

**Victoria University of Wellington, School of Government
Health Services Research Centre**

Where next for primary health organisations in New Zealand?

Judith Smith and Jacqueline Cumming

Executive summary

This paper sets out a synthesis of five reports commissioned by District Health Boards New Zealand and the Ministry of Health as part of their 'change in primary care' project within the Joint Work Programme on Primary Health Care Strategy (PHCS) implementation. The synthesis focuses on the next stage of development for primary health organisations (PHOs) in New Zealand, what needs to change, and how the effectiveness of PHOs might be assessed.

The report takes as its starting point evidence that implementation of the PHCS has been more successful in relation to reducing the cost of access to care and increasing utilisation of primary care services, whilst struggling to bring about desired changes in terms of extending primary care service provision at the practice level and enabling better integration of a diverse range of primary and community health services accessed by consumers.

What needs to change?

Based on review of the five reports and the identification of key issues confronting PHOs as they seek to undertake the next phase of PHCS implementation, the following have been identified as priorities for action:

1. There is a need for work at both national and local level to specify the remit of PHOs, and in particular what they are expected to achieve, and how this is distinguished from the role and expectations of DHBs.
2. A careful exploration is required of the incentives and levers that would enable PHOs to better integrate primary and community health service provision at the patient level.
3. Policy makers should work with the health sector to scope devolved models of flexible and integrated primary care funding that can be tested out in local settings, within an appropriate framework of accountability and governance.
4. Work is needed at a national and local level to reframe the relationship between government and general practice and to further develop clinical engagement and leadership within PHOs.
5. In order to better co-ordinate care at a patient level, integrated patient management IT systems are required, along with an exploration of new ways of investing in primary and community health care facilities.
6. There is a need for more extensive and co-ordinated development of management and leadership in primary care, and across primary/secondary care, at both regional and national levels.

How might PHO effectiveness be assessed?

We tentatively set out here proposed criteria for assessing the effectiveness of PHOs in the next phase of development, linked with the facilitators of change within PHOs that have been identified through the process of synthesising reports commissioned as part of the 'change in primary care' project of the PHCS Joint Work Programme.

It is worth noting here that the reports underlined the importance of PHOs working closely with DHBs to implement the PHCS – and hence PHO effectiveness is closely related to that of the DHB and how the organisations work together in local 'health policy communities' to develop primary health care. The criteria set out here are tentatively proposed as a set of questions that might form the core of a process of review between DHBs and PHOs when assessing local progress with PHCS implementation:

1. Has the PHO got a clearly specified remit, including a memorandum of understanding with its DHB about respective roles and responsibilities in relation to primary care funding and development? Has the PHO got a set of clearly identified objectives about what it intends to achieve, both as an individual entity and with the DHB?
2. Has the PHO got a clearly articulated plan for how it will work with practices and other providers, including the DHB, to develop more integrated services for local people, including an approach to measuring progress at the service delivery level?
3. Does the PHO have a clear sense of how it will use or pilot different funding approaches as part of its plan to develop more integrated services?
4. What evidence does the PHO have about the extent to which general practice professionals feel engaged in the work of the PHO and able to shape or lead change?
- 5(i) What is the PHO doing to develop integrated patient management systems in primary and community care? (ii) Does the PHO have a plan for investment in developing primary and community health facilities locally, and does this take account of any provider role undertaken by the PHO?
6. What is the PHO doing to develop management and leadership capacity and capability, and how does this connect with regional and national activity in this area?

Conclusion

The synthesis set out in this report suggests that PHOs have reached something of a watershed. They have achieved some of the aims of the PHCS (e.g. improving access to primary care for disadvantaged groups, reducing the cost of first contact care) but seem constrained in their ability to bring about significant change to the model of service delivery in primary care.

What is clear is that work now needs to be undertaken by policy makers, managers, clinicians, PHO board members, and others in the primary care sector in order to shape the policy mechanisms, financial arrangements, information systems, and organisational development activity required to enable PHOs to move forward and achieve those PHCS aims which to date remain largely unrealised.

In particular, PHOs need to be given the levers and incentives to work with the local health community (e.g. practices, NGOs, allied health providers, DHB, management services organisations, IPAs) to extend, strengthen and better co-ordinate primary care services in a manner that continues to address inequalities in health and to improve the overall health of the population.

Introduction

This paper sets out a synthesis of lessons emerging from five projects funded by District Health Boards New Zealand (DHBNZ) and the Ministry of Health as part of their Joint Work Programme on the implementation of the Primary Health Care Strategy (PHCS). The paper explores what has inhibited and facilitated progress made by primary health organisations (PHOs) in New Zealand, and uses this analysis as the basis for setting out the issues facing PHOs, together with suggested responses. A set of proposed criteria that could be used for assessing PHO effectiveness is also included in the paper, and where appropriate, account is taken of other research and analysis carried out in relation to the PHCS.

Background

The New Zealand Primary Health Care Strategy (PHCS) was published in 2001 (King, 2001a) and set out high level aims that included: improving access for people to primary health care services; reducing health inequalities among the population; increasing community participation in the governance of primary health care; and developing more multidisciplinary and team-based primary health care provision.

