KEI MUA I TE AROARO O TE RŌPŪ WHAKAMANA I TE TIRITI O WAITANGI

BEFORE THE WAITANGI TRIBUNAL

IN THE MATTER OF

the Treaty of Waitangi Act 1975

AND

IN THE MATTER OF

the Health Services and Outcomes Kaupapa Inquiry

EVIDENCE OF KERIANA LOUISE BROOKING

7 September 2018
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INTRODUCTION

1. I, Keriana Louise Brooking of the Ministry of Health, Deputy Director Service Commissioning, state I am authorised by the Ministry of Health to give this evidence on its behalf.

My Background

2. I am Ngāti Pāhauwera, Ngāti Kahungunu ki te Wairoa. I am the Deputy Director, Service Commissioning at the Ministry of Health. In 2001, I began my health career as the General Manager, Planning and Funding at Hauora Tairawhiti, before shifting in 2003 to CEO of Tūranganui Primary Health Organisation (PHO) in Gisborne. In 2010, following the amalgamation of five PHOs through the central North Island, I was appointed as the Deputy CEO of Midlands Health Network, before joining the Ministry of Health in 2014.

3. As Deputy Director Service Commissioning, the primary purpose of my role is leading Service Commissioning’s infrastructure and support functions. Further, my responsibilities include co-leading the primary care strategic priority work, lead negotiator for the Primary Health Organisation Agreement, oversight for the home community support sector, union, DHB and Ministry of Health settlement agreement implementation and oversight for the maternity strategic priority work.

Structure of this evidence

4. In this evidence I will respond to a number of topics that have been raised by claimants, referred to in statements of evidence or identified as issues by the Waitangi Tribunal. Broadly, my evidence will outline:

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1 The Service Commissioning business unit manages the relationships between the Ministry and health and disability service providers. This includes funding, purchasing, performance management, commercial advice and contractual arrangements. The business unit works closely with the Strategy and Policy and the Finance and Performance business units to design, plan and fund health and disability initiatives.
4.1 the implementation of the Primary Health Care Strategy (the PHC Strategy), at a national level, from 2001 until today;

4.2 how the primary health care funding model evolved to support the objectives and vision of the PHC Strategy; and

4.3 the Ministry of Health’s accountability framework for ensuring the objectives and vision of the PHC Strategy were realised.

IMPLEMENTING THE PRIMARY HEALTH CARE STRATEGY

5. The Primary Health Care Strategy (the PHC Strategy) was released by the Ministry of Health in 2001. The overarching purpose of the PHC Strategy is to provide a clear direction for the development of primary health care so that it can play a central role within the wider health system in improving the health of all New Zealanders and removing health inequalities.

6. The PHC Strategy sets out a new vision for primary health care with a greater emphasis on population health and the roles of the community, health promotion and preventive care. To achieve this vision, the PHC Strategy outlines the need to involve a range of professionals in providing care, and to move to public funding for primary health care based on the needs of an enrolled population.

7. Frances Margaret McGrath’s brief of evidence, filed on behalf of the Ministry of Health, provides further detail on the role and intent of the PHC Strategy.

Major structural and funding changes

8. The PHC Strategy has involved three main changes in Government policy concerning the structure and funding of the health sector. These changes are:

8.1 the establishment and development of Primary Health Organisations (PHOs) to plan and provide some primary health care services at a local level. PHOs are local, non-governmental,
not-for-profit organisations, contracted by their local District Health Board (DHB) to manage primary health services for their enrolled populations. The establishment of PHOs is outlined in Frances Margaret McGrath’s brief of evidence;

8.2 the introduction of, and subsequent increases to, government funding for primary health care to reduce fees patients pay for primary health care services and to encourage the development of new services; and

8.3 the move from government subsidies that supported a predominantly fee-for-service primary health care model to government funding for a capitated or population-based model.

9. In this brief of evidence I will detail the Ministry of Health’s role in implementing these major structural and funding changes. Experience of their implementation at the district level will be covered by other evidence for the Ministry of Health.

**Principles for transitioning to a new primary health care system**

10. The PHC Strategy set out three principles to ensure a stable and constructive transition to a new primary health care system. These principles were:

10.1 protecting and building on the developments already made in primary health care;

10.2 collaborating with the primary health care sector, providers and communities in the implementation of the PHC Strategy; and

10.3 implementing stepwise, evolutionary change.

*Protecting and building on the developments already made in primary health care*

11. The PHC Strategy was developed to address existing problems in primary health care and support the delivery of a primary health care system that would respond to future changes and challenges in the health system and in
New Zealand society. The Government considered a clear direction for primary health care was essential to build on recent progress made in primary care and the wider health care system, including:

11.1 the emergence and growth of new primary care organisations, including Māori health providers, rural community trusts, some urban trusts, Pacific providers, and various groupings set up by general practices;

11.2 the rise in multi-disciplinary health teams, and the changing roles and boundaries for many primary health care practitioners including GPs, nurses, pharmacists, and midwives;

11.3 a growing emphasis on population-based services and matching care to community needs, supported by improved primary care information and systems to inform practice and clinical decisions; and

11.4 greater focus on early intervention and disease prevention services such as immunisation, and cervical screening, risk assessment for cardiovascular disease and diabetes. Where populations were large enough, these performance measures were also available by ethnicity.

12. These developments are outlined in more detail in Frances Margaret McGrath’s brief of evidence.

Collaborating with the primary health care sector in the implementation of the PHC Strategy

13. The Ministry of Health’s collaboration with the primary health care sector was intended to be a key feature of the implementation of the PHC Strategy, as it would help to ensure that all issues were considered in developing the new arrangements.

14. The Ministry of Health supported the sector to implement the PHC Strategy by:
14.1 Setting the expectations of DHBs through funding agreements and accountability documents. These accountability documents were to include performance measures specifically related to primary health care and the implementation of the PHC Strategy. It was intended that there would be close monitoring of DHB performance by the Ministry of Health until the key objectives of the PHC Strategy were achieved.

14.2 Developing toolkits and policy guidelines to support DHBs to contract with primary health care providers. These toolkits and guidelines are outlined in further detail later in this brief of evidence. They were intended to support DHBs to build relationships with local providers and to support local providers and communities to develop district plans for primary health care and manage local contracts.

15. Overall, through the PHC Strategy, the Ministry of Health created a permissive policy environment to allow for the implementation of the PHC Strategy in districts with diverse local conditions and different levels of readiness. This permissive policy environment has remained from 2001 until today.

16. During the early implementation of the PHC Strategy, the Ministry of Health worked closely with DHBs and primary care organisations\(^2\) to pre-empt and respond to implementation challenges. For example, in 2001, when the PHC Strategy was released, only a few Māori providers had general practice services. These services had not been in business for as long as mainstream general practices, Independent Practitioner Associations (IPAs) and primary care organisations. Therefore they did not have large enrolled client registers and were faced with viability issues. The Ministry of Health worked with Māori providers and new Māori PHOs to address their

\(^2\) Prior to the establishment of PHOs, primary care organisations existed. Primary care organisations were Independent Practitioner Associations and other community health organisations (including community Māori health providers, Union and Community Health Services). Primary care organisations are outlined in Frances Margaret McGrath’s brief of evidence.
economic viability issues by funding a range of provider sustainability initiatives and setting requirements for DHBs and larger PHOs to actively collaborate with them.

Implementing stepwise, evolutionary, change

17. Because of the size and scale of change, the PHC Strategy set out a gradual approach to implementation. Initially, the Ministry of Health did not set out what would be achieved and by when, apart from the high level directions and actions described in the PHC Strategy. These key priorities and actions are outlined in Frances Margaret McGrath’s brief of evidence. The various steps the Ministry of Health took to support the health sector to implement the PHC Strategy are detailed throughout this brief of evidence.

18. Overall, the Ministry of Health allowed for flexibility in how the PHC Strategy was implemented, and was supportive of different approaches. By setting a permissive policy environment, the Ministry of Health enabled local communities and health care providers to generate local responses to their health needs. This was considered by many to be a positive feature of the PHC Strategy. However, over time a number of limitations with this arrangement have become apparent. These include:

18.1 a complex chain of governance, ownership, business and accountability models which has limited the levers available to the Minister of Health and the Ministry of Health in holding individual primary health care practices to account for delivering on the PHC Strategy;

18.2 difficulty addressing equity beyond strategic policy levels and equity considerations not shaping subsequent Ministry of Health funding decisions to a great enough degree, programme development, implementation and monitoring; and

18.3 variation in DHB and PHO capability which has impacted on how the PHC Strategy has been implemented.
19. Since 2001, the Ministry of Health has made several attempts to address limitations in the primary health care system and barriers to achieving the intent of the PHC Strategy. In the same period the Government has not been prepared to make further structural system changes. Across the health system there has also been an ongoing struggle to put equity principles into practice, indicating willingness in principle but difficulty in achieving results. This means that outcomes have not been distributed equitably and participation has not always been enabled for all groups, including Māori. However, there are examples of good practice and positive outcomes, some of which are outlined in evidence filed on behalf of the Ministry explaining experience of primary health issues from a district-level perspective.

ARRANGEMENTS BETWEEN THE MINISTRY OF HEALTH AND DISTRICT HEALTH BOARDS

20. The New Zealand Public Health and Disability Act 2000 (the NZPHD Act) created a semi-devolved health and disability system. Where central government sets the overall strategic direction for the health and disability system, sets expectations about the standard of service delivery and provides funding to health organisations and providers, but most of the day-to-day functions and detailed decisions about the health and disability system happen at a district level. These detailed decisions include administration, support and procurement services.

21. The NZPHD Act established DHBs and gave them overall responsibility for implementing the health policies of the Government and for providing or funding health services in their districts. This includes DHBs’ statutory responsibility to pursue the objective of reducing “health disparities by improving health outcomes for Māori and other population groups”. The role, responsibilities and accountabilities of DHBs are set out in the evidence of John Kenneth Hazeldine.³

³ Wai 2575, #A3.
DHBs are required to plan, purchase and provide the majority of health services for their local population. DHBs oversee, and exercise varying control over, funding for all levels of care, including the provision of primary care services.

The strengths and challenges of a semi-devolved health system

The strengths of New Zealand’s semi-devolved health system lie in its ability for local organisations and health providers to meet the needs of the people living in their communities. Challenges of the system include ensuring national consistency and equity of service delivery, maintaining value for money, and encouraging collaborative health system leadership across primary and secondary care.

In addition to material covered in John Kenneth Hazeldine’s brief of evidence, this section outlines the formal arrangements the Minister of Health has in place to hold DHBs to account for the provision of health services for their local population, including primary care services.

However, due to the health system’s complex set of governance, ownership, business and accountability models, the levers available to the Minister of Health and the Ministry of Health are varied and exert differing levels of control. These range from formal, for example the ability to issue statutory directions, or tag ongoing funding to specific performance outcomes, to informal, for example through influence and relationship management.

It is important to note the Ministry of Health has at times held concerns about the variable capability of DHBs to focus on primary health care in addition to secondary care and to meet their obligation (under the NZPHD Act) to pursue the objective of reducing “health disparities by improving health outcomes for Māori and other population groups”. The Ministry of Health acknowledges that this may be a reflection of more serious underlying problems with the health sector’s accountability framework and, possibly, the planning and management arrangements for DHB services.
In relation to the provision of primary health care services specifically, some issues have also arisen due to the complex system of primary health care funding and accountability, that rests on a framework of partial contracting (i.e. the ability for providers to continue to charge patients a fee-for-service), and tensions in government-general practice relationships, such as the resistance and lobbying from general practices and general practice organisations to remain independent from the government and maintain the right to charge patient fees. These tensions, as they played out in the 1990's are outlined in Frances Margaret McGrath’s brief of evidence in the section titled “the emergence of the dual health system”.

**DHB Accountability**

28. As Crown agents under the Crown Entities Act 2004, DHBs are accountable to the government of the day through the Minister of Health. The accountability documents that guide DHBs planning and performance can be broadly split into three groups:

28.1 government expectations (Annual Letter of Expectations and Enduring Letter of Expectations);

28.2 accountability documents (Statement of Intent, Statement of Performance Expectations, Crown Funding Agreement, Operational Policy Framework, Service Coverage Schedule, Annual Report, and Quality Accounts); and

28.3 planning documents (Annual Plan).

29. These accountability documents are detailed in John Kenneth Hazeldine’s brief of evidence.⁴

30. In each of its planning documents, DHBs are expected to carry out joint planning with PHOs. In addition to the information provided in John Kenneth Hazeldine’s brief of evidence, this section provides further detail.

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⁴ Wai 2575, #A3.
on the accountability documents DHBs use when planning for the provision of essential primary care services.

*Health Needs Assessment*

31. The New Zealand Health and Disability Act 2000 required DHBs to conduct health needs assessments in their districts. The Health Needs Assessments enabled DHBs to investigate, assess and monitor the health status of their resident population, and their needs for services. Health Needs Assessments compared the health status of Māori and non-Māori by providing a descriptive data analysis. In some DHBs, Māori providers played an important role in contributing to the Health Needs Assessments to form a good understanding of Māori health need in the district.

32. Health Needs Assessments formed an integral part of DHBs’ overall planning cycle as these provided robust, high quality evidence that informed local policy development and funding decisions. Further, the assessments assisted in the development of DHB annual, regional and service planning and better enabled DHBs to direct activity, resources and funding for identified need.

33. A specific whole of population Health Needs Assessment is no longer required under the NZPHD Act, but DHBs are required to “regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services” by section 23 of the NZPHD Act. This requirement is reinforced in the Operational Policy Framework, which is a set of business rules, policies and guideline principles that outline the operating functions of DHBs, as outlined at page 56 of John Kenneth Hazeldine’s brief of evidence.5

34. The Ministry of Health acknowledges that DHBs meet this obligation under the NZPHD Act to varying degrees.

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5 Wai 2575, #A3.
Previously, DHBs also had a statutory requirement to develop five to 10 year strategic plans that outlined how they would fulfil their functions and objectives under the NZPHD Act. These plans were known as District Strategic Plans. DHBs’ District Strategic Plans were informed by their Health Needs Assessments. The plans were reviewed by the Ministry of Health every three years and the NZPHD Act required the Minister of Health’s consent to DHBs’ District Strategic Plans every three years, or when a DHB made a significant amendment.

The District Strategic Plan was intended to inform a DHB’s population about the DHB’s strategy for meeting the district’s health needs. Therefore the plan was expected to be easy for the public to access, read and understand.

As well as expressing the DHB’s strategy for meeting local health needs, the District Strategic Plan was also expected to reflect the overall direction of health and disability strategies. Section 38(3)(a) of the NZPHD Act required that, in developing or amending a District Strategic Plan, DHBs must:

- assess the health status of their respective populations;
- identify any factors that may adversely affect this status;
- assess the population’s needs for health services; and
- determine the contributions those services are intended to make towards the health outcomes sought.

The New Zealand Health and Disability Amendment Act 2010 replaced the requirement for individual DHB Strategic Plans with shared Regional Services Plans, outlined below, to give effect to more collaborative health and disability service planning and purchasing of administration, support and procurement.
39. Although District Strategic Plans are no longer a legislative requirement, many DHBs still complete strategic plans.

*Regional Service Plans*

40. The Regional Service Plan identifies the goals of a particular region and sets out how these goals will be achieved. DHBs are generally grouped together into four main regions, namely:

40.1 Northern – Northland, Waitemata, Auckland and Counties Manukau DHBs

40.2 Midland – Waikato, Lakes, Bay of Plenty, Tairawhiti and Taranaki DHBs

40.3 Central – Hawke’s Bay, Whanganui, Mid Central, Hutt Valley, Capital & Coast and Wairarapa DHBs

40.4 Southern – Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs

41. The DHBs of each region work together in order to identify better ways of organising, funding, delivering and continuously improving health services to the people in their region.

42. The rationale behind Regional Service Plans is that DHB collaboration across regions will increase efficiency and provide a better standard of care across a greater area than if each DHB were to act alone.

43. The Minister of Health approves each Regional Service Plan and the DHB regions provide regular reports to the Ministry of Health on their plans.

44. DHBs are expected to consider which work programmes developed as part of their regional service plans may require specific governance and leadership approaches, with tailored membership, to appropriately represent the key stakeholders and to ensure the best outcome is achieved.
45. The Ministry of Health expects that achieving health equity is a focus for all DHB and regional activity. Regions are expected to identify inequity when assessing the health needs of their population and outline actions to improve equitable access and outcomes in their Regional Service Plans, within each of the regional enablers outlined below.

DHB Annual Plans

46. Each DHB has a statutory requirement to produce an Annual Plan that sets out the expected planned performance for the financial year. This provides accountability directly to the Minister of Health, who has to agree to each Annual Plan. The Annual Plan sets out how a DHB currently delivers and will deliver health services locally to meet Government priorities, with a focus on health equity, and how this can be provided in a financially responsible manner, in line with the DHB’s role and functions.

