

GREATER  
WELLINGTON  
HEALTH  
TRUST



PO BOX 27-380  
WELLINGTON  
TEL (04) 801 7808  
FAX (04) 801 8715  
Email: [wipa@gwht.org](mailto:wipa@gwht.org)

# **Developing A Primary Health Organisation For Greater Wellington:**

## **A View From The Greater Wellington Health Trust**

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## Executive Summary

Although the PHO is the central structure for the government's proposed vision of a primary health care sector, official guidance about the development of PHOs remains very general.

The structure of a PHO is appropriately derived by beginning with the functions it must carry out. Such an analysis suggests that:

- A PHO must have well established front line providers of primary health care services.
- A PHO must have an effective overall management/support function which is capable of community involved governance, quality improvement, information management, payment processing and regional service delivery. These functions will require a minimum critical mass in order to be carried out efficiently and effectively.
- Front line providers will work with some other providers more closely than others, for reasons of common philosophy, common population structures or to provide a diverse range of services collectively.
- A PHO structure of front line providers which manage themselves flexibly as clusters and which have the support of a regional function with strong community involvement, will fit the requirements of PHOs, while ensuring that the PHO has the operational capability to deliver upon the primary health care strategy.

The experiences of UK Primary Care Groups confirm that achieving critical mass is important for many of the broader functions of primary health organisations, particularly for a focus on population health improvement and interfacing with the community. Mergers of small PCGs have rapidly occurred. The average population covered is now approximately 190,000 people.

Populations, and therefore the health services provided to them, are not satisfactorily defined in a simple fashion. Appropriate definitions must incorporate aspects of demography, need and geography simultaneously and flexibly. This implies that effective targeting mechanisms are inherently complex, rather than simple criteria of geography, demography or need in isolation from each other.

There are important risks associated with the process for developing PHOs, including fragmentation of providers; polarisation of providers and communities; raised community expectations and inadequate funding. Many of these risks are minimised if a PHO is developed comprehensively with a diverse group of front line providers and enough of a population to achieve a strong operational infrastructure. Conversely, a piecemeal development of small PHOs is unlikely to be in a position to achieve the aims of the Primary Health Care Strategy and may in fact threaten the infrastructure of primary care across communities.

The Greater Wellington Health Trust supports the direction of the Primary Health Care Strategy. The strategy can most effectively be implemented by establishing a comprehensive PHO for the Capital and Coast area which has the involvement of a wide range of community and provider stakeholders. The Greater Wellington Health Trust seeks to work with other stakeholders to achieve this end, and is prepared to commit its resources to do so.



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# 1 Government Policy And Implementation Plans

## 1.1 Background

In February 2001 the government released its Primary Health Care Strategy (King, 2001), to cautious approval from the primary care sector. The overall direction was endorsed by many primary care providers, although the strategy was quite general and did not provide any details of funding approaches for implementation. Many aspects of the strategy were continuous with previous policies, which was a ground for criticism in some quarters (Women's Health Action Trust, 2000). Over a year later the implementation of the strategy remains a subject of broad discussion and debate.

The main implementing structure of the primary health care strategy will be the primary health organisation (PHO). This paper seeks to fill a gap in the debate about PHO development by relating the broader issues and principles of the Primary Health Care Strategy ("the strategy") to the concrete issues of promoting change in the primary care sector. It analyses the official guidance which has been released to date, and derives a view of PHO structure from a consideration of the functions which PHOs will be called upon to perform. It considers the environment of population issues and operational risks in which PHO development must operate, and finally considers options at a local level for developing PHO structures in the Greater Wellington Area.

## 1.2 Official Guidance

The strategy's main acknowledgement of implementation issues was an endorsement of three:

- Protecting gains already made and developing successful initiatives
- Involving the primary care sector, providers and communities in the implementation
- Focussing on evolutionary change which is consistent with the strategy.

These principles suggest a cautious approach, intended to minimise risk and disruption to the sector while implementing new programmes where possible.

There has been further guidance from the Ministry of Health for communities and provider organisations seeking to make progress towards the goals of the strategy, but there remains little that is specific. To some extent this reflects the desire to have primary care arrangements locally developed with buy in from specific communities, rather than centrally driven. However, much primary care funding remains under strict central control, exacerbating the tension between local self determination and nationally consistent health policy. The role of District Health Boards in determining the use of funds for primary care sector development in their own area is still unclear.

The key documents which bear upon PHO development are:

*The New Zealand Health Strategy*. The New Zealand Health Strategy sets the broader context for the primary care strategy. It articulates some general principles, including:

- Acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi.
- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention by all sectors.
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
- A high-performing system in which people have confidence.
- Active involvement of consumers and communities at all levels.

The New Zealand Health Strategy highlights 13 specific population health objectives for the New Zealand health sector.

*He Korowai Oranga.* He Korowai Oranga is a discussion document for the government's Maori health strategy. It proposes four pathways to improve whanau health. These are:

- Development of Whanau, Hapu, Iwi and Maori communities. The crown will work collaboratively with whanau, hapu and iwi.
- Maori participation in the health and disability sector. The active participation by Maori at all levels of the health and disability sector.
- Effective health and disability services. Whanau will receive timely, high quality, effective and culturally appropriate health and disability services to improve whanau health and reduce inequalities.
- Working across sectors. The health and disability sector will take a leadership roles across the whole of government and its agencies to achieve the aim of whanau ora by addressing the broad determinants of health.

An important implication for primary health organisations is that PHOs will promote Maori participation at all levels of their organisation, recognising the rights conferred upon the Maori population by the Treaty of Waitangi. A further important implication is that traditionally mainstream primary care services have an obligation to provide culturally appropriate services to Maori within the populations they serve.

*The Pacific Health and Disability Action Plan.* This plan sets out six priorities for Pacific Health:

- Child and youth health.
- Promoting healthy lifestyles and wellbeing.
- Primary health care and preventive services.
- Provider and workforce development.
- Promoting participation of disabled Pacific peoples.
- Health and disability information and research

The important aspects for PHOs in this document are the encouragement for Pacific providers and mainstream providers to work together, and the high need for workforce development, both at the level of Pacific provider organisations and individual Pacific health professionals.

*The Primary Health Care Strategy.* The original strategy, released in February 2001, stated the essential aspects of PHOs, which can be summarised as follows. PHOs:

- Will be funded on a population basis to provide services to an enrolled population
- Will include services to improve and maintain health, as well as first line illness services.
- Will involve communities in governance, and demonstrate responsiveness to community priorities and needs.
- Will demonstrate that all provider groups have a say in organisational decision making.
- Will be publicly accountable not for profit organisations.
- Will have voluntary membership among health practitioners.

*Minimum Requirements for Primary Health Organisations.* This brief document was released in November 2001. It essentially reiterates the six points about PHOs from the strategy of the previous February, emphasising that population based funding and enrolment will be important tools for PHOs. This document is attached in full in Appendix Three.

*A Guide For Establishing Primary Health Organisations.* Released in March 2002, this document emphasises that DHBs, communities and provider organisations must all be involved in the establishment of PHOs, noting that providers often have more intimate knowledge of enrolled populations than DHBs. The main aspect of this paper is that it emphasises, with a little more detail than earlier documents, the functions of a PHO in improving health, co-ordinating services. The paper discusses the application of a nationally consistent funding formula to enrolled PHO populations, and canvasses a number of possible governance and community participation arrangements which may be appropriate for PHOs. It suggests a list of questions for DHBs to use when discussing PHO establishment and assessing whether provider organisations are ready to become PHOs.

*Draft Service Specifications.* The draft service specifications are still fairly general. In summary, they organise services according to:

- Improving health: health promotion, education and intersectoral linkages.
- Maintaining health: screening and early detection of illness, use of recall systems, ongoing care and support for chronic and terminal conditions, family planning services, immunisation, liaising with public health providers regarding communicable diseases.
- Restoring health: providing information for self care, urgent treatment and referral services, recommending treatment options, arranging diagnostic therapeutic and support services, coordinating rehabilitation processes and managing referrals to other providers.
- Co-ordinating care: developing relationships with other providers, both within primary care and with relevant agencies from other sectors.
- Service processes: analysing and critically assessing the health needs of the population and identifying inequalities in population subgroups.

The draft specifications emphasise that there will be requirements to document quality processes and improvements. The specifications also note that casual users will have

access to first level services, such as urgent treatment. By implication, the more population oriented services will apply only to enrolled users.

*Draft Enrolment Rules.* The draft enrolment rules describe a mechanism by which PHOs will enrol populations. Information about the enrolled population will be verified by Health Benefits (HB), and PHOs paid a bulk sum according to a population formula. Casual patients will be funded on a fee for service basis, which may be deducted from the payment to another PHO if that person is enrolled elsewhere. PHOs may, it is implied, use whatever payment mechanism is appropriate internally to distribute funds to member practitioners.

*Implementing The Primary Health Care Strategy And Improving Access To Primary Health Care Services.* This cabinet committee paper, signed off in March 2002, discusses more details of the overall governmental approach. It states more directly than other documents that low cost (or free) primary health care for all New Zealanders, regardless of personal circumstance, is the long term aim of the government's strategy. It expresses five approaches to be endorsed by the government:

- *High need populations.* Fund PHOs in high need areas to provide low charges (at an agreed maximum level) for their entire population, as well as addressing non financial barriers to care for those population (by using mechanisms such as outreach services, and extended nursing services).
- *To increase the rate of GMS subsidy for under six year olds* to a level which adjusts for inflation from the original amount set in 1997.
- *Progressively to lower the cost of access to services.* This will be achieved by applying new funding to a greater number of PHOs, by reducing the threshold defining high needs populations, and by increasing national subsidy levels until the community services card become redundant.
- *Sustainable rural services.* Supporting rural PHOs, especially in the field of workforce development and retention.
- *PHOs across the country.* PHOs to be established across the whole country, even if the threshold for high needs funding does not initially encompass all of those PHOs.
- *Changes to the Community Services Card.* Until the card become redundant as a result of the other approaches, the effectiveness of the card will be improved by simplifying and making more automatic the process of receiving a card.

