

Building Capacity of Primary Health Organisations to Meet Population Health Objectives

March 2007

CAPACITY SUSTAINABILITY COLLABORATION INNOVATION

towards 2010



1. Background

In 2003 MidCentral District Health Board (DHB) released a local Primary Health Care Strategy that had been developed after 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 provided the following:

- a blue print for the development of Primary Health Organisations (PHOs)
- a pathway for increasing the capacity of the primary health care sector to meet community needs, with particular emphasis on the development of primary health care teams
- a focus on the need for the DHB to work with the sector to improve management of priority areas, particularly chronic medical conditions and service areas such as mental health.

The vision in the local strategy is built on strong, diversified, local primary health care teams working collaboratively to address the health needs of individuals and local communities. As with the national strategy, the ultimate goals are improved health outcomes for communities and the reduction of inequalities.

PHO development in MidCentral's district has followed the local strategy and is quite unique within the national context. There are four PHOs (Otaki, Horowhenua, Manawatu and Tararua) serving defined geographical areas. These areas correspond to Territorial Local Authority boundaries and align with the DHB's Health Needs Assessment. The four PHOs share a single Management Services Organisation, Compass Health. As a consequence of this structure MidCentral's PHOs have the best possible foundation for delivering on the aspirations of the national and local primary health care strategies. They are well placed to enable local community and provider engagement and to respond to local issues and priorities. On the other hand they also benefit from the economies of scale, access to specialist expertise and standardisation that come with a much larger organisation.

Achievement of the goals of the national and local primary health care strategies require coordination and focusing of effort at the local level. They require a combination of personal health and population health strategies. This is the role for which PHOs have been created. At present PHOs occupy a somewhat ambivalent position. While they have been set up to address population health goals such as health inequalities, the resources they command are predominantly limited to general practice. There is a range of other primary health care resources in our communities. These services are funded by District Health Boards directly and by other agencies such as the Ministry of Health. The multiplicity of funders of primary health care services carries with it a number of problems and risks – for example, non-alignment of priorities between funders, potential for funding gaps and for duplication of funding, and the imposition of increased transaction costs on providers.

At present the relationship between PHOs and the various other providers of local primary health services (both personal health and population health) is based on cooperation. In some instances PHOs have developed funding relationships with Non Governmental Organisation (NGO) providers. In other instances there is little contact.

The DHB believes that the capability and capacity of primary health organisations to meet population health objectives such as better health outcomes can be improved by better coordination of primary health care activities. The purpose of this paper is to create discussion amongst NGOs, PHOs and the community about how relationships in the primary health care sector might be developed to the benefit of all parties and in particular how the role of PHOs might be enhanced. For the purposes of discussion, three potential roles have been identified:

1. Non Governmental Organisations (NGOs) and other primary health care providers continue to work with PHOs on a collaborative basis, with relationships improving over time
2. PHOs become the funder of local NGO and other primary health care services
3. PHOs assume responsibility for providing all local primary health care services.

2. Scope of this Report

The scope of this report includes the following services:

1. Non Governmental Organisation (NGO) providers of primary health care services. These are independent not-for-profit organisations
2. Community services provided by MidCentral Health (MCH), the provider arm of the DHB. These services include district nursing, school dental, specialist community nursing, public health nursing, health promotion, community paediatric services and sexual health services
3. Independent businesses providing health services on a "for profit" basis. These include laboratory, pharmacy, radiology, primary maternity, NASC and general practices.

This paper considers future relationships between PHOs and providers of primary health care services. It does not discuss the issue of how a new set of relationships might be created (the change process). Once we have identified the future alignment of PHOs and providers we can begin to develop a transition process. Any transition process will be consistent with the national policy that NGO participation in PHOs should occur be mutually beneficial.

There are particular issues relating to Maori provider organisations and the Treaty of Waitangi that need to be considered. These issues are not explored in this paper. It is important to note, however, that services "by Maori and for Maori" are a critical component of primary health care services. Furthermore, it is not possible for PHOs to achieve health objectives without engaging with Maori and Maori providers.

