Building Capacity of Primary Health Organisations to Meet Population Health Objectives

Reflections from the Sector

July 2007

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towards 2010

1. Overview

In April 2007 MidCentral DHB released a discussion paper entitled *Building the Capacity of PHOs to Achieve Population Health Objectives.* The objective of the paper was to obtain input from the primary health care sector about the future role and scope of PHOs, particularly in terms of their relationships with the many and varied providers of primary health case services. The paper identified three archetypical relationships between PHOs and providers (umbrella, funder, provider) with the purpose of stimulating debate.

Following release of the document, DHB staff attended meetings around the district with PHO boards, provider groups, MidCentral Health teams and professional groups to allow them the opportunity to express their views.

The engagement process was well supported by the sector. Participants demonstrated a high level of commitment to the goal of improved health outcomes and reduced inequalities for our communities. There was also strong commitment for the national Primary Health Care Strategy and for PHOs, both as a concept and as configured in our district. The sector was equally unanimous in believing that PHOs have some way to go to achieve their potential. This report summarises the input received from the meetings and submissions.

2. Background

MidCentral DHB is somewhat unusual nationally in that PHO development was guided by a local Primary Health Care Strategy. The Strategy was released in 2004 and was the outcome of extensive engagement with the primary health care sector. It built on the national Primary Health Care Strategy (released in 2001) but contextualised to the local environment. In particular, the local strategy directed the DHB to do the following:

- Invest in primary health care capacity so that in future the sector will be able to meet the needs of local communities. In particular, the Strategy talks about the need to develop primary health care teams.
- Establish PHOs across the district.
- Develop service plans to cover high priority areas such as chronic medical conditions (diabetes, cardiovascular, respiratory, etc) and other service areas (child health, mental health, etc).

With respect to the latter item, the DHB has developed a suite of service plans and has invested approximately $13m pa of sustainable funding in these plans. The bulk of the funding has gone to primary care with the creation of something in the order of 70 new clinical positions across a range of nursing, medical and allied health professional groups. Most of the primary health care positions have been created through PHOs.

With respect to the establishment of PHOs, the Primary Health Care Strategy provided the following:

- A commitment to the concept of PHOs and an understanding of how PHOs would fit within the broader context of primary health care services
- A proposed 'architecture' for PHOs within the district
- Guiding principles for how PHOs should be developed.

The district is now served by four PHOs (Otaki, Horowhenua, Manawatu and Tararua) serving defined geographical areas that correspond to Territorial Local Authority boundaries. The PHOs range in size from 6,000 to 97,000 enrolees, as can be seen from the following table:

Name	Date Established	No. Enrolees	Area Served	Org. Form
Otaki PHO	April 2004	6,000	Otaki ward of Kapiti DC	Trust
Tararua PHO	April 2003	15,000	Tararua DC	Not for profit limited liability company
Horowhenua PHO	July 2004	25,000	Horowhenua DC	Not for profit limited liability company
Manawatu PHO	January 2005	97,000	Manawatu DC & Palmerston North CC	Not for profit limited liability company

All PHOs were formed as the outcome of local community initiatives. In each case they represent a coming together of local communities, Iwi/Maori and health service providers.

The DHB did not take an active role in the formation of any of the PHOs, although it did facilitate the early stages of the formation of Manawatu PHO, which was the last to form.

All PHOs meet the Ministry of Health's minimum requirements for PHOs in terms of organisational form and composition of governance boards. PHO boards have good composition and are well supported by Iwi, GPs, nurses and the community in general. Three of the four PHOs are not for profit limited liability companies. The fourth, Otaki PHO, is a trust.

PHO board processes are reported to be improving with time. They are increasingly well managed, well documented and evidence based enabling boards to be more objective in their deliberations. Despite this, participation on PHO boards continues to be demanding on board members. There has been some change in PHO board composition over time but this does not seem to be higher than one would expect for the type of organisation.

A single Management Support Organisation, Compass Health Limited, supports the four PHOs. Compass Health is a limited liability company and was formed as a joint venture between Manawatu Independent Practice Association (MIPA) and the Wellington Independent Practice Association (WIPA) on the initiative of the four PHOs. The MSO is not owned by the PHOs, but rather holds contracts with each PHO defining the services that it will provide. Compass Health employs all PHO staff, including PHO managers. Compass Health has its own governance board.

PHO workplans and agendas are substantial and tend to be heavily loaded with operational matters relating to contractual responsibilities and central/regional priorities and initiatives. Funding for MidCentral's PHOs is typical of the national situation. They receive management fees for their administration, funding for first contact health services (which is passed through to general practices) and a limited amount of discretionary funding through Services to Improve Access and Health Promotion programmes.

First contact health services represents the bulk of PHO funding and also constitutes the most significant contractual responsibility. PHOs are responsible for the provision of 24 hour a day, 7 day a week, general practice based first contact services. In turn, PHOs have back-to-back contracts for service with general practices throughout the district.

In addition to the standard national services, MidCentral DHB has transferred a number of service contracts to PHOs. These include services previously held by Manawatu IPA and Tararua IPA, some of which were established with referred services savings. More recently the DHB has contracted additional services to PHOs as part of the service plans (diabetes, cardiovascular, etc). This has involved PHOs in the establishment of new services.

In some cases PHOs have contracted other organisations to deliver services (e.g., general practices, NGOs, independent providers) and in other cases PHOs have delivered services themselves, either directly or through Compass Health. All PHOs hold at least one contract with other organisations.

3. Future Development

While the key structural elements of PHOs in MidCentral's district were conceptualised in the local Primary Health Care Strategy, the reality has been created by the collective efforts of the sector and local communities. The DHB acknowledges the people who have made PHOs a reality, whether they have worked in a professional or voluntary capacity.

