs for visits... there isn’t enough incentive for them to keep people away [with the mixed model we have]... or to look at different models of providing care... we have incentivised them to bring people in [through Care Plus etc]... they are overworked... they are making lots of money... they have appointed some more nurses but they have ended up too busy.”

“Some GPs just haven’t come into the groove and there are some who resist change and think that the way they used to work... there is nothing wrong with that... and they get very annoyed about having to report to the PHO every five minutes about their outcomes and being constrained by rules and regulations that the PHO puts around them...”
“[Local] GPs were the last to break away from the IPA or even would prefer to go independent... so they came kicking and screaming into the PHO and there was some suspicion around PHOs and what that entity was... but good changes are occurring... Care Plus participation has gone from 20% to 70% [of expected]... there is some very good work being done there... health promotion has been generously funded but uptake has been poor...”

“The GP culture change takes a long time... I think moving the funding away from a strict fee for service has helped immensely... if you take away the incentive to treat each patient as an episode by saying we will give you the same amount of money, just treat them as a whole... it makes it easier for a lot of GPs... I think they do try hard, I think they do the best they can... and they do it differently within each practice...”

“It’s like herding cats... it’s a philosophy change... what they see the funding is for and what it was designed for can be somewhat different...”

In summary, provider development was seen as a PHO function with the DHB playing a supportive role of variable intensity. The impact of the PHO on provider development was limited by PHO capacity, and by practice autonomy and overwork. For many GP practices there was little energy available for change and there was insufficient incentive to adopt a population approach. Nevertheless there were a large number of programmes in place seeking to improve provider quality, management and approach.

There was significant variation between PHOs and even more between practices. Large practices had more capacity to make changes but practices attached to a business model were less likely to adopt a population approach.

**A1.3.9 Community Education (CE)**

DHB managers were asked about the provision of community education in terms of self-management and the appropriate use of health services. In general this was felt to be a joint DHB/PHO function; in addition some DHBs had contracted aspects of CE to NGOs.

“We have a number of contracts with NGOs for health promotion, health education... we put a fair amount of resource into it...”

However, some aspects of CE were undertaken by Departments of Public Health directly funded by the Ministry and in some cases serving more than one district. Further, some CE activities were directly mandated by the Ministry.

“Most of [CE] lies with the Public Health... they have eight staff [in our small district].”
“It goes through the Public Health in the provider arm... they are directly funded by the Ministry and cover [another district] as well... the structure is different from the DHBs and accountability is limited... it’s an interesting and strange concept...”

“We have a huge amount of health promotion going on within the funding division... it tends to be all prescribed by the Ministry.”

Many DHB managers felt that CE was a function in an early phase of development and that advances could be made in the content and coordination of messages.

“It could be better. What is the range of services available? I don’t think the public know...there is a need for marketing but who does it and how it is done is not planned yet.”

 “[We have] not done a lot... we could probably make some gains by having a unity of message with the PHO... we try and consult each other around press releases... we certainly try to engage the PHO but it is not that easy... it’s hard to get actual practice staff commitment... people are so stressed...”

“We are looking more broadly at how we can keep our public informed and encourage self-help.”

A number of PHO CE projects were mentioned by DHB managers; who also recognised that PHO resources were limited.

“PHOs do some work around health literacy...”

“Some of the practices do [HP, HE] but it is very patchy... a lot more could be done about connecting up those providers and getting a more integrated approach to the whole wellness issue...”

“Funding for health promotion is quite small so PHO involvement is resource restricted.”

All DHBs had a website as did many PHOs; one DHB had mandated and supported PHO websites.

“PHOs have websites and there is a link from the DHB website to the PHO sites.”

“DHB has paid for all providers to have a home page where they can talk about their services.”
Other means of communication with the public that were mentioned included: DHB help-lines; advertising; posters (especially at the hospital and in GP offices); newsletters; the local paper; participation in local activities (e.g. Waitangi Day); and secondary school projects.

“The DHB does education through the local newspaper... we have a page in the local rag. We run a facilitation line and [...] I advise them where they can go for health care if they cannot register with a practice and which practice they should wait list with... or advise them about after-hours or ED.”

“We use advertising, we have posters in each GP clinic, the same as the ones we have in the hospital...”

It was reported that many people were unaware of PHOs; they had a relationship with a practice and received information only from that practice.

“We have PHO websites... [but] many people do not know what a PHO is...People still historically choose their GP and the fact that they align with a [PHO] is neither here nor there to them. We need a campaign to educate people about what a PHO is and what we can expect from them.”

One DHB mentioned self-management groups and training a cadre of community members able to give advice about general or specific aspects of self-management.

“Jointly we coordinate and run several [...] self-management education groups and this has been positively evaluated [...]. Generic self-management and disease specific self-management is offered. We have also trained people [...] in order to build up a critical mass of PHO and lay leaders in self-management for the communities.”

Information on the availability of services was also needed by new providers as well as by patients.

“New practitioners need packages of information so they know who is out there who is doing what.”

The “Healthy Eating, Health Action” (HEHA) programme has been rolled out by the Ministry over that last two years. This has involved the participation of the DHB, PHOs and NGOs, and represents an area of cooperation between all players.

“We have a really good HEHA programme going which works very strongly in collaboration with the PHO...”
An area where efforts had been made to inform the public was the availability and appropriate use of after-hours care. Activities included: appropriate information from HealthLine (a phone information service); appropriate and coordinated messages on provider answer-phone services; and other types of social marketing (see above).

“Looking at emergency services and the use of GP after-hours we are working with the Ministry and the PHOs on various projects around HealthLine – making that an augmented service and getting the message out that the Emergency Department is for emergencies and (otherwise) contact a GP.”

“[we are] trying to get [appropriate] messages on GP phones...”

“[we are] trying to get an awareness from the community, I think that is one bit the DHB will have to lead, so we get a consistent approach...”

In summary, health education is undertaken at each level of the health care system from the Ministry to the individual clinician, and a wide range of communication methods are used. Coordinated efforts tend to be made around specific issues, often after-hours care.

HE is under-developed and patchy. Social marketing of PHO services is hindered by lack of population awareness of PHOs.

A1.3.10 Community Development

Community development is a responsibility of central and local government. DHB managers reported working with a wide range of government agencies including: regional and local councils; the Ministry of Social Development and WINZ; Housing New Zealand; the Department of Justice; ACC; and ALAC.

“We do health impact assessments with the council and on the development of their long term plans... we work really closely with the Ministry of Social Development around income... Housing New Zealand... there is quite a lot of multi-sector work going on...”

Working with non-health bodies could be problematic; small councils had few resources to put into community development and MSD was found to have different drivers as well as ponderous processes.

“It’s really hard to align the mandate... MSD has different drivers and different criteria and different definitions... and they are an unwieldy organization to work with... they have quite long and convoluted processes... they don’t move fast... we have good relationships with the local folk.”
Joint programmes included:

1. Support of high risk individuals (Department of Justice, ALAC and a community group).
3. Drug and alcohol control strategies (ALAC).
4. Improving commercially available food choices for students (local govt.).

Within health, DHB manager saw this function as spread between DHB and PHO but noted the limitations of PHO resources as well as difficulties experienced by PHOs without geographical boundaries.

“PHOs say they have difficulties (referring to involving communities) because of the way [the population of the district] is distributed with few geographical boundaries.”

Some DHBs felt that working with their community was time intensive but useful; others found it hard to achieve community representation. It was felt that Māori were more likely to respond to community development initiatives than Pākehā.

“They (referring to the community advisory groups) did not work well because we did not get community involvement.”

One PHO had a programme to work with gang members and a DHB manager felt that a parenting education programme had important community development aspects.

“I think community development is key... a really good example is pregnancy and parenting education... people often meet people who they are friends with twenty years late...”

In summary, community development interventions have been initiated or supported by DHBs and PHOs. Relatively little resource had been put into this area and there were sometimes difficulties defining and representing the community.
A1.3.11 Structural Issues

The final questions of the interview with PHCMs concerned the overall progress of the implementation of the PHCSE and the factors that facilitated and prevented change. Managers were asked to mention any strategic changes they would like to recommend.

It was clear from the interviews that much has been achieved since the implementation of the PHCS. Further progress was anticipated but managers noted that change was incremental and felt that it would be realistic to anticipate substantial improvement only over a period of several years.

“If we commit to this for another five years I think we are going to see some really great things.”

At present there is a hierarchy reaching from the Ministry to front-line health workers via DHBs, PHOs and practices. Managers felt that this represented a dispersion of responsibility with duplication of effort across levels. Further, there were differences of approach and attitude between institutions.

Difficulties could arise between the Ministry and DHBs. DHB managers had often worked in a particular area for a number of years and were familiar with the issues that needed to be resolved. Staff from the Ministry of Health (or from DHBNZ) might be relatively new to the area and rarely had intimate knowledge of local issues. As a result they might want to take a “green fields” approach and were focussed on quantifiable information and generalised approaches.

“They wanted to have a workshop… [but] we know what we need to do… they want to see the evidence but are not being patient enough… Everybody is doing things differently, it’s hard to measure, it would be so much easier [for them] if everybody was doing the same thing…”

“Where you have continuity and stability is at the point of service… and at the PHO… and with Planning and Funding… where we have the greatest change and movement is at the Ministry of Health… the PHCS implementation team at both the Ministry and at DHBNZ… people come and go… and you have to educate them and they are in charge of the next phase! [They are] completely out of touch with what is happening on the ground… you have this sense of déjà vu when anyone new shows up…”

The Ministry might specify programmes and goals in a way that ignored variations in local realities and undermined local solutions.
“The Ministry should be acting in a much more strategic way... stop being proscriptive... we do not want, at a DHB level, to receive the before-school check policy which is so prescriptive you don’t have a single inch to move...”

“We are the only DHB in the country which is doing a general practice based HPV... we cannot understand why the Ministry has demanded a school-based HPV programme... when we have perfectly good general practices who want to see kids... we dug our toes in and made ourselves very unpopular but the Ministry has agreed...”

“While some of these things may be national priorities they may not be priorities in any particular district... for example elective services would be relatively [unimportant] in this district...”

Managers felt that a “bottom-up” approach worked better than one mandated centrally. They felt that the Ministry should not make “operational” decisions; DHBs should be left to “get on with it” in a way appropriate to local conditions.

“[They should] give the DHB their funding and let them get on with it...”

“It would be good if the Ministry was there in terms of policy and DHBs got on and did it! And I don’t see that happening.”

There could also be conflict between the Ministry and DHBs related to unrealistic Ministry expectations of the capacity of the DBH to implement new programmes.

“We are getting increasing demands placed on us from the centre... and those are becoming quite onerous... both in terms of reporting and in terms of new programmes... the last few months we have had about seven or eight new programmes... we are being managed from the centre much more...”

“Ministry has to consider all new initiatives [that] roll out because it puts a burden on DHBs and providers.”

There were also situations in which the Ministry bypassed the DHB in dealing with PHOs or other organisations.

“There have been interactions direct between the Ministry and primary care and that is not helpful at all.”

Conflict could arise between the DHB and PHOs. The DHB was responsible for the whole population of the district while the PHOs were only concerned about serving their enrolled population. In some cases it was difficult to identify the population served by the PHO.
“Part of our problem is that PHOs do not service one geographical area so that makes it more difficult to deliver services... they overlap.”

“PHOs say they have difficulties [involving communities] because of the way [PHOs are] distributed with few geographical boundaries.”

The DHB needed to address issues of equity and variation which did not necessarily concern PHOs.

In addition, PHOs were focused on general practices rather than on all aspects of primary care. PHOs had often not integrated additional professionals, such as pharmacy, midwifery and therapists, into the service, nor had they included NGOs, such as Māori providers.

“PHOs and the PHCS was primarily focused around doctors and [practice] nurses and was not inclusive of pharmacists, other therapists... you were meant to engage Māori but that did not mean you were to engage Māori providers or other NGOs... so what you have here is a service driven by GPs doing their own thing... it means that there is whole lot of people outside who would be useful but can’t get traction... because there is no incentive for the PHO to engage them...”

Since most PHOs do not include NGOs, new work cannot easily be distributed to non-general practice providers.

“As it stands right now I cannot see it working... if any service that came up we would say here you go... you do the RFP [Request for Proposal] etc... they have a network and they do not have a structure in place for people outside of the network so it will all go to that network and would be captured in that way... all providers are not under the PHO, that’s the problem, all providers do not align to a PHO.”

One means of reducing duplication would be to delegate DHB responsibilities to PHOs but a manager felt that this would not work because of the alignment of PHOs with general practice.
“That would mean me trusting the PHOs to do the stuff which we do... and to be perfectly honest, I don’t think that is going to work and I’ll tell you why... because PHOs are aligned to general practice and they have to be aligned to general practice because if they are not, general practice is just going to wander off and do its own thing... the stuff [PHOs] come up with is always sympathetic and gentle on general practice... what about equity, what about the priority areas, what about the variability in prescribing rates? What about the Get Checked programme or Care Plus that nobody is doing? There are population issues and practice issues that are too hard for the PHO because that will upset their relationship with general practice.”

PHOs may sub-contract work, further attenuating the influence of the DHB and increasing the transaction costs involved.

“I think the PHO thing is completely rooted... I used to be gung-ho and a real fan of it... the problem is that it is a replication of resources... and we having contracts with the PHO which then has contracts with another provider... I have no influence on what is happening down there... the level of resources and overheads going in [to the PHO] is huge... they are really expensive to run and they are just another set of overheads over our overheads... it’s duplicating what the DHB is doing... you could say “don’t do it“ but that would mean me trusting the PHOs to do the stuff which we do... and to be perfectly honest, I don’t think that is going to work.”

One manager mentioned that NGOs had looked to the PHO to provide leadership but that none had been forthcoming.

“NGOs say we supported the creation of PHOs but we had in mind that the PHO would provide some leadership and coordination in our community... OK, so they don’t have anything to do with maternity but that would not stop them from getting together with maternity people and talking about what needs to happen and doing it... but that is not what has happened... in actual fact what they have done is hogged the resources to themselves and duplicated what NGOs are providing... [NGOs say] we never hear about [PHOs] unless they want to do something to us... and the PHO response is that we have nothing to offer you... we have no resources, no money, no control and we are so busy doing this other stuff... we haven’t got time anyway... “

Some DHBs are working to move PHOs away from the general practice focus.

“PHOs are still pretty much a GP focused outfit... we are trying to move them to being connectors of providers and services in a much more holistic way...“
“We did go through some concerns... that we listening to the PHOs and tending to ignore the other NGOs in the primary care sector... we are working quite hard to move the PHOs from a GP focused entity to... one which coordinates activity in the whole of the primary care sector... but of course the funding mitigates against that.”

The capacity of PHOs to generate change in general practice, as well as to improve integration of primary care, was limited by their need to retain practices. As a result, beyond distribution of funding, some PHOs were relatively inactive and were not successful in transmitting DHB messages to practices. Further, the PHO attenuated the relationship between DHB and provider.

“There is a bit of distance between the practices and the DHB... we have an issue of how the information is relayed... it goes through the PHOs... sometimes you need a direct link with the practices as opposed to being filtered through the PHO... with the PHO structure sometimes that information gets lost... [when new programmes come out] the PHO either puts their spin on it or do not understand it themselves so some of the benefits may be lost...”

“We deal with PHOs but there is a whole management arm that sits under them and then the general practices do not always align that well with their PHO or even know what their PHO is doing.”

These difficulties were exacerbated by lack of clarity about the role of PHOs; in particular some provided services while others confined their activities to funding GPs.

“Clarity is a big issue... all the portfolio managers have a different view and so do the PHOs... and where do the NGOs fit?”

It was acknowledged by DHB managers that PHOs found themselves in a difficult position. Many PHOs were unstable and might not be sustainable in the medium term, particularly if their role extended beyond general practice. They did not have the back-up services available to a DHB.

“The PHO has not had the capacity or capability to take over many of the contracts.”

“[The capacity of the PHOs to do the job] depends on how the job is defined. If the definition is bringing in NGOs and other primary care providers, then no. If it is simply a general practice structure, then yes.”

“Workforce development, capacity, service development, information systems, HR... all that stuff that the DHB just has... incentives for that would benefit the PHOs”. 
These problems were particularly acute for smaller PHOs. Some of these increased their capacity by obtaining contracts for additional services. All were dependent on the commitment of their staff.

“We ask them [referring to a PHO of 10,000 and a PHO of 100,000] to deliver on the same things regardless of size, situation or ability.”

“The bigger PHOs have better infrastructure and can provide better support and services to their providers. The smaller ones are a little bit more in survival mode.”

“I would say all of them are on the edge of capacity... the small PHOs really struggle... they cannot even fund cooperation…”

“If you are really living the Primary Health Care Strategy... the most important thing is that you are really representing the community with the greatest integrity... [some small PHOs do that but] it depends on an incredible dedication on the part of the health care professionals... on altruism…”

Cooperation between PHOs was inhibited by competition and differences in approach. Many PHOs feared that they would lose their identity if they joined with other organisations.

”The competition model is just not working. We currently have one PHO actively taking practices from another.”

“We have PHOs with less than 10,000 enrolled people and we have other PHOs that have 100,000 plus and they are chalk and cheese.”

“Lots more things could be shared in terms of economies of scale and efficiencies. But now [PHOs] are all set up as their own empires.”

“[Some of our] PHOs are working together collaboratively now... their governance will meet and put in proposals together ... but [others] not so... based on personality issues... at a top level... one lead PHO is not going to work…”

“They can see the benefits of merging but the sense of identity is too strong.”

Several managers felt that there should be a single PHO for each district; however, it was acknowledged such an arrangement was problematic given differences within the district related to high need populations or geographical disparity.

“It would be far easier if there was one PHO per DHB.”
“[It would be desirable to have] only one PHO; everything for us is multiplied by six, it’s just not efficient”.

“There probably are too many PHOs... if you think of getting PHOs to take on activities such as needs assessment, providing more services in the primary setting, taking on devolved services from the secondary area... and the outgoing Ministers signals about PHOs becoming more leaders... some of them are too small... they are not going to have that capacity... it’s not going to happen... some of the small PHOs are Māori providers that provide very distinct services...”

“A joint management structure in one district makes it easier to roll out new initiatives and work with the PHOs... [In others] five different PHOs, five different boards, five different CEOs... it’s tricky.”

“Ideally we would want to amalgamate the three smaller [PHOs]; work has been done on this because they struggle because of size.”

While MSOs provided valuable support to PHOs they were also focussed on general practices and in some cases inhibited the development of PHO capacity. MSOs were also seen as expensive and not necessarily responsive to DHB needs. Interestingly, one MSO was seen as “heavy-handed” by GPs; this would suggest that they were able to push for change in general practice.

“I still don’t think we have the structure right... [MSOs] are still working on an IPA model...”

“[The previously MSO] was quite problematic... they had no local staff... it was a PHO in name... but it was not fulfilling the functions of a PHO... [the manager] would come one day a month and when it came to the primary mental health care initiative... they were not keen to employ staff... it wasn’t kind of the point... [The new MSO is] quite responsive...”

“On the face of it they have enough enrolled population. It’s a good medium sized PHO and they have a nicely defined geographical area...but...an incredible amount of money has gone to the IPA.”

“[The MSO] is a brilliant concept and it has definitely brought to our district a level of expertise that was lacking hitherto... on the other hand GPs say they do not have a very good relationship with them because they are heavy handed... they do what they want to do and not necessarily what the [DHB] wants them to do... they can be argumentative and they are very expensive...”

DHB managers felt that, in general, GPs were reluctant to take on the goals of the PHCS. Their capacity to engage in planning activities was limited by their workload. In addition,
general practices operated independently and this inhibited their capacity and willingness to act in cooperation with other practices.

“We are not easily able to utilize the skills of GPs and clinicians in our planning and strategy work because they cannot afford to take a morning off and be involved with Planning and Funding on their strategy work and we cannot afford to pay that amount of money... it leaves us open to the criticism that [our plans] have big holes in them, because we do not have clinical input...”

GPs are asked to undertake increasing amounts of work without appropriate funding.

“GP practices are feeling that they are continuously getting more work shoved on them.”

“It’s hard... either we fund the practices to do a population health approach or we recognize the fact that they will do what they can and there needs to be another tier, either PHO or DHB run, which does the rest... if I was running a business and I was being asked to do more and was never seeing any more money, I would look at other options...”

Further, most GPs were running small businesses and this was thought to be incompatible with the aims of the PHCS. In particular, there was no incentive to enrol “difficult” patients; in this category, new solo mothers, those with debts to the practice and Māori were mentioned

“[The PHCS] requires a not-for-profit approach... when you are working in a small business model there are a whole lot of other values that creep in... this is probably the biggest issue for the model... the PHCS was not predicated on a for-profit model... People should be able to enrol with a PHO not a GP... there could be a whole range of providers... because people enrol with a GP the money gets captured... this is a big issue with the nurses...”

“Solo parents who have come in from out of area who are finding it hard to link up with a responsive primary care service... they do not have their doors open and are not very welcoming at the moment...”

“If you have run up a debt with a GP now you don’t get in until you have paid what you owe... we have had evidence here where any member of a Māori family has debt they have been told to go away... and it makes it difficult for [people who are entitled to free services but] couldn’t access them because the practice said ‘by the way you still owe us...’ so they may not feel able to go into the practice and get the free smears...”
“In terms of the business model of the individual practices... I would prefer to see it as a much more collaborative model with a joint mandate with the DHB... it’s almost like you didn’t go far enough with PHOs...”

There were several underlying tensions in primary care. One was the shortage of doctors, nurses and managers.

“We have a closed book situation here, so people are unable to enrol and it impacts on our ED... we keep the PHOs informed of the number of un-enrolled people.”