This document is included in its entirety in Appendix Two.

### **1.3 Funding Announcements**

The Ministry of Health has recently made several funding announcements relevant to primary care.

The first, more general announcement was that within the three year health funding plan the Minister proposes to set aside sums for primary care development amounting to \$50 million in 2002/3, \$165 in 2003/4 and \$195 million in 2004/5 (King 2002c). Although announced as a funding increase of \$410 million, there is in fact an increase

of less than \$200 million to baseline primary care funding. By comparison, current national GMS and capitation funding runs at approximately \$230 million (Ministry of Health 2000).

It is not clear to what extent the funds set aside for primary care are at risk from hospital deficits or increases in other areas of health expenditure, such as disability support services or pharmaceutical and laboratory utilisation. It is worth noting that hospital deficits are frequently reported in the media as being in the range of \$200 million. The Wellington District Health Board alone is reported to be forecasting a deficit of up to \$20 million. A national increase of 5% in pharmaceutical utilisation could easily account for the majority of the first year of additional primary care funding.

In April the Ministry of Health announced two funds for contestable proposals. They each amount to \$2.8 million per annum nationally. One fund is for high needs populations. The population served by qualifying providers must be composed of more than 50% of people in high needs categories (NZDep96 categories 9 and 10, or Maori or Pacific Island). The guidelines expect that the funding will be spread across approximately 25 providers. Realistically, this level of funding is likely to purchase a level of service roughly equivalent to 1-1.5 additional community nurses for each of 25 providers across the country. The second fund is for PHO establishment costs. Both funds are administered centrally by a committee of staff within the Ministry of Health. Providers seeking funds are required to have the support of their District Health Boards, but DHBs appear to have no direct power in the allocation process.

Finally, in May the Ministry of Health released a more detailed draft funding paper for comment. This confirms that PHOs will be funded through a nationally consistent needs based formula. It also confirms that this will take several years to achieve.

The Ministry of Health proposes a 'Low Cost Access' formula which would allow all enrollees to be charged low or zero co-payments, or access free care. There would be no need to use community services cards (CSCs). In the first instance, the Low Cost Access formula will be available only for PHOs, or practices within PHOs, which serve populations with high concentrations of NZDep Quintile 5 or Maori or Pacific people. The formula is based on \$35 for children under 6 and \$25 per capita for all others, with additional practice nurse subsidy. The proposed weightings in the formula, for ethnicity and deprivation are as follows:

	Non-Maori, Non-Pacific (Other)	Maori or Pacific
Deprivation Quintile 1-4	1.0	1.2
Deprivation Quintile 5	1.2	1.4

High User Health Cards will remain to target significantly increased subsidies to those who qualify. The criteria are being reviewed with the intention of increasing uptake from 1% to 3% of the population.

Until there is enough funding for all PHOs to be on the Low Cost Access formula, an Interim formula will apply to other PHOs/practices. The Interim Formula will continue to use CSC status both for determining funding and setting co-payments. All

providers who wish to form PHOs will be encouraged to do so even though, for those on the Interim formula, this may not entail additional funding in the short term.

Over time, as funding allows, the per capita amounts in the Interim formula will be increased towards the levels in the Low Cost Access formula. This will start in 2003/04 with increases for all school-age children, and for the elderly with CSCs. At the same time the threshold for the Low Cost Access formula will gradually be lowered so that more PHOs and practices can move onto it.

The Government intends to move towards funding pharmaceuticals and laboratory tests through PHOs using a needs-based formula. Additional funding components are also proposed for PHO establishment, management support, rural support, quality payments, nursing initiatives, and immunisation. These will be available to all PHOs as 'add-ons' to the Low Cost Access and Interim Formulae. A list of all the funding components is set out in Appendix Two.

#### **1.4 Discussion**

The distinction between short and long term aspects of the vision for primary care has important consequences for the development of PHOs. The long term aim is clear: universal access to effective primary care services for the whole population regardless of ability to pay or other personal circumstances. However there is a short term imperative to target limited new funding to populations where the greatest difference can be made. Therefore the immediate emphasis of plans to implement the strategy is upon developing services which will contribute to health gains and reduce inequalities in access to primary care services by targeting those most in need of primary care.

Implementing the strategy therefore requires results in the short term while pursuing the longer term goal of changing the whole primary care system. Striking a balance between these two objectives will be the most difficult challenge for DHBs and the primary care sector. While the government has acknowledged that the transition to the long term implementation of the strategy will introduce new inequities, DHBs and the primary care sector should still seek to minimise such inequities where this is possible. The risks of short term transitional arrangements becoming permanent funding models is discussed at greater length below and in section five.

There is a need for more clarity about the concept of population management, the level at which it operates and the specific functions involved. The degree to which true population management, including analysis of total populations and of high need groups within the context of whole population is part of short term PHO development needs to be clarified and discussed at greater length. Some of these issues are discussed further in section two.

The uncertainty and the quantum of funding is another risk which is discussed in more detail in section five of this paper. It is hard to reject the proposition that the government does not have enough resource to implement its policy properly. The Minister has publicly commented that the timeframe for full, equitable funding may be as much as ten years (King 2002b). Realistically, the health sector should consider an appropriate strategy should the funding proposals be only partly complete at the

time of a change of government. The Minister has stated that new inequities will be introduced during the transition to a long term equitable primary care system. But if the transition period is too long there is a risk that such transitional inequities will become entrenched.

The more immediate risks to funding have already been alluded to: there are many pressures upon health funding which could diminish the funds available for implementing the primary health care strategy. Moreover, there has been no public discussion about the secondary funding implications of increased access to primary care. In the short to medium term improved access is likely to be followed by increased secondary admissions and pharmaceutical expenditure as practitioners make appropriate referrals for populations who did not previously access primary care services. To some extent this can already be observed in the area of diabetes: pharmaceutical and laboratory expenditure in areas related to diabetes is increasing as a result of improved diabetes services in primary care. If this effect is not taken into account the strategy of increased funding for primary care services may in turn create pressures upon health sector funding, particularly for referred services.

The general thrust of the primary care strategy is still one which meets with a high level of agreement across the sector. However there remain fundamental issues of implementation which are not clear. In particular the expectation of PHOs and the extent to which their funding arrangements and service levels will change in the short term are not clear to the sector. At the same time there are raised expectations from communities about the potential impact of their participation in governance and the level and nature of services. This lack of clarity risks causing division among community and provider groups, which may have different understandings of government policy and are likely to be pitted against each other in the struggle to achieve the most improvement locally with a very small increase in primary care funding.

The role of DHBs is also ambiguous. The funding mechanisms which have so far been announced are under the central control of the Ministry of Health. It is not clear to the wider sector (and probably not to DHBs themselves) what, if any, discretion DHBs will have over new primary care funding and over the establishment of PHOs. If no new service funding is available for PHOs in many areas, but PHOs can still be established, does that mean that any organisation which feels that it meets the Ministry criteria can declare itself a PHO? If so, does the DHB have any role to play in that process? If the DHB cannot provide new service funding, does it actually have any mandate to be involved, and why should anybody take any notice of it?

There is a great need for more official guidance which can address these issues in a clear way, for the benefit of DHBs, communities and providers in the primary care sector. A lack of guidance will inevitably lead to division and misunderstanding among providers and communities, which will not serve the interest of implementing the primary health care strategy in a timely and effective manner.

## 2 PHO Functions, Structure and Funding

The starting point for exploring appropriate structures for PHOs should be to review PHO functions. Once these are adequately described, the requirements of structure will be clearer. Within those broader requirements it will be necessary to consider local issues of population and existing provider configuration in order to develop an approach which is suitable for any one region.

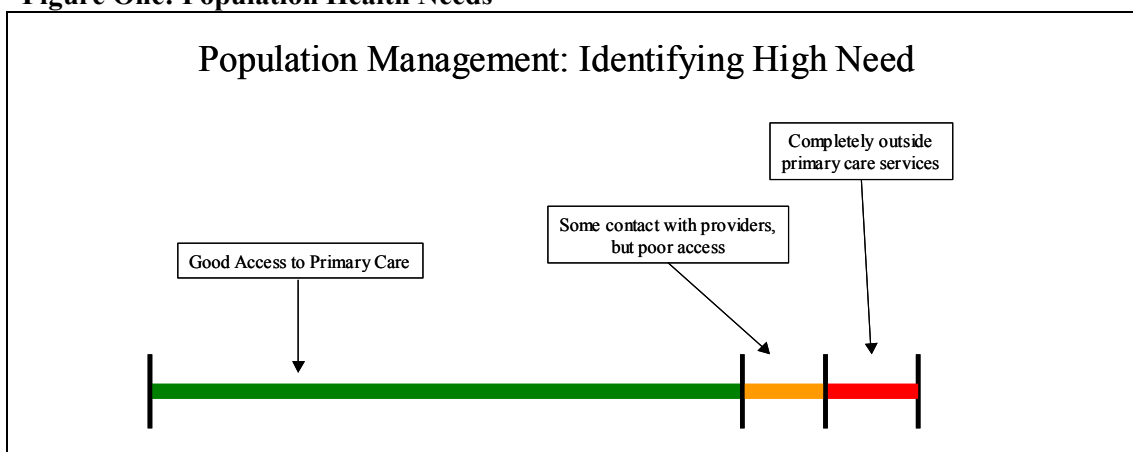
This section reviews some of the more general functions which a PHO must provide, and suggests a broad approach for thinking about PHO structure. This will be followed with more detail, which is applicable to the specific case of Wellington, in subsequent sections.

### 2.1 Addressing Population Needs

Primary Health Organisations have been developed within a framework of population health needs. This aspect of a PHO functions at two levels. Firstly there are the direct population oriented health services which might be provided alone or in conjunction with specialised public health providers. Such services could include health promotion, particularly where it is allied with personal health services managed directly by the PHO. For example, sexual health is an area where population services can appropriately complement personal health services, and a PHO should aim to align these as much as possible.

