A Guide for Establishing Primary Health Organisations
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PHOs and How to Establish Them

This Guide for Establishing Primary Health Organisations (PHOs) should be read in conjunction with the Primary Health Care Strategy and the Minimum Requirements for PHOs released by the Minister of Health in November 2001 (refer Appendix One). It is designed to be useful to District Health Boards (DHBs) and to providers and communities when they are planning primary health care locally and working to set up PHOs. It explains what PHOs are, what they will do, and covers some key considerations in their establishment.

The Guide is intended as a collection of helpful ideas, examples and tools. It does not set further requirements. Since the Minimum Requirements are deliberately permissive of different approaches, DHBs should be careful not to restrict this approach or stifle innovations by setting their own more rigid requirements. Providers are encouraged to approach DHBs with their suggestions, and DHBs should develop their own plans in light of such proposals.

What is a PHO?

PHOs are the local structures through which DHBs will implement the Primary Health Care Strategy. PHOs will be not-for-profit provider organisations funded by DHBs to provide primary health care services for an enrolled population. A PHO will provide services directly by employing staff or through its provider members.

PHOs are about providing primary health care services to meet the needs of their enrolled populations; they are not to become an extra level of administration in the health system. At present we have various organisations of primary health care providers that have service agreements with DHBs. It is expected that, over time, these organisations will be involved with forming PHOs and delivering services according to the strategy. To interpose a PHO between existing organisations and the DHB would be to add an extra layer of administration with few advantages but significant costs.

Protect gains and build on successes

It is important in the new environment that we continue to build on the successful initiatives and gains of the past. These gains include the provision of more responsive population-focused services, team approaches to care and community input into governance.

For example, the primary health care sector has benefited from an increase in the number and variety of Māori health providers and Pacific providers. The process of establishing PHOs should secure and progress these gains. It will be important for the new environment to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori. Similarly, the continuing development of Pacific providers will be important in meeting the needs of Pacific people.
General practice has also evolved in recent years with most joining Independent Practice Associations (IPAs) to share infrastructural support and foster quality improvements. Increasingly, IPAs cover a range of primary health care services and take a population focus. For example, programmes focus on major preventive care issues such as smoking cessation, immunisation, diabetes care and screening, Hepatitis B screening, breast screening, cervical screening and asthma management.

Community input into governance structures of primary health organisations is not new. Union health services, for example, from their inception developed as community-owned services with community input in their governance. Some rural areas have developed similar primary health care structures, for example, community trusts, which own and govern health services in their locality.

Each of these have contributed to a uniquely New Zealand mix of service provision and the challenge is how best to learn from the strengths of each to create a collaborative, responsive and effective primary health care sector to improve health outcomes and reduce inequalities.

Examples of PHOs developing from existing arrangements are provided in Appendix Three.

The following areas of progress will also become important in future:

- the development of closer links between communities and primary health care providers
- planning on a population basis for preventive services and primary treatment services, including for those hard to reach
- improved capacity to carry out population health programmes, for example, immunisation and screening
- improved co-ordination between primary and secondary care
- greater emphasis on mental health (including alcohol and drug services) in the community and in the role of primary health care in providing services
- the changing perception of disability and alterations in disability support services delivered in the community
- greater utilisation of the skills and expertise of a wide range of health professionals
- developing the primary health care nursing workforce
- implementing strategies to retain the primary health care workforce in rural areas
- increased co-ordination and integration between primary health care and public health providers (both DHB and NGO providers)
- increased co-ordination and integration between primary health care and the rest of the health sector, as well as with other relevant sectors such as education and social welfare.
General principles for transition

The Primary Health Care Strategy states the following principles for implementation:

1. protect gains already made and build on successful initiatives
2. involve, discuss and collaborate with the primary health care sector, providers and communities
3. focus on stepwise, evolutionary change that is progressively consistent with the strategy.

The first priority will be groups with the greatest health needs both in terms of additional services to improve health and in reducing financial barriers to first-contact services.

Who will be involved in setting up PHOs?

Community participation is a key part of the strategy, and PHOs also need to ensure that all their providers and practitioners can influence decision-making. This has implications for how all the stakeholders approach their tasks – community groups, providers, PHOs (or their forerunners), DHBs and the Ministry.

Communities: Some communities are already actively involved in governance and delivery of health services. These include Māori groups, rural communities, groups of Pacific people and a number of local authorities. These interested communities will be engaging with their DHB and with local providers. In other places the initiative may come more from the DHB or from provider organisations but in all PHO development, evidence of genuine community input is required.

DHBs: DHBs will fund and monitor PHOs. They have a statutory duty to assess population health status and need for health services, develop strategic and annual plans and consult with their communities and providers. Boards will work closely with those who are interested in setting up PHOs in their districts. Each Board will develop its own processes for these tasks and will signal these in their annual plans. The board is ultimately responsible for deciding PHOs in their district. DHBs will need to consider the overall pattern of development of PHOs in their region, encouraging PHO development in areas of high health need and encouraging smaller communities wishing to form PHOs to consider economy of scale issues.

Providers: Many providers will, in the future, operate as part of a PHO. Providers need to start making the appropriate linkages with DHBs, with other providers, with their communities and with organisations that are looking at PHO status in future. Public health services (both DHB and NGO) may be involved in helping to establish a population focus for PHOs.

Primary health care providers who do not join a PHO will be able to work toward identified health needs and targets through strong collaborative arrangements with PHOs and in discussion with DHBs.
All providers can contribute to DHB strategic and annual planning processes, particularly in terms of the more intimate knowledge that providers have of the needs of enrolled populations.

**Primary care organisations:** Existing organisations need to demonstrate that, in their preparations for PHO establishment, they include and consult with their communities, their full range of providers and practitioners and the DHB. There are already examples of how this can work, especially in some rural areas and with some providers that are involving communities and a range of practitioners. These organisations must have close links with their local DHB to ensure that they are moving in directions that fit with district and national plans.