“We have real problems developing in rural areas with fewer GPs willing to take over the businesses.”

“A major problem [for one rural PHO] is around recruitment and retention, not only of GPs but nurses as well.”

“The PHO have used locums which is more costly for them... they have struggled for the last 18 months...”

Second, the PHCS did not address the division between primary and secondary health care. This was critical in the care of chronic conditions and likely to expand with population ageing.

“I don’t think the PHCS did anything for the relationship between primary and secondary... it doesn’t provide incentives... it doesn’t speak to the fact that we need to do away with that divide...”

Third, the piecemeal growth of programmes had resulted in poor coordination and high transaction costs. It was felt that a more trusting approach to contracting should be adopted and that the focus should be on monitoring outcomes rather than inputs.

“We should contract with people confidently and let them get on with it... make sure the service specs are right and that there is good evaluation...”

“It’s a symptom of the fact that the PHCS is new and PHOs are young... but our contracting is far too piecemeal... The PHOs are chopping things up into little bits... we are looking to a whole big PHO contract with a whole series of service lines... and we want to measure outcomes, not inputs... we want a flexible, streamlined, contracting system... with minimal buckets of funding which looks at patient and population outcomes as opposed to directing inputs at the front end...”
“Incentives should be quality outcome driven as opposed to incentive for input or process.”

Furthermore, evaluation measurements should be aligned. Examples were given of different data required by the DHB and the Ministry in the evaluation of the same activity.

“I would like to see some alignment of the target setting regimes... there is a lot of monitoring that is not particularly consistent... if you could sort that out you could start to have a joint agenda... you don’t need a lot of measures, you just need some key ones... we have a lot of agenda driven stuff that is not helpful... [to] the PHO, a lot of stuff that appears to be left field and does not take any notice of all the hard work that they have done... if the Ministry would take a deep breath and say we do not need different health targets for the PHOs and the DHBs... then you would have a reason for the PHOs to sit down and say [for example], ‘How are we going to get a 90% immunisation rate... [we both have this target] but we use different information!’”

Finally, the PBFF tended to underestimate the cost of providing special services for groups of high need and difficult to service people.

“We have the sickest people, have the highest proportion of Māori and we are the poorest. The current PBRF doesn’t account for this.”

In summary, DHB managers see themselves as aware of local conditions and responsible for the whole population of their district. In some circumstances the Ministry has created difficulty by imposing national programmes, while PHOs have not been in a position to serve the whole community nor to expand beyond general practice. There are disincentives to GPs taking up the goals of the PHCS.

Informants mentioned the need for clarity in defining the roles of DHBs and PHOs. However, each district has made progress within the constraints of the local situation. It is possible that any effort to standardise the structure of primary care would do more harm than good.

Just as the Ministry over-specified some requirements of the DHBs, the DHBs did not feel that they could trust all PHOs to implement the Strategy.
A1.4 Discussion

In this section we discuss the findings from the survey of DHB primary care managers, summarising their views on the state of primary care in New Zealand. The first part reviews the general situation and the second part discusses particular issues that have been identified above.

A1.4.1 General Situation

In the seven year since it was promulgated, there has been significant progress in implementing the Primary Health Care Strategy. More than eighty Primary Health Organisations have been set up and the great majority of the New Zealand population is enrolled with one. There is evidence that fees have been reduced for vulnerable populations and that utilisation of PHC has increased. Many PHOs and their constituent practices have initiative creative programmes, often funded with SIA money, to adopt a population care approach. In some instances there is good co-operation between services of different types.

However, a key impression gained from DHB managers is that there is a great deal of variation across DHBs, PHOs and practices. Some have generated little change, particular problems have been resolved in some places and not in others, and solutions have differed across organisations.

This variation is related to a lack of detail in the specification of PHOs; while all had to possess certain features and perform certain functions, issues of size and situation were left to the DHBs and influenced by the existing grouping of general practices in their district. As a result PHOs vary on three fundamental dimensions. First, the number of enrollees varies by a factor of 100 from three to three hundred thousand. Most large PHOs are based on large, pre-existing IPAs (and some obtain management services from IPAs now morphed into MSOs), while many small PHOs are based on small pre-existing provider organisations set up to serve more vulnerable populations. Second, some PHOs have become providers of service in their own right while others have not, and, fourth, the population served by each PHO may be geographically distinct or may overlap with other PHOs of a similar, or of a different, type.
Each of these characteristics have lead PHOs to respond to the PHCS in a different way and each has distinct advantages and disadvantages. Many large IPA-based PHOs tend to be attached to the status quo ante; they sometimes lack close relationships with their practices which are mostly GP-owned small businesses. Large PHOs have the resources to undertake projects of many kinds. Small PHOs have closer relationships with their constituent practices and those previously set up to deal with vulnerable populations are in sympathy with the goals and approaches of the PHCS. However, they may lack resources to fulfil their basic obligations and have limited capacity to generate new programmes and approaches.

PHOs that provide services are in a stronger position to encourage coordination of primary care but may be perceived as a threat by professions or provider organisations currently outside their network.

Overlapping PHOs may be in competition for medical practices and may resist joining rivals in district initiatives. It is also problematic for them to identify and engage with the community they serve, particularly individuals who are not enrolled with a PHO. However, the existence of several overlapping PHOs in a district does provide greater choice for consumers, particularly if there is a PHO dedicated to serving more vulnerable populations.

A second key impression is that there are implementation issues related to the multiple layers of responsibility passing from the Minister of Health to individual clinicians by way of the Ministry, DHBs, MSOs, PHOs and practices. Who has responsibility for what may be unclear and differences of approach may lead to friction. Those at each level may consider the demands of the level(s) above to be unreasonable and the response of the levels below to be inadequate.

Departments of Public Health add additional complexity to this hierarchy. Their precise role varies by district and their responsibility may cover more than one district.

The Ministry has the ultimate responsibility to move PHC forward but each DHB has the detailed knowledge of the situation on the ground. This is particularly relevant given the variable situation across districts alluded to above. Ministry programmes are seen to be unduly prescriptive and DHBs believe that the Ministry should set overall goals and allow the DHB to work out the details that make sense in their particular situation.
Each DHB has responsibility to provide health care to the whole population of the district and has reservations about delegating this to the PHOs. They note that each PHO: is only interested in its own population; lacks analytical, management and governance resources; and are focussed on general medical practices to which they are beholden. DHB managers noted a fundamental conflict between the population health approach and the exigencies of practices as small businesses; this is worsened where practices and practitioners are overworked and have little energy to embrace change.

The situation of PHOs will be reported elsewhere but, in summary, they may experience the DHB as being unnecessarily prescriptive and practices as being resistant to change. Many managers felt that PHOs were ineffective in encouraging practices to improve processes or adopt a population approach.

Despite confusion about the roles and responsibilities of the players and areas of conflict between them, significant progress has been made in each of the areas discussed above. New programmes have been implemented and relationships are being built.

DHB managers were clear that further development will be incremental. It seems unlikely that mandated structural change would be useful and it would destroy the relationships that have been built up over the last six years. Managers were clear that joint-ventures and partnerships between DHB and PHO, and across PHOs, was the way to move forward. A number of specific issues (see below) have been identified which should be addressed; it is thought that solutions need to be found locally.

It would be desirable to take advantage of the layered structure of the New Zealand health system. In general it is suggested that the Ministry set national objectives and identify appropriate indices to monitor their achievement and that the DHB seek solutions which fit the district situation. PHOs can take advantage of their connection with small area populations to gain feed-back and to organise and improve care.

Greater clarity on the location of responsibility is required. Table A1.1 gives a list of functions and their current location.  

9 Since the research was completed the Minister has announced the creation of a “National Health Board” to undertake planning and funding across all districts. If this is to reduce friction and improve efficiency its responsibilities will have to be carefully defined. How will national planning at the Board be distinguished from policy at the Ministry, and what aspects of planning and funding will remain with individual DHBs?
### Table A1.1. Location of Responsibility in the Health System

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<th>Responsibility now</th>
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<td>Direction of PHC</td>
<td>Ministry</td>
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<tr>
<td>Setting goals and monitoring progress</td>
<td>Ministry</td>
<td>Simplify</td>
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<td>Data analysis</td>
<td>Ministry, DHB, PHO</td>
<td>Divide/clarify responsibility</td>
</tr>
<tr>
<td>Health needs analysis</td>
<td>Ministry, DHB, PHO</td>
<td>Divide/clarify responsibility</td>
</tr>
<tr>
<td>Service co-ordination - district</td>
<td>DHB</td>
<td></td>
</tr>
<tr>
<td>Service co-ordination - small area</td>
<td>PHO</td>
<td>Needs defined population</td>
</tr>
<tr>
<td>Service co-ordination - primary/secondary</td>
<td>DHB/PHO</td>
<td></td>
</tr>
<tr>
<td>Ensuring service capacity</td>
<td>DHB</td>
<td></td>
</tr>
<tr>
<td>Ensuring medical service quality</td>
<td>PHO (MSO)</td>
<td></td>
</tr>
<tr>
<td>Ensuring other service quality</td>
<td>Contractor</td>
<td>See note</td>
</tr>
<tr>
<td>Individual health care</td>
<td>Clinicians/practices</td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>Professionals/management</td>
<td>See note</td>
</tr>
<tr>
<td>Community development</td>
<td>DHB</td>
<td></td>
</tr>
</tbody>
</table>

Note – Includes a wide range of disparate services including: independent professionals (midwives, pharmacists, counsellors); NGOs (health education, mental health, addiction, social support); and DHB services (district nursing, retinal screening, etc.).
### A1.4.2 Specific Issues

**Relationships** – The on-going development of relationships between DHB, PHO and practices would encourage cooperation and partnerships between those caring for district populations.

**Data** – Improved population data would allow PHOs to develop needs analyses for their own population; it could also increase the quality of DHB HNAs. At present databases rely on utilisation records; while these could be improved, surveys of non-users may also be required.

Improved clinical data sharing between hospitals and practices would save resources and reduce the risks to people passing in and out of secondary care.

**Small PHO support** – Small PHOs provide care for vulnerable populations including Māori, Pacific and deprived people in the cities, and small communities in rural areas. If they are to continue this essential work and adopt new approaches to population health, support needs to be provided to counter dis-economies of scale. Such support might include back-office functions, staff support and recruitment (as already supplied by MSOs in some cases). Compliance costs might also be reduced by simplified contracting and reduced reporting requirements.

**Practice change** – Many managers indicated a resistance on the part of practices to change. The changes required of PHC by the PHCS include: a focus on prevention; identification and removal of inequalities in access to care; and co-ordination of services. There is also an expectation that the role of nurses in practices will expand and that practice professionals will work as a team.

It might be suggested that many GPs will only be comfortable with the first of these (prevention); they might say that it is the only one that comes within their training. GPs might also say that population issues are beyond their purview and that they do not wish to promote their services to those who do not request them. They might indicate that they are not interested in heading a team of disparate workers or of co-ordinating disparate services (beyond the needs of the individual patient). Resistance to undertaking these extra functions is understandable among those sharing such views, especially if they are already overworked and see no financial reward attached to them.

If this analysis is correct, it would be appropriate to situate these functions (“the population approach”) with PHOs. PHOs should continue to work with practices to improve clinical quality and management processes.
Inclusion and co-ordination of community services – The many health services provided in the community are in urgent need of co-ordination. While most PHOs remain identified with general medical practice and have no financial relationship with the majority of other health professionals or NGOs, they have little capacity to, or interest in, extending the range of services they provide or co-ordinate.

If appropriate incentives were provided, services now provided by DHBs might be devolved to PHOs, services contracted for by DHBs might be contracted by PHOs or DHBs might pay PHOs to undertake a coordination role. Co-ordination might be improved by employing additional people in practices or by co-location of services.

Distribution of services – At present independent professionals may work where-ever they like. Although the PHCS allocates funding, via capitation, in alignment with population needs, professionals may compensate for smaller workloads by increasing direct patient charges. It is possible that the incentives contained in the VLCA scheme could be widened to encourage doctors and others to work in areas with higher need. The scheme could also be expanded to increase the incentive to charge low fees.
A1.5 Interview Guide - DHB Primary Health Care Managers

A. Functions

Questions for each function

Who (DHB, MSO, PHO, Practices, NGO, other) is doing it now?

How effective is the process and what are the key achievements?

How do you know how well the function is being addressed?

Are there overlapping programmes to address the function?

Who should take care of this issue in the future?

1. Analysis of population needs

2. Service planning
   a. Designing new, or redesigning old, services
   b. Ensuring service capacity is adequate and appropriately distributed
   c. Maintenance of affordability, acceptability, convenience

3. Community health service provision
   a. Community nursing (district, public health, out-reach)
   b. Problem specific – sexual health, mental health, retinal screening, chronic disease case management, etc.

4. Primary/secondary care liaison
5. Provider development
   a. Clinical quality
   b. Efficiency and teamwork
   c. Governance and management
   d. “Population approach”
      (keeping people well, seeking-out patients with unmet needs, addressing inequalities in access and health outcomes)

6. Community education
   a. Health literacy (danger signs, when to consult etc.)
   b. Available services
   c. Encouraging appropriate up-take of services

7. Community interventions (safe environment etc)

8. Community development (inclusion and involvement)

B. General

1. Are there any overall structural changes that would be desirable?

2. What would facilitate or prevent these changes?

3. Are PHOs in your district sustainable? Do they the capacity to do their job?

4. What additional incentives would be useful at the PHO or provider level?
APPENDIX 2

SURVEY OF GENERAL MEDICAL PRACTICES

A2  Executive Summary

A survey of a random sample of 99 practices was undertaken early in 2009; findings:

- Response rate 94% (93/99)
- Increase in GP numbers 3.9% but owners down 3.8%
- Vacancies for GPs in 15.6% of practices
- Increase of PN numbers 14.3%
- Vacancies for nurses in 13.3 of practices
- 21.5% of practices “too busy”
- But significant spare capacity, mostly in larger practices
  (overall, practices were operating at 82% of capacity)
- 22.6% of practices were not taking new casual patients
- 8.6% of practices were not enrolling new patients
- 36% of practices enrolling new practices were selective
- Asked about sustainability, 11.6% of practices said to be at risk
- Almost all practices indicated that income from PHO depended on roll
- 17% of owners/partners were on fixed incomes
- 55% of non-owners were on fixed incomes.
A2.1 Methodology

A survey was undertaken of practices that are members of HealthStat. This is a panel of 99 practices maintained by CBG Health Research Ltd. They are a random sample, stratified by district, of all practices in New Zealand using MedTek Patient Management Systems. Contact was made by telephone with the managers of each practice and agreement obtained to complete a short questionnaire. The questionnaire shown below was faxed out and returned to CBG; $250 was paid for each completed questionnaire. Ninety three questionnaires were returned, a response rate of 94%.

The results of the survey are reported below under the headings: practice staff numbers; busyness; availability for new patients; sustainability; and distribution of income. Responses to an open-ended question on problems encountered are also reported.

A2.2 Results

Practice Staff Numbers – Practices were asked to provide details of staffing at the time of the survey with an indication of how numbers had changed over the previous two years. As shown in Table A2.1, the 90 practices who responded to this question included 254.6 FTE GPs of whom 46% were owners or partners. Over the two year period, the total number of FTE GPs had increased by 9.5 (3.9%) but the number of owners had decreased by 4.5 (3.8%). There were vacancies for 22.2 FTE GPs, with vacancies at 15.6% of practices. On average each individual GP represented 0.84 FTE with owners representing 0.89 FTE and non-owners 0.75 FTE.

Table A2.1. Staff numbers with Changes over Previous Two Years (N = 90).

<table>
<thead>
<tr>
<th></th>
<th>Owners</th>
<th>Non-Owners</th>
<th>All GPs</th>
<th>Practice Nurses</th>
<th>Other clinicians</th>
<th>Reception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (FTE)</td>
<td>117.0</td>
<td>137.6</td>
<td>254.6</td>
<td>211.6</td>
<td>24.2</td>
<td>224.9</td>
</tr>
<tr>
<td>Change (2 years)</td>
<td>-4.5</td>
<td>14.0</td>
<td>9.5</td>
<td>26.5</td>
<td>0.6</td>
<td>21.2</td>
</tr>
<tr>
<td>Vacancies</td>
<td>5.0</td>
<td>17.2</td>
<td>22.2</td>
<td>14.0</td>
<td>1.0</td>
<td>3.4</td>
</tr>
<tr>
<td>FTE per person*</td>
<td>0.89</td>
<td>0.75</td>
<td>0.84</td>
<td>0.83</td>
<td>0.97</td>
<td>0.85</td>
</tr>
</tbody>
</table>

There were 211.6 FTE PNs and the number had increased 26.5 (14.3%) over the two year period. There were vacancies for 14 PNs with vacancies at 13.3% of practices. Individual PNs represented 0.83 FTE. There were 24.2 FTE other clinicians reported.
There were 224.9 FTE reception/administrative personnel and the number had increased 21.2 (10.4%) over the two year period. There were vacancies for 3.4 such workers and each individual represented 0.85 FTE.

On average there were 0.89 nurses per GP and 0.56 reception/administrative personnel for each clinician (GP or PN).

**Busyness** – When the practices were asked to indicate how busy they were, 34% chose “could take more”, 44% chose “about right” and 21.5% “too busy.” When asked to express in percentage terms, whether they could take more patients (now <100%), or if they should cut back (now >100%), of the 88 who responded only 15 (17%) chose the latter option. The mean value indicated that practices were operating at 95% of capacity but when a mean, weighted by the size of the practice (as number of FTE doctors and nurses) was taken, the value dropped to 82%. This indicates that there is significant spare capacity in the larger practices.

**Acceptance of new patients** – Practices were asked to indicate if they were able to accept new patients. As seen in Table A2.2, of the 93 responders, 22.6% did not accept new casual patients and 8.6% did not accept new enrolled patients. Of those who could enrol new patients, 36.5% were selective about who they would enrol. Fourteen (26%) noted requirements (patient living in suburb - 9, related to existing patients or recommended - 3, moved from out-of-town - 2) and eleven noted disqualifications (bad debts - 4, already with local doctor - 3, methadone users or drug seekers - 3, history of multiple transfers - 1).

<table>
<thead>
<tr>
<th>New Casuals</th>
<th>New Enrolled</th>
<th>Anyone</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Yes</td>
<td>72</td>
<td>85</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>% No</td>
<td>22.6</td>
<td>8.6</td>
</tr>
</tbody>
</table>

**Sustainability** – Practices were asked if the practice was sustainable. Forty six (48%) chose “Doing well,” 38 (40%) “Holding its own” and 11 (11.6%) “At risk.”
**Problems** – Practices were invited to comment on the problems they faced. Fifty nine (63%) took up this opportunity and generated a total of 83 comments; there were eight suggestions as to how the situation could be improved.

The largest number of comments (47) was related to insufficient resources. Twenty three mentioned difficulties in finding sufficient staff (GPs 12, Locums 7, nurses 4). Fourteen indicated that income was too low and five mentioned deficiencies in community or secondary services, and five mentioned limitations imposed by facilities.

Twenty three indicated that the workload was excessive (After-hours 9, administrative work 6, unreasonable patient demands 4).

Suggestions for improvement included better links with community services (4) and hiring additional staff (2).

**Determinants of practice income** – Practices were asked to indicate on what practice income from the PHO was dependent. Of the 93 responders, all but two indicated that it depended on the number and characteristics of the enrolled population. Of the two exceptions, one did not provide any answer and the other indicated that income was dependent on the number of services provided (“fee per service”). Twelve practices said that income was also dependent on the volume of service; this may have included some who were reporting fees earned at the practice itself.

**Determinants of GP income** – Practices were asked what factors affect GP incomes; the response is tabulated in Table A2.3. Among GP practice owners/partners, the size of the individual list affected income in 52% of cases, the number of patients seen in 69% and the fees earned in 69%. It should be noted that multiple factors influence income and the total for all factor is 211%. There may be some difficulty in determining the relevant factors; list size, patients seen and fees earned would all be significant for a solo-practitioner. It is noteworthy that a fixed income is received by 31% of owners.

Among non-owners, 82% received a fixed income with some receiving income based on work volume and fees earned.
Table A2.3. Distribution of General Practitioner Income

<table>
<thead>
<tr>
<th></th>
<th>Number Eligible</th>
<th>Number Responding</th>
<th>List Size</th>
<th>Fixed Income</th>
<th>Patients seen</th>
<th>Fees earned</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>60</td>
<td>54</td>
<td>28</td>
<td>17</td>
<td>32</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>67*</td>
<td>90</td>
<td>52</td>
<td>31</td>
<td>59</td>
<td>69</td>
<td>211</td>
</tr>
<tr>
<td>Non-Owners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>71</td>
<td>67</td>
<td>9</td>
<td>55</td>
<td>24</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>79*</td>
<td>94</td>
<td>13</td>
<td>82</td>
<td>36</td>
<td>27</td>
<td>158</td>
</tr>
</tbody>
</table>

*Percentage of all responding practices. Combined percentage 146%; 46% of practices

A2.3 Discussion

Respondents represented about 8% of New Zealand General Medical Practices; they are, however, likely to be representative being a random sample stratified by district and with a good response rate. Of interest, is a decrease in the proportion of GPs who are owners and a significant number of vacancies for both doctors and nurses despite recruitment over the previous two years.

Some practices were “too busy” but overall there was some spare capacity. A significant number of practices were not accepting new patients or were selective over who they would accept.
A2.4 Questionnaire - Primary Health Care Strategy Evaluation

In each category, how many people work in the practice now and how many were there two years ago? If you have any vacancies, note how many in each category.