Implementation of the PHCS has led to a number of achievements, including: a reduction in the cost of access to primary health care; increased utilisation of primary health care services; a stronger focus on the management of chronic disease within primary health care; a wider range of health promotion services at primary health care level; and the establishment of 80 primary health organisations (PHOs) intended to fund, develop and strengthen primary health care provision locally (Cumming et al, 2005; Cumming and Gribben, 2007; Smith, 2008).

Evaluation and commentary on the implementation of the PHCS has increasingly focused on the extent to which PHOs have been able to make a significant difference to the models of care delivered within general practices and other primary health care providers (e.g. Cumming et al, 2005; Cumming and Gribben, 2007; Smith and Ovenden, 2007; Gauld, 2008; Smith, 2008; Love, 2008; Croxson et al, 2008; Smith et al, 2008).

A number of projects commissioned by the Joint Work Programme have explored the role and function of PHOs and primary health care providers, and have sought to provide insight into how providers, PHOs and DHBs might work together to achieve the next stage of development of the PHCS. These projects were published by DHBNZ and the Ministry of Health in November 2008 (see www.dhbnz.org.nz or www.moh.govt.nz) under the title 'Change in primary care: New Zealand experiences', and the individual papers and authors are as follows:

- Evolution in practice: aspects of change and development in New Zealand primary health care (Tom Love)
- PHO model development: case studies of seven PHOs (Julie Martin, Julie Artus and Jenn Blatchford)
- Summary of general practice and frontline primary health care service delivery: principles and opportunities, themes from five DHB workshops (John Baird with Carolyn Gullery and Jenn Blatchford)

- Summary of PHO functional development: DHBNZ internal draft discussion paper (John Baird, with Carolyn Gullery, unpublished)
- Developing high impact changes for primary health care in New Zealand (Judith Smith, Janet McDonald and Jackie Cumming)

In this paper, the key messages from these five reports are distilled, and explored within six themes: the role of the PHO; developing integrated primary and community health care; models of funding and budget-holding; engagement and governance; infrastructure support; and leadership and management. This analysis is used as the basis for suggesting what needs to change in the next phase of PHO development and the report concludes by suggesting criteria by which the future effectiveness of PHOs might be assessed.

1. The role of the PHO

The diversity of size, governance arrangements, functions and management support infrastructure of PHOs is a recurring theme within the reports reviewed for this synthesis. The variability in roles, responsibilities and staffing noted by Martin et al in their study of seven PHOs is confirmed by a recent survey of all PHOs in New Zealand carried out in July 2008 (Smith and Cumming, forthcoming) which pointed to significant diversity across PHOs in areas such as size of the enrolled population, size and make-up of the governance board, level of payment to board members, interpretation of PHO role and functions, and priorities for the next phase of development.

The fact that PHOs are an extremely diverse set of organisations is unsurprising, given the permissive manner in which they were established, with a set of minimum requirements (that were rather limited in their scope and largely related to PHO governance) being used to guide their establishment. What emerges from the reports reviewed here however is a strong sense that this diversity, whilst arguably reflecting the range of community settings across New Zealand, is (when combined with lack of clarity about role) in fact an impediment to PHOs being able to make progress with implementing the PHCS. In particular, it seems that the lack of clarity about the role and functions of PHOs, together with limited leverage over the allocation of funding to providers, leaves PHOs struggling to develop and extend frontline primary care provision (especially within general practice) in a manner that would enable care to be better integrated across general practice, PHO services, DHB provider services, and other allied health and NGO services.

In their study of seven PHOs, Martin et al drew on Mid-Central DHB's analysis of PHO roles as being those of an umbrella organisation that seeks to co-ordinate local services, a funder that contracts with providers to ensure health service provision, and a direct provider of primary health services. These authors asserted that the roles of a PHO as co-ordinator/umbrella, and as primary care funder/contractor appeared to be more dominant within the case study PHOs. They found less support for the role of a PHO as a direct service provider, a finding that was confirmed in the recent PHO survey reported by Smith and Cumming (forthcoming). Similarly, Smith et al (2008) in their study of how to bring about high impact change in New Zealand primary health care noted that whilst some people talked of PHOs in a way that suggested they

were local planners and funders of primary and community health services, others clearly saw them as developers of providers (or of networks of providers).

In the same study, strategic planning and funding of primary care, along with general practice support, emerged as the functions considered as most important to PHO chief executives. If planning and funding of primary care is the core function of PHOs, this raises a critical question as to how this relates to the DHB's role in being the statutory planner and funder of health care for its local population, and the nature of devolution of such a responsibility to PHOs. As further evidence of this lack of clarity as to the remit of PHOs, Baird and Gullery, in their draft discussion paper about PHO functional development, suggested a set of seven functions for PHOs, functions which arguably could apply to DHBs as much as to PHOs: community engagement; health needs analysis; funding and planning; population health; co-ordination and continuity of care; quality improvement; and relationship management.

