

Ministry of Health: Monitoring the progress of the Primary Health Care Strategy

This is the report of a performance
audit we carried out under section
16 of the Public Audit Act 2001.

October 2008

ISBN 978-0-478-32617-8

Contents

Auditor-General's overview	5
The Ministry of Health's approach to the Strategy	5
How the Ministry has monitored the Strategy	6
More coherent information needed	7
More complete information needed	7
Importance of well-designed measures	7
Our recommendations	9
Part 1 – About our audit	11
The focus of our audit	11
Our audit criteria	12
What we did not audit	14
Our sources of evidence	15
Part 2 – The Primary Health Care Strategy	17
About the Primary Health Care Strategy	17
The health and disability sector, and the Ministry's responsibilities for the Strategy	19
Part 3 – Collecting information about the Strategy's progress	21
The Ministry's monitoring and evaluation framework	21
Monitoring of PHOs' performance by DHBs and the Ministry	23
Monitoring of DHBs' performance by the Ministry	23
Independent evaluations commissioned by the Ministry	23
Gaps in collecting information	24
What the Ministry needs to do	25
Part 4 – Reporting information about the Strategy's progress	27
Reporting information about progress	27
Gaps in reporting information	28
What the Ministry needs to do	32
Part 5 – Using information about the Strategy's progress	35
Using the information collected	35
Gaps in showing how information has been used	36
What the Ministry needs to do	36
Appendices	
1 Changes to primary health care structures since 2001	37
2 Changes to primary health care funding since 2001	39
3 Changes to expenditure on the Primary Health Care Strategy from 2002/03 to 2007/08	43
4 Summary descriptions of primary health care subsidies and initiatives	45
Figures	
1 A performance management cycle	12
2 The Strategy's Six Key Directions and Five Priorities for Early Action	18
3 Examples of the methods the Ministry uses to report on the Strategy	27
4 List of published evaluation reports about the Strategy, to March 2008	29
5 Examples of how inconsistent public reporting and a lack of measures make it difficult to understand the significance of the information being reported	32
6 Numbers of PHOs and enrolled patients, from 2002/03 to 2007/08	37

7	Introduction of new subsidies and initiatives from 2002/03 to 2007/08	39
8	Funding to PHOs compared with the number of enrolled patients from 2002/03 to 2007/08	40
9	Phased introduction and expenditure for the First Contact and Pharmaceutical subsidies from 2002/03 to 2007/08	40
10	Expenditure on the General Medical and First Contact subsidies from 2002/03 to 2007/08	41

Auditor-General's overview

In 2001, the then Minister of Health launched the Primary Health Care Strategy (the Strategy), which the Government regarded as introducing the most significant changes to primary health care in more than 50 years.

The Strategy sought to achieve many goals, which were set out in its vision statement:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

People will be part of local primary health care services that focus on better health for a population, and actively work to reduce health inequalities between different groups.

It was estimated that carrying out the Strategy could take five to 10 years. It is a large and difficult task, which involves participation by many primary health care stakeholders.

My staff audited how the Ministry of Health (the Ministry) has monitored progress toward the Strategy's goals. Overall, the Ministry needs to review its measures to ensure that it can assess progress toward all of the goals in the Strategy's vision statement. Once it has that progress information, it needs to report it publicly and regularly in a consolidated report.

The Ministry of Health's approach to the Strategy

Through the Strategy, the Ministry has introduced major structural and funding changes to the health sector. About 80 primary health organisations (PHOs) have formed to provide primary health care services through more than 1,000 contracted providers (such as general practices and general practitioners). More than four million patients are enrolled in PHOs. The Ministry has phased in significant increases in primary health care funding, and the funding is no longer based on a fee-for-service model. Most of the new funding was phased in from 2002/03 to 2007/08; more than \$3.2 billion was spent on primary health care funding during that period.¹

Because of the size and scale of change, including the complexities involved with negotiating agreements with many parties, the Strategy described a "stepwise, evolutionary" approach to implementation. Initially, the Ministry did not set out what would be achieved and by when, apart from the directions and actions described in the Strategy.

In 2005/06, the Ministry and district health boards (DHBs) recognised the need to shift their focus from implementing structural and funding changes to achieving the Strategy's wider goals. A consultation process produced a "Joint Work

¹ The First Contact subsidy and increases to the Pharmaceutical subsidy account for \$2.2 billion. Other subsidies and initiatives account for a further \$1 billion (see Appendix 3).

Programme” report that described the situation in 2001 and 2005, and described about 100 outcomes to be achieved by 2010. The Ministry and DHBs are leading projects to achieve the Joint Work Programme’s outcomes. The projects’ progress is reported, although not publicly. The Ministry and DHBs do not report explicitly on progress toward the 100 outcomes.

Some differences the Strategy has made

There are indications of improvements in primary health care. An evaluation report by the Ministry concluded that, from 2001/02 to 2004/05, lower cost access to primary health services had improved consultation rates for most patient groups.

More recently, the Ministry has been reporting improvements in performance for a broader range of health indicators as evaluation and health survey data becomes available. The Director-General of Health tells me that he is getting good feedback about the Strategy’s achievements from the health sector. New Zealand’s performance compares well against international primary health care indicators.

My staff have not assessed or verified the Strategy’s achievements. The audit focused on what information the Ministry was collecting and reporting to assess progress toward each of the Strategy’s goals. My staff expected the Ministry to use the information collected to maintain progress and ensure that the Strategy’s goals would be achieved.

How the Ministry has monitored the Strategy

Once the initial implementation effort was over, the Ministry put significant resources into a range of monitoring and evaluation initiatives. The Ministry has collected and reported a lot of information about the changes brought about by the Strategy. The information has included the effect on people’s health, the number of PHOs and the number of people enrolled with them, some aspects of PHOs’ and DHBs’ performance, the phasing in of funding for the Strategy’s subsidies and initiatives, and independent evaluations of the Strategy’s implementation.

The Ministry has reported this information many different documents, including its annual reports, the Director-General of Health’s health and independence reports, reports to Ministers of Health, and reports to Cabinet.

The Director-General of Health informed me in August 2008 that the Ministry is developing advice to Government to establish a comprehensive performance management framework for the next phase of the Strategy. Part of the framework involves aligning the indicators used to monitor PHOs’ performance with the

health targets used to monitor DHBs' performance. Until then, the current monitoring of PHO and DHB performance will continue, alongside the schedule of independent evaluations and periodic national health surveys.²

More coherent information needed

The Ministry needs to organise its monitoring and evaluation to better assess and report progress against all the goals inherent in the Strategy's vision statement.

The Ministry's approach to reporting information is fragmented, which makes it difficult to get a full and clear picture about the progress that has been made toward achieving the Strategy's goals. After my staff had brought the information together, it was difficult to decide its significance because reported achievements are not always set in the context of expected results.

The Ministry is already aware that there are some gaps in the information being collected. For example, there are gaps in indicators for community involvement and self-management. The Ministry intends to monitor in more depth the management of long-term diseases. The Ministry might identify further gaps, duplication, or measures that need to be modified when it prepares a more comprehensive monitoring framework.

More complete information needed

The Ministry needs to bring together all the existing information it has into a single report to provide as full and clear picture as possible for the health sector, Parliament, and the public about the progress made toward the Strategy's goals. The Ministry should produce these consolidated reports regularly, and tailor their content more appropriately for the audience.

Importance of well-designed measures

Being able to report meaningfully on performance, particularly for major initiatives, is a core part of public sector accountability.

Well-designed measures can function as effective drivers of change. A set of measures that covers all important aspects of a strategy and is well designed from the outset can help to support changes occurring in all the areas where change is needed or wanted.

Agencies that collect and report information in some areas but not others create a risk that Parliament and the public will perceive that a strategy's implementation

² On 12 September 2008, the Minister of Health, Hon. David Cunliffe, made a speech about primary health care to communicate decisions recently made by Cabinet. He said: "Looking further forward I want to see existing performance initiatives aligned and a comprehensive and closely aligned performance management system developed across DHBs, PHOs and providers. This will ensure performance management is more consistent between DHBs, PHOs and providers and that it is more focused on measuring outcomes, rather than inputs."

and results are also uneven, and potentially ineffective and inefficient. This may not be the case, but the perception is difficult to counter without good information.