(*FTE = full time equivalents; a morning, afternoon or evening shift = 0.1*)

<table>
<thead>
<tr>
<th>Category of Personnel</th>
<th>FTE 2 years ago</th>
<th>FTE now</th>
<th>Number now</th>
<th>Vacancies now</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs – owners and partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs – NOT owners or partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other clinicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reception and administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For the following questions please tick and fill in the boxes:

1. Is the practice able to accept new casual patients?  
   - Yes □  
   - No □

2. Is the practice able to register new patients?  
   - Yes □  
   - No □
   b. If yes, do you register anyone who applies?  
      - Yes □  
      - No □
   c. If no, who would you accept or not accept:  

3. How busy is the practice?  
   - Could take on more □  
   - About right □  
   - Too busy □  
   Enter how busy as a percentage?  

% (90% = could manage 10% more; 105% = should cut back by 5%)
4. For regular daytime work, which of the following affects GPs’ incomes?

<table>
<thead>
<tr>
<th></th>
<th>Owners/partners</th>
<th>Non-owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal list size</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Salary or fixed fee per session</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Number of patients seen</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Co-payments earned</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. How would you describe the sustainability of the practice?

   Doing well ☐    Holding its own ☐    At risk ☐

6. Is funding for first contact services from the PHO dependent on... (please tick as many as apply):
   Number and characteristics of enrolled patients ☐
   Number of consultations ☐ Other ☐ Please specify

7. Please list any problems facing the practice and changes in the health care system which would assist
APPENDIX 3

INTERVIEWS WITH PHOS

A3  Executive Summary

A purposive sample of ten diverse PHOs was drawn and interviews conducted, in 2009, with the PHO manager and representatives of two practices in each.

While there was a general sense of progress in implementing the Strategy, the main impression was of variability both in activities undertaken and in opinions expressed.

PHOs had implemented a wide variety of programmes, some through GMPs, some by arrangement with other organizations and some directly.

Both PHOs and practices noted difficulties related to health services and professional groups not initially covered by the Strategy. In particular, community-based nursing services, which had a natural affinity with GMP, lost effectiveness and efficiency by operating separately.

In some areas, PHOs and GPs were in conflict. Some GPs felt that PHOs were encroaching on their domain and independence; some PHO managers felt that they were unable to interest GPs in the PHO and in the population health goals of the Strategy.

A3.1  Methodology

Ten PHOs were selected so as to ensure that there was representation of large and small organisations as well as those with low cost access practices. Examples were taken across the North and South Islands.

Each PHO was contacted and the manager asked to participate in an interview; an information sheet and an interview guide were then sent out and contact made at the agreed time. All PHOs approached agreed to cooperate. Information on the two Māori and Pacific PHO are reported elsewhere. PHO interview guides are shown at the end.
A3.2 Findings

A3.2.1 Structure

Each board was appointed following some sort of nomination process. General practitioners, PNs and practice managers were all represented on the boards but the majority of board members were community members, many specifically representing Māori. All managers interviewed felt that their PHO Board operated well. Two comments were made about board function: sometimes it was necessary to “sell” clinical programmes to non-clinical members; and it was sometimes difficult to obtain interested GP participation. Also, the focus of the GPs might differ from that of the PHO.

“With the GPs we only get one at a time... I think that [lack of interest from GPs] is a key constraint on the strategy...”

“There is some tension... [The GPs’] desire is best practice, clinical focus... they have a focus on ‘what can we do for the money?’ Sometimes the PHO might have more of a community development focus...”

The majority of the PHOs used an MSO for backroom functions. One manager mentioned that, although it provided welcome collegial support, the MSO appeared to be understaffed and sometimes tasks took longer than previously when they did them themselves.

“The collegial support is wonderful... we share a lot of information and knowledge... that is incredible... staff who were isolated now have that collegial support... when we have staff on extended leave we are able to share the resource from other areas which is great... it’s good not to have to do the statistical staff and we can provide data from across the PHOs as evidence...”

“There do not appear to be enough FTEs within [the MSO] to meet the needs of each PHO... small PHOs do not generate much income [for them]... some things were easier to do when we were doing it ourselves... we had a quicker, smarter turn around... now there are competing priorities with other PHOs.”

A3.2.2 PHO Client Services

About half the PHOs provided services directly and several contracted individuals or organisations for services other than general practice. In some cases PHOs worked with other providers rather than contracting their services.

“We provide mental health services [directly]...and diabetes support, patient education... also training services for practice nurses... we have trainers on staff...”
“We have two Māori providers and then there is a whole lot of little NGOs... we have a robust relationship, rather than a contract, with the little NGOs, [perhaps] because we were initially collocated with them...”

“We will contract NGOs... ring me next week. Our plans are to do this more and more...”

There was a sense that the choice to provide services directly had been made reluctantly and when no adequate alternate provider had been found. Several managers mentioned that they did not want to be seen to be “taking over” and that existing services sometimes felt threatened by the PHO.

“Where a service does not exist at all in our community and it has been identified as crucial... we often need to develop it ourselves and run it... we are often an incubator. Where possible we will contract another provider... We contract [professionals] where the service is available across our providers... for example dieticians...”

We are already seen as quite a large organisation... but we should not be providing services that other people can... Most of our services we contract out, the philosophy of this PHO has been to support local providers... if that is impossible we set up the service ourselves and look to devolve it... we have about 13 staff and we contract out to about 80.”

A3.2.3 Status of PHOs

PHO managers were asked about the status of the PHO and its plans for the immediate future. Responses to the first questions varied from “doing extremely well” to “stable.” One mentioned that having “started from scratch” they had been slow to develop but were now doing well with good infrastructure and a good relationship with member practices.

“We started from scratch... in the beginning we felt a bit disadvantaged... now we feel in an advantageous position because we were moving fast... we were not held up by the MSO... We have established a good base... we have a quality infrastructure in place and good co-operation from our members... supporting our GP members is a vital part of our being sustainable.”

The stated reasons for a positive status included:

1. A geographical base (no other PHOs in area covered)
2. Critical mass (in the actual case, 80,000 enrolled patients)
3. An established brand, with good community relationships

“We see engagement as incredibly important and we have achieved this with a community governance group... that group has met for five years, they are our eyes and ears... they have driven a number of initiatives within our PHO... they identified four years ago that we must look at the ‘hidden valleys’... where people are left out and they have searched them out for us...

“We belong to [a district] forum which is unique... it’s the CEOs of every government agency... the TLAs... police... welfare... education. They collectively work together to enhance the health of the community and to promote economic growth...”

4. Cooperation with neighbouring PHOs

“We have a stunning relationship with the other PHOs... we have formed a company to do the things that are better done regionally... [it does] a lot of the back room stuff for the others...”

5. Good clinical governance; a dedicated work force; and dedication to workforce development.

Issues interfering with PHO health included:

1. Fragmented services, given overlapping PHOs

“We have a population here across [the city] but we have a medical centre which is its own PHO, so how do you address population issues?”

In this connection it was further noted that small PHO were less well able to provide services to their population.

“We work well together... the only point is that they do not access our SIA funding and they are disadvantaged in that way.”

2. Short-term contracts (for non-GP services)

“A lot of our contracts outside of the PHO agreements have either a one or a two year time frame and there is not huge certainty... this sort of thing makes it very difficult to enter into long term contracts... right now the big issue is the continuity of service... the PHOs sets up a programme and someone decides to switch the funding off and the programme closes...”
3. Limited funding given better-off population
   
   “I think the PHCS is about everybody [but] the funding streams have a bias towards ethnicity and low decile groups.”

4. Small size and inadequate recognition of rural costs
   
   “As far as sustainability in the future goes, we may struggle to a degree, funding is based on population but rurality and [wide] geographical coverage has not been taken into account. The reporting and management expectations are the same...”

5. Difficulties with information management between practices and across primary/secondary boundary
   
   “The hardest [of the goals of the primary health care strategy] has been good information... we have poor information systems... every practice now uses the same PMS... we have a [regional] IT group...”

6. Poorly designed and inadequately funded programmes imposed by the DHB/MoH (especially Before School Checks)

7. The many community services excluded from PHO funding – especially DHB services and the work of pharmacists and midwives
   
   “[There are problems because] only selected funding lines are included in the PHO contract. Capitation is only for the GPs and not for the nurse practitioners, for example. The majority of community services are still provided by the DHB, from the hospital base. [As a result] we are less effective at looking after the population health.”

8. Lack of GP commitment. It was noted that there was significant variation across GPs and one manager indicated that only perhaps a third were definitely “on board.” Many GPs were said to be cynical about the changes and to anticipate that PHOs might not long endure. Many GPs were attached to fee-for-service; were not interested in population health; and saw the PHO as responsible only for processing claims. These problems were worse in areas where there was a shortage of GPs.
   
   “We have not won the hearts and minds of all our GPs... in fact only a third... they do not understand population health and [only] see the PHO as a transactional agency... generally the practice nurses are leaving their GP colleagues behind in terms of understanding... [The GPs] are doing the same things in the same way and driving themselves almost to burnout instead of taking a step back and seeing how they could do it totally differently...”
A3.2.4 PHO Plans for the Future

Several PHOs were involved in major structural changes such as:

- Separation from an “IPA” with a view to changing the focus of primary health care provision to include additional providers.

  “We think that [the IPA] did a reasonable job but there was a strong focus on practices as the sole provider... and very little integration with other services, secondary care and other potential providers, including Māori and Pacific and other NGOs... One of the reasons we pulled away from the IPA is that no entity should have funds to distribute when they represent the group of people who are the beneficiaries.”

- Joining another PHO

  “The PHO is currently exploring options for its structure, potentially joining a larger PHO... [Some believe] a larger PHO will provide more benefits for them and the enrolled population.”

2. The fusion of several practices.

  “[Several] of the GP practices are combining to form one organisation... they will continue to have [different] locations... initially it will be a joining of management and administration... their intention is to join PMS systems... there may come a time when they will share GPs and nursing...”

3. Creation of new health centres.

  “We have an integrated health care centre ready to roll... [we have a community] with huge social issues and we have the ability to do an amazing project... we want to say to the [new] government ‘let’s do it...’”

Other plans included:

1. Reducing costs and duplication

  “We had already seen the need to cut the bureaucracy and reducing duplication...”
2. Creation of new services (e.g. community nursing to encourage appropriate attendance)

“The other big project we have... we are looking at a community programme where we would bring in advanced level nursing for practice clusters so each nurse would be aligned with a population and a set of practices... so the nurses work with the practices or in the community... it will be driven by demographic and clinical high need. We believe that [almost everyone] is enrolled with a PHO but a number of them are not actively engaged with their practice... they see the practice if they are critically ill and absolutely need to but other than that there is minimal interaction... a number of these are demographic high need - the Māori, Pacific and [NZDep] 9 and 10... the community nurse project will address these people...”

3. Efforts to find “hidden valleys” of unmet need and address inequities, particularly in Māori health.

4. Improving community relationships (for example, creation of an advisory group)

“Our strategy is to turn it on its head a bit through a community advisory group and a clinical governance group and we will take direction on what our priorities are going to be... as opposed to ‘we have a bunch of money... how can we get it out to the practices.’”

“The community advisory group... allows us to take not just a health approach but also an environmental and social approach...”

5. Increased collaboration with DHB community services, NGOs and other professional groups.

“The PHO [...] is now at a stage where it has been able to develop its services and increase its communication with a range of stakeholders to broaden out from being GP centric to a more balanced approach to PHO services.”

6. Extending services beyond health by collaboration with other agencies by taking on contracts with, for example, MSD and ACC, and other logical partners

“The board has told me to extend relationships beyond health... for us that is MSD... the District Council... also with Iwi... most Hapū have plans to improve health and it’s ‘how can we work with you on that?’”

7. To address non-medical determinants of health (poverty, housing, child abuse programmes).
A3.2.5 Reducing Inequalities

All the PHOs were working to reduce inequalities; activities included: education of the PHO Board and practices; working with Māori health care providers and other Māori organisations; outreach to marae and kōhanga reo; and the use of outreach workers. Many of the latter were local people with good community connections and often themselves Māori; several PHOs were focussing their needs analysis on Māori. The importance of working with Māori was well recognised.

“We are doing some training for the Board and practices [on cultural awareness]...” “[We are] enabling a closer working relationship between local practices and Māori providers through contract and service design... The Board made the decision to focus SIA funding on Māori population... Development of regional profile of health need will assist to better target resources.”

“That is our aim, [to reduce inequalities]... we have employed local people, a number of them are Māori... we try to build relationships...”

“If we don’t make the services fit Māori we will not get any health gain.”

It was noted that it is difficult to measure, and so evaluate, efforts to reduce inequalities.

“We have tried to look at reducing inequality and it’s hard to put something down about are you reducing inequalities... you may know 30 years later! We maybe look at the outputs rather than the outcomes.”

It was noted that doctors and nurses tended to focus on clinical need rather than social need and one manager of a PHO in a better-off neighbourhood indicated that the community did not recognise the problem.

“Practices have not always got it... they are focussed on clinical high need rather than demographic high need... that is partly because they do not see the people who are not engaged... and often those people have the highest need and cost is a major barrier... the [new] funding has a made a huge difference in cost for me to go to the GP but I do not have a community services card... for those people that did it’s not cheap... and we have a supply and demand situation so our fees are not cheap...”

“People who live [around here] don’t understand the Māori culture itself... people don’t understand why it is a problem... We have had some meetings with Māori organisations”
Several PHOs indicated that the relationship with their DHB had improved as both organisations came to understand their roles and as personal trust developed.

“It’s maturing... the DHB was almost as new as the PHO... they were grappling with the same stuff as the PHO on a bigger scale... the relationship with the DHB is the strongest it’s ever been and progressing...”

“We have a really good relationship with [the DHB]... I would not have said that when I started... I do not think that was anybody’s fault... it was just [teething problems] with the start-up of PHOs and a lot of frustration...”

Social connections were thought to make relationships smoother.

“We have always had a fairly positive relationship with the DHB... previously I worked [there]... [and] it’s a small district... it’s hard to play hardball when you know you are going to meet the CEO in Church on Sunday...”

PHOs in two districts had joined or formed a single body which acted as the agent for all; this made the process easier for the DHB.

“It’s been good... since we joined [an MSO] it’s been great to address things from the wider perspective of all [district] PHOs... we meet regularly...”

“The [combined structure] has given us the ability and given the DHB the confidence to give us [new] contracts...”

Some PHO managers were critical of the DHB. It was indicated that one DHB board was hospital focussed and two PHOs suggested that the DHB was reluctant to devolve services because of the loss of overhead that would be entailed.

“We have a very good operational relationship with the CEO and her team... but the board members are a hospital board and they have not engaged with us and I think their understanding of a PHO is very limited... I do not think they understand what primary care is all about... “

“We are interested in the devolution of the DHB community services... the District Nurse [services] have been raised [as an issue] but the DHB is not keen on that... it would probably be better for the patients but it would affect the [DHB] provider arm... there has not been a lot of traction... On one level they would like to [transfer services] but at another they think this is going to hit their bottom line... they take 25% overhead on all services while we might be taking 10%...”
One PHO manager noted that lack of resources and personnel change at the DHB had interfered with the relationship. Another felt that a good relationship had deteriorated and that the DHB in question had begun to make unilateral decisions and to communicate erratically.

“The relationship used to be one of mutual respect, collaborating on the development and implementation of new services and discussion of issues that impacted on primary care. More recently, that level of partnership has deteriorated. [They] now makes decisions in a unilateral way and there is a decrease in information sharing... In addition, the traction I believe our PHO had made in being considered alongside the larger PHOs in the region has been lost... The [ ] larger PHOs are now invited to forums and engaged in issues by the DHB that the [ ] smaller PHOs are not now included in.”

A3.2.7 PHO Influence with Practices

While some PHO managers reported good relationships with general practitioners, most agreed that initially the relationship had been uncertain, and developing and maintaining the relationship required constant attention.

“We feel that we can influence activities quite a lot; in the beginning there was not the greatest relationship with the practices... the PHOs were seen as imposed structures... clinical leadership is the selling point...”

One manager felt that the independence of GPs was fundamentally problematic.

“I don’t understand how they got the industry to this point... you have private providers being supplemented by capitation, being asked to measure their own performance and getting paid on it and having control over what they might or might not do... how can that be sustainable? Now we have a mind-set... whenever a new indicator comes out they go ‘are we going to get paid for that?’ Someone is going to have to put a stake in the ground about the structure instead of being woolly about ‘you can do this if you want to.’ Ninety percent of my time is taken up with keeping the practices happy. You have got to look at this and say, ‘This is a nonsense.’”

One PHO had replaced an IPA-based MSO with one jointly created by several PHOs. Many of the GPs thought this was undesirable and there was considerable tension. Another PHO had no direct contact with practices, with this function delegated to the MSO.
“We have made a decision not to micro-manage the providers... how they actually meet the targets is up to them... if they deliver what we ask it’s not our role to say, ‘You should do it this way’... we have influence but it would not be a major one... They do things because it makes sense to them...”

Managers indicated that strong clinical leadership led to better PHO-practice relationships. GPs were said to respond well to statistical feedback (e.g. immunisation rates) and to appreciate high quality CME. They could be motivated by appropriate financial incentives.

“A few of the programmes that assist us in sending that message include the performance management programme, clinical audit and also the [clinical facilitation]... that we arranged with [them].

“We put incredible effort into on-going training of all sectors of the primary health care workforce... we have a professional development coordinator... we bring in experts from all over New Zealand... we have a relationship with the University... we have large numbers of medical students here every year...”

Practices also valued the provision of services which facilitated care, for example, transport assistance. However, strong personal relationships between PHO management and GPs were seen as essential. Practices need to be included in decision making.

“So we have a got a registered nurse as an account manager for the practices, so they are responsible for contacting the practices on a daily basis... that is very effective...”

“You would need to ask practices [about PHO influence]. However, the PHO has led forums to assist implementation of services and develop consistency across the region and across practices. The PHO has made new services available to practices and has implemented services with the GP practice as the physical hub which has been a deliberate strategy given our rural context.”

PHO managers indicated that they would want practices to develop a stronger team-based approach; this would allow GPs to share the load with nursing staff and focus on those tasks which only they could undertake. PHOs also wanted GPs to exploit consultations to uncover unmet health needs and social problems.

“We are aware that whenever there is a new programme, something drops off the bottom. What I would like to see is that the GPs are not overburdened because they are sharing the load with the nurses...”
It was understood that practices needed to focus on profitability but this was thought sometimes to conflict with meeting public health needs. Other difficulties faced by practices and general practitioners included high workloads and lack of space. Many GPs were thought to be risk averse; in some cases they were concerned about competition from free nursing services. Variability between individual general practitioners was stressed.

“One of the barriers with the community nursing project is we would be providing that as a non-cost service... ‘Why are you providing for free what my patients would have to pay for if they came to see me?’ Primary care is one of the only services that you have to pay for at all...”

“We have a whole lot of little practices and they do not have the physical space... they have nowhere to put an extra nurse...”

“The GPs are older and they do not know who they are going to sell their practices to and what we have discovered in the consultation is that they are risk averse... to build on two more rooms is just too risky.”

“[We talked with the GPs] about what the business model could and should look like into the future... what we identified was that there were different GPs... some of them were wanting one thing and some another... and one model is not going to fit all... so we are going to meet with them individually and speak with them confidentially... and then try and group like with like.”

A3.2.8 Relationship with ACC

Most PHO managers indicated that they had no relationship whatsoever with ACC. One said that they were a case management pilot with ACC and another that they would like to work with them on accident prevention.

A3.2.9 Other Issues

One PHO noted that there would be advantages to enrolling people with the PHO rather than with the practices.

“It’s a dilemma, as a PHO we are responsible for the patients but they are funded through general practice and all of the capitation goes straight through to general practice... my personal opinion is that they should be enrolled with the PHO... “

Another PHO mentioned the development of relationships with midwives.
“We have engaged with all the midwives... they have placed midwives in some of our practices... they want to get GPs back into antenatal [care]... Some of the independent midwives are working for a very special group in our community so we need relationships with them... “
A3.3 PHO Interview Schedule

1. How would you describe where the PHO is at the moment?
   - What factors are helping/hindering?
   - How sustainable is the PHO?

2. What plans has the PHO for the near future?
   - Relate this to problems identified in #1

3. How is your relationship with the DHB developing?
   - Re: Contract; Strategic planning; Service delivery

4. Confirm structure of PHO (MSO, Board, staff).
   - What are the strengths and weaknesses of this structure?
   - Does the PHO plan to change this?

5. Confirm makeup of PHO (general practices, NGOs, others).
   - What are the strengths and weaknesses of this makeup?
   - Does the PHO plan to change it?

6. Does the PHO itself provide health services?
   - What are the strengths and weaknesses of this arrangement?
   - Does the PHO plan to change it?

7. How has the PHO influenced practice activities, management?
   - Have you used incentives around first contact funding?
   - Has it been effective? If not, why not?

8. Are there any specific issues relating to the care of ACC patients?
   - Are you involved in any injury reduction programmes?

9. How is the PHO working to reduce inequalities?
   - How is this working? (Māori, Pacific, Vulnerable) and how do you know?
   - Where next for plans to further reduce inequalities?

10. We plan to talk with two or three practices in the PHO – would you be willing to identify a practice that has been responsive to the PHCS? AND – would you be willing to identify a practice that has been less responsive?
APPENDIX 4

INTERVIEWS WITH A PURPOSIVE SAMPLE OF PRACTICES

A4.1 Methodology

During the interview with each of the seven PHOs, recommendations were sought on GPs or practice managers who would be willing to be interviewed. In each case, two were selected, one thought to be positive about the PHCS and one thought to be negative. These individuals were contacted and, on agreeing to be interviewed, a time was set and an information sheet and an interview guide sent out.