The other, and perhaps more immediate, population management function which is relevant to PHOs is the management of personal health services within the context of the whole population. The current state is that within the total population many individuals already have good access to primary care services. Some part of the population has some contact with primary care, and are probably on provider registers, but do not have as good access to services as they could have. A further part of the population are completely outside the current scope of primary care services. These different groups within the population are shown schematically in the diagram below.

**Figure One: Population Health Needs**



A PHO which functions effectively to manage personal health services for a community will need to have a strong grasp of the characteristics of the total population. The PHO will have to understand where the community and the individuals within that community fit into the overall picture. A PHO will therefore need a considerable capacity to collect, analyse and act upon information about people and health services. Without such a capacity a PHO will not be able to be confident (or provide the DHB with confidence) that it is providing services to population groups in greatest need. Some aspects of this capacity are discussed further below, as a part of management/support functions.

## **2.2 Front Line Functions**

Ultimately PHOs are front line providers of health services dealing with individuals making up populations. This is the function which users of health services experience directly and are most interested in. This experience is personal to each individual. The functions which are to be carried out at this level are already beginning to be clarified, particularly in the discussion about draft service specifications and enrolment. At the delivery level core primary care services, as are currently provided by general practice and a range of other providers, must be available to people who present to the service and must be delivered in ways which meet their needs overcoming the many barriers to access which exist for some people. Well documented barriers to access and to achieving better health status include: information and education, cost, transport, language, cultural appropriateness, adequate housing, and nutrition.

Making a difference at the frontline will involve a comprehensive primary health care team which has links at the local level to the wider group of people involved in primary care such as community health workers, specialist nurse educators, pharmacists, and secondary care referral services. The primary care team will also work with people within other agencies such as Housing NZ, Work and Income, ACC or Child Youth and Family to address issues which impact on health status. Significant new funding will be required to remove the cost barrier and to add new services including interpreters, health promotion and education services and for developing a more extensive Maori and Pacific workforce and provider network.

The current population needs, cultures and preferences are diverse, and are served by an equally diverse array of primary health care providers. Within PHOs individual provider facilities are likely to come from a huge variety of backgrounds, and have a great variety of ideas about how best to manage their service. This is probably irrelevant, in most respects, to the specific function. Indeed, since individual people choose to work in great variety of different settings and arrangements it is arguable that a PHO should have the greatest possible diversity among front line providers in order to accommodate the preferences of the workforce. The current group of providers include third sector models which employ practitioners, such as church sponsored services, HealthCareAotearoa clinics and Iwi providers, and independent business models such as most general practices, pharmacists, laboratories, radiologists, optometrists, dentists and physiotherapists. Front line providers may have one of a variety of governance arrangements.

The front line providers will enrol users and will collect individual level information for payment and planning purposes. They will serve as one of several conduits for communities to express their health needs.

Front line providers may take the form of geographically located clinics with varying degrees of outreach (for example, many health centres currently serve rest homes or workplaces on an outreach basis), or varieties of mobile provider who work throughout local communities.

In some cases the a front line function may be a single primary care clinic or other facility, while in other cases front line providers may like to work together for some aspects of their service. For example, front line providers with a shared philosophy or kaupapa may wish to cluster for some purposes, and front line provider governance and management may reflect such groupings. There are many examples of such clusters already operating within the primary care sector. In Wellington some front line providers have joined WIPA, some have joined HealthCareAotearoa, and others have organised themselves into different sorts of groupings. In each case these reflect front line providers with different views about the best way to organise themselves. This diversity is important in a vibrant health sector, and should be preserved by the PHO structure. Such diversity is what will enable a PHO to maintain services which will be attractive both to the diverse workforce and to diverse communities.

### **2.3 Support Functions**

In order to achieve the greatest effectiveness with front line personal health care services PHOs must also carry out a number of population oriented functions. This is clearly one of the most important directions of the primary health care strategy. Such functions will encompass two general aspects:

- Support for the primary care personal health services across the population as a whole. For example, providing quality assurance and training programmes for front line providers, collating and processing enrolment data, administering payment mechanisms, providing IT advice, negotiating with the DHB for regional service funding, facilitating the development of new services, managing reporting requirements for the DHB. The management/support function will incorporate the ability to collect and analyse information about the population, and to use such information with the various front line providers in such a way as to help them to work effectively with their communities, particularly in identifying and closing gaps. This is likely to include both quantitative analysis and informed discussion with the community. This function should include intersectoral liaison, working with agencies from other sectors to support the front line activities of health providers.
- Direct management of some personal health services which need a minimum scale to be effective. In some cases community providers work more effectively when managed across larger communities than a single health facility can serve. For example, specialist community nurses may only provide a few hours each week of time to any one front line health clinic. In this sort of case it makes sense for the management to be across several front

line providers, and for the individual provider to have links with other similar staff for purposes of covering leave and sickness, for professional development and peer review and for collegial support more generally. This sort of arrangement requires a certain critical mass to work most effectively, and may often be more appropriately managed through a support function than directly by front line providers. The specific circumstances of the community and providers in any one area will vary, so the arrangement for these services is likely to differ across the country. But some services to which this logic applies may include immunisation coordination, specialist diabetes and asthma nursing, mental health workers, social workers and health educators.

The management/support function must clearly be compliant with the requirements of the primary health care strategy with respect to non profit status and the involvement of both community and diverse provider groups in governance.

It is important to recognise that both front line functions and management/support functions are already a part of the primary care sector in New Zealand. The mechanism of a PHO will provide a means for strengthening and formalising these functions in an approach which, to refer to the guidance on implementation, will focus on protecting gains and building upon current successful initiatives whilst focusing on addressing the disparity of health status within the community.

To summarise, the PHO as a whole will have two sets of functions which can be viewed as front line or management/support functions. Examples and characteristics are shown in the table below:

<b>Provider Service Function</b>	<b>Strategy Directions and PHO Requirements</b>
<ul style="list-style-type: none"> <li>– Provide core primary care services directly to the target population(s).</li> <li>– Involve the comprehensive primary health care team in providing services.</li> <li>– Collect individual level information for payment and planning purposes.</li> <li>– Serve as a conduit for the target community to express their health needs.</li> <li>– Paid for services by the management/support function.</li> <li>– Large range of sizes: from a single clinic or professional to potentially quite large clusters of practices or clinics.</li> <li>– Clusters may organise around some common feature, in particular a shared philosophy, kaupapa or general approach. For example, target some particular group of the population (eg. Maori or Pacific Island providers), or like to organise in some specific way (such as solo general practices, or nurse led clinics).</li> <li>– Have input into the overall organisational</li> </ul>	<ul style="list-style-type: none"> <li>– Access to comprehensive services.</li> <li>– Services for improving and maintaining the health of the population, and first line services to restore health.</li> <li>– Voluntary membership of PHO.</li> <li>– Information for continuously improving quality.</li> <li>– Work with local communities and enrolled populations.</li> </ul>

<p>direction</p> <ul style="list-style-type: none"> <li>– Whatever governance arrangement is appropriate for the specific provider and community.</li> </ul>	
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<b>Management/Support Organisation</b>	<b>Strategy Directions and PHO Requirements</b>
<ul style="list-style-type: none"> <li>– Coordinates enrolment across the provider networks, and passes on to HB for payment.</li> <li>– Distributes funds amongst the participating provider networks according to whatever system is agreed among them.</li> <li>– Not for profit, with governance a combination of the provider networks and the community.</li> <li>– Collates information for accountability reporting to the DHB</li> <li>– Employs specialist workers in common across provider networks</li> <li>– Manages quality assurance, and support for professionals in each provider network</li> <li>– Coordinating health education and promotion measures</li> <li>– Coordinates input into policy processes.</li> <li>– Identifies needs and provides information to help provider networks with targeting their populations with relevant services.</li> <li>– Support with legislative compliance and provider standards</li> <li>– Intersectoral liaison</li> <li>– Referred services management</li> <li>– Significant event monitoring</li> <li>– Service design and development</li> <li>– Negotiates regional contracts</li> <li>– Supports negotiation of front line contracts</li> </ul>	<ul style="list-style-type: none"> <li>– Involve the community in governing processes.</li> <li>– Not for profit bodies, accountable for public funds.</li> <li>– Involve communities in governance process.</li> <li>– All providers and practitioners involved in decision-making.</li> <li>– Identify and remove health inequalities.</li> <li>– Co-ordinate care across service areas.</li> <li>– Develop the primary health care workforce.</li> </ul>

## 2.4 Structures

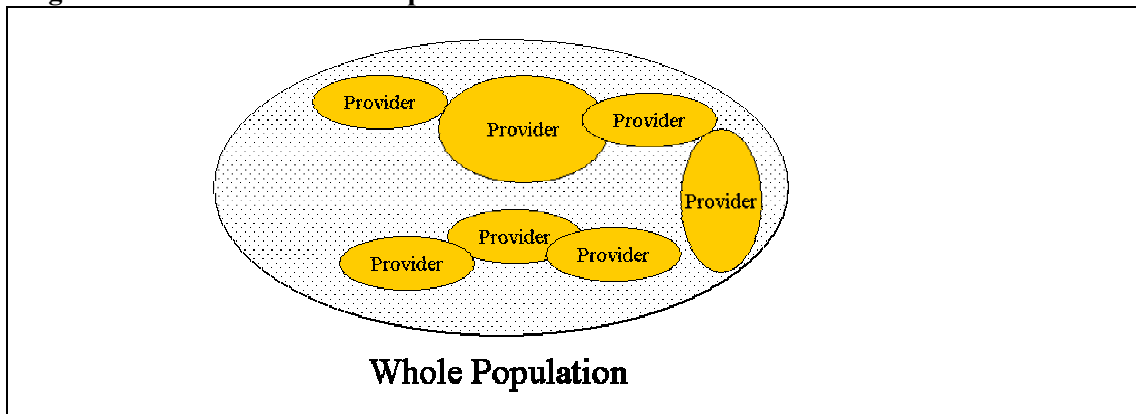
Given the variety of functions which a PHO must fulfil, some aspects of structure start to become clearer. The structure must consist of both a front line service and a management/support function. It must do so while achieving the greatest possible efficiency and effectiveness with the resources at hand, at both front line and

management/support levels. The diversity of the front line services must be enhanced, rather than choked, by the management/support function.