47. The Ministry of Health provides DHBs guidelines for annual planning each year. In these guidelines, the Ministry of Health sets the expectation that achieving health equity should be a focus for all DHBs and DHBs are expected to consider and include actions in their Annual Plans that will help them achieve health equity in their populations, including health equity for Māori.

48. DHBs are also expected to engage with relevant stakeholders, including their primary care partners, when developing Annual Plans.

Māori Health Plans

49. DHBs previously produced annual Māori Health Plans. These plans were used to plan, report and monitor work that underpinned the DHB’s efforts to achieve health equity and improve health outcomes for Māori. Māori Health Plans provided a summary of a DHB’s Māori population and their health needs and outlined the DHB’s plans address Māori health issues in order to achieve indicator targets set nationally and locally.

50. Māori health performance measures, previously outlined in the Māori Health Plan, were incorporated into DHB Annual Plans in 2017/18 and the focus on equity has been strengthened in these plans.

51. There was some resistance from DHBs and other health organisations to the integration of the Māori Health Plans into the annual planning process due to concerns about a loss of monitoring and accountability of DHBs to improve Māori health outcomes. Te Tumu Whakarae, the National Reference Group of Māori Health Strategy Managers within DHBs, provided recommendations to the Ministry of Health for the continuation of the DHB Māori Health Plan.

52. The Ministry of Health’s rationale for amalgamating the Māori health plans with DHB annual plans was to improve Māori health outcomes by strengthening the accountability, focus and profile on Māori health not only to the Minister of Health but also to DHB Chairs and Boards.

53. While the amalgamation of the Māori health plans has meant a reduction in visibility for Māori health, there are certain DHBs who continue to develop a stand-alone Māori health plan. The amalgamated plan aims to ensure all priorities of the government and DHB are given equal status. The amalgamated Annual Plans are formally approved by the Minister of Health, while Māori health plans were not.

PRIMARY HEALTH ORGANISATIONS

54. Through the PHC Strategy, the Ministry of Health introduced PHOs, not-for-profit organisations of primary health care providers, to work with DHBs and communities to achieve the vision and key directions of the PHC Strategy. DHBs still maintain overall responsibility, under the NZPHD Act, for managing resources and service delivery to meet their populations’ health and disability needs. However, the PHC Strategy envisioned that DHBs would work through PHOs to meet their statutory obligation to provide services that were organised around the needs of a defined group of people and to achieve local health goals.
55. The role and intent of PHOs, as expressed in the PHC Strategy, is outlined in Frances Margaret McGrath’s brief of evidence in the section titled “Working with local communities and enrolled populations”.

**Establishing PHOs**

56. The early process of implementing the PHC Strategy required DHBs to work closely with those organisations and communities who were interested in setting up PHOs in their districts. DHBs were responsible for ensuring the optimal number and configuration of PHOs to guarantee the provision of comprehensive primary health care services to the whole population, while maintaining efficiencies and avoiding unnecessary duplication of services. In acknowledgement of DHBs local expertise, the Ministry of Health gave each DHB the freedom to develop its own processes for establishing PHOs.

57. The first two PHOs were developed in South Auckland in July 2002 (a Māori PHO and a Pacific PHO). These two PHOs were used by the Ministry of Health as a proof of concept and helped shape the operational policy for further PHO established. The pace of PHO establishment varied with local realities, however by 2008 82 PHOs had been established across New Zealand, with almost all New Zealanders enrolled in a PHO via a general practice.

**PHOs came from different starting points**

58. PHOs were primarily created and evolved from existing services providers, including Māori and Pacific providers, Independent Practice Associations and other organisations. In its initial PHO establishment guidance the Ministry of Health acknowledged that newly forming PHOs came from various starting points, some emerging from groups that had largely been community focused, while others from a provider base – particularly from general practice organisations. The Ministry of Health also acknowledged that each of these starting points had various strengths and challenges and that expected PHOs would need to ensure adequate mechanisms for all
providers and practitioners to join their organisation and participate in decision-making.

59. However, besides providing a range of PHO establishment guidance (outlined below) to the health sector, the Ministry of Health had no objective or transparent process for establishing PHOs and did not take into consideration or target establishment funding according the different financial position of the organisations forming new PHOs, i.e. the conserved resources held by some Independent Practitioner Associations or the Māori Provider Development scheme funding some Māori providers received. Conserved resources and the Māori Provider Development Scheme are outlined in Frances Margaret McGrath’s brief of evidence. I outline the different starting points of organisations wanting to form PHOs and the Ministry of Health’s response later in my brief, in the section titled “A primary health care funding model was established to improve services and drive new models of care”.

Māori providers and PHOs

60. During the process of PHO establishment, in addition to concerns about different financial starting points, concerns were raised by Māori health providers joining PHOs about how they would continue to deliver their comprehensive services in a kaupapa Māori framework and how they could effectively participate in governance of PHOs to improve the health of their people.

61. Issues arose when partnerships between Māori and mainstream providers had formed and exposed their different value sets. Some Māori communities and providers articulated a view that nothing less than a “Treaty of Waitangi 50/50” PHO governance partnership would give positive effect to planning and delivering effective services for Māori. Several large Independent Practitioner Associations actively sought Māori health providers to join a 50/50 governance arrangement.
62. In response to some of the concerns raised by Māori health providers wanting to form or join PHOs, the Ministry of Health required that applications for PHO establishment funding, discussed below, describe the level of participation key stakeholder groups, including Māori and/or Pacific groups, had in the proposed PHO arrangements. These requirements only applied to PHOs applying for establishment funding but not for PHOs going live without additional establishment funding.

63. In addition to this requirement of PHOs, the Ministry of Health’s Māori Health Directorate (outlined in Frances Margaret McGrath’s brief of evidence) facilitated and funded the formation of a PHO Māori Reference Group to enhance the representation of Māori within the PHO establishment process and to be a focal point for discussions on the issues impacting Māori communities and Māori providers. The PHO Māori Reference Group aimed to ensure Māori participation in the PHO establishment process and negotiated the addition of Māori specific clauses into the national PHO standard contract (outlined further below).

64. Māori health providers also communicated that they were receiving inconsistent information about PHOs from the Ministry of Health and DHBs. Some DHBs also communicated that they were grappling with the task of establishing PHOs in their district and had limited experience in primary health care and Māori primary health. In response to these issues the Ministry of Health provided DHBs and PHOs with guidance and regular updates on PHO establishment and early development.

Ministry of Health policy and guidance on PHO establishment and development

65. PHO establishment was an additional (and considerable) responsibility for the 21 new DHBs, who were also in the process of establishing themselves in the restructured health sector under the NZPHD Act. In the early years of formation, DHB staff often had limited primary care and public health experience. Furthermore, DHBs had even less experience in working with Māori health providers. As a result, the PHO establishment process was
largely facilitated by the Ministry of Health working closely with DHBs and with various organisations interested in setting up PHOs in the district.

66. To facilitate PHO establishment and implementation, the Ministry of Health developed some national processes (for example, new funding formulae, service specifications, rules for enrolment), as well as guidelines, toolkits and other support for implementing the PHC Strategy, including:

66.1 PHO minimum requirements;
66.2 establishment service specifications for essential primary health care services;
66.3 guidelines for establishing PHOs;
66.4 guidelines for PHOs in improving Māori health; and
66.5 PHO enrolment requirements.

67. DHBs and other key stakeholders were involved in developing these tools with the Ministry of Health.

68. The original PHOs primarily evolved from existing services providers, including Māori and Pacific providers, Independent Practitioner Associations, Union and community providers and other organisations.

Setting minimum requirements for PHOs

69. In 2001, prior to PHO establishment, the Minister of Health released a set of minimum requirements for the structure and function of PHOs. The minimum requirements provided DHBs with a nationally consistent set of criteria for the qualities and qualifications of emergent PHOs. DHBs were required, under national service coverage specifications, to ensure people had access to a set of primary health care services. DHBs entered into service agreements (PHO Agreements) with newly established PHOs that specified these primary health care services in more detail. The PHO Agreements required PHOs to continue to meet the minimum requirements
and specified the services that all PHOs must provide, including objectives, service components, access, payment for the services, and reporting requirements.

70. The purpose of the minimum requirements was to drive local decision making while ensuring the development of consistent standards of primary health care across the county. They were deliberately permissive of different approaches to meet local need, allowing DHBs to work with PHOs and primary health care providers to develop plans that responded to the health needs of their population. The main focus of the requirements was on achieving the visions and objectives of the PHC Strategy, including better health outcomes, reduced health inequalities and improved access to services. The requirements set the parameters within which DHBs and local groups would develop their own primary health care services to meet local need.

71. The minimum requirements required that PHOs:

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

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

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

72. The PHO minimum requirements outlined key considerations for DHBs when establishing a PHO, including:

72.1 DHBs will use the PHO funding formula to fund PHOs according to their enrolled populations (this was developed by the Ministry
with the intent to reflect characteristics of the population that
determine need for primary health care services). The PHO
funding formula is outlined in this brief of evidence in the section
titled ‘a primary health care funding model was established to
improve services and drive new models of care’.

72.2 PHOs will enrol people through their chosen primary care
providers using a national agreed set of rules, setting out people’s
and providers’ rights and responsibilities and establishing
requirements for information collection and protection.

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

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

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

73. DHBs determined whether a PHO was meeting the minimum
requirements, both in terms of services delivered and its overall structure
and governance, before allowing it to become a PHO. A set of national
guidelines (outlined next) were distributed by the Ministry of Health to
assist DHBs, primary providers and their communities with tools and ideas
for PHO establishment and meeting minimum requirements.

74. Some DHBs established further key requirements that ensure all PHOs
have dedicated actions to improve the health of Māori to the level enjoyed
by the rest of the community.

75. Apart from setting the minimum requirements for PHOs, the Ministry of
Health did not actively support DHBs to ensure their PHOs met these
requirements.
Ministry of Health guidance on establishing Primary Health Organisations

76. In 2002, to support the establishment of PHOs, the Ministry of Health released ‘A Guide for Establishing Primary Health Organisations’, to be used in conjunction with the PHC Strategy and the minimum requirements for PHOs, released by the Minister of Health in November 2001.

77. The Guide was designed to be useful to DHBs and to primary health care providers and communities when they were planning primary health care locally and working to set up PHOs. It explained what PHOs were, what they were intended to do, and covered some key considerations in the establishment of PHOs. The Guide was intended as a collection of helpful ideas, examples and tools and did not set further requirements. Since the Minimum Requirements were deliberately permissive of different approaches, DHBs were expected to use the Guide and the Minimum Requirements to support locally appropriate and innovative approaches to providing primary health care services. Providers were encouraged to approach DHBs with their suggestions, and DHBs were expected to develop their own plans in light of such proposals.

Establishment Service Specifications for Essential Primary Health Care Services

78. In 2002, the Ministry of Health published the ‘Establishment Service Specifications for Essential Primary Health Care Services provided by Primary Health Organisations’. This was developed by the Ministry of Health and DHBs with input from provider and professional groups.

79. While the PHO Minimum Requirements, set out high level parameters for DHBs on expected requirements and expectations of PHOs, alongside the DHBs own role in PHO establishment, the establishment service specifications set out the minimum set of essential primary health care services that all PHOs were required to provide to their enrolled populations. This included specifications relating to access to services, service components, service linkages, quality requirements and reporting.
requirements. The specifications built on previous work and models used in existing contracts and were used by PHOs for the first 1-2 years.

80. The establishment service specifications required PHOs to work towards the following objectives:

80.1 General – essential primary health care services will be evidence and best practice based (where possible) and will aim to improve, maintain and restore health and ensure access to care. They should be provided for individuals across their life span, for families, whānau and communities taking a broad view of health, including physical, mental, cultural, social and spiritual dimensions. Services should be co-ordinated with other health care services and will aim to reduce health inequalities.

80.2 Māori Health – PHOs, with reference to He Korowai Oranga: The Māori Health Strategy, are expected to contribute to improvements in whānau ora, and to the reduction in Māori health inequalities. Specific Māori health priorities are outlined in the Primary Health Care Strategy under Māori Health and Disability Priorities:

80.2.1 PHOs will work with iwi, Māori communities and providers to develop and implement a Māori Health Plan that outlines how it will contribute to improving outcomes for Māori for the services contained in this service specification.

80.2.2 PHOs will be required to provide evidence of how they have worked with iwi, Māori communities and providers to develop and implement the Māori Health Plan and to demonstrate how implementation of the Plan has improved health outcomes and/or access for Māori.
80.2.3 Pacific Health – PHOs providing services for Pacific communities (in particular, those DHBs with specific Pacific accountabilities) will, with reference to the Pacific Health and Disability Action Plan, be expected to work with Pacific communities and providers in planning and delivering services to contribute to the reduction in Pacific peoples' health inequalities.

80.2.4 The specifications included associated requirements for PHOs, including understanding the health needs of their population, cultural competence, quality systems, coordination and management of referred services. It also set out the reporting requirements which would be important in establishing the Ministry’s capitation or population-based funding.

80.2.5 The establishment service specifications required all PHOs to develop a Māori health action plan appropriate to the needs of their enrolled population, which can contribute towards reducing health inequities.

**PHO Services Agreement**

81. The PHC Strategy expected PHOs to be ready to take up service agreements and receive funding for the provision of services. Organisations or collections of primary care providers wanting to become a PHO were expected to enter into an agreement with their local DHB, setting out nationally consistent reporting requirements and specific performance measures that relate to the PHC Strategy’s key goals.

82. The Ministry of Health requires all DHBs to contract with PHOs on the basis of a Standard PHO Services Agreement. The first PHO Services Agreement was developed and negotiation between the Ministry of Health, DHBs and representatives of the primary health provider sector. It reinforced policies already developed by Government including the PHO
Minimum Requirements, the PHO Funding Formula, the Establishment Enrolment Rules, the establishment service specifications.

83. The first PHO Services Agreement set out the following requirements for all PHOs:

With reference to He Korowai Oranga: The Māori Health Strategy, you are expected to contribute to improvements in whanau ora, and to the reduction in Māori health inequalities.

Specific Māori health priorities are outlined in the strategy under Māori Health and Disability Priorities;

You will work with iwi, Māori communities and providers to develop and implement a Māori Health Plan that outlines how you will contribute to improving outcomes for Māori for the Services;

You will be provide evidence of how you work with iwi, Māori communities and providers to develop and implement the Māori Health Plan and to demonstrate how implementation of the Plan has improved health outcomes and/or access for Māori.

Amendments to the PHC Services Agreement

84. In 2004, the PHO Agreement Amendment Protocol Group (PSAAP) was established to consider and make decisions and recommendations on variations to the standard PHO Services Agreement. PSAAP still operates and involves DHBs (including a mandated representative of Te Tumu Whakarae), PHOs, contracted providers and Ministry of Health working collaboratively to ensure that primary health care services are provided on a “best for patient and best for system basis”. PSAAP meets four times per year.

85. Each year the PHO Services Agreement is updated to reflect any price increases or new services DHBs will contract for nationally. Contract negotiations through PSAAP provides an opportunity for health sector representatives, including Māori, to articulate what changes need to be made
to the PHO Services Agreement. This process reflects the working relationship the Ministry of Health envisioned in the PHC Strategy.

**The current PHO Services Agreement**

86. The purpose of the current PHO Services Agreement (Version 5.1, 1 July 2018), alike previous versions is to:

86.1 set out the roles and responsibilities that a DHB and PHO each have to ensure that primary health care services are funded and delivered in their district/region;

86.2 provide a framework for DHBs and PHOs to work collaboratively and in good faith, in an environment of trust, openness, and transparency;

86.3 ensure that the Government is able to determine whether the services are being delivered in a way that reflects its policy objectives;

86.4 continue to maintain the strong accountability of PHOs and contracted providers to continuously improve performance through the measurement of their achievement against quality improvement indicators and national health targets, and the recognition of this performance through the System Level Measures (discussed further below);

86.5 provide for the PHO to deliver Nationally Consistent Services;

86.6 provide for the PHO to deliver certain Services as determined by the Alliance; and

86.7 provide for DHBs and PHOs to enter into separate agreements for the delivery of services on a local basis that are outside the

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scope of the Nationally Consistent Services, and the Alliance Services.

87. The PHO Agreement, also states that:

87.1 “as a Crown agent, the DHB must act in a manner that is consistent with the Treaty of Waitangi Principles of partnership, participation, and protection in the delivery of health and disability services, in order to address disparities in health” and requires both parties to the contract (the DHB and PHO) to act in accordance with the Crown's principles for action on the Treaty of Waitangi and incorporate Whānau Ora approaches as appropriate.