Eleven interviews were completed out of a possible 14; five with managers and four with GPs. One individual could not be contacted and one PHO referred the request to the MSO who forbade contact with practices.

The following description attempts to give the ‘feel’ of the responses; sometimes a response was only given once but other practices might have echoed the same thought if they had been asked a direct question. In several cases a practice assessed a particular change as positive while another assessed it as negative. This seemed to relate to the different activities of each PHO and to the situation of the practice before the PHO came into being. There was significant overlap between the comments of those thought to have a positive opinion of the PHCS with those thought to be negative.

A4.2 Findings

A4.2.1 Impact of PHCS on the Practice

The representatives of the practices were asked to describe positive and negative impacts that the PHCS had had on their practices. Responses varied dramatically.

“I don’t think there are any [negative effects], it has been a very positive thing.”

“I have to honestly say that there have not been any [positive changes since joining the PHO].”

Several practice indicated that since joining a PHO, there was more involvement with the community, particularly with Māori.
The enrolment process had been time consuming and had taken many months to complete. During this process some practices had experienced significant changes in the number of enrolled patients and some noted an uncomfortable level of competition for patients between practices. There had been further competition following the introduction of VLCA funding; practices who took this up were attractive to patients but might offer a lower quality service or shorter hours. They also tended to serve a younger population with simpler health care needs. Other practices indicated that there was better cohesion between practices since they had joined a PHO.

“My income went down. I came into the PHO late and other practices had taken my patients and I had to dispute claims... it is in the doctors’ interest to increase their [enrolled] population... it does not mean that their quality has gone up.”

Enrolment allowed the target population to be defined and encouraged the practice to identify areas of unmet needs. However, the public did not understand enrolment and explanations were time consuming.

“Having a defined population... forcing you to go out and look...”

Increased funding had enabled fees to be reduced in most practices. Capitated subsidisation of health costs lead to a steady flow of funds to the practice which made financial management easier. One doctor said that the combination of capitation and fee-for-service patient co-payments achieved the advantages of both systems.

 “[Advantages include] cheaper prices at all ages now and more services [from the PHO].”

“The cash-flow has been more even... and there are extra funding lines.”

“You get paid even if they do not come in, you get a stable income.”

“And I think the New Zealand situation reduces the abuse you get in a completely free system.”

Several practices indicated that their income had increased and that their financial viability was strengthened under the PHCS. Some doctors said that their personal income had increased initially but that increased costs, particularly those related to nurses via the MECA agreement, had cancelled this out.

“There has been a big increase in income and we can afford locums and holidays.”
“Initially [the PHCS] increased income but we were early to accept capitation... we are way behind the practices that have just accepted it. We are stuck with the fees review process which is unsupportive of general practice... my income has gone down. It’s absolutely not keeping up, mostly because the costs are skyrocketing... 30% increase in nurses... two doctors in our practice are looking at other alternatives outside general practice... going to Australia or [into] cosmetic medicine... “

Several doctors noted with apprehension the control of patient fees introduced in 2005.

Some practices said that they now made more use of nurses which allowed doctors to spend more time with complex patients. Others said that there had been no change in the use of nurses and that the doctors saw the same patients as before.

“We have changed the way we do things... it’s much more team based and people are not fighting over patients...”

“I am more able to focus on sick people and my nurse’s focus on the well... the PHO has done a lot of education to enable them [to do this work].”

“No, I don’t think it has done that [referring to change in the role of nurses], the nurses have always done their part of the consult, follow-up.”

“I don’t think it actually changed the way I practice at all, I don’t believe that I saw people unnecessarily and I did not consciously make any changes to the way I practiced...”

One doctor feared that nurses conducting follow-up of patients with chronic conditions might miss new, and potentially serious, problems.

“We have been getting Care Plus done by nurses but someone with a lung transplant should not be seeing a nurse... similarly nurses have been seeing people with obstructive airway disease and not thinking the same way doctors would have... we have had a few near disasters... real people are more complex than protocol driven disease management.”

Several practices indicated that additional funding streams, including those related to SIA funding, were beneficial to the practice. However, some gave instances of useful funding streams or services (e.g. a Healthy Living Programme), having been terminated.
“Some of the funding streams have disappeared... We had some funding for one of the nurses to visit people at home... that [] disappeared and I don’t know where it came from...”

Several practices felt that separate funding for individual types of service was undesirable and many commented on the excess overhead related to the need for separate claims and reporting. It was also felt that simpler outcome measures should be adopted to assess the adequacy of care and that providers should be trusted.

“Trust people to do their best. No one comes to work in the morning to do a bad job. Use audit sensibly, not as a petty tool.”

“Again – trust us!”

Services funded at the practice and positively assessed included CVS risk assessment and Care Plus (note that other informants have expressed a negative judgement on Care Plus).

A number of services provided by the PHO were well thought of, counsellors and mental health services being mentioned. It was felt, however, that some PHOs had embraced services that were too expensive or of too little proven value. There was also concern that there was duplication of services between the PHO and practices

“The counsellors offered by the PHO are good.

“[The workers] are doing a good job as far as mental health is concerned but I do not know how long they can keep that type of service up... I had someone who had two key workers appointed to look after them at a huge cost... they will run out of resources...”

“There is only so much money and there seems to be a lot of duplication... they are driving around in 4x4 cost-a-lot vehicles and they drive miles just to give someone advice on exercise... someone feels better but the outcomes are not reported.”

Many practices valued the PHO vision of community participation and appreciated its role in coordination of primary care services. Another important function was to find and enrol people not connected to the health services except in emergency.

“I still believe in this vision of a partnership between providers and community... coming together to work for the community... but it may not be like that.”
“They have done a lot of useful things in the community, they have helped with doctors going into high schools... they have helped getting a medical centre going in [a needy] suburb... they help with healthy homes, diabetes, psychological counselling...”

Other positively viewed functions included development of additional funding, delivery of shared services, the provision of CME and CNE and other types of practice support. Practices also valued PHO advocacy with the DHB and the MoH.

“They are negotiating for the additional contracts for us to provide the services... and advocating for us... as a small rural outfit... they make sure with the DHB and the MoH that the policy is as it should be for us... they provide the counsellor and CME and CNE education... they have a bit more clout than we do as a little practice...”

“The PHO needs to advocate on our behalf... they do a lot of good community things... but they need to ensure the future [availability of GPs].”

Some practices said that they had better computing systems with the PHO; one noting that the PHO had devised improved reporting forms. Others noted that the demands on computing systems had also increased and that some PMS programmes were poorly adapted to deal with this.

Some practices said that they had better peer review processes, and better CME and CNE, under the PHO. Others said that there was less clinical leadership, fewer reviews of, for example, medication use, and poorer CME. It was noted in one case that the PHO was smaller than the IPA and less able to draw on a range of leaders or to organise large meetings with a strong sense of peer support.

“The PHO provides CME but not the get-together kind of collegiality and refreshment. There is a lot less education going on than there was before... no attempt to rationalise [care].”

It was considered an advantage that the PHO was able to represent primary care services at a “high level” and that the PHO could strategise across practices. However, several practitioners noted that there was extra work and stress associated with PHO activities. In addition, the PHO increased overhead in primary care.

“The PHO has twenty staff for [about 100k people] mainly managers and secretarial but they do not add much to the coal face.”
Some felt that the PHO imposed government mandated structures on practices, effectively blackmailing them into conformity. Some regretted the PHO focus on controlling fees and thought that free services lead to dependency and abuse. This was particularly the case with ACC.

“The preoccupation with low fees or [no] fees builds dependency and in the case of ACC fraud and abuse – look what’s happened with the physio and chiropractic budget blowouts.”

“I do not think they support GPs around funding, they do not see it as one of their roles.”

“[They should] sort out ACC [and] remove the incentive to get patients onto ACC as they get a better access to health care than those do publically funded.”

Members of a small PHO felt that it was too small and that its funds were too limited. In addition, small PHOs could not attract an adequate level of management expertise. Some practices felt that the PHO stifled innovation at the practice level and supported the model of clinical practice of the ‘lowest common denominator.’ Others noted that there was no clinical representation in their MSO.

“Locally provincial PHO’s have amalgamated exec functions to a management company - no doctors on the combined board where lots of the decisions are now made...”

**A4.2.2 Planned Changes**

Several practices were planning major changes; these included: merging with other practices; moving to a bigger building; and creating a new centre with a patient observation facility.

Two practices indicated that they would like, respectively, to enlarge the building and create a merged “super practice” but were unwilling to do so, given a perceived lack of stability in primary care funding and organisation, and the “marginalisation” of GPs.

“We are very reluctant to go into a super practice... there is uncertainty about what the DHB might do in the future... we are at an age when we do not want to go out and spend lots of money on a new venture... and we have all been the boss in our own practices for twenty years and we would have to come together...”

“We feel we have been marginalised and so can’t be bothered to the same degree going the extra mile to make things work.”
Several practices had plans to improve and extend practice quality, for example by: strengthening peer review; undertaking a Cornerstone review; improving the PMS system; developing GP special interests; and providing home support.

Several also wanted to increase the work undertaken by nurses, to start special clinics or to undertake minor surgery. Some planned to include extra professionals in the team. These included variously: a social worker; a dietitian; a pharmacist; and a district nurse.

One practice wanted to increase community engagement and mentioned the difficulty generated by the presence in the same community of a practice with a different philosophy.

A4.2.3 Resolving Inequalities

Practices were asked what they did to reduce inequalities in access to primary health care. Many had no comment on this but several mentioned reducing or removing fees, arranging for delayed payment of bills or providing transport assistance. However, practice capacity to take these actions was limited by increasing costs. Willingness to deal with problem patients was also limited; one practice mentioned dis-enrolling “obnoxious, non-compliant patients.”

Several mentioned the use of providers sympathetic to vulnerable populations; actions included: appointment of Māori nurses, the use of a Māori health care provider and a PHO funded mobile nurse. In a district with dairy farms, a practice mentioned efforts to reach itinerant workers through an employers group.

A4.2.4 Relationship with PHO

The majority of the practices reported a positive relationship with their PHO but there were areas where the relationship was described as “stormy” or “strained.” Many practice/PHO problems could be relieved by better communication.

“We have a good relationship with the PHO... it’s a small one and everyone knows everybody else... communication is open and honest both ways and I feel respected...”

“It’s good... the PHO is just round the corner... they have [practice] managers’ meetings.”

“Over time [the relationship] has got better... there has always been a matter of communication but now the PHO manager comes through monthly and talks to us and that has been really helpful... also two of our staff are on the PHO board.”
“One of the things the doctors would say [to the PHO] is to listen more to them...”

“Sometimes things have been put in place and we do not hear about until after.”

“I get the feeling that they have come in and have taken over funding streams and haven’t consulted with us about whether [changes] are good or bad... There are a lot of practical things that we are not informed about... we have not been informed about how to submit the data.”

Criticism focussed on PHO’s attempts to limit practice self-determination and the difficulty of influencing the PHO. It was alleged that big PHOs have no relationship with practices at all. One GP recognised that the PHO could not always please practices but another felt that the PHO treated GPs as “idiots.”

Several informants noted that it was difficult to get GPs interested and contributing to PHO governance. One GP noted that such participation was time consuming and stressful.

“As a practice we do not have a lot to do with them.”

One GP felt that the PHO and the practices were moving in different directions.

“We are just ships going in different directions, really... there is no competition, we can’t swap PHOs and they just do what they want to do.”

Further, the PHO was taking over things on the edge of general practice; the implication of this was that PHO services were sometimes seen as impinging on general practice rather than helping with the care of patients. This reinforced the idea that the PHOs were competitors not allies.

“[There are few] new clinical initiatives for traditional GP – [they are] funding programs [that] chip away around the edge of traditional GP - i.e. youth clinics, nurse lead this and that clinics. GP’s feel marginalised.”

“[They should] develop links with pharmacy / physio / dental / pharmacy – real functional teams, not PC nurse led stuff.”

“They have to be careful not to step on practices’ toes by taking work we normally do and palming it off to somebody else... that is going to get them off-side.”

“I have a feeling they are not our allies at the moment.”
In some areas, practices saw the PHO as dominated by nurses who knew little about primary care and were hostile to doctors, particularly male doctors. One doctor felt uncomfortable interacting with the PHO. This undermined clinical leadership and it would be preferable if the PHO were more attentive to doctors input and advocated for doctors and practices. The PHO should encourage the empowerment of nurses and other health professionals via the doctors.

“Our PHO’s have been taken over by nurse managers who are distant from the reality of primary care. Their agendas drive stuff.”

“Almost all are managers from nursing background, secretarial. Docs are not trusted – [their] opinions are “clouded by self-interest” [it’s the] “fox in the henhouse.”

“They need to be really careful about the way they have 80% nurses... it becomes ideological and overtly hostile... it’s not a welcoming place.”

“What the PHO has just done is approve a $100k position for a nurse leader for the community... what our community needs is a pan-sectoral leadership... I think they have made a major strategic error... You need someone who comes from outside and can look at the whole workforce in primary care across the vocational boundaries and make it better for everyone. The PHO has had no success with engaging chemists or dental.”

“Clinical leadership is undermined. It needs to be fostered.”

A4.3 The Future of Primary Care

When asked about the future of primary care most practices focussed on the expansion of its function to include services now delivered by secondary care and professionals now funded outside the primary care envelope. It was felt that these services could be delivered more cheaply in primary care, that attendance would be better than in secondary care and that continuity would be improved.

“Almost all of the district nursing could be managed in the community... a DN visit was costing about $90 at the DHB, we could be providing those services at half that...”

“We could be doing a lot more to diagnose people earlier and preventing them going to hospital... we cannot get X-rays or scans... we seem to be blocked and we have to refer people to specialists... at a cost of $160... we could save them a lot of money...”
“If it’s a GP request, then our DHB radiology treat it as non-urgent [you] wait 3 to 6 months for simple x-rays. Paradoxically it’s easier to send more to ED where people [] get investigations then and there.”

“We have shown that GPs can manage DVT and cellulitis etcetera and save a lot of money... but when you say it would cost you $200,000 they do not want to know...”

Other professionals that should come within the ambit of the PHCS included: pharmacists; physiotherapists; acupuncturists; dieticians; midwives; psychologists; and counsellors. Maternity was seen as a particularly problematic area.

“Maternity is a disaster... we have been doing a lot of advocacy to get maternity more integrated into general practice again... it’s very fragmented particularly for rural people... we have been trying to have relationships with the midwives in the areas but they are few and they are coming and going a lot... many people go to [the city, 100 kilometres away] but there a large group who cannot do that...”

Provision of some services in primary care could reduce the pressure on secondary services; the GPs would need to be trained by local specialists so that their skills were recognised.

“I think it is very healthy [for doctors to develop other interests] and it relieves pressure on other areas...”

“We have several bottle-necks [here] where specialist services are simple not available, for example, it’s practically impossible to get colonoscopies done and I would love to see GPs with special interests being trained by specialist to do procedures like that... so the load can come off the hospital system... we [already] refer complex ACC issues to GPs with a special interest... you can get things dealt with quickly without having to resort to a consultant... I think there would hardly be a GP in town who did not have a special interest in something or other... it would be far cheaper to pay a GP $100 than having them done in the hospital for maybe six times that amount... there would have to be the recognition that the consultants have to do the training... so that they can recognise that the GPs have the skills and are up to speed...”

There was concern in some areas that DHBs were unlikely to devolve services and that they were not responsive to the concerns of PHOs or of primary care. In particular, the position of emergency departments was contradictory; being free, they attracted patients who could be managed at less cost to the system in primary care.
“After-hours is an on-going ulcer in this district... [The ED is very busy but the GP after-hours clinic is much less busy] but the ED doesn’t turn anyone away and it’s free... and you will get X-rays and ultra-sounds while you wait... they say one thing but do something completely different. And it creates the wrong impression for the punters and the doctors... so we are sending more to ED than we need to...”

“50% of what they see in the Emergency Department is general practice medicine... but people can’t or do not want to pay GPs fees so the go to ED... EDs are happy because increased numbers will increase their staffing... and general practice is way more efficient for 50%...”

Some DHB were seen as wanting the practices to make up for their deficiencies.

“The DHB is not particularly supportive, we have a lot extra work from the DHB... could we do this, could we do that... could we recall this patient because they do not have a computer system for recalls...”

“Generally speaking if someone is really ill and need to be admitted they get really good care... but I get people sent back... they have to have complications before they can be operated on... we have skin cancer patients who could have been handled with a simple excision end up needing a skin graft...”

“And I think they will be pushing to keep people out of hospital and they will be pushing more assessment stuff to us... as equipment gets cheaper, we might be doing chest X-rays... remote specialist appointments.”

The need to improve data transfer with secondary care was a sore point in some areas.

“[We are] able to get lab test results electronically now but not discharges nor clinic letters and there are no e-referrals. The DHB [system] isn’t compatible with [ours] so our new PC’s can’t access theirs.”

At a more general level, beyond the expansion of primary care, comments were made about problems with supervision in large practices. A related issue was lack of continuity where patients were seen by many doctors.

“To practice by yourself you have to have a fellowship... in some of these large practices, at any one time, there may only be one person with a fellowship... you see that happening more and more... the trouble is that the person with the fellowship is spread thin on the ground in terms of supervision...”
“With larger practices you are presenting with symptoms but the penny might not drop if you are seeing different practitioners all the time...”

A4.4 Practice Interview Schedule – Professional Manager or Senior Partner

1. Since joining a PHO have there been positive changes for the practice?
2. Since joining a PHO have there been negative changes for the practice?
3. Are there any changes in the practice that you would like to make?
4. What services do you offer in addition to GP consultations?
5. What is the practice able to do to reduce inequalities in health?
6. How would you describe your relationship with the PHO?
7. How would you describe the role of the PHO?
8. Do you have any general comments to make about primary health care policy and where it might go in future?
APPENDIX 5

DISCUSSION OF FINDINGS FROM PHASE III PHO AND PRACTICE INTERVIEWS

The overall impression from the PHO and practice interviews was of variability, with different organisations doing different things and individuals having widely varied opinions.

There was a general feeling of progress, particularly in relation to community involvement. Innovation had been easier when the PHO was alone in serving a particular population and when the number of people enrolled was relatively large.

PHOs had been able to take up programmes designed by the DHB or MoH and to provide services across practices. Sometimes these services were provided by existing groups or professionals, and, when not available in the particular community, had been provided by the PHO itself. In general, GPs valued services that helped them manage patients.

Information management was sometimes problematic both within practices, within PHOs and across the PHO/DHB divide.

Many people commented on the fractured nature of community health services and thought that the PHO should manage or coordinate services now provided by individual professionals or by other organisations, including the DHB.

Practices appreciated PHO representation and advocacy with the DHB and MoH. They also valued the coordination of care provided by the PHO and some thought addressing social determinants of ill-health and seeking out people poorly connected to health services was useful.

However, involvement of GPs in the changes required by the PHCS was problematic. Many GPs were disinclined to participate in planning and governance activities, and the PHO had relatively little leverage in promoting practice change. Some practice representatives felt that the changes created difficulties for them. Components of these difficulties included:

1. Conflict between practice and community interests, particularly the review of fees charged directly to patients;
2. Services which duplicated those already provided by practices, particularly when these services were free to the users. Some services were not thought to be cost effective;

3. The feeling that primary health care was increasingly controlled by nurses whose understanding of primary care might be limited and whose agenda might be different from that of general medical practice;

4. Multiple funding streams which were thought to produce fractured care and required an onerous level of reporting

5. Many informants felt that the scope of primary care included in the PHCS should be broadened and some GPs felt that their scope of practice should be broadened by training in areas of special interest. Of particular concern was the availability of free emergency care which attracted patients away from general practice with resulting inefficiency.
APPENDIX 6

SUMMARY OF EARLIER REPORTS

In this section, we summarise the key findings from earlier reports from the Evaluation of the Implementation of the Primary Health Care Strategy. The first report covers material from a preliminary assessment of the development of Primary Health Organisations.

6.1 Survey and Interviews with Selected PHOs – 2002

Published as:


Note: This research was funded by the Ministry of Health prior to the start of the formal evaluation of the Primary Health Care Strategy. However, the results are included here as they are relevant to this final report on the evaluation findings.

The Health Service Research Centre/Te Hikuwai Rangahau Hauora was contracted by the Ministry of Health in April 2003 to study the experience of Primary Health Organisations (PHOs). Data was gathered from 21 of the 22 PHOs that had been formed by April 2003; interviews were conducted with 12 selected PHOs and nine returned questionnaires.

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

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

District Health Boards (DHBs) were noted to be generally supportive of the establishment process, and overall the on-going relationship with individual DHBs was described as being good.
Inconsistency and variation in the contracting process was noted. Several different versions of the PHO contract had been signed. Not all PHOs had an agreed contract before going “live.”

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

Clear guidelines and consistent advice were particularly needed around enrolment.

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

PHO funding being tied to enrolment based on general practice (GP) registers was seen as a disadvantage because: 1) it appears to undermine the potential for a multidisciplinary/holistic approach as envisioned by the PHCS; 2) GPs bear the financial risk in the PHO; 3) non-revenue generating partners may have an equal role in governance, but their clients are not recognised within the PHO unless registered with a particular general practice.

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

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

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

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

A wide range of new services were being provided or planned under the PHO model.
6.2 Interviews with Selected PHOs, Practices and Other Informants – 2004

Published as:


This first report of the Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy covers the period from October 2003 to October 2004. It reports on interviews undertaken with PHOs and non-PHOs and with key stakeholder organisations.