A PHO must start from the premiss that there is a comprehensive, diverse population. The majority of the population already has access to front line primary health care services. The challenge is to ensure that the remainder of the population also has such access, and that a broader range of effective services are available, which will deliver upon the aims of the Primary Health Care Strategy.

The diagram below denotes a population which is served by a variety of front line providers of different sizes and with different philosophies about providing care. Some of the population is covered by providers, while some parts do not have providers. For those who do have access there is a wide choice about which sort of provider individual people prefer.

**Figure One: Providers In A Population**

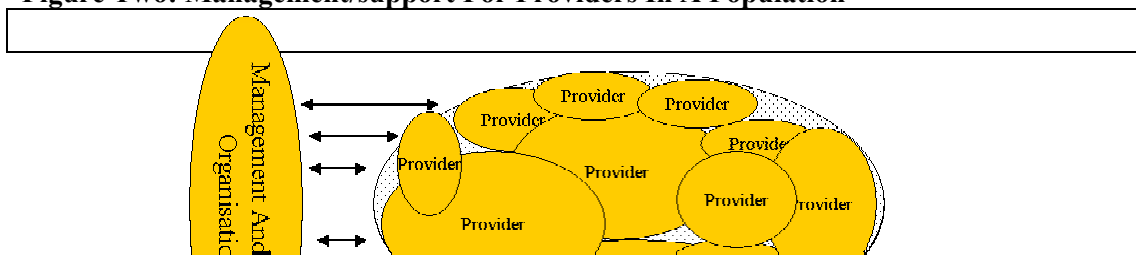


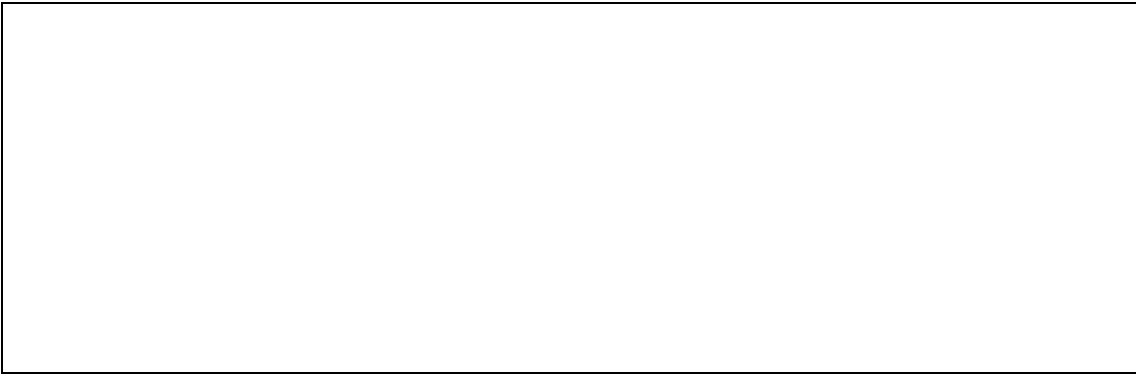
The provider front line function is at the heart of a PHO, for it is this which an individual person sees when they seek health care. Front line providers may choose to organise themselves in a distinctive way when they have some specific idea about how they wish to configure their service, or about the ownership and governance which they believe is appropriate. The organisation of front line providers may be at the level of individual provider clinic, or across some cluster of front line providers which have something in common and wish to work together within a single governance structure.

However the supporting function is needed to provide quality assurance for the front line, as well as to manage more specialised services which are not easily provided on a small scale. The support function will also have the specialised task of managing information and analysis which will help the individual providers in targeting their populations appropriately and effectively, and will have the strategic function of helping the providers to serve the whole population effectively and appropriately, in which case the total population will be served by both existing providers who develop their services, as well as new providers.

The management/support organisation is shown in the figure below:

**Figure Two: Management/support For Providers In A Population**





A PHO is the sum of its parts: it must incorporate a comprehensive range of diverse front line services, but it must also have an effective support arm which manages services across all the front line providers, and involves the community in governance. It is this combination of front line and management/support functions which constitutes a PHO. Without these elements, implemented on an appropriate scale, a PHO is unlikely to have the capacity to achieve the aims of the Primary Health Care Strategy.

There is scope for more detail within this vision of a PHO. Clusters of providers could work together in different configurations for different purposes in order to achieve an effective local network. For example, if there are local subregions within the overall PHO area, there will be a need for links among providers to form a “glue” of collegial activity focussed on a single subregion.

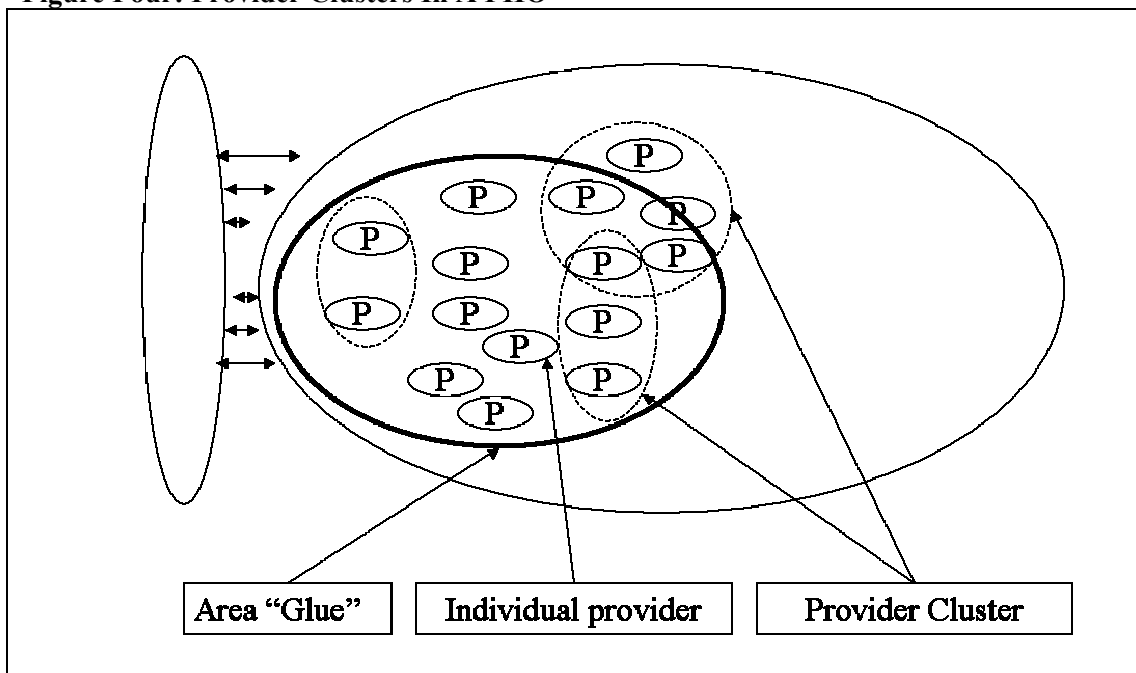
Individual providers may cluster in different ways for different purposes. For example, some provides may organise a maternity cluster, but still be members of other clusters for other services. Clusters might take different forms, with different degrees of formality. A cluster might be as informal as a periodic meeting between representatives of prescribers and pharmacists in order to clarify current issues (eg. substitution rules), or it might be a more formally organised subgroup of providers who have a specific shared governance arrangement.

On this view the ability to form a range of clusters of varying degrees of formality is a particularly important part of PHO structure. In some cases clusters must be relatively loose. For example, where there are regional services which cross large areas, it is not in the interest of a small community to construct a rigid boundary around themselves. After hours services or regional specialist services may not operate effectively if there are overly rigid requirements about which providers must be accessed for specific services, especially if populations are mobile. Where rigidity might constrict choice or require complex administrative processes to attract funding or information across boundaries clusters should be less formal. They might consist of shared referral protocols or some other relatively loose mechanism which will meet a need for front line providers to work together without being too prescriptive. On the other hand clusters could appropriately be formally organised groups of front line providers who wish to undertake a specific project, such as providing maternity services or sharing front line staff. The flexibility of clusters is essential to preserve the dynamic nature of the primary care sector, which constantly adjusts and develops at every level to adapt services to the local environment.

This clustering already goes on in the sector to a great degree. Local providers within a small geographic area are usually aware of each other, of the referral opportunities they have and of the options for referring outside the area. At the front line level local providers already have significant relationships with their communities, and often work together on common projects, services or events. There is thus already a fair amount of “area glue”, but a PHO represents an opportunity further to develop such arrangements, and to ensure that users and providers do not fall through gaps through lack of knowledge about local services.

Some aspects of the complexity of clusters within a PHO are shown in the diagram below:

**Figure Four: Provider Clusters In A PHO**



It should be noted at this point that the term ‘PHO’ is currently used as in this paper to describe an organisation inclusive of the front line network and the management and support entity but it is also used by others to describe just the provider network or for defining a cluster based on geography or ethnicity. It is also possible in this context to describe a structure with a number of PHOs linked to one management and support organisation. This confusion around the language describing structure complicates the PHO discussion.

## 2.5 Governance

Governance will be one of the key aspects of PHO function. As with other PHO functions, details are likely to vary from area to area but some key aspects will be needed in all PHOs. The details of governance will depend upon the diversity of the population served by a PHO, the range of stakeholder groups which exist in the PHO area and the specific interests of stakeholders in various activities of the PHO. For example, a PHO might have specific governance groups for some of its projects, notwithstanding the overall governance structure. In Wellington, WIPA has already

modelled this, by involving specific stakeholders in particular projects such as mental health or school health services.