3. The Primary Health Care Strategy

In 2001, the Government published the New Zealand Primary Health Care Strategy. The overarching goals are to improve health, to improve access to primary health care, and to reduce health inequalities. A key platform of the Strategy is the creation of Primary Health Organisations. The Strategy calls for a focus on wellness and population health, better co-ordination of care and collaboration between providers, more multi-disciplinary teamwork with expanded roles for nursing, better management of on-going medical conditions, and increased investment in the primary health care workforce capacity. These objectives reflect the desire expressed within the Strategy to broaden primary health care from its traditional focus on general practice to a more multi-disciplinary effort combining biomedical and population health approaches to meeting the health needs of communities.

A central feature of the Strategy has been the establishment of Primary Health Organisations (PHOs) throughout the country. PHOs are independent (ie, non-governmental), not-for-profit organisations and there is an expectation that providers and health professionals will participate alongside local people (including Māori and Pacific Island communities) in their establishment and on-going operation.

PHOs are expected to work with local health care providers to develop new primary health care services appropriate to the needs of the local community, working in partnership with other providers. PHOs are expected to achieve both regional and national priorities and meet local needs, and to move all services in the direction indicated by the Strategy. Thus, PHOs are, in essence, the main agent for achieving the goals of the Strategy at community and service delivery level. Participation in PHOs by stakeholders, including general practice and the community, is seen as an important driver of change

The Primary Health Care Strategy (PHCS) places the emphasis on knowing our population and being smarter in our design and delivery of services. The Primary Health Care Strategy describes PHOs as the local structures for organising the delivery of services around the needs of their enrolled populations. In the first instance PHOs have focused primarily on improving health outcomes through general practice organisations and their enrolled populations. It was never intended to stop at that point but to create primary health structures that could have greater knowledge and ability to affect the health status and resolve the health inequities that still exist.

At present a wide range of organisations deliver primary health care services, most of which exist formally outside of PHO structures. The Primary Health Care Strategy is not explicit about the role and future of these organisations within PHOs and the primary health care context. This lack of clarity has been a significant concern to the Non Governmental Organisation (NGO) sector. (Best Fit for non-government organisations in primary health care, MoH 2006).

The Government has, however, expressed its commitment to building strong and respectful relationships with community, voluntary and iwi/Māori organisations, and recognised the unique and vital role these organisations play in New Zealand society (Statement of Government Intentions for an Improved Community–Government Relationship, 2001). Government and the community sector depend on each other to achieve shared goals of social participation, social equity and strengthened communities.

Recently the government released *Best Fit for NGOs in Primary Health Care* (2006), which further develops policy settings concerning NGO providers of primary and population health services and PHOs. Key features of the policy are as follows:

- In order to achieve the Primary Health Care Strategy's vision of better population health outcomes and reduced inequalities, all key stakeholders, including PHOs and NGO service providers, need to be fully engaged, working collaboratively and 'fit for purpose'
- the Ministry of Health and DHBs need to ensure that their strategic approach promotes collaboration among key stakeholders to realise the vision, rather than competition for resources.
- NGO providers will be encouraged to affiliate and contract with PHOs, however this should be voluntary for NGOs as it is for other health practitioners. Transfer of contracts to PHOs should be based on mutual benefits.
- A flexible, local approach is needed to the issue, because a one size fits all approach will not work.

The direction of these policy settings is towards closer alignment of PHOs and NGO providers of primary health care services. The policy settings also provide some guidance in terms of how relationships might be modified. This will need to be taken into account in future papers.

4. MidCentral PHOs and Progress to date

In the MidCentral District the development of PHOs was guided by the local Primary Health Care Strategy (2004). It called for an evolutionary approach built on community and stakeholder initiative (rather than DHB driven), geographically based PHOs responsible for total population groups (rather than population subsets), and meaningful participation by Maori and community.