**PHO enrolment requirements**

88. Enrolment is a fundamental and enabling principle of the PHC Strategy as it describes the process by which a person formalises their longitudinal relationship with their chosen Contracted Provider.

89. Enrolment lays the foundation for a pro-active, co-ordinated population-based approach to preventive care, chronic disease management and systematic practice-level performance measurement and quality improvement. It also underpins accountability by defining the population for which the Contracted Provider and PHO is responsible and funded for. Therefore the Ministry of Health has worked with DHBs to enable robust enrolment processes are followed to ensure the accuracy and timeliness of enrolment data.

90. The Ministry of Health with DHBs, released the national enrolment rules in April 2002. These rules covered the enrolment process, specified what patient information must be collected at the point of enrolment, and outlined individual's and provider’s rights and responsibilities. For example, people will be able to be enrolled with only one PHO at any time. However, enrolment will not restrict an individual’s right to seek care from another provider on a casual basis whether inside or outside the PHO.
91. In 2015, the National Enrolment Service was developed by the Ministry of Health in response to requests from the primary care sector for a more timely and accurate system for calculating capitation based funding payments (capitation based funding is detailed in the funding section of this brief of evidence).

92. The National Enrolment Service is the ‘single source of truth’ for all national enrolment data. The National Enrolment Service is designed to allow a real time records of patient enrolments and to provide primary care providers with direct access to the National Health Index. This is a significant change for primary care. Prior to the National Enrolment Service, primary care providers had to go through the Ministry of Health contact centre to create new National Health Index numbers for patients and to update patient identity details. Direct access to the National Health Index provides the opportunity for more timely and accurate maintenance of patient health identity data, as most patients see their general practice much more often that they access other health services. National Health Index data includes age, gender, ethnicity and geocoded address.

**Broader Ministry of Health strategic direction for primary health care**

93. In addition to the range of accountability and planning mechanism to support DHBs and PHOs to implement the PHC Strategy, the Minister of Health is responsible for strategies that provide a framework for the health and disability system. The Minister of Health uses a range of other population and health strategies to provide more specific directions for particular population groups or health conditions, and guide the system in achieving its vision for the whole health system, including primary health care. Some of these strategies are:

93.1 the New Zealand Health Strategy;

93.2 the New Zealand Disability Strategy;

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8 A person’s NHI number is stored on the National Health Index (NHI) along with that person’s demographic details.
93.3 He Korowai Oranga: Māori Health Strategy; and

93.4 ’Ala Mo’ui: Pathways to Pacific Health and Wellbeing’

94. These strategies are briefly outlined in Frances Margaret McGrath’s brief of evidence.

95. It is also important to note that since 2001 updates to some of these strategies were made as the Minister of Health deemed appropriate. The current population and health strategies are outlined in the further brief of John Kenneth Hazeldine (page 15).

**Accountability for implementing population and health strategies**

96. Active monitoring of the health system’s performance is important in ensuring that the contributions of different organisations, such as DHBs and PHOs are aligned with the government’s intentions and the contributions of other contributors in the health system.

97. Some population and health strategies set by the Minister of Health include action plans and in partnership with the health system, and other government agencies, the Ministry of Health monitors work undertaken on the actions.

**Accountability for implementing He Korowai Oranga: Māori Health Strategy**

98. ‘Whakatātaka 2002 – 2005’ a Māori Health Action Plan accompanied He Korowai Oranga: Māori Health Strategy 2002. Whakatātaka outlined the first two to three years of implementation of He Korowai Oranga and specified the roles, responsibilities, performance expectations, measures and initiatives for achieving the Māori Health Strategy. Whakatataka identified four priority areas:

98.1 building quality data and monitoring Māori health;

98.2 developing whānau-ora-based models;

9 Wai 2575, #A3.
98.3 ensuring Māori participation in workforce development and governance; and

98.4 improving primary care.

99. The Minister of Health was provided with regular DHB progress reports on each of the action areas and a partnership forum between DHBs and the Ministry of Health provided oversight on the implementation of the plan, and ongoing development of a national Māori health strategy and policy.

100. ‘Whakatātaka Tuarua 2006 – 2011’, the second Māori Health Action Plan built on the first. Both plans focused on influencing systems and processes alongside building whānau and Māori community development. The plans included reporting requirements for DHBs on Māori specific indicators.

101. The Ministry of Health monitored the implementation of He Korowai Oranga mainly through its monitoring of the two action plans and used this evaluative information to improve performance. As well as Whakatātaka, some service areas had their own specific action plans or frameworks for Māori, including the:

101.1 Māori Mental Health Strategic Framework;

101.2 Māori Disability Action Plan (2002); and


PRIMARY HEALTH CARE FUNDING

102. The aims of the PHC Strategy required a new approach to funding and a new funding model. Funding was a significant lever for change. The PHC Strategy aimed to improve access for all New Zealanders, identify and risk stratify a defined population, shift the focus from a transactional fee-for-service approach to a more proactive, preventative and disease management approach and reduce equity gaps. As a significant lever for change, additional funding was needed to enable the change in approach and focus, improve universal access and reduce equity gaps. The amount of funding
was a significant investment in primary care, one of the largest in recent history—over $620 million between 2004/05 and 2007/08.

103. The first focus of the funding was to improve all New Zealander’s ability to access primary health care by decreasing patient co-payments for primary health care services. High co-payments had been consistently identified as a barrier to access, especially for deprived populations, including Māori.

104. Patient enrolment was intended to identify a specific population and enable the development of a rich primary care database, underpinning the PHOs population approach to service development. This allowed PHOs to identify patient cohorts—patients with long term or multiple conditions, with high needs groups, and vulnerable families—and, using their bulk capitation funding, plan and target services and care in order to improve outcomes and reduce equity gaps.

**Capitated funding**

105. PHC Strategy funding is calculated and delivered using a capitation methodology. Capitation payments are based on the numbers of the enrolled PHO population. That means that PHOs are paid according to the number of people enrolled, not the number of times a provider sees patients.

106. Capitation funding, calculated annually, is delivered in quarterly bulk payments to each PHO based on a specified subsidy level for each enrollee.

107. The major capitated funding stream is called first level services. First level services are the full range of primary health care services delivered to improve, maintain, and restore the health of individuals and communities, along with co-ordinating care. Funding is based on enrollee demographics including weightings for age, gender and whether the enrollee has a High Use Health Card. Eligibility for the High Use Health Card is determined when the patient needs to have visited a health practitioner at the general practice they are enrolled in, 12 or more times in 1 year, with the
consultations being related to a particular condition or condition(s) which are ongoing.

108. The First Level Services subsidy levels were based on national average GP utilisation rates (by age and sex), from 1998/99. Population and expenditure data based on GP claims for General Medical Services were used to calculate the subsidies.

109. In addition to this First Level Services funding, both interim and access PHOs received Services to Improve Access and Health Promotion funding, specifically targeted to improving access and population health for high needs populations. Both of these additional funding stream formulae include ethnicity and deprivation and are paid on a capitated basis like for first level services.

110. Access PHOs, those with at least 50 percent Māori, Pacific or people living in NZDep 9 or 10 enrolees, used this formula across the age bands from the outset of PHO establishment. Access PHOs, identified by their high needs populations, received the bulk of early implementation funding as they had access to all the new age-band subsidies immediately. In exchange for the higher funding levels and to ensure access for high needs people, Access PHO patient co-payments were limited and had to be approved by DHBs.

111. All other PHOs, known as Interim PHOs, had to rely on the gradual roll out of individual age group funding streams to receive additional new funding. For Interim PHOs, the roll-out of new funding for the different age bands occurred as follows:

111.1 ages 6-17 in October 2003

111.2 ages 65+ years in July 2004

111.3 ages 18-24 on July 2005

111.4 ages 45-64 years in July 2006
111.5 ages 25-44 in July 2007.

112. During this time, Community Services Card holders who were enrolled in Interim PHOs were able to receive reduced fees on presentation of their card. Community Services Cards are for people on a low to middle income.

113. The Strategy’s intention was to have both type of PHOs using exactly the same First Level formula by 2007. The assumption was that by this time, as all the new funding streams with their additional funding had been rolled out, all New Zealanders would have equitable access to primary care services. Thus only the two targeted funding streams, Services to Improve Access and Health Promotion, would be necessary to continue to reduce equity gaps.

114. Capitation bulk funding was expected to enable PHOs to target services to populations and/or individuals with high needs, both environmentally such as vulnerable families and clinically such as those with co-morbid conditions. This was expected to include services like diabetes outreach clinics on marae and education and exercise programmes for at risk groups.

115. Ultimately the bold aims of the PHC Strategy were not fully achieved for a variety of reasons. The introduction of PHOs came directly on the heels of the implementation of the devolved health system and DHBs. With the need to develop the organisational capacity and capability, along with driving an enabling organisational culture, capacity and capability within the health system, was stretched to its limits in most parts of the country.

116. The primary care sector was not a level playing field, though the implementation of the Strategy assumed this. The Strategy wanted to drive higher levels of community involvement and took an ‘all comers’ approach. However in actuality, primary care and community organisational capacity and capability ranged from that of well-established Independent Practitioner Associations (IPAs) to community of interest groups (eg Māori, Pacific, refugees) starting from scratch. The Strategy’s implementation made no accommodation for where each developing PHO started.
This meant PHOs development into mature and well-functioning organisations was uneven, The already well-resourced IPAs rapidly reconfigured into high functioning PHOs while community groups, such as potential Māori providers, struggled to establish the required infrastructure and governance. The Strategy’s implementation and funding made no acknowledgment of the different starting points of developing PHOs while holding them all accountable in the same way.

Interestingly, while the IPAs reconfigured their business model, this did not necessarily translate into the proactive and preventative service model(s) envisioned by the Strategy. As IPAs continued to view funding as fee-for-service, anchored in their approach of a patient co-payment for a 15 minute appointment, the higher level of which for a GP drove GPs to see all patients. There was little use of a multi-disciplinary team or a push to use the workforce differently. However some of the community groups, once they had established some form of organisation, developed interesting and innovative service models using multi-disciplinary teams, including new roles for nurses, and the introduction of support roles like navigators who support individuals and whānau into and through services. Unfortunately, some of these groups, limited by a lack of resources both financial and capacity/capability, struggled to establish sound business structures. Some of these groups, with no additional funding on the horizon, found that they were not sustainable.

The primary care sector, while working to develop the required structures, felt the funding was insufficient to achieve the PHC Strategy’s aims, particularly for organisations servicing high needs people. The intent to improve access to all, meaning ethnicity and deprivation were not included in first contact funding, apparently disadvantaged high needs providers, including Māori. On reflection we now see that this funding proved insufficient to service these high needs populations. Acknowledging the higher level of resources required to reach the most disadvantaged populations possibly could have contributed to more success at fulfilling more of the aims of the Strategy. The Services to Improve Access and
Health Promotion funding streams, which did include ethnicity and deprivation, and were targeted to high needs groups (including Māori), in hindsight, proved insufficient to make up for the lack of these weightings in first contact funding.

120. While the Ministry listened to the sector's concerns, and implemented new initiatives to ‘fix’ some of these concerns, a planned assessment framework was not used. It appears that a more focused approach to assessing the success of individual initiatives, such as a Plan-Do-Study-Act approach could have given the Ministry a better picture of the multiple problems overlaid on each other. This could have been used to assess whether individual initiatives achieved the stated aim, or were they successful and assisted in developing a system view of the individual issues and their collective impact. Some solutions were marginal and did not always enable achievement of all of the PHC Strategy’s aims, including reduction in equity gaps.

**PHO Establishment Funding**

121. PHO establishment funding was made available to DHBs to assist PHOs to set up in their districts. In the case where the establishment of a new PHO resulted in higher payments than previously allocated by the DHB, the Ministry of Health provided extra funds to the DHB. The amount of additional funding was provided as new PHOs were established. Once a PHO was established, the Ministry of Health provided funding through a PHO management fee.

122. There was no formula for determining the establishment funding a PHO would receive, and therefore establishment funding varied between PHOs. The Ministry of Health appeared to give no consideration to the different starting points between organisations forming PHOs. Independent Practitioner Associations for example, did have existing resource available
through historical agreements and processes such as budget holding. However, smaller and newly forming PHO networks, including many Māori providers, were often members of agencies that continued to be supported by government funding for back office functions such as through Health Care Aotearoa, and through Ministry of Health funding for Māori provider development, such as the Māori Provider Development Scheme, during the period of PHO establishment.

**Patient Fees**

123. PHOs receive government funding on the basis of their enrolled population to subsidise primary health care services. These subsidies are intended to benefit patients directly through reduced primary health care fees. Most patients still cover a proportion of the cost of primary care services through co-payments paid by the patient to their primary care service provider at the time of the consultation. People not enrolled in a PHO face higher co-payments.

124. Because they are private businesses, general practices can charge co-payments for services. These co-payments can constitute up to half, or more than half, of revenue for many general practices. Fees have increased over time to keep pace with costs. Co-payments vary nationally, but general practices (or PHOs) must publish their fees schedule.

125. Subsidies for capitation rates have increased over the years, along with the introduction of co-payment regulation, since the Government’s policy objective was to reduce financial barriers to access general practice care, particularly for Māori, Pacific peoples and those on a low income.

126. The PHO Services Agreement (Part F Clause F.21) commits the Government to make best endeavours to maintain the value of primary care

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10 Where a health provider held a fixed budget to deliver a defined range of services to an enrolled group of patients on the provision that any savings be retained by the IPA for investment in new primary care services.

11 Health Care Aotearoa was formed by union and related health centres as a national network of non-profit primary care providers.
funding. If a funding increase is agreed for the year, the Ministry of Health prescribes this rate increase and it usually applies to all the government subsidised services that make up the capitation based funding for primary care.

127. While there are no legislative or regulatory restrictions on the level of co-payments that can be charged, the Agreement sets out a Fees Framework that requires general practitioners to demonstrate how increased co-payment charges applied to enrolled patients will translate into reduced fees. Co-payment levels are monitored by DHBs to ensure that the patient co-payment fees charged by general practitioners supports governments intentions to subsidise low or reduced cost access to first level services. Providers are required to go through a fees review process prior to increasing their co-payment charges to enrolled patients.

Other Capitated Funding Streams

Services to Improve Access

128. Services to Improve Access funding was established in 2002 to enable PHOs to introduce innovative and culturally appropriate approaches to reach people with high health needs who may not be accessing the services they need because of various cultural and other barriers such as language, distance and transport. Services to Improve Access funding was not designed to reduce the cost of first-contact care but was part of new population based initiatives to improve accessibility of services for groups of people in ways other than reducing consultation and prescription charges.

129. Services to Improve Access funding provided flexibility to encourage a more diverse range of professionals to take a key role in delivering primary care services. Many services to improve access are led by primary care nurses and community nurses with input from other health providers and in collaboration with organisations such as schools, marae and community groups. These include initiatives that enabled care to be delivered to those
experiencing difficulty reaching health services, or encouraging people to attend health clinics, for example:

129.1 outreach or mobile nursing and GP services;
129.2 marae or community-based services;
129.3 school-based clinics;
129.4 combined clinics to reduce the number of visits;
129.5 health promotion, screening and immunisation at local events such as school gala days or community fairs.

130. Before the Services to Improve Access funding could be accessed, PHOs were required to submit a proposal to their DHB demonstrating how the additional funding would be used to improve access for the targeted populations. Services to Improve Access funding was allocated based on the age, gender and ethnicity of the PHO’s enrolled population. The funding was calculated by applying weightings to the first–contact per capita primary care funding formula by ethnicity and level of deprivation. This was applied equally across Access and Interim practices as follows:

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<td>Deprivation deciles 1-8</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Deprivation deciles 9/10</td>
<td>1.2</td>
<td>1.4</td>
</tr>
</tbody>
</table>

131. Enrolees who were Māori or Pacific and in deprivation deciles 9 or 10 attracted a combined weighting of 40 percent to the base per capita amounts. The greater ethnic weighting was justified based on evidence that Māori and Pacific peoples in deprivation deciles 9 and 10 had poorer health outcomes compared with other people in deprivation deciles 9 and 10. While the ethnicity and deprivation weightings were significant, age was the
most influential factor in the allocation of SIA funds to PHOs for eligible enrolees aged 0-4, followed by enrolees aged 65 and over.

**Health Promotion**

132. Health Promotion funding was introduced in 2002 for population based initiatives that provide education and information promoting health. Health Promotion funding was available to PHOs to deliver population-based initiatives, such as healthy eating and physical activity, that target populations who have not been reached through existing promotional activities.

133. Health Promotion funding was provided at a base per capita rate per annum ($2 initially). Weightings for deprivation and ethnicity then augment the health promotion allowance, so that for example someone who lives in a Deprivation decile 9 or 10 and was Māori was funded a higher amount). There was also an additional funding stream (approximately $1m nationally) to allow public health service providers to work with PHOs and DHBs to assist them in planning health promotion programmes and activities.

