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1 Executive Summary

1.1 Overview of Project

1.1.1 Project Scope

In March 2004, the Ministry of Health (MOH) contracted Capital Strategy Limited to undertake a review of PHO management services.\(^1\) The review comprised a survey/questionnaire and meetings with a sample of 14 PHOs. In addition, discussions were held with the 10 corresponding DHBs and a number of other stakeholders.

The key deliverables being to answer the following questions:

- Are PHOs performing the management services outlined in PHO service agreements?
- Where are PHOs deficient in providing the management services outlined in the service agreements?
- What are the main contributors to deficiencies in providing the management services outlined in the service agreements?
- What is the cost to PHOs of providing the full level of management services?
- How do management costs vary between PHOs?
- What aspects of the PHO influence the efficient and effective provision of management services?
- How do management costs vary between PHOs by size?
- Is the current management services fee appropriate?
- Are there lessons from other sectors that can be applied to the structuring and purchasing of PHO management services?
- Should the Ministry and DHBs change any aspects of its policy to achieve optimal results?

1.1.2 Project Outcomes

The two obvious starting points for this project were to identify: “what are management services” and “what is the basis of the management services fee” - given that PHOs are separately funded by the MOH to provide management services under the PHO Service Agreement (“Contract”).

\(^1\) Refer to Appendix 1 for a copy of the RFP.
**What are “management services”?**

The first obvious starting point requires a clear definition and view across the sector as to what PHO “management services” encompass. A review of the Contract indicated that management services are spread around the Contract and are not defined as such.

This lack of clarity provided no common starting point for a definition of management services and an inability to compare across PHOs as to quality of delivery and the extent to which they are being delivered. PHO survey responses confirmed they are also of the view that management services are not well defined.

Some PHOs and MSOs have made good efforts in attempting to assemble and define management services. There is some divergence in interpretation of management services depending on the reference point: the Contract versus the Primary Health Care Strategy (PHCS); i.e. some consider that the Contract does not interpret widely enough the expectations on PHOs and outcomes sought in the PHCS.

The attempts at defining management services at a PHO level indicates the lack of a clear signal and shared understanding between the MOH, DHBs and PHOs as to what management services are and what is an adequate level or quality of service. This has in turn meant that the approach to accounting for management services costs is far from common across PHOs. This has hindered the ability to meet aspects of the project scope such as:

- What is the cost to PHOs of providing the full level of management services?
- How do management costs vary between PHOs?
- How do management costs vary between PHOs by size?

Development of a platform for defining management services has thus been a key output of the project. Capital Strategy was able to incorporate information supplied by PHOs in developing a ‘standard’ list of management services in the survey questionnaire. The final list (amended in light of survey responses) appears to have met with general acceptance amongst stakeholders involved in the survey, and could reliably be used to define management services in the Contract.

**Is Funding Adequate?**

The second obvious starting point is the management services fee (MSF). There appears to be no clear logic in the current MSF formula for funding management services; particularly as the formula is essentially based on the previous PCO funding model of $6,300 per GP and not on the basis of a definition of baseline requirements for a PHO focussed on an enrolled population (of variable size).

In order to assess whether the MSF is adequate, the normal method would be to compare actual funding against a cost-benchmark or set of benchmarks, deemed to approximate or reflect efficient or ‘best’ PHO practice.
This would require for instance allowing for the costs of additional management services required of PHOs compared to the previous PCOs. However, the diversity in approaches to defining and accounting for management services has inhibited the ability to construct robust benchmarks or models of PHO management services costs based on the survey responses in this project.

When commencing the project there was a reasonable expectation of being able to complete a comprehensive and comparative analysis of management services delivered by PHOs, and the cost of carrying these out. Unfortunately this was not possible. The main comparable financial information obtained from PHOs includes only Board fees, general overheads and aggregate HR salaries. This led to the inability to develop PHO models based on management services outputs.

Thus models could only be developed on an input basis and at a very indicative and general level. The two models developed are based on a variety of information sources. Some PHOs have also developed their own models based on their views of sustainable levels of funding.

The models essentially recognise that all PHOs face fixed costs (no matter what their size). They are also focussed on small to medium sized PHOs and do not encompass large PHOs. The reasons for this include:

- There was a clear need from survey information (including views expressed by DHBs) to address inadequate funding for small through to the smaller medium/medium sized PHOs.
- The majority of large PHOs in the sample obtain management services from MSOs, and the information provided was insufficient for the group as a whole to allow a generalised model to be developed whilst also preserving confidentiality of responses.²

The case for increased funding to large PHOs was thus not so clear cut, although the MOH has the option to extend the additional funding in the models to large PHOs if it considers this is justified.

The models are also proposed as a basis to develop transitional funding for PHOs until robust analysis can be completed in 1-2 years time based on reporting against a consistent framework for both financial and service level information on defined management services and other outputs.

Closely linked to any recommendation on the adequacy of the MSF formula, is the issue of PHO size. There is no explicit policy on PHO size and PHO enrolled populations range from 3,600 (smallest) to 334,675 (largest). Many small PHOs have been established to represent the diversity of particular communities of interest. Having said this, as long as there is tolerance and accommodation of small PHOs as part of the PHCS (i.e. there continues to be no explicit policy on PHO minimum size) then it is appropriate to allow for fixed costs to be incorporated into the MSF in some way.

² A model for large PHOs could be developed (at an input or output level) by working in conjunction with several large PHOs and MSOs to assemble a common information base. This would require analysing information in more detail than was possible in the current project.
Given their experience to date, many PHOs (and DHBs) have now developed views on an appropriate PHO size to ensure PHO viability. Many concur with the view that PHOs face a level of fixed costs, no matter what their size.

Two options for the funding of management services were developed based on the reasoning that the MSF should better recognise the existence of fixed costs as well as support a wide range of PHO sizes:

1. One option is a fixed funding floor for PHOs which provides PHOs up to 20,000 enrolled population with a base level of funding. The MOH would have the option of extending this to all other PHOs recognising that they all have fixed costs and to ensure equity of funding across all PHOs. For many PHOs this is akin to an additional FTE - a common desire expressed by many PHOs that would contribute to the delivery of management services.

2. A second option is an extension of the current MSF capitation formula for PHOs up to 20,000 enrolled population. Again, the MOH would have the option of extending this to all other PHOs recognising that they all have fixed costs and to ensure equity of funding across all PHOs.

Aside from these recommendations, the MOH should still seek better information and cooperation across the sector in order to develop more robust models on the cost to deliver management services. An issue with the survey was that there is no clear basis for recommending an increase or decrease for large PHOs due to the lack of comparable financial information across the sample of large PHOs.

These options are put forward for discussion purposes, and require further in-depth modelling and analysis on the extent of subsequent changes to the capitation formula for PHOs over 20,000 enrolled population, and to assess equity issues. Such funding models, for instance, can otherwise create anomalies in funding levels around break-points in population. This would be subject to the MOH’s consideration of its policy on PHO size; i.e. whether there is a minimum sustainable size of PHO, including the extent that small PHOs are necessary to implement the outcomes in the PHCS in particular areas or among particular populations.

 Concerns have been expressed that increases in the lower funding tiers (without any explicit policy on minimum PHO size) will immediately translate into a splintering of medium to large PHOs to garner the additional funding. This is a knee-jerk reaction that would lead to inefficiencies within the sector and even more duplication. It also contradicts the common view of a lack of capacity and skills across all levels of the sector. The MOH and DHBs would need to more stringently monitor PHO performance to ensure perverse outcomes did not eventuate. This is not to say that the MOH may not review its minimum requirements for PHOs. Any assessment of optimal PHO size still needs to be addressed with regard to whether PHOs (no matter what their size) are delivering the health outcomes of the PHCS.
At the same time as providing more funding to PHOs, a financial reporting framework needs to be implemented across the PHO sector to provide a more robust basis for the development of financial models and to allow for comparability across PHOs. This will enable more detailed modelling of PHO management costs and the adequacy of the MSF. It is also fundamental to the ability of PHOs, DHBs and the MOH to monitor costs.

In addition, as PHOs are still in the early stages of the implementation of the PHCS, there is still the opportunity for continual self review by PHOs on the efficient utilisation of resources (both at PHO and provider levels). Incentives for this include technical assistance provided by the MOH to reduce duplication of effort across PHOs; consideration of how shared service models may work in each PHOs area including the assessment of what management services are appropriate to be delivered in-house versus what could be delivered as part of a shared service arrangement.

A peripheral issue that requires mention is that of the overall framework and direction of PHOs. The view was expressed that PHOs are faced with competing demands; i.e. they are constantly bombarded with programmes that are not prioritised by either the MOH or DHBs. For example, PHOs are faced with planning and implementing First Line services, Care Plus, Over 65s, Maori Health Plans, Pacific Health Plans, SIA, HP, clinical indicators, referred services, immunisation as well complying with management services requirements. Some overall framework or strategy from the MOH as to where PHOs are heading would go some way to assisting PHOs own planning.

Section 1.3 below provides a summary of the key findings of the project, based on the framework sought by the MOH.

1.2 Comparative Issues: Management Services and Clarity and Integrity of Financial Information

When commencing the project there was a reasonable expectation of being able to complete a comprehensive and comparative analysis of management services delivered by PHOs, and the cost of carrying these out. Unfortunately this was not possible for a number of reasons, including:

- In one case, the absolute lack of financial information available.
- The quality of the financial information provided varied considerably across the sample of organisations.
- The lack of a consistent reporting framework meant costs could not be put on a like with like basis.
- The complex inter-relationships between related party PHOs and MSOs, the lack of financial information provided on the MSO and the individual PHOs so as to be able to isolate out relevant costs, and the difficulty of establishing comparable data.
- The lack of defined service standards or service levels associated with management services to enable a valid comparison of costs associated with service level provided across PHOs (the level of service varied significantly in
our judgement but there were no absolute measures available to support conclusions).

1.3 Key Findings
Key survey findings are summarised as follows:

1.3.1 Are PHOs performing the management services outlined in PHO service agreements?
While reference is made to “management services” within the Contract there is no specific schedule or definitions outlining what they encompass.

As part of the project, a management services list was developed. It is recommended that this list sit alongside the Contract as a “best practice” guide/framework. This would provide clarity to both DHBs and PHOs as to what constitutes “management services”. It would also assist in the future development of performance objectives to measure PHO performance of management services.

It is recommended that further assessment of the list of management services be carried out to ascertain what aspects could be undertaken within a shared services model (such as core back room type functions) versus those management services that are more appropriate to be kept in-house).

The medium to larger PHOs indicate that they tend to be delivering the requirements of the Contract. (This is the view of the PHOs rather than that based on documented service levels or quality indicators).

The smaller PHOs indicate they are only able to perform some aspects well, and are unable to perform other management functions at all (or at a low level of adequacy).

1.3.2 Where are PHOs deficient in providing the management services outlined in the service agreements?
Performance monitoring and reporting requirements, business planning (e.g. preparation of business cases), research and analysis, community liaison, development of protocols, quality management, referred services.

1.3.3 What are the main contributors to deficiencies in providing the management services outlined in the service agreements?
The main contributor is resourcing: PHOs (particularly the small to medium PHOs) don’t have the funding to hire staff to undertake all requirements.

Other contributors included (in no particular order):
- Origin of a PHO:
  - There was general consensus that those PHOs with an IPA background were more able to come through the initial establishment phase successfully than those without because they
already had a level of infrastructure and community networks in place.

- New start up PHOs required a significant amount of time to be spent on developing inter-sectoral networks. This took staff (generally the CEO) time away from delivering actual management functions.

- Capability across the health sector (i.e. the inability to recruit sufficient suitably qualified and experienced people [across all levels - DHB and PHO]).

1.3.4 What is the cost to PHOs of providing the full level of management services?

The financial information available and disclosed was not sufficient, along with lack of definition of required service levels, to completely answer this question. Nonetheless several conclusions were able to be developed from the information available.

Many PHOs indicated that additional funding to support more staff would ensure the full level of management services is provided.

Funding for an extra 1 to 1.5 FTEs (e.g. business analyst/project management type roles) would enable PHOs, particularly the small to medium sized PHOs, to achieve the requirements of the Contract.

A model of two ‘minimum qualifying’ PHOs was developed to determine the ‘hypothetical’ financial requirements of a PHO. Cost estimates are based on information obtained from several sources as part of conducting interviews and the questionnaire survey of PHOs.

The models reflect evidence that all PHOs require a core of staff resource to undertake management services. They also provide a means of contrasting PHO costs at a generalised level since the survey data does not provide enough detail to show how step-changes occur in either fixed or variable costs as PHO size increases.

The survey responses show that it costs between $200,000 to $300,000 per annum to provide core management services regardless of the size of the PHO (say up to 50,000 enrolled population). This includes fixed costs/overheads (but excludes variable costs).

Variable costs will generally add $100,000 to $200,000 per annum to the management costs of a PHO. These include clinical analysis and governance, community liaison, communication and marketing etc. These are more in the nature of variable costs as they are more likely to differ between PHOs due to the characteristics of their enrolled population (i.e. size as well as other variables such as population density and health needs status).

The models should be used as reference points only for considering the implications of (any) changes in current MSF funding formula, rather than as guides for minimum levels.
1.3.5 How do management costs vary between PHOs?

The issues around the viability and integrity of the collected financial information are discussed in section 1.2 above. The information retrieved from PHOs varied in detail, quality and quantity to the point that it was not possible to make meaningful financial cost comparisons other than at the very highest level. (A high level overview of costs according to PHO size is provided in 1.3.7 below.)

There has been a high reliance on in-kind/unpaid work from PHO staff, providers and Board members.

Most PHOs commented on the level of hidden costs they had experienced since establishment. These create additional burdens on PHOs as they have to devote (in some instances significant) time and resources to resolving such issues, the cost of which has to be borne from management services funding. Having said this, many PHOs are still in their establishment phase and such costs may dissipate in the medium to long term. Examples of such costs include: sector development costs; IT infrastructure and software issues; communications and marketing; legal disputes; travel costs incurred in rural areas.

To enable financial comparability in reporting across PHOs, a reporting framework/template should be developed. This will enable monitoring (by DHBs) of management services across PHOs and ensure that one is comparing “apples with apples”. To facilitate this, some recommendations on a way forward are:

- Development of a consistent PHO financial reporting framework to ensure comparability across PHOs, whereby the MOH should:
  - Prescribe definitions of classes of costs and revenues to be reported, and provide training for PHOs.
  - Set up auditing mechanism(s) to ensure compliance
  - Review costs and performance after 1-2 years, by making comparisons between PHOs once they have comparable information; then
  - Refine definitions/reporting/measurements and universally apply best practices.
  - Investigate the option of moving towards an outputs approach to the reporting framework.

- Development of a national resource centre of best practice.

1.3.6 What aspects of the PHO influence the efficient and effective provision of management services?

- A PHO’s origin (i.e. PHOs with an IPA background already have a level of infrastructure and community networks in place).
- Top-slicing other funding sources to contribute to the funding of management services.
• The provision of DHB support and capacity building assistance.

• There are clear economies of scale in provision of management services as PHO size increases. These include both staff and overhead costs, and can be realised either through a PHO enrolling more people, or by accessing services that serve a larger pool of enrollees.

Management costs in the developed hypothetical models fall significantly if the PHO is able to ‘avoid’ full or half-time FTEs (i.e. utilise part-time managers/staff) and also reduce its proportion of ‘other overhead’ costs to 30% or below. This is consistent with the survey information showing economies of scale in management costs the larger the PHO.

Efficiencies can be achieved in both remuneration costs and other overhead costs. The models show that given funding constraints, if smaller PHOs in particular are going to be capable of providing management services to an adequate level and to meet additional requirements in the foreseeable future (i.e. RSM), they will need to investigate options for shared services and contracting out.

The pathways for achieving this would appear to include:

• PHO mergers

• Clusters/networks of affiliated PHOs establishing a shared service operation (whether regional shared services across like minded PHOs within a particular DHB or possibly cross boundary)

• DHBs establishing a shared service operation for some or all of its PHOs.

• Purchasing services from an MSO.

This would result in some smaller PHOs moving closer toward the cost range for small PHOs linked to MSOs. However, these results certainly do not suggest that small PHOs should be encouraged to aim for the low-end given these cost estimates are not associated with any evidence of the adequacy of management service levels.

In fact the model results suggest that an increase in the MSF would be appropriate for small PHOs to recognise the existence of fixed costs and to provide capacity to meet current expectations and to accommodate increasing workload requirements on PHOs. This is subject to two provisos that:

(i) Small community-based PHOs are seen as a key component of achieving the overall Primary Health Care Strategy and should not therefore be driven to converge into a small number of large PHOs nationwide.

(ii) All PHOs should be encouraged to identify which types of management services are ‘primary’ (i.e. integral and instrumental to reflecting the values and aspirations of the PHO and which should therefore be internalised) as opposed to ‘peripheral’ (i.e. practices and processes, whether of a routine or specialist nature, which can be obtained externally).
A way forward for (ii) above is for the MOH to provide a framework to assist PHOs in order to reduce duplication of thinking across PHOs.

The MOH could develop guidelines and criteria or provide direct technical assistance to assist PHOs conduct robust cost-benefit analysis of the option of in-house provision versus contracted-out or the various shared service options.

The outcomes of the analysis will be different for many PHOs (reflecting local conditions) but a framework will provide incentives towards more effective utilisation of resources.

It is difficult to determine whether a PHO is operating efficiently and effectively based on a review of management service costs alone. That is, management services are but one aspect of the overall functions of a PHO.

It is recommended that a performance reporting framework is developed along the following lines:

- Encompassing the development of performance objectives (in additional to clinical performance indicators) to monitor PHO efficiency and effectiveness.
- To be progressed by forming a Working Party with representatives from the MOH, DHBs, PHOs, MSOs.

The monitoring of PHO performance by DHBs is reliant on a DHB’s resources. It is still early days in terms of monitoring - many PHOs are still in the establishment phase. DHB monitoring to date has been mainly focussed on establishment and not long-term viability.

The MOH could provide targeted technical assistance to DHBs to assist in the monitoring of PHOs (e.g. inter-DHB comparisons of PHO management costs and service levels).

1.3.7 How do management costs vary between PHOs by size?

Although the above comments in sections 1.1 and 1.2 highlight problems with the data, in general terms the larger (surveyed) PHOs can generally deliver a management services cost per enrolled person of approximately $4-$6 per annum, while smaller PHOs will spend approximately $7 to $38 (medium PHOs were $6 to $29).\(^3\)

Management services costs as a % of total costs for larger PHOs ranged from 5%-9% whereas it was 4%-16% for small PHOs and 7%-21% for medium PHOs.

The larger PHOs tended to contract out most of their management services to an MSO whereas the smaller PHOs tended to only contract out register management.

\(^3\) Note: The cost information provided by PHOs represents their current cost to deliver management services to a particular level determined by the PHO; it may not truly represent the actual cost to PHOs of providing the full level of management services. (Refer to section 6.5.2 for further details).
It is anticipated that many small PHOs (under 20,000 enrolled population) will need to access shared or joint service arrangements if they are to achieve adequate levels of performance of management services.

In determining its policy for the size of PHOs, the MOH has been careful not to prescribe a minimum (or maximum) size. At the same time, the MOH does not wish to see PHOs fail given the associated cost and impact on patients. Based on the survey, it is thus apparent that the smaller PHOs are struggling to remain viable within the current level of resources allocated to them. Some of them are not large enough to spread management costs and thus deliver all the management services required under the Contract.

Based on the survey feedback, the MOH needs to consider whether it continues to maintain a hands-off approach to its policy on PHO size or takes a more prescriptive approach by reviewing and adjusting the Minimum Requirements for PHOs.