By reporting only changes, reports are inevitably silent about any changes that should have occurred but have not. If reported changes are not compared with starting positions and anticipated results, then important achievements may not be recognised. Changes that were intended to occur but have not may not be identified. Problem areas that should be recognised may remain undetected.

In June 2008, I published a discussion paper about performance reporting – *The Auditor-General's observations on the quality of performance reporting*. In it, I encouraged public entities to think carefully about the outcomes they are working towards and to explain in their external reporting the reasons for what they are doing, the focus of their reporting, and the rationale for – and relationships between – the various elements and measures.

I do not expect entities to measure and report on everything. Rather, the aim should be to provide a coherent and reasonably complete picture of overall performance, through a mixture of financial and non-financial information. That same message is relevant here.

I thank the Ministry's staff for their helpful co-operation during the audit.



K B Brady
Controller and Auditor-General

6 October 2008

Our recommendations

We recommend that the Ministry of Health:

1. review its measures to ensure that they are complete and that it can assess progress toward all of the goals in the Primary Health Care Strategy's vision statement for the next three years;
2. regularly produce consolidated reports – the first by 30 June 2009 – about progress toward the Primary Health Care Strategy's goals and summarise how the information collected is being used to ensure that the Strategy will be successful;
3. ensure that performance reports about the primary health organisations that have been in the Primary Health Organisation Performance Programme for more than 15 months are promptly written and published;
4. work with district health boards and primary health organisations to review, by 30 June 2009, the Primary Health Organisation Performance Programme so that performance results are published once primary health organisations are eligible for performance payments; and
5. require and provide plain English reports about the Primary Health Care Strategy.

Part 1

About our audit

1.1 The Primary Health Care Strategy (the Strategy) was launched in February 2001 as an essential step toward achieving the New Zealand Health Strategy. The Ministry of Health (the Ministry) is responsible for ensuring that the Strategy is carried out, which includes monitoring and reporting progress and using the information it collects to inform its decision-making. We audited the Ministry's role in monitoring the Strategy's progress.

1.2 In this Part, we discuss:

- the focus of our audit;
- our audit criteria;
- what we did not audit; and
- our sources of evidence.

The focus of our audit

1.3 A core purpose of performance reporting is to enable public accountability for the responsible use of public resources. This includes demonstrating that public services are being delivered effectively and efficiently. As well as their external accountability purpose, performance reports should reflect good management practices. Such practices involve clearly articulating a strategy, linking that strategy to operational and other business plans, monitoring the delivery of operational and business plans, and evaluating the strategy's effects.

1.4 Figure 1 sets out a simple performance management cycle. This starts with a clear set of strategic goals (in this case, the Strategy's vision statement) that are fulfilled through projects or programmes. The projects' or programmes' progress against the strategic goals is then measured, and the total performance is evaluated and reported on for accountability purposes.

1.5 Our audit focused on the "measuring progress" and "reporting performance" parts of the cycle (see Figure 1). We also audited whether the Ministry could show that it was using the information it collected to maintain progress and changing the Strategy's implementation (where needed) to ensure that the Strategy would be successful.

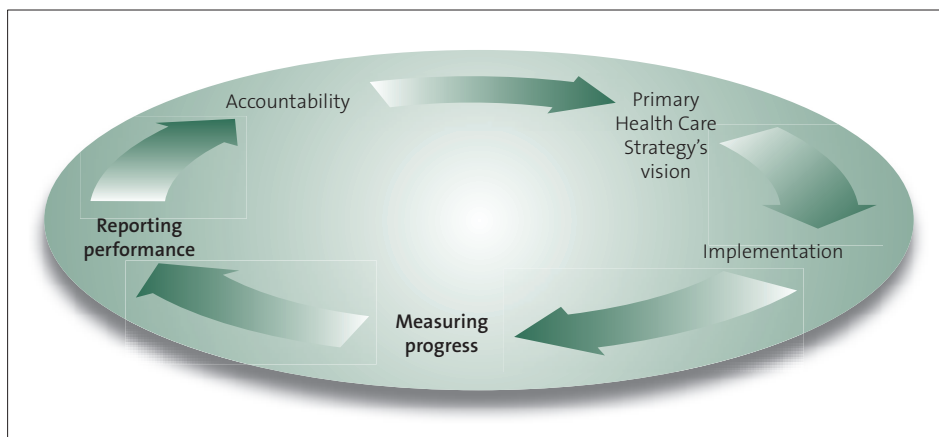
1.6 We had several reasons for auditing the Ministry's monitoring of progress against the Strategy's goals:

- The Strategy's five- to ten-year implementation period was an essential step in achieving the New Zealand Health Strategy. Measuring progress and reporting performance is important for ensuring that the Strategy is on schedule, so the Government's wider health aims will be achieved.

- The Strategy required significant changes to primary health care structures and funding methods. When making major structural changes in any sector, it is important that the changes result in the expected improvements – in this case, improved primary health care services that improve individual and population health.
- Ineffective progress monitoring could lead to individuals and population groups waiting longer than necessary to have more accessible and better quality primary health services and care.
- Significant extra expenditure has been used to carry out the Strategy. Those who manage the funding or are responsible for monitoring expenditure must be accountable for reporting the value gained – or advising when gains can be expected.

Figure 1**A performance management cycle**

A sound framework for carrying out any strategy will use a performance management cycle.



Source: Adapted from International Organization of Supreme Audit Institutions Working Group on Environmental Auditing (2004), *Sustainable Development: The Role of Supreme Audit Institutions*, ISSAI 5130.

Our audit criteria

- 1.7 We consulted the Ministry in detail about the focus of our audit and our audit criteria. The Ministry supported the audit's focus and helped to develop, and commented on, our preliminary and final set of criteria.

- 1.8 We audited whether the Ministry was collecting and reporting information to assess the Strategy's progress. We expected the Ministry to have a framework that allowed it to:
- set measures for each of the Strategy's goals;
 - report whether progress against the measures was meeting expectations, including whether progress was on schedule; and
 - use the information collected to maintain progress and ensure that the Strategy's goals would be achieved.
- 1.9 We use "measures" as a collective term for the methods available to the Ministry to monitor and judge progress against the Strategy's goals, such as written narrative reporting, targets, milestones, indicators, results, and inputs. The Strategy's goals contain outcomes, and we expected the Ministry to have prepared measures for those outcomes. We expected the Ministry's measures to include a baseline or starting position to judge progress against.
- 1.10 Below the level of the Strategy's goals, measures could be useful for monitoring its implementation, such as its Six Key Directions and Five Priorities for Early Action. This could involve a commitment to publish annual (or biennial) reports about the progress being made on each direction and priority. The reports could describe any projects or programmes under way or proposed and their timelines, and highlight matters that help or hinder progress.
- 1.11 We do not have a prescriptive view about what measures the Ministry should have. It is for the Ministry, not us, to choose suitable measures for each level of monitoring. However, we expected measures to be set for all the Strategy's goals.
- 1.12 We do not necessarily expect the Ministry to have these examples, but measures could have been set for:
- phasing in the new funding;
 - involving X% of practising General Practitioners (GPs) in primary health organisations (PHOs) within Y years;
 - enrolling X% of high-needs patients within Y years;
 - demonstrating community involvement with PHOs;
 - demonstrating the involvement of a wider range of health professionals providing services to enrolled patients;
 - showing that high-priority groups of patients have better care co-ordination; or
 - reporting on critical projects to show that PHOs have changed the way they deliver services to focus on population health.