134. PHOs are required under the PHO service agreement to agree with the DHB the health promotion activities that the PHO would undertake. This includes agreement that:

134.1 the PHO will work with whānau, hapū, iwi, consumers, and other groups within its community, relevant public health service providers and regional public health units to plan and deliver health promotion programmes.

134.2 Activities must be consistent with population health objectives and public health programmes at national, regional and local levels

134.3 The PHO will submit its health promotion strategy to the DHB for approval, including demonstrating how the health promotion funding would be used to achieve the desired outcomes
Management Services

135. In keeping with the population focus of the Primary Health Care Strategy, the Management Services Fee was established in 2002 to support PHOs to deliver management services related to enrolment and reporting to DHBs that were beyond the scope of the previous Primary Care Organisations (PCO) management responsibilities.

136. The Management Services Fee was paid on a per enrolled person basis. In addition to funding previously paid to PCOs, new funds were available to cover the additional management functions of PHOs. Where a new PHO was forming, the DHB also received additional funds.

137. The Management Services Fee rate was initially set at three levels based on the number of enrolled members in a PHO. In the 2002/2003 year the PHOs received:

137.1 $6.93 for its first 20,000 enrolled members;

137.2 $6.30 for each enrolled member over 20,000 and under 75,000; and

137.3 $5.67 for each enrolled member above 75,000.

138. Tiered rates were a way of recognising that PHOs had some of the same fixed costs regardless of their size. The scaling of the management fee has wider implications for achieving the intent of the Strategy as the Ministry had been careful not to set a minimum size for PHOs recognising that there is a trade-off between efficiency and responsiveness to local issues. However, smaller PHOs expressed concerns that the level of the management fee meant they would be forced to merge, potentially reducing their responsiveness to their communities, constituent providers, and DHBs.
**Care Plus Pilot**

139. In response to concerns that some New Zealanders with high health needs were missing out on higher subsidies if they were not enrolled in Access PHOs, a separate funding arrangement called Care Plus was introduced. The Care Plus project developed out of a 2002 Independent Practice Association Council (IPAC) proposal to replace the Access and Interim PHO population based funding formulae with a way of targeting priority patients. The Ministry of Health worked closely with the Council and provider groups to develop the Care Plus proposal. It was initially piloted in three PHOs during 2003/2004 and evaluated before being rolled out for all PHOs on 1 July 2004.

140. While the Access formulae was focused mainly on reducing the cost of accessing primary care services for patients, Care Plus focused on improving access to coordinated and quality care for patients with chronic conditions. It targeted individuals who needed to visit their GP or nurse often, due to significant chronic conditions, acute medical or mental health needs, or a terminal illness. Care Plus aimed to:

140.1 improve the management of chronic conditions;

140.2 reduce inequalities;

140.3 improve teamwork within PHOs; and

140.4 provide lower-cost services for high need primary health users.

141. Care Plus provided additional capitation funding (approx 10 percent) to target those patients with the highest health needs in PHOs. Care Plus could only be offered to enrolled people who:

141.1 were expected to benefit from ‘intensive clinical management in primary health care’; and either

141.2 had two or more chronic health conditions, or
141.3 had a terminal illness, or

141.4 had two acute medical or mental health related admissions in the past twelve months, or

141.5 had a total of six ‘first-contact’ consultations and/or emergency department visits in the past twelve months, or

141.6 were on active review for elective health services.

142. Care Plus funding is based on the expected number of Care Plus patients in a PHO. Overall, funding allowed for 5% of the enrolled population to be Care Plus or High Use Health Card patients. Care Plus did not replace the High Use Health Card and High Use Health Card patients would still receive discounted care for some general practice visits. The percentage of Care Plus patients varied across PHOs depending upon the make-up of their enrolled populations. Age, socio-economic status and ethnicity affected the expected number of Care Plus patients. PHOs decided how to use this funding to provide tailored services through their practices.

143. Care Plus patients were usually managed in the practice by a team of health professionals and received:

143.1 low or reduced cost access to nurse and/or doctor expertise and time;

143.2 continuity of care that included a Care Plan jointly developed with the patient and ongoing support through pre-planned regular reviews; and

143.3 advice on improving health outcomes through better self-management, with support to identify and meet realistic personal health goals.
Other Primary Care Funding and Supports

Rural support

144. The Primary Health Care Strategy recognised the need to ensure a stable primary health care infrastructure for rural areas. In the latter part of 2001, the Ministry established the Rural Expert Advisory Group to make recommendations on how the Primary Health Care Strategy should be implemented in rural areas.

145. The Rural Expert Advisory Group recommended that a rural primary health care premium be paid to PHOs encompassing rural areas to enable them to retain and recruit a skilled rural primary health care workforce. PHOs had the flexibility of using the rural premium in a manner that best fitted local circumstances to support the rural primary health care team, retain the workforce and therefore ensure sustainable primary healthcare services for rural communities. The rural premium was comprised of two parts:

145.1 a flexible resource for supporting and retaining the primary health care team; and

145.2 a targeted resource aimed at supporting shared roster arrangements.

146. As recommended by the Advisory Group, the other initiatives to assist with recruitment and retention included:

146.1 national initiatives for recruitment of primary health care workers encouraging them to work in rural areas both on a short term and long term basis; and

146.2 transitional funding to enable an early start on workforce retention and reasonable rosters while PHOs are being developed.
Workforce retention

147. The following table provides the amount of workforce retention funding a PHO would receive according to a formula based on the degree of “remoteness” (indicated by the rural ranking score of the GPs) in 2002/2003. Whilst GP ranking will set the level, PHOs will be able to use the resource flexibly to assist with the retention and recruitment of all primary healthcare professionals in rural communities. For some remote rural localities served by rural nurses with GP back-up, for example Stewart Island, a notional rural ranking scale will be applied to the nurse(s).

<table>
<thead>
<tr>
<th>Rural Ranking Score</th>
<th>$ per capita$12m (GST incl)</th>
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<tbody>
<tr>
<td>35-40</td>
<td>7.42</td>
</tr>
<tr>
<td>45-50</td>
<td>11.13</td>
</tr>
<tr>
<td>55-65</td>
<td>14.83</td>
</tr>
<tr>
<td>70+</td>
<td>18.54</td>
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</table>

148. As with most aspects of funding for strategy implementation, it was not possible to fully fund all the rural support initiatives in the first year. Accordingly, in 2002/03, DHBs received a portion of the funding indicated to focus on retaining rural GPs and nurses providing first level services.

149. For 2003/04, DHBs received workforce retention funding according to the formula, based on the number of registered patients on the rural GP’s practice register. For both 2002/03 and 2003/04, DHBs were able to apply the workforce retention funding to providers who were not part of PHOs. After that point, DHBs had to apply to the Ministry outlining firm plans for PHO establishment, including the relevant rural providers, or lose the funding.

Per capita relates to registered patients (excluding casual visitors). For 2002/03, census populations were used as a proxy.12
Reasonable rosters

150. Reasonable on-call rosters are important for maintaining rural people’s access to urgent primary health care out of normal business hours as well as aiding practitioner recruitment and retention. Funding to support reasonable rosters is being allocated on a case-by-case basis to those localities where, for geographical reasons, rural practitioners have limited rosters (i.e. they don't have enough staff to cover the roster). Applications for reasonable roster funding were accepted during 2002/03 from providers, whether or not they belonged to a PHO. For those applying from 2003/04 onwards, only practices that are part of PHOs, or have firm plans to become part of PHOs, were eligible for reasonable roster funding.

National Rural Recruitment and Locum support Service

151. Due to widespread ongoing workforce crises in rural general practice in the 1990s, the government introduced a series of rural initiatives in the early 2000s including the rural recruitment contracts. Without the Rural General Practice Network's involvement in the recruitment services, underpinning the other rural initiatives, the quality rural general practice workforce we have today, would not exist.

152. In 2001 the Ministry contracted the Network to establish and provide a short-term locum service for rural GPs. In 2004 a contract for longer term (and permanent) recruitment service for GPs and Nurse Practitioners was established. The overall purpose of a national rural recruitment and locum support service is to ensure equal opportunities for all general practitioners working in Eligible Practices to get essential time off, and to support retention of the rural workforce. Rather than leaving each practice or locality to manage their own recruitment as best they can, a national programme provides equity and offers a dedicated centre of expertise for smooth immigration, credentialing and orientation of the locums.

153. These services are provided via by the Network’s NZ Locums recruitment team. The NZ Locums team of experienced and skilled recruiters and
administrators work alongside the Network staff to provide essential support to rural health providers across New Zealand.

**Immunisation**

154. Immunisation services are primarily delivered through primary care, with the exception of school-based immunisation programmes for children in School Years 7 and 8. All immunisations on the National Immunisation Schedule 13 are fully funded, and immunisations for children aged under 18 years of age are free regardless of citizenship or immigration status.

155. Improving access to immunisation services to reduce inequalities in immunisation coverage was recognised as a priority in New Zealand from the early 2000’s. At that time, coverage for Māori children was significantly lower than for other ethnicities at around 50 to 60 percent.

156. Following implementation of the PHC Strategy, the preferred form of payment for immunisation was fee-for-service. Providers already being paid on a capitation basis for immunisation were able to continue to be paid in that way. Achieving immunisation was incorporated into the quality payments scheme.

**Improved primary mental health services**

157. There is good New Zealand and international evidence showing a high prevalence of mental health problems amongst people presenting to primary health care services. However, mental health problems are frequently missed in primary care consultations with an estimated 50% of problems not being detected explicitly.

158. Mental health initiatives and innovations in PHOs funding ($5m) was part of the package of initiatives being undertaken to develop PHOs and support implementation of the Primary Health Care Strategy.

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13 The Ministry of Health’s National Immunisation Schedule is the series of vaccines that are offered free to babies, children, adolescents and adults.
The Ministry initiated a requests for proposals from PHOs for provision of primary mental health initiatives in 2004 with a focus on mild to moderate mental health problems. These proposals coincided with the release of the Ministry of Health’s PHO Service Development Toolkit for Mental Health in Primary Care. The purpose of the Toolkit was to ensure PHOs had the relevant evidence and information about potential strategies that would assist in shaping PHOs capacity and capability to deliver services that responded appropriately, safely, culturally and holistically to the mental health needs of their enrolled populations. Over a 2 year period funding was provided to establish new primary mental health initiatives involving 41 PHOs with a budget totalling $12m.

In 2007 new funding was provided in 2007/08 Budget for a further 14 primary mental health initiatives to be developed by PHOs and the total budget was increased to $24m by 2008/09.

DHBs continued to provide a general primary care response to the needs of people of any age with mild to moderate mental illness. In addition to this, access to primary mental health interventions are fully funded for the following specific population groups:

161.1 the enrolled population focused on Māori, Pacific and/or low income; and

161.2 all youth in the 12 to 19 year age group (regardless of PHO enrolment) who require primary mental health services.

Primary mental health services aim to increase access to talking therapies and other psychosocial interventions. They are delivered mostly through contracts with PHOs across all DHBs.

**Nursing Initiatives**

Some new funding was made available to support the development of innovative models of primary health care nursing practice to contribute to primary health care through PHOs. The Ministry of Health appointed an
Expert Advisory Group for Primary Health Care Nursing, which made a number of recommendations including to ‘fund, monitor and evaluate innovative models of primary health care nursing practice and disseminate examples of best practice to the wider sector’.14

164. In 2003 the Ministry of Health announced contestable funding, available over three years, for the development of primary health care nursing innovation projects. Eleven innovation projects were selected including a Kaupapa Māori Primary Nursing Service through Auckland DHB. An evaluation of the initiatives found that while all made progress and had some success against their own and the Ministry’s goals, there were key barriers to the development of the innovations including:

164.1 the early stage of development of the PHOs within which innovations were integrated,

164.2 the diversion of nurses into the Meningococcal B vaccination programme, shortages of nurses with the right skills,

164.3 shortages of Māori and Pacific nurses,

164.4 absence of or lapses in leadership, and (sometimes)

164.5 insufficient buy-in from nurses or other providers.

Reducing inequalities contingency fund (RICF)

165. To further assist the development of innovative health services delivery while PHOs were being established, the government allocated specific funding of $2.8 million per annum in 2001/2002 and $2.4 million on an ongoing basis to help providers enhance services that could reduce inequalities. The funding was available to services that were moving in to a PHO environment and was available through a process administered by DHBs. Proposals that were supported were then provided to the Ministry of Health for consideration in two funding rounds in May and October

2002. To be eligible for funding providers had to meet certain criteria including:

165.1 serving an enrolled population with known poor health status, typically at least 50%;
165.2 Māori, Pacific or deprivation index 9 and 10;
165.3 already have, or planning, services that increase access using a range of providers;
165.4 working towards PHO membership;
165.5 committed to providing low cost access for all enrolled patients;
165.6 have community and DHB support; and
165.7 have a register of patients with good quality ethnicity and address data.

166. There were 35 time limited initiatives funded through the Reducing Inequalities Contingency Fund which was established in 2000 to increase access to primary health care services.

167. The initiatives were diverse in their content and objectives, but could be classified in four groups:

167.1 community health workers – the delivery of health care services in the home and community;
167.2 free/low cost access to services – various mechanisms are employed to reduce access costs;
167.3 centre-based activities – the delivery of health care services to particular age groups in non-traditional settings, generally in community facilities owned or used by the target group; and
outreach services – these services aim to reach out to people in the community to assist them with their health and social needs.

The RICF, funded Māori initiatives including outreach services such as the Taitamariki Suicide Prevention Community Development Programmes, Māori Healthy Housing and Employment Programme and Intersectoral Community Action for Health.

After funding was approved the RICF projects operated in a very fluid policy environment. Over the period of implementation many PHOs had also received additional funding for Services to Improve Access and for Health Promotion. Many providers therefore participated in other projects (funded by DHBs and from other sources) that had objectives overlapping with those of the RICF.

**Other Services**

There are primary health care services for which PHOs will receive funding (in some cases time limited) other than those described in this evidence. Generally, these services are targeted for a specific population (e.g., refugees) or specific disease state (e.g., diabetes disease state management). These services were initially limited to certain primary health care providers. Over time, the Ministry of Health intended to incorporate as many primary health care services as practicable into a single funding package allocated through a needs based formula.

**Enabling the primary health care work force**

The Strategy set out a clear direction for the development of primary health care in New Zealand, with the vision of improving population health and reducing inequalities by encouraging new models of primary health care. A new funding model was one element to achieving the goals of the strategy, another was improving the primary health care workforce.

Therefore following the release of the Strategy the Ministry introduced a range of health workforce initiatives that allowed practitioners to work as
team with enhanced opportunities to use specialised knowledge and expertise in a way that was collaborative, efficient and ethical. For example, to effect this, DHBs and PHOs were required to coordinate and manage resources for the services to ensure best use of workforce and associated diagnostic and therapeutic services. The Strategy aimed to move away from services configured around historical patterns of population demand and traditional models of care towards support for a more flexible mix and distribution of primary health care professionals. The Strategy also recognised the need to move away from a focus on hospital services and admissions and towards service delivery through the integration of primary care with other parts of the health service.

**Nurse Practitioners Scope of Practice introduced**

172. Primary health care nursing was critical to the implementation of the Primary Health Care Strategy. The profession of nursing in New Zealand had changed significantly since 1901 when the Nurses Registration Act was introduced. There had been an increase in nurse-led community services and initiatives, rapid growth of information technology impacting the delivery of health care to patients, and the development of new medical technologies.

173. The Nurse Practitioner was a new scope of practice launched by the Ministry of Health and the Nursing Council of New Zealand in May 2001. A Nurse Practitioner is an advanced nursing role that is a unique blend of nursing and medical knowledge, clinical leadership, scholarship, research, planning and advocacy.

174. Nurse Practitioners have a population health focus consistent with the Government’s direction signalled in the Primary Health Care Strategy. The Primary Health Care Strategy provided opportunities for nurse practitioners to practise as part of primary health care teams, lead specialty focussed clinics in community settings, or establish independent primary health care nursing practices that offered a range of assessment, diagnostic, treatment and support services.
175. After the Nurse Practitioner scope of practice was introduced in New Zealand the number of Nurse Practitioners steadily increased and education and career pathways were developed. However, despite the perceived value of the role uptake was slow. From 2012 sector-wide discussions began to address challenges around the roles, and as a result a demonstration Nurse Practitioner Training Programme was developed in 2016 in collaboration with tertiary education providers, employers, the National Nursing Organisation (NNO) group and the Ministry of Health. The programme aimed to take a more strategic, coordinated and timely approach to nurse practitioner registration than other education pathways. In a 2017 review, the scope of nurse practitioner practice was broadened to ensure that the workforce was flexible enough to respond to the range of health needs in the population.