1.3.8 Is the current management services fee appropriate?

Larger PHOs tended to rate the adequacy of management services funding from 3 to 4 whereas the smaller PHOs tended to rate their funding as inadequate (rating of 1).\(^4\) There is, however, no corresponding definition or measure of what service levels are required or are being delivered.

It was particularly apparent that the MSF was inadequate for small PHOs, and also for the smaller medium sized PHOs, and that as a result a range of areas in the contract were not being adequately performed.

In terms of the adequacy of the MSF for large PHOs (and some of the larger medium sized PHOs), the position was not so clear cut. Some large and larger medium PHOs considered that the level of current funding was either adequate or there wasn’t a need for much additional funding, and this view was generally supported by the corresponding DHBs. Some large PHOs however considered additional funding was required.

Two options for the short to medium term are put forward for consideration by the MOH. These options are put forward for discussion purposes, and would require further in-depth modeling and analysis. The options recognise the existence of fixed costs for small PHOs and provide capacity to meet current expectations and to accommodate increasing workload requirements on PHOs.

- Option One: Restructuring the MSF by providing a fixed funding floor of $280,000 (excluding GST) for all PHOs up to 20,000 enrolled population:
  - The additional cost in the MSF to the MOH would be $5.9 million (excluding GST) per annum (if it was applied to all small PHOs).\(^5\)
  - A review of PHO minimum size may be required.

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\(^4\) Rating of Adequacy of Funding: PHOs were asked to rate the adequacy of funding for management services ranging from 1 (=inadequate) to 5 (=adequate).

\(^5\) Based on PHOs in existence prior to 1 July 2004.
• Option Two: Increasing the bottom tier of the MSF capitation formula from $9.61 to $14 per capita for the enrolled population up to 20,000:
  o The additional cost in the MSF to the MOH would be $1.5 million (excluding GST) per annum (if it was applied to all small PHOs).  
  o A review of PHO minimum size may be required.

• If this funding for the first 20,000 population from Options One and Two was applied to the medium PHOs and the large PHOs the additional costs to the MOH would be $2.11 million and $0.97 million respectively.

• The formation and structure of PHOs should be driven by the health needs and desired health outcomes of populations. Although funding should be a secondary consideration, in order to prevent existing PHOs disaggregating or reforming to take advantage of the proposed revised funding arrangements, the MOH would need to:
  o introduce rules such as the funding would only apply to those PHOs already in existence at 1 July 2004, and would not apply to any reconfigured PHOs in relation to the enrolled population applying at that time
  o require establishment plans for new PHOs to demonstrate:
    • that the PHO would be sustainable at the proposed level of enrolled population or else to outline and justify why a smaller size is appropriate in order to achieve specified health outcomes for the targeted community
    • the steps that would be taken to achieve cost efficiencies through shared services or other arrangements to enable the PHO to adequately deliver management services within the funding available to it.

• The effectiveness of these options would need to be evaluated and reviewed in 1-2 year’s time when comparative reporting and analysis has been implemented.

Further in-depth modelling would still be required on the extent that subsequent changes would be required to the MSF capitation formula for PHOs over 20,000 enrolled population and to analyse equity issues. This should be done bearing in the mind: the hypothetical PHO models developed in section 7; current gaps in funding; MOH’s available funding for PHO management services and the financial impacts of future programmes on PHOs.

The MSF would be reassessed once the additional modelling was completed.

An important aspect of the options is for the MOH and DHBs to provide incentives or obligations to ensure PHOs access shared service arrangements, to form networks or if necessary to merge.

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6 Based on PHOs in existence prior to 1 July 2004.
The survey results indicated that small PHOs in particular believe they lack the infrastructure required to be in a position to implement the clinical governance and administrative systems associated with referred services management (RSM). The MOH could investigate the option to include a service establishment component in the RSM funding formula which would only apply to small PHOs. Two approaches are identified:

- An initial one-off establishment grant to meet set-up costs (e.g. improving information systems, reporting processes and workforce training).
- A premium built-into the annual funding stream to enable the PHO to access analytical and clinical expertise (i.e. whether in-house or from a management services organisation).

An option for the medium to long term MSF could be to consider bulk funding of PHOs:

- PHOs would be provided a level of revenue to fund their organisation on an annual basis (covering programmes, management services, overheads etc).
- This would ensure continuity of funding (as opposed to quarterly fluctuations) and the ability to forward plan.
- Would address PHO concerns around non-enrolled populations.

In conjunction with any adjustment to the MSF, there is a need for the development of performance objectives and stronger DHB monitoring of PHOs to provide the inherent tensions required to ensure efficient and effective utilisation of resources.

Some PHOs are top-slicing other funding streams to fund the shortfall in management services (e.g. the % taken varies, but 5-15% was quoted). Whereas some PHOs are not top-slicing as they consider such funding streams should be utilised for what they were intended (i.e. to fund patient services) or they believe it is not allowed under the Contract.

The MOH has policies concerning SIA and Care Plus services. In both cases, a reasonable top slice is fine, although the actual level has to be approved by the DHB.

It is recommended that the MOH develop guidelines on top slicing of all PHO revenues to fund management services, particularly the legality of such practice; and communicate these more clearly (to DHBs and PHOs). Once all DHBs and PHOs are aware that a certain amount of top-slicing is sanctioned, standard PHO practice should emerge.

Some PHOs indicated that they have started to look more broadly for NGO and other government funding.
1.3.9 Are there lessons from other sectors that can be applied to the structuring and purchasing of PHO management services?

Comparatives were made with other sectors and within the health sector but the results can only provide an indicative range for administration/management costs of typically 5-15%.

Comparisons across sectors are hard to determine in that few organisations provide detailed lists of the components of administration/management costs.

Meaningful comparisons were not possible due to the variability of financial information provided by PHOs.

1.3.10 Should the Ministry and DHBs change any aspects of its policy to achieve optimal PHO management results?

There are a number of policy areas that could be reviewed by the Ministry. These are included in the above sections and also summarised in 1.4 below for clarity.

1.4 Summary of Options

Based on the analysis, the following options are recommended to the Ministry of Health as a way forward in the further development and ongoing review of PHO management services.

These are provided in the options matrix on the next page together with suggested timeframes and pathways to progress.
# Matrix of Options/Recommendations and Timeframe for Investigation/Implementation

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Timeframe for Investigation and Resolving Issues</th>
<th>How to Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defining Management Services</strong></td>
<td>Short to Medium Term: Decide whether list of management services requires further development. Decide whether (or not) it should be incorporated within Contract or sit alongside as a Best Practice guideline.</td>
<td>Medium to Long Term: Reassess MSF based on revised costs and additional modelling (including review of structure of MSF)</td>
</tr>
<tr>
<td><strong>Funding and Purchasing Management Services</strong></td>
<td>Decision on transitional funding provisions (Options One and Two) Further in-depth modelling of PHO costs (only possibly after implementation of financial reporting framework)</td>
<td>MOH</td>
</tr>
<tr>
<td><strong>Delivery of management services - Shared Services</strong></td>
<td>MOH to develop: framework for assessing peripheral versus primary management service functions; guidelines/criteria to assist PHOs to conduct cost-benefit analysis of in-house vs contracted out or shared service options PHOs to utilise framework and to consider best shared services approach applicable to their PHO and community of interest</td>
<td>PHOs move towards implementing the appropriate shared services approach for delivery of management services</td>
</tr>
<tr>
<td><strong>PHO Financial Reporting Framework</strong></td>
<td>MOH to develop agreed PHO financial reporting framework Implementation of agreed PHO financial reporting framework</td>
<td>MOH</td>
</tr>
<tr>
<td><strong>Monitoring PHO performance</strong></td>
<td>Development of PHO performance objectives for management services (utilising agreed list of management services)</td>
<td>Implementation of PHO performance objectives for management services</td>
</tr>
<tr>
<td><strong>MOH Policies</strong></td>
<td>PHO size / minimum requirements; Top-slicing</td>
<td>MOH</td>
</tr>
<tr>
<td><strong>MOH Technical Assistance</strong></td>
<td>Development of Best Practice Guidelines and assistance encompassing: Templates; Governance; Training Programmes; Community Liaison; DHB monitoring of PHO performance of management services.</td>
<td>Development of national resource centre of best practice</td>
</tr>
<tr>
<td><strong>National PHO Forum</strong></td>
<td>Decide on scope and viability; regional PHO forums</td>
<td>MOH / PHO to drive and implement</td>
</tr>
</tbody>
</table>
1.4.1 Defining Management Services

- The management services list to sit alongside the Contract as a “best practice” guide/framework and to be used as a basis for measuring PHO performance of management services.

1.4.2 Funding and Purchasing Management Services

- Options for the short to medium term include:
  - Option One: Restructuring the MSF:
    - Restructuring the MSF by providing a fixed funding floor of $280,000 (excluding GST) for all PHOs up to 20,000 enrolled population.
    - Further in-depth modelling would still be required on the extent subsequent changes would be required to the MSF capitation formula for PHOs over 20,000 enrolled population and to analyse equity issues. This should be done bearing in the mind: the hypothetical PHO models developed in section 7; current gaps in funding; MOH’s available funding for PHO management services and the financial impacts of future programmes on PHOs.
    - The MSF would be reassessed once the additional modelling was completed.
    - Incentives or obligations to be provided to ensure PHOs access shared service arrangements, to form networks or if necessary to merge.
    - The effectiveness of this option to be evaluated and reviewed in 1-2 year’s time when comparative reporting and analysis has been implemented.
  - Option Two: Increasing the MSF Capitation Formula:
    - Provide an increase in the bottom tier of the MSF from $9.61 to $14 per capita for the enrolled population up to 20,000.
    - Provide incentives or obligations for small PHOs to access shared service arrangements, to form networks or if necessary to merge.
    - Further in-depth modelling would still be required on the extent subsequent changes would be required to the MSF capitation formula for PHOs over 20,000 enrolled population and to assess equity issues. This should be done bearing in the mind: the hypothetical PHO models developed in section 7; current gaps in funding; MOH’s available funding for PHO management services and the financial impacts of future programmes on PHOs.
    - The MSF would be reassessed once the additional modelling was completed.
The effectiveness of this option to be evaluated and reviewed in 1-2 year’s time when comparative reporting and analysis has been implemented.

Option for the medium to long term includes:

  o Bulk funding of PHOs:
    ▪ PHOs would be provided a level of revenue to fund their organisation on an annual basis (covering programmes, management services, overheads etc).
    ▪ The funding would not necessarily be based on enrolled population. It would roll-up all programme and MSF monies together, and each PHO would therefore need to assign an appropriate proportion of its revenue to meet management services (and other) costs in discussion with its providers.
    ▪ This would ensure continuity of funding (as opposed to quarterly fluctuations) and the ability to forward plan.
    ▪ Would address PHO concerns around non-enrolled populations.

  o Referred Services Management:
    ▪ Investigate the option to adjust the MSF for RSM for small PHOs:
      ▪ An initial one-off service establishment grant to meet associated project management and service set-up costs to allow a front end loading for ‘establishing’ proper platforms/capacity to implement RSM (e.g. improving information systems, reporting processes and workforce training).
      ▪ A premium built-into the annual funding stream to enable the PHO to access analytical and clinical expertise (i.e. whether in-house or from a management services organisation).

  o Rural Funding:
    ▪ The MOH needs to determine whether a proportion of the $13 million in extra rural funding received by PHOs would be available to assist with additional management services expenses in rural areas.

1.4.3 Delivery of Management Services

  o Development of incentives for PHOs to investigate options for shared services and contracting out:
    ▪ PHOs to be encouraged to identify which types of management services are ‘primary’ versus ‘peripheral’.
    ▪ The MOH to provide a framework to assist PHOs in order to reduce duplication of thinking across PHOs.
    ▪ The MOH could develop guidelines and criteria or provide technical assistance to assist PHOs conduct robust cost-benefit analysis of the
option of in-house provision versus contracted-out or the various shared service options.

- The MOH to review its policy on PHO size.
- Clarification of MOH policy (and provision of guidelines) on top slicing.

1.4.4 PHO Financial Reporting Framework

- Development of a consistent PHO reporting framework to ensure comparability across PHOs, whereby the MOH should:
  - Prescribe definitions of classes of costs and revenues to be reported and provide training for PHOs.
  - Set up auditing mechanism(s) to ensure compliance.
  - Review costs and performance after 1-2 years, by making comparisons between PHOs once they have comparable information; then
  - Refine definitions/reporting/measurements and universally apply best practices.
  - Investigate the option of moving towards an outputs approach reporting framework.
- Development of a national resource centre of best practice.

1.4.5. Monitoring PHO Performance: Development of a Performance Reporting Framework

- Development of performance objectives (in addition to clinical performance indicators) to monitor PHO efficiency and effectiveness
  - This could be progressed by forming a Working Party with representatives from the MOH, DHBs, PHOs, MSOs.
- The MOH could provide targeted technical assistance to DHBs to assist in monitoring PHOs.

1.5 Next Steps

Feedback should be sought by the MOH from the sector on the findings and options reflected in this report.

This feedback and ensuing discussion should then be used to formulate a project plan to analyse the options proposed and implement changes to management services provision and funding.
2 Introduction

2.1 Purpose and Scope of Project
In March 2004, the MOH contracted Capital Strategy Limited to undertake a review of PHO management services.7

The review comprised a survey and meetings with a sample of 14 PHOs. In addition, discussions were held with the 10 corresponding DHBs and a number of other stakeholders.

The key deliverables being to answer the following questions:

- Are PHOs performing the management services outlined in the service agreement?
- Where are PHOs deficient in providing these services?
- What are the main contributors to these deficiencies?
- What is the cost of providing the full level of management services?
- How do these costs vary by PHO?
- What aspects of the PHO influence the efficient and effective provision of management services?
- How do costs vary by PHO size?
- Is the current management services fee appropriate?
- Are there lessons from other sectors or countries that can be applied structuring and purchasing PHO management services?
- Should the Ministry and DHBs change any aspects of its policy to achieve optimal results?

This report is a result of the review which focuses on the following key strands of work:

- An assessment of how PHO management services vary between PHOs (including the cost of providing classes of management services, the adequacy of current funding, and the adequacy of current delivery of management services).
- The development of two ‘model’ PHOs based on an inputs approach.
- Recommending options available to the MOH for funding and purchasing management services in the medium to long term.

7 Refer to Appendix 1 for a copy of the RFP.
2.2 PHO Service Agreement and Management Services

Primary Health Organisations (PHOs) are required to deliver management services under the PHO Service Agreement (Version 16.1 and its variations, “Contract”). While reference is made to “management services” within the Contract there is no specific schedule or definitions outlining what they encompass.

2.3 PHOs and Provision of Management Services

Management services can be provided in a number of ways; e.g. PHOs can:

- Provide management services in-house
- Contract out all or some services (e.g. contract out all or most management services to an MSO [management services organisation])
- Contract out some services to providers.

These are not mutually exclusive - some PHOs undertake a mix of the above.

2.4 PHOs and Funding of Management Services

PHOs receive ongoing funding (under the Contract) from the MOH (via their DHB) to perform management services, based on a per enrolled person basis.

The management services fee (MSF) was originally established in July 2002. It was increased to account for inflation (July 2003 and July 2004) and to address concerns about the adequacy of the fee raised by smaller PHOs (January 2004). Refer to Tables 1 and 2 below showing the MSF (exclusive of GST) for 2003/04 and 2004/2005.

Table 1: Management Services Fee (Access and Interim) - PHOs Less than 75,000 Enrolled Population

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Size of Enrolled Population</th>
<th>2002/03 (July 02-Jun 03)</th>
<th>2003/04 (July- Dec 03)</th>
<th>2003/04 (Jan-June 04)</th>
<th>2004/2005 (July 04-Jun 05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Up to and including 20,000</td>
<td>$6.16</td>
<td>$6.32</td>
<td>$9.46</td>
<td>$9.61</td>
</tr>
<tr>
<td>Medium</td>
<td>Between 20,001 and 75,000</td>
<td>$5.60</td>
<td>$5.74</td>
<td>$4.60</td>
<td>$4.67</td>
</tr>
<tr>
<td>Large</td>
<td>Greater than 75,000</td>
<td>$5.04</td>
<td>$5.17</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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8 Ministry of Health, PHO Capitation Rates for 2004/05.

Capital Strategy Limited - Review of PHO Management Services
Table 2:  Management Services Fee (Access and Interim) - PHOs Greater than 75,000 Enrolled Population

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Size of Enrolled Population</th>
<th>2002/03 (July 02-Jun 03)</th>
<th>2003/04 (July 03 - Jun 04)</th>
<th>2004/05 (July 04 - Jun 05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Up to and including 20,000</td>
<td>$6.16</td>
<td>$6.32</td>
<td>$6.41</td>
</tr>
<tr>
<td>Medium</td>
<td>Between 20,001 and 75,000</td>
<td>$5.60</td>
<td>$5.74</td>
<td>$5.83</td>
</tr>
<tr>
<td>Large</td>
<td>Greater than 75,000</td>
<td>$5.04</td>
<td>$5.17</td>
<td>$5.25</td>
</tr>
</tbody>
</table>

PHOs are paid each month based on their enrolled population at the beginning of the funding quarter. The funding quarters are January-March, April-June, July-September, October-December.

Initial funding for management services was primarily derived from the management funding paid to Primary Care Organisations (PCOs). The management fee for PCOs ($6,300 per GPs) was converted from a per GP fee to a per person fee. A sample of 11 PCOs was used to establish the PCO base. The average per person amount was estimated to be $4.35 (excluding GST).

The rationale behind using the PCO management fee as a base was that PHOs would be required to undertake many of the same management tasks as PCOs. However, it was recognised that there would be additional responsibilities associated with managing a PHO: formal enrolment, community consultation and representation, processing of patient registers, and upgrading information systems. These extra functions were determined to cost $1.25 per person.

The average management fee of $5.60 was then scaled to reflect efficiencies. The MOH recognised that PHOs have some of the same fixed costs regardless of size, hence these costs are a greater burden on smaller PHOs and a lesser burden on larger PHOs. The MOH established tiered rates as a way of recognising these economies of scale.9

The January 2004 changes were targeted at small to medium sized PHOs, with the biggest gain being for those PHOs with fewer than 20,000 people. The change was in response to smaller sized PHOs expressing concern about being able to deliver services on the existing fees level.10 The management services fee also has been adjusted twice for inflation, July 2003 and July 2004.

PHO concerns regarding funding levels were also expressed in the 2003 report by the Health Services Research Centre/Te Hikuwai Rangahau Hauora. It reviewed the experiences of early PHOs - those established between 1 July 2002 and 1 April

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An outcome of this was the view that “overall funding levels were seen to be limited. In particular the funding streams for health promotion and management costs were felt to be inadequate.”

3 Methodology

3.1 Contact with the Ministry of Health and the Advisory Team

An initial meeting was held with representatives from the MOH and the cross-sector Advisory Team overseeing the project. Discussions focused on the objectives of the project, the sample of PHOs to be surveyed and to provide guidance in defining “management services”.

Subsequently, regular project update meetings were held with MOH representatives. A workshop with representatives of the MOH and the Advisory Team was held towards the end of the project to discuss the draft report, in particular the outcomes and options for the MOH.

3.2 Targeted PHOs

A representative sample of 15 PHOs (later reduced to 14)\(^{12}\) was developed and approved by the MOH and the Advisory Team.

The sample identified was representative of the diverse nature of PHOs, in terms of their enrolled population, funding formulae, size, background, rural and urban coverage, ethnic composition, establishment dates and the management experience of the PHOs.