The result of this has been the establishment of four PHOs ranging in size from 6,000 enrolees to 97,000 enrolees. The following table identifies the PHOs:

PHO Name	No. enrolled (01/04/2006 quarter)	No. enrolled Maori - 01/04/2006 figures	No. enrolled Pacific - 01/04/2006 figures	% of Census Population enrolled in PHO
Horowhenua PHO	25,098	4,715	673	84%
Manawatu PHO	97,059	10,664	1,678	98%
Otaki PHO	6,156	1,922	104	79%
Tararua PHO	15,256	3,030	64	85%
Totals	143,569	20,331	2,519	93%

Otaki PHO has been established as a trust. The other PHOs are limited liability companies. All organisations comply with the Ministry of Health's PHO minimum requirements in terms of not for profit status, Maori and community participation in governance.

MidCentral DHB's Primary Health Care Strategy also called for the establishment of a single management services organisation to support local PHOs to enable them to benefit from economies of scale and district-wide coordination of activities. This has now come to pass with the formation of Compass Health Limited. It is contracted to provide management support services to all four PHOs.

The predominant focus of PHOs to date has been general practice. This has arisen if for no other reason than because first contact primary health care services are the minimum requirement for PHOs and generate the bulk of PHO income. General practice is not, however, the entirety of PHO funding streams.

PHO funding streams

- Capitation, Careplus and Performance Management Programme funding streams which are all paid out to practices,
- Management fees for the operation of the PHO,
- Services to Improve Access funding to address the health needs of population groups that have not previously accessed enough primary health care. PHOs have invested this funding in a wide variety of general practice and NGO based initiatives.
- Health Promotion funding, which has been allocated to health promotion initiatives

The presence of Services to Improve Access and Health Promotion funding (in particular) has seen PHOs begin to engage with other, non-general practice services.

Locally the DHB has invested additional resources in PHOs as part of the implementation of Diabetes, Cardiovascular and Cancer service plans. In total an additional 40 full time equivalent positions have been created through the four PHOs.

The DHB has also invested workforce and infrastructure development in the primary health care sector, both through PHOs and through other agencies. Support includes funding to general practice teams and to individual professional groups. Particularly relevant is the investment in the development of primary health care nursing through the Nursing Development Team.

Other Providers of Primary Health Care

In addition to PHOs and general practice there is a wide variety of other providers of primary health care services in the district. Most, but not all, providers delivering primary health care services are contracted through the DHB. Some are contracted by the Ministry of Health. The following table identifies the range of services provided by NGOs, MidCentral Health and Independent Business:

Primary Health Care Services Not Provided by PHOs

NGO	MCH	Independent Business
Community nursing services	District nursing	Laboratory
Mental health	Specialist community services	Pharmacy (national contracts)
Sexual health services	Public health nursing	Radiology
Women's health	Health promotion	Independent Midwives
Youth health	Community paediatric service	Adolescent dental services
Rural inpatient beds	Sexual health services	Emergency dental services
Tamariki Ora	School dental services	
Whanau Ora		
Healthy lifestyle		
Mental health services (including A&D)		

The relationships between PHOs and other primary health care providers vary significantly. Some providers are represented on PHO Boards and/or hold contracts with PHOs. Other providers operate independently with few connections to the PHO.

Health Status within the District

The 2005 Health Needs Analysis highlighted the fact that the health status of MidCentral's population is below the national average in a number of critical areas. In particular, deaths through cardiovascular disease and cancer are higher than would be expected based on population demographics.

Furthermore, the Needs Analysis also highlighted the presence of inequalities of health outcomes within the district. Maori health outcomes are consistently poorer than non-Maori across the district. The health status of Horowhenua residents is also consistently poorer.

There is evidence within the district of Hart's Inverse Care Law which describes the tendency for people with the greatest health need to receive the least health care.