Baird and Gullery connected the lack of clarity about functions of PHOs to a desire on the part of the health sector for a stronger sense of direction about next steps for PHCS implementation. This was also noted by Smith et al, who noted primary care stakeholders' calls for 'coherence to overall strategic direction for the [primary health] system', and for 'permission' to thus be granted to district health boards (DHBs) and PHOs about how to get on and make change locally.

In Baird and Gullery's report of primary care workshops held across the country, they suggested that a further component of the lack of clarity about PHO roles is that they are not required to take responsibility for geographically defined populations, being instead responsible for an enrolled population. They pointed out that this makes it difficult to plan and deliver population-wide initiatives, and can complicate the ways in which DHBs co-operate and work with multiple local PHOs.

Whilst diversity of PHO form and function appears to have been a given within the New Zealand primary health system in recent years, the analysis in these five reports suggests that the time is now ripe for a more clear and focused remit for PHOs, and in particular clarifying what they are expected to achieve. A 'back to basics' review of the purpose and functions of PHOs may be required, exploring their role in areas such as funding, service redesign and development, clinical governance and quality, and health improvement, and identifying how this relates to the role and expectations of the DHB.

Issue: there is a lack of clarity about the role and functions of PHOs, which risks compromising their ability to take forward the next phase of development of primary health care provision in New Zealand.

Response: there is a need for work at both national and local level to specify the remit of PHOs, and in particular what they are expected to achieve, and how this is distinguished from the role and expectations of DHBs.

2. Developing integrated primary and community health care

Throughout the five reports reviewed here, there is a strong sense of people's desire to bring about better integrated primary and community health services within New Zealand. This reflects one of the core aims of the PHCS about the need for stronger and more extended provision of first-contact primary care services in order that people could experience well-co-ordinated and personal care in community settings (King, 2001a).

Smith et al (2008) noted that the need for better integrated primary and community care was the most commonly reported priority given by the people interviewed for their study on high impact changes in primary care, and Love (2008, p9) noted that a strong driver of change in general practice was 'the development of new, extended primary care functions which go beyond the traditional practice of primary health care'.

In Love's paper, eight case studies of service delivery and operational models within general practice are explored, and these offer an insight into how far providers are able to use the available funding and organisational environment to bring about change in how they manage their practice and deliver services for local communities. Love reports good progress with nursing development in general practice, based on the eight case studies in his report (albeit that these were selected for being 'examples of positive change in primary care) largely enabled by new funding streams such as Care Plus and Services to Improve Access. He notes less change in the activity and role of doctors, where the focus is reported to still be on consultations in the 15-minute and fee-for-service mode. Effective teamwork at the practice level is revealed, but this is regarded as being less embedded at the individual patient case management level. Larger practices are asserted to offer opportunities for more co-location and teamwork, with a caution about the need to still personalise services within such larger arrangements. Love argues that effective management and leadership are critical to the development of more integrated and extended models of general practice, a theme that is returned to later in this paper.

More specific information about what people are seeking when they talk about 'better integrated primary and community health care' is set out by Smith et al who describe people's desire for: GPs to be able to provide (or be able to access) a wider range of services in the community setting (e.g. diagnostics, specialist opinion); for better integration of care for individual users; and for pooling of funding streams so that DHBs and PHOs could put in place new models of care. Similarly, Baird et al's report of DHB workshops described local managers' and clinicians' wish for an integrated patient information management system as being a key enabler of more co-ordinated care within general practice.

Baird and Gullery's draft discussion paper on PHO functional development underlines the importance of continuity and co-ordination as a core function of both general practice and PHOs, and suggests that this entails: the provision of complementary services in a way that avoids duplication, gaps or inappropriate timing; the connection of care received from different providers in a way that ensures coherent meeting of individual need; and a focus on wellness and health improvement for individuals and the population. Put another way, Baird and Gullery's three dimensions of well-co-

ordinated and continuous care (as suggested in their draft discussion document) could be considered as being:

- the assurance of access to comprehensive urgent and routine primary care when it is needed;
- the proper co-ordination of care from a range of providers for people with complex needs; and
- the assumption of responsibility for maintaining the health of the practice population and for delivering preventative services.

Whilst the reports offer this insight into people's desire for better integrated care delivered in ways that are somehow more multidisciplinary and comprehensive than is typically the case at present, they also reveal that both PHOs and providers currently face significant challenges in bringing about such integrated care in practice. A strong sense is given of an aspiration for more integrated local care provision, yet of frustration at PHOs' apparent inability to lever such change within the current policy and funding environment.

Martin et al pointed out that many PHOs, together with their management services organisations, were embarked on initiatives aimed at improving care co-ordination, often via the provision of additional nursing time for care management in practices or the development of outreach services. They did however note that this activity tended to be concentrated on specific population groups or clinical conditions and that 'PHOs did not comment on strategies to improve co-ordination across and between services' (p8).

This raises a core question as to what needs to be put in place to enable PHOs to work with practices, and other community health providers (e.g. NGOs, DHB community services, allied health providers) to develop models of care that are significantly more integrated from a patient's perspective, and thus able to ensure the three dimensions of co-ordinated care referred to above.