MDHB is committed to the ongoing development of the primary health care sector and believes PHOs are, and will continue to be, an important part of the matrix. With the key elements of the local Primary Health Care Strategy in place, the DHB believes it is a good time to assess the current status of PHOs and to look forward to the next steps in their evolution. The goal is to improve the health of our communities and to reduce health inequalities.

In April 2007 MDHB released a discussion paper entitled *Building Capacity of PHOs to achieve Population Health Objectives.* The objective of the paper was to obtain input from the primary health care sector about the future role and scope of PHOs, particularly in terms of their relationships with the many and various providers of primary health care services. The paper includes within its scope a broad range of primary health care services including those provided by the following:

- Non Governmental Organisations (NGOs)
- Private providers
- MidCentral Health, the provider division of MidCentral DHB.

One provider group that was excluded from the *Building Capacity* paper was Maori providers. This was done because of the perception that there are specific Treaty of Waitangi issues relating to the DHB's relationship with Iwi that needed to be addressed separately. The Building Capacity paper did, however, note the importance of PHOs coming to grips with Maori health issues and of working with Iwi and Maori providers to do this.

The *Building Capacity of PHOs to achieve Population Health Objectives* paper identified three archetypical relationships between PHOs and providers:

- Umbrella — the PHO coordinates and networks services
- Funder — the PHO contracts other providers to deliver care
- Provider — the PHO delivers health care services.

The purpose of identifying these archetypes was to stimulate debate about the vision for the next stage of development of PHOs.

Following the release of the document, DHB staff attended meetings around the district. Separate meetings were held with PHO boards, providers and professional groups. Some people attended multiple meetings reflecting the fact that they wear a number of different hats. Discussions were reasonably free form but also reasonably brief, fitting in with other meeting requirements. Attendance and participation at meetings was very good reflecting strong interest in the subject matter. Some written submissions were received.

The role of DHB staff at the meetings was to facilitate an opportunity for the participants to express their viewpoints and ideas. This involved advocating in a general way the need to move forward from the existing situation but DHB staff did not express any opinions or views about preferred models.

Despite the formal exclusion of Maori providers from the Building Capacity paper, Maori nevertheless participated in the process and provided some excellent insights, which have been included in this report.

Early discussions highlighted some issues with terminology. People found the term "NGO" somewhat distracting because it was associated with large well established organisations like Plunket and St Johns. Furthermore, PHOs are also NGOs and in some cases providers of service. Some PHOs see themselves as providers of general practice services when in fact they do not do this directly. Accordingly the language was adjusted and the discussion was phrased in the following terms:

PHOs	PHOs
Providers	Any organisations directly delivering care to clients. Providers can be NGOs, private providers, general practice, etc.

These are the terms used in this report.

Through the engagement process the DHB observed very strong commitment to the national Primary Health Care Strategy and a willingness to work collectively to achieve better health outcomes within our district. There was also support for the broad architecture of PHOs within the district, and a willingness to work with the PHOs. There was, however, also frustration that PHOs were not quite right yet and that they had not yet delivered observable change in health services or improved health outcomes. The engagement process confirmed that clarity of scope and role of PHOs is indeed an area that needs further refinement.

4. Scope of PHOs

PHOs are local organisations:

There was very widespread support for the notion that PHOs are locally based organisations, concerned with local communities, their health needs and the services to meet these needs.

> **Quote***: PHOs should be accessible, visible, accountable and available*

There was a general view that PHOs should be accountable to local communities although there were differing views as to whether PHO governance and structures supports this at present. Some people considered that the balance between local focus and district-wide priorities, projects and obligations was about right whereas others, including some PHO board members, felt there was too much emphasis on management content over community.

> **Quote***: PHOs should be about locality, locality, locality*

Views were divided as to whether PHOs should be promoted locally (branded) or whether they should be the "hidden hand" with public attention focused on the services that are delivered. There was agreement, however, that at present communities have very little awareness of PHOs and their activities.

There was also general agreement that the scope of PHOs should be broader than just general practice, although this was not unanimous. A minority view was that PHOs should be limiting themselves to the core business of general practice, dealing with issues such as GP availability, after hour's services, workforce development, register and enrolment issues, and changing general practice models of care – particularly advancement of nursing roles. Most people, however, felt that as well as fulfilling these tasks, PHOs should also be interacting with a broad range of agencies, services and individuals in order to deliver benefit to their communities.

There was support for the inclusion of population health strategies within the PHO frame of reference, but there were diverse views about what these services are, how they work, their value and their role in PHOs. Some groups had expert knowledge of population health strategies, while others had very little understanding.

> **Quote:** *There has been too much focus on disease rather than prevention*

Most people agreed that PHOs need to understand their local communities' health needs, and that this had to include both quantitative and qualitative information. The issue of health promotion was often discussed. PHOs already have health promotion plans and health promotion resources. The term health promotion covers activity at a variety of different levels. Some of this is most appropriately delivered at the local level. There was general agreement that population health strategies need to be coordinated between PHOs and with the DHB to ensure best impact and value for money.

There was also support for PHO engagement with the many non-general practice providers of publicly funded health services in local communities. People generally felt that engagement should extend beyond those providers delivering services relating directly to general practice or to other PHO contractual obligations, to include other agencies and individuals working locally.

Some felt that PHOs should be working beyond the scope of conventional health services into areas that align with the determinants of health. For example, through interaction with the social service agencies that so powerfully affect the lives of individuals. Some people supported this model of local intersectoral activity unequivocally whereas others were more cautiously supportive because of concerns about the resources it required and the risks of the net being spread too thinly and of a loss of focus, both of which undermine the PHO's ability to return gains to the community.