Due to the lack of data from the primary health care sector, the Health Needs Analysis is based on secondary care data such as hospitalisations and death. Even so it is striking that the conditions highlighted as of concern are all best controlled in the primary health care sector. This relates particularly to the management of chronic disease.

The combination of resourced, coordinated and focused district wide programmes targeting specific priority health areas and effective PHOs coordinating services for populations at the local level present the best possible chance of improving the health of our communities. This is the context within which the DHB has committed to the development of PHOs. It also explains the importance attributed to a unified local focus on improving health status and reducing inequalities.

5. Defining the Critical Issues

This part of the report defines the critical issues that need to be addressed if we are going to achieve the objectives of the national and local primary health care strategies. These issues become the indicators against which potential options can be measured.

Funders and Providers

Our primary health care system is characterised by the involvement of a multiplicity of agencies organised through a system of contract and funding relationships. Some primary health care providers have contract and funding relationships with PHOs but most providers have contract and funding relationships with the DHB or Ministry of Health. Some providers have relationships with multiple funders.

Essentially there are six funders of primary health care in our district – the four PHOs, the DHB and the Ministry of Health¹. The funding priorities and contract arrangements (eg, pricing, reporting) for each funder vary. This is inefficient at least. There is significant risk that the activities of the various funders will not be coordinated or that they will not be able to get the best return for the limited resources available. In this sense funding and contracting relationships are working against the goal of primary health care strategy, which is towards greater collaboration and better managed care. The first critical issue is therefore:

Critical Issue 1: Simplify the organisational and contractual structures between organisations and align them with key strategic directions.

¹ Note in addition to these 7 agencies funded from Vote: Health there are other agencies such as the Accident Compensation Corporation, Work and Income New Zealand, Territorial Local Authorities and patient fees and charges.

Broadening the Role of PHOs

If PHOs are to fulfil the vision of the Primary Health Care Strategy they need to broaden their scope beyond general practice. They need to engage the full range of personal health and public health services. Specific benefits that might be looked for include the following:

- Improvements in services through local management (as opposed to DHB level)
- Better networking between agencies because of direct, local relationships
- Better targeting of resources to local needs
- Improved community participation through PHO mechanisms
- Clinical gains as a result of coordinated multidisciplinary service delivery.

Primary Health Care Teams are at the centre of MidCentral DHB's Primary Health Care Strategy. The concept of primary health care teams is based on a static or predetermined mix of professions or functions. Rather it is seen as dynamic and responsive according to the defined need of the population and within that the individual.

The ability to create these teams is constrained when both service delivery is fragmented between providers and funding is fragmented between funders.

Critical Issue 2: Support the creation of primary health care teams that are dynamic and responsive to defined need

PHOs and Primary Health Care Services delivered by NGOs and Independent Business Services

Health resources are always constrained and the constraints are not always financial. In many instances constraints include the professional workforce and other factors, such as information and facilities. As a sector we need to take advantage of economies of scale and the greater effectiveness that can be achieved through synergies between organisations and professional groups (e.g., in primary health care teams). This includes providing services that are designed around patient need and not service function.

Better coordination of services to our communities needs to occur at the local level. It requires an understanding of both the local health needs and local resources available.

NGOs and Independent business are by definition autonomous organisations. Their autonomy and entrepreneurial spirit is part of their culture. Many of these organisations formed as a result of a passion to meet a specific community need or health service gap. Some times against the odds they succeed due to their entrepreneurship. It is important that autonomy, entrepreneurship and passion are retained within the system.

The health service can ill afford additional costs as a result of duplication of services or the transaction costs associated with managing relationships. This is particularly an issue where an NGO or Independent Business has dealings with more than one PHO. There is also

potential for these organisations to face conflicting strategies, priorities and messages between the four PHOs.

There are some NGOs and Independent Businesses that do not logically fit with PHOs. For example, Plunket is a national organisation and contracts directly with the MoH. Some are so specialised and function specific that splitting the resource would create functional critical mass issues, for example laboratory services. It would be necessary to develop other mechanisms to manage these contracts.