What is clear from these reports is that people throughout the New Zealand primary care system want to be able to 'get on with it' and find ways of incentivising and enabling more integrated and multidisciplinary care within localities. Key impediments to this include: the complex current funding arrangements for primary care (see below for more on this); the lack of a geographical focus for PHOs; lack of clarity in relation to PHO roles and responsibilities; and organisational arrangements which struggle to co-ordinate services provided variously by PHOs, practices, NGOs, private allied health providers, and DHB community provider services.

Issue: primary care in New Zealand is characterised by a complex and diverse range of providers – PHOs' ability to develop new integrated service models appears to be compromised to some extent by current policy and organisational settings.

Response: a careful exploration is required of the incentives and levers that would enable PHOs to better integrate primary and community health service provision at the patient level.

3. Models of funding and budget-holding

A theme common to the five reports is the complexity of existing funding streams for primary health care, with critique focusing on the existence of multiple and complex programmes of funding which entailed significant direction and reporting via DHBs and the Ministry of Health (e.g. Care Plus, services to improve access, health promotion, rural funding streams). As Martin et al put it (p8)

‘We observed that the funding approach, incorporating several different funding streams, did not appear to have encouraged co-ordination across service areas.’

Whilst there was evidence in the reports that such funding had led to some broadening of service provision and development in team-working with primary care (e.g. as noted by Love and by Martin et al), there was also concern expressed about the limitations faced by PHOs in relation to exerting any influence on how new funding for first contact care is allocated and used within practices. This appears to be particularly the case where there are multiple PHOs in an area and practices can defect to another PHO if they feel the PHO is trying to exert too much influence over them.

Both Love and Smith et al noted that despite a capitation approach to the allocation of government funding for primary care, in reality, many providers remained in a fee-for-service mindset that was reflected in continuing reliance on a model of care with episodic individual GP and/or nurse consultations as the predominant approach to care. As Love puts it:

‘the shift in the Primary Health Care Strategy to capitation rather than fee for service has not, in itself, emerged as a clear driver for change at practice level. It may have facilitated the payment of GPs on a salaried basis in some cases, but it is not clear that salaried arrangements would not have taken place even if GMS funding was still provided on a fee for service basis’ (Love, 2008, p15).

This is unsurprising given the way in which the funding arrangements have been established, whereby funding for first-contact care is effectively ‘passed on’ by PHOs to practices without any effective contractual leverage in relation to what happens to the money, over and above the expectation that fees for access to general practice will remain low (Croxson et al, 2008; Smith and Cumming, forthcoming).

What is clear is that, in Martin et al’s words (p14) ‘the structure of funding mechanisms remains a key driver of the pattern of service delivery’. In saying this, they seem to imply that the process of implementing funding streams such as Care Plus alongside first contact care resource which remains effectively in a fee-for-service approach, has constrained PHOs’ room for manoeuvre. This reflects the fact that PHOs were, in effect, set up as mechanisms to enable the allocation of new funding streams to primary care, hence the close relationship between those funding streams and the functions and activity of PHOs is both understandable and arguably appropriate. However, the challenge now clearly facing PHOs, and underlined in each of these reports, is how to enable PHOs to move to their next stage of development and play an active role in shaping the provision of primary and

Where next for primary health organisations in New Zealand?
HSRC, Victoria University of Wellington

community health services across the complex range of providers (DHB, PHO, NGO, practices, private allied health providers).

Changes to the funding approach suggested in the reports as enabling PHOs to carry out their role in changing the model of service provision in primary care include:

- clarifying where the overall responsibility for primary care funding lies – in DHBs or in PHOs;
- taking a more flexible approach to local funding for a practice or locality/PHO population, perhaps through ‘global’ or ‘pooled’ budgets that bring together the different funding streams;
- piloting different approaches to primary care budgets in ways that suit local circumstances;
- ensuring that any such piloting is based within a clear framework of delegation, governance and accountability (both clinical and community); and
- exploring the implications of requiring PHOs to have a strict geographical (as opposed to registered population) focus.

Baird et al, in their report of DHB workshops, summed up the issues related to funding and budget-holding in primary care:

‘the lack of flexible funding was [...] a barrier to achieving outcomes and a disincentive to change. The alignment of incentives across the health system, mixed funding models, the removal of siloed funding, and allowing funding to be shared, integrated and intersectoral, were commonly suggested associated opportunities’ (pp17-18).

In any development of new models of funding for primary care, an appropriate balance will need to be struck between local flexibility, and what needs to be nationally consistent. Whilst the reports reveals some of the frustration experienced by PHOs and DHBs when seeking to work with the current mix of primary care funding streams, there is however a risk that enabling new and more devolved arrangements could further complicate the system, unless carefully thought through and tested out within a robust framework of accountability and governance.

Issue: current funding arrangements for primary care are unnecessarily complex and appear to prevent PHOs taking a global or locality approach to planning and funding of local services.