- 1.13 We expected the Ministry to have a well-designed set of measures and, where possible, to use existing and reliable measures. For example, the Ministry could have used some of the data used to produce *The Future Shape of Primary Health Care* (see paragraphs 2.4 and 2.5).
- 1.14 We expected the Ministry's measures to cover the full breadth of the Strategy's goals, because this would help to avoid concentrating measures – and therefore the attention of district health boards (DHBs) and PHOs – in one area. Concentrated measures could result in little or no change occurring in other areas. We also expected that the aspects measured in each area might be modified as the Strategy is carried out.
- 1.15 We did not expect the Ministry to necessarily have a measure for every activity. We expected the Ministry to have been selective, and considered the cost-effectiveness of collecting and reporting information when setting measures.
- 1.16 Reporting against a broad range of measures would enable the Ministry to highlight good progress and practices, study areas of slow progress, and address any problem areas. Being able to report and celebrate achievements also helps to encourage and support further changes.
- 1.17 Being clear about measures sets the direction for everyone with a role in fulfilling the Strategy. Measures help to identify priorities, clarify roles, and support purposeful progress towards goals. They allow people and organisations to provide leadership at all levels within the health and disability system, even though each party has its own specific role. Not enough or inadequate measures increase the risk of piecemeal change, which would result in isolated or sporadic reporting of improvements. Isolated improvements may be worthwhile on their own, but their value in showing the Strategy's progress is limited.
- 1.18 Care in setting short-term and medium-term measures is especially important when changes can take years to show up in health statistics for the wider population. It would be unrealistic to expect improvements in some national population health measures within two to three years if progress is not likely to be visible until after 10 or more years.

What we did not audit

- 1.19 We did not audit whether the Strategy's goals are being achieved or if the Strategy is producing value for money. Our focus was on whether the Ministry is collecting and reporting information about the Strategy's progress that would help Parliament and the public to judge such matters.

- 1.20 We did not audit the primary health care funding or the financial information reproduced in our report because it was not necessary for examining the Ministry's monitoring of the Strategy's progress.

Our sources of evidence

- 1.21 We collected evidence for our audit by interviewing current Ministry employees (and a past employee with extensive knowledge about the Strategy) and employees of District Health Boards New Zealand,¹ which is involved in the PHO Performance Programme² on behalf of DHBs.
- 1.22 The Ministry provided us with documents, including evaluation reports, internal documents, and reports to Cabinet, Parliament, and Ministers of Health. We also used information on websites belonging to the Ministry and District Health Boards New Zealand, and links provided from those sites.

1 District Health Boards New Zealand was formed by all 21 DHBs in December 2000 to co-ordinate their activities on selected issues.

2 The PHO Performance Programme was previously the PHO Performance Management Programme.

Part 2

The Primary Health Care Strategy

- 2.1 In this Part, to provide the context for our audit, we:
- describe the Strategy; and
 - briefly describe the health and disability sector, and the Ministry's responsibilities for the Strategy.

About the Primary Health Care Strategy

- 2.2 "Primary health care" covers a broad range of out-of-hospital services. Not all of these services are government funded. Primary health care includes services such as:
- GP and mobile nursing services;
 - pharmacy and laboratory services;
 - community health services such as maternity, family planning and sexual health services, dentistry, and mental health services; and
 - physiotherapy, chiropractic, and osteopathy services.
- 2.3 Putting a national strategy into practice can be difficult, especially if it involves changing the way people think about and deliver services, which is what the Strategy intends to achieve. The Strategy also introduced new organisations and funding mechanisms that altered relationships between different parties in the health sector.
- 2.4 The Strategy was the Government's response to concerns the Minister of Health (the Minister) at the time had highlighted in an earlier discussion document *The Future Shape of Primary Health Care*.¹ The four main concerns were:
- differences in the health of different groups of people (called populations);
 - high levels of preventable illness;
 - high levels of preventable hospital admissions; and
 - barriers to getting primary health care services.
- 2.5 *The Future Shape of Primary Health Care* also discussed the need to ensure that government funds spent on general practice, prescribed medicines, and diagnostic tests reach the people in greatest need. It identified concerns about the number and distribution of services in some rural and urban areas, the cost of using services, and how acceptable services were to users.
- 2.6 The Minister launched the Strategy in February 2001. It set out a vision for primary health care services. The vision statement includes six inherent goals:
- People will be part of local primary health care services that [1] improve their health, [2] keep them well, [3] are easy to get to and [4] co-ordinate their ongoing care.*

1 Hon. Annette King (2000), *The Future Shape of Primary Health Care: A Discussion Document*, Wellington.

People will be part of local primary health care services that [5] focus on better health for a population, and [6] actively work to reduce health inequalities between different groups.²

2.7 Figure 2 sets out the Six Key Directions and Five Priorities for Early Action listed in the Strategy. According to the Minister, the Strategy would “evolve over the next few years and may not be fully realised for five to ten years”.³

Figure 2

The Strategy’s Six Key Directions and Five Priorities for Early Action

The Six Key Directions identified in the Strategy are:

- work with local communities and enrolled populations;
- identify and remove health inequalities;
- offer access to comprehensive services to improve, maintain, and restore people’s health;
- co-ordinate care across service areas;
- develop the primary health care workforce; and
- continuously improve quality, using good information.

The Six Key Directions had 40 corresponding actions, which we have not reproduced here because of their length. The actions include enrolling people with PHOs, making PHOs openly accountable to the public for the quality standards they plan to achieve, and having DHBs actively monitor the availability and effectiveness of information about primary health care.

The Strategy’s Five Priorities for Early Action are:

- reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health and to improve access to first-contact services;
- supporting the development of PHOs that work with the people enrolled with them;
- encouraging developments that emphasise multi-disciplinary approaches to services and decision-making;
- supporting the development of services by Māori and Pacific providers; and
- facilitating a smooth transition to widespread enrolment with PHOs through a public information and education campaign to explain enrolment and promote its benefits for communities.

Source: Hon. Annette King (2001), *The Primary Health Care Strategy*, Wellington, pages vii-ix.

2.8 New entities, called PHOs, were to be created as the core means for improving primary health care services, although any organisation or health care worker with a primary health care role could contribute to the Strategy’s goals. PHOs were to be funded differently from the existing methods, and primary health care funding

2 Hon. Annette King (2001), *The Primary Health Care Strategy*, Wellington, page vii.

3 Hon. Annette King (2001), *The Primary Health Care Strategy*, Wellington, page viii.

was to be increased. The Government said it would provide an extra \$2.2 billion over several years from 2002 to carry out the Strategy.

- 2.9 The principles for “ensuring a stable and constructive transition” were:
- *in the first instance, protect the gains already made and build on successful initiatives*
 - *involve, discuss and collaborate with the primary health care sector, providers and communities in the implementation of the Strategy*
 - *focus on stepwise, evolutionary, change which is progressively consistent with the Primary Health Care Strategy.*⁴
- 2.10 The Government regards the Strategy as introducing the most significant changes to primary health care in more than 50 years. The Government saw the Strategy as an essential step in achieving the New Zealand Health Strategy, which is a foundation strategy for the health and disability sector. The New Zealand Health Strategy focuses on tackling health inequalities. It aims to ensure that health services are directed at those areas that will ensure the highest benefits for the total population.

The health and disability sector, and the Ministry’s responsibilities for the Strategy

- 2.11 The New Zealand Public Health and Disability Act 2000 established DHBs, and 21 of them were created on 1 January 2001. Through Crown Funding Agreements, the Minister holds DHBs responsible for providing, or funding the provision of, health and disability services in their district.⁵
- 2.12 The Ministry is responsible for ensuring that the Strategy is carried out. This includes monitoring and reporting progress, and using the information it has to inform its decision-making and ensure that the Strategy’s goals will be achieved. DHBs are responsible for carrying out the Strategy in their own districts. DHBs may provide some primary health care services, and contract with PHOs and other providers for other services. PHOs are responsible for looking after their enrolled patients.
- 2.13 The Appendices to this report describe in greater detail the changes to the structure and funding of primary health care services that are part of carrying out the Strategy.

4 Hon. Annette King (2001), *The Primary Health Care Strategy*, Wellington, page 27.

5 The Ministry’s website describes in detail the health and disability system (see www.moh.govt.nz).

Part 3

Collecting information about the Strategy's progress

3.1 In this Part, we comment on:

- the Ministry's monitoring and evaluation framework;
- monitoring of PHOs' performance by DHBs and the Ministry;
- monitoring of DHBs' performance by the Ministry;
- independent evaluations commissioned by the Ministry;
- the gaps in what the Ministry has done to collect information; and
- what needs to be done to improve the Ministry's monitoring of the Strategy's progress.