PHOs also need to have the capacity to manage new responsibilities. There would be great demands on their ability to lead significant service changes. PHOs are established but have had very little time to consolidate their activities and then explore their strategic opportunities. More change could find PHOs struggling.

Maturity in PHO governance processes is also relevant if PHOs are to manage NGO contracts. This might involve a clear separation of governance and management responsibilities and an absence of sectional interests dominating board processes. This would be necessary to avoid create conflict or worse the loss or reduction in the capabilities that exist in the primary care setting now. One of these capabilities might include the trust and relationships that exist between providers and the patient/client/customer.

Lastly, there is the tangible cost of change. The resource requirements to negotiate services and develop contracts, the cost of team changes are all very tangible costs to making change. These efforts will, if only temporarily, distract service delivery providers from their work.

There are number of issues discussed above but the critical issues are:

Critical Issue 3: Gain improvements in efficiency and effectiveness

Critical Issue 4: Create strong local relationships and patient oriented services

Critical Issue 5: Create population intelligence

Critical Issue 6: Retain entrepreneurial spirit and innovation

Critical Issue 7: Make any change manageable.

PHOs and Primary Health Care Services Delivered by MidCentral Health

MidCentral Health (the DHB's provider arm) delivers a range of primary health care and public health services that might usefully be incorporated within the PHO framework. These include the following:

- District Nursing Services
- Specialist community services (community referred), including diagnostics
- Community Paediatric Service
- Public Health Nursing
- Health Promotion

Currently these services work with general practice to a greater or lesser extent. The relationships often rely on formal referral processes, whether it is for diagnostic tests or community nursing services. Clinicians are generally focused on solving the individual's immediate health problem. Dedicating time to other matters and conducting a level of informal communication is variable at best. Communication of this type is totally dependant on the clinicians' dedication to commit time.

There is potential to streamline the services people receive. This means services can be more patient orientated and less function orientated. There are daily examples where patients/clients/customers receive contradictory or even conflicting advice, both being fine in their own right but confusing and potentially dangerous when combined. With a single point of coordination, from a complete and comprehensive team, the outcomes for the patient may be better and certainly any duplication of human, medical and diagnostic resource would be reduced. Under this scenario the transfer of the duty of care would alter. The potential gain for the health sector is better utilisation of our stretched secondary resource through a reduction in specialist follow-up work.

A realignment of these services to PHOs would avoid the possibility that the services will be replicated in primary health care. It would help build critical mass in the PHO environment and would contribute significantly to multidisciplinary teams.

What are the potential risks and problems?

Currently these functions enjoy the benefits that exist within a large organisation. These include the critical mass dynamics associated with some of these service areas and also important professional development and alignment considerations. Generally these services are of a more specialised nature than other primary health care services and the training, development and support is sustained by the association with hospital specialties.

A core function of MidCentral Health's community health services is to facilitate discharge from hospital. This is mission critical for MidCentral Health and is also a major risk factor for the broader health system, if for no other reason than its potential financial impact. Any

change in organisational alignment would have to be managed in such a way that the hospital discharge function was highest priority.

To have these resources distributed would create some new challenges. While creating critical mass for the primary care environment it comes at the cost of breaking down the critical mass of the community nursing functions. Attracting high calibre workforce for these functions has been possible due to this critical mass. The risk of a distributed model is the loss of the ability to have functional specialists like Health Promotion that currently have difficulties across the country in attracting good health promotion workforce.

Lastly there will be issues of confidence in secondary care clinicians releasing patients at the earliest stage. Under the current system the clinicians have influence over the skills and systems under which the community nursing care delivered in the community. This provides them a level of confidence that they can confidently release a patient into the community early.

Given the issues raised above it is unlikely that MCH's primary health care services could be moved to PHOs in the short term without introducing significant risk into local health services. Further work would be required on a multi-party basis to develop service options. Stakeholder buy-in from all parties would be essential.