Treaty of Waitangi relationships will be a crucial aspect of PHO governance. The three underlying elements of the Treaty; partnership, participation and protection, each have implications for PHO function. Specifically, partnership suggests that a PHO will need to have mechanisms for involving Maori in governance at a high level, participation suggests that a PHO will need to work to involve Maori directly in service provision, and protection suggests that a PHO will have to build sensitivity to Maori needs into all of its services. Appropriate governance will be the key to achieving these three aims. A more detailed analysis of the implications of Treaty principles for PHOs is needed both for PHOs in general, and for any specific PHO development.

## **2.6 Funding**

The quantum and nature of funding a PHO might receive has been discussed earlier in this paper. There are a number of more operational funding questions which have implications for the function and structure of a PHO.

The funding flow from the DHB or MOH into PHOs and ultimately to frontline providers of services is a sensitive issue which raises questions of confidence in the financial governance of the contracting entity, confidence that individual frontline providers will retain their fair share, confidence in the robustness of payment systems, and a fear that funding will be wasted in administrative processes with little left for frontline services.

Positive or perverse funding incentives should not be ignored. Most of the primary sector is based on a private small business model and even community owned facilities and providers are driven by the need to operate within funding allocations. Funding will drive behaviour and service provision at all levels. There are many examples of where this has driven service design in positive ways, and conversely where funding streams are inappropriate and have the opposite effect. Historically each of the four Regional Health Authorities took different views of incentives for driving quality performance. This variability is re-emerging in the DHB environment.

Ultimately funding pays for services for individual enrolled consumers. The strategy states that consumers may enrol with a provider of their choice but also have the freedom to access other providers if they wish. This range of providers may or may not be within a single PHO. The funding pathway must be sophisticated enough to cope with this strategic framework while remaining administratively simple. The smaller a PHO, the more likely it is that consumers will often move outside the PHO providers either by choice or by need. Transaction costs between providers, and the risks associated with providing services which have not been funded, have the potential to be very significant.

A PHO which has the role of developing and managing services will need working capital. Managing the timing differences in cash flows can be a big issue for providers, particularly when single items of service are very expensive. For example,

the community referred radiology service for the Capital and Coast area pays approximately \$200,000 per month to providers. Equally the payment may vary in any month by up to 15%. Managing that sum of money, many times over within one PHO, requires both good financial management and good payment mechanisms and enough cashflow to allow payments to be made in a timely and reliable fashion.

Under a capitated bulk funding framework, funding will have to be disbursed to individual front line providers. PHOs have options about how this could be managed, which will vary according to local arrangements amongst providers. For example, all funding could pass through a central PHO structure to individual providers. Alternatively core service funding could pass directly to individual providers, leaving the management/support function to deal largely with funding for services requiring critical mass, referred services or regional service projects. The appropriate approach for any one PHO will depend upon the degree to which front line providers wish to be independent of a management/support agency, or wish the central agency to undertake routine functions such as distributing core service payment. Either way, the management/support function will need to have some expertise and resource to manage funding and payments.

## **2.7 Discussion**

This view of PHO structure raises some specific questions. These include the scale of the organisation, the potential for introducing layers of bureaucracy and the role of the District Health Board.

The scale of the organisation will be very dependent upon local circumstances, but it is important to note that the management/support function will need a certain minimum size in order to function effectively and efficiently. This applies to those clinical services where staff must work together to achieve effective peer support and quality processes in a collegial environment, rather than being isolated practitioners. It also applies to both clinical and management services where the workforce is scarce, or where only a larger organisation can support people of appropriate specialisation. For example, geographic information systems may be an important analytical technique for PHOs to use when identifying issues in their population. But such specialised skills cannot be carried by a small organisation. PHOs must be able to build the capacity to carry out these functions effectively, otherwise there is little point. Moreover, there will be economies of scale with some functions, such as administering payment systems which require IT support.

In this respect it will be important to learn from the experience of those organisations in the health sector which have carried out some of the primary care management/support functions over the past decade. IPAs have developed some of the capacity to carry out coordination functions, but this has taken time and growth within those organisations. Other groups have developed a coordinating function between geographically diverse providers in order to achieve the critical mass needed for effective management/support services. HealthCare Aotearoa is a prominent example of this.

It will be important to avoid introducing new layers of bureaucracy into the primary care sector. PHOs must not simply be a new layer over current arrangements. While they should build upon existing achievements, they should not duplicate them. Equally, current arrangements will need to evolve and develop new capabilities. The most effective way of avoiding duplication will be to organise current resources into PHOs, which should be achievable while maintaining diversity at the provider level. The management/support function of a PHO should not be viewed as a new, unnecessary level of management within the sector. In some respects it represents a more formalised version of a management function which has already developed naturally in response to the need for such a function. In other respects the primary care strategy genuinely requires that the primary care sector will perform new functions, and must allow for appropriate management mechanisms to carry out those functions.

The inherent tension between the diversity of front line providers and the economy of scale for some of the management/support functions will play out differently in the varying environments of District Health Boards across New Zealand, but a workable compromise must be found in each case. In some places it will be appropriate to have a single PHO for a DHB area, while other cases will be able to justify having support functions operating at a smaller level than the whole DHB region. The historical separation (or otherwise) of services within sub areas of a DHB will be an important factor in deciding this question at a local level, as will the identity of local communities and the level of trust which communities and providers have amongst each other.

It may be objected that if a PHO is to operate at a large geographic level it will be indistinguishable from a DHB. But while a DHB may have some expertise in common with PHOs, the function is distinct. The primary care expertise within the DHB has its main focus upon planning and funding, while a PHO has an operational focus. Even the management/support and analysis functions of the PHO are directed towards supporting operational service provision rather than towards planning and funding. Although a PHO may sometimes be geographically contiguous with a DHB, the task of the PHO is therefore different - the PHO must have intimate knowledge of provider arrangements and detailed community interests in a way that the DHB will not need to have. For example, DHBs have an important role in monitoring the outcomes of quality guidelines or clinical change management in primary care, but do not have expertise in the implementation of these clinical governance activities. Quality improvement, one of the six key directions of the strategy, requires an environment of mutual trust among clinicians. There are currently many examples of effective clinical quality improvement in New Zealand primary care organisations. By contrast, direct intervention in quality improvement activities by a DHB funding and planning role may be seen as punitive, and could preclude the buy in of clinicians to quality improvement processes. The gains which New Zealand has made in managing clinical quality should not be lost.

On the other hand the DHB has an important role in managing the external oversight of the PHO and ensuring that appropriate accountability mechanisms are in place. It will be important to maintain the separation of the DHB in order to preserve clarity around some of these operational functions as opposed to arms length planning and funding activities.

However there may be room to involve the DHB in the governance of PHOs in some areas. The arguments around this will vary somewhat from region to region, and will depend upon the historical relationship of DHBs to their providers as well as to the contingent distribution of resource and expertise about primary care.

## **2.8 The Individual Point of View**

One way of clarifying the functions which will be expected of a PHO and the roles of its constituent parts is to work through an example of how it might function in the future for an individual person.

### **The User's Point of View**

Alice is a person in her early twenties who lives in Cannons Creek. She is often breathless, and finds that even mild exercise is very difficult. Upon the advice of a friend she goes to see a doctor at a local clinic, which has free consultations for people in her area. The doctor diagnoses her problem as asthma, and suggests that it can probably be controlled with regular use of preventive medication while she should try to develop a regular exercise pattern which she can manage. The doctor explains to Alice why the drug will help her, gives her a prescription and suggests that she see an asthma educator who will spend more time discussing her condition and explaining how to manage it with the least disruption to her life.

Alice picks up the inhalers from the pharmacist. She has a visit from an asthma educator, who works through an asthma plan with her and gives her advice about exercise. Alice begins to use her preventer on a regular basis, but she does not notice any change in her asthma. She phones her general practice, and makes another appointment. The doctor finds that while Alice is using her preventer inhaler, she is not using it very well and is not actually receiving the medication effectively. Alice spends some time with the practice nurse learning how to use the inhaler better, and is followed up again by the asthma educator some weeks later. Alice's asthma is now under control. Alice periodically telephones the practice for a repeat prescription which she picks up and takes to a pharmacy, and visits the practice from time to time for a general review of her asthma.

### **The Provider's Point of View**

A PHO consists fundamentally of front line primary health care services which are the first line of contact when a patient seeks help from the health system. Individual provider organisations will involve a comprehensive primary health care team of professionals. This will include, at the minimum, nursing and medical professionals and support staff. Alice used the skills of all of these people in her general practice consultations.

Doctors and nurses at Alice's practice had attended a number of continuing education sessions about asthma, and a pharmacist had reviewed the doctors' prescribing for asthma drugs shortly before Alice had her consultation.

There were two referred services which Alice made use of. One of these was asthma education. The asthma educator works with people from a number of specific clinics, but is one of a group 12 educators across the whole of Wellington. They provide cover for each other when somebody is on leave and they work together on continuing education programmes to maintain their knowledge and to share their resources. As well as the individual education which Alice received, the asthma educators work with groups of people in the community and deliver health promotion messages in their local area. It was one of the people who had been to a group education session who originally advised Alice to have her breathlessness checked out by a doctor.

Alice picked up her inhalers from a pharmacist. When she did so the pharmacist substituted a generic inhaler for the one which had originally been prescribed, because it would be cheaper for Alice. The pharmacist was able to do this because an agreement between the local doctors and pharmacists set out when it was or was not appropriate for pharmacists to substitute medicines.

When Alice had her consultations with the front line provider the receptionist asked whether her details needed to be updated, and gave her a leaflet which explained that information about her consultation would be collected for funding and for health planning purposes. She asked the receptionist what this meant, and the receptionist explained that the practice was paid for the number of people who were enrolled with it, and that they collected the statistics of people who used the practice so that they could continually improve the services offered in Wellington. The PHO paid the front line provider for having Alice on the register, and information about Alice's consultation was subsequently collated into a health needs analysis. The health needs analysis was included in a quarterly report to the District Health Board, which read the report in detail, and in consultation with the PHO increased funding for asthma education services.