As part of the analysis, the 14 PHOs were sorted according to size (i.e. small, medium or large) - the basis for this being the tiers used by the MOH in the MSF capitation formula.

Refer to Table 3 for the distribution of the sample PHOs according to size. This is offset against the distribution of the 73 established PHOs in NZ (as at 1 July 2004)\(^{13}\) to provide a context for the project.

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Size of Enrolled Population</th>
<th>Number of PHOs in Sample</th>
<th>Number of PHOs in NZ (as at 1 July 2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Up to and including 20,000</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Medium</td>
<td>Between 20,001 and 75,000</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Large</td>
<td>Greater than 75,000</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>14</td>
<td>73</td>
</tr>
</tbody>
</table>

\(^{12}\) 15 PHOs were initially selected but one PHO subsequently declined to participate. Refer to Appendix 2 for a list of the 14 participating PHOs.

\(^{13}\) Established PHOs as at 1 July 2004 (Source: www.moh.govt.nz/pho).
3.3 Defining “Management Services”

A first step was to document management service responsibilities under the Contract. This was done in conjunction with the MOH and the Advisory Team. Management services/tasks were grouped into five key functions (see Table 4 below).

The result being an amalgamation of views\(^\text{14}\) on what “management services” potentially encompasses under the Contract (Version 16.1, Variation 1.0; and proposed changes to January 2004 variation). Appendix 3 provides a more detailed list/description of management services together with the corresponding contract reference. With some services it is not clear whether they may or may not be covered in the contract (these are also indicated).

Table 4: Summary of Management Services grouped according to function

<table>
<thead>
<tr>
<th>Function</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| 1 Governance                    | • PHO Board  
• PHO Management  
• Clinical governance and training                                      |
| 2 General Management            | • Administration (data management/records)  
• General business overheads  
• Business/Financial Management  
• Staff Management Costs  
• Communications and Marketing  
• Human Resources  
• ICT  
• External Liaison and Collaboration  
• Contract Management            |
| 3 Planning, Control and Co-ordination | • Business Planning (including strategic and annual planning, preparation of business cases for PHO Board)  
• Community Liaison (i.e. consultation and engagement with community)  
• Practice Management (enrolment register)  
• Protocols  
• Research, Analysis and Service processes  
• Co-ordination/Service linkages  
• Maori Health Action Plan  
• Pacific Health |
| 4 Performance Monitoring and Reporting | • Compliance with eight minimum criteria  
• Daily record of service user  
• Audit  
• Quality  
• Reporting Requirements |

\(^{14}\) This included previous work done for the MOH (by Sandy Brimblecombe); IPAC; Health Rotorua.
3.4 Survey/Questionnaire

A survey/questionnaire was developed and finalised in conjunction with the MOH and the Advisory Group. An initial draft was also discussed/peer reviewed with Auckland DHB, Counties Manukau DHB and others.

The survey/questionnaire was a mix of closed and open ended responses, encompassing:

- PHO general information
- Defining management services
- Delivery of management services
- Cost of providing and funding management services
- Other PHO services and funding.

3.5 Data Collection Process

First contact with the participating PHOs was via a letter from the MOH (copied to respective DHBs) advising PHOs of: the review, the sample of PHOs chosen to participate and the appointment of Capital Strategy.

Capital Strategy then contacted the participating PHOs to: advise of the process, arrange a suitable meeting time, provide a copy of the survey and the list of management services, and to request relevant documentation.

Capital Strategy met with representatives of each PHO and DHB over April/May 2004. Meetings were held in Whangarei, Auckland, Hamilton, Gisborne, Wellington, Christchurch and Dunedin. Good cooperation was received from the sector in terms of information provided and willingness to offer up thoughts and opinions.

The majority of the PHOs had completed the survey (in part or in total) prior to the meeting (which tended to last approximately two hours). At the meeting, key aspects of the survey were discussed and additional documentation was provided to Capital Strategy (if available).

In addition, meetings/phone discussions were held with a number of other key stakeholders (nominated by the MOH and the Advisory Team).

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15 A copy of the survey is provided in Appendix 4.
16 Copies of all correspondence, including the MOH’s media release at the beginning of the project, are provided in Appendix 5.
17 A list of the people consulted for the project is provided in Appendix 6.
Additional information on management and administration costs was assembled from other health services operations (both in New Zealand and overseas) and other sectors for comparative purposes.

3.6 Analysis

3.6.1 Quantitative

Key quantitative data (both from the survey questionnaire and from other sources) was captured in a spreadsheet and analysed to identify key themes or trends across the 14 PHOs. The data compiled for each PHO includes:

- Annual management services costs (split, where able, according to management function areas) and corresponding revenue received (as identified by the PHO)
- Total annual costs and revenues received (where available)
- Enrolled population.

The source of this data was:

- Annual reports
- Annual budgets and/or forecasts for 2004/05, monthly financial reports, Business Plans
- Survey responses, anecdotal and other information gathered at each meeting.

For comparative purposes, additional information was sourced as follows:

- Budget information for an Auckland secondary school.
- Management/administration costs for medical practitioners and DHBs.
- Survey of overheads of a sample of Territorial Local Authorities (TLAs).

3.6.2 Qualitative

Qualitative information was collated for each PHO and DHB to identify key themes and/or trends across the 14 PHOs and 10 DHBs. Additional health sector information was also sourced via the internet.

3.7 Confidentiality

Discussions with the PHOs and DHBs were undertaken on a confidential basis. All documentation was received on the understanding that confidentiality would be maintained and that any attributed comments would be checked with the PHO in the first instance.
3.8 Feedback from Participating PHOs, DHBs and Other Stakeholders

Participating PHOs and DHBs together with a number of other stakeholders were sent a copy of the draft report. Comments and feedback were received from a number of parties. These were collated and reflected in the final report where appropriate and also provided to the MOH (without being attributed to any particularly party).
4 Context of Assessing Management Services

Analysis of management services costs and funding requires consideration of the three dimensions of Function, Form and Funding (as reflected in Diagram 1 below).

Whilst PHOs share some features, these dimensions are not uniform for each PHO.

As the policy environment within which PHOs operate is not prescriptive, PHOs are characterised by varied arrangements in their form, the functions they undertake, and their funding sources.

Because of this diversity it is not straightforward to compare management services across PHOs; either in terms of the range and type of services undertaken, or their costs or funding sources.

Diagram 1: Three dimensions of analysis of management services

Diagram 2 below illustrates the general system within which PHOs operate. It highlights how an individual PHO may have multiple sources of revenue from which it can fund management services.
The focus of this report is on the cost of management services incurred by or residing with PHOs. However, the research shows there are reasons to expect that the financial accounts of many PHOs do not fully capture the level of effort and resources being spent on management services.

Reported information on the cost of management services is likely to underestimate the true quantity or level of service undertaken when it excludes:

- Management functions performed outside of the PHO by DHBs or providers on behalf of the PHO (i.e. where service costs are absorbed by another party and not paid for by the PHO).
- Voluntary effort by PHO Board members, staff and others associated with the PHO.

The total cost of management services as well as the sources of funding applied to management services can only be estimated by tracing the funding flows and service-relationships between the various organisations shown in Diagram 2 below.

This would require further research and investigation beyond the analysis of information and responses received to the questionnaire survey in this report. Whilst the responses do not allow information to be assembled in a format that
gives a complete picture of PHO costs and funding of management services, the results do put the MSF in context. The MSF funding component is only one part of the funding picture and any changes in the MSF structure need to be made with an understanding of the options PHOs have to access additional revenue or to reduce their costs.

In other words, the question of whether the MSF is adequate or not for funding management services is addressed in practice by some PHOs by:

- Accessing alternative revenue from:
  - local and central government agencies for public and community health services, or
  - levying providers/service delivery units for allocated support costs, or
- Reducing costs through:
  - contracting out or setting up shared services, or
  - providing a reduced or non-standard set of management services, or
  - making other changes in cost structure (e.g. revise basis of election of PHO Board).

In making funding decisions, it is to be expected that individual PHOs will make choices that reflect their individual priorities and circumstances.

Consideration of options to change the MSF therefore needs to take into account likely PHO behaviour to influence their management funding situation. For instance, an increase in the MSF for small PHOs might encourage:

- Unrealistic expectations about their long-term viability
- Fragmentation of existing large PHOs
- Slow-down in mergers
- Avoidance of take-up of shared services (in whatever form).

Therefore, other policy rules or measures should be associated with the funding formula to encourage complementary responses from PHOs. Policy rules could include:

- Making new funding apply to existing PHOs only in their current configuration (as done with the January 2004 top-up); or
- Sanctioning/prohibiting top-slicing of other funding sources for core management purposes; or
- Specifying service levels or performance measures (KPIs) for particular management services.
5 Defining Management Services

5.1 PHO Views on Management Services under the Contract

As part of the Survey, PHOs were provided with the draft list of management services. They were asked to compare this list with their view as to what constitutes “management services” under the Contract.

PHOs generally agreed with Capital Strategy’s list of management services.

Views expressed by PHOs included the following:

- Management services were not well defined in the contract.
- The contract provides no reference to some governance and management services deemed essential for any PHO but inherent in the Primary Health Care Strategy (PHCS); e.g. servicing PHO Board, managing community consultation, managing strategies to build enhanced teamwork across primary health care providers.
- It was thought the Contract doesn’t cover relationship requirements with all stakeholders, not only GPs but other agencies and sectors - these linkages are crucial if the PHO is to fulfill requirements of the PHCS.
- One PHO indicated that while Capital Strategy’s list seemed to cover management services in the Contract, the issue being the degree of compliance within that.
- It was also unclear to some PHOs in determining when a management activity ceases to be a PHO management activity and become a practitioner’s activity.

One PHO had undertaken its own analysis of what constituted “management services” in the Contract and the PHCS (i.e. implicit in the PHCS but not recognised in the contract). This framework was consistent with Capital Strategy’s list, which has been expanded as follows:

- “PHO Board” to include election/selection processes (for trustees)
- “Staff development and training” to include:
  - Education and training (for all staff) on Maori health policy, Maori values and belief;
  - Support and development of the Maori workforce
- “General business overheads” to include legal costs.
- “Business planning” to include rural reporting.

A range of views were expressed in terms of taking prescriptive and flexible approaches to defining management services; e.g.:
• Can’t be too prescriptive as:
  o Individual PHOs differ and flexibility allows for different situations/responses.
  o Smaller PHOs need more support due to the fact that their resources are stretched thin.

• Defining management services within the Contract would prove to be very restrictive, taking away the flexibility necessary for a PHO to meet unforeseen needs as they arise.

• Better to define to ensure they are properly funded. To some extent cannot be better defined until the role of PHOs is better defined and the policy is more consistently applied between DHBs - should not adopt a “jam jar” approach.

• Suspect that PHOs are so diverse that this exercise is difficult to achieve.

• Some PHOs considered they could benefit from development of ‘best practice’ guidelines for management services; it would also identify appropriate service levels to plan for.

5.2 Defining Management Services: Options for Going Forward

The MOH needs to decide its approach to the definition of contracted management services - the issue being whether it takes a flexible or prescriptive approach. Options include:

• Incorporate in Contract:
  o Taking a more prescriptive approach to the definition of management services under the Contract.
    ▪ This could be undertaken via PSAAP (i.e. PHO Service Agreement Amendment Protocol Group) whereby the suggested management services list could be encompassed within future variations of the contract.
    ▪ Bearing in mind the views of the sample PHOs, this approach is not recommended.

• Sit alongside Contract:
  o A flexible approach could see the management services list sitting alongside the Contract as a “best practice” guide/framework and a basis for measuring PHO performance of management services.
    ▪ Uncertainty as to what constitutes “management services” makes it difficult for DHBs to monitor PHO performance in its delivery of management services. There is also a lack of clarity for a PHO’s objectives in terms of contracted management services.
    ▪ A more effective approach could see the management services list assisting in the future development of performance
objectives in order to measure a PHOs performance under its Contract.

- This approach is recommended.

- Further assessing the list of management services to ascertain what aspects could be undertaken within a shared services model (core back room type functions) versus those management services that are more appropriate to be kept in-house). (This issue is discussed later in this report.)
6 Situational Analysis: Assessment of PHO Management Services

6.1 Impact of a PHOs Origin

The origins of the sample PHOs varied (refer Table 5):

- New start ups were more likely for small to medium PHOs; whereas
- Larger PHOs were more likely to have originated from established IPAs.

<table>
<thead>
<tr>
<th>PHO Origin</th>
<th>Size of PHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Start Up</td>
<td>Established IPA</td>
</tr>
<tr>
<td>Small</td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
</tr>
<tr>
<td>Large</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes:
- “Other” indicates that PHOs were either formed by a group of providers with pre-existing alliances or were already established Maori health providers.

A common view was expressed that those PHOs evolving from long established IPAs have a distinct advantage over new start-ups:

- Infrastructure is already in place (e.g. the PHO already has a financial base, inter-sectoral knowledge and networks, staff, IT upon which to build) thus to a certain extent it is “business as usual”
- New start-ups, particularly for very small PHOs, have struggled to put in place infrastructure (based on the establishment fee) - not only from staffing, knowledge and IT perspectives - but also from a need to spend a significant amount of time building relationships within the sector.

6.2 Governance

The sample indicated a variety of PHO governance structures (refer Table 6).

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Trust</th>
<th>Company (non-profit)</th>
<th>Incorporated Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>3</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Large</td>
<td>1</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>
The issue of capability across the health sector was raised by many PHOs and DHBs; in particular the:

- Inability to recruit suitably qualified and experienced people (across all levels of the health sector), particularly with the experience to support the design and implementation of innovative programmes and services.
- Shortage of Maori advisers with clinical experience who have the time to sit on Boards.

The MOH may need to think laterally to address this issue. It has been suggested that as part of its provision of resources to PHOs, a list of the relevant training programmes (together with their providers) may be useful.

At times the distinction between the PHO and MSOs has become blurred. Principles of good governance would suggest that the appointment and recruitment process for Directors on PHO Boards be subject to either external controls or audit (by the Ministry or the DHB), and that each PHO has a senior officer appointed by and accountable directly to the Board (rather than being an employee of or directly/indirectly accountable to management of a MSO or a separate but “related” organisation).

Table 7 shows the range in the size of Boards across the sample PHOs as well as the range in the level of funding of Board fees.

**Table 7: Sample PHOs: Board Size and Fees**

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Range of Total Number of Board Members (per PHO)</th>
<th>Range of Total Board Fees (p.a.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>4-10</td>
<td>$0 - $21,000</td>
</tr>
<tr>
<td>Medium</td>
<td>6-10</td>
<td>$22,000 - $73,000</td>
</tr>
<tr>
<td>Large</td>
<td>6-19</td>
<td>$70,000 - $125,000</td>
</tr>
</tbody>
</table>

**Notes:**
- $0 indicates that the financial information indicated that the PHO was not allocating any direct funding to its Board (although Board members may have been compensated through their practices).
- Some financial information identified as Board Fees may include payment for expenses over and above annual Board fees.

There are a few instances of Trustees/Board members forgoing director’s fees due to the lack of PHO resources - this is not an ideal situation.

There were also instances of directors contributing significant time and effort since establishment (due to a lack of PHO resources) for which they don’t receive additional remuneration. This is also not an ideal situation as directors are stepping over the boundaries between governance and operational decision making. There are instances of this across all sizes of PHOs.
6.3 PHO Viability & Enrolled Population: Does Size Matter?

6.3.1 Views on Appropriate Size/Enrolled Population for a Viable PHO

In determining its policy for the size of PHOs, the MOH has been careful not to prescribe a minimum (or maximum) size. This is based on the belief that the strategy is evolutionary; that it is up to the DHBs to determine the appropriate mix and size of PHOs in each DHB district.

Many small PHOs have been established to represent various groups of interest. As well, they believe they may not have a voice if they were part of a larger PHO.

Survey/interview comments included:

- Some smaller PHOs see the need to merge in the future to ensure their viability (and are investigating this option with other PHOs).
- Some small PHOs indicated that the nature of the enrolled population can create additional burdens on management services costs; e.g. a significant high needs population, refugee and migrant populations.
- Some larger PHOs cannot see how the smaller PHOs will survive (as they won’t have the funding, resources, infrastructure and IT to undertake programmes) and that some of them may fail in the near future.
- Some PHOs and DHBs believe the MOH may need to be specific about the minimum sustainable enrolled population base for PHOs.
- There were a mix of DHB views about optimal size and number of PHOs in DHB areas:
  - There was a consensus view of discouraging the proliferation of PHOs and unsustainable sizes.
  - Experience across DHBs varies - from a prescriptive approach to the number of PHOs within a DHBs area to a flexible approach with no restrictions on the number of PHOs or their size.

A number of PHOs (in particular the smaller ones) indicated what they saw as an appropriate size (and budget) for a PHO in order to be viable. Enrolled populations ranging from 60,000 to 100,000 were put forward as being an optimal size for a viable PHO. It was suggested that 20,000 was far too low. It was also suggested that about 35-40,000 in a low cost access area would be marginally sustainable.

Based on the survey, there are five PHOs with enrolled populations less than 20,000 (across NZ, there are 38). It is apparent from the survey that the smaller PHOs are struggling to remain viable within the current level of resources allocated to them. Some of them are not large enough to spread management costs and thus deliver all the management services required under the Contract. The MOH does not wish to see PHOs fail as a result of unreasonable funding constraints, given the associated cost and impact on promoting primary care services across the country. Small PHOs are currently more at-risk with regards to their viability. This is not to say that the medium to large PHOs do not consider that funding is adequate for their size.
There are trade-offs between efficiency/effectiveness and responsiveness to local needs, i.e.:

- Smaller PHOs tend to believe they understand and are closer to their enrolled population than larger PHOs. Because of this, they consider they are more likely and able to deliver on the outcomes of the Primary Health Care Strategy (PHCS) (than the larger PHOs).

- There may be a need for small PHOs that are high cost relative to others, particularly in rural and remote areas.

Any assessment of optimal PHO size still needs to be addressed having regard to whether PHOs are delivering the health outcomes of the PHCS.

The Greater Wellington Health Trust indicates that the functions of a PHO “will require a minimum critical mass in order to be carried out efficiently and effectively.”

The experiences of UK Primary Care Groups and Trusts (PCGs and PCTs) also confirm that achieving critical mass is important for many of the broader functions of primary health organisations, particularly for a focus on population health improvement and interfacing with the community. Mergers of small PCGs have rapidly occurred, doubling the average size of PCG population to approximately 190,000 people.

Conversely, it is also argued that the size of primary care organisations is only one of the factors that affect their performance: others include their policy priorities, functions, other organisational features, and the environment in which they operate. Bojke indicates that “there is no evidence that increases in size of primary care groups and trusts beyond 100,000 patients will automatically generate substantial improvements in overall performance or economies of scale.”

A recent NZ article indicates that “The UK experience suggests that similar pressure would arise in NZ even though there is no evidence that larger PHOs would necessarily be better performers than smaller PHOs.”

6.3.2 PHO Size/Enrolled Population: Options for Going Forward

Based on the survey feedback, the MOH needs to consider whether it:

- Continues to maintain a hands-off approach to its policy on PHO size:

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19 Ibid.


21 Cumming, J.; Population based funding and primary health care in New Zealand: What changes can we expect? Health Care & Informatics Review Online; 1 February 2002; Vol 6, No. 1.
Leaving it to the discretion of DHBs, a potential outcome being some natural attrition of small PHOs over time (either through mergers or their inability to survive) as well as inconsistent application across DHBs.