6.2.1 Methodology

The aim of the interviews was 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. A qualitative, inductive, approach was adopted with a formalised method of coding emergent ideas to ensure that the experience of the informants was accurately reported.

Twenty-four PHOs were selected to participate, representing the range of sizes, structures, geographical locations and enrolled populations of such organisations nationwide. Within each PHO, representatives from an average of two providers were asked to participate in the research. In addition, staff members in eight non-PHO practices were interviewed during the evaluation period. Within each PHO, separate interviews were held with representatives from governance/management (e.g., 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 were held with medical and nursing leaders, Māori and/or Pacific programme managers and community members, as appropriate. Each interview may have involved several people but did not mix those with possibly conflicting positions. A total of 165 interviews were undertaken.

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 to gain an understanding of their views on the Strategy and its implementation. Ten interviews were undertaken. Analyses from these interviews are included here.
Semi-structured interview guides were created to ensure that all relevant research aims were covered during each type of interview. With the permission of the participants, all interviews were recorded. Notes were taken from each interview, and returned to interviewees for checking.

6.2.2 Findings

The Strategy was supported and was thought likely to improve access, enhance coordination and allow a better understanding of the population served. Some were concerned that administrative changes would occur without realisation of the intended benefits.

While GPs were pleased that the public resources for primary health care were to be increased they were concerned that their role had been inadequately recognised in the Strategy. While they felt that their participation was unavoidable they were worried about the long-term financial implications for themselves and their practices. It appeared that some practitioners have come to believe that the prospects are positive.

The community appeared to be well represented at board level although in some PHOs there was concern about medical dominance. Most Boards operated on a consensus basis. Interaction with the general community was handled by multiple informal and formal mechanisms, the latter including various types of community groups. Māori were often well positioned to achieve community input. It was considered that the general community was poorly informed about the Strategy, that some sub-populations were hard to reach and that many were uninterested.

It was felt that more resources should have been put into the implementation process. The first result of this was the difficulties with payments related to patients changing PHO or making casual visits. It was also 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 been increased, affordable care was not available to many.

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. With regard to communication, small PHOs were struggling with inadequate management resources and large ones with anonymity. Relationships within PHOs were positive.

It was generally agreed that fee reductions had improved access to primary care but there was concern that people just unable to qualify for a community service card were missing out. Public health issues were just beginning to be addressed with innovative programmes related to changing health determinants and identifying populations with low use of services.
Freedom from fee-for-service funding appeared to allow some practitioners to increase the quality of their consultations. Implementation of quality monitoring was underway but did not seem to have gone beyond that instigated by the better IPAs. Improved register data was seen to allow better estimation of population health need.

There are many opportunities for nurses under the Strategy. Individual practices vary enormously in nursing development, depending mainly on the preferences of the GPs as employers. Nurses felt that recognition, including financial recognition, of levels of skill, and the development of a career pathway would increase the willingness of nurses to take additional training. Appropriate training, reducing barriers to education and a graduated accreditation programme were recommended.

There is concern that the medical and nursing workforce may be inadequate to the tasks required by the Strategy. This will be exacerbated if some practitioners are unwilling to provide after-hours care. Medical practitioners may react negatively to the changes implied by the Strategy but many appear pleased with the idea of teamwork and the possibility of salaried employment free from business worries. The training programme for general practitioners (as of nurses and other health professionals) must generate a supply adequate to the need.

There was a suggestion that ACC processes should be aligned with Strategy. Informants identified potential risks to ACC in the current situation mainly associated with new medical misadventure rules.

There appears to be little change in the use of secondary services. Respondents felt that it was relatively urgent to resolve issues of historical poor distribution, to monitor use and to move towards devolved budgets.

There are examples of PHOs and practices working co-operatively with each other and with other community organizations; where PHOs are in a de facto competition for patients, co-operation may be harder to achieve.

Informants concerns for the future centred on the failure to realize the full potential of the Strategy, including: inexpensive care; a population health focus; genuine community involvement; and incorporation of other services. Similarly, outcomes need to be monitored as the ultimate test of the system.

The difficulties with the implementation of the Strategy, as revealed by our informants, can be divided into five categories which will be considered in turn. It should be noted that none of these difficulties are issues for all PHOs.
Continuing high fees – High fees are seen to remain a barrier to service for patients in interim, and some access, practices for those with little discretionary income. The roll-out of capitated payments for those aged 18 - 64 (by July 2007) will ameliorate but not resolve this issue and PHOs are already seeking permission to increase the level of co-payments they may charge. Informants have made the following suggestions in this connection: a) cost out good primary care to establish a fair price (and subsidy); b) reward low price; or c) return to a targeted subsidy. Informants from DHBs have been clear that resolution of this issue is critical to the success of the Strategy. It is noted that some people are unconcerned about the cost of care and the key requirement may be to have many, but not all, practices offering services with low fees. It is further noted that many young GPs appear to appreciate the freedom from business worries associated with salaried employment and that interviews with such practitioners, mainly in access practices, revealed acceptance and approval of the present low-fee regime.

Slow progress – Informants noted slow progress in relation to community involvement; population health; development of the nurse role; expansion of the primary health care team; co-ordination with secondary care; and liaison with other agencies. On these issues, informants indicated to us that the Ministry has adopted a permissive approach. DHBs appreciate this attitude given that they have the clear responsibility to manage the process. However, informants mention a degree of uncertainty about the requirement that organizational and cultural changes be pursued. It has been suggested that further guidelines need to be provided to ensure that progress continues.

Overlapping PHOs – Where PHOs overlap geographically the people they serve can easily move between providers. This leads to problems with “claw-backs” and difficulty in the identification of population need. In this connection our informants have mentioned: a) the need for accurate, speedy and transparent process by HealthPAC; and b) DHB and Ministry informants mentioned a shared management function to handle claw-backs in-house and to combine rolls in the identification of population need.

Small PHOs – Management fees are related to the size of the enrolled population and small PHOs have insufficient management resource. Compliance requirements are similar for the biggest and the smallest PHOs. A review of management funding is underway and will deal with this issue. Shared management functions should be on the agenda.
Workforce capacity – Many informants were concerned about the capacity of the workforce, both general medical practitioners and practice nurses, to accommodate the increased expectations of the Strategy. The key factor was considered to be the recruitment and retention of doctors and nurses to primary care. Our informants drew attention to the following points: a) a need for more spaces in the Family Medicine Training Programme; b) a need to cover nurses’ training costs (time as well as fees); c) a need to ensuring acceptable remuneration (especially in comparison to that of doctors and nurses in hospitals); d) a need to expanding the role of nurses and recognizing different levels of skill.

Dealing with these issues of will allow the Strategy to deliver the benefits it promises and confirm the general approval of the direction chosen by the Government in the development of the public health care system.
6.3 Interviews with Selected PHOs, Practices and Informants – 2004 – Patient Fees

Published as:


In this report, a number of key issues are explored relating to the payments made to general practitioners to support primary health care delivery, the arrangements for which have changed significantly as a result of the implementation of the Primary Health Care Strategy.

6.3.1 The Institutional Arrangements Introduced under the Strategy

The Primary Health Care Strategy (the Strategy) altered funding arrangements for primary health care (PHC), with the intent of promoting a population-health approach and of promoting the role of non-GP health professionals.

Under the Strategy, the main mechanism for delivering public funding to PHC has changed from fee-for-service to capitation, and from targeted to universal public funding. Capitated funding is delivered to primary care providers by entities introduced under the Strategy: primary health organisations (PHOs). There is no requirement to use capitation as a mechanism for distributing funding within PHOs, however, which leaves open the possibility that providers might continue to receive public funding in the more traditional form of fee-for-service.

In addition to receiving public funding, most practices charge patients a co-payment or fee. An important part of the Strategy has been increased funding to primary care, with the policy intent of reducing the fees paid by patients.

The institutional arrangements governing the setting of fees have changed as the Strategy has been implemented – including the introduction of the PHO Standard Agreement Amendment Protocol Group (PSAAP) and associated processes, and the Very Low Cost Access payments scheme.
6.3.2 Research Process

The analysis in this paper is drawn primarily from semi-structured interviews conducted with a range of PHC stakeholders as part of the Evaluation. In these interviews, stakeholders were asked a range of questions relating to the issue of “keeping, or bringing, the level of co-payments down”. The interviews were conducted in 2006. Since they appear to reflect underlying themes, we believe that the results continue to be valid.

We also report results from three relevant questions that were included in the surveys conducted as part of the Evaluation. These surveys were undertaken with practice managers, GPs, and practice nurses. Full details of the survey methods and response rates are included in an accompanying report, Status and Activities of General Medical Practices (Raymont and Cumming 2009).

GPs’ response to the Strategy: fees as a metaphor - Despite widespread support for the objectives of the Strategy, there was also widespread criticism by GPs and professional groups about the way it was introduced. The criticisms and subsequent debate often seem to have focused on the issue of fees charged to patients. It appears that fees have become a metaphor for so much more than patient charges, but with different meanings to the government and to GPs.

To the government, fees are a metaphor for patient access; a shift to capitation accompanied by a reduction in fees is seen as symbolic of improved access and a population-health approach. To GPs, by contrast, fees represent the freedom to charge patients and are a symbol of GPs’ autonomy and their status as trusted professionals.

There is a body of work in organisational theory showing the inevitability and ubiquity of metaphors in organisations. Implicit in this literature is the possibility of changing the discourse and debate, and moving towards less conflictual ways of interacting.

The Level of Patient Co-Payments - Consistent with empirical evidence, most GP survey respondents believed that fees had decreased; and most supported this as an objective. Some were positive about the level of funding they had received under the Strategy and considered it had had a beneficial impact on their practice. Others considered that, given the needs of their enrolled population as well as rising demand and rising costs, their fees had hit a “floor”. A number of interviewees noted that process of implementing the Strategy had created a level of uncertainty which meant that it would not be financially rational for them to lower their fees further.

Opposition to control of fees - As well as opposing any further reductions in fees (without there being additional public funding), many interviewees expressed resistance to government control or intervention in setting patient fees. Concern was expressed that the government would have insufficient information for setting fees accurately, or
for reflecting variations between practices and changes over time in costs and demand. A small number of interviewees considered that the government should not interfere in the operation of market forces. (We note that, by contrast, some other interviewees volunteered a belief that it was right for the government to seek accountability for the use of public funding.)

Opposition to control of business and professional practice - A desire to protect income is not the only – or even the primary – reason why GPs are opposed to government intervention. For some GPs, their ability to be a private business and to determine their own patients’ fees is symbolic of their status as autonomous professionals. To these interviewees, fees are a metaphor for so much more than patient charges. Moreover, some GPs appear to view it as their professional duty to set charges at a level that patients can afford, and to pass on as much as possible of the increased funding. If this is the case, accusations that they are not doing so are likely to be “heard” by these GPs as accusations that they are not acting as responsible professionals. It also appeared that some GPs consider the arguments over funding to impugn their worth – they perceive that they are under-funded and therefore not valued or valuable.

Population-Health Services and the Strategy’s Funding - A core objective of the Strategy is a desire to introduce a population-health focus by moving the funding of general practice and PHC away from a fee-for-service model towards one based on capitation. This implies a shift away from a system where patients pay the GP for each visit they make, towards one where the GP receives a per-annum sum of money which is intended as the funding for whatever care that a patient might need (including health promotion and illness prevention).

PHOs receive capitation-based funding; but there are no regulations governing how that funding is delivered to practices and how it is delivered to PHC professionals or used for providing services within practices. The Evaluation’s interviews and survey data confirm that key decision-makers (PHC professionals) are often still practising under fee-for-service incentives without the incentives or flexibility offered by capitation funding. It is challenging to develop a population-health approach when income is (or is perceived to be) dependent on patient visits. Many interviewees wrestled with this, and with seeking to improve the health of the practice population while continuing to generate sufficient income.
The Perceived Role of PHOs and DHBs in Setting Fees – At the time the interviews were conducted, there was significant diversity between different district health boards (DHBs) and different PHOs in their approach to managing fees charged by practices. Some appeared to be “powerless”, some took a deliberately “soft” approach, and some appeared to be directly interventionist.

6.3.3 Discussion and Policy Options

Fees as a metaphor for so much more - Our analysis suggests that, while the aims of the Strategy were largely supported by general practice, the intention to use public funding to reduce patient fees raised wider fears about government control of general practice. General practice fees appear therefore to have become a metaphor for the relationship between the state and general practice and, within that, for a process whereby the government’s mistrust of a powerful professional group and that group’s concern at a perceived attempt to erode its autonomy and sense of professionalism is acted out.

Stakeholders appear to be unhappy – and, perhaps, resigned – about the state of this relationship. However, organisational analysis in the metaphorical and sense-making tradition suggests that the situation could be reframed and, over time, a new relationship (and hence metaphor) shaped. There is now an opportunity to change the way in which stakeholders construct the relationship between general practice and the state.

Taking forward the Strategy in order to meet population-health objectives and access objectives - As long as there continues to be a widespread fee-for-service culture in PHC, it will be difficult to develop population approaches to the provision of health care. However, when considering this, it is also important to note that many practices are using the new funding to develop new approaches to providing PHC services.

The role of contracts in PHC - The incremental approach to implementing the Strategy has seen a gradual introduction of arrangements that can be viewed as a shift towards more formal contracting. However, it is important to note that in this type of context contracts will inevitably be incomplete, giving informal arrangements (including trust) a vital role in making sure that the government’s outcomes are reached. Moving beyond the dysfunctional focus on fees will be vitally important to restoring trust and making sure that the sector as a whole is able to perform to its potential.

6.3.4 Conclusion

Our analysis of fees and funding within the Strategy is intended as a contribution to the debate about the Strategy’s implementation. A vital part of advancing the core aims of the Strategy will be to change the metaphor and remove the focus on fees.
6.4 Analyses of Fees and Consultation Rates – 2001/02-2004/05

Published as:


This report seeks to answer the following questions, for different population groups and funding models:

Since the introduction of the PHCS, what changes have there been in the fees that patients pay when they use primary health care services? How are changes in fees related to government policy objectives?

Since the introduction of the PHCS, what changes have there been in the use of primary health care services by New Zealanders?

Are more patients being seen by nurses?

What changes are there in the pattern of ACC claims made, before and after the PHCS? Are more new ACC claims being made?

6.5 Methodology

A random sample of 99 practices had been drawn for a previous project; these were all users of a particular operating system. Of these 79 were chosen at random and a further 21, using other systems were selected at random. In each case the selection was stratified by district and in proportion to the population of each district. Data was obtained for the period June 2001 to December 2005. Since the size of enrolled populations increased over the period of the research, the number of people covered by the research increased from approximately 214 thousand to 423 thousand (or 10% of the New Zealand population).

Data included patient demographics, NHI (see full report for details of Ethics approval), and card status; and dates of visits and amount billed. There are a number of difficulties in estimating average fees and visit rates; these are listed below – for a more detailed discussion, see full report; include:

- Inability to recognise services apart from standard doctor and nurse visits – thus, maternity and immunisation services are excluded as are new services developed by practices.
- Lack of distinction between visit and administrative access to PMS – resolved by only including visits associated with an invoice.
• Inability to distinguish visits which include a procedure – resolved by excluding visits associated with a fee of more than $100.

6.6 Findings

6.6.1 Fees

Since the introduction of the PHCS, what changes have there been in the fees that patients pay when they use primary health care services? How are changes in fees related to government policy objectives?

In relation to doctor and nurse visits, we find that overall, across both Access and Interim practices, over the period from 2001/02 to 2004/05:

Fees have been rising for children but the average fees paid by other patients have fallen in response to the new funding provided by the PHCS. Fees have fallen particularly for those aged 65 years and over.

However, because not all groups in the population have been eligible for the same increase in subsidies over time, we need to break the data by funding model (Access or Interim) and by population group, to understand the impact the changes. When we break the data down by funding model (see Figures A6.1 and A6.2 below) we find that:

In Access practices, across the entire study period, fees have fallen for all age groups. Between 2001/02 and 2004/05, fees have fallen, for those over six, by between $1.86 and $4.57 per consultation, or by around 20%. For those aged six years and under already low fees (50c) fell slightly.

In Interim practices, fees have risen for those aged six years and under. For those aged 6-17 years of age, fees rose slightly in the first and second years of the study, stabilising in the last year of the study, coinciding with the roll-out of new funding in October 2003. For those aged 18-64, fees have risen slightly in each year of the study. Fees rose slightly for the first two years of the study for those aged 65 years and over, before falling in the last year of the study as new funding was rolled out in July 2004. Fees averaged $26.12 in 2003/04 prior to the roll out of new funding, falling to an average of $21.18 in 2004/05 following the roll out, i.e. a fall of $4.94 or 19%.
Figure A6.1. Mean Fees by Age for All Doctor and Nurse Encounters – 2001/02 – 2004/05

Figure A6.2. Mean Fees by Age for Doctor and Nurse Encounters: –2001/02 – 2004/05
When we break the data down further and consider the experiences of people with and without community services cards (CSCs) (determined by whether an individual as ever held a CSC), by different socio-economic circumstances and by ethnicity, we find that (see Table A6.1):

**Table A6.1. Mean Patient Fees ($) by Funding Model, Age and CSC Status 2001/2-2004/5**

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<td></td>
<td>6-17</td>
<td>N</td>
<td>12.47</td>
<td>13.81</td>
<td>10.9</td>
<td>9.23</td>
<td>1.34 (11%)</td>
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<td>7.22</td>
<td>7.72</td>
<td>6.77</td>
<td>6.34</td>
<td>0.50 (7%)</td>
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<td>-0.43 (-6%)</td>
<td>-0.88 (-12%)</td>
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<td></td>
<td>18-24</td>
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<td>24.6</td>
<td>17.44</td>
<td>17.09</td>
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<td>16.57</td>
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<td>-0.43 (-3%)</td>
<td>-2.97 (-18%)</td>
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<td>13.91</td>
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<td>0.10 (1%)</td>
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<td>29.02</td>
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<td>33.95</td>
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<td>39.08</td>
<td>2.04 (6%)</td>
<td>1.52 (4%)</td>
<td>1.57 (4%)</td>
<td>5.13 (15%)</td>
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<td>Y</td>
<td>24.42</td>
<td>25.52</td>
<td>27.5</td>
<td>29.44</td>
<td>1.10 (5%)</td>
<td>1.98 (8%)</td>
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<td>N</td>
<td>33.17</td>
<td>34.3</td>
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<td>1.27 (4%)</td>
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<td>26.82</td>
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<td>1.18 (6%)</td>
<td>1.32 (6%)</td>
<td>-2.69 (-12%)</td>
<td>-0.19 (-1%)</td>
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In Access practices, within each age group, the data show that those with CSCs pay a lower average fee than those without cards; however, the larger falls in fees are occurring for those without CSCs, except for those aged six years and under where the falls in fees have been higher for those with CSCs.

In Interim practices, within each age group, fees are also lower on average for those with cards than for those without cards. Fees are not rising as fast for children with cards as for those without cards and the increases in fees have been less for those without cards than for those with cards across the 6-64 year old age group. For those aged 65 years and over, fees have fallen further for those without community services cards.

In terms of changes in the average level of fees over time, in Access practices we see falls of between 4c for children with and without community services cards to falls of $8.67 for those aged 65 years and over without community services cards. Percentage falls in fees range from 5% for children without community services cards, to between 11% and 26% for most other population groups, to 35% for those aged 65 years and over without community services cards. For doctor visits, we see similar patterns: in Access practices we see falls of between 8c for children with community services cards to falls of $8.98 for those aged 65 years and over without community services cards. Percentage falls in fees range from 7% for those aged 65 years and over without community services cards, to between 11% and 27% for most other population groups, to 34% for those aged 65 years and over without community services cards.

New funding was introduced for Interim practices in October 2003 for those aged 6-17 – with a $5 increase in subsidy rates for those with CSCs and a $10 increase in subsidy rates for those without CSCs. Although this policy relates to the scheduled fees for doctor only visits, we would expect to see a reduction in the fees actually charged to patients in our data (which covers both doctor and nurse visits). Average fees for those with CSCs rose slightly, while a slight fall in the average fees paid by those in this age group is noticeable between 2003/04 and 2004/05 for those without CSCs (where fees fell from an average $19.06 to $18.75; a fall of 31c or 2%). The fall in fees is more noticeable in Interim practices following the new subsidies introduced in July 2004 for those aged 65 years and over, with fees falling by an average of $2.69 (12%) for those with CSCs and $10.17 on average for those without cards (a fall of 31%) between 2003/04 and 2004/05. For doctor visits, average fees fell by $12.23 or 33% for those without CSCs and by $3.34 or 13% for those with CSCs. The government was seeking falls in schedule fees of around $26 for those without CSCs and of $11 for those with CSCs (including adjustments for inflation).
In relation to deprivation, as measured by a deprivation index NZDep, the research shows that overall, fees are lower within each funding model for those in the more deprived communities. Reductions in fees are generally benefiting those in more deprived communities more than those in less deprived communities in Access practices. The pattern is more mixed in Interim practices.

In relation to ethnicity, over the entire study period, average fees have reduced for Pacific patients by 12% and for Māori by 10%. Fees have increased slightly (by 3%) for the “Other” ethnic group (including New Zealand Europeans) and increased by 22% for Asian patients. Thus, changes in fees are benefiting Māori and Pacific ethnic groups by more than other ethnic groups, potentially reducing fees for two high needs groups relative to other groups in the population. This is likely to reflect the fact that Access practices have a higher proportion of Māori and Pacific people enrolled with them and it is these practices which have received new funding for all age groups over the study period. Asian populations have faced the highest increase in fees over time.

6.6.2 Consultations

Since the introduction of the PHCS, what changes have there been in the use of primary health care services by New Zealanders?