There were two distinct perspectives on how the PHOs should begin the process of engaging with a broader range of agencies. Some considered that it should be a natural, organic, process growing out of the community and by which the willing work together – a "coalition of the willing". This would enable gains to be made where they could be easily achieved. This opportunistic pattern of development would deliver quick easy gains and would model tangible benefits for others to see. Other people favoured a more purposeful approach based around the achievement of specific goals or objectives – for example, engaging with all the agencies involved with a local health issue, a particular client group or a chronic health condition.

There was a widespread view that most PHOs had not yet adequately engaged with other local provider stakeholders. Providers were generally of the opinion that PHOs had focused mainly on general practice and needed to broaden out. Most PHO board members and management staff also felt that broader engagement needed to occur, but this was tempered by an awareness of the following:

- PHOs already interact with quite an extensive range of providers - more than most people are aware of. Typically this engagement occurs around key priorities and projects, particularly service development and service delivery. Every PHO is now contracting with at least one NGO provider, often with a number of them. This has usually been achieved out of SIA funding, which is the only truly discretionary funding available to PHOs. Furthermore, NGOs and other providers are present on a number of boards.
- PHOs have experienced difficulties with previous attempts to engage providers (opportunities presented and not taken).
- PHOs are confronted by a demanding work programme, particularly around implementation of the DHB's service development plans but also time consuming issues related to the need to provide frontline services. On the other hand, there are limited resources available to PHOs.
- A feeling that PHOs should talk to providers when they have something to offer them, but that in general that PHOs are not able to meet the expectations that would be created by engaging with providers.

5. Role

5.1. The Umbrella model

Just as most people supported the view that the scope of PHOs should be broader than just general practice, so there was also a high level of support for the idea that the prime function of PHOs is to coordinate, facilitate and support activity towards the goal of improved health within local communities. This aligns strongly with the umbrella model outlined in the DHB document. This role was particularly favoured in terms of an expanded scope for PHOs, working with a variety of traditional health services, community organisations and social services to benefit communities.

Support for the role of PHO as coordinator comes from right across the sector – from PHOs, provider organisations and professional groups.

Suggestions for specific coordination roles include the following: facilitating the exchange of information between providers; the networking of providers; information technology development within the health sector; the general development of the systems that underpin the delivery of primary health care; the development of frameworks and quality programmes for health professional groups working in the district but not already covered by arrangements.

> **Quotes:**
> ***PHOs should be about coordination, brokerage, holistic care, advocacy and access.***
>
> ***A good PHO should be about people, not business***
>
> ***We (NGOs) are looking for support not control***

Some providers expected the PHO to demonstrate *leadership* of providers within the local community, engaging with providers and helping them to resolve their issues and to work better. This included involvement in areas that were not within the scope of PHOs' existing contracts – for example, in areas like primary maternity services.

> **Quote:** ***Happy people play better together***

There were also expectations from provider organisations and health professional groups that PHOs would facilitate and coordinate at a clinical level. For example, by adopting the following roles:

- By facilitating the exchange of patient level clinical information between health professionals
- By organising the coordination of the care for individual patients (by identifying who was the lead provider for specific patients).

There was specific expectation from providers and health professionals that PHOs would work to promote the formation of "primary health care teams" from the diverse health resources currently delivering care in communities under the auspices of various organisations.

The general theme emerging from discussions was that the health sector has become more complex over the last few years and that coordination at the local level is an increasingly important function.

> **Quote***: The fundamental premise for PHOs was to build capacity in primary health care***

5.2. Other roles – a Contractor of services

There was not a lot of support for PHOs assuming more contractually based responsibilities within the primary health care sector.

> **Quote:** ***I don't believe building capacity of primary care will happen by just putting contracts through the PHO.***

Providers and health professionals expressed a number of reasons against such a move, many of which related to risks that it would generate for themselves and/or their clients. During the engagement process, the following issues were raised:

Risk to provider organisations
Providers considered that PHOs represented threats to the autonomy, independence and entrepreneurial spirit of provider organisations because PHOs were not seen as being able to provide an environment within which these attributes would flourish.

Some providers and health professionals considered this arose because of a lack of experience, capacity and knowledge on the part of PHOs. They felt that PHOs were not well informed about their localities or the services working in their localities. For example, in establishing new services, PHOs did not understand what was available locally and instead of building on this they established new services. This view seems to have been particularly associated with the implementation of the DHB's Service Plans, but it also touches on duplication between the DHB and PHO as funders.

Other people were concerned that some PHOs operated as a competitor with existing providers, or worse, Compass Health had on the PHO's behalf. Providers felt that the playing field was not level, particularly with the DHB's policy of supporting PHOs.

Providers were also concerned that PHOs encouraged competition between providers – for example, by using competitive processes to allocate SIA funding.

Impact on the delivery of care
People were concerned that moving contracts from the DHB to PHOs might result in disruption of care. This reflects a sense of the complexity and vulnerability of patients and of care arrangements. A number of concerns were raised about PHOs' ability to sustain services that are currently operating on a district-wide basis. An example of this is the District Nursing Service, which plays a vital role facilitating the discharge of patients from hospital. District-wide provision of District Nursing was seen as enabling a higher level of functionality than would be the case if it were devolved.