3.2 We expected that the Ministry would have considered how it would measure progress towards the Strategy's goals. A recent document produced by the World Health Organization shows that others share this expectation of the health sector:

Whereas policy-makers in the past often reformed without critically evaluating their efforts, they now need to define expectations, track resources and demonstrate outcomes. Performance measurement makes possible a structured assessment of how health systems are doing and flags up what can be done better.¹

The Ministry's monitoring and evaluation framework

- 3.3 Once the initial implementation effort was over – enabling PHOs to form and setting up the new subsidies and funding arrangements – the Ministry put significant resources into a range of monitoring and evaluation initiatives. Some early or relatively specific projects have been completed. Others have yet to report, because they are substantial studies tracking long-term changes.
- 3.4 Three years after the Strategy's launch in 2001, the Ministry outlined a monitoring and evaluation framework to report on the Strategy's implementation and outcomes. The framework had two main parts: monitoring PHO performance, and commissioning a series of large and small independent evaluations of the Strategy's implementation and outcomes.
- 3.5 The framework was broken up into individual projects, which were reported separately.

1 Figueras, J., McKee, M., Lessof, S., Duran, A., and Menabde, A., (2008), *Health systems, health and wealth: Assessing the case for investing in health systems*, page ix, WHO European Ministerial Conference on Health Systems, World Health Organization, Estonia.

3.6 During 2006/07, the Ministry carried out a project, focused on DHB accountability and performance against the Strategy, to:

- *document the current monitoring framework;*
- *complete a gap analysis of current monitoring reporting and evaluation approaches; and*
- *produce a “development pathway to support ongoing development of the monitoring framework, including an implementation plan”.²*

3.7 The result of the project was a new framework. The new framework linked the existing primary health care indicators used to monitor DHBs' and PHOs' performance (see paragraphs 3.10-3.14) to the New Zealand Health Strategy. It showed gaps for areas such as community involvement, self-management, care co-ordination, and improved access (including patients' use of services and the fees they pay), which are important parts of the Primary Health Care Strategy.

3.8 The Ministry also identified that it could improve the use of the existing indicators by bringing them together to compare population groups at a district and lower level. This had not yet been done because of the substantial effort it took to collate and analyse the information from several databases (see paragraphs 4.10 and 4.11). The Ministry made plans for improved reporting that included producing a single report for each DHB of its performance against all the indicators it is measured against. A single report would enable all DHBs and the public to see which DHBs perform better overall, and if some DHBs have strengths or weaknesses in some areas. Reports consolidating DHBs' performance have not yet been produced.

The Joint Work Programme

3.9 In 2005/06 (the fifth year of the Strategy's implementation), the Ministry and DHBs shifted their focus from establishment to concentrating more on achieving “the delivery aims central to the Strategy”.³ This resulted in the Joint Work Programme, which describes about 100 outcomes to be achieved by 2010 based on assessments against starting positions in 2001 and 2005.⁴ At higher levels, the Joint Work Programme is organised into five goals, 11 themes (with sub-themes), and four work streams. Projects to implement the Joint Work Programme are organised in keeping with the Strategy's Six Key Directions (see Figure 2).

2 Ministry of Health (2006), *Clinical Services Directorate Business Plan 2006-07*.

3 Feek, C and McKernan, S (2006), *Primary Health Care Strategy Implementation Programme 2006-2010: Working Document for Sector Engagement – March 2006*, Ministry of Health, Wellington.

4 Feek, C and Clarke, C (2006), *Primary Health Care Strategy Implementation Work Programme 2006-2010: The Next Steps*, Ministry of Health, Wellington. The publication was withdrawn from the Ministry's website in September 2007, awaiting revision. A revised programme had not been published as at 16 September 2008.

Monitoring of PHOs' performance by DHBs and the Ministry

- 3.10 The Ministry introduced a programme to monitor PHO performance in 2005. It was a programme that PHOs could voluntarily join. Responsibility for monitoring PHOs' performance has since been devolved to DHBs. PHOs, in turn, are to monitor and help improve their members' performance. A few of the indicators being monitored have target dates for their achievement. Other indicators require incremental annual improvements to be made.
- 3.11 Under the PHO Performance Programme, information has been collected since 1 January 2006 for 29 PHOs, and all PHOs had joined the programme by 1 January 2008. PHOs report their performance quarterly to their DHB. After PHOs have been in the programme for six months, they are eligible to receive performance payments that are based on progress against the programme's indicators.
- 3.12 The Ministry plans to phase in two more sets of indicators to focus PHOs' attention in priority areas. These indicators will focus on long-term conditions such as cardiovascular disease and diabetes. The second set was to have been introduced in mid-2007, but this date was amended to 1 July 2008. The Ministry now plans to introduce the second set of indicators in October 2008. There is no date set for phasing in the third set of indicators.

Monitoring of DHBs' performance by the Ministry

- 3.13 As all devolved primary health care is funded by DHBs, monitoring DHBs' performance is one method of assessing the performance of all primary health care providers (not only PHOs), and any benefits from better co-ordination between primary health and hospital services. DHBs' Crown Funding Agreements with the Minister contain expectations for DHBs' performance.
- 3.14 The Ministry has increased its monitoring of DHBs' performance. The number of primary health indicators has grown from one in 2002/03 to 11 in 2007/08. Some of the primary health indicators have target dates for their achievement. Some of the indicators within the nine health targets for DHBs introduced on 1 July 2007 are influenced by primary health care. The Ministry also requires DHBs to submit written narrative reports about specified community issues affecting primary health care within their districts (such as Māori participation in PHOs).

Independent evaluations commissioned by the Ministry

- 3.15 The Ministry is managing a portfolio of independent evaluations of the Strategy, focusing on three areas:
- the Strategy's implementation;
 - the effect the Strategy has had on the delivery of primary health care services; and
 - changes in the population health.

- 3.16 The evaluations' findings (and sometimes interim findings) are reported as they become available, so they can be used to improve the Strategy's implementation.
- 3.17 The central part of the evaluation portfolio is the "Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy", which began in mid-2003 and is due to be completed in June 2009.
- 3.18 We discuss in Part 4 the nine published reports and 15 studies yet to be published.

Gaps in collecting information

Monitoring and evaluation framework

- 3.19 The Ministry's monitoring and evaluation frameworks are yet to set out a comprehensive set of measures to guide progress for each of the Strategy's goals. Therefore, it is difficult to assess the Strategy's progress. However, it is clear from the Ministry's reports that improvements have occurred in some areas.
- 3.20 The Ministry told us it did not set measures from the outset (particularly milestones with due dates) because, in the first few years, it wanted to focus on setting up PHOs and phasing in the new funding arrangements. It did not know how quickly PHOs would be formed. Its "stepwise" approach took account of the need to negotiate agreements between many parties – the Ministry, DHBs, PHOs, other providers, and national professional bodies. The Ministry made decisions for the next one or two years based on the status in the current year.
- 3.21 People reading the Ministry's many reports must try to match the reported information against the Strategy's vision statement, directions, actions, and priorities, and try to work out for themselves if progress is satisfactory. The problem then is that each reader judges the information against their own (rather than the Ministry's) expectations, or is left asking "So what does this mean?"
- 3.22 For example, the annual consultation rate for people aged 65 years and older increased from 7.2 to 8.8 visits from 2001/02 to 2005/06. While acknowledging the improvement, without an expectation being set it is difficult to know how much more improvement (if any) is needed, and by when, to achieve the Strategy's goals.
- 3.23 In our view, the Ministry would benefit from an overall framework that organised its measures to produce a coherent, comprehensive, and useful picture of progress towards the goals inherent in the Strategy's vision.

Aligned indicators for measuring progress

- 3.24 The indicators used for parts of the Strategy are not aligned with the indicators used in other primary health programmes. The Ministry has recognised this and reported that:
- Work is ... underway to get alignment between the PHO Performance Programme indicators descriptions that are also indicators in Get Checked and in the Health Targets. ... [A] minimum [data] set for primary health care would assist by ... ensuring standard definitions in key areas ...⁵*
- 3.25 It is easier and more efficient to collect, analyse, and report information when the indicators used for measuring the progress of different primary health care programmes are aligned. It means comparisons of the results from different programmes are more valid.