With an increase in funding available for primary health care services as a whole, and with many New Zealanders benefiting from reductions in fees, we would expect that consultation rates will increase as New Zealanders use more primary health care services. Certainly this is a key aim of the PHCS.

Across the population in our sample as a whole, we find that:

The data show increases in consultation rates across all age groups over the 2001/02-2004/05 period, in particular amongst those aged 65 years of age and over, with an extra 1.68 consultations per annum (a 24% increase). The next highest increase is amongst those aged 45-64 years of age (0.73 consultations, a 17% increase), followed by those aged 0-5 years of age (0.65 consultations, a 14% increase). Lower increases occurred for those aged 18-24 (0.24, 11%), 25-44 (0.27, 10%) and 6-17 years of age (0.14, 7%).

When we break the data down by funding model we find that (see Figures A6.3 and A6.4 and Table iii below):

The data show increases in consultation rates in Access practices across the entire study period. In these practices, greater increases in consultation rates have occurred amongst those aged 65 years and over (1.6 consultations, 22%); 18-24 (0.4 consultations, 22%); under six (0.8 consultations, 19%) and 45-64 years of age (0.8 consultations, 18%).
In Interim practices, there has also been an overall increase in consultation rates across the entire study period, although the increases in percentage terms are lower in Interim practices for all age groups other than those aged 65 years and over, while being very close for those aged 45-64 years of age. The greatest increases in consultation rates is amongst those aged 65 years and over (1.7 consultations, 25%), 45-64 (0.7, 17%) and those aged under six (0.5, 11%).

**Figure A6.3. Mean Consultation Rates for Doctor and Nurse Encounters – 2001/2 - 2004.5**

![Graph showing consultation rates by age group and year](image-url)
When we break the data down further and consider the experiences of people with and without community services cards (CSCs) (determined by whether an individual as ever held a CSC), on different socio-economic circumstances and by ethnicity, we find that:

There are increases over the entire study period in consultation rates for all groups, except for those aged 18-24 in Interim practices and without CSCs.

In Access practices, percentage increases in consultation rates are highest for those aged 0-5 without CSCs (41%), followed by those aged 65 and over (31%), 18-24 (28%) and 6-17 (25%) without CSCs. Within each age group, increases in consultation rates are higher for those without CSCs.

In Interim practices, increases in consultation rates are highest for those in the older age groups (those aged 65 years and over without (28%) and with CSCs (26%) and those aged 45-64 without CSCs (22%)). Increases in consultation rates are slightly higher for those without CSCs than for those with CSCs for those aged 0-5 years of age, 6-17 years of age, and 65 years and over, while those with CSCs have had higher rates of increases than those without CSCs for those aged 18-64.

In Access practices, increases in consultation rates are higher in lower socio-economic groups for those aged 6-17, 25-44, 45-64 and 65 years and over. The increase in visits to primary health care providers is higher amongst children from better off groups than for those from lower socio-economic groups while for those aged 18-24, both lower and higher socio-economic groups are benefiting from the PHCS.
In Interim practices, increases in consultation rates are around the same for those aged 6-44 and those aged 65 years and over from both lower and higher socio-economic groups; with children in higher socio-economic increasing their use of services slightly more than children from lower socio-economic groups, and adults aged 45-64 from lower socio-economic groups increasing their consultation rates more than those from higher socio-economic groups.

Consultation rates have increased for all ethnic groups. The increases are similar for Pacific, Māori, and “Other” (with 0.5, 0.6 and 0.6 more consultations on average per year, increases of around 16-18%). The smallest increase is amongst Asian populations (0.3 consultations on average per annum, or a 13% increase).

### 6.6.3 Nursing Services

Are more patients being seen by nurses?

As a result of changes in the reporting requirements, practices now need to record nursing visits. Although many will have been recording these visits accurately prior to the introduction of the PHCS, we cannot separate out from our findings an increase in the proportion of nursing visits over time from improved recording. We do, however, find an increase in the proportion of nursing visits over time. These analyses will be repeated in 2008 with data collected for a further year and we will explore the proportion of nursing visits at that time.

### 6.6.4 ACC

What changes are there in the pattern of ACC claims that GPs make, before and after the PHCS? Are more new ACC claims being made?

The proportion of ACC claims and the proportion of new ACC total claims does not show any change before and after the introduction of the PHCS. This suggests that practices are not shifting costs to ACC. Although they may have a financial incentive to shift costs to ACC, the increases in overall funding may be leading to improvements in revenue and income which are off-setting financial incentives to shift costs, or there are other disincentives to claiming from ACC which are also off-setting the increased incentives to claim on ACC. These other disincentives may include the paperwork requirements for an ACC claim versus a claim through capitation funding.
6.6.5 Conclusions

The overall goals of the PHCS are to improve health and to reduce inequalities. The government has introduced a number of new policies aimed at achieving these high level goals, including the introduction of new funding for primary health care, in part to enable reductions in fees that patients pay when they access services; the establishment of new organisations, PHOs, to manage the services for their enrolled populations; and the move from fee-for-service funding at the practitioner level to capitation funding of PHOs.

This report focuses on changes in the fees that patients are charged over time; changes in the use of services over time; changes in nursing consultation rates over time; and changes in ACC claims over time. The report does not directly measure health and inequalities; it is hoped that later work by the Evaluation team will explore issues relating to health and inequalities in more depth, focusing in particular on the impact of the Strategy on measurable intermediate outcomes.

This report shows that fees have generally fallen for the groups where new funding has been provided by government. In particular, fees have been falling for those in Access practices, and for those aged 65 years and over in Interim practices. Larger falls in fees are occurring for those without community services cards, as we might have expected. The one group where fees are rising is for children, who have not benefited from higher capitation rates (other than through adjustments in 2002 for the general level of inflation between 1997 and 2002 and through annual adjustments since 2002 to maintain the value of the subsidies).

We have also shown that the new funding is providing significant benefit for many New Zealanders given that we may have expected fees to have risen over the study period.

In terms of the roll out of new funding, the government aimed to have zero fees for children; fees of between $7-$10 for those aged 6-17 and fees of $15-$20 for adult consultations in Access practices, and, according to our analyses, other than for children, this is being achieved, both in terms of doctor and nurse consultations overall but also to consultations where a doctor is seen.

In terms of Interim practices, the data show that the roll out of new funding to those aged 6-17 lead to only a small reduction in the overall fees paid by those without cards and a small increase in fees paid by those with cards, although the increases in subsidies for this age group were less than for those in other age groups. Reductions in fees for those aged 65 years and over were much greater: in the year after the roll out, fees for doctor and nurse visits fell by an average of $10.17 (31%) for those aged 65 years and over without cards and $2.69 (12%) for those with cards. For doctor visits, average fees fell by $12.23 or 33% for those without cards and by $3.34 or 13% for those with cards.
The government was seeking falls in schedule fees of around $26 for those without cards and of $11 for those with cards.

In terms of consultations, it appears that the government’s aim of increasing consultation rates for primary health care is being achieved. There have been increases in consultation rates across almost all age, funding model, CSC, deprivation and ethnic groups. Increases have been particularly high in Access practices, especially for those without community services cards; and for those aged 65 years with and without community services cards and those aged 45-64 with community services cards in Interim practices. Consultation rates have increased for all ethnic groups, with similar increases for Pacific, Māori and Other ethnic groups, and smaller increases for Asian populations.

The overall increase in average consultation rates appears to be relatively small in terms of the number of consultations, but increases for some groups in the population are over 20% for some in Access practices. Increases in Interim practices are generally lower, as might be expected given that new funding has not been allocated to all groups in Interim practices, although increases in consultation rates in Interim practices have increased by more than 20% for those aged 45-64 without CSCs and for those aged 65 years and over without and with CSCs.

Overall, the Strategy is resulting in lower fees for primary health care for many New Zealanders, and consultation rates are also increasing over time. Further analyses of our data are required to identify the contribution of different factors to the changes we are seeing in our data, and in relation to identifying the implications for policies to reduce inequalities. These analyses will be undertaken as this evaluation progresses, including providing information on the impact on health (as measured by intermediate health outcomes) over time.
6.7 Survey of Nurses and Interviews with Selected Informants – 2006/7

Published as:


This report outlines the development of primary health care nursing (PHC) in New Zealand since the introduction of *The Primary Health Care Strategy (PHCS)* in 2001 (Minister of Health, 2001).

The report presents the findings relevant to practice nurses (PNs) from interviews undertaken in 2006 with a purposeful sample of 20 Primary Health Organisations (PHOs) representing different types in terms of size, funding, Māori and Pacific, general practice staff, and other key stakeholder organisations including seven DHBs. It also includes the findings from a survey conducted with general practice staff in 2007. In addition data from structured interviews with nurse leaders in 2006 is included as an extension to the evaluation. The nurse leaders were drawn from a broad range of institutions, these included: the Nursing Council of New Zealand, the Ministry of Health, District Health Boards (DHBs), PHOS, the New Zealand Nurses Organisation (NZNO), the College of Nurses Aotearoa, and academics involved in the teaching of PHC nursing programmes. Māori nurses, Pacific nurses and Practice Nurses were also included in the sample.

The data were analysed in relation to existing reports and evaluations impacting on PHC nursing, and national and international literature. The reports included evaluations of Care Plus, the reducing inequalities projects (RICF), and the eleven PHC nursing innovation projects. The findings are discussed under three headings: capability, capacity and collaboration.

The PHCS represented a significant opportunity to develop the role of nurses working in primary health care. Overall, data examined for this report indicated that since the introduction of the PHCS there has been substantial growth in the development of nursing roles and nurses’ capability in the PHO environment especially in the management of chronic conditions and working with people in underserved and vulnerable groups.
The two factors that have most influenced the expansion of the nurses’ roles are firstly, where practices and PHOs have embraced the intentions of the strategy to improve the health of the population, nurses’ roles have expanded, increasing access to services. Secondly, where nurses’ roles have expanded to provide better access to appropriate services it has usually been as a result of additional funding streams, for example, Care Plus, RICF, SIA and the Nursing Innovations. This has resulted in more cost-effective services, increased acceptance by clients/patients of nurses as first port of call, increased choice of provider for clients/patients, freeing up of GPs’ time, and greater job satisfaction for the general practice teams.

While nurses working for Māori providers reported they were already providing many of the services before the introduction of the PHCS, within the new environment they gained service contracts for mobile clinics and nurse-led initiatives.

Currently few Nurse Practitioners (NPs) are working in PHC but the role has the potential to enhance access to services and choice of provider, develop innovative ways of reaching communities and meet health needs for under-serviced populations. NPs have extensive clinical and contextual knowledge of their specialty area that enables them to respond to the health needs of their communities and develop appropriate and cost-effective services. Inclusion of NPs with prescribing rights in PHC teams would provide a very real advantage for enrolees and increase efficiency and effectiveness for practices.

Where there have been substantial developments in the PNs’ role PHO managers and GPs have encouraged their nurses to undertake new and innovative developments, they have recognised that nurses add value to patient consultations, and have ensured that good leadership is provided in their practices. In addition the GPs have demonstrated effective teamwork, had good staff retention and supported nurses’ to undertake postgraduate education. The nurses who have expanded their practice have had positive attitudes about the opportunities for development, have been keen to respond to their communities’ needs and have undertaken postgraduate education to enhance their skills and knowledge, often despite heavy workloads. Frequently these nurses have been employed in larger practices. Effective mentoring of nurses has been successful for involving them in governance at the PHO level.

The reported external barriers to nurses expanding their roles were: the employer/employee relationship between GPs and PNs, GPs’ attitudes, lack of support and motivation from GPs, the current funding structures, poor remuneration, heavy workloads, lack of educational opportunities, lack of leadership, lack of physical resources, and patients not recognising the nurses as autonomous health professionals. Some nurses also reported a lack of self-confidence, a belief that their current role is appropriate, and for some a lack of willingness to embrace change.
Both Care Plus and RICF have provided opportunities for nurses to expand their practice and offer innovative services to under-served populations and people with high needs, to reduce inequalities in health, but the ad hoc nature of the programmes has limited their ability to enhance access to appropriate services for all those eligible, in a sustainable way. It is imperative that the learning from these opportunities contributes to the development of new services and new ways of working.

Four main areas that require focus if PHC nurses are to further develop their roles and contribute to achieving the vision of the PHCS include: funding of PHC services; education at both undergraduate and postgraduate levels; leadership, mentoring and governance; and recruitment and retention.

Current funding models that are tied to GPs are not conducive to nurses working in innovative and expanded roles that would provide their communities with effective care. Nor are they conducive to PHOs employing Nurse Practitioners or for NPs to be contracted as providers as they are not able to access funding for the services they deliver in an equitable way. One solution would be to provide practices with a single, baseline funding stream and required clinical key performance indicators and quality measures. This would then be supplemented by generous incentives for general practices and other providers who pursue the goals of the Strategy in terms of reducing inequalities in health and improving health outcomes.

The PHCS requires PHC nurses and doctors to provide population based services as well as personal health services and this has meant a reorientation of PNs’ work. For many PNs this requires learning new knowledge and skills and for those entering this specialty area it requires undertaking further education to acquire the core knowledge and skills necessary for practice.

The nurse leaders reported the need for leadership at both the DHB and PHO level for PHC nurses, mentoring for all levels of PHC nurses, and providing opportunities for the nurses to develop the necessary skills and to take an active role in governance at the practice, PHO and DHB levels.

Both recruitment and retention of PNs are key concerns, especially experienced nurses and Māori and Pacific nurses. While 80% of the nurses in this study found practice nursing to be rewarding there was considerable variation between practices in terms of retention. Some nurses and practices suggested the high turnover was due to the nurses’ lack of control over the work environment, high stress, heavy workloads, lack of time to introduce new initiatives, inability to access resources and infrastructure, especially space. Other practices reported very stable workforces.
The 2005 MECA (Multi-employer Collective Agreement) for DHB nurses resulted in a depleted PHC nursing workforce and led to the reduction and even cessation of some services. The recently agreed MECA for PHC nurses, while not providing them with pay parity with DHB nurses, should go some way towards resolving this issue.

Establishing an environment that encourages innovation, attracts and retains appropriately skilled nurses, and is focussed on achieving the vision of the PHCS has implications for both policy and practice. This research has identified four key areas for these: funding; education; leadership, mentorship and governance; and recruitment and retention.
6.8 Survey of General Medical Practices and GPs 2006/7

Published as:


6.8.1 Methodology

This report analyses data obtained from qualitative interviews undertaken in 2006 and from surveys undertaken between August 2006 and June 2007. The interviews were undertaken with practices, PHOs, DHBs, and individuals involved in the management and monitoring of the Primary Health Care Strategy’s implementation.

Seven DHBs and 20 PHOs were selected for these interviews. Purposive sampling was used for the selection, to allow over-representation of PHOs with a Māori and Pacific focus, and adequate representation of PHOs in rural, city or metropolitan areas and in North Island and South Island locations.

Survey questionnaires were based on the findings of the qualitative interviews. They were developed by the researchers, with input from the Steering Committee.

A list of PHC practices was obtained from HealthPAC; all were contacted by phone and asked to participate. Each practice and 50% of general practitioners (GPs) and practice nurses were invited to complete the questionnaires. The response rate from each group was low: 276 practices (26.7%), 277 GPs (25.6%) and 384 practice nurses (38.0%) returned questionnaires.

All types of practices and PHOs were represented in the returned questionnaires. There was, however, some under-representation of rural, smaller and Access-funded practices, and of older and part-time GPs; and there was some over-representation of small PHOs.

Approximately 130 interviews were conducted (100 with practice personnel).

6.8.2 Description of Practices and GPs

Practices were distinguished on the basis of size (number of GPs), funding formula, rurality (defined as having a score on the Ministry’s Rural Ranking Scale), whether previously capititated, type of ownership (community/private), and size and age of the practice’s PHO.
The average number of GPs per practice was three and the modal value was one. There was an average of one nurse for each GP and one support person for every two clinicians (GPs and nurses). There were more nurses in community-owned practices.

There were differences between types of practice. Large practices were open for longer hours, less likely to close for a half-day in the week, and more likely to be open for some period at the weekend. They were more likely to provide specialist medical, surgical and pharmacy services on site. Community-owned practices were more likely to provide sexual health, mental health, and health education services.

The mean age of responding GPs was 49. Thirty-eight percent of them were women. Sixty-six percent were owners of, or partners in, the practice. The average number of hours worked per week by GPs was 41; 69% worked between 31 and 60 hours. Of this time, 71% was spent in patient contact. Two-thirds of GPs undertook after-hours work – and on average these GPs contributed to a roster of eight clinicians (thus they worked one after-hours period in eight).

GPs reported that, since their practice had joined a PHO, patient numbers had increased by an average of 2.5%. In the 5% of practices that were not members of a PHO, there had been a decrease in patient numbers of 1.9% in the two years before the survey.

Sometimes the GP discussed patient management with another clinician – with a practice nurse (in 14.5% of cases) or another GP (5.4% of cases). Each week on average they contacted the hospital 8.3 times, a community health service 3.3 times, and a non-health agency 2.2 times.

In general, practices and GPs supported the Strategy – although with some reservations. Most of the GPs:

- welcomed the increase in PHC funding
- welcomed an increase in the role of nurses
- felt that other professionals should be included in PHC funding
- felt that funding should be targeted individually rather than by population characteristics
- felt that the system should provide “affordable low-cost access” (only one-third felt that it should provide “universal low-cost access”)
- noted the incentive under capitation to under-service, to avoid change, and to reject “high-cost” patients or families.
• twenty percent of the GPs believed it was undesirable to seek out enrollees who did not visit the practice.

6.8.3 Access and Affordability

There was general agreement that the number of visits to practices had increased and that this was related to the increased subsidy and an associated reduction in fees. In general, most practices reported that they had become busier over time. But non-PHO practices reported (in equal numbers) both increased and decreased work.

It was clear that practices serving disadvantaged populations had lower fees. Among respondent practices, the unweighted average of scheduled fees for general medical services were, relative to the mean: community-owned practices 51%; Access-funded practices 64%; rural practices 87%, Interim-funded practices 113%, and non-PHO practices 119%. There were similar differences in fees for ACC visits. There been a general decrease in the money that patients owed to the access-funded practices. Most GPs in practices serving disadvantaged populations favoured increased subsidisation and “universal low cost access.”

Improved access was suggested by the fact that the percentage of “late” patient visits had decreased somewhat, especially at access-funded and large practices; but so had the percentage of “unnecessary” visits. Access-funded practices had fewer enrolled patients per GP, and this ratio was inversely related to practice size (size defined as number of FTE GPs).

The reluctance of some enrollees to seek medical help was noted – particularly men (especially Māori) and rural populations. Polynesian women were reported to be reluctant to seek screening services or to attend sexual health clinics.

Practices reported a number of innovations designed to improve access. Thirty-seven percent of all responding practices provided some form of transportation assistance, and 69% of community-owned practices did so. A wide variety of outreach services were in place. GPs averaged 4.4 home visits per week (GPs in solo practices 5.7); and practice nurses averaged 1.32 (practice nurses in community-owned practices 3.6). Forty-four percent of all practices reported access to community health workers (69% of Access-funded practices did so).

Opinion was divided on the Care Plus programme, designed to improve access for those with chronic conditions. Most practices found it onerously bureaucratic and uptake varied from 0.73% of enrollees at solo-practices to 1.45% at access-funded practices; the mean was 1%.
6.8.4 PHO-Practice Relationships

Practice and GP views on their PHO varied from enthusiasm to distrust. However, over a variety of categories, PHO influence was judged to be “about right” by 50% to 70% of respondents.

Practices were asked to assess 12 PHO services using a five-point scale. For each one of these services, about 10% of practices reported that it was not provided, 15% scored it as one or two (poor provision), and 47% scored it as four or five (good provision). About a quarter (26%) of practices wanted more services from their PHO, especially assistance with locums – and this was more likely to be the case if the PHO was small or the practice community-owned.

There was a level of frustration in the practice relationship with the DHB. Approval of new projects was thought to be too slow, and reporting requirements (paperwork) were seen as excessive. It was also felt that DHBs and the Ministry did not understand the exigencies of small business and tended to waste money on non-clinical issues.

6.8.5 Sustainability

Many of the GPs were concerned about recruitment and retention of an adequate GP workforce. They cited vacancies, practice closures, and difficulty in obtaining locums. Many practices were operating at the limit of their capacity.

There was some evidence that recruitment of GPs in recent years had been inadequate - on average, GPs expected to retire in 8.6 years and had spent an average of 18.5 years in general practice. Further, 24% of all practices and 35% of community-owned practices reported vacancies for GPs, with the mean duration of the vacancy being eight months. Twelve percent of all practices had vacancies for nurses.

GPs believed that they were undervalued by the Ministry, and noted that their income and support compared unfavourably with that of specialists. They also noted that primary care medicine would be more attractive if continuing education, management services and infrastructure was better supported.

Of particular concern to GPs was the lack of good secondary health care services. DHB emergency care was rated good by 56% of GPs and poor by 6%; elective services were rated good by 18% and poor by 37.5%. GPs affiliated with Māori practices and with large practices were more likely to be dissatisfied with secondary services.

Nevertheless GP work satisfaction, measured across seven categories, was 3.5 out of five (the range across the seven categories was 3.2 – 3.9). GPs in solo, rural and Māori PHO practices were least satisfied.
Most GPs reported an increase in income over the previous two years. This was less likely to be the case for GPs in non-PHO, solo and Māori PHO practices, and for salaried GPs.

**6.8.6 Implications**

The implementation of the Strategy has aided the development of some practices and increased access for some populations.