- Providing incentives to small PHOs to investigate merging with other similar PHOs or developing a shared services approach to management services. (These approaches are further discussed later in this report.)
- Accepting that there may be some small to medium PHOs (e.g. by virtue of their rural location or ethnicity focus) that are delivering the outcomes of the PHCS but may need additional management services funding to remain viable.

- Takes a more prescriptive approach regarding its policy on minimum size:
  - Reviewing and adjusting the Minimum Requirements for PHOs.
  - The impact of this approach would need to be measured against the outcomes of the PHCS and the Ministry’s initial rationale not to take a prescriptive approach.

### 6.4 Provision of Management Services

#### 6.4.1 Provision by Sample PHOs

The provision of management services by the sample PHOs ranged from in-house delivery, contracting out some services (e.g. register management), some (or all) services being delivered (or funded) by providers, to contracting out all management services to a management services organisation (MSO\(^{22}\)). Several small PHOs levied providers/practices to pay for management services.

Several PHOs had previously contracted their management services to an MSO but had since brought them back in-house.

Table 8 below shows the provision of management services for the surveyed PHOs. Note that some PHOs gave more than one response for the way they delivered management services.

**Table 8: Provision of Management Services by PHO Size**

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>In-House</th>
<th>Contract Out (Some or all)</th>
<th>Providers/Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Large</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

\(^{22}\) Examples of an MSO (not limited to this Survey) include Pegasus Health, Pinnacle, ProCare, South Link, WIPA.
6.4.2 Shared Services: The Road Less Travelled

For those PHOs that provide management services in-house, there was mixed response when asked had they considered shared services as an option. Comments from both PHOs and DHBs included:

- PHO(s) has considered shared services but considered the cost of contracting out some areas far exceeds what it costs the PHO to deliver in-house.
- One Board didn’t necessarily see shared services as a good thing in that a shared services agency may not necessarily know the PHO’s community - the PHO would be wary of losing its link to its community.
- Some PHOs commented on the duplication of tasks at PHO and DHB level.
- Problems in terms of capacity of small PHOs joining together - downside is losing innovation and the way in which PHOs operate - if a small PHO with a focus on a high needs population joins a large PHO then the high needs population may miss out on services (e.g. it was commented that some Maori providers had gone into larger PHOs in which their interests weren’t recognised to the extent they had been previously).
- Similar philosophies are important - there needs to be shared values and understanding with all PHOs looking to share functions - would like to work with PHOs with similar values, some haven’t got same approach.
- Some have identified where shared functions could work - data analysis, framework analysis.
- PHOs should not be ‘forced’ into purchasing management services from IPA based management agencies for solely economies of scale reasoning.
- Better to have a shared service agency for Maori\(^{23}\); another for community-owned. A number of PHOs were not sure just how it would work along iwi lines.
- Reluctance to seek shared services as PHOs wanted to build capacity within their own organisation.
- Some DHBs would encourage shared backroom services in order to keep it simple and not duplicate tasks and effort across PHOs.
- The health sector needs to make a decision regarding the path to shared services if it wants PHOs to remain viable.

\(^{23}\) It is noted that there is a national-strategy assessing the feasibility of a Maori MSO.
• There was no shared view nationally on the future form of PHOs (say in 5 years), that PHOs were too busy establishing and taking on new programmes to consider any strategic planning.

• A DHB indicated that while it would encourage shared backroom services (such as process-type services to reduce duplication across PHOs) it would still want to see its PHOs maintain their unique characteristics, i.e. it wouldn’t want to see the “watering down” of its PHOs bearing in mind the PHCS’s focus of local solutions for local communities.

Economies of scale from shared services are apparent from the survey responses but further analysis is required to confirm over what size-range and other related conditions. This particularly applies to:

• MSO costs and charges for services provided by MSOs to PHOs.

• The establishment costs and sustainable level of income required by stand-alone shared service organisations.

• The costs and appropriate basis of charging for services provided to a network by an individual member organisation.

Shared services need to be encouraged if small PHOs are going to deliver management services adequately within the limited funding (even with recommended increases), although MoH needs to be mindful of what services should be shared and be realistic about the options available to smaller PHOs. Whilst some small PHOs prefer self determination and have a reluctance to share data (particularly the case for register management), they also associate risk with obtaining services from a remote provider.

Some momentum is evident from smaller PHOs pursuing discussions with each other with a view to sharing costs/resources. In Northland, all the PHOs are moving towards the development of a shared services agency providing some central and regional services for the Northland PHOs.

For some PHOs it is a timing issue - they are still in their establishment phases, can see the move towards either merging or sharing resources but it is further down the track.

This issue is further discussed in section 7.

6.5 Cost of Providing Management Services

6.5.1 Data Clarity and Integrity Issues

Prior to reporting on the findings (in particular comparative financial results), it is necessary to issue health warnings on the level of integrity of the data utilised in the analysis.
In short, the information retrieved from PHOs varied in detail, quality and quantity to the point that it is not possible to make meaningful financial cost comparisons other than at the very highest level.

In other words, it has been assumed that PHOs will generally be able to distinguish between a clinical/health cost versus a management cost (and report accordingly). However, even here it is very likely (or definite) there are differing definitions in use.

For example, some PHOs will define a clinical program’s analysis cost as a clinical/health cost, other’s will class it as a management cost. Therefore financial analysis is only useful in a generalised way.

To elaborate further on the difficulty in comparing PHO financial information, we believe the reasons for the disparities include:

- The varying positions of development of PHOs.
  - In general terms, larger established PHOs had better quality reporting systems (including policies, procedures and internal definitions) than smaller ones.

- In general, PHOs were unable to provide detailed costs for each management service function as set out in the table in question 18 of the survey (although they could all identify Board Fees). It is recognised that such a request may have been ambitious at this early stage of PHO development.

- The varying levels of financial information:
  - In many cases, the management cost information was not for the same period as Total Cost and/or Revenue information, and in one case, the detail of management costs did not reconcile with the disclosed total of management costs.
  - One PHO was unable to provide any robust financial information - this limited the extent of comparable financial analysis.

- There were instances where PHOs would either only supply detailed financial information on the grounds that confidentiality was maintained; or it would not supply complete financial information on the grounds of confidentiality and commercial sensitivity.
  - For example, one PHO would only provide the cost of management services and not the total costs and revenues - this limited the extent of any comparable financial analysis.
  - PHOs only providing detailed financial information on the grounds that confidentiality was maintained has resulted in the financial analysis in this report being provided at a very high level. Thus only limited conclusions can be drawn from the information.
  - We find this unusual in that PHOs are public organisations, and in most if not all cases, their financial results will be published as a matter of public record.
Further, if the MOH wishes to operate in as transparent a mode as possible, then it would be in all parties’ interests if pre-agreed financial and operational information were made public. Therefore it may be a matter of the MOH issuing/reiterating its policy on PHOs providing financial and other information for public consumption.

However, in our opinion, the main reason that the information varied in detail, quality and quantity is because there appears to be no defined and universally applied rules about the classification of “management” costs versus “clinical/health” costs (i.e. costs that are not management costs). Further, there appears to be no prescribed accounting treatments and reporting conventions and templates. Recommendations on a way forward to rectify this situation are discussed in section 6.7.3.

6.5.2 Analysis of PHO Costs

Initial analysis indicates that the larger surveyed PHOs appear to have economies of scale and are more cost effective with respect to the provision of management services (e.g. the cost of providing management services as a proportion of enrolled population).

This is evidenced by the fact that:

- Larger PHOs in the survey can generally deliver a management services cost per enrolled person of approximately $4-$6 per annum, while smaller PHOs will spend approximately $7 to $38 (medium PHOs were $6 to $29).24
  - Note the cost information provided by PHOs represents their current cost to deliver management services to a particular level determined by the PHO; the cost information provided by PHOs (and the associated ratings of adequacy) do not necessarily represent the extent to which a PHO is able to provide contracted management services.
  - The cost information may not truly represent the actual cost to PHOs of providing the full level of management services: i.e.
    - It may exclude management services functions performed outside of the PHO by DHBs or providers (i.e. where service costs are absorbed by another party and not paid for by the PHO).
    - Voluntary effort by PHO Board members, staff and others associated with the PHO.
    - There may be cross-subsidisation with other PHO contracts.

- Management services costs as a % of total costs for larger PHOs ranged from 5%-9% where it was 4%-16% for small PHOs (7%-21% for medium PHOs).

Whilst economies of scale may be evident for large PHOs, there can also be diseconomies. For example, PHO planning and co-ordination across a diverse range

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24 All costs are exclusive of GST.
of practices with different information systems and processes can be disproportionately resource and time consuming.

The larger PHOs also tended to contract out most of their management services to an MSO whereas the smaller PHOs tended to only contract out register management. (Refer Tables 9 and 10 below for a summary of the financial analysis. The results should be read in conjunction with Section 6.5.1 above regarding the difficulties and variability in the level of the financial information provided.)

Larger PHOs tended to rate the adequacy of management services funding from 3 to 4 whereas small PHOs tended to rate their funding as inadequate (rating of 1).25

Table 9: Summary of financial information for management services costs

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Provision of Management Services</th>
<th>Range of PHO Expenditure on Management Services ($000)</th>
<th>Expenditure Range/ Enrolled Population</th>
<th>PHO Rating of Adequacy of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>In-House 4, Contracted Out 2, Providers 3</td>
<td>$82 - $496</td>
<td>$6.88 - $38.21</td>
<td>1-4</td>
</tr>
<tr>
<td>Medium</td>
<td>In-House 4, Contracted Out 3, Providers 1</td>
<td>$334 - $915</td>
<td>$5.58 - $28.60</td>
<td>1-3</td>
</tr>
<tr>
<td>Large</td>
<td>In-House 1, Contracted Out 4, Providers 1</td>
<td>$836 - $1,766</td>
<td>$4.17 - $6.27</td>
<td>3-4</td>
</tr>
</tbody>
</table>

Notes:
- Provision of Management Services: some PHOs gave more than one answer.
- Financial results should be read in conjunction with Section 6.5.1 re data clarity and integrity issues.
- All costs are exclusive of GST.
- Expenditure Range/Enrolled Population: Each PHO’s expenditure on management services was assessed on a per person basis:
  - Small PHOs: When removing the $38.21 outlier, the small PHOs ranged from $6.88 to $15.71. It is likely the expenditure on management services associated with the $38.21 included costs that were unable to be defined and thus may have “over estimated” management services expenditure.
  - Medium PHOs: The medium PHOs with the more substantial enrolled populations tended towards the lower range of cost. Whereas those medium PHOs ranging in size from 20,000 to about 50,000 had expenditure ranges at the higher end.
- Rating of Adequacy of Funding: PHOs were asked (in the survey) to rate the adequacy of funding for management services ranging from 1 (=inadequate) to 5 (=adequate).
  - Small PHOs: Most PHOs rated a 1; one PHO rated a 4 (one PHO did not respond).
  - Medium PHOs: Two PHOs rated a 1, two PHOs rated a 3 (one PHO did not respond).
  - Large PHOs: One PHO rated a 3, two PHOs rated a 4 (one PHO did not respond).
- Programme management (SIA, HP) component: The information available and disclosed by PHOs was not sufficient to identify PHO expenditures attributable to project management of SIA or HP programmes. PHOs in general considered that the project management component associated with such programme costs (or projects within these categories) was typically around 10%.

25 Refer Table 9.
Table 10: Summary of management services costs as a % of Total Costs & Total Revenue

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Range of Management Services Costs as a % of Total Costs</th>
<th>Range of Management Services Costs as a % of Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>4% - 16%</td>
<td>4% - 14%</td>
</tr>
<tr>
<td>Medium</td>
<td>7% - 21%</td>
<td>7% - 20%</td>
</tr>
<tr>
<td>Large</td>
<td>5% - 9%</td>
<td>5% - 9%</td>
</tr>
</tbody>
</table>

Notes:
- The above results are for 13 of the 14 sample PHOs - one PHO declined to provide total costs.
- Financial results should be read in conjunction with Section 6.5.1 re data clarity and integrity issues.
- Some small PHOs may be providing services for patients that are not enrolled (e.g. refugees).

6.5.3 Assessment of Scope for Making Savings and Efficiencies

The above results show broadly that economies of scale are achieved as PHO size increases. The resulting question for the MOH is “how can it achieve maximum management cost-benefit, whilst balancing PHO diversity”.

The challenge facing the sector is to achieve a satisfactory trade-off between emphasising efficiency of PHO management services costs, and fostering the strategic intent for PHOs to extend the ‘reach’ of health services to target communities.

One way forward is to isolate those management services outputs that can be shared across organisations or supplied by a larger organisation thereby capturing the benefit of economies of scale, without compromising the ability of the PHO to focus on its target community. The types of services that would probably fall into this category are: register and other database management, financial reporting, IT services, insurance, bulk purchasing, possibly budgeting, and the peripheral property/other asset and associated costs and certain clinical management services (such as quality assurance systems and audit, and referred services management, e.g. pharmacy facilitators). This is further discussed in section 7.

As mentioned previously, there has been a high reliance on in-kind/unpaid work from PHO staff, providers and Board members (thus the full cost of management services is not being funded in a number of PHOs). One medium PHO has officially ended voluntary work carried out for them, as it considers there is an unacceptable OSH risk. As a result the PHO has curtailed a number of activities until they can afford to pay staff or contractors to carry them out.

Most PHOs commented on the level of hidden costs they had experienced since establishment. These create additional burdens on PHO as they have to devote (in some instances significant) time and resources to resolving such issues, the cost of which has to be borne from management costs. Having said this, many PHOs are still in their establishment phase and such costs may dissipate in the medium to long term.
Whilst the MOH is aware of some of these issues, they are summarised below:

- **Sector development costs:**
  - Attendance at PSAAP meetings (i.e. attendance at such meetings in Wellington), create additional burdens on PHO costs, particularly for smaller PHOs.
  - The time/cost of managing relationships (e.g. DHB, MOH, other PHO and other inter-sectoral relationships); and in particular of managing complex iwi/urban Maori relationships.
  - The need to build trust and cooperation, the need to build governance and management capacity, the need to manage/operate across DHBs and the need to manage expectations of PHOs capacity to perform in an environment of change, DHB interpretation of government policy, fluctuating enrolments and the lack of certainty of revenue for more than one quarter at a time.

- **Issues associated with Register Management, IT infrastructure and resolving computer software issues between the practice/provider level, the PHO and HealthPac:**
  - Time and resources committed (by PHOs) to analysing registers in order to re-instate “lost” patients within PHO practice(s).
  - IT infrastructure - considerable time and resources spent in terms of set-up and dealing with software issues. Little provision for broadband infrastructure for submitting large registers.
  - Time and resources committed to addressing payment fluctuations as a result of inaccurate data and thus inaccurate deductions/adjustments (with subsequent results being that practices over or under paid).

- **Communications and Marketing:**
  - Marketing and promotion documents often have to be translated into multiple languages adding significant costs. This particularly applies to urban PHOs and practices that deal with Pacific Island populations (e.g. 7 languages in one case), and large refugee and immigrant populations. This tends to impact more on the small PHOs who often proportionality have more of such people in their community of focus.

- **Legal Disputes:**
  - A potential area of insufficient funded risk exposure is that of legal disputes between the PHO and practitioners\(^{26}\) as such claims can be difficult and or expensive to insure against.
  - One small PHO surveyed has incurred considerable expense fighting a dispute which, as a result, has cut into funds that would otherwise have been allocated to other projects.

\(^{26}\) The draft management services list in Appendix 2 indicates that section D of the Contract deals with risk management and resolving disputes.
• Travel Costs Incurred in Rural Areas:
  o Significant travel costs are incurred by PHOs with practices spread widely across rural areas. Additional costs are also borne by PHOs when specialist (e.g. clinical) advisors or practitioners need to travel to and spend time with practices across the whole region, where often there are a small number of relevant patients at these practices. Some form of “rural loading” for MSF funding could be an option to consider.
  o It needs to be determined whether a proportion of the $13 million in extra rural funding received by PHOs would be available to assist with these additional management services expenses in rural areas.

6.5.4 Comparatives: With other sectors and within the health sector

Comparatives were made with other sectors and within the health sector. Comparisons across sectors are hard to determine in that few organisations provide detailed lists of the components of administration/management costs. The results can only provide indicative ranges for administration/management costs.

(i) Secondary Colleges

Administration expenses for a large Auckland secondary college represented 9% of total expenses (of approximately $9.5 million)\(^{27}\). The chartered accountants retained by the Board of Trustees to prepare monthly and annual accounts confirmed that expenses were in line with comparable schools and colleges, and this was supported by independent enquiry by the Board and principal.

(ii) Territorial Local Authorities

An unpublished benchmarking study of a sample of Territorial Local Authorities (TLAs) indicated that, on average, total support costs are 16% of total operating expenditure.\(^{28}\) Refer Table 11 below.

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\(^{27}\) Teachers’ salaries, curricular costs, and direct property expenses made up the bulk of what would be considered as operating expenses.

\(^{28}\) Ernst Young unpublished benchmarking study of a sample of Territorial Local Authorities (TLAs) overhead costs (expressed as a % of total operating expenditure).
Table 11: TLAs: Benchmarking of Overhead Costs (as % of Total Operating Expenditure)

<table>
<thead>
<tr>
<th>Overhead Costs</th>
<th>% of Total Operating Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Total support costs</td>
<td>16%</td>
</tr>
<tr>
<td>Property costs</td>
<td>3%</td>
</tr>
<tr>
<td>IT costs</td>
<td>3.2%</td>
</tr>
<tr>
<td>Information management</td>
<td>1.4%</td>
</tr>
<tr>
<td>Finance cost</td>
<td>2.8%</td>
</tr>
<tr>
<td>Customer contact cost</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other costs</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Notes:
- Count: The number of TLAs that could provide an estimate of that category of costs.

(iii) Medical Practitioners

Direct management expenses for medical practitioners are approximately 11% of total revenue, and wages (for typically one) administrative employee, a further 11%. Other costs for this business category were assumed to be operating expenses. This is based on the median result of a survey of 86 participants conducted by the University of Waikato\(^{29}\). Refer Table 12.

Table 12: Management Expenses as a % of Total Revenue for Medical Practitioners

<table>
<thead>
<tr>
<th>Expenses</th>
<th>% of Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Excluding Wages - Administration</td>
</tr>
<tr>
<td>Administration</td>
<td>2.41</td>
</tr>
<tr>
<td>Wages - Administration</td>
<td>-</td>
</tr>
<tr>
<td>Occupancy expenses</td>
<td>6.40</td>
</tr>
<tr>
<td>Plant and equipment</td>
<td>1.30</td>
</tr>
<tr>
<td>Phone and fax</td>
<td>1.11</td>
</tr>
<tr>
<td>Total</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

Notes:
- Administration: Includes cartage, freight, accounting & legal fees, printing & stationery, postage & consumables; excludes administration (non-clinical) staff.
- Wages - Administration: Includes office administration staff (i.e. not clinical staff).

\(^{29}\) 2003 New Zealand Business Benchmarking Survey, Management Research Centre, University of Waikato.

**Capital Strategy Limited - Review of PHO Management Services**
DHBs

The national target for management and administrative costs is 10.5% to total provider revenue.\(^{30}\)

Referring to Table 10 above, it is noted that the large PHOs were within the range of 5-9% whereas most of the small to medium PHOs were above this. Again any comparisons should be treated as indicative as the components of management and administrative costs are not necessarily the same for DHBs and PHOs.