Critical Issue 8: Improve coordination of care and reduce duplication

Critical Issue 9: Improve interaction between primary and secondary care, and between public and personal health

Critical Issue 10: Support the professional development of community specialists

Critical Issue 11: Facilitate early discharge of hospital patients into the community

Summary of the Discussion Section

The key points from this section are:

PHOs are a very strategic component of the delivery of primary health care service. This means the MoH and DHB are placing the responsibility for improvement in health outcomes and addressing health inequalities in our district with PHOs. PHOs need to have capabilities and be competent in each of the specified capabilities if they are to succeed in this very tough challenge.

As part of the sector development it is important that services are coordinated and structured in a manner that allows PHOs to develop sector capabilities and capacity. This means there is an opportunity for PHOs to provide leadership alongside NGOs, Independent Business and MCH community services in developing a capable and competent primary health care sector.

The next section summarises these critical issues. Three alternative pathways are then discussed and measured against their ability to meet these critical issues.

Summary of Critical Issues:

Critical Issue 1: Simplify organisational and contractual structures between organisations and align them with key strategic directions

Critical Issue 2: Support the creation of primary health care teams that are dynamic and responsive to defined need

Critical Issue 3: Gain improvements in efficiency and effectiveness

Critical Issue 4: Create strong local relationships and patient orientated services

Critical Issue 5: Create population intelligence

Critical Issue 6: Retain entrepreneurial spirit and innovation

Critical Issue 7: Make any change manageable

Critical Issue 8: Improve coordination and reduce duplication

Critical Issue 9: Improve interaction between primary and secondary care, and between public and personal health

Critical Issue 10: Support the professional development of community specialists

Critical Issue 11: Facilitate the early discharge of hospital patients into the community

6. Alternatives

This section describes three alternative pathways to bring NGOs, Independent Business and MCH community services closer to PHOs. Each alternative is then tested against each critical issue to provide further understanding of their relative merits.

- NGOs and other primary health care providers work with PHOs on a collaborative basis to meet the health needs of our communities
- PHOs assume responsibility for funding local primary health care services
- PHOs assume responsibility for providing local primary health care services

Alternative 1 - NGOs and other primary health care providers work with PHOs on a collaborative basis to meet the health needs of our communities

The first alternative is that the existing contracting and funding arrangements remain in place and that PHOs continue to develop collaborative linkages with primary health care providers as they can. This approach allows that NGOs may wish to stand apart from the PHO, to enter into some form of non-contractual relationship with the PHO, or to join their local PHO as a contracted provider. If the latter is the case the funder (usually the DHB) would transfer the contract and funding when requested. In summary the position is non-directive and any change would be voluntary on the part of providers and PHOs.

This approach would see organisations with a positive relationship working together. Longer term it would demonstrate to other community providers the potential gains and positive outcomes that joining a PHO can provide.

One disadvantage of this approach is that it will be an evolutionary process. It relies on PHOs having the leadership capability and capacity to effectively engage and manage successful relationships.

The benefit of this slow approach is that it would preserve existing capabilities and capacity of the community providers while ensuring a positive change in the organisations. This is likely to create better internal working relationships and team synergy. The experience and people skills are more likely retained under this approach as people will more readily see the benefits and have belief in the changes.

In summary this approach is provider-led. It does allow for a slow and steady approach to collaboration but the organisational structures, funding and contractual relationships will remain complex and out of alignment with the desire to develop patient orientated service delivered by dynamic primary health care teams.

Summary: Alternative One

No.	Critical Issue Description	Does the Alternative Resolve the Issue?
1	Simplification of organisational and contractual structures	No
2	Primary health care teams that are dynamic and responsive to defined need	Likely but slow and limited progress
3	Creating economies of scale	No and any progress would be limited progress
4	Creating strong local relationships and patient orientated services	Likely but slow
5	Creating population intelligence	Unlikely
6	Retaining entrepreneurial spirit and innovation	Yes
7	Making any change manageable	Likely
8	Reduce duplication and patient confusion	No
9	Reduce the divide between public and personal health	No
10	Continue the professional development of community specialists	Status Quo
11	Continue the ability for early discharge of patients into the community	Status Quo

Alternative 2 – PHOs assume responsibility for funding local primary health care services

This alternative involves PHOs assuming responsibility for local funding of primary health care services. Existing providers would continue to deliver services, but under contract to the PHO rather than the DHB or Ministry of Health. Accountability lines would be to the DHB through the PHO.