What the Ministry needs to do

- 3.26 Setting measures is fundamental to assessing progress. It is difficult to assess progress against the Strategy's vision if achievements are not analysed and reported within the context of expected results.
- 3.27 The Ministry uses some measures it has about primary health care to report against the New Zealand Health Strategy. These measures and other existing measures could be brought together to report on the Primary Health Care Strategy's progress. This would also show where there are further information gaps that should be filled, and the Ministry could explain what it intended to do to fill those gaps.
- 3.28 The Strategy said it might take 10 years before improvements in public health would be realised. There are about three years from the publication of this report until 2011, which will be 10 years after the Strategy's launch. The Ministry should set measures for what it expects to be achieved by 2011, and beyond 2011 if the Strategy's goals have not been achieved by then. It should collect and report information about progress against the measures. The Ministry should explain how it will use the information to maintain progress.
- 3.29 The Ministry needs to set clear measures (as we define them in paragraph 1.9) for the six goals inherent in the Strategy's vision statement. Once this is done, the information currently collected about PHOs' and DHBs' performance may need to be amended. We are aware of the need not to overload the sector with reporting requirements. We expect the measures to be manageable and meaningful.
- 3.30 In our view, the Ministry could consider using the Joint Work Programme to help set measures for the Strategy. When we wrote this report, the Ministry's

⁵ Ministry of Health (2007), *Health Report Ref. No.: 20070693: Review of the Primary Health Care Strategy Monitoring Environment*, Wellington.

measures and reporting did not cover the outcomes of the Joint Work Programme. We are not suggesting that all 100 outcomes have their own measures. The outcomes represent the most detailed specification of the changes the Ministry and DHBs want to make. Measures could be set for some or all of the Joint Work Programme's goals, themes, or work streams (see paragraph 3.9).

Recommendation 1

We recommend that the Ministry of Health review its measures to ensure that they are complete and that it can assess progress toward all of the goals in the Primary Health Care Strategy's vision statement for the next three years.

Part 4

Reporting information about the Strategy's progress

4.1 In this Part, we comment on:

- what the Ministry has done to report on the Strategy's progress;
- the gaps in what the Ministry has done; and
- what needs to be done to improve the Ministry's reporting.

Reporting information about progress

4.2 The Ministry reports changes as they occur. There are many reporting methods, which we have organised into three groups – formal accountability documents and regular reports, other publicly released documents, and confidential reports (see Figure 3).

Figure 3

Examples of the methods the Ministry uses to report on the Strategy

Examples of the methods of reporting	
Accountability documents and regular reports	<ul style="list-style-type: none"> • Statements of intent • Annual plans • Annual reports • The Director-General of Health's annual Health and Independence reports, which are reports about the state of the public health • Reports giving and analysing the results of periodic New Zealand Health Surveys
Other publicly released documents	<ul style="list-style-type: none"> • Quarterly reports about DHBs' performance • Evaluation reports prepared by contracted entities and commissioned by the Ministry • Press releases by the Ministry and the Minister • Speeches and presentations by Ministry staff to conferences or meetings • Responses to questions asked by members of Parliament and select committees
Confidential reports (unless public release is approved)	<ul style="list-style-type: none"> • Four annual reports to Cabinet (due in December, 2004-2007*) • The Ministry's weekly reports to the Minister • Reports as needed from the Ministry to the Minister

Source: Office of the Auditor-General.

* The reports were provided to Cabinet in November 2004, April and December 2006, and June 2008. The November 2004 report was publicly released on 4 April 2005 and is titled *Primary Health Care Strategy: Monitoring its achievements*, SDC(04)174.

4.3 The Strategy information most often reported has been about the:

- number of PHOs;
- numbers of patients enrolled with PHOs;
- phasing in of primary health care funding subsidies and initiatives; and
- amounts that patients pay in fees.

- 4.4 The Ministry also regularly reports on health outcomes in its accountability documents, which include indicators influenced by primary health care services.

Reporting about PHOs' performance

- 4.5 The Ministry has access to, and is able to analyse, information from the PHOs' reports under the PHO Performance Programme. PHO Performance Programme reports are meant to be published 15 months after PHOs join the programme.

Reporting about DHBs' performance

- 4.6 The Ministry publishes quarterly summary reports on its website about DHBs' performance against primary health indicators. This provides a summary of year-to-date progress. Reports are also available for DHBs' health targets, by DHB and for each three-month period. Annual reports about progress against the targets will be included in the Director-General of Health's Health and Independence reports. The Ministry does not publish summaries of the DHBs' written narrative reports.

Reporting the results of independent evaluations

- 4.7 Figure 4 lists the evaluation reports published so far, which are available from the Ministry's website. The Ministry planned to publish a further 15 quantitative, qualitative, and economic reports and analyses in 2007 and 2008. These had not been published when we wrote our report. The Ministry advised Cabinet that the first of these reports could be published from about September 2008.

Gaps in reporting information

Unpublished information about the PHO Performance Programme

- 4.8 The first reports about PHO performance were due to be published after 31 March 2007, but this has not happened.¹ The Strategy intended PHOs to be publicly accountable for the quality of their services, so reports about PHO performance need to be published. Because the Ministry, DHBs, and PHOs have enough confidence in the data for PHOs to be eligible for performance payments after six months in the programme, we suggest that reports about PHOs' performance should be published after six months, rather than 15.

Fragmented information

- 4.9 Information collected about the results of the Strategy's implementation is reported in multiple documents (see Figure 3). There is no single report that periodically collates and reports the information collected about the Strategy's progress toward the goals inherent in the Strategy's vision statement.

1 The Ministry tells us that this is being negotiated with PHOs and their providers.

Figure 4
List of published evaluation reports about the Strategy, to March 2008

Nine reports have been published between December 2003 and March 2008.

Report title	Summary purpose
<i>Primary Health Organisations: The first year (July 2002 – June 2003) from the PHO perspective</i> , December 2003	To describe PHOs, experiences of PHO implementation, and perceived strengths and weaknesses of PHOs so far.
<i>Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy</i> , May 2005	To understand how PHOs and their member providers were responding to the intermediate outcomes of the Strategy, including the effect on reducing health inequalities. To describe the implementation of the Strategy with a specific focus on PHOs.
<i>Review of the Implementation of Care Plus</i> , August 2006	To answer three broad questions: Was Care Plus reaching those individuals with high primary health care need? What were the effects of the Care Plus programme? What were the best ways of organising and delivering Care Plus services?
<i>Improving Access to Primary Health Care: An evaluation of 35 reducing inequalities projects</i> , January 2007	To understand what types of approaches were successful in reducing inequalities and why.
<i>Evaluation of the Primary Health Care Strategy: Practice Data Analysis 2001-2005</i> , September 2007	To examine changes, for different population groups and funding models, between 2001/02 and 2004/05, including changes in the amount patients were paying and how they related to policy objectives, changes in the use of primary health care services, whether more patients were being seen by nurses, and changes in the pattern of ACC claims.
<i>The Evaluation of the Eleven Primary Health Care Nursing Innovation Projects</i> , September 2007	To describe the establishment of the innovations and how well they had achieved the expected outcomes, identify the factors contributing to success, draw lessons from the overall evaluation to help others enhance the role of primary care nurses, and disseminate the results.
<i>Intersectoral Community Action for Health (ICAH) Evaluation</i> , March 2008	To assess whether the programmes had a positive effect on health and disability outcomes, particularly those for population groups experiencing worse health outcomes; identify critical success factors for the ICAH projects; and assess the process and outcomes of one sub-project in each ICAH programme.
<i>Primary Mental Health Initiatives Interim Report</i> , December 2006, October 2007	To report on primary mental health initiatives and innovations projects in 41 PHOs. The final report was due in June 2008.
<i>Key Directions for the Primary Health Care Strategy: case study report and composite success model</i> , June 2007	To report a series of case studies about the use of information in primary health care services to improve clinical practice, organisational performance, and health outcomes. The aim was to draw on the experience from some case studies to create a “composite success model” that would guide future information planning and support learning across the health sector.

Source: Adapted from information provided by the Ministry of Health.