6.6 Funding Management Services

6.6.1 Adequacy of Management Services Fee

PHOs and DHBs expressed the following views:

- Common view that the current MSF is not adequate:
  - Majority of PHOs indicate they are unable to provide the full level of management services required under the Contract, based on the current management services fee (this applies to both smaller and large PHOs).
  - MSF funding is not enough to cope with the demands expected of a PHO.
  - PHOs are massaging funding of other services to support management services.
  - Belief that there has been a significant underestimate of what it takes to set up an organisation from scratch.

- Conversely, some thought the current MSF was adequate.

- Some DHBs thought the level of funding was too low for the smaller PHOs but adequate for the medium to large PHOs.

- Some PHOs indicated that they have started to look more broadly for NGO and other government funding (e.g. TPK, MDS, TLA).

6.6.2 Fluctuations in Funding

Whilst most PHOs indicated that they had fairly stable enrolled populations, there were instances of PHOs experiencing fluctuations in funding. This was more of an issue in the urban environment, particularly Auckland. These were mainly due to register management and software issues, although the nature of the enrolled populations (e.g. transient, mobile, not loyal, may have multiple providers) often forced a competitive environment where practices were competing for patients.

Some PHOs indicated that these fluctuations provided no certainty of revenue from one quarter to the next.

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A problem in rural areas is geo-coding of patient addresses - up to 30% cannot be geo-coded in some areas (and practices are reluctant to enter in proxy addresses into practice management systems as this can cause problems if emergency services need to locate patients in remote areas). This also creates potential funding shortfalls for PHOs (e.g. HP and SIA funds) and practices.

6.6.3 Structure of Management Services Fee

PHO and DHB views on this were mixed:

- Some were indifferent to the structure of the fee; one DHB suggested abandoning the fee altogether.
- Some did not buy into the enrolled population funding model; e.g.:
  - It didn’t reflect the complex and diverse health needs of particular segments of the population such as refugee migrant populations and the homeless that were not enrolled.
  - No incentives to attract hard to reach people, particularly for the PHO to determine how to get people in the door that don’t go to practitioners (but are aware that they exist).
  - Thought the fee should be linked to performance outcomes (e.g. working with the community and the successes achieved) - although it has been noted that there is a potential risk that PHOs would focus on what they can do to achieve a bonus, rather than focusing on health outcomes.
- From a transparency perspective, and to keep a focus on improving management capability, it should remain as a separate funding stream.
- Some agreement that the structure should be a mix of fixed and variable costs; i.e.:
  - Fixed - Set a minimum fixed fee to cover fixed costs - all PHOs face a minimum of fixed costs no matter what the size (e.g. overheads re a minimum level of staff, IT, office etc).
  - Variable - A top up could be made based on the enrolled population (this would then account for the size of the PHO).

6.6.4 To Top-slice or Not?

There were mixed views on PHO attitudes to top-slicing. For smaller PHOs, there is an apparent shortfall in the MSF and the actual cost. Some PHOs (not limited to small PHOs) are top-slicing other funding streams to fund the shortfall in management services (e.g. the % taken varies, but 5-15% was quoted).

Some PHOs are not top-slicing:

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31 The MOH has policies concerning SIA and Care Plus services. In both cases, a reasonable top slice is fine, although the actual level has to be approved by the DHB.
• Consider other funding streams should be utilised for what they were intended; e.g. SIA, HP goes straight to providers to fund patient services.
• One PHO expressed the belief that it is not allowed under the Contract - they considered it was improper to use funds for other programmes to which it was intended.
• One PHO indicated it was not aware of the MOH’s views as to transparency of the policy and whether it was legal.

Top-slicing of funds did provide some issues in the financial analysis. It became difficult to unwind the various sources of management services funding (both capitation and non-capitation) for some PHOs (e.g. a PHO may have provided a $ amount for management services revenue but it was apparent that this total amount was not solely from the MSF).

Whilst the MOH has policies concerning SIA and Care Plus services, it is apparent policies and guidelines for top slicing need more clarity.

6.6.5 Funding Management Services: Options for Going Forward

• Management Services Fee - short to medium term:
  o A short to medium term solution for the MOH would be to increase the bottom tier of the MSF formula (i.e. up to 20,000 enrolled population) to recognise the needs of the smaller PHOs (particularly if they have no IPA background). Two options are modelled in Section 7.
  o In conjunction with this, there is a need for the development of performance objectives and stronger DHB monitoring of PHOs to provide the inherent tensions required to ensure efficient and effective utilisation of resources (see section 6.7.3).
  o Maintain the transparency of a separate fee.
  o The MSF would be reassessed once additional modelling was completed (refer Section 7).

• Management Services Fee - medium to long term:
  o An option could be to consider bulk funding of PHOs:
    ▪ PHOs would be provided a level of revenue to fund their organisation on an annual basis (covering programmes, management services, overheads etc).
    ▪ The funding would not necessarily be based on enrolled population. It would roll-up all programme and MSF monies together, and each PHO would therefore need to assign an appropriate proportion of its revenue to meet management services (and other) costs in discussion with its providers.
    ▪ It would still be important that PHOs report expenditure on a comparable basis such that individual efficiency and effectiveness could be determined. The objectives would be to
shift the PHO focus more to an output focus (rather than on input costs), and reduce the administrative and compliance overheads associated with having a separate MSF contract.

- Transparency of what is spent on management services by PHOs is required so as to be able to compare like with like for delivery of management services. Similarly, with revenue sources (i.e. there is a need for clarity so as to know whether the MSF is the main source of revenue and has integrity as a dedicated funding stream for management services purposes.

- Bulk funding would still be associated with transparency in accounting for outputs and performance objectives so that PHOs could be compared.

- This would ensure continuity of funding (as opposed to quarterly fluctuations) and the ability to forward plan.

- If based on service levels or outputs (not necessarily to the enrolled population) then it would address concerns of some PHOs about covering management costs for non-enrolled populations.

- Although PHOs can claim fees for service for the non-enrolled population that is eligible for government subsidy, this can be problematic for PHOs that, for instance, deal with significant refugee and migrant populations. An alternative could be to provide PHOs with targeted funding to assist with refugees and migrants, based on a business case being presented.

- Whatever the funding outcomes for PHOs, there is still the need for the development of performance objectives and stronger DHB monitoring of PHOs to provide the inherent tensions required to ensure efficient and effective utilisation of resources (see section 6.7).

- **Top Slicing:**
  - The MOH needs to develop guidelines on top slicing of all PHO revenues to fund management services, particularly the legality of such practice; and communicate these more clearly (to DHBs and PHOs).
    - Once all DHBs and PHOs are aware that a certain amount of top-slicing is sanctioned, standard PHO practice should emerge.
    - If a common accounting treatment is also adopted, it will then be easier to make comparisons of management costs across PHOs (e.g. based on management costs as a proportion of total revenue).
6.7 Delivery of Contracted Management Services

6.7.1 PHO Views

PHOs were asked to rate their ability to deliver contracted management services (refer Table 13 below).

The medium to larger PHOs indicated that they tend to be delivering the requirements of the Contract. (Although this is the view of the PHOs rather than based on documented service levels or quality indicators - performance objectives relating to management services would assist in determining this.)

Interviews conducted for the survey showed an impressive level of commitment by staff and Boards of all PHOs, and the information received provides evidence of quality systems and innovations being developed across all sizes of PHOs.

Sharing of successful initiatives at a national level should be further encouraged so as to promote efficiencies. It would be desirable if this knowledge and intellectual property was able to be pooled in a better fashion for the overall benefit of the sector, and also to avoid unnecessary duplication of effort and “re-inventing the wheel”.

A national PHO forum, driven by the PHO sector in conjunction with the MoH, may provide such an environment for bringing innovative service delivery to the attention of the sector.

Some of the programmes and initiatives developed out of small PHOs are quite inspiring given their limited resources, particularly in relation to community based initiatives such as provision of nurses to support practices, community based public health events, and provision of a courtesy coach for patients. Whilst not all PHOs surveyed have yet developed back-to-back contracts (between the DHB-PHO-practices) several smaller PHOs have done so, committing internal staff time and significant legal expenses. Some small PHOs, despite their limited funding, still manage to pay practices for administrative work.

However, smaller PHOs freely acknowledge that there are many management services functions under the Contract that they are either not delivering at all or are only delivering to a limited extent. Areas not being done well or not at all include: performance monitoring and reporting requirements, community liaison, protocols, research and analysis, quality management, referred services.

The key reason for this is resourcing - PHOs (particularly the small to medium PHOs) indicate that they don’t have the staff to undertake all requirements.

- Many PHOs indicated that additional funding to support more staff would ensure the full level of management services is provided. Funding for an extra 1 to 2 FTEs (e.g. business analyst/project management type roles) would enable them to achieve the requirements of the Contract.

- Smaller PHOs have inadequate capacity to undertake strategic planning. The need to ‘search and discover’ alternative options for management
services is not regarded as a priority given other core PHO tasks requiring management attention.

- Significant unfunded/in-kind support (both from Board and management perspectives) has been provided since establishment for many PHOs. This mainly applies to the smaller PHOs but is also applicable to one of the large PHOs. PHOs consider it has been a necessity in order to establish the PHO, it particularly applies for the first 12 months. Represented by:
  - Chairs/members of the Board providing support to management in terms of developing Maori Health Action Plans, SIA proposals, building relationships
  - Providers/practices providing support (by way of dedicated staff) to the PHO which are unable to be funded by the PHO.

As mentioned in section 6.2, the issue of capability across the health sector was raised by many PHOs and DHBs; in particular the inability to recruit suitably qualified and experienced people (across all levels of the health sector), particularly with the experience to support the design and implementation of innovative programmes and services. It has been suggested that as part of the MoH provision of assistance to PHOs, a list of relevant training programmes may be useful.

Table 13: Sample PHOs: Rating on their ability to deliver management services

<table>
<thead>
<tr>
<th>Management Services Tasks</th>
<th>Size of PHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO Board</td>
<td>Small</td>
</tr>
<tr>
<td>2-5 (3.6)</td>
<td>5</td>
</tr>
<tr>
<td>PHO Management</td>
<td>1-5 (3.2)</td>
</tr>
<tr>
<td>Administration (data management/ records)</td>
<td>1-5 (3.2)</td>
</tr>
<tr>
<td>General business overheads (e.g. rent and other associated property operating costs, computers, vehicles, debt servicing costs)</td>
<td>3-5 (4.2)</td>
</tr>
<tr>
<td>Business/Financial Management (inc budgeting, insurance, payment for services, risk management, demonstrating PHO not for profit body)</td>
<td>3-5 (4)</td>
</tr>
<tr>
<td>Staff management costs</td>
<td>1-5 (2.7)</td>
</tr>
<tr>
<td>Communications and Marketing</td>
<td>1-5 (2.4)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>2-5 (3)</td>
</tr>
<tr>
<td>Information Communications &amp; Technology</td>
<td>2-5 (3)</td>
</tr>
<tr>
<td>External Liaison and Collaboration</td>
<td>1-5 (3)</td>
</tr>
<tr>
<td>Contract Management</td>
<td>2-5 (2.8)</td>
</tr>
<tr>
<td>Business Planning (including strategic and annual planning, preparation of business cases for PHO Board)</td>
<td>2-5 (3.2)</td>
</tr>
<tr>
<td>Community liaison (i.e. consultation and engagement with community)</td>
<td>1-5 (2.6)</td>
</tr>
<tr>
<td>Practice Management (enrolment register)</td>
<td>4-5 (4.5)</td>
</tr>
</tbody>
</table>
### Size of PHO Management Services Tasks

<table>
<thead>
<tr>
<th>Management Services Tasks</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocols</td>
<td>1-5 (2.8)</td>
<td>1-4 (3)</td>
<td>5</td>
</tr>
<tr>
<td>Research, Analysis and Service processes</td>
<td>1-5 (2.4)</td>
<td>1-2 (1.3)</td>
<td>2-5 (4)</td>
</tr>
<tr>
<td>Co-ordination/ Service linkages</td>
<td>2-5 (2.8)</td>
<td>1-2 (1.3)</td>
<td>2-5 (4)</td>
</tr>
<tr>
<td>Maori Health Action Plan (including Maori Participation)</td>
<td>1-5 (2.8)</td>
<td>1-3 (2.3)</td>
<td>2-5 (4)</td>
</tr>
<tr>
<td>Pacific Health Plan</td>
<td>1-5 (2.3)</td>
<td>1-5 (3)</td>
<td>5</td>
</tr>
<tr>
<td>Compliance with eight minimum criteria</td>
<td>1-5 (3.4)</td>
<td>1-4 (3)</td>
<td>4-5 (4.7)</td>
</tr>
<tr>
<td>Clinical governance and training</td>
<td>1-5 (3)</td>
<td>1-4 (2)</td>
<td>5</td>
</tr>
<tr>
<td>Daily record of Service User</td>
<td>3-5 (4.2)</td>
<td>1-3 (1.7)</td>
<td>4-5 (4.7)</td>
</tr>
<tr>
<td>Audit</td>
<td>1-5 (2.6)</td>
<td>1-4 (2)</td>
<td>2-5 (4)</td>
</tr>
<tr>
<td>Quality management</td>
<td>1-4 (2.4)</td>
<td>1-3 (1.7)</td>
<td>2-5 (4)</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>1-5 (2.6)</td>
<td>1-3 (1.7)</td>
<td>3-5 (4.3)</td>
</tr>
<tr>
<td>Pharmaceutical and Laboratory Management</td>
<td>1-5 (2.2)</td>
<td>1-3 (2)</td>
<td>5</td>
</tr>
</tbody>
</table>

**Notes:**
- The survey question required PHOs to assess their ability to deliver services, based on a scale from 1 (=inadequate) and 5 (=adequate).
- The number in brackets represents the average rating for each task.
- Not all PHOs provided responses.

PHOs in the Waikato-Coromandel (Midland) area are receiving an additional payment for quality over and above management services funding. This is a by-product of the previous capitation funding formula received by IPAs, and amounts to about $1.4 million for the area. This arose partially by history, and partially by the fact that there is no definition of the scope and focus of quality in the Contract. It is suggested that this area needs to be properly defined, along with specification of associated performance measures.

This additional funding has enabled PHOs in the Midland area to resource and develop quality management and assurance systems, whereas in other areas of NZ this aspect of the Contract is often still “in the bottom drawer”. The money is generally paid out on a lagged basis to practices based on incentive/performance related indicators. The performance payment framework that is being introduced from January 2005 should achieve similar results for all PHOs.

### 6.7.2 DHB Support of PHOs and Monitoring of Contract

There is variability in DHB expectations applied to PHOs and with their enforcement of the Contract:

- Many PHOs recognised the support they had received from their respective DHBs and stressed the importance of having good working relationships with their DHB.
- Some DHBs indicated that their PHOs have met expectations to date.
- A number of DHBs recognised the life cycle of PHOs:
o Indicated that they haven’t been pushing the boundaries with their PHOs, they would wait until they were well established.

o Working across PHOs would happen - it just couldn’t be expected at the beginning.

- DHBs typically aren’t actively enforcing the Contract with their PHOs (with respect to management services) though some are commencing audits.
- Some DHBs are experiencing resourcing issues at the moment and do not have the ability to monitor the PHOs and cannot see how this will change in the future.
- DHBs have not tended to provide additional financial support - although some have, and continue to provide capacity building support.
- Some DHBs with more immediate concerns such as significant budget deficits do not see themselves having the ability to assist PHOs (e.g. by establishing a shared service provider).

6.7.3 Monitoring PHO Efficiency & Effectiveness: Options for Going Forward

(i) Short to Medium Term: Management Services/Comparability in Reporting Across PHOs

The issues around the viability and integrity of the collected financial information have been discussed.

To enable financial comparability in reporting across PHOs, a reporting framework/template should be developed. This will enable monitoring (by DHBs) of management services across PHOs and ensure that one is comparing “apples with apples”. To facilitate this, it is recommended that the MOH:

- Prescribe definitions of classes of costs and revenues to be reported (including measurement of outputs) and provide training for PHOs
- Set up auditing mechanism(s) to ensure compliance
- Review after 1-2 years, by making comparisons between PHOs once they have comparable information; then
- Refine definitions/reporting/measurements and universally apply best practices.

DHBs also need to monitor PHOs from an audit perspective to ensure that all monies received are dedicated to the purpose for which they were intended. For example, some small PHOs operate “bucket accounting” in that all monies received from whatever source are brought together each month, and despite the source of funding or its designated purpose, the money is dished out to the projects and expenses accorded the highest priority for that month. These PHOs generally keep a reasonable track of the money in and out, so by the end of the year the money would be by and large spent in the areas it was supposed to be.
This is obviously not a desirable state of affairs, but is driven by insufficient funding. Fortunately these PHOs generally have astute and competent staff so the situation hasn’t spiralled out of control, but it could easily do so if key staff left, or weren’t as committed or as ethical.

PHO reporting could also be developed so that outputs generated (e.g. records managed) rather than inputs spent (e.g. IT costs) are the basis. This will enable better comparison between PHOs because it measures the results achieved (and thus the extent to which PHOs are delivering on the outcomes of the PHCS). Further, it facilitates (both MOH and DHB) comparison between PHOs with different population characteristics including numbers of enrolled patients.

The monitoring of PHO performance by DHBs is reliant on a DHB’s resources. It is still early days in terms of monitoring as many PHOs are still in the establishment phase. DHB monitoring to date has been mainly focussed on establishment and not viability. An area where the MOH could assist is providing targeted technical assistance to DHBs to assist in monitoring PHOs. This should be further investigated by the MOH.

(ii) Medium to Long Term: Development of Performance Objectives

It is difficult to determine whether a PHO is operating efficiently and effectively based on a review of management costs alone. That is, management services are but one aspect of the overcall functions of a PHO.

In addition, a PHO’s primary objectives are embedded in the outcomes of the Primary Health Care Strategy, thus a holistic approach needs to be taken when monitoring a PHOs efficiency and effectiveness. This is not to say that some conclusions cannot be formed looking primarily at management services and a PHO’s utilisation of its resources.

It is recommended that economic performance objectives be developed to sit alongside the clinical performance indicators (CPIs) as a means of further measuring a PHO’s efficiency and effectiveness. The CPIs are a first step in monitoring performance but there needs to be the added dimension of economic indicators to get the full picture.

The list of management services developed as part of this project is the natural starting point to assist in the development of performance objectives for management services.

Some PHOs, particularly from an MSO perspective, recognised the need to develop performance indicators to facilitate the evaluation of the impact of the PHO and its achievements (measured against the Contract requirements). There was also recognition of the need for standards to be established in order to assess the quality of the primary care services funded by a PHO. One PHO further recognised that such indicators need to reflect a nationally coordinated and consistent approach.
Parallels can be drawn with quadruple bottom line reporting undertaken in other sectors (both private and public) whereby entities report against economic, environmental, social and cultural performance objectives. Diagram 3 illustrates how this framework could be enhanced for PHOs.

Diagram 3: Potential Reporting Framework for PHOs

This would then enable DHBs to monitor the performance of their PHOs and enable comparisons across PHOs as to potential problems with delivery of services.

Examples of the types of management services performance objectives are provided in Table 14. It is recommended that these be further developed. This could be progressed by forming a Working Party with representatives from the MOH, DHBs, PHOs, MSOs.