Response: policy makers should work with the health sector to scope devolved models of flexible and integrated primary care funding that can be tested out in local settings, within an appropriate framework of accountability and governance.

4. Engagement and governance

It is clear from the set of reports that the development of PHOs has provided important local infrastructure for primary health care providers, infrastructure that is perceived as valuable in underlining the key role that primary care plays in the health system, and that provides a platform on which to base further development of primary and community health services. In particular, the role of a PHO in seeking to be the focus of community involvement in primary health care, along with being a forum for general practice and primary care support, engagement and development, is underlined in the reports.

When minimum requirements for PHOs were set out in 2001 (King, 2001b), these set out an expectation that PHOs would engage with the local population and with health providers, in two main ways. Firstly, the organisations were expected to work with population groups that had poor health, and also with primary care providers, in order to ensure that services were co-ordinated around the needs of local people. Secondly, PHOs were asked to demonstrate that communities, iwi and consumers were involved in their governance and decision-making, and that all providers and practitioners were able to influence decision-making. These twin strands of community and clinical/professional engagement and governance continue to define both the strengths of PHOs and also the tensions that are often experienced within the governance and operation of these bodies.

In their examination of seven case study PHOs, Martin et al note that to a greater or lesser degree, each of the PHOs saw themselves as having a relationship with the local community, both through community membership of PHO boards and via other advisory and consultative arrangements put in place by the PHO. These authors identified ‘community engagement’ as a core PHO activity and pointed out that there was a spectrum of approaches to carrying this out in practice within PHOs. This commitment by PHOs to involving community representatives in their governance has been confirmed in studies forming part of the PHCS evaluation (e.g. Smith and Cumming, forthcoming; Barnett et al, forthcoming). What is less clear is how far PHOs are engaging service consumers in their service planning and review.

The nature of what is usually referred to in international literature on primary care organisations as ‘clinical engagement’ (namely the active participation in and support of a primary care organisation by its constituent doctors, nurses and other professionals) was less clear within these reports on PHO development in New Zealand. Martin et al referred to ‘relationship management’ as a core PHO activity, reporting that PHOs regarded the relationship with GPs as something to be ‘managed directly’ or through a management services organisation or independent practitioner association. The relationship between a PHO and its constituent GPs was deemed to range ‘from being viewed as “challenging” to being highly integrated and committed to PHO processes’ (Martin et al, p13). In this way, it appeared that the involvement of general practice within PHOs was at least sometimes seen as something that needed to be managed, along with the relationship with other stakeholders such as the DHB or NGOs, rather than being something that was integral and central to the PHO and its organisation and governance.

In their report on how to bring about change within primary care in New Zealand, Smith et al asserted that better engagement and support of clinical professionals was

needed, drawing on interviews with primary health care stakeholders in New Zealand, and on international research evidence. These authors pointed to the well-documented disenfranchisement of general practice during PHCS implementation, and emphasised the desire apparent in the primary health system ‘to now move on and find ways of focusing on service development as a uniting force at national and local level’ (Smith et al, p14). It was argued that clinical leadership was critical to drive further service development in primary care, together with the effective management of teams. Interestingly, Love (2008, p17) drew almost identical conclusions from his review of eight innovative general practices seeking to deliver integrated care:

‘All the practices discussed elements of individual leadership among the staff. In some cases it was particularly clear that one or two individuals had played a strong role in identifying future directions and persuading colleagues of the need for change. Such roles can extend over decades, and a practice with a strong leader can maintain a high level of change and innovation for a very long time.

Whilst Love’s comment refers to the level of a general practice (what might be considered the micro-level in a local primary health system), rather than to the PHO (which might be viewed as the meso-level of that system), international evidence about how to achieve better integrated care (e.g. Ramsay and Fulop, 2008; Rosen and Ham, 2008) highlights the importance of clinical leadership of change at both levels in a health system, and suggests that efforts to develop integrated care should start at the level of clinical teams, with funding and organisational arrangements being put in place to support the plans and activity of such clinical teams. The importance of robust governance for such initiatives is emphasised, and thus we see again the need for strong and meaningful community (and managerial) governance alongside enthusiastic clinical leadership and ownership of change.

Issue: PHOs have embraced the requirement to involve community representatives in their governance arrangements, but have been less successful in engaging clinical professionals, and in particular GPs, in leading and managing change.

Response: work is needed at a national and local level to reframe the relationship between government and general practice and to further develop clinical engagement and leadership within PHOs.

5. Infrastructure support

Given the diverse and complex range of providers within primary and community health care in New Zealand, it is not surprising that a theme to emerge from these papers on primary care development was the need for infrastructure support to facilitate more co-ordinated working across providers. Participants in the research underpinning the reports pointed to the need for mechanisms that can enable consumers to experience better co-ordinated care and reduce unnecessary duplication (for example in asking people for their clinical history, requiring attendances at many different service locations). The two main areas of infrastructure support that emerge as being a priority for PHOs looking to develop better integrated care are as follows:

- an integrated patient management IT system across primary and community health (and secondary) care providers; and

- an exploration of new ways of investing in the development of facilities for primary and community health provision.