This simple example illustrates some of the services which would be likely to be provided by a PHO in Wellington. Alice would probably have considerable choice of the particular front line primary care service which she went to. It might have been a service operated by Iwi, by a private general practitioner or by a Third Sector organisation. In each of these cases she would have experienced a level of care which was supported by some quality improvement processes in common across all of those providers (eg. the pharmacist reviewing prescribing, or the continuing education), but the place she went to for care would have been her choice, based upon her preference for individual professionals and for the background of the clinic.

However it is difficult for an individual primary care provider to offer more specialised services. The asthma educator usually works with the people referred to them from four practices in the area (and therefore has some continuity when working with colleagues in those practices), but needs the support of their asthma educator colleagues in order to cover annual leave and time off for training without disrupting the services, and to provide peer review and quality improvement processes. This service is more appropriately managed through a single structure that supports many individual front line providers. Similarly, the continuing education for doctors and nurses and the pharmacist prescribing review are services appropriately provided through a single support structure across a number of individual front line services.

The sheer economy of scale means that these sort of services are difficult to manage upon the scale of individual providers.

There are also important roles for a management/support organisation in managing the information associated with Alice's consultation. The tasks of managing enrolment registers and doing the complex analysis required for monitoring health needs are not simple, and involve people with specialised skills. They cannot be duplicated across individual providers, or even small groups of providers, without diverting resources from front line health care delivery.

The special challenge in a PHO environment however is to such a scenario but where Alice may have several co-morbidities or where there are significant barrier. For instance Alice may not have the information upon which to decide to access an appropriate provider, or there may not in fact be one located locally. She may not have friends to discuss this with. She may not be able to afford the fees, and/or may already have a significant debt at her local practice. She may live in an overcrowded and damp house. She may have a language barrier, or no transport. She may not understand the information given to her about her follow-up or about her medication. She may stop using it. And so the complexity of response required to meet Alice's needs compounds. At the provider level this may require better health promotion and information about services, a greater level of funding to remove the cost barrier, it requires good information systems and the ability to co-ordinate a range of services including interpreters and it will require an inter-sectoral response to address the housing issues.

### 3 Populations

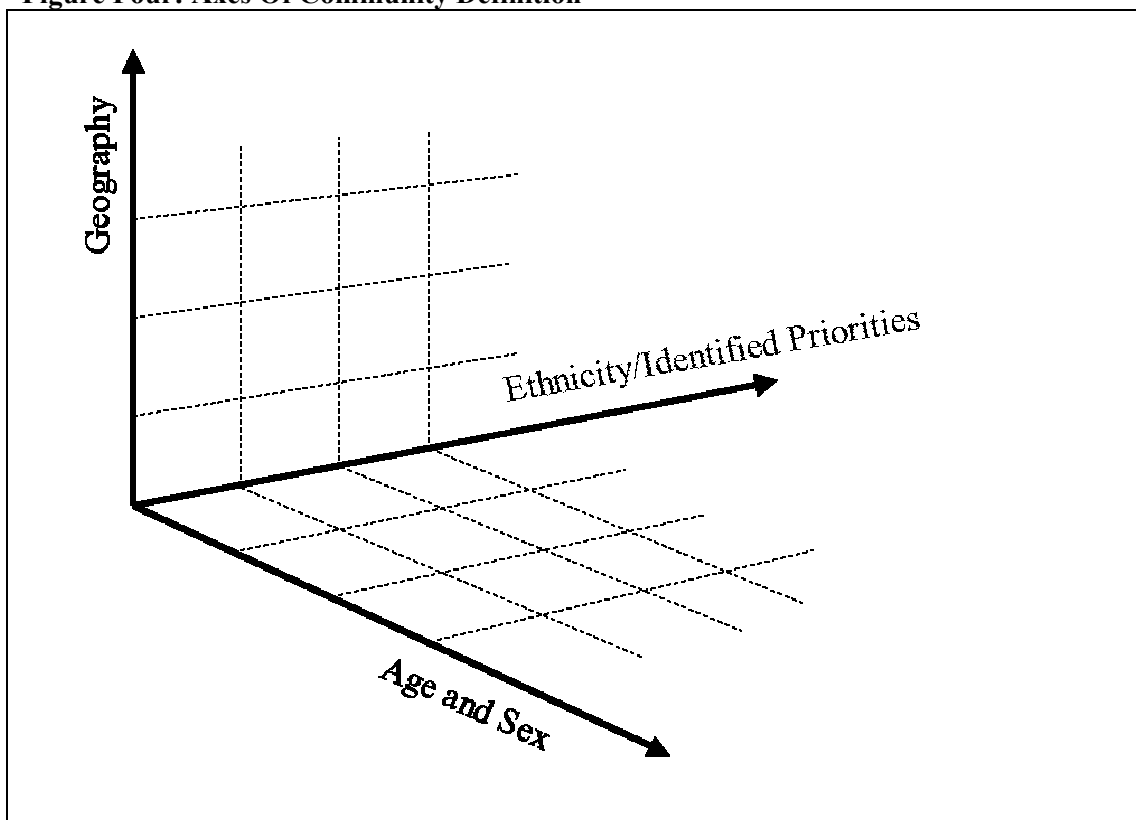
Primary Health Organisations must be responsive to the populations which they serve. This is one of the essential characteristics of a PHO and one of the key aims of the current changes in primary care. However, effective targeting is an easily expressed goal, but a complex matter for implementation. In order to consider how a PHO in Wellington must be configured if it is to respond effectively we must consider some general issues about defining populations, as well some of the specific aspects of the Greater Wellington population.

#### 3.1 Defining Populations

Primary Health Organisations must be responsive to the populations which they serve (King 2001a). This applies in two important respects: services must be appropriately tailored to serve individuals within whichever population grouping they function, and populations must have an effective voice in the services which they use. The approach taken to defining populations will be a key factor in determining how PHOs in any given area operate, and in turn what the issues are for the development of PHOs.

We can identify three potential ways of defining populations: by demographic factors such as age and sex; by health need expressed as ethnic priority, disease epidemiology and community priority; and by geographic area. These defining factors are shown below as axes on a three dimensional graph.

Figure Four: Axes Of Community Definition



An individual will occupy a position on each of the three axes at once. Individual users of health services are not completely defined by parameters along only one of the three axes, but are simultaneously young, Maori, living in Ngaio and have need for maternity services (for example). If individual identity along these axes is holistic in this way, then the same argument applies to defining the identity of a population. Within the context of personal health services an individual could find themselves defined as a member of a population along any one of these three axes for different purposes - an effective PHO must be able to provide health services to an individual which are appropriately matched to that person's position on each of the three axes, which may in turn be variable. Moreover, a PHO must consider a wider environment than health services alone, and will need to work with populations in a way which promotes effective intersectoral cooperation. PHOs will therefore need to work with populations defined by both epidemiological health needs and broader social needs which have an impact upon health, such as housing, education and environmental circumstances.

It is a relatively easy task to define a population on any one axis, and this has been the trend of recent years as health programmes have been targeted towards disease groups, demographic groups and geographic areas. Over the past five years we have seen projects in Wellington which are based around people with diabetes, people who live in Porirua, people who are members of specific ethnic groups, people who have COPD, people of school age and people with sexual and reproductive health needs. These programmes have all been greeted enthusiastically by both providers and consumers of care, and each one represents integration and improvement of primary care services around a population definition on one of the three axes. Further integration of services is a key aspect of user expectations from the new strategy (Age Concern 2002).

While health services defined upon one axis often integrate across a new area (where people have respiratory disease, for example), they are at least potentially open to the criticism of fragmenting across other areas (for example, age and geography and other health needs). Integrated health services which cater for populations of people with specific diseases have been an important and successful development in New Zealand's health system over the past decade, but if we are to see continued improvement we should aim to integrate across all three axes.

In practical terms, then, the task of defining a population for the purpose of deriving the appropriate services and structure of a PHO should start from the DHB health needs assessment and should proceed by considering a population on one of the axes and brainstorming the corresponding services and needs of communities across the other axes. The example of respiratory services is worked through in outline in the box below.

#### **Respiratory Services**

- Epidemiology/priority axis: Respiratory services, affected by housing and environmental factors.
- Demographic axis: Important for Maori in Capital and Coast DHB, particularly young Maori (asthma), as well as for older people of lower socio-economic status (COPD). Almost all members of the population suffer periodically from upper respiratory tract infections, such as colds and flu.

- Geographic axis: The services should be available to the whole population, but it is particularly important that barriers for young Maori and Pacific Island people be addressed and higher deprivation older people. Services should be available, at a minimum, in those areas with the highest concentration of people at risk of respiratory disease. In a Wellington context there are few areas which do not have a significant population of population groups at need of these services, so while there should be some targeting, it probably should not be very narrow (South Wellington, some pockets of northern suburbs, Porirua and Kapiti all have significant populations of either Maori, Pacific Island people or older people of higher deprivation). In addition, some services, particularly for respiratory tract infections are needed by almost the whole population across all geographic areas.
- Services: Should preferably include a range of diagnosis and management, including pharmaceuticals and patient education. Primary care services should be integrated with health promotion and education, as well as with appropriate secondary care services (eg. for serious acute asthma attacks, or COPD exacerbations) which in turn should have links with suitable community rehabilitation programmes. Many general practice and pharmacy services are needed for upper respiratory tract infections.
- Quality assurance is needed for the professionals involved, eg. for spirometry and prescribing activities.
- There should be links with consumer groups such as the Asthma and Respiratory Foundation and local asthma societies, both for providing services and for obtaining community input.
- A PHO could work with local and central government housing agencies to review risk factors for respiratory disease, and to consider modifying high risk housing environments.

The respiratory example has been described in outline – in practice it will be necessary to work through this process in detail for every priority area on the epidemiology/priority axis. When this is complete a similar exercise will be needed for each group on the demographic axis. Finally the geographic axis should be worked through. When this exercise has been done the populations and services which are particularly important for a PHO will fall out, with indications of the degree and geographic specificity of targeting for some groups of services.