Table 14: Examples of Performance Objectives

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Examples of Performance Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic</td>
<td>▪ Payments made to appropriate parties</td>
</tr>
<tr>
<td></td>
<td>▪ Payments received and verified as correct</td>
</tr>
<tr>
<td></td>
<td>▪ Financial records up to date</td>
</tr>
<tr>
<td></td>
<td>▪ Quarterly reporting to DHB of PHO financial information</td>
</tr>
<tr>
<td></td>
<td>▪ SIA, HP, Careplus, RSM: Quarterly spend against budget</td>
</tr>
<tr>
<td></td>
<td>▪ Board support functions</td>
</tr>
<tr>
<td></td>
<td>▪ Relationship building</td>
</tr>
<tr>
<td></td>
<td>▪ Strategic and Annual Planning</td>
</tr>
<tr>
<td></td>
<td>▪ Performance monitoring and reporting</td>
</tr>
<tr>
<td>Social / Cultural</td>
<td>▪ Progress on development of Maori Health Plan, Pacific Health Plan</td>
</tr>
<tr>
<td></td>
<td>▪ Community Liaison</td>
</tr>
<tr>
<td></td>
<td>▪ Research and needs analysis</td>
</tr>
<tr>
<td>Environmental</td>
<td>▪ Recycling practices</td>
</tr>
<tr>
<td></td>
<td>▪ Disposal practices for clinical waste and hazardous materials</td>
</tr>
<tr>
<td>Clinical</td>
<td>▪ As per CPIs being rolled out by the MOH; Quality indicators.</td>
</tr>
</tbody>
</table>
6.8 The Future - Expectations and Demands on PHOs

6.8.1 PHO Views

PHOs were asked their views on what factors would increase management services costs in the future. Key areas were as follows:

- Ability to cope with competing demands on resources.
- More pressure and not enough resources to implement programmes (in particular expectations from DHBs).
- It is costly and inefficient for PHOs to individually work out how to implement programmes and then undertake implementation. This is especially the case for small PHOs as the cost implications are huge for them. There should be generic ways to do functions. A centralised resource base for the sector on methodologies, best practice guidelines, sample plans, etc would be of particular assistance to smaller PHOs.
  - One DHB suggested that its PHOs should work together to develop a collaborative framework for Careplus to ensure consistency of approach across PHOs.
  - Another DHB was concerned that PHOs saw the development of Maori Health Plans (MHPs) as a huge task when in effect it should be relatively simple (i.e. they should not be reinventing things).
    - In practical terms the PHO’s plan should flow out of the DHB’s MHP which in turn flows from He Korowai Oranga.
    - They should all have some consistent themes and fit neatly together (i.e. He Korowai Oranga is the national strategy, DHB MHP turns the national strategy into a regional strategy, PHO MHP picks up on the primary care initiatives identified in the DHB’s MHP).
    - While there may be particular innovative initiatives in particular areas, most of the plan should be consistent with overarching plans above it.
- Ability to implement clinical performance indicators, particularly from an infrastructure perspective.
- Referred Services Management:
  - Some PHOs indicated that as they had no history of this, they would be a new start up with no trained pharmacy and laboratory facilitators.
  - Clinicians may not be used to being assessed.
  - Results may show under prescribing - not over - as some patients may not be able to afford prescriptions.
6.8.2 Options for Adjusting the MSF for Referred Services Management

The survey results show that small PHOs tend to believe they are not currently performing referred services adequately: 3 out of 5 PHOs rated themselves as 1 (‘inadequate’). This compares with a 5 (‘adequate’) given by all the large PHOs which responded to this question.

A number of PHOs suggest the MSF should be adjusted as part of the introduction of the RSM framework. Small PHOs in particular believe they lack the infrastructure required to be in position to implement the clinical governance and administrative systems associated with RSM.

This situation is also reflected in the funding gap shown in the PHO Model I in section 7.

An option would be to include a service establishment component in the RSM funding formula which would only apply to small PHOs. Two approaches are identified:

- An initial one-off service establishment grant (for small PHOs) to meet associated project management and service set-up costs to allow a front end loading for ‘establishing’ proper platforms/capacity to implement RSM (e.g. improving information systems, reporting processes and workforce training). Such a payment could be tagged to specific expense items, and could also be granted based on completion of a funding request according to a template.

- A premium built-into the annual funding stream to enable the PHO to access analytical and clinical expertise (i.e. whether in-house or from a management services organisation).

The objective of this approach would be to address equity issues of the smaller PHOs that are not able to do enough in this area due to limited resources (whereas the larger PHOs have the capacity to deliver services).

6.9 Issues Faced Since Establishment & Suggestions for the Future

PHOs took the opportunity to raise a number of issues and concerns they had had to face since establishment (as well as a number of suggestions). Those not already covered in the above sections include:

- Instances of “sharp” and “unethical” enrolment practices were cited by several PHOs:
  
  - Patients attending practices other than their normal practice (e.g. out of hours clinics on an emergency or one-off basis, clinics out of town when on holiday) have unbeknown to them signed a form which has enrolled them at that practice. The patient, when they return to their normal practice, then finds they are no longer enrolled or funded for the next three months if they sign up again.
Guidelines and auditing of enrolment practices need to be urgently addressed as it affects the credibility of the whole system.

- Process inefficiencies:
  - Some PHOs expressed concern at their DHB’s delay (and the need to wait for MOH feedback) in approving plans and funding (e.g. business plans, HP and SIA plans and funding). In some cases this results in delays in a PHO’s ability to put a service in place. It also impacts on management services whereby PHOs carry the risk while experiencing delays in funding (e.g. they make appointments to service plans but then are required to wait while plans are approved but costs still incurred).
  - The resource requirements (at all levels - PHO, MSO, practices) involved in providing applications for funding for programmes e.g. Over 65s; particularly for resource constrained PHOs whereby this becomes the focus of the PHO and other work is required to be put on hold.
  - Risk of ‘over-management’/focussing on compliance and not on quality of outputs - too much time is invested in management services at the risk of focussing on health outcomes; i.e. PHOs are focussing on the work they need to do in order to get funding rather than focussing on delivering change in order to deliver the outcomes of the PHCS.

- Suggestions for the future included:
  - A national resource centre of best practice, accountability, templates (not located inside DHBNZ but semi attached to MOH).
  - Regional PHO forums for CEOs - For example, in Waitemata/Rodney there is a monthly PHO CEO forum (this is akin to the regional CEOs forum for the 8 councils of the Auckland region).
7 Towards the Development of a “Model” PHO and Options for the Management Services Fee

7.1 Background to Development of Models

7.1.1 Methodology

Following discussions with PHOs, the (limited) results of the financial analysis and the feedback from many PHOs that funding for management services is not sufficient, a model was developed to determine the ‘hypothetical’ financial requirements of a PHO.

Cost estimates are based on information obtained from several sources as part of conducting interviews and the questionnaire survey of PHOs.

The following model of two ‘minimum qualifying’ PHOs is based on an input approach by:

- Estimating the scale of resources required to adequately perform contracted management services;\(^{32}\) and also
- Making provision for increased capacity and expertise within the PHO to perform increased requirements anticipated from ‘referred services management’ in particular.

The models should be used as reference points only for considering the implications of (any) changes in current MSF funding formula, rather than as guides to minimum funding levels.\(^{33}\)

PHOs, particularly smaller PHOs, should not assume that they should automatically receive funding to the extent outlined in the models.

7.1.2 Fixed Versus Variable Costs

The models reflect evidence that all PHOs require a core of staff resource to undertake management services such as Board support, general management, contract management, information collection, analysis and reporting and business planning.

\(^{32}\) Note that this approach does not strictly estimate the resources required to deliver a given quantity or quality of management services (e.g. register management, Board support, referred services etc).

\(^{33}\) The models are indicative only and are not known to reflect any actual PHO.
The models provide a means of contrasting PHO costs at a generalised level, since the survey data does not provide enough detail to show how step-changes occur in either fixed or variable costs as PHO size increases.

The survey information at the level of individual types of management service is not sufficient to allow fixed and variable costs to be separately analysed (for small, medium or large PHOs). However, the responses do show in general terms that it costs between $200,000 to $300,000 per annum to provide core management services regardless of the size of the PHO (say up to 50,000 people). This includes fixed costs/overheads such as office rent, insurance, and governance support, as well as costs of management and administration, register management, financial reporting, IT etc which will tend to vary to a limited extent with PHO size.

However, this cost range does not include clinical analysis and governance, community liaison, communication and marketing etc which are more in the nature of variable costs, and more likely to differ between PHOs due to the characteristics of their enrolled population (i.e. size as well as other variables such as population density and health needs status).

These costs will generally add $100,000 to $200,000 per annum to management of a PHO. The two models are broadly consistent with these cost ranges for a stand-alone PHO.

7.1.3 Comparative Information from Survey

Many of the small PHOs (10-20,000 population) responded in the survey that they lack capability to provide some general management services. These include:

- Organisation or business planning tasks such as investigation of options for contracting out or establishing shared service arrangements.
- Managerial presence
- Conducting relationship activity between the PHO and its stakeholders.

Asked to quantify the capability gap, these PHOs gave a common response that an additional 1 to 1.5 FTEs would take them closer to a situation where they could deliver management services to an adequate level.

Other information supplied by PHOs can be used to check against the models:

- Suggestion by several PHOs included:
  - A total staff of 4.5 FTE and a budget of $490,000 would be appropriate for a 'minimum qualifying PHO'.
  - Any PHO needs as a minimum a manager (for stakeholder relationship management, including DHB liaison), an administrator, and one clinical person. For a small PHO this could correspond to the equivalent of 2 FTEs, for a cost of about $150,000 to $200,000 in salaries and overheads plus the costs of governance (board fees and board servicing).
• Estimates of management service costs for small PHOs (around an average 25,000 population) being in the range of $8.50-$14.00 by accessing shared services through an MSO.

7.2 Models I and II

7.2.1 Basis of Models

The size of the enrolled populations for the models are:

• Model I - up to 20,000
• Model II - from 50,000 to 70,000.

Both models are based on FTE inputs multiplied by an overhead factor:

• The overhead factor for each model is derived from analysis of several sources of survey information.
• The FTE figures similarly are based on survey information. Each PHO is believed to need to have a minimum staff resource (in order to maintain a presence).34
• The information provided on clinician salaries varied from $90,000 to $140,000, thus a conservative approach of $100,000 was taken.

A conservative approach to costs has been taken with respect to the information provided by PHOs on what would be an adequate level of funding.

An indicative model for large PHOs has not been developed due to insufficient information being obtained through the survey.

7.2.2 PHO Model I: Enrolled Population up to 20,000

Assumptions:

• Stand alone organisation.
• 3.5 FTEs plus associated overheads.
• Overhead allowance at 40% of remuneration costs.
• Suggested budget for PHO - $350-400,000.
• Activities covered include: Board support, general management, register management, financial and non-financial analysis and reporting, community liaison, communications and marketing, clinical services leadership, referred services management, and business case development for SIA and health promotion services (excluding implementation).

34 Assumes each PHO will have a CEO. Number of FTEs reflects feedback from PHOs whereby some PHOs only have part time CEOs and are not fulfilling all obligations.
7.2.3 PHO Model II: Enrolled Population 50,000-70,000

Assumptions:

- Stand alone organisation.
- 5.0 FTEs plus associated overheads.
- Overhead allowance at 30% of remuneration costs.
- Suggested budget for PHO - $550-600,000.
- Activities covered include: Board support, general management, register management, financial and non-financial analysis and reporting, community liaison, communications and marketing, clinical services leadership, referred services management, and business case development for SIA and health promotion services (excluding implementation).

Table 15: PHO Model I: Enrolled Population 20,000

<table>
<thead>
<tr>
<th>Position</th>
<th>FTEs</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Executive officer</td>
<td>1</td>
<td>80</td>
</tr>
<tr>
<td>Administration support #</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Analyst/planner</td>
<td>0.5</td>
<td>35</td>
</tr>
<tr>
<td>Clinical director *</td>
<td>0.5</td>
<td>50</td>
</tr>
<tr>
<td>Nurse leader *</td>
<td>0.5</td>
<td>30</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td>260</td>
</tr>
<tr>
<td>Plus overheads @ 40% (GST inclusive)</td>
<td></td>
<td>104</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>364</td>
</tr>
</tbody>
</table>

Notes:

- # includes financial management
- * actual mix of clinical staff appropriate to each PHO will depend on community and provider characteristics

Table 16: PHO Model II: Enrolled Population 50,000 - 70,000

<table>
<thead>
<tr>
<th>Position</th>
<th>FTE</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Executive officer</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Administration support #</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Analyst/planner</td>
<td>1</td>
<td>70</td>
</tr>
<tr>
<td>Clinical director *</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Nurse leader *</td>
<td>1</td>
<td>60</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td>445</td>
</tr>
<tr>
<td>Plus overheads @ 30% (GST inclusive)</td>
<td></td>
<td>133.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>578.5</td>
</tr>
</tbody>
</table>
### 7.2.4 Comparison of Models I and II

The models are simplistic but, in the absence of detailed information on management costs in a format comparable across PHOs, they provide a transparent basis for contrasting PHO management costs based on a few variables.

By changing assumptions about the various input costs and FTE levels based on size or other characteristics of a particular PHO (e.g. the administration implications of co-ordinating a variety of provider services), the effects on relative costs can be readily estimated.

Main points to note from comparing the two models:
- Both models provide for a full-time managerial presence to deal with general management tasks including co-ordination of relationships with providers, community interests, DHB and the MOH.
- Average management services cost per enrolled person is $18.20 for the small PHO (at 20,000) versus $8.26 for the medium PHO (at 70,000).
- Model I total cost of $364,000 exceeds management services funding based on the MSF (1 July 2004) rate of $216,225 by 68%. This implies a breakeven population of 34,000 at the PHO cost of $364,000.
- Model II total cost of $578,500 exceeds management services funding based on the current MSF (1 July 2004) rate of $478,913, by 21%. This implies a breakeven population of 89,000 at the PHO cost of $578,500.

### 7.3 Pathways to Achieving Efficiencies: Options for Going Forward

#### 7.3.1 Investigating Options for Cost Savings

Management costs in Model I fall significantly if the PHO is able to ‘avoid’ full or half-time FTEs (i.e. utilise part-time managers/staff) and also reduce its proportion of ‘other overhead’ costs to 30% or below. This is consistent with the survey information showing economies of scale in management costs the larger the PHO.

Efficiencies can be achieved in both remuneration costs and other overhead costs. The models show that given funding constraints, if smaller PHOs in particular are going to be capable of providing management services to an adequate level and to

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**Notes:**
- # includes financial management
- * actual mix of clinical staff appropriate to each PHO will depend on community and provider characteristics

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**Capital Strategy Limited - Review of PHO Management Services**
meet additional requirements in the foreseeable future (i.e. RSM), they will need to investigate options for shared services and contracting out. PHO and DHB views on shared services have already been discussed in section 6.4.2.

The pathways for achieving this would appear to include:

- PHO mergers
- Clusters/networks of affiliated PHOs establishing a shared service operation (whether regional shared services across like minded PHOs within a particular DHB or possibly cross boundary).
- DHBs establishing a shared service operation for some or all of its PHOs.
- Purchasing all or some management services from an MSO.

An initial high level assessment of the pros and cons of each approach are indicated in Table 17 below.

**Table 17: Shared Service Approaches: Pros and Cons**

<table>
<thead>
<tr>
<th>Options</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO mergers</td>
<td>• Avoids duplication of staff and overheads</td>
<td>• Small PHOs risk loss of own identify if absorbed aligned to larger PHOs</td>
</tr>
<tr>
<td></td>
<td>• Economies of scale by providing services to a larger pool of enrollees</td>
<td>• Risk of diminished focus on particular communities of interest</td>
</tr>
<tr>
<td></td>
<td>• Better utilisation of specialist resources</td>
<td></td>
</tr>
<tr>
<td>Clusters/networks of affiliated PHOs</td>
<td>• Information sharing and collaboration</td>
<td>• Potential for conflict between shared service operation and autonomous PHOs</td>
</tr>
<tr>
<td>establishing a shared service operation</td>
<td>• Avoids duplication of staff and overheads</td>
<td>• Need for leadership to drive and co-ordinate across network</td>
</tr>
<tr>
<td></td>
<td>• Better utilisation of resources</td>
<td>• Diverse PHO philosophies may be barrier</td>
</tr>
<tr>
<td></td>
<td>• Provides depth of staff resources and systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Driven by the PHOs.</td>
<td></td>
</tr>
<tr>
<td>DHBs establishing a shared service operation</td>
<td>• Better utilisation of resources.</td>
<td>• View that DHBs have a limited amount of primary care experience</td>
</tr>
<tr>
<td>for its PHOs</td>
<td>• Avoids duplication of staff and overheads</td>
<td>• Lack of resources held by DHB.</td>
</tr>
<tr>
<td></td>
<td>• DHB should have an overall view of what happening within its PHOs and be able to identify common functions that are duplicated across its PHOs.</td>
<td>• Success dependent on DHB relationship with its PHOs</td>
</tr>
<tr>
<td>Purchasing all or some services from an MSO</td>
<td>• MSOs have experience in delivering management services</td>
<td>• PHO uncertainty as to whether it is getting value for money.</td>
</tr>
<tr>
<td></td>
<td>• Economies of scale by accessing services supplied to a larger pool of enrollees</td>
<td>• Inability/inexperience of PHO to monitor performance of PHO.</td>
</tr>
</tbody>
</table>
The cost benefits can easily be seen by taking the example of one variant of a network approach. That is, where one PHO in a network establishes capacity for the network in one or more management service areas that is then shared across the other PHOs. This approach:

- Avoids duplication of staff and overheads (whether full or partial FTEs) in each individual PHO
- Provides depth of staff resources and systems in one organisation that caters for staff leaving and also where particular skills are hard to recruit or attract to a particular area.

(i) Business or Register Analysis

A single full time business analyst could serve (say) 3 small PHOs in a network. The job description could entail focusing on project management of common add-value projects, and to conduct strategic planning and analysis.

This approach would also avoid duplication of individual organisation effort and costs of developing plans, protocols, and systems. Similar costs and cost savings would also apply to a person providing register analysis, and this could also involve modelling and illustrating population health trends and patterns on a comparative basis.

Table 18: Business or Register Analysis: Estimated Cost Savings for 3 Small PHOs in a Network versus Stand Alone Provision

<table>
<thead>
<tr>
<th>Network Provision (3 small PHOs)</th>
<th>Stand Alone PHO Provision</th>
<th>Total Cost Saving</th>
<th>Cost Saving Per PHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 FTE $70,000</td>
<td>3 x 0.5 FTEs $105,000</td>
<td>$49,000</td>
<td>$16,300</td>
</tr>
<tr>
<td>Overheads (exc GST) $28,000</td>
<td>Overheads (exc GST) $42,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total $98,000</td>
<td>$147,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If such an approach was employed in a larger network of (say) 6 small PHOs the savings would be the same for each PHO but larger for the MOH. This approach would add depth to the network, and enable a greater degree of collaborative work.

Table 19: Business or Register Analysis: Estimated Cost Savings for 6 Small PHOs in a Network versus Stand Alone Provision

<table>
<thead>
<tr>
<th>Network Provision (6 small PHOs)</th>
<th>Stand Alone PHO Provision</th>
<th>Total Cost Saving</th>
<th>Cost Saving Per PHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 FTEs $140,000</td>
<td>6 x 0.5 FTEs $210,000</td>
<td>$98,000</td>
<td>$16,300</td>
</tr>
<tr>
<td>Overheads (exc GST) $56,000</td>
<td>Overheads (exc GST) $84,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total $196,000</td>
<td>$294,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is assuming every small PHO could either afford to hire, or could recruit an analyst at 0.5 FTE. The reality is the positions are often not able to be
provided, or are well short of a 0.5 FTE where the level of effectiveness needs to be questioned (or else comprises a lot of unpaid work which is not sustainable)

(ii) Clinical Management Services

A single full time clinical director could also serve (say) 3 small PHOs in a network. The job description could entail focusing on network wide quality assurance systems and audit, referred services change management and facilitation, etc.