- 4.10 The Ministry considers that the four annual reports to Cabinet combined the up-to-date findings from evaluations, research, and analysis into a single report. However, the Ministry has also identified that:
- As there is currently no single report bringing together [primary health care] data, it is difficult to see trends across indicators, e.g. that a DHB may be performing well on indicators relating to child health ... but not indicators relating to ... services to adults.*
- Bringing the current indicators together into reports that enable a DHB to compare their performance against national averages ... can be done, but at considerable effort.²*
- 4.11 Rather than continue with the current resource-intensive system, the Ministry has decided that it would be a better investment to improve the information systems (through *Primary Health Care Strategy: Key Directions for the Information Environment*, August 2007) so that reporting can occur more easily.
- 4.12 In our view, it has been, and is, possible for the Ministry to systematically report changes under the Strategy, even though it does not have a comprehensive set of measures covering each of the goals in the Strategy's vision statement. For example, the Ministry could have produced and published reports about action taken to fulfil the Six Key Directions (and corresponding actions) or Five Priorities for Early Action. The Ministry has reported on some aspects of each, but no reports have listed and reported against all the directions, actions, and priorities.
- 4.13 Although a lot of information is collected and reported, it is difficult to get a full and clear picture about the progress made because the Ministry has not systematically reported against all six goals inherent in the Strategy's vision statement.
- 4.14 It is useful for reports covering single topics or shorter periods, such as reports about smaller evaluation studies, to be published as they become available. The Ministry should continue to do this. However, periodically bringing information from all the different sources together would provide a rounded assessment of the changes that have occurred.
- 4.15 There has been no public reporting about progress against the Joint Work Programme's outcomes. The Ministry has reported progress about discrete projects to the Minister and DHBs, but these do not constitute reports about the whole programme's progress.

² Ministry of Health (2007), *Health Report Ref. No.: 20070693: Review of the Primary Health Care Strategy Monitoring Environment*, Wellington.

No communications and reporting strategies for the Strategy

- 4.16 The Ministry does not have a communications strategy for reporting about the Strategy that:
- identifies audiences for reports; and
 - ensures that reports are understandable and relevant for each audience.
- 4.17 Many of the Ministry's reports (especially, but not only, the evaluation reports) are technical and densely written. We accept that technical data needs to be available. However, because the Ministry publishes most of its reports widely and publicly, plain English interpretations or summaries of technical information would be useful.
- 4.18 Except for reporting to Cabinet, the Ministry does not have a clear schedule setting out what information about the Strategy it will report and when, or when it will incorporate occasionally updated information (such as the results of health surveys) into its accountability reports (see Figure 3).

Problems with information systems

- 4.19 In 2001, the Strategy identified that:
- ... accurate and useful information about enrolled populations and their health needs is critical to quality as well as to the successful adoption of a population health focus in primary health care services.*
- ... the development of further information initiatives will be a key priority for the Ministry of Health, DHBs and PHOs.*
- ... all parties need to work together to ensure that accurate and useful information is collected and shared ... building a standardised primary health information infrastructure.³*
- 4.20 We referred to the Ministry's plans to address this issue in paragraph 4.11. The plans, in principle, seem sensible to us.

Difficulty finding basic information and deciding its significance

- 4.21 We had difficulty finding some fairly basic information in published reports about changes under the Strategy. Once we had the information, we had difficulty deciding its significance. We give some examples in Figure 5.

³ Hon. Annette King (2001), *The Primary Health Care Strategy*, Wellington, page 25.

Figure 5

Examples of how inconsistent public reporting and a lack of measures make it difficult to understand the significance of the information being reported

Example 1

It was not a straightforward task to produce Figure 6 in Appendix 1 from published reports, even though the information about the number of PHOs and number of enrolled patients is some of the information most often reported. We needed to go through several documents to find the PHO numbers, and they were not reported for the same date each year. Enrolment figures were reported for different dates. We asked the Ministry to provide figures as at the end of June each year.

Example 2

The Ministry's *Annual Report 2005/06* mentioned that, by April 2006, there were 81 PHOs with a combined enrolled population of just under four million people, which is about 95% of the total population.* We could not discover from the reports whether 95% was the maximum potential enrolment expected then or ever. For example, we are aware that, in some locations, people are waiting to register with a general practice, and therefore to enrol with a PHO.

Example 3

The Ministry's *Annual Report 2005/06* said the new subsidies had reduced financial barriers to accessing primary health care services. Almost 70% of PHOs (56 of the 81 PHOs) had shown higher use of primary health care services by high-need groups compared with non-high-need groups.* However, without any targets, it is not clear to us whether 70% was a good result for 30 June 2006.

* Ministry of Health (2006), *The Annual Report 2005/06 including The Health and Independence Report*, Wellington, page 121.

What the Ministry needs to do

- 4.22 We have identified areas where the Ministry could improve its reporting of the Strategy's progress. It could:
- produce consolidated progress reports about the Strategy; and
 - publicly report the results from the PHO Performance Programme.

Produce consolidated progress reports about the Strategy

- 4.23 To get more value out of the information the Ministry already has, it should produce consolidated reports summarising, from existing information, what it knows about progress toward the goals inherent in the Strategy's vision statement.
- 4.24 The reports could also include other relevant information, such as short summaries of any evaluation reports that have been published since the last report. The reports should explain why progress is ahead, on, or behind schedule, and how the Ministry is using the information collected to maintain progress and ensure that the Strategy will be successful.

- 4.25 The reports could include commenting on progress with the Six Key Directions and 40 corresponding actions, and progress with the Five Priorities for Early Action.
-

Recommendation 2

We recommend that the Ministry of Health regularly produce consolidated reports – the first by 30 June 2009 – about progress toward the Primary Health Care Strategy's goals and summarise how the information collected is being used to ensure that the Strategy will be successful.

Publicly report results from the PHO Performance Programme

- 4.26 The Ministry should ensure that information about the performance of PHOs is reported as soon as possible. It was intended that reports about PHOs' performance would be published after the PHOs had been in the programme for 15 months. However, we suggest that the programme be amended so results are published once PHOs are eligible for performance payments. In our view, if the data is reliable enough to be used for performance payments, then the data should be published in some form of report about the performance of PHOs.
-

Recommendation 3

We recommend that the Ministry of Health ensure that performance reports about the primary health organisations that have been in the Primary Health Organisation Performance Programme for more than 15 months are promptly written and published.

Recommendation 4

We recommend that the Ministry of Health work with district health boards and primary health organisations to review, by 30 June 2009, the Primary Health Organisation Performance Programme so that performance results are published once primary health organisations are eligible for performance payments.

Part 5

Using information about the Strategy's progress

- 5.1 In this Part, we comment on:
- how the Ministry has used the information it has about the Strategy's progress;
 - the gaps in what the Ministry has done; and
 - what the Ministry needs to do to improve its use of monitoring and evaluation information.

Using the information collected

- 5.2 The Ministry told us that it takes an evidence-based approach and incorporates the information it has collected into its policy-making and operational decision-making systems. The Ministry had difficulty in clearly showing us how it used the information to monitor the Strategy's progress and recommend whether to maintain the current course or make changes. The Ministry was most easily able to show that information had been used where the response involved financial expenditure. For example:
- The Ministry monitors primary health care expenditure against forecasts, which provides information about the use of the subsidies and initiatives.
 - The Ministry explained that it had introduced a mechanism for general practices to get permission for proposed increases to their advertised fees. The reason for the approvals system is to maintain the goal of lower-cost services.
 - The Zero Fees for Under 6s subsidy was introduced after identifying that the number of general practices offering free care to children less than six years old had dropped to unsatisfactory levels.
 - The Very Low Cost Access payments were introduced to ensure that patients' pay less when enrolled with participating PHOs.
- 5.3 The Ministry provided us with limited examples of reports analysing and responding to independent evaluation reports. For example, the original Care Plus Programme was modified using information gained from the programme's evaluation and advice provided to the Minister by the National Health Committee about meeting the needs of people with chronic conditions.
- 5.4 When the Ministry publishes evaluation reports on its website, it sometimes includes a brief statement of the Ministry's early reaction to the report. The statement may be part of a media release or included on the webpage. A good example is a newsletter called *Primary Mental Health Care in New Zealand* (November 2007) that, among other things, responds to interim evaluation results and links the results to current and planned work.

- 5.5 The Ministry was able to show how the last report listed in Figure 4 was incorporated into a document called *Primary Health Care Strategy: Key Directions for the Information Environment* (August 2007). This document sets out how to create an improved information environment that supports the Strategy.