**Ministry of Health:** The Ministry has the task of developing some national processes (for example, funding formulae, service specifications, rules for enrolment), as well as guidelines, toolkits and other support for implementing the strategy. DHBs and other key stakeholders will continue to be involved in developing these tools. The Ministry will monitor progress around the country towards implementing the primary health care strategy and establishing PHOs.

**Stepwise evolutionary change process**

Evolutionary change is not meant to imply slow change. The key notion in the principle of stepwise evolution is that change will usually be built on or evolve from existing arrangements and that there will be continual movement towards the full achievement of the vision.

While priority will go to the populations of highest need, providers and communities over the whole of New Zealand will benefit from improved primary health care. PHOs will therefore be needed across the country within a matter of two or three years. DHBs should support their development so as to move towards a comprehensive approach to primary health care for their whole district.

Ongoing supportive discussions between DHBs and PHOs will be important to effective forward movement. Annual planning and reporting processes give the opportunity for the PHO to review achievements and set new goals for the following period. The DHB should expect forward movement but the pace of change will vary with local realities. It is recognised that it takes time to build relationships for effective multidisciplinary teams and governance structures.
What a PHO Will Do

Implementing the Primary Health Care Strategy is a key first step towards achieving the goals set out in the New Zealand Health Strategy. The Primary Health Care Strategy aims to improve health and reduce health inequalities by moving to a system where services are co-ordinated around the needs of a defined group of people. Primary Health Organisations (PHOs) will be organisations of providers working with their communities to achieve this.

Essential services that a PHO will provide

PHOs will aim to improve and maintain the health of their populations and restore people’s health when they are unwell. They will provide at least a minimum set of essential population-based and personal first-line services.

(Minimum requirements for PHOs)

The services to be covered by all PHOs will include some ‘population health services to improve health, screening and preventive services; support for people with chronic health problems; and information, assessment and treatment for any episodes of ill health’ (Primary Health Care Strategy).

DHBs will enter service agreements with PHOs and in so doing will use nationally consistent service specifications. A set of establishment service specifications for the essential services has been developed by the Ministry and DHBs with input from provider and professional groups. They build on previous work and models used in existing contracts. The establishment specifications will be used by PHOs for the first 1–2 years and a process will be developed for their review.

The specifications include associated requirements for PHOs such as understanding the health needs of their population, cultural competence, quality systems, co-ordination and management of referred services. They will set out expectations about availability, affordability, quality and cultural competence.

The specifications will follow a similar format to that used for other health services and will be included in the Operating Policy Framework that all DHBs follow.

Many potential PHOs already provide the essential services, often alongside other services. Some may need to broaden their current services.

For example, most IPA providers undertake assessment, treatment, management of chronic conditions and a range of individual health education and promotion services. They may, however, need to strengthen their ability to take a population perspective of the needs of their enrolled people, and make extra efforts to encourage people with high health needs within their locality or community of interest to enrol.
On the other hand, some smaller community-based providers, including a number of Māori and Pacific providers, have focused largely on offering health advice and support to people at the local community level. Some nurse-led services include comprehensive health assessments, planning of health care interventions, disease management and referrals as needed. In recent times collaborative arrangements have been developing with general practices to provide a full complement of primary health care. These arrangements will need to be encouraged and supported to assist these organisations to transition to PHO status. This will include developing capacity to manage spending on pharmaceuticals and laboratory services for the enrolled population. (It is important to note, however, that there will be no requirement to hold financial risk for these referred services.)

**Addressing health inequalities**

PHOs will be required to work with those groups in their populations (for example, Māori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs.

(Minimum requirements for PHOs)

There is considerable evidence that some groups of the New Zealand population have consistently worse health outcomes than others. This is particularly the case for Māori, Pacific people and those on low income or who come from the most deprived parts of society.

Although there are many causes of health inequalities, primary health care must be involved in reducing them and in ensuring that it does not worsen inequalities – part of the solution, not part of the problem.¹ Primary health services can certainly have a direct impact on some indicators of inequality. For example, an examination of hospital admission rates by ethnicity shows that admissions that could be avoided by earlier primary health care are more common among Māori and Pacific people.

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To make a difference in this area, PHOs will need to focus on knowing their communities and ensuring that planning, prioritisation and service delivery will contribute to reducing health inequalities. Many community-based providers will have useful information about the enrolled population of a PHO, such as Well Child services, maternity providers and others. The PHO can utilise the information held by local providers in developing its population profile and determining health priorities.

DHBs are the bodies that will carry out the more formal type of population needs analysis and PHOs will use this information (rather than duplicate the processes) while also defining issues of particular relevance to the sub-population they serve. PHOs will need to be able to describe the age, gender, and ethnic makeup of their enrolled populations as well as knowing the patterns of distribution of major health problems and of service use (and non-use) by groups in the population. PHOs will need robust and inclusive processes for ongoing input from the communities they serve to inform service planning.

Already, many provider organisations collect detail about the people they cover and the services they provide and use this information in their annual planning and reporting. Those not already doing so will need to give more attention to identifying the groups in the population with the most need and what the organisation can do to make a difference.
Similar actions can be carried out at the practice level. Well-run practices that are implementing the population approach will know the people who have chosen to enrol with their practice and will be looking out not only for those people who come in regularly but also to follow up those who may be missing out. Tools such as disease registers, recall systems and practice protocols for best management of ongoing conditions will be important. It will also be important for PHOs to develop new methods of delivering services to those who need them, such as mobile and community outreach services.

In future DHBs and their local PHOs should be discussing how much progress they are making in reducing the health differences between groups in their communities. Useful indicators will be needed to demonstrate success. These will be aligned with local priorities and plans but might include process measures (such as the extent to which ethnicity and socioeconomic data are collected and used at provider and organisational level) and outcome measures (such as reducing the difference between groups in hospital admissions for some avoidable causes).

He Korowai Oranga – the Māori Health Strategy identifies improved quality, effectiveness and appropriateness of health services as a major pathway to improving Māori health outcomes and reducing Māori health inequalities. It also encourages providers to support whānau to strengthen their own health development.