Table 20: Clinical Management Services: Estimated Cost Savings for 3 Small PHOs in a Network versus Stand Alone Provision

<table>
<thead>
<tr>
<th>Network Provision (3 small PHOs)</th>
<th>Stand Alone PHO Provision</th>
<th>Total Cost Saving</th>
<th>Cost Saving Per PHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 FTE</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overheads (exc GST)</td>
<td>$40,000</td>
<td>$150,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$140,000</td>
<td>$210,000</td>
<td>$70,000</td>
</tr>
</tbody>
</table>

This analysis is supported by information provided by a network of PHOs that incorporates an MSO. In this network’s experience, the pooled specialist resource could not generally be hired by each PHO at a local level, and certain shared/pooled services (e.g. national and regional engagement with Ministries, NGOs, Councils, etc) could not even be contemplated at a local level. The equivalent value of FTEs provided across the network equated to about $800,000, or a cost saving on a per capita basis of about $3. In addition there were improved levels of service provided, through being able to address some management services not otherwise possible at a local level.

PHOs shifting to shared service or network arrangements would result in some smaller PHOs moving closer toward the cost range for small PHOs linked to MSOs. However, the modelling results overall certainly do not suggest that small PHOs should be encouraged to aim for the low-end given these cost estimates are not associated with any evidence of the adequacy of management service levels.

In fact the model results suggest that an increase in the MSF would be appropriate for small PHOs to recognise the existence of fixed costs and to provide capacity to meet current expectations and to accommodate increasing workload requirements on PHOs. This is subject to two provisos that:

(i) Small community-based PHOs are seen as a key component of achieving the overall PHCS and should not therefore be driven to converge into a small number of large PHOs nationwide.

(ii) All PHOs should be encouraged to identify which types of management services are ‘primary’ (i.e. integral and instrumental to reflecting the values and aspirations of the PHO and which should therefore be internalised) as opposed to ‘peripheral’ (i.e. practices and processes, whether of a routine or specialist nature, which can be obtained externally).
A way forward for (ii) above is for the MOH to assist in this assessment.

Providing a framework to assist in identify primary and peripheral management services would reduce duplication of thinking across PHOs. The MOH could develop guidelines and criteria or provide technical assistance, to assist PHOs conduct robust cost-benefit analysis of the option of in-house provision versus contracted-out or the various shared service options.

This may well be an interactive process as PHOs are at various stages of growth and experience. It is also about managing risk, about what is comfortable for a PHO to contract out versus the capacity and need to keep some functions in-house. Again, a vehicle for information sharing of experiences of this nature across the sector would be beneficial.

The outcomes of the analysis will be different for many PHOs (reflecting local conditions) but a framework will provide incentives towards more effective utilisation of resources.

Examples of primary versus peripheral management services are provided in Table 21 below. These are not definitive and are meant as a basis for discussion. The list of management services (Appendix 3) is used as the basis for the analysis. In addition, information was sourced from some of the surveyed PHOs utilising a sample of MSO Service Agreements to consider whether elements of a task were primary versus peripheral.

A suggested way forward would be the establishment of a Working Party comprising PHO, DHB, MSO, MOH representatives. PHO representatives would need a background across all types of PHO delivery of management services (i.e. small, medium, large, contracting out and keeping in-house; including those PHOs that have previously contracted out their management services and now delivery in-house or vice-versa).

**Table 21: Management Services: Examples of Primary versus Peripheral**

<table>
<thead>
<tr>
<th>Management Service / Task</th>
<th>Primary</th>
<th>Peripheral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>PHO Board, PHO Management</td>
<td>Administration (data management, administration standards and record keeping, maintain full and proper financial and business records, security and preservation of records, advising DHB of any change in circumstances, NHI compliance)</td>
</tr>
<tr>
<td>General Management</td>
<td>Administration (core administration tasks, administration standards and record keeping, maintain full and proper financial and business records, security and preservation of records) General business overheads Business and financial management (business planning, demonstrating PHO not for profit, risk management)</td>
<td>Business and financial management (budgeting, termination for fraud, insurance, Payments for services, claiming requirements, payments,</td>
</tr>
</tbody>
</table>

**Capital Strategy Limited - Review of PHO Management Services**
<table>
<thead>
<tr>
<th>Management Service / Task</th>
<th>Primary</th>
<th>Peripheral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff Management Costs</td>
<td>recovery of overpayments and costs of audit)</td>
</tr>
<tr>
<td></td>
<td>Communications and marketing</td>
<td>Information &amp; Communications Technology</td>
</tr>
<tr>
<td></td>
<td>Human Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>External Liaison and collaboration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contract management</td>
<td></td>
</tr>
<tr>
<td>Planning, Control &amp; Coordination</td>
<td>Business Planning*</td>
<td>Practice management (register requirements)</td>
</tr>
<tr>
<td></td>
<td>Community liaison*</td>
<td>Protocols</td>
</tr>
<tr>
<td></td>
<td>Research, analysis and service processes*</td>
<td>Research, analysis and service processes</td>
</tr>
<tr>
<td></td>
<td>Maori Health Action Plan*</td>
<td>Coordination / Service linkages</td>
</tr>
<tr>
<td></td>
<td>Pacific Health*</td>
<td></td>
</tr>
<tr>
<td>Performance Monitoring &amp; Reporting</td>
<td>Compliance with eight minimum criteria</td>
<td>Clinical governance and training*</td>
</tr>
<tr>
<td></td>
<td>Reporting requirements (public reporting/annual report, yearly report to DHB, quality indicators and targets, clinical performance indicators, ad hoc reports to DHB)</td>
<td>Compliance with eight minimum criteria</td>
</tr>
<tr>
<td></td>
<td>Health promotion and access proposals*</td>
<td>Daily record of service user</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reporting requirements (details of patient register, changes to practitioners, service utilisation, immunisation services, rural reporting, ad hoc reports)</td>
</tr>
<tr>
<td>Referred Services Management</td>
<td></td>
<td>Pharmaceutical and Laboratory Management*</td>
</tr>
</tbody>
</table>

**Notes:**
- * Some tasks may lend themselves to being developed (in principle) on a collaborative basis with other PHOs (but not necessarily being contracted out to an MSO).

### 7.4 Management Services Fee: Options for Restructuring and Increasing

#### 7.4.1 General

Applying the above analysis to small and medium PHOs suggests that the MOH could consider two options in relation to increasing the MSF for small, and possibly medium, PHOs over the next 1-2 years until a review is completed based on comparative cost effectiveness against defined performance objectives, measures and targets. At this time it would then be possible to re-evaluate, based on robust information, an appropriate basis for the MSF from this point in time.

These options are put forward for discussion purposes, and would require further in-depth modelling on the extent subsequent changes would be required to the capitation formula for PHOs over 20,000 enrolled population and to assess equity.
issues. Such funding models, for instance, can otherwise create anomalies in funding levels around break-points in population. This would be subject to the MOH’s consideration of its policy on PHO size; i.e. whether there is a minimum sustainable size of PHO, including the extent that small PHOs are necessary to implement the outcomes in the PHCS in particular areas or among particular populations.

In conjunction with this, there is a need for the development of performance objectives and stronger DHB monitoring of PHOs to provide the inherent tensions required to ensure efficient and effective utilisation of resources.

7.4.2 Option One: Fixed Funding Floor for Management Services Fee

Provides a fixed funding floor for management services of $280,000 (excluding GST) for all PHOs up to 20,000 enrolled population. The current policy on PHO size may need to be reviewed.

This fixed funding level is proposed (rather than the $350,000 base figure suggested in Model I above) as there are apparent economies that can be achieved in accessing shared service arrangements either within a network of PHOs or through establishing or using an MSO’s services.

It would be important for the MOH and DHBs to provide either incentives (through assistance or review/audit) or an obligation (through a funding request based on a business case) to establish such arrangements. Unless shared service options are accessed by the PHO, this level of funding potentially would not provide an adequate delivery of management services, and this would become apparent in any review or audit process (hence providing an incentive on the PHO Board).

The effectiveness of this option could be evaluated and reviewed in 1-2 years time, when comparative reporting and analysis has been implemented.

Based on PHOs in existence prior to 1 July 2004, the additional cost in the MSF to the MOH for this option would be $5.9 million (excluding GST) per annum if it was applied to all small PHOs. Refer Table 22 below.

Table 22: Option One: Fixed Funding Floor for Management Services Fee - PHOs Less than 20,000 Enrolled Population

<table>
<thead>
<tr>
<th>Size of PHO</th>
<th>Size of Enrolled Population</th>
<th>Management Services Fee (GST exclusive)</th>
<th>Additional Cost to MOH (pa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Up to and including 20,000</td>
<td>$9.61 per enrolled person</td>
<td>Fixed Fee - $280,000 pa</td>
</tr>
</tbody>
</table>

Table 23 below provides examples of the impact of the proposed MSF, utilising the MSF in Table 22 above. For example, PHOs with an enrolled population of 20,000 would be better off by $87,800 under this option.
Table 23: Impact of Option One: Fixed Funding Floor for Management Services Fee - PHOs Less than 20,000 Enrolled Population

<table>
<thead>
<tr>
<th>Enrolled Population</th>
<th>Current MSF (2004/2005)</th>
<th>Proposed MSF</th>
<th>Difference (by which PHOs are better off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000</td>
<td>$48,050</td>
<td>$280,000</td>
<td>$231,950</td>
</tr>
<tr>
<td>10,000</td>
<td>$96,100</td>
<td>$280,000</td>
<td>$183,900</td>
</tr>
<tr>
<td>15,000</td>
<td>$144,150</td>
<td>$280,000</td>
<td>$135,850</td>
</tr>
<tr>
<td>20,000</td>
<td>$192,200</td>
<td>$280,000</td>
<td>$87,800</td>
</tr>
</tbody>
</table>

If the fixed funding floor was carried through to PHOs in the range of 20,001 to 75,000 (assuming the $4.67 capitation fee was still maintained for this group) the additional cost to the MOH would be $8 million per annum.\(^{36}\) Thus the medium sized PHOs would benefit as a consequence by having a higher funding stream for its first 20,000 enrolled population.

The option does not provide for any additional funding for large PHOs (i.e. over 75,000 enrolled population). If it was applied to the large PHOs on the same basis, the additional cost to the MOH would be $0.97 million per annum.

7.4.3 Option Two: Increase Management Services Fee Capitation Formula

Provide an increase in per capita funding for the bottom tier of the MSF from $9.61 to $14 enrolled population up to 20,000. The current policy on PHO size may need to be reviewed.

This level of funding would not reach the $280,000 floor proposed in Option One until 20,000 enrolled population is reached. Therefore it would be important for small PHOs to access shared service arrangements, to form networks, or if necessary to merge. Otherwise there is a risk that either these very small PHOs will either not survive, or will fail to deliver management services and the PHCS could be compromised in their catchment area.

The effectiveness of this option could also be evaluated and reviewed in 1-2 years time, when comparative reporting and analysis has been implemented.

Based on PHOs in existence prior to 1 July 2004, the additional cost in the MSF to the MOH for this option would be $1.5 million per annum if it was applied to all small PHOs. Refer Table 24 below.

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\(^{36}\) This includes the additional cost of $5.9 million.
Table 24: Option Two: Increase in Management Services Fee Capitation Formula – PHOs Less than 20,000 Enrolled Population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Up to and including 20,000</td>
<td>$9.61 per enrolled person</td>
<td>$14 per enrolled person</td>
<td>$1.5m</td>
<td></td>
</tr>
</tbody>
</table>

Table 25 below provides examples of the impact of the proposed MSF, utilising the MSF in Table 24 above. For example, PHOs with an enrolled population of 20,000 would be better off by $87,800 under this option.

Table 25: Impact of Option Two: Increase in Management Services Fee Capitation Formula – PHOs Less than 20,000 Enrolled Population

<table>
<thead>
<tr>
<th>Enrolled Population</th>
<th>Current MSF (2004/2005)</th>
<th>Proposed MSF</th>
<th>Difference (by which PHOs are better off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000</td>
<td>$48,050</td>
<td>$70,000</td>
<td>$21,950</td>
</tr>
<tr>
<td>10,000</td>
<td>$96,100</td>
<td>$140,000</td>
<td>$43,900</td>
</tr>
<tr>
<td>15,000</td>
<td>$144,150</td>
<td>$210,000</td>
<td>$65,850</td>
</tr>
<tr>
<td>20,000</td>
<td>$192,200</td>
<td>$280,000</td>
<td>$87,800</td>
</tr>
</tbody>
</table>

If the increase in the bottom tier was carried through to PHOs in the range of 20,001 to 75,000 (assuming the $4.67 capitation fee was still maintained for this group) the additional cost to the MOH would be $3.6 million per annum. Thus the medium sized PHOs would benefit as a consequence by having a higher funding stream for its first 20,000 enrolled population.

The option does not provide for any additional funding for large PHOs (i.e. over 75,000 enrolled population). If it was applied to the large PHOs on the same basis, the additional cost to the MOH would be $0.97 million per annum.

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37 This includes the additional cost of $1.5 million.
Table 26: Option One and Option Two: Pros and Cons

<table>
<thead>
<tr>
<th>Proposed MSF Option</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Option One: Fixed Funding Floor      | - Structured on a logical basis of there being a minimum level of fixed costs regardless of size  
                                          - Funding level is set lower than estimated minimum fixed costs to provide an incentive to access achievable cost economies through shared service or other arrangements  
                                          - Increased funding assists small PHOs to continue providing services to focused population groups where health outcomes may justify an otherwise unsustainable size | - Higher cost than option of adjusting capitation formula  
                                          - Will require strict rules to prevent existing PHOs disaggregating or reforming to solely access additional funding  
                                          - Increased funding reduces incentives for small unsustainable sized PHOs to investigate pros & cons of merging with other PHOs  
                                          - Will create funding inequities within small PHOs in that a 5000 population PHO will get the same funding as a PHO serving 20,000 |
| Option Two: Increase MSF Capitation Formula | - Lower cost than option of a fixed funding floor  
                                          - Provides incentive for mergers or formal network arrangements to aggregate effective funding to a 20,000 level as additional funding for very small PHOs is otherwise not significant  
                                          - Increased funding assists small PHOs to continue providing services to focused population groups where health outcomes may justify an otherwise unsustainable size  
                                          - Creates lesser funding inequities across PHOs in sizes up to 20,000 population than a fixed funding floor | - Does not recognise minimum level of fixed costs, and may not reach a sustainable level of funding for very small PHOs  
                                          - Will require strict rules to prevent existing PHOs disaggregating or reforming to solely access additional funding  
                                          - Increased funding reduces incentives for small unsustainable sized PHOs to investigate pros & cons of merging with other PHOs |
8 Summary of Options and Next Steps

8.1 Options
Based on the analysis, the following options are recommended to the MOH as a way forward in the further development and ongoing review of PHO management services.

8.1.1 Defining Management Services
- The management services list to sit alongside the Contract as a “best practice” guide/framework and to be used as a basis for measuring PHO performance of management services.

8.1.2 Funding and Purchasing Management Services
- Options for the short to medium term include:
  - Option One: Restructuring the MSF:
    - Restructuring the MSF by providing a fixed funding floor of $280,000 (excluding GST) for all PHOs up to 20,000 enrolled population.
    - Further in-depth modelling would still be required on the extent subsequent changes would be required to the MSF capitation formula for PHOs over 20,000 enrolled population and to analyse equity issues. This should be done bearing in the mind: the hypothetical PHO models developed in section 7; current gaps in funding; MOH’s available funding for PHO management services and the financial impacts of future programmes on PHOs.
    - The MSF would be reassessed once the additional modelling was completed.
    - Incentives or obligations to be provided to ensure PHOs access shared service arrangements, to form networks or if necessary to merge.
    - The effectiveness of this option to be evaluated and reviewed in 1-2 year’s time when comparative reporting and analysis has been implemented.
  - Option Two: Increasing the MSF Capitation Formula:
    - Provide an increase in the bottom tier of the MSF from $9.61 to $14 per capita for the enrolled population up to 20,000.
    - Provide incentives or obligations for small PHOs to access shared service arrangements, to form networks or if necessary to merge.
Further in-depth modelling would still be required on the extent subsequent changes would be required to the MSF capitation formula for PHOs over 20,000 enrolled population and to assess equity issues. This should be done bearing in the mind: the hypothetical PHO models developed in section 7; current gaps in funding; MOH’s available funding for PHO management services and the financial impacts of future programmes on PHOs.

The MSF would be reassessed once the additional modelling was completed.

The effectiveness of this option to be evaluated and reviewed in 1-2 year’s time when comparative reporting and analysis has been implemented.

- Option for the medium to long term includes:
  - Bulk funding of PHOs:
    - PHOs would be provided a level of revenue to fund their organisation on an annual basis (covering programmes, management services, overheads etc).
    - The funding would not necessarily be based on enrolled population. It would roll-up all programme and MSF monies together, and each PHO would therefore need to assign an appropriate proportion of its revenue to meet management services (and other) costs in discussion with its providers.
    - This would ensure continuity of funding (as opposed to quarterly fluctuations) and the ability to forward plan.
    - Would address PHO concerns around non-enrolled populations.
  - Referred Services Management:
    - Investigate the option to adjust the MSF for RSM for small PHOs:
      - An initial one-off service establishment grant to meet associated project management and service set-up costs to allow a front end loading for ‘establishing’ proper platforms/capacity to implement RSM (e.g. improving information systems, reporting processes and workforce training).
      - A premium built-into the annual funding stream to enable the PHO to access analytical and clinical expertise (i.e. whether in-house or from a management services organisation).
  - Rural Funding:
    - The MOH needs to determine whether a proportion of the $13 million in extra rural funding received by PHOs would be available to assist with additional management services expenses in rural areas.
8.1.3 Delivery of Management Services

- Development of incentives for PHOs to investigate options for shared services and contracting out:
  - PHOs to be encouraged to identify which types of management services are ‘primary’ versus ‘peripheral’.
  - The MOH to provide a framework to assist PHOs in order to reduce duplication of thinking across PHOs.
  - The MOH could develop guidelines and criteria or provide technical assistance to assist PHOs conduct robust cost-benefit analysis of the option of in-house provision versus contracted-out or the various shared service options.
- The MOH to review its policy on PHO size.
- Clarification of MOH policy (and provision of guidelines) on top slicing.

8.1.4 PHO Financial Reporting Framework

- Development of a consistent PHO reporting framework to ensure comparability across PHOs, whereby the MOH should:
  - Prescribe definitions of classes of costs and revenues to be reported and provide training for PHOs.
  - Set up auditing mechanism(s) to ensure compliance.
  - Review costs and performance after 1-2 years, by making comparisons between PHOs once they have comparable information; then
  - Refine definitions/reporting/measurements and universally apply best practices.
  - Investigate the option of moving towards an outputs approach reporting framework.
- Development of a national resource centre of best practice.

8.1.5 Monitoring PHO Performance: Development of a Performance Reporting Framework

- Development of performance objectives (in additional to clinical performance indicators) to monitor PHO efficiency and effectiveness
  - This could be progressed by forming a Working Party with representatives from the MOH, DHBs, PHOs, MSOs.
- The MOH could provide targeted technical assistance to DHBs to assist in monitoring PHOs.
8.2 Next Steps

Feedback should be sought by the MOH from the sector on the findings and options reflected in this report.