Supporting professional groups
Concerns were raised about the impact of a movement of services to PHOs on various professional groups. In relation to small professional groups, there was concern about a potential loss of identity and critical mass. Another common theme was the ability of PHOs to provide appropriate professional structures to support professional groups such as specialist nursing. There was a concern that these groups would become fragmented or that they would find themselves in situations where clinical staff were reporting to a non-professional PHO manager rather than within a clinical team. There was a general concern that placing specialist staff within PHOs would isolate them from the source of their specialist expertise – secondary care – resulting in an erosion in skills and service over time.

Increasing inefficiency
PHOs adopting funding roles was seen as a potential source of additional costs within the system with more resources required for administration both at the PHO level and the provider level. For example, through increased reporting obligations. Providers were concerned that increased costs would fall on them, but there was also a shared perspective that health funding is limited and needs to focus on service delivery.

During discussions PHOs signalled that they would need considerable additional capability in order to undertake new roles such as coordination and management/ governance of provider contracts. This capacity already exists at the DHB, but not at a level that could be devolved to PHOs on a zero sum basis. In other words, there would need to be increased capacity overall. Various participants in the process also expressed more general concerns about the existing duplication of governance arrangements within the sector - between the DHB (and its various committees), PHOs, NGOs and Compass Health.

On the other hand, there is some potential for reducing administration costs through the use of common support services. Compass Health has a desire to provide support services to other provider organisations and in the medium term this might help offset some of the transaction costs.

It is important to note that providers and health professional groups were not the only ones with concerns about PHOs adopting greater contracting responsibilities. In meetings PHO board members were often concerned that adopting other roles (funding, etc) would undermine the PHO's relationships with these organisations, specifically that it would undermine cooperation, to the detriment of the PHO's ability to achieve its goals.

The sector was not unanimous in its view that PHOs should not adopt funding/contracting roles. There were a minority of provider and professional participants who were comfortable about the prospects of working under the auspices of a PHO. For example, pharmacists were generally supportive, sometimes even enthusiastic, about participating in PHOs. While it is unlikely that the core pharmacy contract would ever be able to be devolved to PHOs (it is a national agreement), it was felt that enhanced pharmacy services would work very well if contracted through PHOs. There are also other ways base pharmacy services can be drawn into PHOs, for example, through referred services management arrangements.

It should also be noted that a significant number of providers already have contracts directly with PHOs.

Within PHOs there was a minority but well articulated perspective that PHOs need to hold and manage contracts with providers in order to deliver the maximum health gain to their communities. Having contracts conferred on PHOs a number of benefits, including the following:

> Quote: *As a PHO it would be good to have a few more tools in the box*

- The ability to adjust contracts and services specifications to meet local requirements.
- More leverage with providers to achieve better coordination of services and to achieve the PHO's objectives.

- The ability to performance manage service provision so as to get the best possible outcomes for the community.

As already mentioned, PHOs already hold numerous contracts with a variety of organisations, including providers of first contact services and SIA services. Through Compass Health PHOs have invested in contracts management capability, which is critical for them as they manage their responsibilities.

There are a number of situations where it is not practical for PHOs to hold contracts for services. Core pharmacy services has already been mentioned as one contract type that is unlikely to be suitable for PHO management because it works on a national contract framework. There are also other providers that deliver care across PHO or even across DHB boundaries. Some of these are very important in terms of local primary health care outcomes – for example, ambulance services and Plunket services. In these cases contracting options are not available and other mechanisms for engagement are required.

The DHB funds some regional coordination services such as for immunisation and cervical screening. These are both very relevant to general practice and the DHB prefers that they be delivered through PHOs. However, it would be entirely counterproductive to split the services between individual PHOs. The practice to date has been to use a lead PHO which takes contracting responsibility on behalf of all the PHOs. This strategy has also been used with some services that are provided locally but that are too small scale to be split between PHOs.

The lead funder concept is used extensively by DHBs to manage contracts with providers and is regarded positively. On several occasions during meetings PHOs indicated their dissatisfaction with this model. The PHOs saw this as fundamentally inconsistent with their focus on local issues. The DHB will need to look at different ways of achieving the same outcome.

5.3. PHO as a provider organisation

Under the provider model, the PHOs would gradually assume responsibility for delivering primary health services. This would give them direct control over what services are delivered and how. It would improve coordination of activities and concentration of effort on priority activities. It would arguably be more efficient because it involves one lot of organisational overheads. If it extended to include general practice, it would enable issues relating to medical and nursing clinical practice and models of care to be addressed directly.

PHOs are already directly providing a range of health services, particularly those related to the DHB's service plan investment programme. This includes, for example, the diabetes service plan and the chronic care team. The latter includes smoking cessation, exercise and nutrition resources.

There were a few voices supporting this approach. One argument was that the primary health care sector is becoming very congested and inefficient because of the presence of a multiplicity of providers and consolidation of services within PHOs would provide much better value for money. Another suggestion was that PHOs should be free to take over and deliver services where there were performance issues with providers or where there are other specific advantages – e.g., efficiency reasons. This approach suggests that PHOs might work with a contracted provider for a time, but that if the desired gains did not eventuate, the service would be delivered by the PHO.

At the national level at least, nursing is supportive of PHOs employing primary health care nurses because it is seen as a way of overcoming the limits on nursing practice imposed by the employment relationship between the GP and Nurse within the traditional general practice. This is often associated with the private business model of general practice but in fact it seems more likely to be a function of the size of the general practice. Where practices are larger there is more potential for nurses to be employed within sound professional structures.

Despite these voices supporting PHOs assuming responsibility for the deliver of all or some services, PHOs, providers and professionals generally did not see a lot of value in the approach. Providers, quite rightly, perceived that such a move was detrimental to their interests. They were concerned about the loss of entrepreneurship, passion, flexibility and social capital that have been features of the health system in recent years. They were also concerned about the loss of volunteer effort, which is also a feature of many NGOs, and of consumer choice.