Māori Provider Development Scheme

176. As outlined in Frances Margaret McGrath’s brief of evidence, the Māori Provider Development Scheme was established by a Cabinet directive in 1997 to provide grants to support the development of Māori health disability support service providers. The scheme is currently administered from Vote Health from the Non Departmental Other Expenses funding stream, currently providing $9 million (GST inclusive) per annum. This level of funding has remained relatively constant since its establishment, with some minor fluctuation between 2008 and 2014.

177. The Māori Provider Development Scheme provides organisational development support for Māori health and disability providers and financial assistance to students undertaking health related tertiary studies through the Hauora Māori Scholarships.

178. The Māori Provider Development Scheme is informed by, and supports, the objectives of the New Zealand Health Strategy, the New Zealand Disability Strategy, He Korowai Oranga – Māori Health Strategy, the PHC Strategy and other strategic policies.
179. Māori providers or individuals must meet Māori Provider Development Scheme eligibility criteria before they can apply for funding, applicants must be:

179.1 an existing Māori health provider or Māori organisation which has contracts with the Ministry of Health and/or DHB

179.2 an existing Māori health provider or Māori organisation that is in the process of negotiating a contract with the Ministry of Health and/or District Health Board; or

179.3 part of a joint venture with a Māori health provider.

180. The Māori Provider Development Scheme supports the Māori health sector in two ways.

180.1 MPDS provides a contestable development fund for Māori health providers to support their capacity and capability building including audit compliance, health and safety compliance, infrastructure development and workforce capability.

180.2 MPDS provides contestable scholarships annually for Māori health students pursuing study in medicine, nursing, midwifery, allied health, dentistry, community health work.

181. Since the establishment of the scheme, on average 130 Māori health providers and 550 Māori health students have been successful recipients of grants per annum.

RESPONDING TO PRIMARY HEALTH CARE STRATEGY IMPLEMENTATION ISSUES

182. The rapid formation of PHOs between 2002 and 2007 and the introduction of complex transitional funding approaches to implement the Primary Health Care Strategy presented some challenges for the health sector. The following are some of the Ministry of Health’s responses to implementation issues.
Improving Māori Health: A Guide for Primary Health Organisations

183. In 2004, Improving Māori Health: A Guide for Primary Health Organisations was published by the Ministry of Health. The Guide was the result of collaborative work undertaken by Te Tumu Whakarae, Māori representatives of DHBs, Māori PHO members and the Ministry of Health; and approved by the wider PSAAP group. This document was to provide additional information for PHOs in meeting the requirements of the Māori health clauses in the national PHO Agreement Version 16.1 (and amendments). The Guide responded to a lack of appropriate activity by PHOs in some instances regarding use of the Services to Improve Access funding.

184. By the end of 2003, the Ministry acknowledged that there had been a number of lessons and issues that needed to be applied to the future development of PHOs, including that: many Māori providers needed extra support to participate fully in the PHC Strategy, and that changing traditional ways of working would take time, with most PHOs focused on getting new systems and structures functioning smoothly. Māori-led PHOs faced challenges in working with providers with a different value base and how providers without GP services would ‘fit’ in the new structures. Improving Māori Health: A Guide for Primary Health Organisations provided guidance for PHOs in identifying activities to improve Māori health and gradually re-orientating the way PHOs plan and deliver their services for Māori.

185. The guide outlined how PHOs could work to fulfil the special relationship between iwi and the Crown under the Treaty of Waitangi, including:

185.1 Partnership – Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health services.
185.2 Participation – Involving Māori at all levels of the service, in decision-making, planning, development and delivery of services where appropriate.

185.3 Protection – Working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

186. The guide contained information from the national PHO contract clauses, Ministry of Health guidelines (eg, He Kawe Korero) and existing primary care Māori Health Action Plans. It guided the development of PHO Māori Health Action Plans to ensure that appropriate activities were included in plans submitted to DHBs.

**Care Plus 2004 onwards**

187. In 2003 the Care Plus Advisory Committee and the Ministry agreed on the content of an independent review of the first year of Care Plus implementation. The review was completed in 2006 and found:

187.1 general support for the concept of Care Plus amongst most practices as a programme targeting patients with high health needs and chronic conditions;

187.2 80% of PHOs were delivering Care Plus in some or all of their practices by April 2006;

187.3 Care Plus appeared to be reaching patients with chronic high need, particularly those with diabetes and ischaemic heart disease;

187.4 Māori and Pacific patients appeared more frequently in Care Plus enrolments than their population rates; and

187.5 most patients surveyed felt their care had improved under Care Plus.
The 2006 review also identified that Care Plus was not as well suited to patients needing intensive interventions requiring multiple primary health care contacts over a short period of time such as mental health patients or terminally ill patients. While many providers felt that the overall level of funding for Care Plus should be increased, the review at that time did not find strong evidence that the funding model itself should be significantly altered. The review also outlined concerns about administration overheads and other transaction costs.

Following the 2006 review, the Ministry identified a number of complex interdependencies between Care Plus and other programmes such as Get Checked (diabetes programme), the High User Health Card and Coordinated Care for Long Term conditions. The Ministry undertook a policy review considering two options for the future of Care Plus. The first would modify the Care Plus programme eligibility criteria and funding, in part to recognise the higher rates of long term conditions experienced by Māori and Pacific populations; and the second would transform Care Plus in to a long term condition management fund.

Through discussions with selected DHBs and the sector a clear preference emerged to transition Care Plus in to a long term condition management fund, to ultimately be devolved to DHBs. The Minister at the time supported recommendations that Care Plus should be transitioned from an enrollee-based capitation payment to a long term conditions structured management fund from 2009/2010. The Fund would allow PHOs greater discretion in how resources were used and how services to high need patients were delivered. Funding was to be distributed to PHOs on a weighted population basis and would give greater recognition of the higher rates of long term conditions experienced by Māori and Pacific populations.

An implementation plan for the transition of Care Plus in to a Long Term Condition Management Fund was distributed to the sector for comment in 2008. Implementation of this work did not occur due to a change in
Government. With this, the Ministry’s efforts shifted to focus on the new Government’s priorities for primary health care.

**After Hours Funding**

192. While New Zealand compared favourably against four other countries (Australia, Canada, United Kingdom and United States) on accessibility of primary care services on nights, weekends and holidays, co-payments were high and the sector was concerned about the resiliency of after-hours services. The intent was that after hours services were to be included in the First Contact capitation funding. However, the sector (PHOs, general practices) maintained that after-hours services were not included in First Contact funding, and required additional funding which also recognised the additional costs to provide after-hours services.

193. An After Hours Primary Health Care Working Party was established in November 2004 and it published its report in July 2005. ‘Identify and remove health inequalities’ was one of the Working Party’s principles, along with the guidance that planning for after-hours primary health care should be congruent with He Korowai Oranga: Māori Health Strategy.

194. This report clarified that the accountability for 24/7 primary health care service delivery remains with PHOs and recommended that the DHBs take the lead in developing resilient, accessible and effective after hours primary care services. Its 15 non-binding recommendations (to DHBs, PHOs, ACC and the Ministry of Health) also included exploring new payment options for ACC, principles to be used in developing after-hours services, clarification of the use of Services to Improve Access funding to reduce

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15 2004 Commonwealth Fund International Health Policy
16 After hours primary health care is designed to meet the needs of patients which cannot be safely deferred until regular or local general practice services are next available – Report of the After Hours Primary Health Care Working Party – Towards Accessible, Effective and Resilient After Hours Primary Health Care Services.
17 Separate capitated funding stream designed to improve access to services for high needs populations (Māori, Pacific and/or NZDep index 9 – 10). This funding cannot be used to reduce co-payments across the whole enrolled population.
after hours co-payments, the development of a Sector Disposition Tool\textsuperscript{18}, a review of the Primary Response in Medical Emergencies Service and the immediate development of District After Hours Services Plans along with this requirement in the yet to be released District Annual Plan Guidance. There were no specific recommendations about equity or after hours services for Māori.

195. The District After Hours Plans were high level and PHO involvement in development differed across the country resulting in varying levels of PHO buy-in. Without the identification of specific after hours services (location, fees, hours, etc), and in most cases no additional PHO or practice level funding, after hours primary care services continued to be an issue with rising co-payments, service gaps and sector complaints about this 24/7 requirement without additional funding.

196. Sector pressure and public complaints about co-payments increased and in 2008 the Government allocated $9 million for primary care after hours services. This funding was allocated to DHBs based on their PBFF share (refer to John Hazeldine Brief of Evidence). The Ministry released funding to a particular DHB on approval of the DHB’s plan outlining how the funding would be used to improve primary care after hours services. Use of the funding varied throughout the country and included purchasing nurse telephone triage services, funding nurses on-call and, in rural and provincial areas, supporting the local hospital’s emergency department to provide primary care services overnight.

197. The Office of the Auditor-General undertook two audits (2010 and 2014) of DHB primary care services. Although the audits acknowledged that arrangements were confusing to patients in some locations, with a varying level of access to supportive services such as laboratory and X-ray, they

\textsuperscript{18} A tool to assist the after-hours health professional determine which service – primary health care or the emergency department – patients should most appropriately attend for treatment.
concluded that all DHBs met their contractual requirements for primary care after hour services.19

A joint Ministry of Health and District Health Board work programme

198. From the launch of the Strategy until approximately 2005, the sector had made significant progress implementing structural changes, such as the creation of PHOs, as part of the Strategy. In 2005, the Ministry of Health and DHBs recognised the need to shift their focus from implementing structural and funding changes to achieving the Primary Health Care Strategy’s wider goals – reducing health inequalities, engaging communities, and improving the prevention and management of chronic conditions.

199. The next phase in the implementation of the Primary Health Care Strategy introduced a new way of working for the sector, with a greater focus on the roles and relationships of DHBs and PHOs. PHOs were expected to be more responsive to the changes needed at the local level, and DHBs were expected to take more responsibility for the Strategy’s implementation. This reflected the fact that a significant portion of funding had been devolved to DHBs; and recognised that further changes required needed to be led from the sector.

200. A consultation process with sector representatives produced a Joint Work Programme outlining progress between 2001 and 2005, describing the next implementation focus areas, and acknowledging the importance of engagement and participation by communities, Māori, providers, and the wider health sector in achieving the PHC Strategy. A primary goal of the joint work programme was to increase the focus on reducing health inequalities between high need populations and the total enrolled population.

201. The key initiatives that flowed out of the joint work programme were:

201.1 a review of the Primary health organisation funding formulae;

19 Access to face to face consultation within 60 minutes for 90% of their population.
201.2 an initiative to increase very low cost access to primary care; and

201.3 Introduction of the PHO Performance Programme (PPP).

**Review of the primary health organisation funding formulae**

202. When the PHO funding formulae were implemented in July 2002, the Ministry of Health committed to a review within three to five years to assess the formulae appropriateness in light of PHO experience. There had also been a number of calls from the sector to review the funding formulae given ongoing concerns about rising patient co-payments and the ineffectiveness of capitation funding alone in achieving the wider aims of the Primary Health Care Strategy. In particular, PHOs with especially high need populations had raised concerns that the funding formulae were not adequate to respond to the needs of their enrolled populations.

203. In March 2004, Cabinet had approved the establishment of a Ministerial Review Unit with the State Services Commission (SSC) to plan, monitor, and coordinate reviews of policies and programmes within the core public service to ensure they were based on need not race. Following the Review Cabinet directed the Ministry of Health to review the PHO funding formulae and propose alternative means of allocating certain primary health resources using morbidity or mortality data, instead of ethnicity. The Ministry were to report back to Cabinet in March 2006.

204. In 2006, the Ministry of Health appointed an Expert Advisory Group (EAG) to review the PHO funding formulae. Due to the timeframes of the review it did not seek to address major funding allocation options, such as whether capitation funding should be replaced with another funding model, and did not consider issues related to the sufficiency of total funding or sustainability issues. Instead, it focused on ensuring that the current capitation formulae (across three capitation funding streams) were aligned to the PHC Strategy objectives:

204.1 First Contact funding formula as it represented the majority of primary health care funding;
204.2 Services to Improve Access (SIA); and

204.3 Health Promotion funding.

205. The key findings of the review were:

205.1 the current PHO funding formulae had been relatively successful in universally lowering the cost of access and creating more accessible primary health care for all New Zealanders;

205.2 there was a case for further refinement of the formulae to supporting the Primary Health Care Strategy goal of reduced inequalities, in particular moving away from formulae based on historic utilisation, and considering inclusion of ethnicity and other variables in the First Contact formula;

205.3 analysis of unmet need showed that both ethnicity and deprivation were significant factors in explaining variations in unmet need. Other compelling evidence showed that Māori and Pacific Peoples suffer from earlier death and higher and earlier morbidity than other ethnicities;

205.4 the preferred socio-economic/demographic predictors of health need were age, gender, ethnicity and deprivation;

205.5 in addition to any short term changes to the formulae to better address health inequalities, there was scope for the funding formulae to be enhanced over time as more data and information become available and increasingly include components that reflect population morbidity;

205.6 the First Contact formula needed to encourage new models of care which involved greater utilisation of nurses;
205.7 a First Contact funding option could be developed based on both
Ambulatory Sensitive Hospitalisations\textsuperscript{20} and utilisation data that
included GP and nurse consultations; and

205.8 the Expert Advisory Group was unable to make an informed
decision (due to insufficient information) on whether the SIA and
HP funding streams were appropriate or whether they should be
combined with the First Contact funding stream. Therefore the
Group did not comment on the utility and options for Services to
Improve Access or Health Promotion.

206. The review also acknowledged that funding mechanisms alone would be
insufficient to achieve the primary care strategy goals and that to be
successful it must work in conjunction with:

206.1 clear policy settings;

206.2 a learning environment that focuses on improved health outcomes;

206.3 incentives for behaviour/system change and change management;

and

206.4 appropriate accountability and monitoring frameworks.

207. The funding formulae review process had significant buy in from the sector,
and the recommendation that the funding should be better directed to high
and unmet need populations had significant sector backing.

208. The Ministry outlined to the Minister risks in implementing a revised
formulae including that:

208.1 without elements such as behavioural change and improved
contract/performance management there was a risk of there being
fewer tangible outcomes;

\textsuperscript{20} The Ministry defines ASH as hospitalisations of people less than 75 years old resulting from diseases
sensitive to prophylactic or therapeutic interventions that are deliverable in a primary health care setting
change could impose added cost and complexity to the sector, with feedback from some in the sector on the importance of a period of stability around capitation funding; and

unless additional funding was provided to the “losers” from any formula change, they would be less supportive of the Strategy in the future.

The Ministry advised the Minister that any change to the First Contact formula within the existing budget would result in ‘winners and losers’. Therefore an understanding of the revenue impact at PHO and practice level would be an important aspect of implementing any change to the formula.

The Minister of Health did not agree to proceed with the Expert Advisory Group's funding formulae review recommendations, including applying updated utilisation rates (both doctors and nurses) by Age Group, Gender, Ethnicity and Deprivation Quintile (weighed for unmet need) to the First Contact formula.

Instead, the Minister directed the Ministry of Health to analyse other options for spending the additional budget money in line with the principles developed by the Expert Advisory Group. These principles were:

any additional funding should be directed to populations with the greatest need;

funding should be directed to services most able to address unmet need and should, support new models of practice that best address the needs of such populations; and

additional spending (delivered through the funding formulae) should be linked to appropriate accountability and contract mechanisms.
212. Options that the Ministry were directed to analyse and/or progress included:

212.1 increase Interim PHO funded capitation rates for children 0-14 years to align with Access funded PHOs (to occur at the same time as roll out for the 25 – 44 age group funding) for roll out in July 2007; and

212.2 options for additional spend on Budget 2007 including to: extend the Very Low Cost Access Initiative, enhance Services to Improve Access, Care Plus and Health Promotion; and innovation funding.

213. In response to the work undertaken as part of the Joint Work Programme and PHO funding formula review, the government introduced a range of additional initiatives to help achieve the Primary Health Care Strategy objectives. These included:

213.1 additional funding to support rural practices;

213.2 Very Low Cost Access (VLCA) funding to further support PHOs to provide low fees to high need populations and reduce health inequalities;

1.1. funding to promote innovations in nursing services and primary mental health care services; and

213.3 a PHO performance management programme to support clinical governance and continuous quality improvement in primary health care.

Introduction of the Very Low Cost Access scheme

214. In October 2006, part way through the review of the PHO funding formulae, the government introduced the Very Low Cost Access (VLCA) scheme in response to concerns about barriers to primary health care access that were associated with increasing patient fees. VLCA was a mechanism to fund low co-payments for whole practice populations.
215. VLCA is a voluntary scheme that general practices can opt into or out of. For those practices that opted in a top-up was offered over base capitation, with the only requirement being that all adult patients would be charged the same low co-payment:

215.1 Zero fees for children 0-5 years.

215.2 $10 for 6-17 years.