Attention might be directed to the needs of transient populations and those unable to attend a low-cost practice. A more even distribution of practices – one based on population need – would improve access and increase efficiency.

Further incentives are needed to encourage practice change and to ensure that patients are not excluded because their health care needs are time-consuming.

Practices could be supported – and recruitment of personnel could be assisted – if after-hours care was made attractive, if reporting was simplified, and if DHBs and the Ministry were more supportive.

There are opportunities to support practices by encouraging PHOs to adopt “best-practice” initiatives.
6.9 Survey of Primary Health Organisation Managers and Board Members 2006-7

Published as:


6.9.1 Introduction

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

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

The Evaluation’s research uses four main methods: key informant interviews; survey questionnaires; and quantitative analyses in support of an economic analysis of the impact of the Strategy. This report uses data from a Second Phase of key informant interviews (127 overall) and from three survey questionnaires (undertaken in 2006/7), to examine the role of PHOs in the reformed PHC environment.
6.9.2 Functioning of PHO Boards

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

In reporting the way they perceived their roles, nearly half of respondent board members indicated that this included ensuring accountability and ensuring clinical quality, with lesser percentages indicating that representing provider interests (44%), ensuring management performance (41%), developing new services (39%), communicating with DHBs (39%) and representing community interests (38%) were of importance. Unsurprisingly, the early history of a PHO appeared to influence the extent to which the board had a clear and agreed view of the PHO’s role. Where the PHO had evolved from a community trust or similar organisation, there was a shared perception that people had common goals due to a history of shared local governance, and experience of community and clinical leaders working together. Some informants asserted that where a PHO had grown out of an IPA and continued to receive management services from there, then the PHO tended to focus on the needs and priorities of GPs. Clearly, in the absence of central guidance, PHOs have been left to work things out locally. Some informants noted the importance of PHO size, with small PHOs able to reach agreement more easily but with less capability to fulfil requirements.

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

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

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

Informants reported a wide range of service initiatives, particularly in the areas of improving access to core consultation services, through Services to Improve Access (SIA) funding. These included lower fees, additional nurse consultations, use of interpreters, longer consultations, telephone triage, the extension of practice hours and the involvement of community health workers. Outreach services to improve access (e.g. clinics for migrants, school-based clinics, marae services) have proved popular, and initiatives to extend or ‘add value’ to core services have been important (Care Plus, management of mental health conditions). Several informants expressed concern over the sustainability of extended services. Beyond core consultation services, some PHOs have actively developed health promotion projects (particularly in the area of lifestyle management), although at the time of the research these were not widespread.
Despite a strong majority of PHO Board Member Survey respondents (77%) reporting that their board had been able to influence the activities of practices to a desirable extent in introducing new programmes, interview informants indicated two major areas of constraint that provided service development challenges to PHOs: the capacity to do the work at all due to issues such as space or workforce, and the tension between a “general practice” and wider “PHC” view of PHOs.

6.9.4 PHO Relationships Within the System

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

PHOs reported that from the early days of implementation relationships had been good between PHOs, despite ideological differences relating to ownership and funding structures. Relationships were nurtured through regular meetings and forums, and chairs and managers maintained close contact. Philosophical differences between community and IPA-led PHOs and differences in funding between Access and other PHOs were a potential source of tension. Nevertheless there were quite early examples of joint delivery of services across PHOs, and the concept of ‘lead’ PHOs (not always the largest) for mutually agreed service projects was soon developed. Relationships between PHOs and MSOs were reported as good, with many PHOs highly dependent on MSO support, but in an increasingly circumscribed role related to financial management and IT/data development and analysis. Relationship management, professional matters and service development were clearly seen as PHO rather than MSO responsibilities. PHOs that engaged MSOs reported very positively on their performance, particularly in financial and IT areas.
Community relationships operate at multiple levels, some of which have already been noted. Overall PHO Managers (68%) rated their relationships with community agencies as good. Māori PHOs, in particular, reported very positive community relationships and a number of PHO and DHB informants commented on the strong tradition of community relationships for both Māori and Pacific PHOs. Overall Board Member Survey respondents reported favourably on the time and effort their PHO management put into such relationships, although they also appreciated MSO involvement. Several managers reported that PHOs were working in partnership with non-government organisations.

6.9.5 Conclusions

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

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

At its narrowest, the scope of PHO activity includes a focus on strengthening practice services. At its broadest, it involves a more strategic and community-wide view of service development. Both can be seen as core activities, but it is not possible from the data gathered at this stage in the Evaluation to assess how far individual PHOs are addressing these. There is variety in how specific issues are addressed in PHOs – for example: workforce, patient fees, capacity development, service development – and there are tensions between fee restraint and sustainable practices. Some PHOs are more pro-active in addressing these matters; others consider them either beyond their role or their capacity. Despite constraints, there are many examples of innovation in workforce and service development, and in community outreach and engagement.
The critical relationship between PHOs and DHBs appears to be maturing, although a number of issues remain to be worked through. In some cases PHOs and DHBs are developing parallel services, and it may be valuable to consider opportunities for more joint planning and funding activity. The relationships between PHOs are beginning to emerge as important factors in managing the clinical and financial vulnerability of small PHOs and in ensuring local and regional equity or services.

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

As part of the evaluation of the Primary Health Care Strategy a survey of PHOs was carried out between August 2006 and June 2007. The majority of the findings were reported in the paper summarised above - that report should be consulted for details of methodology. Some additional data are reported here.

All PHOs were approached and data was obtained from 44 PHO managers, a response rate of 54%. Table 6.2 shows the response rate by PHO type; it will be noted that medium-sized access PHOs were over represented (90%) and that large IPA-based (44%), medium-sized interim/mixed (35%) and Pacific PHOs (33%) were under represented.

Table A6.2 Response Rate by PHO Type

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Responded</th>
<th>Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large IPA based</td>
<td>9</td>
<td>4</td>
<td>44.4</td>
</tr>
<tr>
<td>Medium mixed/interim</td>
<td>17</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>Small, interim/mixed</td>
<td>15</td>
<td>8</td>
<td>53.3</td>
</tr>
<tr>
<td>Medium Access</td>
<td>9</td>
<td>8</td>
<td>88.9</td>
</tr>
<tr>
<td>Small, Access</td>
<td>13</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Māori</td>
<td>15</td>
<td>9</td>
<td>60.0</td>
</tr>
<tr>
<td>Pacific</td>
<td>3</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>81</td>
<td>44</td>
<td>54.3</td>
</tr>
<tr>
<td>All interim/mixed</td>
<td>41</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>All access</td>
<td>40</td>
<td>26</td>
<td>65.0</td>
</tr>
</tbody>
</table>
6.10.1 PHO (Non-health Service) Activities

PHO managers were asked to indicate if the PHO undertook a list of functions and whether the function was delegated to a Management Services Organisation (MSO). The data are presented in Table A6.3. Of the 16 functions specified, the majority (75%) were undertaken by 90% or more of the PHOs. Such functions included: liaison with the community, other providers and the DHB/MoH/HealthPAC; support of providers, including financial management, IT support and improved practice quality; new initiatives; and needs analysis. Most PHOs (86%) undertook secondary liaison and most (70.5%) were direct providers of health services. Only a few PHOs undertook to supply locum doctors (32%) or fill-in nurses (25%).
### Table A6.3 Activities Undertaken by PHO or MSO

<table>
<thead>
<tr>
<th>Activity</th>
<th>% Undertake</th>
<th>PHO</th>
<th>MSO</th>
<th>% MSO</th>
<th>Future (priority)</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaise with community</td>
<td>100.0</td>
<td>42</td>
<td>2</td>
<td>4.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Support GPs /other providers</td>
<td>97.7</td>
<td>43</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Liaison with DHB</td>
<td>97.7</td>
<td>40</td>
<td>3</td>
<td>7.0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Relationship with MoH/HealthPAC</td>
<td>97.7</td>
<td>33</td>
<td>10</td>
<td>23.3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Liaison with community health providers</td>
<td>95.5</td>
<td>41</td>
<td>1</td>
<td>2.4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Liaison with community non-health providers</td>
<td>95.5</td>
<td>41</td>
<td>1</td>
<td>2.4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Quality initiatives</td>
<td>95.5</td>
<td>37</td>
<td>5</td>
<td>11.9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Teamwork and practice processes</td>
<td>95.5</td>
<td>35</td>
<td>7</td>
<td>16.7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>IT/data development</td>
<td>95.5</td>
<td>17</td>
<td>25</td>
<td>59.5</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>New programmes</td>
<td>93.2</td>
<td>39</td>
<td>2</td>
<td>4.9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Finance management</td>
<td>93.2</td>
<td>26</td>
<td>15</td>
<td>36.6</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Needs analysis</td>
<td>90.9</td>
<td>33</td>
<td>7</td>
<td>17.5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Secondary liaison</td>
<td>86.4</td>
<td>31</td>
<td>7</td>
<td>18.4</td>
<td>2 (1)</td>
<td>3</td>
</tr>
<tr>
<td>Direct provision of services</td>
<td>70.5</td>
<td>21</td>
<td>10</td>
<td>32.3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Provide locums</td>
<td>31.8</td>
<td>8</td>
<td>6</td>
<td>42.9</td>
<td>12 (1)</td>
<td>17</td>
</tr>
<tr>
<td>Fill-in nurses</td>
<td>25.0</td>
<td>8</td>
<td>3</td>
<td>27.3</td>
<td>12 (1)</td>
<td>20</td>
</tr>
</tbody>
</table>
Some of these functions were delegated to the MSO. This was common for IT functions (60%), and frequent for provision of locums (43%), finance management (37%) and the direct provision of health services (32%). The MSO was rarely involved with: liaison with the community and other providers; or new initiatives.

The final category, provision of temporary clinical staff, is related to more general workforce issues and was addressed in a separate question. The data is given in Table A6.4. More than two thirds of PHOs provide CME and CNE, and two fifths employ nurses and one fifth employ doctors. Three fifths are engaged in some sort of recruitment initiative. Access-funded PHOs are less likely to provide education and more likely to employ nurses.

Table A6.4 Professional Education, Clinician Employment and Recruitment

<table>
<thead>
<tr>
<th></th>
<th>CNE</th>
<th>CME</th>
<th>Employ Nurses</th>
<th>Employ Doctors</th>
<th>Recruitment Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>72.7</td>
<td>69.8</td>
<td>41.9</td>
<td>20.9</td>
<td>60.5</td>
</tr>
<tr>
<td>Access</td>
<td>64.0</td>
<td>58.3</td>
<td>52.0</td>
<td>20.8</td>
<td>62.5</td>
</tr>
<tr>
<td>Interim and Mixed</td>
<td>84.2</td>
<td>84.2</td>
<td>27.8</td>
<td>21.1</td>
<td>57.9</td>
</tr>
</tbody>
</table>

6.10.2 Make-up of PHOs

Non-general practice providers in PHO - PHO managers were asked to list the non-general practice providers who were part of the PHO and the services that they provided. Thirty one of 44 (70%) respondents listed non-general practice providers; Table A6.5 shows the range of organisations mentioned. The most frequent group to be included were Māori and Pacific organisations which were mentioned by 17 PHOs (39%). In some cases there were several (up to seven) such organisations mentioned.
Table A6.5 Providers Included by PHO

<table>
<thead>
<tr>
<th>Provider</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori /Pacific Community Group</td>
<td>17</td>
</tr>
<tr>
<td>Individual professionals</td>
<td>13</td>
</tr>
<tr>
<td>Other Community Group</td>
<td>6</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>3</td>
</tr>
<tr>
<td>District Council</td>
<td>1</td>
</tr>
<tr>
<td>Accident and Medical Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Translation Services</td>
<td>1</td>
</tr>
</tbody>
</table>

These providers were responsible for the services listed in Table A6.6.

Table A6.6 Services Provided from within PHO

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle/Health promotion</td>
<td>18</td>
</tr>
<tr>
<td>Oral health</td>
<td>1</td>
</tr>
<tr>
<td>Support (including cultural)</td>
<td>11</td>
</tr>
<tr>
<td>Performance management</td>
<td>1</td>
</tr>
<tr>
<td>Community nurses/outreach</td>
<td>10</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1</td>
</tr>
<tr>
<td>Medication review/management</td>
<td>7</td>
</tr>
<tr>
<td>Podiatry</td>
<td>1</td>
</tr>
<tr>
<td>Mental health/counselling</td>
<td>5</td>
</tr>
<tr>
<td>Relationship building</td>
<td>1</td>
</tr>
<tr>
<td>Chronic care (including palliative)</td>
<td>3</td>
</tr>
<tr>
<td>Retinal Screening</td>
<td>1</td>
</tr>
<tr>
<td>Multiple</td>
<td>4</td>
</tr>
<tr>
<td>Tattoo removal</td>
<td>1</td>
</tr>
<tr>
<td>After-hours care</td>
<td>1</td>
</tr>
<tr>
<td>Transport</td>
<td>1</td>
</tr>
<tr>
<td>Massage/mirimiri</td>
<td>1</td>
</tr>
<tr>
<td>X Rays</td>
<td>1</td>
</tr>
</tbody>
</table>
Health Providers outside PHO - PHO managers were also asked about health organisations with which the PHO had an informal, non-business, relationship and what services these provided. Thirty eight of 44 (86%) respondents listed such providers; Table A6.7 shows the range of organisations mentioned. The most frequent group to be included were Māori and Pacific organisations which were mentioned by 15 PHOs (34% of respondents) PHOs. In some cases there were several (up to seven) such organisations mentioned. Relationships with other community health organisations, pharmacies and national disease groups (Health Foundation, Diabetes New Zealand etc.) were also frequent. DHB services were also mentioned but are not included in the table.

Table A6.7 Providers Outside PHO

<table>
<thead>
<tr>
<th>Organisation Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori /Pacific community orgs</td>
<td>15</td>
</tr>
<tr>
<td>Other community organisations</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>12</td>
</tr>
<tr>
<td>National disease Groups</td>
<td>10</td>
</tr>
<tr>
<td>Plunket</td>
<td>8</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>5</td>
</tr>
<tr>
<td>Sport organisations</td>
<td>4</td>
</tr>
<tr>
<td>Other PHOs/GPs</td>
<td>2</td>
</tr>
<tr>
<td>Midwives</td>
<td>1</td>
</tr>
</tbody>
</table>

The services provided by these organisations are listed in Table 6.8; the most frequent were well-child and population health (20%), dispensing (18%), and community nurse outreach (16%).
**Table A6.8 Services Provided Outside the PHO**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Count</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Child / Population health</td>
<td>9</td>
<td>Mental health</td>
</tr>
<tr>
<td>Dispensing</td>
<td>8</td>
<td>Activity</td>
</tr>
<tr>
<td>Community nursing</td>
<td>7</td>
<td>Dietetics</td>
</tr>
<tr>
<td>Social Services/community work</td>
<td>5</td>
<td>Meals on Wheels</td>
</tr>
<tr>
<td>Sexual health / Screening</td>
<td>5</td>
<td>Transport</td>
</tr>
<tr>
<td>Education</td>
<td>4</td>
<td>Retinal Screening</td>
</tr>
<tr>
<td>Healthy Homes</td>
<td>3</td>
<td>Maternity care</td>
</tr>
</tbody>
</table>

**Non-health providers** - PHO managers were asked about non-health community organisations with which the PHO had a relationship and what services these provided. Thirty four of 44 (77%) respondents listed such organisations; Table A6.9 shows the range of organisations mentioned. The most frequently mentioned organisation was Work and Income New Zealand (61%).

**Table A6.9 PHO Relationships Outside Health**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Count</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work and Income NZ</td>
<td>27</td>
<td>Inter-sectoral Forum</td>
</tr>
<tr>
<td>Ministry of Social Development</td>
<td>9</td>
<td>Women's Refuge</td>
</tr>
<tr>
<td>Local Council</td>
<td>7</td>
<td>Te Puni Kōkiri</td>
</tr>
<tr>
<td>Education Providers</td>
<td>6</td>
<td>Families Commission</td>
</tr>
<tr>
<td>Māori Trusts (various)</td>
<td>6</td>
<td>Office of Ethnic Affairs</td>
</tr>
<tr>
<td>Child Youth and Family</td>
<td>6</td>
<td>Home Insulation Provider</td>
</tr>
<tr>
<td>Housing New Zealand</td>
<td>4</td>
<td>Age Concern</td>
</tr>
<tr>
<td>Department of Corrections</td>
<td>3</td>
<td>Youthline</td>
</tr>
<tr>
<td>Police</td>
<td>2</td>
<td>Fire Service</td>
</tr>
</tbody>
</table>

*Includes WINZ, CYFS, Family Start*
In summary, PHOs had a wide range of relationships with organisations and professionals, some within and some outside the PHO. Only four (9%) PHOs indicated that they had no relationships with non-general practice service providers.

6.10.3 PHO Services to the Population

PHO managers were asked to summarise programmes or initiatives undertaken to enhance or add to the services provided by their member general practices. Their responses are summarised in Table A6.10 which gives the number and percentage of responding PHOs which provided each type of service and a list of activities mentioned. The classification of the activities used by the PHO respondent is maintained although some activities might be classified elsewhere. The number of PHOs reporting the provision of each service is given (if more than one). It should be noted that many of the services mentioned would be provided by practices without the intervention of the PHO.

Table A6.10 Non-general Practice Services Provided by PHOs

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Response Count and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Health Services</td>
<td>13 (29%)</td>
</tr>
<tr>
<td>Home insulation, water quality, waste disposal, gardening, advocacy, community health workers, elderly and mental health support, other</td>
<td></td>
</tr>
<tr>
<td>Health Education</td>
<td>20 (44%)</td>
</tr>
<tr>
<td>Health promotion, lifestyle advice and green prescriptions, support of physical activity, other</td>
<td></td>
</tr>
<tr>
<td>Out-reach to the disenfranchised</td>
<td>13 (29%)</td>
</tr>
<tr>
<td>Dedicated GP, practice nurse, community health workers, Māori health worker, Pacific health worker, activities related to specific illnesses or problems, other</td>
<td></td>
</tr>
<tr>
<td>Improve access</td>
<td>14 (31%)</td>
</tr>
<tr>
<td>Transport assistance, mobile or remote clinics, nurse clinics, extended hours, subsidised visits, other</td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>18 (40%)</td>
</tr>
<tr>
<td>Cardiovascular disease and diabetes, cervix and breast, other</td>
<td></td>
</tr>
<tr>
<td>New Clinical Service</td>
<td>17 (38%)</td>
</tr>
<tr>
<td>Chronic disease management, mental health, Free sexual health clinic, podiatry, psychology, pharmacy, other</td>
<td></td>
</tr>
<tr>
<td>Secondary Liaison</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>Discharge planning, specialist visits in practices</td>
<td></td>
</tr>
<tr>
<td>Quality programmes</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>Staff education, Cornerstone Accreditation, other</td>
<td></td>
</tr>
<tr>
<td>Direct Employment of practice staff</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>All practice staff, practice nurses</td>
<td></td>
</tr>
</tbody>
</table>
There was some variation in the number of additional services provided by PHOs with some making no entries in the questionnaire and others making as many as nine. Māori PHOs were less likely (mean entries 1.3) than other categories of PHOs (mean entries range 2.7 to 3.5) to record additional services.

**Devolution of DHB Services** - PHO managers were asked if they favoured taking on services currently provided by the DHB or the Ministry. Of the 44 PHOs responding to the survey 35 (80%) supported devolution of services. The general opinion was that community services worked better when provided by community-based organisations (37). The main reason given was that there could be better integration (12). Other advantages included: better availability (2), especially in rural areas (1); less delay (2); better prioritisation (1); better outcomes (1); and more prevention (1). There would be business opportunities for general practices (1) and patients could be charged (1).

The services that should be devolved were described in terms of professional groups or activities. There were 25 mentions of community nursing functions, including: district nurses (13); public health nurses (5); community resource nurses (2); school nurses (1); and Plunket nurses (1). Social workers (1), occupational therapists (1), physiotherapists (1) and community health workers were also mentioned (1).

There were 42 mentions of activities that should be devolved, including: various aspects of chronic disease management (15); dietetic services (4); mental health services (4); dental care (4); and sexual health services (2). There were also single mentions of maternity care, immunisation coordination and HEHA. It was also suggested that primary care should manage budgets for laboratory services (2), pharmaceuticals (2) and radiology (1).

The services provided are listed in the table; the most frequent were health promotion (41%), support (23%), and community nurse outreach (23%).

**Overlap with other PHOs** - Where there are more than one PHO providing services to a particular area, a number of potential problems arise. It is harder for each PHO to relate to the community and they may compete for staff. Managers were asked whether their PHO overlapped with others and whether they overlapped with another PHO of the same funding type. Table 6.11 shows the responses. There was overlap in slightly over half the cases (57%). PHOs overlapped with other PHOs of the same type in about half the cases and with PHOs of the opposite type in about a third of cases.
Table A6.11 Frequency of PHO Overlap

<table>
<thead>
<tr>
<th></th>
<th>Overlap Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Access</td>
<td>25</td>
</tr>
<tr>
<td>Interim</td>
<td>12</td>
</tr>
<tr>
<td>Mixed</td>
<td>7</td>
</tr>
<tr>
<td>All</td>
<td>44</td>
</tr>
</tbody>
</table>

6.10.4 Challenges and Changes

PHO managers were asked to describe challenges facing the PHO and to suggest changes that might be made to the PHCS. Their answers to both questions are combined in the following summary of their responses.

PHOs reported that they found it hard to find resources for community consultation and for planning new programmes. They indicated that the whole enterprise of change management should be better resourced. One solution to this would be for DHBs to adopt a more cooperative stance, emphasising joint planning rather than gate-keeping, and streamlining the approval process. It would also help if there was better alignment of national, district and PHO goals, with, in particular, greater clarity about the use of health promotion and SIA funding.