Providers pointed out that the move to a single provider of primary health services is contrary to government policy, which is to work with NGOs. It is also impossible or impractical for many services – for example, for pharmacies, which must be owned by a registered pharmacist. They also cautioned against the assumption that a single provider can provide all the solutions, or that it will be more efficient. General practice was cited as an example, where the need for a sustainable service model into the future is likely to require us to provide a range of different employment options, including independent business.

Quite a number of provider participants believed that PHOs should explicitly renounce the provider role and that they should always focus on coordination of others and possibly funding others to deliver services. Others felt it was acceptable under certain circumstances. For example:

> **Quote:** ***Its unclear when the role of the PHO switched from information and coordination to being a provider. That's not the model of a PHO we signed up to.***

- Short term to ensure service continuity – e.g., running a general practice that would otherwise have closed, pending transfer to a new provider or amalgamation with another service
- When no other providers are available or interested
- When there are specific service requirements that make the PHO the most sensible provider.

Another alternative was that PHOs should never be a provider, but that Compass Health could be the provider under a contract to the PHO, as would any other provider.

6. Discussion

The process highlighted support for the concept of PHOs and a commitment to working with PHOs from most parts of the sector. It also highlighted that the issue of the role and scope of PHOs needs further clarification and development if we are to get the full benefits of our commitment and the investment to date. The role of PHOs is a subject that is being debated extensively within the sector and there are many different views and perspectives. There is no consensus as to the answer.

There is, however, general agreement on some points. There was general agreement that the scope of PHOs should be greater than just general practice. It should extend to include engagement with agencies, individuals and skill sets with the purpose of adding value to the health of local communities. It is important that:

- PHOs retain their focus and be mindful of the resources they have available to them.
- Engagement between PHOs and other organisations and individuals should occur around priorities and plans, rather than opportunistically, because this is more likely to achieve health gains within the limited resources available.
- Engagement should begin with the core health services and move outward in a progressive process rather than occurring all at once.

In considering the three archetype relationships put forward by the DHB, previous sections also noted a strong preference for the umbrella role. This sees the PHOs fulfilling a coordinating and facilitating role at the local level based on equal, collaborative relationships with other agencies. Some people felt this was consistent with the original intention of PHOs, to which they had signed up.

The general view from the meetings was that the umbrella model of a PHO was still an ideal rather than a reality in our district. Providers, health professionals and even PHOs were concerned that more contractually based relationships would involve risks to them and their clients. In the case of providers, these risks arise from a range of concerns about the way PHOs are configured and functioning. These concerns do not just limit the PHOs' ability to assume the contracting role – they also impact on their ability to achieve the umbrella role.

The following sections will explore these concerns.

6.1. Provider expectation of PHOs

A very useful part of this engagement process has been the opportunity to identify the expectations different groups have of PHOs. They are significant, sometimes contradictory, and generally not consistent with the resources or realities of PHOs. They might be summarised as follows:

- By now there should be observable improvement in the health status of communities – particularly reductions in inequalities
- We should see change in the way services are delivered, particularly general practice services
- Providers should be engaged with, and participating in, PHO activities – at both governance and service delivery level

- Providers should have benefited from PHO activity by now – e.g., through investment in provider development, through improved relationships with general practice, and not least of all, through new services.

Reality for PHOs over the last few years has included the following:

- Contractual obligations for delivery of first contact services through general practice, which includes a host of operational responsibilities including management and development of a diverse group of providers and the logistics of ensuring service coverage is achieved and maintained.
- Delivery of various other contracted services.
- Centrally driven priorities and work plans such as implementation of the PHO Performance Management Programme, Care Plus, fees roll out, and the recently introduced general practice fees review process, most of which require extensive involvement with general practice.
- Implementation of the DHB's service plans initiatives, a significant proportion of which have gone through PHOs and be managed by Compass Health.

Provider perceptions of PHOs appear to reflect a lack of engagement with PHOs. This may be attributable to the fact that PHO emphasis has focused on the tasks outlined above, or possibly that interaction with providers has tended to occur around these tasks. Whatever the case, PHOs need to be far more active in their engagement with providers, moving well beyond the sphere of those they need to work with to achieve their contractual obligations. The engagement is essential to ensure that people's expectations of PHOs are consistent with the reality of what is being achieved.

6.2. PHOs as competitors

Providers and health professional groups judged that PHOs had so far engaged primarily and preferentially with general practice, disregarded other providers and in some instances duplicated services already provided by other providers or potentially provided by them. Some providers felt that some PHOs had set themselves, or Compass Health, up as a competitor to existing provider organisations. People struggled to differentiate between PHOs and Compass Health and many considered that PHOs were dominated by Compass Health, which they saw as a GP organisation.

The establishment of new services within PHOs clearly vexed many providers. They saw this as contrary to the original intention of PHOs, as evidence that the PHO was a threat to them rather than a partner and as an indicator that PHOs did not respect or value other providers. They also felt that PHOs had not taken time to integrate new services with those already existing in communities.

Here also we can see the effect of the sector's experience of the DHB's service plan investment. The PHOs' decision to deliver the new services rather than contract them from others was to some extent determined by the way they were contracted by the DHB. Responding to concerns from the sector that health professionals working in primary health settings need to be employed within appropriate professional frameworks, the DHB contractually required PHOs to work together to create district-wide cross-PHO clinical teams. The simplest option available to PHOs to achieve this requirement has been to create the teams within Compass Health. It also has had the added benefit of enabling the

PHOs to meet the DHB's requirements around management of the service establishment process.