215.3 $15 for adults 18 years and above.

216. VLCA payments provided a 15 percent increase in First Contact capitation paid through PHOs. In addition the PHOs received an additional 15 percent increase in Services to Improve Access funding which is also targeted at high needs populations. VLCA provided recognition of the extra effort involved in providing services to high need populations, and in keeping fees low for the people who can least afford primary health care.

217. The VLCA scheme recognised that PHOs and their practices serving high needs populations were experiencing difficulty sustaining low cost access despite the gradual roll out of increased funding since the PHC Strategy’s introduction. It was estimated that 68% of the enrollees that would benefit from the initiative were Māori, Pacific or living in areas of high deprivation. By enabling access to mainly high needs populations it supported the policy of reducing inequalities, however it acknowledged that high need populations that do not reside close enough to ‘low fee’ practices would not benefit from the initiative. Initially 218 out of the 1084 general practices in New Zealand joined the VLCA scheme. This included a number of Māori PHOs.

218. The Zero Fees for Under 6s scheme aimed to improve child health outcomes by removing financial barriers to access both daytime and after-hours general practice and prescription medicines. The importance of access to health care for children under six years of age has previously been recognised by the government with the introduction of the Free Child
Health Care Scheme (FCHCS) in 1996, with the aim of providing free in-hours doctors’ visits for children under six.

219. Non-VLCA practices were eligible to apply for the Under 6s payment if they committed to providing free standard consultations to children under six. Practices who received the VLCA payment were not eligible to apply for the Under 6s payment.

**PHO performance management programme**

220. In 2006, a pay-for-performance programme was introduced, called the PHO Performance Programme (PPP). The programme was designed by the Ministry of Health, DHBs, and primary health care representatives to strengthen the role of PHOs and to reinforce the combined health sector efforts to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs.

221. Initially, joining the programme was voluntary for PHOs. In order to participate in the programme and be eligible for the incentive payments, PHOs were expected to meet a number of pre-requisites demonstrating how they intended to implement the programme. DHBs approved their PHO performance plans. Establishment funding was provided by the Ministry of Health in recognition of the work involved for a PHO during the set up phase of a PHO entering the PPP. The funding was paid in two stages with 80 percent paid on DHB sign off of an establishment plan and 20 percent paid on DHB sign off of a performance plan.

222. The initial focus for PPP was on developing indicators that were relatively simple for PHOs to implement. The initial indicators were therefore mainly process and output measures of performance, rather than being designed to measure patient outcomes. Later indicators more closely reflected the intent of the PHC Strategy and placed greater emphasis on chronic conditions and quality improvement.
223. The PPP had a strong focus on reducing health disparities. This was achieved through:

223.1 measuring performance separately for high needs populations where appropriate;

223.2 weighting payments towards progress against targets for the high needs populations for those indicators relating to an area of health disparity; and

223.3 a weighting for high needs population in Referred Services Management (RSM) formulae. 21

224. The PPP was reinforced with financial incentives to record and pursue targets across clinical, process and financial indicators. The total amount of performance payments, $23 million, were relatively small in relation to total PHO incomes.

225. PHOs were eligible to receive payments as they improved their performance on indicators against targets. However, some indicators were provided for information only and did not qualify for a payment. PPP was a challenge for some smaller PHOs and some Māori PHOs who did not have as strong an infrastructure to meet the reporting demands of the PPP. It was also challenging because they had a more difficult population to reach and therefore found it harder to meet the targets. In some instances these PHOs negotiated very low targets in the first year which were never re-negotiated and which meant in subsequent years they were paid for lower performance than would otherwise have been expected.

226. For the majority of indicators the closer the PHO moved towards its target the greater the proportion of the payment they would receive. The PPP also created an information feedback loop to give PHOs access to their own performance data to use in their improvement processes.

21 For example for pharmaceuticals and laboratory testing
227. Although investment in PPP was relatively small, improvements in data use, clinical governance, and population-based initiatives that had been motivated by the programme yielded sufficient system-wide benefits to make the investment effective. Overtime, all PHOs were enrolled in the PPP and had established clinical governance structures and processes to ensure that clinicians were engaged in improving performance. The PPP gradually moved toward a greater quality improvement focus.

**Working Together for Better Primary Health Care**

228. In addition to the considerable amount of work the Ministry of Health and DHBs undertook to implement the Primary Health Care Strategy through the Joint Work Programme, in 2006, the Minister of Health agreed to establish a Workforce Taskforce. The Taskforce provided advice on actions necessary to improve the capability of the health workforce, and identified barriers to making the best use of the primary health care workforce in implementing the Primary Health Care Strategy.

229. The Taskforce was informed by a wide range of stakeholders in the primary health care sector and drew on the primary health care expertise of its own membership in identifying relevant barriers and formulating possible solutions. In May 2008 the Ministry of Health published the Taskforce’s report *Working Together for Better Primary Health Care.*

230. The Taskforce identified five significant barriers for primary health care workforce in implementing the Primary Health Care Strategy.

230.1 The primary health care funding model was seen as fragmented, siloed and not providing sufficient incentives or flexibility to achieve changes to service delivery. Capitation funding largely went to GP services with limited access for other health professionals. The contracting framework between DHBs and PHOs was criticised as prescriptive, with high compliance requirements and minimal delegation of authority.
230.2 complex organisational structures and functions of the primary health care system operating within cumbersome and convoluted contracting processes with uncertain responsibilities and reporting difficulties.

230.3 leadership roles at different levels of the primary health care sector were not clearly defined or aligned

230.4 training of primary health care clinicians and management overly focused on preparing for work in hospital environments and did not sufficiently emphasise treatment in the community.

230.5 no national quality improvement framework for primary health care.

231. The Minister of Health agreed to a number of Taskforce recommendations related to improving the primary health care funding formula and improving training and service delivery in primary health care. Other recommendations agreed to by the Minister were the provision of a professional leadership and clinical governance board to provide governance and training to PHOs and assessing feasibility of primary health care pilots to demonstrate multi-disciplinary working. The Ministry of Health progressed these recommendations alongside related initiatives.

Māori PHO and provider sustainability

232. In the context of the WAI 1315 claim, Māori PHOs and providers raised sustainability issues with the Ministry. Specifically, claimants raised that the PHO funding formula was not adequate to address the predominantly high needs populations that Māori providers serve.

233. The Ministry's response to this was two-fold. In the first instance, the claimant groups and their representatives were invited to be participants in the Ministry/DHB joint work programme. In addition, the Ministry agreed that it would embark on a sustainability project.
234. The purpose of the sustainability project was to quantify the financial, clinical and cultural issues which the claimants allege negatively impact on the sustainability of their PHOs and their general practices. It had two phases and was undertaken by Deloitte.

235. The first phase of the Sustainability Project, in 2007, delivered a report that outlined at a very high-level that additional funding may be required for all small PHOs. Following the presentation of the high level estimate it was determined that a more in-depth analysis of these issues was required to substantiate the hypothesis that sustainability was a critical issue for these PHOs and their practices.

236. The second phase of the sustainability project focused on gathering information and quantifying the sustainability issues for these PHOs and their practices under the following domains: financial, clinical and cultural. As part of this phase, the Ministry engaged the services on an independent clinical advisor (Dr Peter Jansen) and established a cultural working group. These mechanisms were intended to assist in the completion of this sustainability project.

237. Phase II of the project began in March 2008 and ended again in September 2008 when the claimants filed for an urgent hearing in the Waitangi Tribunal on the grounds that they did not believe that working with the Ministry on the Sustainability Project would be sufficient to answer their claim issues. The claimants ultimately withdrew their urgency claim and the work continued.

238. In 2009, the scope of the second phase was broadened to include a range of providers and PHOs that serviced predominantly high needs communities - such as Pacific providers. This second phase occurred alongside the development of the Better, Sooner, More Convenient Business Cases.

239. In 2010 the Ministry worked with Deloitte on the production of the final report. There were issues in finalising the report as some of the statements were regarded as subjective by the Ministry. A final report was never
delivered and the most up to date report, still in draft is attached as Appendix X.

240. In terms of the findings that were discussed in the report, these were incorporated into ongoing policy development. The focus at this time was on implementing Better, Sooner, More Convenient, with the next piece of work that addressed the issues specifically being the Very Low Cost Access Practice Case Studies.

**Review of DHB accountability arrangements**

241. In November 2006, the Ministry, in liaison with DHBNZ Accountability Reference Group, undertook a review of DHB accountability arrangements, planning and performance reporting processes and, in particular, the key annual accountability documents. Interviews were conducted with DHB chairs, chief executive officers and funding and planning managers.

242. The review sought to reduce compliance activity, in particular, the requirement to report on the implementation of strategies, action plans and guidelines (other than in connection with health targets and the Government’s key priorities, as specifically identified in the Minister’s Letter of Expectations for the year concerned) and to sharpen focus on DHB performance improvement. In addition, the review sought to:

242.1 assign appropriate responsibility for planning and decision-making to a mature DHB sector by minimising prescriptive compliance requirements;

242.2 simplify accountability processes and documents, clarifying the linkages between documents and ensuring that only meaningful and relevant information is collected; and

242.3 sharpen the focus of the DHB accountability arrangements on improving performance and on the reporting of performance in a vital few areas.³
In October 2007, the Ministry of Health produced its report, Accountability: A better way of working together (Report of the DHB Accountability Arrangements Review). The report signalled the need to shift the Ministry of Health’s focus from DHB capacity building to improving performance. Since the establishment of DHBs, the Ministry of Health’s focus had been on building DHB capacity and capability, the development and maintenance of nationally consistent levels of service provision, and the delivery of the Government’s key health and service priorities. However, the report outlined that as the DHB sector matured the Ministry of Health would shift its focus, and accountability arrangements, from capacity building to improving performance.

As a result of this Ministry of Health report, the District Annual Plans (outlined DHB Accountability section of this brief of evidence) were updated to have a sharper focus on fewer key areas and the Ministry of Health was less prescriptive than in the past. The main focus of the guidelines was on planned progress in relation to health targets and the Government’s key priorities.

National Health targets

Following the DHB accountability arrangement review, in August 2007, the government launched national Health targets to provide a greater focus for action and lift health system performance in priority health and disability areas.

Health targets were a set of national performance measures designed to improve the performance of health services that reflected significant public and Government priorities. In 2007, there were ten Health Target areas. All Health targets were indicators of progress against the Government’s strategies and priority policies. These strategies and policies included, but were not limited to, the Primary Health Care Strategy, Oral Health Action Plan, Cancer Control Plan, Quality Improvement Plan for Cardiovascular Disease and Diabetes, Mental Health and Addictions Strategy, ‘Clearing the

247. Primary health care had a direct influence on achieving the ten Health targets at point of service provision, namely:

247.1 improving immunisation coverage;

247.2 reducing ambulatory sensitive (avoidable) hospital admissions;

247.3 improving diabetes services;

247.4 reducing the harm caused by tobacco; and

247.5 improving nutrition, increasing physical activity and reducing obesity.

248. The health targets were reviewed annually to ensure they aligned with the current health priorities. DHBs report their progress to the Ministry of Health four times a year, as at 30 September, 31 December, 31 March and 30 June. In turn, the Ministry of Health reported its results to the Minister of Health and the public.

249. A National-led government (elected in 2008) re-launched the programme of national health targets with fewer, clearer targets, some different targets that reflect its priorities as against those of its predecessor and enhanced its focus on how DHBs and others were encouraged to meet the targets. The government also introduced public reporting of health targets as a way of using reputational concerns as a lever for improving performance in Health Target areas.

250. At the same time, the new government also removed differential targets for different ethnic groups, reinforcing the expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity. The government continued to require reporting by ethnicity (not publically) to ensure visibility of results and monitored DHB performance by ethnicity. The Ministry of Health expected performance to improve for all
components of the population, and supported DHBs who were struggling to meet the health targets overall, and across ethnic groups, or DHBs with a large high needs population, through the use of health target Champions.

**New health targets in development**

251. In 2017, the new Government directed the Ministry of Health to develop a new set of performance measures to replace the national health targets. The Ministry of Health is currently developing these performance measures and these will be in place by early 2019.

252. The new focus will be on population health outcomes and will aim to ensure the optimal use of health resources. In developing these new measures the Ministry has been asked to consider the following criteria:

252.1 a mix of health system and population health improvement measures;

252.2 alignment with government priorities, for example, child wellbeing and mental health;

252.3 quantifiable and timed measures;

252.4 availability of data to monitor progress;

252.5 sector engagement and support; and

252.6 focus on health issues with alignment to socio-economic determinants.

253. It is also an expectation of the government that all new measures will be reported on by ethnicity and DHBs will be held to account for ensuring improvements across all ethnic groups. The performance measures will be regularly reported on to the public.

**BETTER, SOONER, MORE CONVENIENT**

254. The new Government in 2008 questioned the Strategy’s implementation progress and its impacts. Although there had been progress made on
improving access to primary health care, mainly through reducing co-payments, there had been limited progress in implementing service delivery improvements envisaged under the PHC Strategy. Very few general practices service models had changed, use of the workforce had not advanced as expected and general practice still operated as previously with reactive 15 minute consultations on a fee for service basis. Nurses were not being used innovatively and proactive health prevention and disease management programmes were not the norm.

255. In 2009, a Ministerial Review Group was established by the Government to provide advice on how to improve the quality and performance of the public health system. The Group’s report outlined the serious financial challenges faced by the sector, including, the reduced rates of funding growth due to changes in the fiscal environment, and rising health care costs, caused in part by the ageing population and the prevalence of long term conditions. The Ministerial Review Group report emphasised that actions were necessary to reduce bureaucracy, improve frontline health services and improve value in the public health and disability sector.

Very Low Cost Access changes 2009 - 2013

256. Very Low Cost Access, introduced in October 2006, was open to any practice wishing to join the scheme. It provided additional funding to practices and PHOs who agreed to keep patient fees at a set level. The scheme was more popular than expected. As at 1 October 2009, 316 practices were participating in this scheme, which amounted to 29.3 % of the country’s PHO enrolees.

257. As part of the Government’s drive to bring all services within budget, while retaining this funding stream, the eligibility criteria was changed in 2009. From 1 October 2009, practices could only join the scheme if at least 50 per cent of their enrolled patients were Māori and/or Pacific and/or living in high deprivation (NZ Dep quintile 5). Practices who had already joined the scheme could remain, even if they did not meet these revised criteria. In order to go some way to addressing the sector’s sustainability concerns the
VLCA subsidy was also increased by more than 15 per cent for patients under six and by 14.3 per cent for those aged six and over in 2009.

258. Some sector groups expressed that changes in the scheme’s eligibility requirements created inequality due to differential access to government funding between practices already part of VLCA (and not subject to the new criteria) and practices wanting to join the scheme but did not meet the new requirements. Some non-VLCA practices reported concerns that patients would leave to go to cheaper VLCA practices, and that practices supporting smaller groups of high needs patients would not receive the support they needed to care for these populations. The Ministry could not find evidence to support this claim as non-VLCA practices still had access to discretionary funding available through Services to Improve Access and Health Promotion.

259. In 2012 PHO representatives on the PHO Service Agreement Amendment Protocol Group (PSAAP) again raised concerns about the sustainability of some VLCA practices. In response, the government established a working group to examine the nature of any sustainability issues facing VLCA practices. Members of the working group included a representative of the National Hauora Coalition. Five VLCA practices were selected to be in depth case studies. These case studies showed that some VLCA practices were experiencing sustainability issues and that these were due to a mix of clinical, workforce and financial challenges.22

260. In 2013, in response to VLCA sustainability issues the Minister announced a VLCA Practice Sustainability Initiative which included:

260.1 a sustainability fund of $4 million to support the VLCA practices most in need of support; and

260.2 one-off funding to provide for the employment of graduate nurses for 12 months in VLCA practices who had 50 % or more high

22 Very Low Cost Access Practice Case Studies: Summary Report for the PHO Services Agreement Amendment Protocol Group, August 2013
needs enrollees. Following completion of that year, it became the responsibility of the practice and the PHO to manage the continued employment of those nurses. The programme was extended for a further 12 months when additional one off funding was made available.

261. VLCA sustainability funding was allocated to PHOs, on the basis of their high needs enrolled population. PHOs were then responsible for distributing this funding to their VLCA practices on the basis of the issues they were facing.

262. A Patient Access Subsidy was introduced in 2014 for situations where two practices (one VLCA practice and one non-VLCA practice) merged. If the merged practice did not meet the 50 percent criteria for VLCA funding, the Ministry and DHB had the discretion to determine whether the newly merged practice should retain the VLCA funding. If the Ministry and DHB determined it should, the practice would be paid the patient access subsidy payment. The patient access subsidy amount is the amount the VLCA practice would have received (capped). While the patient subsidy funding had had to improve access with lower co-pays for the new practice’s patients who meet the VLCA criteria, the practice could decide how best to use the funding to this end.