In the paper by Baird et al summarising DHB workshops about primary care service delivery, the major enablers of change were deemed to be technology, facilities and funding models. This paper also underlined the relationship between providing infrastructure support to general practice and primary care, and making general practice a more attractive place to work.

In relation to the need for an integrated patient management IT system, it seems that participants in the different projects felt that co-ordination of clinical information was an important priority given the inevitable diversity of providers in the primary health sector, a diversity that was implicitly accepted as being a necessary feature of the primary care landscape that was unlikely to change significantly in the short to medium term. In this way, the reports reflect international research evidence (see Ramsay and Fulop, 2008) about integrated care that asserts a need to focus on co-ordination of patient information and services at the individual level as a key starting point, rather than leaping to try and develop solutions at the organisational level.

This suggests that the next stage of policy development for primary health care and PHOs needs to be closely aligned with policy on patient information and e-health, and that any experiments with new approaches to global funding of locality or practice populations should be supported by information management that seeks to better co-ordinate patient and service information.

The need for investment in developing new facilities for primary and community health services was a theme that recurred in the reports, albeit in a rather quiet and yet insistent manner. Mention was made of 'physical infrastructure constraints', typically in relation to wanting to extend the range of services delivered in a practice or other local clinic setting, or in seeking to bring together a number of small providers into a new shared facility. A further dimension to the concern about facilities was a call for practices to be able to have improved access to a range of services they wish to deliver to their patients, and whilst acknowledging that in many if not most cases in New Zealand it would not make sense to co-locate such services with general practice (e.g. laboratory testing, radiology, pharmacy) there was clearly a desire to receive support from PHOs in developing some form of new primary care centre that could act as a 'service hub' to which practices might refer patients for certain tests and services.

Underpinning such commentary was a sense that people would like to have access to a greater range of options in relation to primary care facilities funding, especially in the context of a desire to see a shift of services from secondary to community settings. Options for this might include risk-sharing arrangements between DHBs and PHOs, public-private partnership schemes for new facilities, or investment by the state in new primary care facilities in a similar manner to that used for secondary care capital developments.

It was suggested that in future, a new generation of general practitioners and private allied health providers would be much less likely to want to assume all the risk in

investing in buildings and equipment as their predecessors did, and hence this was another factor behind calls for a broader range of policy options to support the development of new facilities in primary health care.

It is worth noting that as well as calling for infrastructure development in the form of IT systems and facilities, participants in the different research projects also identified other activities and support that they felt could facilitate better integration across diverse groups of providers, including workforce skill development in areas such as service improvement techniques, cultural competency training, and a stronger focus on evaluation and dissemination of service developments.

Issue: there are core infrastructure issues that currently constrain PHOs seeking to develop more integrated and extended primary and community health services, of which IT and facilities are the most pressing.

Response: in order to better co-ordinate care at a patient level, integrated patient management IT systems are required, along with an exploration of new ways of investing in primary and community health care facilities.

6. Leadership and management

In his paper exploring case studies of innovative general practice provision, Tom Love is categorical in his conclusion that:

‘Issues of leadership and management tend to be more important to the success of a practice than questions of ownership. In many cases changes in service delivery had been the result of strong leadership from individuals in practice’ (p1).

This finding is supported by international evidence on the development of integrated care (e.g. McDonald et al, 2006; Ramsay and Fulop, 2008; Rosen and Ham, 2008) which highlights the importance of local organisations having strong clinical leadership together with management capability that is able to bring together clinical, community and business interests within practical service models.

Although not explicitly expressed as such, the PHO functions and capabilities set out in Baird and Gullery’s draft discussion paper represent a form of ‘management skill checklist’ for PHOs. Ten overall activities are suggested as being required for the fulfilment of PHO objectives and, although at first sight somewhat generic (e.g. community engagement, health needs assessment, population health, relationship management, quality improvement), they do give a sense of the extent of the significant management task facing those who lead PHOs. In their report on implementing change in primary health care in New Zealand, Smith et al (2008) identify the key issues facing PHOs as being:

- bringing about more multidisciplinary team-working in primary care;
- integrating a wider range of community and diagnostic services with ‘core general practice’;

- ensuring more effective co-ordination of individuals' care across different services and sectors;
- putting into place a more health-promoting focus to care provided by general practice; and
- reframing the relationship between general practice and government/health managers, involving GPs and their teams in a more extensive and consistent manner.

In setting out a management approach that might enable the achievement of these ambitious objectives, Smith et al draw upon a review of the literature concerning change in primary care and an exploration of the UK experience of implementing 'high impact changes'. They draw upon the work of Greenhalgh et al (2004) and Bate and Robert (2007) in asserting the importance of managers and clinical leaders having a structured process that encourages reflection on current working practices, and allows the development of a set of shared desired outcomes for local service change. Furthermore, they suggest a need for a set of 'simple rules' or 'design principles' about how people will work together when seeking to develop services in a collaborative manner.