On the other hand the service plan investment programme has had a number of effects on provider organisations. Of particular importance has been the impact of creating a significant number of new positions in what was already a tight labour market. This has given health professionals choice and opportunity and has resulted in the movement of staff between organisations, which has in turn created additional cost for some organisations. Some providers felt that they were in a competitive relationship with PHOs for staff.

It needs to be pointed out that it is not only providers that are uncomfortable with the PHOs taking on new services as part of the service plan implementation. GPs have also been dissatisfied. Their perspective is that the new clinical roles should have been located in general practice.

As well as competing with them, providers also complain that PHOs have encouraged competition between organisations, for example by using contestable RFP processes to allocate SIA funds. PHO intentions were to provide objectivity in the allocation of resources so as to avoid bias, to allow providers to exercise their imaginations and to get the best value for money. In the past the DHB has had similar unsatisfactory experience with contestable processes. Now the DHB uses strategy and planning processes to define the services needed, thus dealing with the bias and innovation issues, and RFPs to select the provider, which is the value for money aspect. This approach reduces the use of RFPs and increases their acceptability to the provider community when they do occur.

Clearly the outcomes achievable by PHOs are going to be less than optimal if providers see them as competitors. PHOs need to clarity their role in the sector and set some ground rules as to if and when the PHO will operate as a provider. The PHOs also need to clarify the respective roles of the PHOs and Compass Health. These roles need to be shaped in a way that makes sense to the sector.

6.3. PHOs' relationships with general practice

Providers were concerned that PHOs are dominated by general practice. They perceive the PHOs' approach to practices as supportive, protective and nurturing. This is true to a point. PHOs through Compass Health provide a lot of support to practices on a variety of different levels – including, for example, around information and business systems. But there is also a strong contractual dimension to the relationship, which extends into performance management where necessary.

The PHO/Compass Health view is that this relationship is necessitated by the contractual obligation on the PHOs to deliver first contact health services through general practice. Compass Health expressed a desire to provide similar levels of support in future to other provider organisations.

Another aspect of the criticism that PHOs are too general practice focused is a concern that PHOs have not achieved any significant change in general practice and haven't succeeded in resolving the numerous pressing problems with general practice (e.g., after hours, workforce, service coverage). A number of providers and professional groups expressed disappointment that practices have not integrated more with other providers, have not addressed high needs priority groups and have not changed their fundamental models of care in line with modern expectations – e.g., around chronic disease management.

International experience is that change in general practice is particularly difficult to achieve and requires a combination of different approaches over time. Experience in England is that as Primary Care Organisations (like PHOs) become larger, broader and more management oriented, their links with general practice diminish. PHOs need to continue to focus a significant part of their efforts on achieving change in general practice. Over the next few years the DHB will want PHOs through Compass Health to continue to work intensively with practices to address issues such as practice infrastructure and collaboration with secondary care. Only in this way will the district achieve a sustainable primary health care service. Again the sector as a whole needs to be aware of what work is being done with general practice and what is being achieved, and PHOs need to balance out support for practices with wider engagement with other providers.

6.4. Governance in PHOs

A number of people raised concerns about the independence and robustness of PHO governance processes. It needs to be noted that in most cases people had not participated in PHO governance processes or attended PHO board meetings. However, having said that, concerns were also raised by some people currently serving on PHO boards. Specific concerns varied and included the following: that Boards are dominated by GPs, that Board members represent their own sectional interests rather than the broader interests of the district and that conflicts of interest are not managed.

Another issue raised several times was that Compass Health, i.e. management, overwhelms PHO Boards. They felt that local issues tended to get lost in favour of debate guided by highly structured (and very large) agenda packs, most of which related to district or national issues, with the key decisions being made behind the scenes. A contrary view was that the support from Compass Health provides rigour and structure to PHO board discussions, which enables them to make more objective and rational decisions based on evidence, focusing their effort on health gain.

At one meeting providers talked about their concern that PHOs would change their strategic direction as a result of changes in Board composition. This reflects a perception that PHO governance and activity is driven by personality rather than by strategy and planning. Again, while there is undoubtedly room for improvement, Boards are increasingly basing decisions on objective, empirical information and formal plans. Compass Health plays an important role in this respect, providing a professional context for the issues considered by Boards.

How people judge the functioning of individual PHO boards relates a lot to perceptions about the underlying purpose of PHO boards. Views on this subject might be characterised as occurring on a continuum. At one end is health governance in the traditional sense of the word. This means exercising governance in relation to the PHO's contractual and legal responsibilities and over those services the PHO funds. This is clearly a very important function within PHO organisations. At the other end of the continuum, there is community participation and the expectation that PHO boards are an exercise in the broader "umbrella" function previously discussed. In this case, representativeness of the board is important and one would also expect a broader scope of debate around the board table. The reality is that PHO boards need to cover both dimensions on the continuum, but health governance is a prerequisite function and needs to be the start point because of its critical importance if our communities are to continue receiving first contact and other services contracted

through PHOs. Community governance can be developed over time as PHOs grow and mature.

The appropriateness of the structure of PHOs was raised on several occasions. Three PHOs are limited liability companies owned by GP shareholders. Some people saw this as a significant problem. An example was given of how dysfunctional this arrangement is: a well attended PHO AGM could not pass any resolutions because there were no shareholders present. On the other hand, the constitution of these PHOs was set so as to give contracted providers some level of comfort and security about the organisation they were committing their fate to. The constitution does not limit shareholding to GPs but includes any contracted provider. A number of non-GP contracted providers are already shareholders and more may choose to be so in future.