Gaps in showing how information has been used

- 5.6 There are limited examples that show how the Ministry has fed what it has learned from its monitoring efforts into policy and operational decision-making.

Problems with capability

- 5.7 In 2007, the Ministry observed:

... limited formal experience and access to capability in relation to sector oriented performance improvement, change management, organisational development and learning, and performance analysis. The Ministry has been, therefore, unable to consistently facilitate and support performance improvement with DHBs in relation to the [Strategy], including fostering DHB links and dissemination of learning.¹

- 5.8 The Ministry has advised us that it now has enough capability to address these matters. We have not audited the steps the Ministry has taken to improve its capability.

What the Ministry needs to do

- 5.9 The Ministry should summarise in its reporting how it has used, or intends to use, the information it collects to maintain or improve progress towards the Strategy's goals. It would be useful to publish the Ministry's response to evaluation reports on the Ministry's website alongside those reports. This would serve two purposes. It would tell the public about what the Ministry intends to do, and it would assure participants in evaluations that the Ministry has considered the findings and made decisions about them.
- 5.10 To be useful, the Ministry's reports need to be suitable for the differing needs of DHBs, PHOs, Parliament, and the public. The Ministry's reports (and reports prepared for the Ministry) would be more accessible if they were written in plain English, or included plain English summaries of technical and densely written information.

Recommendation 5

We recommend that the Ministry of Health require and provide plain English reports about the Primary Health Care Strategy.

¹ Ministry of Health (2007), *Health Report Ref. No.: 20070693: Review of the Primary Health Care Strategy Monitoring Environment*, Wellington.

Appendix 1

Changes to primary health care structures since 2001

PHOs usually consist of a group of general practices (the general practices are described as members of the PHO). In other cases, one or more non-government organisations may have formed a PHO. Figure 6 shows the reported numbers of PHOs and enrolled patients from 2002/03 to 2007/08.

Figure 6
Numbers of PHOs and enrolled patients, from 2002/03 to 2007/08

Most PHOs were set up by the end of the third year of the Strategy's implementation, and within two years of the requirements for PHOs being established. Since 1 July 2005, the number of PHOs has been stable at about 80. The number of enrolled patients has continued to increase slightly since 2004/05.

Year of implementation	Financial year	Reported number of PHOs	Reported number of patients enrolled, as at the end of June (million)
0	2000/01	<i>Strategy launched</i>	
1	2001/02	<i>Requirements for PHOs established</i>	
2	2002/03	47 at 30 June 2003	1.080
3	2003/04	68 at 30 June 2004	3.167
4	2004/05	No figures reported	3.828
5	2005/06	79 at 1 July 2005 81 at 1 April 2006	3.910
6	2006/07	81 at 30 June 2007	3.948
7	2007/08	82 at 13 September 2007 81 at 20 December 2007 80 at 27 May 2008	4.040

Source: Ministry of Health.

It is voluntary for general practices and others to form PHOs. The minimum requirements for forming PHOs were established in the first year of the Strategy's implementation. PHOs are funded by new subsidies and initiatives, which we discuss further below. About 85% of the PHOs in place at 30 June 2008 were formed within three years of the Strategy's launch (see Figure 6). The number of PHOs within each DHB district ranges from one to seven. A PHO can contract with only one DHB, but a PHO's patients may come from one or more DHB districts.

Patients cannot enrol directly with a PHO – they must first be accepted onto a GP's patient register. Once registered, patients are asked if they want to enrol with the GP's PHO. The rate of patients' enrolment was similar to the PHO establishment rate (see Figure 6). About 78% of the number of people enrolled with PHOs at 30 June 2008 enrolled within three years of the Strategy's launch.

Appendix 2

Changes to primary health care funding since 2001

We use “primary health care funding” to refer to the funding for new subsidies and initiatives introduced under the Strategy and the funding for two existing subsidies (the General Medical¹ and Pharmaceutical² subsidies).

The Strategy has resulted in two main changes to primary health care funding. One was introducing a new method for subsidising patients’ visits to GPs (the First Contact subsidy).³ The other was increasing the amount of primary health care funding.

More than \$3.2 billion has been spent on primary health care funding from 2002/03 to 2007/08. We give a breakdown of this expenditure in Appendix 3.

Figure 7 lists the several new subsidies and initiatives that have been introduced since the Strategy was launched in 2001 and the requirements for PHOs were established. Most of the new funding was directed to PHOs. We briefly describe these new subsidies and initiatives in Appendix 4.

Figure 7
Introduction of new subsidies and initiatives from 2002/03 to 2007/08

Financial year	Subsidies and Initiatives
2002/03	First Contact Health Promotion PHO Management Fees Services to Improve Access Other
2004/05	Care Plus
2005/06	PHO Performance Payments
2006/07	Very Low Cost Access
2007/08	Zero Fees for Under 6s

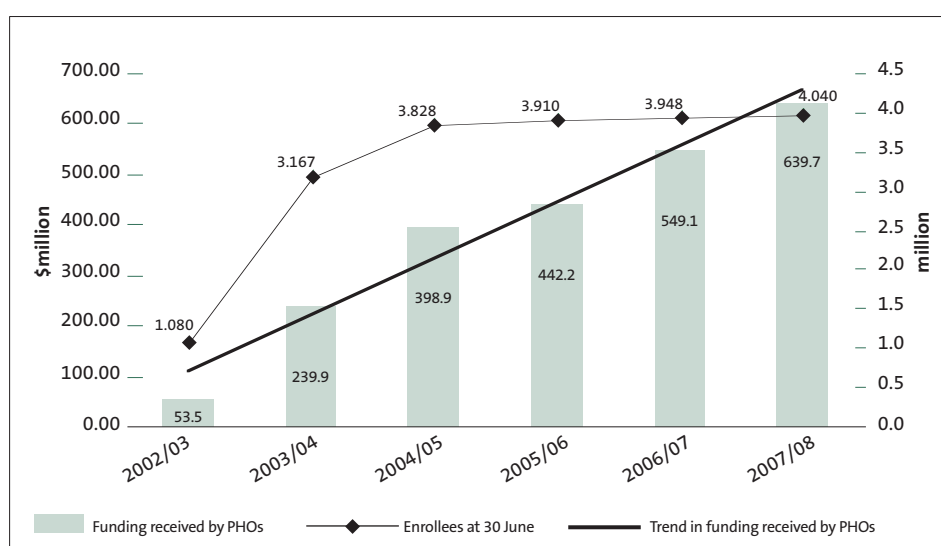
Source: Ministry of Health data.

Figure 8 shows how funding was phased in to cover enrolled patients. Funding received by PHOs increased at a slower rate than increases in the number of enrolled patients, because patients were enrolled before the new funding was fully introduced.

- 1 This is a fee-for-service subsidy paid to GPs for visits by patients who are not enrolled with the GP’s PHO.
- 2 This is a subsidy paid to pharmacies for the costs of dispensing prescribed medicines. The maximum amount enrolled patients pay to collect subsidised medicines prescribed by their PHO is \$3. The maximum amount is \$15 in other circumstances. See Appendix 4.
- 3 This is a subsidy to PHOs for enrolled patients’ visits to general practices or other PHO services. It is a form of bulk-funding also known as capitation-based funding. The amount of the First Contact subsidy is decided by the characteristics of each PHO’s individual patients, such as age and gender. This capitation-based funding formula was also used to decide the funding for other subsidies and initiatives.

Figure 8
Funding to PHOs compared with the number of enrolled patients from 2002/03 to 2007/08

Funding received by PHOs increased at a slower rate than the number of patients enrolled with PHOs, because patients were enrolled with PHOs before subsidies or initiatives were fully phased in.



Source: Ministry of Health data, February 2008.

Notes: Funding has been rounded to the nearest \$100,000. Figures include all adjustments made to preserve the value of funding and to adjust or transfer payments as needed to ensure that each entity receives the correct payments. We have excluded any funding for “Other” subsidies and initiatives, some of which may have gone to PHOs.

The First Contact subsidy and increases to the Pharmaceutical subsidy account for about 70% of primary health care expenditure from 2002/03 to 2007/08. Figure 9 shows how both of these subsidies were phased in from 2002/03 to 2007/08.