There was a feeling that there were unreasonable expectations given the resources available. Compliance demands were often excessive, particularly for small PHOs. Particular services that were under-resourced included after-hours care and chronic disease management. There were also issues with overly complex programmes and multiple funding streams. Some programmes would work well and become oversubscribed; others, with a fixed term, would struggle with the fact that they could be terminated.

Managers noted that PHOs differed and believed that this was not recognised under present arrangements. Some were inhibited by competition between overlapping PHOs; some were underfunded given hard-to-care-for populations; and those with more ambitious and successful programmes were not rewarded. Rural areas were particularly affected with diseconomies of scale, more problematic recruitment and the heavier burden of after-hours care.
Some DHBs were seen as overly hospital-focused with inadequate understanding of primary care. They tended to see PHOs only as service providers and did not recognise their role in identifying service deficiencies and improving service access and quality. They were also reluctant to devolve community services and might actively compete with PHO initiatives.

PHO activity was inhibited by the lack of inclusiveness of the PHCS and by the fragmentation of funding. If more services were included, it would be easier to develop good relationships between providers and to find opportunities for cooperation between services. In particular, all services for Māori should work together; at present NGOs saw PHOs as a threat, and PHOs saw NGOs as lacking accountability.

PHO managers had some thoughts on general practice staff including difficulties in recruitment, un-helped by competition for nurses by DHBs. They also noted that GPs felt dissatisfied and disenfranchised. There was some difficulty in moving GPs towards a population approach given the PHOs ability only to influence, not direct, them.

6.10.5 Summary

Most PHOs undertook a full range of planning and governance roles, although some functions were quite commonly delegated to MSOs. The exception was the provision of fill-in clinicians. However, most PHOs provided education for clinicians, a fifth employed GPs and two fifths employed nurses. Three fifths were active in recruitment.

Most PHOs had developed relationships with a large number of providers, some within and some without, the organisation. These providers were commonly involved with health promotion and well child services, community nursing and patient outreach, social services, dispensing and a number of specific clinical services.

A significant proportion (about a third) of PHOs provided services to their populations that strengthened, or added to, the activities of general practices. These included health education, outreach and access initiatives, new clinical services and non-health support.

Problems reported by PHOs included inadequate resourcing, lack of cooperation by DHBs and difficulties related to the exclusion from the PHCS of many community services. In general differences between PHOs were inadequately recognised.
6.11 Survey of Primary Health Organisations – July 2008

Originally Published as:


The analysis set out in this paper represents a snapshot of the demography of PHOs in New Zealand in July 2008, along with the perceptions of their managers about the role, sustainability and aspirations of their organisation. The data were gathered by CBG Health Research Limited using computer assisted telephone interviewing technology. The managers of all PHOs were approached and 73 of 80 agreed to be interviewed.

6.11.1 Structure

An impression of significant structural diversity is gained from this analysis, in respect of: history, enrollee numbers; management support arrangements; and the size, composition, remuneration and frequency of governance boards and meetings. This raises an important policy question about how far such diversity is desirable within a publicly-funded health system, and whether all PHOs have an equal chance to achieve what is expected of them.

Of PHOs surveyed, 44% had their origins in IPAS, 12% in Iwi or other Māori organisations, 14% in non-Māori community groups and 8% in Health Care Aotearoa.10

PHOs differ significantly particularly in terms of the populations they serve, with enrolled numbers varying from 1.5 to 356 thousand. Half of all PHOs serve populations of less than 20,000 but these PHOs serve only 23% of New Zealanders.

PHOs also differ in terms of their composition – Although general practices are in the majority in just over half of the PHOs, some PHOs have more diverse composition. Two-thirds do not include NGOs or providers other than general practices (although PHOs may have other types of relationships with such organisations).

10 An umbrella organisation for practices serving disadvantaged populations.
PHO boards typically have between four and nine members and an analysis of their composition shows a range of representation with Māori and community representatives each making up 24%, GPs 20% and nurses 9%. This appears to challenge some anecdotal comments made on occasion about PHOs being ‘dominated by GPs’; no PHO board had a majority of GPs, and in almost all cases they represent a third or less of board members. PHO boards appear to have good levels of Māori and community representatives, but have very little representation from practice nurses, Pacific peoples and from ‘Others’.

Many boards were appointed (48%), a few elected (8%) and the remainder a mixture of appointed and elected members. They typically met monthly and were modestly remunerated, however, 13% were unpaid and some were paid $1000 per meeting.

Finally, there is significant variation in staff numbers between PHOs. The mean number of staff was 6.5 but some had none and one had 41. Part of this variation is explained by the contracting-out of various functions to a Medical Service Organisation; 56% of PHOs used an MSO in some capacity.

6.11.2 Role

In relation to what PHOs expect of themselves (given that the PHCS is relatively unspecific about their role), there is evidence from the PHO managers of differing interpretations of the role of a PHO, with the most vivid example being in relation to whether or not a PHO should be a provider of services (where half think yes and half think no). This differing interpretation of role may indeed be acceptable, but it is of note that national expectations of PHOs seem to be that they will all work towards the aims of the PHCS. This raises a question as to whether certain types of PHO, in the current funding and organisational context, will ever be able to achieve some of the PHCS aims such as those related to primary health care provider development and support, which evaluation evidence suggests has been a relatively under-developed area within PHCS implementation to date (Cumming, Raymont et al. 2005; Smith Forthcoming). That so many PHOs may not see themselves as providers of services may well reflect the different origins of PHOs, with some having a view that they do not wish to compete with the service providers which are part of the PHO, including those involved in the governance of the PHO.

That PHOs are planners and funders of primary health care seems to be universally accepted, along with their role in supporting general practice and seeking to develop local primary health care provision. This raises a question as to how the PHO role complements or duplicates that of the district health board, and how the PHO should play a distinctive part in planning, funding and developing primary health care at a local level.
Most PHOs distributed all funding related to the provision of first contact care to practices on the basis of the Ministry funding formula. Only one “top-sliced” the funding for other purposes and only one distributed this funding on the basis of activity.

Services to Improve Access and health promotion funding, on the other hand, was used by most PHOs to provide services directly or to purchase them from practices or other providers. It appears that PHOs obtain financial leverage to effect change through the allocation of these relatively minor elements of funding not being in a position to use the money for first-contact care for this purpose. Given that the policy intention has been for PHOs to pass such funding to practices in order to enable lower fees to be charged to patients, it is unsurprising that PHOs have done this without any attempt to shape the allocation or use of such resource.

It is of note, however, that New Zealand government policy appears to put significant faith in the allocation of the money for first-contact funding on a capitation basis as being a route by which the model of primary care might be shifted from an episodic treatment focus towards one that is more health-promoting and preventative (National Health Committee 2000; King 2001). This flies in the face of evidence from international research literature about the limited potential of a capitation funding approaches to achieve changes in service delivery on its own (Seddon, Reinken et al. 1985; Scott and Hall 1995; Rice and Smith 2001; Robinson 2001). Such concerns have also been raised in New Zealand where patient co-payments remain as a significant element of physician income, and where there is an incomplete contract between funder and providers (Cumming 1999; Cumming 2002; Croxson, Smith et al. Forthcoming). PHOs are clearly not exercising financial leverage over the allocation of funding to practices, funding that is intended to reduce the cost of fees paid to access that care. This raises a question about the role and purpose of PHOs over and above the ‘passing-on’ of funding to practices.

That PHOs have used other funding streams to develop care locally is not in doubt – but there is a question as to how they can move to the next stage of development and play a role in planning, funding and incentivising wider-scale change and to bring about extended, sustainable and better integrated primary care provision. This appears to be widely accepted as the next major challenge for New Zealand’s primary health care sector (Smith and Cumming, Forthcoming), and may require more complete contracts which enable greater specificity and accountability in terms of the changes desired in service delivery, in return for the allocation of new funding. The government will also need to consider how to balance out providing funding to support further change in service delivery against the need to maintain or further reduce the fees that patients pay when they use primary health care services.
The key question in this respect is whether or not PHOs can actually achieve the role expected of them in relation to primary health care development at the provider level, given the funding and policy framework within which they are currently expected to operate. Their infrastructure appears to focus on planning, needs assessment, and the allocation of specific and minority streams of money, despite the PHCS setting out a much more extensive and bold role in relation to extending and changing the nature of primary health care services at a local level.

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

If PHOs are to develop further their role as planners and funders of primary health care, and seek to develop new forms of better integrated primary health care using mechanisms such as more devolved budgets and pooled finding streams, there are issues to be worked through in relation to how PHOs relate to their providers, and to their MSOs. New Zealand has put in place an extensive network of primary health care infrastructure – how to best use that infrastructure in the next phase is a key policy challenge.

Analysis of these survey data has also revealed a degree of vulnerability within the PHO sector that had not been anticipated at the time of designing this stage of the research. With 16% of PHOs feeling that they are at risk, and only 41% considering themselves to be ‘doing well’, it would seem that the time is ripe to revisit the role and expectations of PHOs, along with an assessment of whether they have the capacity to achieve those expectations. Indeed, ‘sustainability’ was the most commonly cited goal identified by PHO managers.

This appears to reinforce the sense of a relatively fragile and complex set of organisations, facing significant expectations in relation to the next phase of implementation of the PHCS. Whilst PHOs vary in their size, governance arrangements, and background, they are united in a desire to be active planners and funders of primary care, supporters of general practice and developers of primary care services. The policy challenge in the next phase is to clarify the expectations and role of PHOs, and to provide them with the funding and organisational flexibility to enact these expectations and thus support local practices and providers in delivering ever stronger and more extensive primary care services for local populations.
6.11.3 References

Croxson, B., J. Smith and J. Cumming (Forthcoming). *Patient fees as a metaphor for so much more in New Zealand’s primary health care system*. Wellington, Health Services Research Centre.


6.12 Practice Fees and Consultation Rates - 2001-2007

Published as;


6.12.1 Introduction

The New Zealand Primary Health Care Strategy (the Strategy) was announced in 2001 and implementation began in 2002. This paper is one of a series resulting from a project to evaluate the implementation of the Strategy, jointly funded by the Health Research Council of New Zealand, the Ministry of Health and the Accident Compensation Corporation. It has been undertaken by the Health Services Research Centre, Victoria University of Wellington and CBG Health Research Ltd of Auckland.

The Strategy included the formation of primary health organisations (PHOs) and an increase in funding of primary health care which was to be paid on a capitation, rather than on a fee-for-service, basis. The goal was to improve the health of the population and reduce inequalities partly through a reduction in fees payable by patients when seen in primary health care settings. Initially, practices serving more vulnerable populations were funded at an increased rate for all enrolled patients (Access practices); at other (Interim) practices, funding increases were introduced progressively, age-group by age-group, between 2003 and 2007.

The Evaluation has included interviews, surveys and the collection of data from practices’ electronic patient management systems (PMSs). This report is derived from PMS data and examines the level and change in fees and consultation rates from 2001 to 2007.

A national random sample of 99 practices, stratified by district, provided data for the study. A majority of the practices was derived from HealthStat, a network of practices using the MedTech PMS that was already providing intelligence data via electronic transfer to CBG Health Research Ltd. Additional practices, using other PMSs, were added to the sample for the purposes of this study. The 99 practices represent more than 400,000 enrolled patients.
Data was obtained on patients’ demographic characteristics, date of enrolment, New Zealand Deprivation Index 2001 (NZDep) quintile of residence, and visits to the practice. PMSs record all entries made and do not distinguish those associated with a patient visit. Entries were considered to represent visits if they were associated with an invoice, including invoices for $0. Visits were excluded if the invoice was for more than $100 since such fees suggest that service of some complexity was provided, and our focus was on more standard consultations. This had the effect of reducing the total number of visits and the range of fees charged to patients, but had no effect on the modal fee.

6.12.2 Findings

A summary of general medical services (GMS) fee levels and consultation rates is provided in Table 6.12 below; the table distinguishes practices by funding formula. At Interim practices in 2007 (compared with 2001/02), fees for those aged 0-5 were less than $2 but had increased over time; fees for those aged 6-17 had increased by 26% to about $15. For those aged over 17, fees were around $23; they had decreased by about 14% except for those aged 65+ whose fees were lower at the beginning of the period than at the end of the period. The decrease in fees charged affected mainly those without a community services card (CSC). The difference between fees charged to those with and without a CSC diminished and became insignificant by the end of the study period.

At Access practices in 2007, fees for those aged 6-17 were about $6 and for the older age groups they were about $14. The fee levels had decreased by between 22% and 29% for those aged 6-64 and by 15% for those aged 65+.

Fees for ACC services were slightly higher (except in children under 6); the mean difference being $4 at Interim practices and $3 at Access ones.

Māori, Pacific peoples and those from poorer neighbourhoods were charged lower fees throughout the study period, but the differential was reduced over this time; that is, fees for these groups did not fall as fast as fees for other groups in the population.

Increased GMS funding produced one-off reductions in fees at Interim practices as new funding was rolled out by age group, but there was a background increase of about 4.5% per year which applied to both general medical services (GMS) and ACC-related services. Overall, Access practices showed a reduction in fees of about 5% per year.
### Table A6.12 Summary of Data on GMS Fees and Consultation Rates

<table>
<thead>
<tr>
<th></th>
<th>GMS fees</th>
<th></th>
<th></th>
<th>GMS consultation rates</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001/02</td>
<td>2007*</td>
<td>% change</td>
<td>2001/02 (full)*</td>
<td>2007</td>
<td>% change</td>
</tr>
<tr>
<td><strong>Interim practices</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>1.17</td>
<td>1.91</td>
<td>63.2</td>
<td>4.39</td>
<td>3.90</td>
<td>-11.2</td>
</tr>
<tr>
<td>6-17</td>
<td>12.19</td>
<td>15.4</td>
<td>26.3</td>
<td>1.89</td>
<td>1.81</td>
<td>-4.4</td>
</tr>
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<td>18-24</td>
<td>26.08</td>
<td>22.55</td>
<td>-13.6</td>
<td>1.97</td>
<td>2.35</td>
<td>19.2</td>
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<td>25-44</td>
<td>27.26</td>
<td>23.54</td>
<td>-13.7</td>
<td>2.68</td>
<td>2.74</td>
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<td>45-64</td>
<td>27.62</td>
<td>23.9</td>
<td>-13.5</td>
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<td>4.77</td>
<td>13</td>
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<td>65+</td>
<td>22.33</td>
<td>24.06</td>
<td>7.8</td>
<td>6.63</td>
<td>8.57</td>
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<td><strong>Access practices</strong></td>
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<td>-27.7</td>
<td>1.82</td>
<td>1.99</td>
<td>9.6</td>
</tr>
<tr>
<td>45-64</td>
<td>19.27</td>
<td>13.91</td>
<td>-27.8</td>
<td>3.20</td>
<td>3.76</td>
<td>17.6</td>
</tr>
<tr>
<td>65+</td>
<td>16.58</td>
<td>14.03</td>
<td>-15.4</td>
<td>4.97</td>
<td>6.03</td>
<td>21.4</td>
</tr>
</tbody>
</table>

*Note: Fees for 2007 were calculated July to December and are reported as ‘2007’. Visits for 2007 were calculated for the full year (to avoid seasonal effects). In the tables that follow, data from the first half of 2006/07 appears in both “2006/07” and “2007 (full)”.

At Interim practices, rates of consultation increased for those aged 18-24 (19%), 45-64 (13%) and 65+ (29%). They decreased for children (-11%). At Access practices there was an increase in rates for those aged 18+ (10% to 21%), the increase being greater in the older groups. Rates of consultation were lower at Access practices; in 2007, relative to Interim practices, rates were about 50%-60% for the three younger age groups and about 70%-80% for the three older age groups. However, there was a drop-off in consultation rates in 2006/07 and when patients with and without a CSC are distinguished, only those with a CSC at Interim practices and older adults at Access practices experienced an increase in consultation rates over the entire study period.
Consultation rates were affected by ethnicity and deprivation. Compared with those of “Other” ethnicity, Māori consultation rates were higher (mean 115%) and increased significantly (by 30%); Pacific peoples’ rates were lower (mean 74%) and decreased (by 14%); Asian rates were lower (mean 60%) and increased significantly (by 35%). With consultation rates among Māori rising faster than among the “Other” ethnic group, the ratio of Māori to “Other” consultations increased over the period. This is also true for Asian populations. However, worryingly, the ratio of Pacific to “Other” consultations fell.

Compared with those living in NZDep 1-4 neighbourhoods, those living in NZDep 5 neighbourhoods and aged 0-24 had lower rates of consultation (mean about 82%); rates for those aged 24+ were comparable between the two groups. The increase in rates was slightly greater for those living in NZDep 5 neighbourhoods compared with those in NZDep 1-4 (mean 7% versus 4%) and aged 6-64.

The data above refer only to general medical services (GMS) consultations. ACC-related consultations were stable between 2001/02 and June 2005. Rates increased by age: from about 0.08 per year for those aged 0-5 to about 0.32 for those aged 64+. During 2005/06 ACC-related consultation rates increased considerably: for the three youngest age groups, the increase averaged about 63%; and for the three older age groups it averaged 35%. The increase, for all ages, was greater at Interim practices (68% versus 40%).

6.12.3 Discussion

This report shows that fees have generally fallen for those aged between 18 and 64. At Access practices fees have fallen modestly but progressively and they are significantly lower than at Interim practices. With the new funding the government aimed, in Access practices, to have: zero fees for children; fees of between $7 and $10 for those aged 6-17; and fees of between $15 and $20 for adults. According to our analyses, this low fees policy is generally being achieved, other than a small average fee for children under six.

If these gains are to be maintained, support for Access practices, now represented by practices funded under the Very Low Cost Access (VLCA) payment scheme, will need to be ensured. The continued lower rates of consultation at these practices are of concern, given the poorer health status of their target population. It is also desirable that low cost services be available where they are needed. Many, perhaps most, communities include a minority of individuals for whom the costs of health care are problematic. It is also possible that an intermediate category of practice with greater funding might be created to serve the more needy people in such communities.
At Interim practices, fees fell with the introduction of new funding, mainly for those previously not funded (i.e. without a CSC). The government was seeking falls in schedule fees of around $25 for those without cards and of $10 for those with cards; our data show that average falls were substantially less than this. Further, what fall there was has been against a background of progressive increase in the fees charged by these practices. For those aged 65+ at Interim practices, invoiced fees were lower at the start of the study period, and the fall in fees that accompanied an increase in funding has been overtaken by the background inflation in fees.

Consultation rates initially increased for most population groups, but there was a drop-off in consultation rates in 2006/07. Consultation rates overall over the entire study period rose for those aged 18 and over, especially amongst the elderly. When the data are broken down by population group, consultation rates were seen to increase over the full study period for those with CSCs in Interim practices and older adults (45+) in Access practices, for Māori (especially those aged 45 and over) and for Asian groups (especially those aged 18-25 and 45+). Worryingly, consultation rates had fallen for Pacific peoples.

A key goal of the Strategy was to reduce inequalities in health, and although these data cannot show the relative impact of the Strategy on health itself, our data are useful for examining issues relating to equity of access and equal use of services across socio-economic and ethnic groups. Our data show that average fees and consultation rates were significantly lower at Access practices throughout the study period. With Access practice enrollees generally being less well-off, the lower fees charged by such practices promotes equity of access. On the other hand, the lower level of consultation rates amongst these practices may suggest that not all this group’s primary health care needs are being met, given the likelihood of poorer health status amongst them. The new funding has kept fees low and led to increased consultation rates for Māori, who have higher consultation rates as might be expected given poorer health status and higher overall health needs. Thus, the Strategy appears to be supportive of improving the health status of Māori relative to other groups in the population. Fees for Pacific remain low, again promoting a more equitable system, although such fees have risen relative to the “Other’ ethnic group. However, consultation rates for this group have fallen; this is of concern given their higher needs among and this warrants further investigation. The new funding has improved the position of the Asian population in terms of fees and consultation rates. Fees for those from more deprived areas remained lower than fees for less deprived areas (again promoting equity of access) but the differential has decreased. Rates of consultations for those from the more deprived areas remain lower than for those in less deprived areas, which might be considered to be of concern given their likely higher health needs. The lower consultation rates for children in more needy populations and the reduction in these rates over the study period suggest that the adequacy of primary health care for this group should be investigated.
Reduced fees do not seem to have been associated with increased rates of consultation. Access practices with on-going lower fees have not achieved consistently greater growth in consultation rates than Interim practices; and those without CSCs who have experienced the biggest reduction in fees have shown no consistent growth in utilisation. It is likely that outreach and other activities aimed at attracting those who tend to under-use services have been successful and explain the growth in consultation rates for those with CSCs attending Interim practices. Lower than desirable consultation rates for Pacific populations, those in Access practices and those from more deprived areas (especially among children) suggest we have some way to go to ensure equitable consultation rates.

In conclusion, in introducing the Strategy and providing significant new funding for primary health care, the government aimed to reduce the fees patients pay and increase consultation rates. We have found that key aspects of government policy relating to fees are generally being met in Access practices, but that reductions in fees in Interim practices may not have been as great as might have been expected. While consultation rates rose initially, a subsequent fall meant that over the whole study period rates increased only for those with CSCs at Interim practices. This fall in consultation rates merits further investigation – in particular to assess whether this trend continued beyond our study period. In relation to equity, questions about the adequacy of service need to be addressed, particularly for Pacific populations, those in Access practices and those from more deprived areas. In particular, we need additional evidence on how, and to what extent, would the health of those with lower consultation rates be improved if the rates were raised and what evidence is there that those with higher consultation rates obtain equivalent benefits?