PHOs will need to work with iwi and Māori communities to develop innovative ways to improve Māori health outcomes, to demonstrate these to funders and Māori communities, and to show what results have been achieved. Areas that PHOs should cover in their planning for Māori health improvement include:

- relationships with Māori communities/iwi/consumers
- access to services, referrals and effectiveness of service provision
- cultural and clinical competence of staff - Māori and non-Māori
- a population health approach to improving Māori health including identifying and addressing priorities
- ethnicity data collection
- monitoring and evaluating outcomes for continuous quality improvement.

It will also be important for all PHOs to demonstrate that they are culturally competent and effective in meeting the needs of any Pacific communities that they serve. This could be done by showing how they intend to implement the Government’s Pacific Health and Disability Action Plan.3

Mechanisms for addressing health inequalities should be integrated in all levels of PHO activity, including strategic planning, governance, management, service provision and any other significant work areas.

2 See the publication page of the Ministry of Health’s website: http://www.moh.govt.nz
3 See the publication page of the Ministry of Health’s website: http://www.moh.govt.nz
It is envisaged that a number of PHOs will be formed from Māori and Pacific provider groupings, and that these organisations will be key contributors to reducing health inequalities. DHBs will be required to continue to support and further develop Māori and Pacific providers.

**Co-ordination**

*PHOs must demonstrate that they are working with other providers within their regions to ensure that services are co-ordinated around the needs of their enrolled populations.*

(Minimum requirements for PHOs)

As stated in the strategy, co-ordination is an important aspect of good primary health care and is a broad concept. The areas that co-ordination can cover are expanded further in the strategy and are listed briefly below. As with other aspects of PHO development, this is an area where PHOs will vary in their starting points and in their rate of development of new linkages. Therefore, a suitable approach may be for the DHB and PHO to each year review progress and agree what further steps are to be taken to strengthen linkages in the next year.

- **Intersectoral co-ordination.** Health services can only contribute in a limited way to improving health status. However, well organised PHOs can be important players in linking communities and various agencies to have a more substantial effect on population health. These might include central Government agencies covering social development, education, housing, child, youth and family, ACC, and police as well as local government and non-government organisations (including consumer advocacy and support services). Some current primary care groups such as many Māori organisations, some Pacific providers, and other community-owned primary care services have already developed a strong focus in this direction.

- **A collaborative, multidisciplinary approach.** No one provider or professional group can meet people’s needs completely. First contact general practice services will include doctors and nurses, while a range of other professionals and community workers will be involved in providing the broad range of primary health care services. Managerial and support staff are needed both where health services directly respond to patients as well as for PHO organisation and population functions. The PHO will also need to develop links with the main community health services that are not included in the PHO’s service agreement. For example, this might initially include maternity care, community nursing, Well Child/Tamariki Ora services, Māori and Pacific providers, pharmacy, physiotherapy (and other specialist therapy services), dental services and so on. Note, however, that these kinds of services could appropriately be included within a PHO, subject to agreement with the DHB.

- **Co-ordination between primary and secondary care.** Hospital and specialist services play an important part in best care of many patients. Good co-ordination and support is required to enable people with ongoing conditions to be cared for in the community, to best manage referrals for specialist care and to ensure that episodes of hospitalisation are well linked in with care in the community to take
account of people’s home and work circumstances. Primary health care providers and PHOs will be well placed to play a leading role in joining up hospital and community services. Links may be needed with assessment and rehabilitation services, palliative care, diabetes teams, emergency services and other specialist areas.

- **Links with public health services.** As noted in the services section, PHOs will be responsible for providing some population health services to improve and maintain people’s health. Public health providers will also continue to have responsibilities in this area so there will need to be active collaboration in planning and delivery. Effective population health approaches require integrated planning and co-ordination at the national, regional and local levels. DHBs have a role in ensuring a seamless relationship between the current population health services and the emerging PHOs. This could include PHO and provider co-ordination with public health nurses, screening and immunisation programmes, health promoters, health protection officers and accident prevention services. Sharing of information, expertise and assistance to build capacity in primary health organisations into public health approaches will also be important.

- **Links with disability support services.** Primary health care providers and PHOs have an important contribution to make in helping people with disabilities overcome barriers to full participation. Linkages with disability organisations and support providers is one part of this contribution.

- **Mental health services.** Much mental health assessment and treatment occurs in primary health care settings. Good linkages with specialist mental health services are important both to ensure appropriate referral as well as to support best practice at the primary level. Specialist services can help primary health care providers develop the right mix of skilled personnel. The effective management of people with chronic mental health problems needs good co-ordination between primary and specialist services. The Ministry will provide a further guide containing suggestions and examples of effective mental health service delivery for use by primary health organisations.

- **Co-ordination for specific groups.** Various populations have particular needs that make co-ordination important. Older people, for example, sometimes have complex and changing needs that require carefully linked services. Children with complex needs, adolescents, refugees and the homeless are other examples of groups who may need different approaches that require careful working together between PHOs and other providers.
Key Considerations When Establishing a PHO

Funding

DHBs will use a national formula to fund PHOs according to their enrolled populations.

(Minimum requirements for PHOs)

The Ministry of Health, along with DHBs and advice from providers, is developing a national funding formula for primary health care that will be used to allocate funding to PHOs according to their enrolled populations.

The variables in the formula will cover age, gender, ethnicity and socio-economic status (the New Zealand Deprivation index combined, at least initially, with Community Services Card and High Use Health Card coverage of the enrolled population). The formula will be consistent with that used to calculate the DHB’s population-based funding.

The formula will, in the first instance, be used to allocate funding currently delivered through the general medical services subsidy and the practice nurse subsidy. It will include other components for things like improving access for high-need populations, health promotion and management support. The formula can be further developed to allocate funding for laboratory tests and pharmaceuticals, for other service areas such as community-based nursing services and additional services in the PHO scope of responsibilities, even though these are not generally funded through population-based funding arrangements at the present time.

Operating such a formula will require PHOs to be able to provide regularly an updated register of the enrolled population according to national specifications.