The importance of carrying out such improvement work in a way that takes account of the Ten Health Targets and PHO Performance Management Programme is underlined, as is the need to ensure that managers use the process of local service redesign as part of the 'reframing' of the relationship between managers and general practice professionals. In this way, Smith et al assert a need for effective leadership and management within PHOs, and for this to focus on collaborative planning and implementation of change to patient services within primary care.

Whilst the management task facing primary care might seem daunting, as it seeks to reshape service provision and enable a more extensive and better co-ordinated range of services for the local population, this set of research reports point to the significant management resource already available to primary care. For example, in addition to the capacity available within PHOs (which is often under strain, as noted in the reports) there are managers with primary care responsibilities based within DHBs, and management services organisations serving PHOs typically draw together a range of service development, analytical, practice support, and general management capability. Furthermore, as emphasised by Tom Love in his paper, practice management is a critical factor in enabling change and development in primary care, and represents an area of health management that receives relatively little policy attention or investment in development.

A theme to emerge from these reports is the need for more effective co-ordination at a local and national level of the management and leadership capacity within primary health care, both in PHOs and in the primary care funding and planning arm of DHBs. Effective co-operation and joint working between PHOs and DHBs emerged from the reports as a critical element in ensuring progress with PHCS implementation locally. This echoes commentary earlier in this paper about the need for more clarity about roles and functions of PHOs and DHBs. It is worth noting that health management forms part of the workforce shortage facing New Zealand, and hence this is a further

reason for seeking to strengthen and better co-ordinate existing primary care management, wherever it is located within the health system.

In the international context, New Zealand has significant management and organisational capacity within primary care, reflecting the policy attention and investment that has been made in this sector since publication of the PHCS. As well as a national infrastructure for primary care planning and co-ordination (PHOs together with DHB planners and funders), there are extensive IPA networks that support both general practice and in many cases perform a management services function for PHOs, a wide range of community-governed health organisations that provide sophisticated and culturally-appropriate primary health care services in high needs communities, and flourishing NGO and private sectors that deliver services to complement publicly funded provision.

What is not so evident is how New Zealand is able to co-ordinate and focus this management and leadership capacity in a manner that will enable the primary health system to meet the next phase of challenges ahead. In particular, the reports reveal a desire for more co-ordinated and better resourced development of management and leadership skills and capacity (both for clinical leaders and health managers) at both a regional and national level, including more opportunities to share and learn from experience across PHOs, and across primary and secondary care.

Issue: management and leadership are critical to the next stage of implementation of the PHCS – that capacity is present in the system, but is insufficiently co-ordinated and supported.

Response: there is a need for more extensive and co-ordinated development of leadership and management in primary care, and across primary/secondary care, at both regional and national levels.

Criteria for assessing PHO effectiveness

We tentatively set out here proposed criteria for assessing the effectiveness of PHOs in the next phase of development, linked with the facilitators of change within PHOs that have been identified through the process of synthesising reports commissioned as part of the ‘change in primary care’ project of the PHCS Joint Work Programme.

In preparing this synthesis, we were struck by the relative lack of commentary in the five reports about the PHO Performance Management Programme and the Ten Health Targets. Little sense was not given about how indicators from the PHO Performance Management Programme relate to PHO functions and progress, nor about how PHOs and DHBs are currently assessing PHO effectiveness and performance. We were also struck by the absence of discussion about how primary care performance information, at both a practice and PHO level, might be used more widely within the planning, development and quality assurance of local health services.

If the development of better integrated primary and community health services is to be a policy priority in the next phase, this will necessitate the collation, analysis and publication of data about service performance within primary and community health services. This will be needed in order to establish whether or not improved

integration is occurring, and if so, whether it is having the desired positive impact on health outcomes (including patient reported outcomes).

The criteria set out here are tentatively proposed as a set of questions that might form the core of a process of review between DHBs and PHOs when assessing local progress with PHCS implementation. It should be noted that as currently construed, these criteria are not necessarily under the control of the PHO. For example, in respect of new funding approaches, there is a need for initial policy development work by the Ministry of Health in partnership with national PHO and DHB organisations. However, the criteria are offered as an indication of how in the future one might wish to assess the effectiveness of PHOs, albeit within whatever national framework of performance and accountability is applied to the public health system:

1. Has the PHO got a clearly specified remit, including a memorandum of understanding with its DHB about respective roles and responsibilities in relation to primary care funding and development? Has the PHO got a set of clearly identified objectives about what it intends to achieve, both as an individual entity and with the DHB?
2. Has the PHO got a clearly articulated plan and objectives for how it will work with practices and other providers, including the DHB, to develop more integrated services for local people, including an approach to measuring progress at the service delivery level?
3. Does the PHO have a clear sense of how it will use or pilot different funding approaches as part of its plan to develop more integrated services?
4. What evidence does the PHO have about the extent to which general practice professionals feel engaged in the work of the PHO and able to shape or lead change?
5. (i)What is the PHO doing to develop integrated patient management systems in primary and community care? (ii)Does the PHO have a plan for investment in developing primary and community health facilities locally, and does this take account of any provider role undertaken by the PHO?
6. What is the PHO doing to develop management and leadership capacity and capability, and how does this connect with regional and national activity in this area?