This sort of approach would enable a PHO (or PHOs) to determine key populations, but to locate them within a framework of needs and priorities and to tailor services around them. It would enable PHOs to consider the intersectoral issues which impact upon health need and to weave these into an overall plan for improving the health of the population. The crucial point is that while geography is an easy attribute with which to define a community, it is not always the most appropriate way of planning for a comprehensive service – New Zealand populations are often very diverse along demographic and epidemiology axes within a given geographic area. Geography should be a criterion for defining populations which is in balance with the other possible approaches – and should be interpreted as a framework for targeting services appropriately, not as a rigid end in itself.

### 3.2 Geographic Targeting

One of the crucially important issues for targeting is the definition of population in such a way as not to create new inequity or hardship. We have alluded to the importance of using more than a geographic dimension to target health services. In this section we will discuss some of the issues for targeting which are raised by geographic diversity.

Geography is a particularly convenient means for targeting health services. In the final analysis an individual primary care service is located in a single place, so it makes sense, on the face of it, that the characteristics of the surrounding area should determine the activities and therefore resources of an individual health centre. However the reality is rarely as simple. Individual communities, even on quite a small scale, can show considerable diversity. The UK NHS introduced geographically based targeting based upon an index of need for more health services (the Jarman index) in the early 1990s. At the time there was much criticism of the index and its application (Talbot 1991). One of the criticisms noted in the debate was that there was room for small scale variation, in which small pockets of high or low need could exist within larger areas of low or high need respectively. Area based determinants of resource could therefore create new inequities in resource distribution. The specific case of an affluent Georgian square within a deprived area of South London was used to illustrate the point. This raises the issue of diversity within geographically defined populations and, in the context of the current discussion, the way in which PHOs must relate to the geographical distribution of diverse populations.

Fundamentally, it must be borne in mind that PHOs are primarily responsible for delivering personal health services to individuals within a population and that it is the nature of the individual which is paramount in constructing the relationship between a given person and their health care service. Population averages and other characteristics may be instrumentally useful means to define some aspects of the population which individuals live in, but in the final analysis many of the services which PHOs must deliver are to the individuals who make up those populations.

The most common method used to measure deprivation in the health sector is the New Zealand Deprivation Index, developed initially from the 1991 census and recalculated for 1996 census data (Salmond 1998). NZDep96 is based upon very small areas, with the specific intention of reducing any masking of deprivation. However there remain a substantial proportion of the population, estimated to be 14% of the total, who are highly deprived upon individual measures but who do not live in the most deprived categories of area (Blakely 2002). While the deprivation index is an instrumentally useful measure for indicating trends in populations it is not, and was never intended to be, a tool for targeting individuals.

## 4 Lessons From Overseas Experience

New Zealand is not the only country which is trying to develop its primary care sector and to reorient primary care towards a more population oriented approach with community input. The UK National Health Service has been developing primary care in some similar directions. While the historical starting point for change in primary care is very different in the two countries, there are still some lessons which New Zealand may be able to learn from change in the UK. This is particularly so in light of the extensive UK research and evaluation programme which has documented and analysed the process of change in primary care over the past five years.

### 4.1 Evaluation Of Primary Care Groups

The main structure for primary care under the changes in the UK is the primary care group (PCG) or Primary Care Trust (PCT). PCTs represent the final stage of evolution of PCGs, which can exist at one of four different levels depending upon the comprehensiveness of the functions which they have adopted. PCGs have many of the roles of New Zealand PHOs, although they also purchase (known in the UK as commissioning) services for the local area. In some respects they mirror the New Zealand DHB system by locating the purchasing body within primary care rather than in secondary care.

#### Roles of Primary Care Groups (NHS Executive 1998)

Improving the health of, and addressing health inequalities in, their community through:

- the identification of the health needs of their community
- contributing to and informing the development of the local Health Improvement Programme
- working closely with social services (and other local government agencies), to ensure co-ordination and integration of service delivery
- the involvement of the public in the work of the Group so as to inform the delivery of appropriate services

Developing primary care and community services across the Primary Care Group so as to:

- develop and support primary and community health care provision
- reduce variation in the provision of primary care services
- improve the quality and standard of care provided to patients through the development of clinical governance
- integrate the delivery of primary and community health services

Advising on, or commissioning directly, a range of hospital services for patients within their area which appropriately meets patients needs by:

- commissioning effective and high quality health services
- monitoring the performance of providers against service agreements
- contributing to the national drive to reduce waiting lists and times

A major finding of the research on PCGs has been the challenge of developing infrastructure. After two years the majority of PCGs monitored in a national tracker

survey reported that their staffing levels were inadequate, and that a shortage of either money or staff resources was an obstacle to progress. A common response to the problem of inadequate management capacity has been to merge PCGs, which has had the effect of bringing typical population size to approximately 193,000 patients (Wilkin 2001). However merged PCGs/PCTs may retain a locality structure within the overall organisation in order to engage at an appropriate level (Regen 2001). The most appropriate size for a PCG is still a point of debate (Bojke 2001).

An important goal of PHOs is to improve and maintain the health of the population. In the NHS the national tracker survey found that at an early stage GP led groups had made faster than expected progress in setting up organisations which could focus upon the broader issues of health improvement, however PCGs noted a need for more support, particularly in the form of good information which they could use for planning purposes at a local level (Gillam 2001). The time and resource involved in developing Health Improvement Plans was a burden upon a small organisation (Regen 2001). Once again, an appropriately resourced infrastructure is crucial to the performance of the organisation.

PCGs have been active in developing clinical governance programmes, although the specific projects they carry out are largely similar to programmes which New Zealand IPAs have already implemented. Properly resourced training and education was an essential tool for PCGs (Regen 2001). This is possibly an area in which New Zealand has less to learn from the NHS.

Primary Care Groups seem to have made some progress in engaging with a wider group of community and service provision stakeholders and are interested in pursuing this agenda further, although there are reservations about the effectiveness of what has been implemented so far (Glendinning 2001). Individual community representatives on PCGs often feel isolated and ineffective. Achieving effective public involvement is perceived as a significant challenge for PCGs (Regen 2001).

## **4.2 Discussion**

The experience in the NHS suggests that a primary care structure such as a PHO is capable of achieving many of the goals which have been identified in the New Zealand Primary Health Care strategy. However a consistent theme which has been repeated in research about PCGs is the challenge of developing and adequately resourcing an infrastructure which has such great demands for its performance. This must be a major risk for New Zealand which has, in some respects, a less developed infrastructure of enrolment and funding mechanisms to begin with. The New Zealand government must make a realistic assessment of the cost of implementing its proposals in terms of management and information resources, as well as in the direct costs of providing care.

The issue of appropriate management resource leads in turn to the question of scale. While this is still a subject of debate in the UK, the lesson of the extensive mergers between PCGs should be noted. Many of the population focussed activities of PHOs are likely to need sophisticated human resources for analysis and project management, which can ill be shared across many small PHOs. Moreover, clinical resources such

as community based nurses may need to work in a service of a given minimum scale if such issues as peer support and service coverage are to be addressed. New Zealand must take care not to fragment primary care structures into units which are too small to be effective.

Achieving public involvement in PCGs has been an area in which the NHS has progressed more slowly, although there are signs of increased buy in to this goal among general practitioners. New Zealand should bear this challenge in mind, and set realistic expectations about progress in this area. Many organisations have already taken steps in this area.

An important difference between the two sets of changes in New Zealand and the UK is that the NHS already had free access to primary care services, whereas New Zealand proposes to implement this at the same time as introducing large scale structural change in the sector. This redoubles some of the pressures upon management resources, while introducing new risks of its own.

## **5 Risks**

Considering the guidance which has been provided from government, the challenges which PHOs will have to face and the experience of primary care transformation in the UK, it is possible to identify a number of risks for the implementation of the primary health care strategy. Risks can be grouped under several headings, including strategic risk (doing the wrong thing), operational risk (doing the right thing badly), financial risk (going broke) and information risk (not knowing what you're doing).

Some specific elements of these risk categories which will be discussed in more detail are: funding, political risk, division among stakeholders and failure of the strategy. This discussion is intended to raise issues under these broad categories. Managing these risks will require a great deal of further work on the part of the Ministry of Health, DHBs, providers and communities.

### **5.1 Strategic Risk**

A major strategic risk in the strategy implementation is that there will be undue focus upon enhancing front line services at the expense of an effective PHO population focus. If the broader aims of the strategy are to be achieved it is vital that PHOs have effective population management functions, and can place communities of need within the broader context of the population at large. This is one aspect of the tension between the short term aim of the primary care strategy – to improve care for specific high need populations – and the longer term aim of altering the overall orientation of all primary health care services.

A second strategic risk arises from The government has proposed that it will take up to ten years from now to implement the strategy fully, largely because of funding constraints (King 2002b). Ten years, measured from the end of the first term, is a very long period of time for any government in New Zealand. If the strategy is only partially implemented before a change of government it seems very unlikely that the current opposition would continue in the same direction, at least as regards universal funding. There would be either a freeze on funding, so existing geographic areas with high and low funding would remain in that state or, more likely, there would be redistribution of primary care funding via other targeting mechanisms. In any case, it seems unlikely that the strategy will be fully implemented in its current form by any government other than the present one, and it is most unlikely that the present government will still be in power in 2012. The most significant consequence is that targeting mechanisms which were intended to be transitional might end up being permanent features of the New Zealand health system.

### **5.2 Funding Risk**

As has been noted, there are important risks around the funding for the strategy. These are:

The simple quantum of resource. If the government has not committed enough resource to the strategy to achieve its aims, then the exercise is set up for failure. This

will be a source of ongoing debate over the coming weeks and months, but it is worth noting that there is much room for doubt on this point. The three year funding plan provides for less than doubling current levels of GMS. However GMS is itself significantly less than half the total cost of current primary care patient services (Ministry of Health 2000). In addition, the strategy proposes new services for primary care which are not currently funded at all (King 2001) and will place extra demand upon the budget. If total funding is not enough, and is not supported by ongoing commitments, it may not be possible for government to achieve agreements from the sector to provide the services it wants. Equally, the sector may be unable to attract the workforce needed to provide the services. There are already substantial workforce problems in primary care which will not be resolved without considerable investment.