There was also a feeling that overall the composition and functioning of PHO boards has improved steadily over time. PHO boards have good representation. There is undoubtedly room for further improvement, including greater maturity in dealing with conflicts of interest. It is important to recognise the commitment and efforts of the board members and the difficulty of the role. Process are open to the public, providers are welcome to attend, which is often overlooked.

6.5. Local teams and district-wide coordination

The direction of travel expressed in the local Primary Health Care Strategy is from centralised specialist services towards enhanced local primary health care teams involving both specialist and generalist services. There is a challenge in this. Providers and professional groups identified a number of concerns about the preservation of district-wide services, including:

- Maintaining critical mass for some professional groups.
- Providing district wide functionality – e.g., emergency response capacity.
- Maintaining and developing expertise by association with specialist services, e.g., at Palmerston North Hospital.
- Providing appropriate professional frameworks within which health professionals can be employed.

These are all valid concerns, however it is arguable that the architecture of PHOs in our district (i.e., 4 PHOs supported by a common MSO) can address them. Some of these issues were raised when the DHB was rolling out the new clinical positions created through the service plans. In response the DHB framed contracts so that PHOs were required to work together to ensure that staff were employed in district-wide teams with appropriate professional structures. There was also a requirement to work in concert with hospital based specialist services within the continuum of care model. This was seen as providing a balance between district frameworks and local teams.

Generally, however, participants in this process wanted to see a continuation of the current pluralistic approach to primary health care. They wanted to see PHOs play a role in providing coordination and focus for service providers for the benefit of service users and the community at large. From the process there was also some evidence that relocation of services to PHOs is not necessarily a prerequisite for change. During discussions many good and bad examples were cited of relationships between services and organisations. Ownership was not a common factor in these, but interaction was. Where there was a

significant level of contact between a PHO and the provider, and more importantly between clinical staff of different services, the relationship often seemed to work well.

Some providers obviously make a conscious effort to interact with PHOs and enjoy the benefits of it in terms of positive relationships. However, there was still a concern that these providers are liaising in the pursuit of their own service goals, rather than engaging in collaborative activity towards shared goals. There is a strong feeling within PHOs, Compass Health and general practice that there are health gains to be made through collaboration between PHO services such as general practice and chronic care teams and other primary health services – particularly those provided by MidCentral Health such as District Nursing, Public Health Nursing, specialist community services and Public Health services.

Collocation was mentioned as a positive contributor to collaboration on several occasions. Where services work together within a common facility, relationships are usually much better and primary health care teams are easier to achieve. Unfortunately within the sector there is very little capacity for collocation. General practice is a good case in point. The service plan-roll out process showed that most general practices have very limited ability to accommodate additional team members. Furthermore, having general practices spread across the district in small isolated teams provides a major logistical barrier for any other service wanting to collaborate with them. This is an issue that the DHB has been discussing with the general practice providers through the second *Looking Forward: Towards 2010* paper *From Corner Dairy to Sustainable General Practice*.

Whether coordination and facilitation within an umbrella model is sufficient to achieve change will be determined by the willingness of provider organisations and professional groups to support and respond to change. It is not going to be enough to liaise in the pursuit of a provider's individual service goals. There needs to be real collaborative activity within the primary health care arena. This is made more difficult by the fact that the end point of change – in this case the future configuration of services – has not been identified, nor is it likely to be in the near future. In general, it is clinical staff changing the way they relate that will drive change. Clinical leadership is the key and it can come from within any organisation – PHO, provider, professional group or DHB. All organisations need to actively promoting clinical staff to lead change.

6.6. PHO-DHB relationships

Comments from PHOs boards and Compass Health staff during the process indicate that the DHB is not always making life easy for the PHOs. The DHB is committed to a strategic pathway that was developed with significant sector input but which occurred in parallel with the establishment of PHOs. PHOs appear to have found it hard to get on board with this strategic pathway and consequently experience each of the implementation steps as a contractual obligation. PHOs have also set about developing their own strategic pathways, and have sometimes done so in isolation from the DHB. This situation creates potential uncertainty for providers. There is clearly a need to link together DHB and PHO planning and funding. This should occur at each level, It should begin with the three yearly Health Needs Assessment, which becomes a collective agreement on the key issues within the district. The next step is the three yearly District Strategic Plan, which becomes a collective agreement on what is to be done. The third step is the District Annual Plan, which is the annual statement of activity.

7. Conclusion

The local Primary Health Care Strategy has charted a pathway for the development of health services within the district. This pathway involves a shift in balance from centralised specialist services towards enhanced multidisciplinary primary health care teams delivering services at the local level. PHOs are a key ingredient in this equation as has been the Service Plan investment programme. The Strategy has a provided a framework for the development of PHOs which is now in place.

Through the engagement process on the *Building Capacity* paper the DHB has observed widespread support for the concept of PHOs and a willingness to interact with them for the benefit of the community. There is a strong sense that PHOs are local organisations and exist to coordinate and facilitate services in specific communities to address local issues. The architecture of PHOs in our district gets a resounding thumbs up. People supported the existence of four PHOs based on TLA boundaries, serving geographical populations rather than enrolled populations. People could also see the benefits of having a single MSO to support the four PHOs.

There was also a strong feeling that PHOs need further fine tuning to fulfil their potential. In particular, there were significant concerns about the clarity of role and scope of PHOs and the relationship between PHOs and Compass Health.