While service agreements will be between DHBs and PHOs, the actual payment machinery will be operated by Health Benefits. Health Benefits will:

- receive lists of enrollees from PHOs
- assure that the registers meet data specifications and comply with a set of rules
- validate data against national datasets
- assign deprivation codes
- cross-match for duplicate records
- calculate the capitation payment for the PHO according to the formula
- match with fee-for-service data to deduct out-of-PHO use by PHO members
- issue payment.
PHOs will be free to use various methods for paying individual practitioners. Some may employ practitioners; others will contract with practices and other providers. Salaries, capitation payments, fees for service, target payments, allowances and blended payment methods are all possible arrangements that may be adopted by PHOs. They each have strengths in certain circumstances and most commentators conclude that a mix of payment approaches is likely to be needed. The Ministry will collate information on these options and make it available for comment in April 2002.

Enrolment

*PHOs will use a national enrolment system to enrol people through primary providers.*

(Minimum requirements for PHOs)

Enrolment is important to allow PHOs to define the populations they cover and therefore plan and deliver population health services to meet their needs. Enrolment will usually take place through the primary health care provider, for example, at the level of the general practice or health clinic.

For the individual, enrolment is important because of continuity of care and to allow the primary health care provider to operate as a co-ordinator of services. Continuity over time and individual co-ordination of services are especially important for people with ongoing health problems.

The Ministry of Health is working with DHBs/DHBNZ to finalise the national enrolment rules in April 2002. These rules will cover the enrolment process, specify what patient information must be collected at the point of enrolment, and will outline people’s and providers’ rights and responsibilities.

For instance, people will be able to be enrolled with only one PHO at any time. However, enrolment will not restrict an individual’s right to seek care from another provider on a casual basis whether inside or outside the PHO.

In many cases, lists of enrollees will initially be built up from existing practice lists. Rules will cover issues of where a person is already listed with more than one provider, where someone wishes to change their enrolment, when their provider leaves a PHO and other similar situations.

People cannot be refused enrolment based on their health status or any form of discrimination. The national rules will, however, allow a DHB to agree to particular arrangements with a PHO if there are reasons to limit enrolment.

The enrolment rules will also clarify issues of enrolment of family members and what happens for individuals who have not received any services for some time.
Community involvement

PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community.

(Minimum requirements for PHOs)

What is meant by community

The ‘community’ associated with a PHO consists of all individuals who are currently enrolled with that PHO. This broad grouping may encompass a number of smaller communities of interest. It is recognised that communities may be very diverse, even within what are perceived to be common interest groups and cultures, and this may impact upon timeframes and levels of engagement for PHO establishment.

Since a key part of the strategy is close links with the local communities, groups planning to establish a PHO need to be able to identify which communities they intend to cover. As a result, PHOs will usually sit within one DHB’s boundaries. However, where particular circumstances arise, and so that a natural community of interest does cross DHB boundaries, the feasibility of establishing a PHO to serve the interests of this community will be discussed between the proposers and the DHBs concerned. A key criterion will be the extent to which crossing DHB boundaries facilitates the achievement of health outcome goals for any given community.

PHO governance processes

PHOs may take various forms (see final section on not-for-profit status and Appendix Three) and have differing governing processes. For example, a charitable trust will be governed by trustees, an incorporated society will have elected officials responsible to the members of the society, and a not-for-profit company will usually have a board of directors.

Because of these different governance arrangements, the minimum requirements do not prescribe any particular way that the community’s voice should be heard at the governing level. However, they do state there must be processes in place for genuine community participation and that these should cover the communities, iwi and consumers.
Examples of community involvement in governing processes

Some existing primary care organisations already involve their communities, iwi and/or consumers in their governing processes in various ways and to differing extents. Some examples of how they do this are given below.

*Health Care Aotearoa* organisations take various legal forms and most are governed by a management committee comprising elected community representatives and staff representatives. The committee sets policy and appoints a manager for day-to-day running. Staff are accountable to the committee through the manager.4

*Pasifika Healthcare* is a community-owned Pacific provider operating in Auckland as a not-for-profit organisation. It is governed by a board elected by the community. Each Pacific Island group elects its own representative. In addition, four more office holders are elected at the annual general meeting of the society.5

*Ngati Porou Hauora* has a majority of community representatives on its board. One representative is elected to the board from each of seven communities. Other board members include a person appointed to represent the clinic trust, a staff representative and a clinical adviser. To obtain additional input, the organisation also holds stakeholder consultation hui in each of its communities to ensure annual business plans reflect community need and to get feedback about current service provision.

*Current IPAs* have started in various ways to involve their communities in governance processes. Several boards have appointed one or two community members to their trust boards (such IPAs are often charitable trusts). Appointments have tended to be made by approaching prominent local citizens. In a number of cases IPAs have established separate community committees directly reporting to the IPA board. Such committees use various processes to attract members, including seeking nominations from local authorities, iwi, church groups, health consumer groups and so on.

Questions DHBs may wish to ask

DHBs need to discuss the proposed arrangements for community input into PHO governing processes. The DHB must ‘be satisfied that community participation is genuine and gives the communities a meaningful voice’.

The sort of questions that might be asked by a DHB in regard to community involvement in governance would be:

- What are the governing processes and what is the relationship between governance and management?
- How does the PHO define its community/communities and how does the community provide input?

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• Has the PHO identified and made contact with local iwi, and are there appropriate ways for the voice of Māori to be heard in PHO governing processes?
• Where the PHO has identified Pacific Island communities, how will the voice of those communities be heard?
• How will users of services have a say in decision-making?
• Where the PHO encompasses rural communities, how will the voice of rural communities be heard?
• Are there processes for informing the community of decisions that have been taken and allowing comment? For example, are meetings of the governing body open and are minutes available?

Wider community involvement

Involving community, iwi and service users in governing processes may not necessarily mean that the PHO is adequately responsive. This requires connections with community at many levels and processes to seek people’s views and take action accordingly. Some examples of ways that organisations can approach this are mentioned below.

Giving people information about services and processes is important and many organisations have newsletters, annual reports, presentations, community meetings and hui as ways of doing this. Where PHOs are actively reaching out to their communities – especially those people who are often the hardest to reach – there are opportunities both to give and to receive information that can be valuable to the organisation’s policy setting processes.