This alternative would require the PHOs to provide a contracting and funding environment in which NGOs and other providers can operate in a sustainable manner. Trust between PHOs

and providers would be key. The PHO would need to be able to decide how it best meets the needs of its population and how to invest and divest accordingly.

This alternative is building on the current primary care system. It builds the sophistication of the system in a manner that might be considered to be more oriented to patient and community health needs as opposed to provider led.

Under this alternative the PHO would have responsibility for understanding the population's health and be in a position to design services and allocate resource. NGOs and Independent Business will remain independent and will work very closely with the PHO. They will continue to focus on their strengths and their relationships with their community. They will also obtain resource from the PHO and share information on their communities.

Adding to the current model will be the PHOs networking with the primary care providers in the same fashion that PHOs work with general practice. The concept is to have competent management systems that develop services that are responsive to patient needs. Firstly, the PHOs can build a population perspective from intelligent information systems that are built on close working relationships with the community and commonality of systems. Secondly, they can prioritise need and develop services and teams to meet these priorities. This is more possible when the organisational and contractual/funding lines have been simplified.

This approach might provide some efficiency gains through economies of scale but these are unlikely to be large because each provider would maintain its own infrastructure. On the other hand, the distributed model is likely to improve service effectiveness through improved knowledge and more effective allocation of resource. The performance and team synergy should greatly increase.

Depending on the role the PHO adopts in this distributed model there is potential to coordinate efforts and design packages that have a positive impact on workforce recruitment and retention. Already we see some of the large PHOs employing skilled clinicians that are supported by the PHO for collegial support. It is conceivable that this model would support a salary model of general practice in the future.

Summary: Alternative Two

No.	Critical Issue Description	Does the Alternative Resolve the Issue?
1	Simplify organisational and contractual structures & align to key strategies	Yes, greatly
2	Support the creation of primary health care teams that are dynamic and responsive to defined need	Yes but organisational barriers will exist
3	Gain improvements in efficiency and effectiveness	Yes but limited
4	Create strong local relationships and patient orientated services	Yes but organisational barriers will exist
5	Create population intelligence	Likely as PHOs define system requirements
6	Retain entrepreneurial spirit and innovation	Yes
7	Make any change manageable	Likely
8	Improve coordination of care and reduce duplication	Improved
9	Improve interaction between primary and secondary care, and between public and personal health	Is possible
10	Support the professional development of community specialists	Yes
11	Facilitate the early discharge of hospital patients into the community	Status quo

Alternative 3 – PHO assumes responsibility for delivery of all primary health care services

Under this model the PHO becomes the organisation for the delivery of primary care health services. All primary care funding will be via the PHO and the PHO will look to provide all service in a manner that meets the need of their geographically defined area. This is expected to involve direct provision of many services that are currently delivered by other agencies. This provides advantages in terms of coordination and collaboration between services through a common organisational structure.

In the long-term this option should result in a better resourced PHO that is efficient and effective in meeting individual and community health needs. PHO ability to attract and retain high calibre leaders, clinicians and administration personnel should be improved. The duplication of infrastructure and systems would be largely eliminated creating more resource for population strategies and patient contact. The organisations will have critical mass to be more knowledgeable and have more resource to implement services that are patient and population responsive. One potential consequence would be the loss of the entrepreneurial spirit that currently exists within NGOs and their ability to connect with their populations and patients. PHOs would need to be encouraged to develop an organisational culture that retained these desirable attributes.