People recognised that because primary health is a complex sector characterised by many passionate independent agencies, a single model of role is unrealistic. PHOs will need to have a variety of roles – some services they will coordinate, some they will contract and some they will provide. However, having said that, there was a reluctance to see relationships with the PHOs progress beyond "cooperation" into any sort of relationship that involved the PHOs in a governance role over other providers. A range of factors were behind this reluctance. Many related to PHOs' ability to deliver an environment in which other providers would prosper. Another set of issues related to PHOs' ability to sustain district-wide connectedness and continuity.

Nearly all of these issues would seem to be manageable within the current PHO architecture and with the good will of all the stakeholders. It is essential that these issues are addressed because they also undermine PHOs' ability to fulfil even the umbrella role.

Whether the umbrella model will be adequate to achieve the goals of the local and national Primary Health Care Strategies will depend to a large extent on how responsive the stakeholders within the sector can be. In particular, whether they can reconfigure their services and organisations around the demands of emerging primary health care teams. Relationships are the key to this.

Over time there may be a natural tendency (i.e., by mutual agreement) for PHOs to take on responsibility for overseeing services delivered by other providers. When situations arise in which the umbrella approach is not resulting in increased collaboration and progress towards the desired outcomes, the DHB may need to take a more hands on approach. This may involve the DHB using the resources available to it to facilitate an outcome that is acceptable to all parties.

The engagement process has provided very valuable feedback that all organisations will be able to use to improve the way they relate to others. Some of the highlights are as follows:

PHOs

There is an opportunity for PHOs to improve their relationships with providers by improving clarity and engagement.

- PHO's need to develop a vision for the future of primary health care services at the local level. They need to do this with input from local stakeholders, particularly providers, and it needs to align with the DHB's direction of travel and workplan.
- Although the respective roles of the PHO and Compass Health are perhaps clear to some of the participants, they are not clear to the rest of the sector. PHOs need to work to simplify these roles and relationships. There needs to be transparency and fairness.
- PHOs have an opportunity to improve relations with providers by declaring their commitment to NGOs and other providers and their intention to provide an environment that nurtures them. This might include the offer of providing support services to them through Compass Health.
- More specifically, providers are concerned about competition and conflict with PHOs. Clearly the perception of competition is inconsistent with collaboration. This can be addressed if PHOs are clear about whether, or under what circumstances, the PHO (or Compass) will deliver services. This could be formalised in a set of business rules or in an MOU format with providers.
- PHOs need to broaden out the range of organisations they are working with, but it needs to occur on an organised basis, working around priorities and projects that are linked to strategy. This will be easiest to achieve if the PHO has an easily articulated vision and a workplan.
- PHOs need to engage with local providers, even if they are not working with them today.
- The sector needs PHOs to continue working with general practices to get them aligned with the Primary Health Care Strategy. This includes taking some responsibility for the vision for local configuration of services, sustainability, as well as the more prosaic issues such as after hours cover and patient enrolment.

DHBs

The DHB's commitment to working with PHOs in primary health care is good, and is well understood in the sector. The DHB needs to review its policies and work practices to ensure that they are contributing to the development of PHOs.

- The DHB needs to engage PHOs in planning and strategy development. This begins with the three yearly Health Needs Assessment and District Strategic Plan. These documents should represent a perspective on the communities' health needs and priorities for action which is held across the sector.
- The DHB needs to engage more with PHOs. In the past engagement with PHOs has occurred mainly through Compass Health and has been focused on contracts. PHO and DHB staff need the opportunity to interact on a broader range of issues.
- There are some specific policies that need to be re-examined. For example, the way the DHB contracts PHOs would seem to contribute to provider perceptions that PHOs are providers. Also, the Lead PHO concept would appear to be causing tension.
- The DHB should look for opportunities to involve PHOs as a partner in funding/contracting activities where appropriate.

There are also some issues relating specifically to services provided by MidCentral Health, the DHB's provider arm. These services need to work much more closely with PHOs, providers and the primary health care sector.

- The Public Health Unit needs to form strong working relationships with PHOs. Population health is an area of real interest to PHOs and an area in which the Public Health Unit has expertise and resources. There needs to be coordination and leadership across the district if we are to maximise the potential of the resources that have been invested, but we can expect that this will take time and commitment to work through.
- District Nurses need to be integrated into local primary health care teams. Existing District Nursing roles are strongly determined by the prevailing division between primary and secondary sectors. This interface is going to change as specialist expertise is increasingly moved into the primary health care sector. This will provide District Nursing with an opportunity and a challenge to redefine its role and relationships. This needs to occur in collaboration with others as part of a primary health care team. There is an opportunity for clinical leadership to come from within District Nursing.
- Public Health Nursing is part of primary health care but also has some district-wide responsibilities. The latter does not preclude Public Health Nursing from being part of local primary health care teams.
- Secondary care services need to free up clinical staff to engage with primary health care in the redefinition of the primary secondary interface. This engagement process and developments elsewhere have demonstrated enormous enthusiasm in some departments.
- Secondary care services also need be thinking about the future configuration of services. The shift in emphasis towards primary health care will transform ambulatory care services, particularly specialist outpatient services. It will impact in the short term on diabetes, cardiovascular and respiratory services.

Providers

Providers need to look for ways of improving their interactions with PHOs.

- Provider's contribution to the development of the sector would improve significantly if expectations were more realistic.
- Providers need to take the opportunities to engage with PHOs. This includes being involved in PHO planning and strategy. Providers can also recognise that in many instances PHOs will be working on priorities and tasks that do not relate directly to the provider.
- Accept that PHOs are here and that they will have an impact, and that sometimes the impact will be uncomfortable.
- The sector at this time is looking for leadership, particularly clinical leadership. This leadership can come from within provider organisations.
- Providers have opportunities to explore the support that Compass Health might provide them, for example, by way of a bureau of services.