Consumer surveys, satisfaction questionnaires, suggestions and complaints processes are important. These can be carried out at the organisational level but also at the practice or clinic level. Information can be sought not only on services that are provided but also on what people would like to see provided.

PHOs may also link to local community and consumer structures as a source of community input. Many local authorities, for example, have health committees, and local consumer health groups exist in many places.

Community involvement in working groups and committees for particular projects is another important way for people to be involved.

The DHB will be interested to discuss with the PHO what mechanisms will be used to gather community input. The DHB may also wish to see where and how such comment has been used by the organisation to change its policy or services to date.

A community participation policy

Emergent PHOs that do not already have a community participation policy in place may benefit from the development and implementation of such a policy. Some ideas for doing so are given in the box below.
Ideas for developing a community participation policy

- The policy should be grounded by a set of principles that reflect the value the organisation places on community participation, including acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi.6

- It should articulate the organisation’s position concerning community participation (including Māori participation) in relation to:
  1. governance of the PHO
  2. strategic planning for the organisation
  3. service planning
  4. service evaluation
  5. resource allocation and development.

- The policy should include a plan for communicating with enrollees, including specific attention to how the PHO will communicate with Māori and with Pacific enrollees.

- The policy should state who is responsible for implementing the policy.

- The policy should state what measures will be taken to monitor its implementation.

- The policy should state when it will be reviewed and how it will be evaluated, for example, what measures or indicators will be used to evaluate the policy.

Provider involvement

*PHOs must demonstrate how all their providers and practitioners can influence the organisation’s decision-making.*

(Minimum requirements for PHOs)

PHOs come from various starting points. Some will grow from groups that have largely been community focused, others from a provider base – particularly from GP organisations. These each have their various strengths. PHOs will need to ensure adequate mechanisms for all providers and practitioners to participate in decision-making.

Where an organisation has grown from a non-provider base (for example, a community-owned or iwi-based group) it will need to put in place channels for communication with practitioners who will often be employees. Where the organisation is based predominantly on one group of providers (for example, an IPA whose members are GPs) the organisation will need to set up processes for all practitioners to have a voice.

There are various ways that the range of providers and practitioners can be involved. Some groups, such as many Health Care Aotearoa members, have staff representatives on management committees. Some IPAs have nurses on their governing bodies.

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Questions DHBs may wish to ask

In considering how a PHO plans to give practitioners a voice in decision-making, DHBs may wish to ask questions such as the following:

- How has the PHO identified the range of providers and practitioners in its organisation?
- Where the PHO encompasses rural communities, are there appropriate ways for the voice of rural providers to be heard?
- In what ways does it intend to involve providers and practitioners in decision-making at various levels in the organisation?
- How does it plan to communicate with providers and practitioners?
- How will it demonstrate that providers and practitioners have been heard and have influenced decisions?

Not-for-profit bodies with full accountability

PHOs are to be not-for-profit bodies with full and open accountability for the use of public funds and the quality and effectiveness of services.

(Minimum requirements for PHOs)

PHOs must be not-for-profit entities. Taxpayer funds are for improving health and ensuring access to services. Not-for-profit bodies must not be carried on for the purposes of profit or gain to any proprietor, member or shareholder. Various legal forms are suitable (see Appendix Three for further discussion).

A key aspect of PHOs will be that they are fully and openly accountable for public funds. This needs to cover a range of financial and non-financial activities, including a description of the method by which funding is to be allocated to the practices or clinics within the organisation. Although the method of allocating funding to individual practices or clinics will not be prescribed, DHBs will need to be satisfied that the method proposed meets the non-profit requirement.

DHBs will also want to check that the proposed method of allocating funding within the PHO is compatible with the aims of the primary health care strategy. Since the strategy requires the PHO to take a population focus, the arrangement within the PHO might include, for example, payments for achieving certain outcomes in respect of high-need enrollees or meeting other performance measures.

The Ministry is preparing some advice on possible models for allocating the PHO capitation funding within the PHO. This will discuss the incentives associated with different models but will not prescribe how this is to be done.

The service agreement between the PHO and the DHB will set out nationally consistent reporting requirements and specific performance measures that relate to key goals. Service agreements may also include additional requirements or measures to meet local priorities.
Questions DHBs may wish to ask

Questions that the DHB will be interested to know include the sort of issues covered in annual reports:

- Is the PHO’s declared purpose consistent with a not-for-profit status?
- Does the PHO have processes for dealing with any conflict of interest that may arise for individual providers involved in both governance and service delivery?
- What services were provided, to whom and to what effect?
- How well did the organisation perform on its plans for the period?
- What does the balance sheet show in terms of deficit or surplus, and how were any surpluses used?
- How much was spent on service delivery and how much on administration?
Where to Start

The first priority for implementing the strategy will be provider groups serving populations with the greatest health need, both in terms of additional services and in reducing financial barriers for access to first-contact services.

There will be developments that can be achieved without additional funding – and there may also be some areas of great need where additional funding cannot be applied towards the strategy in the short term because the necessary infrastructure and processes are not in place. Some of the necessary building blocks (such as the funding formula, IT needed for enrolment and service specifications) are not yet finalised, so the first PHOs will not be fully operational until July 2002 at the earliest.

The strategy requires PHOs to be ready to take up service agreements and receive funding for the provision of services. Without capable organisations the DHBs will not be in a position to move forward. DHBs and providers that begin now will be better placed to take advantage of new funding when it becomes available. However, providers serving high-need groups should not feel they will miss out if they are not part of the first PHOs to become established. New funding will be carefully managed to ensure this does not happen. It is important to take the time needed to foster collaboration within provider teams, between provider organisations and within communities.

DHBs need to identify and work with their priority populations, with any organisations that may become the fledgling PHOs and with key primary health care providers who are willing to work towards implementation of the strategy (including, but not limited to, those who currently have contracts).