The stability of the promised funding. If there are emergent pressures upon overall health expenditure, primary care funding may be at risk. These could emerge from outside primary care in the form of hospital deficits or demand driven Disability Support Services, or from inside primary care in the form of greater referred services expenditure. Indeed, the increased access to services proposed in the strategy is likely to have precisely the effect of increasing demand driven expenditure. Historically the New Zealand health sector has been subject to many such demands upon health expenditure, which have blocked previous attempts to shift funding to areas of greater priority. The ringfences which are in place for the new primary care expenditure are not very solid (less than the former division in NDOCs between personal health and Disability Support, for example), and primary care expenditure may therefore be at risk from hospital deficits.

PHOs will need to manage risk around sustaining enough working capital and cashflow for some services. The experience of running regional services in the Capital and Coast area is that substantial sums of funding need to be managed, both with respect to appropriate management and accountability mechanisms and by operating robust, reliable payment mechanisms. This can pose a challenge in ensuring that the flow of resource from funders is always capable of covering the predicted services. Moreover, small changes in volume of referred services can have large financial consequences. A small number of MRI scans can blow provider radiology budgets, for example, leaving a PHO bereft of other services. It will be crucial to have effective monitoring systems and clinical quality management processes for managing these risks.

### **5.3 Operational Risks**

There are several aspects of the strategy implementation which carry a risk of functioning as well as they must do. The first is the question of scale. If PHOs do not develop enough critical mass to carry out their management/support functions in an effective manner, then they will not be in a position to deliver on some of the key aspects of the strategy. This is one of the major lessons from the UK, where PCGs underwent a vigorous period of mergers immediately after establishment. If PHOs do not achieve sufficient operational capacity to deliver upon their management/support function, there is a risk that additional funds may simply target populations already accessing care. The strategy's aim of benefits from greater funding for frontline

services may still be achieved but the greater vision of a more effective kind of primary care will be lost.

A second important risk of failure is the potential for disturbed equilibrium in the sector during implementation. There are already many primary care services which are being delivered effectively at a front line level. However the infrastructure of workforce and business viability is very fragile. Changes must be carefully planned in order not to disturb service which are already delicately poised. There are particular issues here with geographic targeting. If geographic targeting occurs on quite a small scale, it is likely that people who live in areas which do not receive new funding will travel to targeted areas in order to receive cheap or free services. This will have the effect of overloading services in the targeted areas (which typically already suffer from a lack of practitioners), while threatening the viability of services in the untargeted area. Such an effect has the potential to destabilise primary care services on a large scale, and to create unsustainable pressures for the entire primary care workforce. While achieving critical mass and efficiency is important, care must be taken that change is planned and that there are a minimum of unforeseen and detrimental side effects.

The state of the primary health care workforce represents an important area of risk. A shortage of primary care professionals has been documented (Health Workforce Advisory Committee 2002), and there is anecdotal evidence that replacing general practitioners as partners in practices is becoming more difficult. Finding practice nurses and locum GPs is constantly becoming harder, a trend which has now been observed in urban areas as well as the rural districts which have traditionally had these problems. Practices are already becoming harder to sell, even in urban areas. The future ownership of the infrastructure of primary care is an open question. If the overall shortage of medical, nursing and other health workers continues or worsens, the state of the workforce will represent an important limiting factor for the strategy as a whole. While the strategy does identify workforce development as one of its six main directions, there is a need to analyse workforce issues in more detail with respect to PHOs and their development.

The development of Maori and Pacific Island participants in the primary health care workforce is an important challenge for DHBs and PHOs, and will be a factor in determining the effectiveness of PHOs in implementing Treaty of Waitangi principles in the primary care setting.

There are political risks for the implementation of the strategy. Public acceptance will be an important challenge. If targeting is initially on the basis of geography at a locality level (King 2002a), there may be a public perception of unfairness, since people with similar personal circumstances will have different levels of access to primary care services. Unless the public genuinely has confidence that the system will ultimately become universal, or targeted in more sophisticated ways, there may be public backlash against the strategy. This has several implications. Firstly, the Ministry of Health and DHBs may have difficulty in promoting community engagement to the degree that they would like if communities are suspicious of the whole process. Secondly, providers could be the subject of backlash if they have to explain to individuals why they must pay for services when people in other parts of

the country do not. The political debate about the fairness of the closing the gaps policy may to some extent foreshadow this issue.

Beyond acceptance, public expectation is an important factor. The public communications about the primary health care strategy are already raising expectations among communities. Given the amount of funding which is being made available, it seems likely that many of those expectations will be met with disappointment. Again, this may well result in backlash which could be directed against a number of stakeholders, including DHBs and providers. Wording in press releases, such as “This funding announcement is the most important development in caring for the health of New Zealanders since the first Labour Government introduced patient subsidies in the 1940s” (King 2002c) does little to moderate public expectation about the ability of a PHO in their area to deliver significant changes in the near future. Much of the discourse about PHOs at a local level refers to free services, and may not be tempered with realistic views of the level and timeframe for implementation of higher primary care subsidies.

#### **5.4 Division Among Stakeholders**

Division among stakeholders is a specific aspect of operational risk which has special significance for PHO implementation. It is very clear that if the strategy is to be achieved, many different groups will have to work in a cooperative fashion in order to address some of fragmentation of the sector. However there is considerable risk that stakeholders may not be united upon the implementation of the strategy.

Government agencies may well be divided about the approach to the strategy. Already it appears that DHBs have been given a mandate to develop the primary care sector, but the first round of new funding is under the tight control of the Ministry of Health. Division between the Ministry of Health and DHBs risks undermining the mandate of DHBs by making providers and communities cynical about DHB powers.

The most significant source of division among providers is likely to be the issue of resources. In an environment of very limited new funding where there are very high expectations about performance, providers may well find themselves competing vigorously for small amounts of resource. There is already evidence of this occurring. This is likely to be divisive at every level; clinicians will have different levels of funding from their colleagues practicing elsewhere and sometimes just down the road. Provider organisations will be expected to put effort into developing proposals for funds, but will have to compete in demonstrating the worthiness of their population for the attention of the DHB or the Ministry of Health. Groups of providers and even practices may need to split apart to meet criteria for their enrolled populations. Providers may well prefer to act alone when developing such proposals if they feel that larger scale joint proposals with other organisations will not fit within funding constraints. This effect is likely to lead to small PHOs with very distinct populations, and consequently a risk of gaps between organisations defined on quite a small scale. The structure of PHOs should reflect the functions which are expected of them, rather than be devised to fit rules which are not locally applicable or which divide populations or current provider arrangements without very good reason.

As some communities receive additional funding and others do not there is likely to be tension, particularly if this occurs on a small scale. However given the vision for greater community participation and collaboration between communities and providers, a more serious problem is likely to be divisions between communities and provider groups. DHBs which are not astute in listening to both the expressed needs of the community and the expert advice of providers run the risk of pitting provider and community interests against each other. This would be an unfortunate consequence particularly where considerable progress has already been made in recent years towards shared governance structures.

## **5.5 Information Risk**

The information risks for PHOs are associated with a number of other risks which have already been identified. In particular, if a PHO does not achieve the critical mass to have effective information systems and analytical expertise in its management/support function, PHOs will not achieve the capacity for population analysis and management of primary care services. If a PHO does not have the information capacity to demonstrate that it is effective in providing primary care services to high need groups within the overall population, it will have difficulty in developing new services, and it will in turn expose the DHB and local communities to risks arising from the PHO's own ineffectiveness.

Overall, the information risk must be managed by being clear about the functions of the PHO as a total organisation. There will be a need to balance an emphasis upon the immediate provision of front line services with the development of effective management/support services which can direct and support the front line services so as best to achieve the goals of the strategy. If the issue of information risk is ignored, PHOs may well provide a number of improved front line services in the short term, but they will not succeed in developing the wholly new, population focussed kind of primary care which is the ultimate goal of the primary health care strategy.

## **5.6 Discussion**

This section has identified some, but certainly not all, of the risks which are part of implementing the primary health care strategy. Most are manageable risks, but will require careful attention from all participants in the primary care sector in order to avoid them or minimise their impact. As with any large scale change there will be unforeseen consequences of the primary health care strategy. It is the responsibility of the sector, lead by intelligent analysis from the Ministry of Health and DHBs, to ensure that the strategy brings as little as possible in the way of unpleasant surprises for all stakeholders.

## 6 The Capital and Coast Environment

### 6.1 Populations

The Capital and Coast region covers three main areas within the Capital & Coast District Health Board region: Kapiti, Porirua, and Wellington City.

Such a large urban area includes a very wide diversity of people: in age, income, cultures, and health needs. But it is also a compact area, and people are very mobile within it. Tens of thousands of people commute across the region every working day. As a result, health services have very wide catchments, and people access a range of services in different places (Capital and Coast District Health Board 2002).

The map below shows how the population of the Capital & Coast region is distributed according to the NZ Deprivation Index. The Deprivation Index for a small area has been shown to be highly correlated with the health status of the people living there (Salmond 1998). It should be noted however that highly deprived areas include many wealthy residents, and conversely that areas of low deprivation still include many people of very few means (Blakely 2002). For example, there are areas of low-cost housing in the Wellington suburb of Karori, which is otherwise in the least deprived 10% of the country.

The three graphs below indicate where people of different ethnicities live. In Wellington City, Pacific and Maori peoples are evenly represented at each level of the Deprivation Index.

There are roughly similar numbers of Pacific people and Maori in each of Porirua and Wellington. The main point of difference is that Pacific people in Porirua mostly live in the Cannon's Creek / Waitangirua area, which is classified as being in the most deprived 10% of all areas in the country. In Kapiti there is only a small Maori population, and a negligible number of Pacific peoples.