The single biggest issue with this approach is the scale of change. It would present a significant challenge in terms of change management and there is potential for it to affect the delivery of services. Implementation of this alternative will require careful phasing and project management to ensure all the skills and capabilities are transferred. Long-term the potential for greater health gain may be considered greater than the other options as critical mass creates PHOs that are attractive to work within.

Summary: Alternative Three:

No.	Critical Issue Description	Does the Alternative Resolve the Issue?
1	Simplify organisational and contractual structures & align to key strategies	Yes
2	Support the creation of primary health care teams that are dynamic and responsive to defined need	Yes - long-term
3	Gain improvements in efficiency and effectiveness	Yes
4	Create strong local relationships and patient orientated services	Yes - long-term
5	Create population intelligence	Yes
6	Retain entrepreneurial spirit and innovation	Less likely
7	Make any change manageable	Yes though problematic
8	Improve coordination of care and reduce duplication	Yes
9	Improve interaction between primary and secondary care, and between public and personal health	Has potential to do so
10	Support the professional development of community specialists	Potentially at risk
11	Facilitate the early discharge of hospital patients into the community	Potentially at risk

Summary of Alternatives:

The following is a summary of the 3 Alternatives and provides an indication of the likelihood of ameliorating the critical issues.

No.	Critical Issue Description	Alternative 1 Resolve the Issue	Alternative 2 Resolve the Issue	Alternative 3 Resolve the Issue
1	Simplify organisational and contractual structures & align to key strategies	No	Yes, greatly	Yes
2	Support the creation of primary health care teams that are dynamic and responsive to defined need	Likely but slow and limited progress	Yes but organisational barriers will exist	Yes - long-term
3	Gain improvements in efficiency and effectiveness	No and any progress would be limited progress	Yes but limited	Yes
4	Create strong local relationships and patient orientated services	Likely but slow	Yes but organisational barriers will exist	Yes - long-term
5	Create population intelligence	Unlikely	Likely as PHOs define system requirements	Yes
6	Retain entrepreneurial spirit and innovation	Yes	Yes	Less likely
7	Make any change manageable	Likely	Likely	Yes though problematic
8	Improve coordination of care and reduce duplication	No	Improved	Yes
9	Improve interaction between primary and secondary care, and between public	No	Is possible	Has potential to do so

	and personal health			
10	Support the professional development of community specialists	Status quo	Yes	Potentially at risk
11	Facilitate the early discharge of hospital patients into the community	Status quo	Status quo	Potentially at risk

7. Conclusion

The national Primary Health Care Strategy has provided us with a broad vision for the future of primary health care services, organised around PHOs and featuring comprehensive personal health and population health strategies meeting the needs of their local communities. PHOs have been created throughout our district and are progressively gaining in capacity and confidence. Relationships between PHOs and other providers of primary health services are confused. PHOs may be accountable for meeting local health needs but they are responsible for only part of the health services needed to meet these needs. Non-PHO funded primary health care providers are funded by the DHB or the Ministry of Health. These relationships may or may not align with PHO strategic direction and initiatives.

PHOs' capacity needs to be increased. This report has explored three pathways by which PHO capacity might be increased.

Alternative 1 involves a continuation of the current approach by which relationships between PHOs and other providers are based on collaboration. This approach is evolutionary and the nature and pace of change is determined by providers. It does not optimise the current resources and hinders good performance of the sector.

Alternative 2 involves PHOs adopting funding and contracting responsibilities for local primary health care providers. PHOs would provide an environment in which NGOs and the like could work more closely together on services targeted at local needs. This alternative meets ten of the eleven critical issues. It achieves the required capability and capacity development of PHOs while retaining the integrity and the critical mass that currently exists.

Alternative 3 involves PHOs assuming responsibility for delivering services. This has advantages in terms of integration and coordination of care but represents a very large scale change that would require careful change management if it were not to impact on service delivery. It represents a significant challenge that all providers may wish to plan towards over time in the interest of an efficient and effective health service.