The following provides a guide for emergent PHOs, DHBs, providers and communities to consider in the transition to the new environment.
For emergent PHOs

**Questions that emergent PHOs should consider include:**

Is there a natural community of interest around which to base a PHO?

What linkages have been made with:
- other relevant provider groups?
- the DHB?
- community groups?

How will existing provider organisations be best adapted to meet the community's needs in a PHO form?

How can the emergent PHO facilitate teamwork within its own provider network and with other relevant organisations?

How can the PHO prepare for enrolment?

Which systems does the emergent PHO have in place to identify the groups in its community with known health inequalities?

How will the PHO engage with these groups and how does it plan to address these inequalities?

What changes need to be considered in adopting new governance arrangements?
For DHBs

The DHB has the overview of the health of the region. It should consider how it can facilitate a regional approach to the development of PHOs. A collaborative rather than a competitive approach is likely to help providers form the most effective groupings.

Establishment of PHOs is a central part of the Government’s Primary Health Care Strategy and, as such, DHBs do not need to consult on its merits. They will, of course, wish to work closely with providers and community groups in developing local plans for implementation.

Questions for DHBs to consider include:

Which communities within their boundaries are likely to be natural communities of interest?

How well do the current primary health care provider arrangements meet the needs of the community?

What is the most appropriate arrangement for PHOs within the region, that will:
- best meet the community’s needs?
- allow for the necessary teamwork and integration of services to develop?
- build on the gains made to date?

How can the DHB facilitate active engagement between communities and provider groups to consider options for the development of PHOs within the region?

How will the DHB’s needs analysis information be of benefit to the PHO?

Which outcomes would the DHB expect the PHO to be working toward in relation to groups with unequal health status?

Which DHB provider arm community services would be beneficially co-ordinated from within a PHO?
For providers, practices and practitioners

Many existing primary health care providers are interested in PHO developments.

General practice is a key part of primary health care and will be vital in implementing the strategy. Nearly three-quarters of GPs and general practices already belong to IPAs and other organisations that may be looking either to become PHOs or to be involved in setting up a PHO. Individual GPs and nurses will most likely turn to their organisations for advice. Some will wish to take an active part in decision-making, some will wait and see, while some others may choose to be involved with other PHOs that are being set up.

A few GPs and practices are not currently aligned with any group. They too may wish to make changes in the light of future directions in the strategy and the development of new arrangements.

Primary health care nurses, including nurse practitioners, will also be key players in implementing the strategy. Many nurses currently practising in a range of primary health care or community settings will wish to be involved in framing the future. The Ministry of Health is leading a work programme to develop a national framework for primary health care nursing. With assistance from an expert advisory group, the Ministry will produce advice and recommendations about how nurses can play an active part in implementing the strategy. More information can be found in Appendix Two and on the Ministry’s website under the nursing page (http://www.moh.govt.nz/nursing.html).

Other primary health providers and practitioners can play a part in PHOs even though the services they provide may be outside the range of essential services required of a PHO.

Questions for providers and practitioners to consider include:

Are the services I provide something that PHOs will be required to provide in the first instance? If so, do I want to be involved with the PHO or stay outside? How will this decision affect me and the people I provide services for?

If I want to participate in PHO development do I want to be in early or to wait and see for a while? Is there a choice of PHOs for me to join? What are the pros and cons of each option?

If I am an employed practitioner, do I know how my employer is going to be affected by PHOs – and, if not, how can I find out more and how can I have a say?

If the services I provide are outside the range of essential PHO services, what impact will a PHO (or PHOs) have on how I operate? Would there be advantages for those I provide services to, or for my operation, if I were to be more closely involved with the PHO? If so, how can I go about becoming more closely involved?

7 Definitions of primary health care nurses and nurse practitioners are provided in Appendix Four.
For communities

Some community groups will already be engaged in consultation with DHBs. These groups and others should consider how they might be involved in the development of PHOs within their region. Communities will ideally have an active role in the development of PHOs.

Questions for communities to consider include:

What does the community want from a PHO and how can the community benefit from the development of a PHO?

Which community groups should PHOs engage with?

Are there existing structures and organisations that represent community groups, and which could engage with emergent PHOs?

Are there any community engagement processes in place within the DHB that would provide an opportunity for communities to have their say in the development of PHOs?

Are there subgroups with unequal health status with whom the PHO should be consulting when considering its development and service planning?

Are there groups that are not currently represented and how can the needs of these groups be identified and heard within the new environment?
Appendix One: Minimum requirements for Primary Health Organisations

Minimum requirements for Primary Health Organisations

Date of publication: November 2001

I am very pleased to release this set of minimum requirements for Primary Health Organisations (PHOs).

These requirements are important for getting started on the Primary Health Care Strategy that I released in February this year. District Health Boards, communities and primary health care providers have been eagerly awaiting this information to help them plan for the future.

Providers and communities must be able to move at their own pace. Some are close to being PHOs already, others have further to go. They need to be able to find the best local arrangements to achieve the strategy’s vision and their key relationship will be with the District Health Board. The requirements deliberately leave room for such a variety of approaches.

I expect to be able to make some announcements fairly soon about how Government plans to fund the strategy so that people can get the services they need to improve, maintain and restore their health. Of particular concern and urgency are those high-need groups that have been missing out and they will be the first to move.

The Ministry of Health has an extensive work programme to provide District Health Boards with the support, guidance and essential building blocks for getting the strategy going. The Ministry will shortly be releasing a companion set of guidelines to accompany these minimum requirements. The guidelines will contain tools and ideas so that groups can learn from what has gone before and consider a range of possible choices.

I am confident that effective PHOs will grow from and build on the existing strengths of general practitioners, nurses, community and other health workers. Maori providers, Pacific providers, Independent Practice Associations and other organisations can all evolve into PHOs. They will not be an extra layer of bureaucracy.

I look forward with great interest to seeing PHOs develop up and down the country over the next few years.

Hon Annette King
Minister of Health
Introduction

Implementing the Primary Health Care Strategy is a key first step towards achieving the goals set out in the New Zealand Health Strategy. The Primary Health Care Strategy aims to improve health and reduce health inequalities by moving to a system where services are co-ordinated around the needs of a defined group of people. Primary Health Organisations (PHOs) will be organisations of providers working with their communities to achieve this.