Reducing the number of Primary Health Organisations

263. In 2009, a Ministerial Review Group was established by the Government to provide advice on how to improve the quality and performance of the public health system. The Group’s report outlined the serious financial challenges faced by the sector, including, the reduced rates of funding growth due to changes in the fiscal environment, and rising health care costs caused in part by the ageing population and the prevalence of long term conditions. The Ministerial Review Group report emphasised that actions were necessary to reduce bureaucracy, improve frontline health services and improve value in the public health and disability sector.
264. In mid-2009, approximately 30 percent of New Zealand’s population was in four of the 80 PHOs, with 12% of the population being represented by 41 PHOs. On the basis of this distribution, in 2009 the Government set an expectation that PHOs and their providers would begin to organise themselves in a way that would allow them to offer improved care and services to their enrolled populations.

265. The Minister’s Letter of Expectation to the DHBs for their 2010/2011 annual planning outlined the expectation that DHBs would “investigate and facilitate the opportunities that exist in your district to consolidate PHOs where appropriate, acknowledging existing provider networks”.

266. DHBs and PHOs were expected to identify the best way forward for their districts in achieving greater co-operation between PHOs, and where appropriate amalgamation of PHOs, to improve integration across the health care system and to promote efficiencies within primary health care.

267. The government considered that fewer PHOs would make it easier for the DHBs to plan services and would reduce governance and administration costs. The trade-off with this amalgamation has been that larger PHOs have been further removed from their communities and it has been harder for them to engage with their communities and to effect change amongst providers.

268. Following, the Minister’s direction in the letter of expectation, many smaller PHOs began to merge with larger PHOs that had better infrastructure. The number of PHOs reduced from 80 to 32 by September 2011. These 32 PHOs vary in size and structure, and include South Canterbury DHB which is the only DHB that provides the PHO functions itself.

**Better, Sooner, More Convenient primary care policy**

269. To drive further change including new service models, the government introduced the Better, Sooner, More Convenient Primary Health Care policy (BSMC) in 2009. The vision for primary health care under BSMC was for: a strong and vibrant sector providing:
better management of chronic illness;

improved continuity of care;

greater accessibility;

earlier intervention and disease prevention;

better cooperation with hospitals; and

better, more convenient access to a wider range of health services and professionals.

The direction of Better Sooner More Convenient was to:

create better services for patients through better collaboration of primary and secondary health professionals – sharing patient information more readily and working together with patients to provide effective health care;

ensure patients could access services sooner, by providing more services in the community and creating a smoother flow between different parts of the health system; and

shift health service delivery to ensure it was more convenient for patients, providing patient-focused services to best suit the needs of the population.

BSMC was an acknowledgment that while progress had been made on improving access to primary health care, mainly through reducing co-payments, there had been limited progress in implementing the wider service delivery improvements envisaged under the PHC Strategy.

To address this lack of progress, and to fast track the development of improved service models (for example: Integrated Family Health Centres) the government set up a process to encourage innovative provider groups to develop proposals to improve service delivery models on a large scale.
The Better, Sooner, More Convenient business cases

273. In September 2009, the Minister of Health called for expressions of interest from eligible primary health care providers and/or PHOs or networks across New Zealand, outlining how they could implement the objectives of the BSMC policy over a three-year period. Expressions of interest needed to outline how a provider would provide transformational primary health care service improvement initiatives that:

273.1 improved the health outcomes of their enrolled populations against health targets;

273.2 led to the establishment of Integrated Family Health Centre's in appropriate locations;

273.3 reduced acute demand on publicly-funded hospital services;

273.4 better managed patients with chronic conditions to slow disease progression and improve living standards for those in the community incorporating Whānau Ora approaches where appropriate;

273.5 demonstrated a commitment to continuing service improvement; and

273.6 achieved the above objectives in a way that is cost effective and assures quality and safety for service users.

274. The Minister of Health received 77 expressions of interest and selected nine to develop their business cases and implement the new models of care. The nine groups covered more than 60 percent of New Zealand’s enrolled PHO population. The nine groups were: Alliance Health +, Greater Auckland Integrated Health Network, the National Hauora Coalition (the Māori PHO coalition), Health Care Aotearoa network (which included some Māori PHOs and Māori providers), Midlands Health Network, Eastern Bay of Plenty, MidCentral, Wairarapa, Canterbury and West Coast. The National
Hauora coalition focused on the development of a Whānau Ora model of delivery.

275. To support the groups in developing their business cases, the Ministry provided:

275.1 business case development funding and service development funding for year one implementation deliverables. The funding for each of the business cases was determined on a case by case basis. By February 2011, the Ministry’s investment in the business cases and their implementation was $7.17 million: and

275.2 three business case liaison roles to work with the nine groups and support their business case development.

276. Ministry funding to support early implementation deliverables was provided on the basis that the business cases would contribute to local and national BSMC objectives, and have wider application beyond the nine business cases.

277. To support successful implementation of the business cases the Ministry introduced two inter-related policy changes for the BSMC business cases: alliance based agreements and a flexible funding pool. These changes were in addition to the one-off funding provided. The Ministry also intended to introduce a Better Sooner More Convenient Monitoring Framework to support implementation of the nine sector-led business cases. This was developed collaboratively with DHBs however it was not implemented. It was difficult to identify and then gain consensus between stakeholders. This was the first time an attempt was made to measure the health of the system and over time this developed into the Integrated Performance Incentive Programme.

**Alliance –based agreements**

278. The nine business cases each joined a new form of agreement with their local DHBs. The business cases were required to develop district alliances
with at least the DHB and PHO. Alliances are not legal entities and function under an Alliance Charter which describes the behaviours and principles expected.

279. Alliances were a new way of working, changing the dynamic from ‘master – servant’ to joint responsibility. Alliance agreements create a high trust, low bureaucracy environment with high quality and accountability. They provide a mechanism for clinical leadership in the development of health services. Alliance Leadership Teams should involve clinical leaders who have a community of influence amongst their professional groups and key health delivery organisations. In signing up to an alliance participants are agreeing to allow the Alliance Leadership Team to take decisions that impact on their service delivery.

280. Alliances are expected to plan district level services based on clear evidence (eg data) that balances improved health outcomes with financial sustainability, thus a mix of skills is needed at the alliance table.

281. Due to the DHB’s statutory and regulatory responsibilities there was three ways to make decisions:

281.1 We discuss, we decide

281.2 We discuss, you decide (service providers, eg PHOs, general practice)

281.3 We discuss, I decide (DHBs exercising their regulated/legislated authority).

282. DHBs continued to have their statutory and accountability responsibilities. The business cases led to three-year Alliance Agreements which would expire on 30 June 2013.

**Flexible Funding Pool**

283. In 2010 the government established a Flexible Funding Pool (FFP) for the nine business cases that merged four existing primary health funding
streams into one pool. Non-business case providers continued to access funding from these streams separately. The four funding streams that were merged were: Services to Improve Access, Health Promotion, Management Services and Care Plus. This created a funding pool of $130 million (17% of projected capitation–based PHO funding in 2010) which provided flexibility for the business cases to implement the service delivery models that best met local/regional needs and contributed to agreed BSMC outcomes. PHOs continued to receive the same capitated amounts based on their enrolees demographics.

284. Cabinet mandated that while the FFP could be used flexibly, the original policy intent of each funding stream must still be met. This meant that as long as these policy intents still drove how they were used, the specific business rules for each funding stream no longer applied. The nine Business Cases could use this funding pool to implement the actions in their Business Cases and develop the service delivery models that best met local/regional needs and contributed to agreed BSMC outcomes. Use of the FFP was governed by each District Alliance. Proposals for the use of the FFP were made to the Alliance Leadership Team (ALT) by Service Level Alliance Teams (SLATs), essentially working groups devoted to specific service areas (eg child health, acute demand, long term conditions). Proposals were expected to be evidence based and outline how the funding was to be used along with the expected impact. For example a district alliance that reviewed their health outcomes data might see that they have higher hospital admissions for Māori children aged zero to four years for respiratory conditions. They also note that they have low vaccination coverage for the same cohort. They could propose to use part of the FFP to establish outreach immunisation clinics on specific marae. The expected impact would be increased immunisation coverage for this cohort and reduced hospital admissions for respiratory conditions.

285. The National Māori PHO Coalition (later to become the National Hauora Coalition) was one of the nine BSMC business cases. The Coalition
comprised a national network of 11 Māori led PHOs with a population coverage of approximately 250,000 people (Māori and high needs) and provided partial coverage of nine DHBs across the Auckland, Midland, Bay of Plenty and Whanganui regions. Their business case proposed a Whānau Ora model of care including a results based accountability framework (RBA) delivered by providers across the country through a network of 11 PHOs. This was to include: 11 new Whanau Ora Centres as the delivery mechanisms to support all whānau and high needs families; and programmes focused from pre-conception to four years of age, as well as a long-term condition programme. A Business Case Liaison role funded by the Ministry was assigned to support the Coalition advance its full business case proposal, and the Ministry provided further support as required.

286. The Ministry was aware that the Coalition was working through a number of complex issues as part of developing its business case including:

286.1 providers that were participating in multiple business cases;

286.2 working across multiple DHBs;

286.3 provider amalgamations; and

286.4 Iwi dynamics and governance and provider levels.

287. During 2009/2010 DHBs and the Ministry provided a range of financial and non-financial support to the Coalition, to ensure the success of the Coalition’s Business Case. From 2009 to 2011, the Ministry allocated over $2.4 million to the Coalition for business case development and implementation, with implementation funding phased in over 4 financial years and including an ‘at-risk’ performance component of $300,000 (see Table 1, over). By the 2011/2012 year the total additional funding provided to the National Hauora Coalition for development and implementation of the business case was more than $3.6 million. The Ministry also provided two advance payments to the Coalition to assist with its cash flow, which at the time had become counter-productive to the Coalition’s efforts to
implement their plan. DHBs contribution included seconded staff (a total of 2 FTE across Auckland and Counties Manukau DHBs) at no cost to the Coalition. This was in addition to the significant support provided internally by DHBs as part of their commitment to supporting all business cases.

Table 1: Approved Funding to Business Case Groups to April 2011

<table>
<thead>
<tr>
<th>Business Case Group</th>
<th>Primary Health Care</th>
<th>NHITB</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Business Case</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAIHN</td>
<td>348,492</td>
<td></td>
<td>767,492</td>
</tr>
<tr>
<td>Alliance Health Plus</td>
<td>300,000</td>
<td></td>
<td>407,500</td>
</tr>
<tr>
<td>National Māori PHO Coalition*</td>
<td>700,000</td>
<td>1,716,667</td>
<td>2,416,667</td>
</tr>
<tr>
<td>Midlands Network</td>
<td>650,000</td>
<td></td>
<td>870,000</td>
</tr>
<tr>
<td>Eastern Bay of Plenty</td>
<td>395,000</td>
<td>160,000</td>
<td>555,000</td>
</tr>
<tr>
<td>MidCentral</td>
<td>421,050</td>
<td></td>
<td>421,050</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>307,480</td>
<td>293,940</td>
<td>732,420</td>
</tr>
<tr>
<td>Canterbury Clinical Network</td>
<td>600,000</td>
<td>90,000</td>
<td>690,000</td>
</tr>
<tr>
<td>West Coast</td>
<td>100,000</td>
<td>210,000</td>
<td>310,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3,822,022</td>
<td>3,127,107</td>
<td>7,170,129</td>
</tr>
</tbody>
</table>

* Business Case Implementation funding for the National Māori PHO Coalition was funded over 4 financial years and included an at risk performance component of $300,000

288. From 2010 to 2013 the National Hauora Coalition focused largely on the detailed design and build of the Whānau Ora system. Their governance
structure evolved from a National Māori PHO Coalition to a single organisation amalgamating 10 PHOs. The National Hauora Coalition cited the Manakids programme in South Auckland as a strong example of the Whānau Ora model working in practice, which included collaboration with the Ministry’s Rheumatic Fever Prevention programme, the Coalition and Counties Manukau DHB.

289. From 2013 the National Hauora Coalition was to continue to deliver the aspirations of its business case after its three year Alliance Agreement ended. The Ministry continued to monitor and support the coalition to build their capability, capacity and DHB connections in regions outside of Auckland. Across all business case groups the Ministry continued to provide liaison and support to ensure coordination and relationships between BSMC alliances were maintained. This included assisting with planning for 2013/2014 and out-years.

**Progress implementing BSMC**

290. By April 2011, despite some local examples of success, progress in implementing the business cases was slower than expected with little sense of momentum. On reflection the fact that the Business Cases used a ground up development approach and were therefore largely ‘owned’ and driven by PHOs, prevented achievement of all the Business Case goals. Though agreement by DHBs to the proposed Business Case was required, in many cases this took the shape of a DHB signature rather than joint development and agreement, particularly to any required new funding, which would have required the DHB to reprioritise its baseline funding. Additional barriers to effective implementation of the Business Cases were:

290.1 insufficient unity of purpose communicated effectively by the Ministry and alignment of the available levers (funder, monitor, policy) to reinforce the direction;
290.2 inconsistent understanding of BSMC policy, variable commitment and limited capability in some DHBs to drive change - exacerbated where issues span more than one DHB;

290.3 fatigue from constant change and scepticism amongst primary care professionals affecting their readiness to make further and rapid change (given the right opportunities);

290.4 mixed perceptions about whether progress could be achieved or would instead by frustrated by a complex and inflexible funding/administrative environment (including perceptions that primary care-related national agreements are no longer fit for purpose); and

290.5 unclear accountability arrangements for delivering BSMC at a local level.

291. To facilitate progress, in April 2011 the Minister supported a change in focus toward accelerating the most advanced business cases (CMHDB, Midland, MidCentral and Canterbury) and re-engaging with clinicians across the sector more broadly to demonstrate the link between the success of elements of BSMC and improved patient experience. The Ministry produced and distributed a booklet on the achievements the BSMC to date. The remaining business cases continued to be supported to ensure they delivered on their three year action plans.

292. While the pace of progress for each business case was variable, sound platforms had been established and new models of care were being implemented through the business cases. The Ministry was confident that beyond the end of the Alliance Agreements clinical integration activity through the business case groups would continue to expand.

293. Based on the improving DHB/PHO relationships seen in some of the Business Cases and seeing these forums’ potential impact (refer Canterbury Clinical Network), the remaining DHBs and PHOs were required to
establish district alliances. As they established their alliance these new
groups then gained access to the FFP.

**The PHO Services Agreement 2013**

294. In 2013, a new PHO Services Agreement was introduced for all PHOs to
better reflect the role of primary care in an integrated health system. The
Agreement provides clarity on the respective roles of DHBs and PHOs,
through to providers, reflecting the key role of primary health within the
whole system of healthcare.

295. The revised agreement also removed the need for PHOs to produce
separate PHO level Māori Health plans, favouring PHO commitment to
and involvement in the development and implementation of specific
deliverables in the DHB Māori Health plans. Instead of PHOs separately
submitting a Māori Health Plan to the DHB, PHOs and DHBs agreed to
jointly sign off on the DHBs Annual Plans relating specifically to primary
care and Māori health deliverables. This was based on development of a
high trust relationship between PHOs and DHBs.

296. In 2013 the PHO Minimum Requirements were audited and revised, which
resulted in further mergers of some smaller PHOs as they needed the
support of larger PHO infrastructure. These requirements were consistent
with the goals of the BSMC approach for primary health care service
delivery models.

**Māori workforce development**

*The Māori Workforce Development Fund*

297. The Māori Workforce Development Fund was established by the Ministry
of Health in 2009/10 with an annual budget of $3 million (Gst Excl). The
Māori Workforce Development Fund originally funded 11 workforce
development programmes procured by the Ministry of Health. The Māori
Workforce Development Fund aligns to the Māori workforce objective of
He Korowai Oranga, “to increase the number and improve the skills of the
Māori health and disability workforce”. The Māori Workforce Development
Fund also aims towards equitable representation of Māori in the workforce and:

297.1 Invest in Māori students undertaking health related tertiary studies.

297.2 Expand the skill base of the Māori health and disability workforce

297.3 Enable equitable access for Māori to training opportunities.

298. The Ministry of Health continues to administer the Māori Workforce Development Fund of $3 million (Gst excl) today. The funding now supports eight (including one programme that is across five DHB regions) of the original 11 Māori workforce development programmes until December 2020. The remaining programmes are:

298.1 ‘Māori Health as a Career Programme’ to support more Māori to pursue health professional careers in the health and disability sector, with a focus on Māori students in secondary schools, tertiary institutions and communities across New Zealand (rolled out across 20 DHBs with four regional lead DHBs)

298.2 Otago Project – aimed at to substantially increase the number of qualified Māori health professionals in the registered health workforce

298.3 Whakapiki Ake Project which aims to increase the number of Māori enrolled and successfully completing health related tertiary studies at the University of Auckland

298.4 Ngā Manukura o Apōpō – Tomorrow’s Clinical Leaders, a National Māori nursing and midwifery workforce development programme
**Te Ao Auahatanga Hauora Māori: Māori Health Innovation Fund**

299. Te Ao Auahatanga Hauora Māori: Māori Health Innovation Fund (Te Ao Fund) was established by the Ministry of Health in 2009 to address the service gaps and unmet needs of Māori by the health system.