Figure 9
Phased introduction and expenditure for the First Contact and Pharmaceutical subsidies from 2002/03 to 2007/08

	Financial year						Total (\$m)
	2002/03 (\$m)	2003/04 (\$m)	2004/05 (\$m)	2005/06 (\$m)	2006/07 (\$m)	2007/08 (\$m)	
First Contact	43.7	199.1	326.2	357.2	428.7	487.5	1,842.4
Pharmaceutical	-	7.9	58.0	68.8	110.8	138.1	383.6
Total	43.7	207.0	384.2	426.0	539.5	625.6	2,226.0

Source: Ministry of Health data.

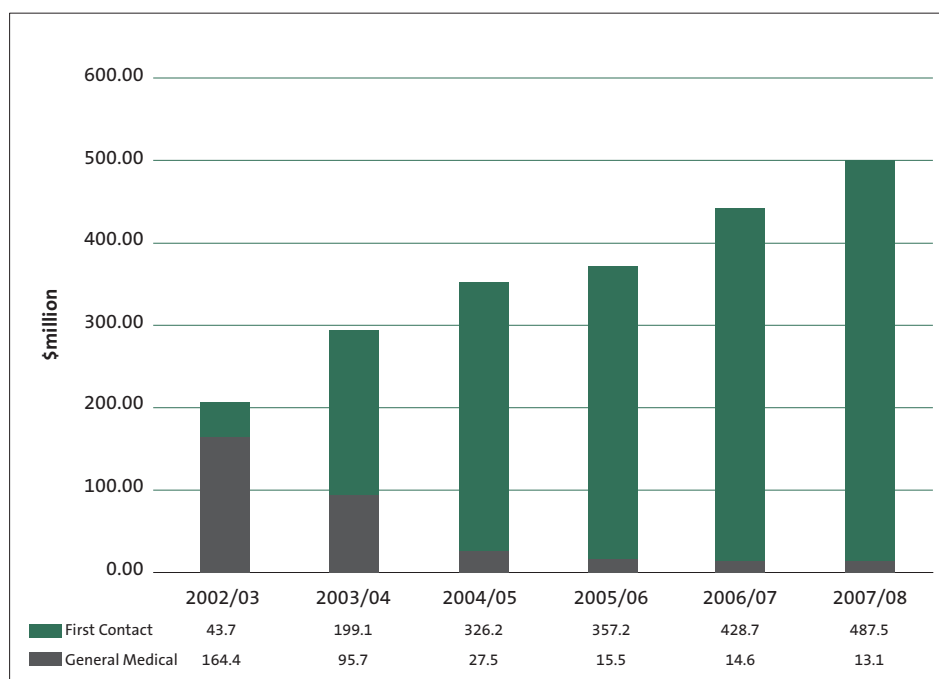
Note: Figures have been rounded to the nearest \$100,000.

The First Contact subsidy was expected to lead to patients paying less to consult their GP or PHO, so they would be less likely to put off making necessary appointments because of the cost of doing so. The Ministry’s *Annual Report 2005/06* said the new subsidies had reduced financial barriers to accessing primary health care services (see also example 3 in Figure 5).

The First Contact subsidy replaced the General Medical subsidy as the main method of funding primary health care, and Figure 10 shows this shift from 2002/03 to 2007/08. Because GPs claim the General Medical subsidy when they see patients who are not enrolled with them, it will not be completely phased out. Non-enrolled patients may pay higher fees when they visit a GP or PHO.

Figure 10
Expenditure on the General Medical and First Contact subsidies from 2002/03 to 2007/08

Annual expenditure on the General Medical subsidy reduced as the First Contact subsidy was phased in. The combined annual expenditure for both subsidies increased from about \$200 million in 2002/03 to about \$500 million in 2007/08.



Source: Ministry of Health data.

Note: Figures have been rounded to the nearest \$100,000.

Appendix 3

Changes to expenditure on the Primary Health Care Strategy from 2002/03 to 2007/08

Subsidy or initiative	Financial year						Total (\$m excl. GST)
	2002/03 (\$m)	2003/04 (\$m)	2004/05 (\$m)	2005/06 (\$m)	2006/07 (\$m)	2007/08 (\$m)	
First Contact	43.7	199.1	326.2	357.2	428.7	487.5	1,842.4
General Medical (net Fee For Service claims and old capitation pays)	164.4	95.7	27.5	15.5	14.6	13.1	330.8
Health Promotion	0.8	3.6	6.3	7.3	8.1	8.5	34.6
Other items	8.0	35.6	27.1	26.2	27.6	43.6	168.1
PHO Management Fees	2.7	14.3	23.8	25.6	26.8	27.9	121.1
Services to Improve Access	6.4	22.7	28.9	32.1	35.5	37.7	163.3
Pharmaceutical	-	7.9	58.0	68.8	110.8	138.1	383.6
Laboratory	-	0.7	2.9	3.0	3.1	3.3	13.0
Care Plus	-	-	7.5	14.3	21.3	27.2	70.3
PHO Performance Payments	-	-	-	5.9	14.7	16.0	36.6
Very Low Cost Access	-	-	-	-	12.4	26.8	39.2
Zero Fees for Under 6s (new)	-	-	-	-	-	3.2	3.2
Capitation manual adjustments	(0.1)	0.2	6.2	(0.2)	1.6	2.5	10.2
Total	225.9	379.8	514.4	555.7	705.2	835.4	3,216.4

Source: Ministry of Health.

Notes: Figures have been rounded to the nearest \$100,000. Figures include all adjustments made to preserve the value of funding and to adjust or transfer payments as needed to ensure that each entity receives the correct payments.

Appendix 4

Summary descriptions of primary health care subsidies and initiatives

Subsidy or initiative	Summary description	Comment
First Contact	A subsidy to PHOs for enrolled patients' visits to general practices or other PHO services.	This subsidy is the main method for subsidising PHOs for patients' visits to GPs and other PHO staff. It is a form of bulk-funding also known as capitation-based funding.
Health Promotion	A subsidy to PHOs to create Health Promotion programmes.	The programmes must take a population-based approach to enrolled patients.
PHO Management Fees	A subsidy to PHOs for their administration costs.	Costs include community consultation and representation, processing patient registers, formal enrolment, and reporting and monitoring requirements.
Services to Improve Access	A subsidy to PHOs to provide new or improved services.	Intended to reduce the differences in levels of health between population groups, particularly those most in need.
Very Low Cost Access	Payments to PHOs voluntarily agreeing to charge patients amounts that do not exceed standard consultation fees.	Practices receiving a Zero Fees for Under 6s payment cannot receive a Very Low Cost Access payment as well.
Zero Fees for Under 6s	Payments to PHOs for general practices that agree to provide free visits for children aged less than six years.	Practices receiving a Very Low Cost Access payment cannot receive a Zero Fees for Under 6s payment as well.
Pharmaceutical	A subsidy to pharmacies for the costs of dispensing prescribed medicines.	For enrolled patients who are prescribed subsidised medicines by their PHO, the maximum amount paid is \$3. In other circumstances, the maximum amount is \$15 (for example, if the patient is prescribed a medicine by a doctor who is not a member of the patient's PHO, such as an after-hours or hospital doctor).
Laboratory	A subsidy to DHBs for laboratory tests ordered by PHOs.	This was extra funding to help DHBs with expected increased demand for laboratory tests that was expected to occur because of increased use of primary health care services resulting from reduced patient fees.
Care Plus	An extra payment to PHOs for patients with high health need.	PHOs select individual patients who, because of their poorer health, have to (or should) visit a PHO more often than was allowed for in the First Contact funding that PHOs received.
PHO Performance Payments	Payments to PHOs that voluntarily join the PHO Performance Programme.	Payments are proportional to the PHOs' achievements in making progress against, or meeting, specific targets.

General Medical	A subsidy to GPs for visits to them by patients who are not enrolled with the GP's PHO.	The First Contact subsidy replaced this subsidy as the main method of subsidising patients' visits to GPs.
Other	Payments to PHOs and others for various initiatives.	For 2007/08, this included payments for influenza, rural services, and mental health services initiatives, and other project costs. In previous years, it included up to seven other assorted initiatives.

Source: Our descriptions are summarised from fuller information available on the Ministry's website (www.moh.govt.nz).