The process for fully implementing the strategy is to be an evolutionary one over the next few years building on the strengths of the existing services provided by general practitioners, nurses, community health workers and others.

Many of these practitioners operate under existing organisational arrangements such as IPAs, Maori Provider Organisations, rural trusts and so on. Implementing the strategy means that DHBs will work with these organisations and their communities in order to find the best way locally to set up Primary Health Organisations.

Key points about PHOs

The strategy (page 5) notes key points about PHOs as follows.

- Primary Health Organisations will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.

- At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people’s health when they are unwell.

- Primary Health Organisations will be required to involve their communities in their governing processes. They must also show that they are responsive to communities’ priorities and needs.

- Primary Health Organisations must demonstrate that all their providers and practitioners can influence the organisation’s decision-making, rather than one group being dominant.

- Primary Health Organisations will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.

- While primary health care practitioners will be encouraged to join Primary Health Organisations, membership will be voluntary.
Minimum requirements

The main focus is on achieving results in terms of better health, reduced health inequalities and easier access to services. The following minimum requirements set the parameters within which DHBs and local groups will find their own best answers. DHBs will decide whether an organisation is meeting the minimum requirements both in terms of services delivered and its overall structure and governance before allowing it to become a Primary Health Organisation. A set of national guidelines will be distributed to assist DHBs, primary providers and their communities with tools and ideas for PHO establishment and meeting minimum requirements. The process of establishing a PHO will reflect the principles of the Treaty of Waitangi – partnership, participation and protection.

What a PHO will do

- PHOs will aim to improve and maintain the health of their populations and restore people’s health when they are unwell. They will provide at least a minimum set of essential population-based and personal first-line services.

  DHBs are required, under national service coverage specifications, to ensure people have access to a set of primary health care services. The service agreements they enter with PHOs will specify these services in more detail. The agreements will include associated requirements such as understanding their population, information systems, co-ordination, and management of referred services within a budget. They will set out expectations about availability, affordability, quality, and cultural competence. For example, PHOs which include rural communities will need to ensure equitable and effective access to primary health care services within their rural communities or within acceptable travel times.

- PHOs will be required to work with those groups in their populations (for example, Maori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs.

  The DHB must be satisfied that the PHO’s planning, prioritisation and service delivery will contribute to a reduction in health inequalities.

- PHOs must demonstrate that they are working with other providers within their regions to ensure that services are co-ordinated around the needs of their enrolled populations.

  The DHB must be satisfied that PHOs demonstrate they are working with other providers as appropriate to co-ordinate care for their enrolled populations in ways that best meet the needs of their communities.
Key considerations when establishing a PHO

- DHBs will use a national formula to fund PHOs according to their enrolled populations.
  
  A formula is being developed nationally so that funding will reflect characteristics of the population that determine their need for primary health care services. The formula will cover the minimum essential services – DHBs may choose to enter other arrangements for other services.

- PHOs will use a national enrolment system to enrol people through primary providers.
  
  People will only be able to enrol with one PHO at any time. They will usually enrol at the level of the general practice or primary health clinic. A nationally agreed set of rules will set out people’s and providers’ rights and responsibilities and will establish requirements for information collection and protection.

- PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community.
  
  The DHB must be satisfied that community participation in PHO governance is genuine and gives the communities a meaningful voice. In addition, DHBs will require PHOs to show how they respond to their communities.

- PHOs must demonstrate how all their providers and practitioners can influence the organisation’s decision-making.
  
  The DHB must be satisfied that PHOs seek the views of providers and practitioners and have sufficient processes to ensure that decisions take account of the range of views.

- PHOs are to be not-for-profit bodies with full and open accountability for the use of public funds and the quality and effectiveness of services.
  
  Before an organisation can become a PHO, the DHB will need to be sure that the organisation has a suitable not-for-profit status and that the requirements for reporting and disclosure will allow the DHB and the public to fully understand the use of public funds and the quality and effectiveness of services in order to evaluate the results.
Appendix Two: Examples of PHOs developing from existing arrangements

The following scenarios look at possible developments from common situations. They are not representative of all providers or groups of providers who may be interested in the transition to a PHO.

An IPA in a provincial town

Often in provincial towns most or all general practitioners in the town and surrounding district belong to a single IPA. Such an IPA is an obvious major stakeholder that the local DHB will work with in its planning for primary health care. There will be an existing contract spelling out some aspects of the relationship and setting down arrangements for existing general practice services. Over time this contract will need to be changed to fit in with the Primary Health Care Strategy.

Such an IPA is a potential forerunner of a PHO for the town. It will need changes to its governance arrangements so as to conform to the requirements for community involvement and to ensure that all providers have a voice and are able to influence decisions. There may also need to be alterations to its legal status to ensure that it is a non-profit organisation.

Involving the community and all providers in policy setting and decision-taking will help the IPA ensure that its services are reflecting local needs and priorities. A small town may be a fairly homogeneous population so one PHO may be appropriate. However, where there is more than one significant community of interest, ways need to be found to reflect the differing needs and allow each community a voice. In some towns a single PHO may be able to make provision for each community to have a voice, whereas in other places the best answer may be several organisations networking to share some of the administrative burden.

Links need to be made with the DHB, local government, iwi and a range of primary health care providers. Co-ordinated population-based services will mean involving public health doctors and nurses and integrating with hospital secondary care as well as hospital-based community services. A PHO must be interested in the many causes of ill health and must build links with relevant organisations beyond the health sector.

At the same time it will be crucial to support the general practices that will continue to provide the mainstay of first-level care. Most IPAs have already developed systems for education, quality improvement and feedback of information for general practitioners and practice nurses. PHOs will want to continue these supports to ensure ongoing quality and the ability to manage within fixed budgets.