300. Te Ao is open to Māori Health Providers who provide health and disability services primarily but not exclusively for Māori. Te Ao Fund is for new approaches to service delivery. The funding is split across five years, starting with seed funding (Te Kākano), spread funding (Te Ruinga), and sharing funding (Te Pataka), it also covers funding for external evaluation. It is about challenging the health sector to take account of the wider issues affecting the health and wellbeing of Māori, and the need to design responsive services that recognise the interconnectedness of health education, housing, justice, welfare, employment and lifestyle elements of whānau wellbeing.

301. The overarching goal of the Te Ao Fund is Pae Ora or Healthy Futures for whānau aligned with He Korowai Oranga: Māori Health Strategy. The innovation funding looks to advance Whānau Ora by affirming Māori approaches that improve Māori health outcomes and reduce Māori health inequity; improve the quality of services to Māori and be more responsive to Māori health needs; and sharing effective ways of delivering healthcare.

302. The Ministry of Health is currently seeking applications to Te Ao Fund 2018-22 seed funding. Te Ao Fund is for approximately $19 million over five years.

**Zero fees for under 13’s**

303. From 1 July 2015 the zero-fees scheme for general practice visits and prescriptions for children aged under six was extended to children up to the age of thirteen. From this date, all VLCA practices were required to offer zero fees to children under 13 years. Opt-in for non-VLCA practices was voluntary, with decisions made at the individual general practice level.
Those practices who opted in received an additional subsidy from the Government.

304. Non-VLCA practices previously in the under-6s scheme had the option of remaining in only the zero fees for under-6s scheme. From 1 July 2015, any practice choosing to opt into the zero fees scheme could only opt into the under-13s scheme, covering all children aged up to 13.

305. Daytime zero-fee visits for enrolled under-13s are funded via capitation funding, with an additional subsidy paid to practices opting in. DHBs were also required to ensure that children under 13 were able to access zero fee after-hours care and prescription medicines within reasonable travel time (maximum of 1 hour).

306. This initiative was designed to improve access to health care for primary and intermediate school aged children, ensuring they can get the care they need when they need it and avoid possible complications and visits to hospital A&E departments.

**New performance improvement arrangements for primary care**

307. Following the DHBNZ Accountability Reference Group review of DHB accountability arrangements in 2006 (discussed in the section titled Performance Management and Monitoring), DHBs, the Ministry of Health and other stakeholders worked to implement a more streamlined and simplified accountability process with more clearly articulated expectations about what mattered most for health system performance improvement and implemented reporting requirements that better reflected this. The Ministry and DHBs also emphasised the importance of building stronger working relationships and better ways of working together to improve health system performance.

308. This new arrangements between the Ministry of Health and DHBs was also reflected in new performance improvement arrangements for primary care, discussed below)
The Integrated Performance and Incentive Framework

309. In October 2013, the Integrated Performance and Incentive Framework (the Framework) was introduced by the Ministry of Health as a quality and performance improvement programme to replace the PHO Performance Programme with the intention to better support the health system to address equity, safety, quality, access and cost of services.

310. The Framework represents a significant change to the way that the performance of primary care, and the rest of the healthcare system, was monitored and incentivised by measuring how the whole system was performing and how each part of the system contributed to that. The Framework sought to balance the local responsibility and discretion that was needed to enable innovation and quality improvement, and at the same time be clear about accountability.

311. The initial scope of the Framework will be primary care services, with patients, practitioners, general practice teams, PHOs and DHBs, working together to plan and provide primary health care within a whole of system context.

312. The development and implementation of the Framework was expected to be gradual and evolve over a number of years, taking into account the needs and priorities for health and disability services in New Zealand. Phase one (2014 to 2015) of the implementation of the Framework, commenced on 1 July 2014 and was viewed as a transitional year. The five initial measures that were implemented to provide continuity with, and transition from, the previous PHO Performance Programme were:

312.1 more heart and diabetes checks;

312.2 better help for smokers to quit;

312.3 increased immunisation rates at age eight months;

312.4 increased immunisation rates at age two years; and
cervical screening coverage.

System Level Measures

313. The Integrated Performance and Incentive Framework was rebranded in 2016 as the System Level Measures Framework. The System Level Measures Framework aims to improve health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. System Level Measures shifted health sector performance measurement from outputs to outcomes, and provided a framework for continuous quality improvement. System Level Measures focus on improving health outcomes for children and youth, and reducing equity gaps for Māori, Pacific and other population groups that consistently experience poorer health outcomes.

314. System Level Measures were co-produced with clinical, managerial and analytical expertise from across the health sector. The measures:

314.1 were outcomes focused;
314.2 were set nationally;
314.3 required all parts of the health system to work together;
314.4 focused on children, youth and vulnerable populations; and
314.5 connected to local clinically led quality improvement activities and contributory measures.

315. The current System Level Measures are:

315.1 ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds (keeping children out of hospital);
315.2 acute hospital bed days per capita (using health resources effectively);
315.3 patient experience of care (person-centred care);
315.4 amenable mortality rates (prevention and early detection);
315.5 babies living in smokefree homes (a healthy start); and
315.6 youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported)

316. System Level Measures recognise that good health outcomes require health system partners to work together. For example, one of the system level measures is ambulatory sensitive hospitalisation (ASH) rates for 0–4 year olds, which is about keeping children well and out of hospital. Achieving this measure requires various parts of the health system, for example clinicians and managers from PHOs, general practice teams, Well Child providers, hospitals, planning and funding units, ambulance and others work, to understand what’s driving ASH rates in their location and then make changes to address these causes.

317. Contributory measures assist in the achievement of the System Level Measures, and are chosen locally by district alliances based on local needs, demographics and service configurations. These are used to measure local progress against quality improvement activities. For example, contributory measures for ‘Acute hospital bed days per capita’ could include length of stay, acute readmissions and flu vaccinations in the elderly.

318. District Alliances\textsuperscript{23} are responsible for implementing the SLMs in their districts, and must harness input from all relevant parts of the health system. The DHB is responsible for submitting a SLM Improvement Plan to the Ministry of Health and providing quarterly reports on behalf of their alliance.

\textsuperscript{23} District alliances are outlined in the Better, Sooner, More Convenient Era’ section of this brief of evidence.
Cross-government approaches and accountability

Whānau ora

319. In April 2010, the Taskforce on whānau-centred initiatives delivered its report to the then Minister for the Community and Voluntary Sector, Hon. Tariana Turia.

320. The Taskforce on Whānau-Centred Initiatives identified six goals that suggest that whānau outcomes will be met when whānau are: self-managing; living healthy lifestyles; participating fully in society; confidently participating in Te Ao Māori; economically secure and successfully involved in wealth creation; and cohesive, resilient and nurturing.

321. In its most significant response to the report, the Government launched an expressions of interest process in June 2010. Participants from eligible providers and provider collectives were asked to express their interest in developing comprehensive whānau centred services. Many of the successful providers and provider collectives were Māori health providers. These providers received funding from Te Puni Kōkiri to undertake change processes to re-orient their services to be more whānau centred.

322. Providers and provider collectives were transforming their services during a time where primary health care services were also undergoing significant changes through the Better, Sooner, More Convenient policy directive. This meant that providers and provider collectives were able to benefit from changing structures with a greater focus on intersectoral collaboration.

Better Public Services programme (2012 – 2017)

323. In 2011, Ministers requested advice on improving the collective impact of the public sector. They appointed an advisory group—called the Better Public Services Advisory Group—of leaders from the public, private, and non-profit sectors. The advisory group recommended a new modus operandi for state agencies—where sectors mobilise around specified results.
324. The cabinet selected ten problems that were important to both the public and public sector. The responsibility for each problem spanned several agencies and required those agencies to work together to achieve success. Work to address these ten problems became collectively known as the Better Public Services Results programme. The Better Public Service programme was launched by Prime Minister Rt. Hon. John Key on 15 March 2012.

325. The Ministry of Health led one result area – to increase infant immunisation rates and reduce the incidence of rheumatic fever

326. An immunisation rate of 93.3 percent was reached in December 2016 for babies turning eight months of age. This represented an increase of 8 percent in infant immunisation coverage since the start of the target (June 2012). The achievement reflected the hard work of GP teams, PHOs, Well Child providers, community outreach teams, midwives, DHB staff and the Ministry of Health’s immunisation programme team

*Better Public Services (2017-2018)*

327. In 2017, a new set of ten Better Public Service results were identified, set across seven result areas. The Ministry of Health led two results areas:

327.1 Healthy Mums and Babies – by 2021, 90 percent of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80 percent by 2019, with equitable rates for all population groups; and

327.2 Keeping Kids Healthy – by 2021, a 25 percent reduction in the rate of hospitalisations for a selected group of avoidable conditions in children aged 0–12 years, with an interim target of 15 percent by 2019.

328. Both of these results comprised the Good Start to Life result area. These results required a strong focus on improving outcomes for pregnant women
and children, and reducing inequities of service access and outcomes between different population groups.

329. In January 2018, the new Government announced that the Better Public Service programme would not continue. Although the Government acknowledged the merit in settings targets, it has intentions to set more explicit targets on issues such as cold, damp homes and levels of absolute child poverty.

330. The Government said that it would develop its own system to monitor system performance and whole of government outcomes.

The Refreshed He Korowai Oranga

A Guide to He Korowai Oranga

331. He Korowai Oranga – Māori Health Strategy set the overarching framework to guide the government and the health and disability sector to achieve the best health outcomes for Māori. He Korowai Oranga means ‘the cloak of wellness’. A Guide to He Korowai Oranga was released in June 2014, expanding the aim of He Korowai Oranga from whānau ora to pae ora – healthy futures. A Guide to He Korowai Oranga acts as a catalyst for increasing Māori participation across the whole health and disability system and played a pivotal role in shifting the health and disability system from focussing on disease and illness to a desire for health and wellness.

Monitoring progress against He Korowai Oranga

332. Whaka Tataka, the Māori Health Action Plan, was discontinued with the release of A Guide to He Korowai Oranga.

333. From 2017/18 the Ministry of Health implemented a new performance framework for DHBs; the first step was streamlined annual plans. A component of this was to incorporate the Māori health measures into the streamlined plans. Māori health performance measures were incorporated into DHB Annual Plans in 2017/18 and the focus on was strengthened in these plans.
The Refresh of the New Zealand Health Strategy

334. In 2016 the Ministry of Health refreshed the New Zealand Health Strategy developed in 2000. The Ministry undertook a wide ranging consultation process to develop the updated New Zealand Health Strategy. Consultation included electronic and face-to-face public forums, hui, fono, and written submissions. The updated New Zealand Health Strategy was developed with the help of sector leaders, independent reports, extensive public consultation, and was informed by other government programmes and initiatives.

335. The updated New Zealand Health Strategy aimed to provide clarity on the future direction of health services and enable different parts of the system to work together to improve it.

336. The New Zealand Health Strategy had five strategic themes to guide the health system:

336.1 People-powered – reflects the Government’s priority of delivering ‘better public services’ and the opportunity to achieve this through taking more people-centred approaches to providing health services.

336.2 Closer to home – reflects the opportunities for shifting services out of such specialist centres, so that we can prevent and manage health conditions safely and effectively in people’s local communities.

336.3 Value and high performance – recognises the need to make better use of our funding, better directing it to where needs are greatest, and that we could achieve this by taking a health investment approach with a long-term mind-set.

336.4 One Team – requires people within the system to have a clear view of their own roles, responsibilities and accountabilities, whether these are in governance, clinical, managerial or other areas.
336.5 Smart system – makes the best use of innovation, research and emerging technologies to enable better performance, more effective collaboration with other government agencies in other sectors.

337. The New Zealand Health Strategy aligned with the objectives of the Primary Health Care Strategy by setting the strategic direction for primary care and community services to support wellness and prevent illness, through providing care closer to where people live, learn, work and play.

‘Ministry on the Move’ – a Ministry of Health restructure

338. In 2016, the Ministry of Health made changes to its organisational structure with the aim to improve performance in a number of areas, including:

338.1 improving outcomes for Māori and achieving health equity

338.2 a stronger focus on equity and evidence-based action

338.3 embedding the improvement of Māori health across the organisation.

339. The organisational restructure considered what the health system needed from the different Ministry of Health functions, and aligned closely with the New Zealand Health Strategy.

340. As part of this process, the functions of Te Kete Hauora, (the Ministry’s former Māori health business unit) was integrated across the Ministry of Health’s new business units. One of the drivers for this change was to boost the whole organisation’s capability and capacity to address Māori health inequities.

341. A new executive role called ‘Māori Leadership’ was formed and is responsible for driving the Ministry of Health’s goal of improving Māori health outcomes and achieving Māori health equity across the organisation. All policy advice, research and programme functions of Te Kete Hauora continue to be delivered in other areas of the Ministry of Health.
CONCLUSION

342. I have outlined the Government’s programme to reform the organisation of publicly-funded primary health care services since the release of the PHC Strategy in 2001. Progress has been made on the six key directions set out in the PHC Strategy and its implementation has resulted in some positive results and outcomes, including stimulating a new population health approach through the establishment of PHOs and extending the range of primary care services.

343. As a result, most New Zealanders’ experience of primary care is largely positive and they are able to access services when they need them.

344. However, the Government has experienced some implementation challenges since 2001 and there have been some unintended consequences of the PHC Strategy. These include, but may not be limited to:

344.1 the creation of a complex funding and organisational system with a variable capacity to deliver on the Government’s reform objectives; and

344.2 an increase in the power and scope of the pre-existing general practice organisations partly due to government deciding not to monitor the governance of PHOs to ensure they worked with their populations and resisted capture from the medical profession.

345. As a result of these shortfalls some primary health care providers have suffered from sustainability issues, and at times have had to close down. More importantly, the whole health system has further work to do to fully realise the intent of the PHC Strategy and remove barriers for those New Zealanders who cannot get the health care they need due to cost and other non-financial barriers. The Government is committed to shaping the primary health care system to ensure it is more responsive to the needs and aspirations of all New Zealanders, including Māori.
The future direction of primary health care

346. The Government wants a primary health care sector that delivers good quality and accessible health services, reduces inequalities and secures better health outcomes for every New Zealander. Primary health care is a central part of an effective system helping all New Zealanders to live well, stay well and get well. This requires greater collaboration and integration across the health system (including the Ministry of Health, DHBs, PHOs, NGOs, practitioners and communities and the people within them, including Māori stakeholders), and changes to service and business models. High-performing primary health care relies on general practice, community providers and iwi providers delivering high quality care in their local communities.

347. In 2017, the new Government committed to a suite of initiatives within the primary health care package to ensure all New Zealanders are able to get treatment when they need it. These initiatives are:

347.1 lowering the Very Low Cost Access fee cap by $10 to $8 for adults and $2 for teens, with a funding increase to Very Low Cost Access practices to cover this;

347.2 extending the Community Services Card to all Accommodation Supplement and Housing NZ tenants, and extending the Very Low Cost Access subsidy to 600,000 more Community Services Card holders, Accommodation Supplement beneficiaries and Housing NZ tenants not enrolled in Very Low Cost Access;

347.3 increasing government funding for all practices that lower their fees by $10, lowering the average non-Very Low Cost Access fee from $42 to $32 and the maximum fee from $69 to $59;

347.4 increasing funding for general practice training places, taking the intake to 300 per year;
carrying out a review of primary care funding to further reduce barriers to primary care and ensure the financial sustainability of practices;

increase all general practice funding by five percent;

one free annual health check for over 65s or seniors, including an eye check;

teen Health Checks for all Year 9 students (13 and 14 year olds);

and

extending free general practice visits to young people aged under fourteen.

In addition to these initiatives, the Government is committed to longer term policy work, including the Health and Disability System Review and Inquiry into Mental Health and Addiction, to shape the future direction of general practice and wider primary health care.

Ashley Robin Bloomfield’s brief of evidence, on behalf of the Ministry of Health, will talk about the future of the primary health care system and the current Health and Disability System Review. It will also propose some solutions to the unintended consequences of the primary health care reforms since 2001, including the issues raised by the claimants in this inquiry.

Keriana Louise Brooking