It is important to note that whilst considering potential measures of PHO effectiveness here, PHOs have to work closely with their DHB in relation to the funding and planning of primary health care. The respective roles of DHBs and PHOs, and arrangements for performance management and accountability for achieving change and development in local service provision, will need to be carefully explored as part of any changes to primary care funding, IT investment, facilities support, and so forth. Indeed, it may be pertinent to consider measures of DHB effectiveness alongside those of PHOs and their practices, a point made by Smith et al when reporting on the conditions necessary for making high impact change in primary care in New Zealand.

Conclusion

The synthesis set out in this report suggests that PHOs have reached something of a watershed – they have achieved some of the aims of the PHCS (e.g. improving access to primary care for disadvantaged groups, reducing the cost of first contact care) but seem constrained in their ability to bring about significant change to the model of service delivery in primary care. In particular, it is not clear what incentives and levers are available to PHOs to develop more effective integration of primary and community health services at the level of the individual consumer.

What is clear is that work now needs to be undertaken by policy makers, managers, clinicians, PHO board members, and others in the primary care sector in order to shape the policy mechanisms, financial arrangements, information systems, and organisational development activity required to enable PHOs to move forward and achieve those PHCS aims which to date remain largely unrealised. In particular, PHOs need to be given the levers and incentives to work with the local health community (e.g. practices, NGOs, allied health providers, DHB, management services organisations, IPAs) to extend, strengthen and better co-ordinate primary care services in a manner that continues to address inequalities in health and to improve the overall health of the population.

Judith Smith and Jacqueline Cumming
London and Wellington, 24 February 2009

References

- Baird J and Gullery C (unpublished) Summary of PHO functional development discussion paper. Wellington, District Health Boards New Zealand internal draft discussion paper
- Baird J, Gullery C and Blatchford J (2008) Summary of general practice and frontline primary health care service delivery: principles and opportunities, themes from five DHB workshops. Wellington, District Health Boards New Zealand and Ministry of Health
- Barnett P, Smith JA and Cumming J (forthcoming) The roles and functions of primary health organisations. Health Services Research Centre, Victoria University of Wellington, Wellington
- Bate, P., & Robert, G. (2007). Toward More User-Centric OD: Lessons From the Field of Experience-Based Design and a Case Study. *The Journal of Applied Behavioral Science*, 43(1), 41-66.
- Crosson B, Smith JA and Cumming J (2008) Patient fees as a metaphor for so much more in New Zealand's primary health system. Health Services Research Centre, Victoria University of Wellington, Wellington
- Cumming J and Gribben B (2007) Evaluation of the Primary Health Care Strategy: Practice Data Analysis 2001-2005. Wellington and Auckland, Health Services Research Centre and CBG Ltd.
- Cumming J, Raymont A, Gribben B, Horsburgh M, Kent B, McDonald J, Mays N, Smith J (2005) Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy of New Zealand: First Report, Health Services Research Centre, Victoria University of Wellington, Wellington
- Gauld R (2008) 'The unintended consequences of New Zealand's primary health care reforms', *Journal of Health Politics, Policy and Law*, vol 33, no.1, pp93-115
- Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F., & Peacock, R. (2004). How to Spread Good Ideas: A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation: Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO), London.
- King A (2001a) The Primary Health Care Strategy. Wellington, Ministry of Health
- King A (2001b) Minimum requirements for Primary Health Organisations. Wellington, Ministry of Health
- Love T (2008) Evolution in practice: aspects of change and development in New Zealand primary health care. Wellington, District Health Boards New Zealand and Ministry of Health
- McDonald J, Cumming J, Harris M, Powell Davies G and Burns P (2006), 'Systematic review of comprehensive primary health care models', Sydney and Canberra: University of New South Wales and Australian National University.
- Martin J, Artus J and Blatchford J (2008) PHO model development: case studies of seven PHOs. Wellington, District Health Boards New Zealand and Ministry of Health
- Ramsey A and Fulop N (2008) The evidence base for integrated care. London, Department of Health
- Rosen R and Ham C (2008) Integrated care: lessons from evidence and experience. London, The Nuffield Trust
- Smith JA (2008) Critical analysis of the implementation of the Primary Health Care Strategy and framing of issues for the next phase. Wellington, Ministry of Health
- Smith JA and Cumming J (forthcoming) Taking the temperature of primary health organisations: a briefing paper. Wellington, Health Services Research Centre, Victoria University of Wellington

Where next for primary health organisations in New Zealand?
HSRC, Victoria University of Wellington

Smith JA, McDonald J and Cumming J (2008) Developing and implementing high impact changes for primary health care in New Zealand: a discussion document. District Health Boards New Zealand and Ministry of Health, Wellington

Smith JA and Ovenden C (2007) Developing integrated primary and community health services: what can we learn from the research evidence?. Counties Manukau District Health Board and the Health Services Research Centre, Victoria University of Wellington, Wellington