The existing IPA leadership will be important in showing general practitioner members how they can continue to play a key role while welcoming new partners, helping the IPA to plan strategically for the future within a PHO, building new relationships and being prepared to open up the organisation to new ideas and new voices.
A rural community

Many rural communities have already established health committees or trusts to address their local health services and these may be the obvious forerunners of PHOs. Typically, they could meet the requirements of the strategy for community involvement and a non-profit entity.

In some cases rural communities, even with their surrounding hinterlands, still amount to populations of only a few thousand people, and running a PHO may not make economic sense as management overheads would be prohibitively large. In these cases several local communities could consider joining forces to form a PHO, but structure the organisation so as to retain a voice for each of their constituencies.

In some rural communities there are already excellent close-working relationships between local nurses, general practitioners and other providers (sometimes including the local rural health facility with hospital beds) that can form the basis for providing co-ordinated services. These various providers often each have existing relationships outside the locality; for example district nurses employed by the District Health Board, Plunket nurses employed by the Plunket Society and general practitioners as members of an IPA. Changes will be needed in order to supply the essential services required from a PHO (eg, the IPA will currently be managing the budget for pharmaceuticals) so early discussions will be needed with these out-of-locality bodies.

An IPA with general practice members spread over several localities

Several current IPAs have general practice members working in widely dispersed localities under the jurisdiction of several DHBs. The future will see primary health care services take more of a population approach and involve participation by local communities. PHOs will be funded to meet the needs of this local population and will be required to involve the community in governing processes. These considerations have led to the conclusion (see page 13 above) that a PHO’s boundary will not normally cross a DHB boundary.

The existing IPA will be considering its future in the light of such developments – as will other current provider bodies that straddle several DHB boundaries such as the Plunket Society. These IPAs can play a very important role in working with DHBs, local communities and their existing members to determine the best configuration of PHOs.

While large, multicommunity organisations covering a wide geographic area would not be able to fulfil the functions of a PHO, they may continue to have important functions in the future. For example, the IPA has expertise in information gathering and analysis, in educational and other supports for quality, in management services and in developing innovative strategies for disease management and better integration of services. PHOs will continue to need such functions and it may be economical for them to contract with an organisation to supply them rather than try to supply them ‘in house’.
A community-based primary health provider

Currently, there are community-based primary health providers who are already structured in ways that would meet the Minimum Requirements for PHOs. For example, some have community ownership, full community participation in their governance, a registered population and a range of health professionals (commonly, GPs, nurses and community health workers). A few already manage budgets for pharmaceuticals and laboratory services. A number are part of the Health Care Aotearoa network while others operate independently.

As with rural trusts, some of these community-based primary health providers may have between 5,000 and 10,000 registered patients. To achieve greater economies of scale, they may wish to explore entering into a common PHO with other health services, either privately or community owned. They will need to ensure that PHO governance remains strongly community focused.

Many of these provider groups, because of their community base, will already have strong links with other agencies, such as Well Child services, housing and welfare groups, health promotion agencies and so on. Development of a PHO may involve the more formal engagement of these other agencies as part of the PHO or formalising the linkages to other sectors and services.
Appendix Three: Legal form

Various options regarding legal form are available to PHOs. Any of the following would be consistent with the Primary Health Care Strategy:

- a non-profit company
- an incorporated society
- a trust.

Non-profit companies

Under this arrangement the organisation registers as a company under the Companies Act 1993 and also registers as a charity for tax purposes. All profits must be spent on charitable purposes. As with trust deeds, the content of the company constitution is crucial in determining the nature of the accountability relationship that exists between the organisation and the community it serves. An advantage of this form of governance structure is that the Companies Act is more up to date than acts governing trusts or incorporated societies.

Incorporated societies

Incorporated societies are regulated by the Incorporated Societies Act 1908. Essentially, the Act stipulates that incorporated societies shall have a membership and officers elected by that membership. Officers are accountable to the membership through an annual general meeting and such other mechanisms as the society’s constitution provides. An annual report must be provided to the Registrar of Incorporated Societies. Incorporated Societies must be not-for-profit.

A strength of incorporated societies is that they make boards directly accountable to a group of members. An incorporated society states in its rules how people become members of the society. For PHO purposes the membership could consist of all enrollees and/or providers.

Trusts

Trusts that are established for charitable purposes are regulated by the Charitable Trusts Act 1957. In addition, the powers and responsibilities of trustees are specified in the Trustee Act 1956. Notwithstanding these two pieces of legislation, there are few restrictions in law concerning the structure and functions of trusts. For this reason a trust is a very flexible solution to the problem of which legal form should be adopted for a PHO.
A legal instrument of some description is required to establish a trust; usually this is a trust deed. A trust deed operates much like a constitution. A trust deed can be expected to contain a statement of the trust’s objectives, including identification of the trust’s beneficiaries. The trust deed might also be expected to contain a process for the appointment of board members. Other features desirable in a trust deed for a PHO might include accountability to the communities that they serve, financial reporting requirements and board composition. It might be desirable for PHO trust deeds to require approval from their DHB or from the Ministry of Health.
Appendix Four: Definitions of primary health care nurse and nurse practitioner

Primary health care nurse

The expert group advising on the development of a national framework for primary health care nursing in New Zealand has defined the primary health care nurse as follows:

Primary health care nurses are registered nurses, with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first point of contact care and disease management across the lifespan. The setting and the ethnic and cultural grouping of the people determine models of practice. Partnership with people—individuals, whanau, communities and populations, to achieve the shared goal of health for all, is central to primary health care nursing.

This definition refers to registered nurses.

Nurses working in the following categories may be included in this definition:

- Child health nurses (eg, Plunket, Tamariki Ora)
- District nursing
- Family planning/sexual health
- Occupational health
- Practice nurses
- Public health
- Nurses working in health promotion/health education
- Disease management nurses (eg, asthma and diabetes nurses)
- Mobile Māori nurses
- Healthline nurses
- Rural nurses
- Community mental health nurses
- School/educational institution nurses

(NB. This list is not exhaustive.)

Primary health care nurse practitioner

A registered nurse prepared at an advanced educational level, with four to five years’ experience in primary health care nursing practice and approved by the Nursing Council of New Zealand.