This feedback and ensuing discussion should then be used to formulate a project plan to analyse the options proposed and implement changes to management services provision and funding.
Appendix 1: Ministry of Health RFP

11 February 2004

TENDER FOR review of primary health organisation (PHO) management services

The Ministry of Health ("the Ministry") is seeking tenders from suitably qualified organisations or individuals to conduct a review of primary health organisation (PHO) management services in New Zealand.

The review will provide a comprehensive assessment of PHO management services, the cost of providing these services, and the options available to the Ministry for purchasing these services in the medium to long term.

The review will identify a sample of PHOs representative of the diverse nature of PHOs, in terms of their enrolled population, location, ethnic composition, and the management experience of the PHOs.

The sample must include at least 12 of the current PHOs, and, be approved by the Ministry. In addition, the successful tenderer will need to discuss with the Ministry, and DHBs any future PHO activities that may have a bearing on PHO management capabilities.

It is expected that information for the review will be obtained by way of questionnaires, and by collecting reports and other documentation from PHOs. However, where appropriate, the successful tenderer should visit PHOs in person. The successful tenderer should also conduct interviews with the relevant DHBs and, in some cases, the Ministry, to gain their assessment of the PHO’s management capabilities.

It is anticipated that the reviewer may also assess information from other similar health organisations and other industry sectors, to develop a benchmark for PHO management performance.

The results of the interviews and research should be analysed and summarised in a report that answers the following questions:

- Are PHOs performing the management services outlined in PHO service agreements?
- Where are PHOs deficient in providing the management services outlined in the service agreements?
- What are the main contributors to deficiencies in providing the management services outlined in the service agreements?
- What is the cost to PHOs of providing the full level of management services?
• How do management costs vary between PHOs?
• What aspects of the PHO influence the efficient and effective provision of management services?
• How do management costs vary between PHOs by size?
• Is the current management services fee appropriate?
• Are there lessons from other sectors that can be applied to the structuring and purchasing of PHO management services?
• Should the Ministry and DHBs change any aspects of its policy to achieve optimal PHO management results?

The Ministry is open to your suggestions as to approaches to delivering the services in the most cost-effective way.

An indicative contract outlining draft terms and conditions for the delivery of the required services is attached (see clause 1.7).

The Ministry may select the most competitive tender(s), and may negotiate on the tender(s), with a view to inclusion of key elements or all elements of the tender in the final contract to be developed. The Ministry will then adapt the indicative contract to the services to be provided. It is only once a competitive tenderer has executed the final contract developed, that the Ministry commits itself to legal acceptance of the tender of that tenderer. Thus, tenderers should take notice that negotiations to the point of execution of the final contract are only negotiations, and are not binding until execution.

Your attention is drawn in particular to clauses 1.4 and 1.5 relating to decisions on tenders and that there is no intention that the tender process creates legal relations between the Ministry and tenderers.

BACKGROUND

The Ministry is responsible for implementing the Primary Health Care Strategy. The strategy, launched in February 2001 by the Minister of Health, Annette King, provides a clear direction for ensuring that primary health care services play a central role in improving the health of New Zealanders.

The Primary Health Care Strategy builds on the population health focus and the objectives of the New Zealand Health Strategy and the New Zealand Disability Strategy, and outlines how a different approach to primary health care will improve the health of all New Zealanders through:

• a greater emphasis on population health, health promotion and preventative care
• community involvement
• involving a range of professionals and encouraging multidisciplinary approaches to decision making
• improving accessibility, affordability and appropriateness of services
• improving co-ordination and continuity of care
• providing and funding services according to the population's needs as opposed to fee for services when people are unwell.
Primary health organisations (PHOs) are the mechanisms that will be used to work with enrolled populations and their communities to achieve the Strategy's objectives. PHOs are non-profit organisations that are governed by local community, provider, and iwi representatives. At present, there are 59 PHOs located in 20 of the country’s 21 District Health Boards.

PHOs are provided a management fee that varies based on the number of people enrolled with them. The management fee, which was originally established in July 2002, has been increased to account for inflation (July, 2003) and to address concerns about the adequacy of the fee raised by smaller PHOs (January, 2004).

The Ministry is reviewing the management services funding for PHOs to ensure that PHOs are able to implement the Strategy now and into the future.

1 PROCEDURE AND TIMETABLE

1.1 Submission of tender

Tenders should reach the Ministry by 27 February 2004 and be sent to:

    Jon Foley
    Senior Analyst
    Ministry of Health

by post: PO Box 5013
Wellington

or by fax: (04) 469 2340

or delivery: 133 Molesworth Street
Wellington

The Ministry will then assess tenders and select the most competitive by 17 March 2004. The Ministry wishes to complete negotiations on competitive tenders, through the signing of the final contract, by 30 March 2004. If these time frames create difficulty for you, please inform the Ministry representative named above.

1.2 Inquiries

General inquiries about this tender may be made to Jon Foley telephone (04) 496 2016 or facsimile (04) 496 2340 during business hours.

1.3 Consideration of Proposals

The minimum requirements for tenders are outlined in clause 3.2 of this document. The tender should contain the information required in clauses 2.1 - 2.4, which includes those minimum requirements. Compliance with these matters will be part of the assessment of tenders by the Ministry. Non-compliance may indicate a lack of attention to necessary detail.
The Ministry may wish to contact tendering organisations for further details about tenders or to discuss the tenders prior to entering negotiations on them.

1.4 Decisions on Tenders

If the Ministry's discussions with tenderers or other circumstances make it necessary to extend the date by which the Ministry selects competitive tenders the Ministry will inform all parties who have submitted a tender. Where the date for the signing of the final contract needs to be extended, the Ministry will advise the competitive tenderers it is negotiating with.

A decision to select a tender may be conditional, for example, subject to certain revisions being agreed. It is likely that such conditions will be discussed with the organisation concerned before negotiations commence towards written agreement.

All organisations sending in tenders will be informed in writing of the Ministry's decisions.

The lowest priced tender or any particular tender will not necessarily be negotiated on or accepted. The Ministry reserves the right at any time to:
- seek additional tenders
- negotiate with any tenderer or other person after tenders have closed
- not proceed with any or all components of the services in respect of which tender is made
- cancel the tender
- retender.

1.5 No intention that Tender Process Creates Legal Relations between the Ministry and Tenderers

This request for tenders will result in negotiations with a view to entering a contract for services, but of itself is not an offer that tenderers accept by submitting tenders. Instead, this request for tenders is to be based on traditional law relating to tenders, being that the request for tenders is an invitation to treat and each tender is an offer upon which the Ministry may negotiate with a view to acceptance once a written contract is executed.

Accordingly, tenderers should take notice that in relation to tenders submitted, negotiations to the point of execution of a written contract are negotiations only, and are not to be binding until execution of the written contract. In this context, your attention is drawn to clause 1.4 above.

1.6 Confidentiality of Information

The Ministry will not, except as required by law, disclose any of the information in your response to any third party.

In submitting your tender, however, you accept that the Ministry may need to disclose all or part of your tender (including prices) and any subsequent contract with you, or
parts of it, in response to requests under the Official Information Act 1982 or by Court order. The Ministry would consult with you on release or withholding of significant details under the Official information Act.

1.7 Contract

An indicative contract is enclosed. Inclusion of the indicative contract at this stage is to assist you to plan your tender and to inform you about the look of a typical contract the Ministry uses. The contract will need adjustment following conclusion of negotiations. Certain clauses of the contract are not negotiable, namely clause 6, indemnity, clauses 7 to 11 and clauses 13 to 16.

The Ministry is not expecting you to address the detail of the contract at this stage. However, if there are clauses of the contract (other than the not negotiable clauses) that your organisation will not accept, please identify them in your tender. You should explain the difficulty and, if you wish, suggest an alternative approach.

The Ministry reserves the right to amend any part of the indicative contract before and during negotiations.

2 CONTENT OF YOUR TENDER

Please include the following information in your tender(s):

2.1 Organisation Details

- Name of your organisation
- Name of your contact person and contact point
- Your organisation's activities / experience / credentials in financial analysis, management service analysis (particularly in the health sector), and primary health care
- The dimensions of the organisation (eg, size, location, turnover, management, staff)
- Name(s) and credentials of the person(s) you propose will provide the service(s) required by the Ministry
- Names and contact points for two or more referees the Ministry may approach.

2.2 Details of Proposal(s)

- Provide the details required in clause 3.2.
- Description or Method of the Services - Describe how you intend to approach and provide the services including an outline of proposed procedures.
• Performance Measures - Performance indicators and targets will be negotiated on the basis of the proposed outputs for the services. You should suggest possible performance measures, quality indicators, timetable and payments.

2.3 Financial

• Price - Specify your price, supported by a budget breakdown of the main components. Identify likely disbursements separately from your price to supply the services. All payments will be GST inclusive, so all prices should be GST inclusive.

2.4 Other Items that may Need to be Included

• Information on the nature and type of insurance arrangements of your organisation

3 THE SERVICES AND GENERAL REQUIREMENTS

The Ministry requires particular services and has general requirements for tenders.

3.1 The Services Required

This review will provide a comprehensive assessment of PHO management services, the cost of providing these services, and the options available to government for purchasing these services in the medium to long term.

The reviewer will:

a. document the management service responsibilities outlined in the latest version of the PHO/DHB Service Agreement. The Ministry will assist in this task by identifying management services tasks from the service agreement.

b. contact PHOs and their representatives to obtain their interpretation of the service agreement.

c. discuss with the Ministry and DHBs, future PHO activities that may have a bearing on PHO management capabilities.

d. identify a representative sample of PHOs who will be the subject of an in-depth review of their management services. This sample should be representative of the diverse nature of PHOs, in terms of their enrolled population, location, ethnic composition, and the management experience of PHOs. The sample must include at least 12 of the current PHOs and must be approved by the Ministry.

e. The reviewer will examine these PHOs based on the following dimensions:
The extent to which they are fulfilling management service responsibilities outlined in the contract;
How they are fulfilling these responsibilities - use of their own staff, contractors, management service entities, PHO practice staff;
Those responsibilities that are least likely to be undertaken and the reasons for not undertaking them;
The costs of providing management services, itemised by service type; and,
Whether PHO believes that it has good control of the management of the PHO.

f. It is expected that this information will be obtained through completion of a questionnaire and collecting reports and other documentation from PHOs.

g. Where appropriate, the reviewer should plan to visit PHOs.

h. The reviewer should also conduct interviews with the relevant DHBs and, in some cases, the Ministry, to gain their assessment of the PHO’s management capabilities.

i. The reviewer should use the results of studies of management costs in similar organisations where available to provide benchmarks for PHO management services.

j. Key deliverables

k. The results of the interviews and research should be analysed and summarised in a report that answers the following questions:
Are PHOs performing the management services outlined in the service agreement?
Where are PHOs deficient in providing these services?
What are the main contributors to these deficiencies?
What is the cost of providing the full level of management services?
How do these costs vary by PHO?
What aspects of the PHO influence the efficient and effective provision of management services?
How do costs vary by PHO size?
Is the current management services fee appropriate?
Are there lessons from other sectors or countries that can be applied structuring and purchasing PHO management services?
Should the Ministry and DHBs change any aspects of its policy to achieve optimal results?

l. The reviewer should be prepared to consult with an advisory committee assembled by the Ministry and DHBs to assist with this review.

3.2 General Requirements for Tenderers

The Ministry wishes to be satisfied about the following matters:
a Professional expertise: You must have, and set out, your appropriate skills and expertise to undertake analysis of management services. You must have, and set out, your appropriate credibility and expertise in the field of business and financial analysis skills applicable to the health sector
   • intra organisational management and management analysis experience,
   • an understanding and appreciation of cultural determinants of service delivery and management,
   • a well developed understanding of, and experience in, government processes.
   • experience in the primary health care operational environment

b Quality: You should demonstrate how you will ensure the services required will be of excellent quality. For example, you need to demonstrate previous experience in, and describe the quality features of that previous experience in:
   • business and financial analysis skills applicable to the health sector
   • questionnaire Design,
   • report writing and presentation,
   • a well developed understanding of, and experience in, government processes
   • experience in the preparation of literature reviews,

c Service Priorities: You must show that you are able to put aside adequate time for the services to be provided under the contract in order to ensure that the provision of the services is not compromised by your other commitments.

d Confidentiality and Conflict of Interest: Except as required by law or as the Ministry may permit, client confidentiality (the Ministry and the public involved in the services) must be maintained at all times. Information already in the public domain is not confidential.

No conflict of interest shall occur. Identify any likely conflicts and how you would resolve them.

e Maori Health: You should take into account the Government's priority objective to improve the health status of Maori by reducing and eliminating the health inequalities that affect Maori.

f Different cultures and abilities: The provision of the required services is likely to involve you contacting people of different cultures and people with disabilities. You should demonstrate your ability to undertake such contact.

g Health Promoting and Inclusive Behaviour: It is important that you promote health. We look favourably on those who practise behaviour that enhances health, and facilitates participation by people with disabilities. This includes such things as taking account of and applying the broad strategic direction for the health and disability sectors under the New Zealand Health Strategy and the New Zealand Disability Strategy. It also includes the Treaty of Waitangi.
principles of partnership, participation and protection. You should be a good employer and have health promoting policies and practices in your workplace. These may include such things as equal employment opportunities, a smoke-free workplace, a responsible host policy, a nutrition policy etc. Summarise how these practices and abilities work within your organisation and provide examples of your organisation’s efforts to promote health.

Joint Ventures or Sub-Contracting: If you intend entering a joint venture or employing sub-contractors in order to provide the services, those other parties to the venture or the sub-contractors must meet the requirements of this tender. You should specify how you would ensure that they would meet these requirements, and each such party should be identified clearly in your proposal.
Appendix 2: List of PHOs Surveyed

<table>
<thead>
<tr>
<th>PHO</th>
<th>DHB</th>
<th>Date Established</th>
<th>Estimated Enrolled Population</th>
<th>Funding Formula</th>
<th>Practices/Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland Pacific Health Trust Board (AUCKPAC)</td>
<td>Auckland</td>
<td>1 April 2003</td>
<td>32,000</td>
<td>Access</td>
<td>5</td>
</tr>
<tr>
<td>Manaia Health</td>
<td>Northland</td>
<td>1 July 2003</td>
<td>73,223</td>
<td>Access</td>
<td>21 (54 GPs; 60 practice nurses)</td>
</tr>
<tr>
<td>Mornington</td>
<td>Otago</td>
<td>1 October 2003</td>
<td>14,310</td>
<td>Interim</td>
<td>1 (11 GPs; 7 practice nurses)</td>
</tr>
<tr>
<td>Ngati Porou Hauora Inc</td>
<td>Tairawhiti</td>
<td>1 October 2002</td>
<td>13,000</td>
<td>Access</td>
<td>7</td>
</tr>
<tr>
<td>Partnership Health</td>
<td>Canterbury</td>
<td>1 April 2004</td>
<td>340,000</td>
<td>Interim</td>
<td>300 GPs</td>
</tr>
<tr>
<td>Piki te Ora Te Awakairangi</td>
<td>Hutt Valley</td>
<td>1 October 2002</td>
<td>12,047</td>
<td>Access</td>
<td>3</td>
</tr>
<tr>
<td>Pinnacle Waikato</td>
<td>Waikato</td>
<td>1 July 2004</td>
<td>133,403</td>
<td>Access with Interim Practices</td>
<td>82 GPs; 90 practice nurses; 15 NGO health providers</td>
</tr>
<tr>
<td>ProCare Network Auckland</td>
<td>Auckland</td>
<td>1 July 2003</td>
<td>283,749</td>
<td>Interim with Access Practices</td>
<td>68 (170 GPs)</td>
</tr>
<tr>
<td>ProCare Network Manukau</td>
<td>Counties Manukau</td>
<td>1 January 2003</td>
<td>251,632</td>
<td>Mixed</td>
<td>59 (161 GPs)</td>
</tr>
<tr>
<td>Rural Canterbury</td>
<td>Canterbury</td>
<td>1 October 2003</td>
<td>59,900</td>
<td>Interim</td>
<td>19</td>
</tr>
<tr>
<td>Tamaki Healthcare Charitable Trust</td>
<td>Auckland</td>
<td>1 April 2003</td>
<td>22,000</td>
<td>Access</td>
<td>7</td>
</tr>
<tr>
<td>Te Kupenga O Houturoa Charitable Trust (TKOH)</td>
<td>Counties Manukau</td>
<td>1 July 2002</td>
<td>21,000</td>
<td>Access</td>
<td>4</td>
</tr>
<tr>
<td>Waiora Healthcare Trust</td>
<td>Waitemata</td>
<td>1 April 2003</td>
<td>10,700</td>
<td>Access</td>
<td>2</td>
</tr>
<tr>
<td>Wellington South East &amp; City (SECPHO)</td>
<td>Capital &amp; Coast</td>
<td>1 April 2003</td>
<td>10,821</td>
<td>Access</td>
<td>22</td>
</tr>
</tbody>
</table>
Appendix 3: Draft List/Description of Management Services

Table 28 provides a detailed list/description of management services/tasks, grouped according to five key functions.

It is an amalgamation of various papers\(^{38}\) and views on what “management services” potentially encompasses under the Contract (version 16.1, Variation 1.0; and proposed changes to January 2004 variation). With some services it is not clear whether they may or may not be covered in the contract (these are also indicated).

Table 28: List of tasks that could potentially cover “management services”

<table>
<thead>
<tr>
<th>Management Service/ Tasks</th>
<th>Description</th>
<th>Contract Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GOVERNANCE</td>
<td>• Administration/co-ordination associated with a PHO Board:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Election/selection processes (for trustees)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Arranging and facilitating (if required) Board meetings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Organising agendas (i.e. preparation, facilitation and distribution, including the provision of financial and other reports on a monthly basis).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Taking and circulating minutes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Carrying out Board instructions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Training in responsibilities of directors (not only on statutory responsibilities but other areas such as ToW obligations).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Ensuring payment of directors.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Ensure Board of directors aware of, and assisted to meet, their obligations. Includes responsibilities for annual financial reporting, for audit and for indemnity insurance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Establish and operate sub-committees (e.g., locality, clinical, community, finance) as determined by the PHO Board.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Make recommendations about, and implement Board decisions regarding, permanent constitutional arrangements for the PHO.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Manage PHO’s public relations, including liaison with media.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Negotiate head contract with DHB, and sub-</td>
<td></td>
</tr>
</tbody>
</table>

\(^{38}\) This included previous work done for the MOH (by Sandy Brimblecombe); IPAC; Health Rotorua.
<table>
<thead>
<tr>
<th>Management Service/Tasks</th>
<th>Description</th>
<th>Contract Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>contracts with providers for PHO Board sign off.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Facilitate preparation of PHO strategic/annual plans for PHO Board approval.</td>
<td></td>
</tr>
<tr>
<td>PHO Management</td>
<td>Development of responsibilities and accountabilities. [There will be some overlap with the above tasks associated with the Board]</td>
<td></td>
</tr>
<tr>
<td>2. GENERAL MANAGEMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>• Core administration tasks associated with organisation</td>
<td>E.8.1</td>
</tr>
<tr>
<td></td>
<td>• Data management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Administration standards and record keeping:</td>
<td>E.8.2</td>
</tr>
<tr>
<td></td>
<td>o Operate under sound financial and business management principles, procedures and practices</td>
<td>E.9.1</td>
</tr>
<tr>
<td></td>
<td>• Maintain full and proper financial and business records</td>
<td>E.9.2</td>
</tr>
<tr>
<td></td>
<td>• Security and preservation of records:</td>
<td>E.9.3</td>
</tr>
<tr>
<td></td>
<td>o Preserve and protect safety, security and confidentiality of records</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Have in place appropriate back-up and disaster recovery procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Must ensure all records properly preserved if services cease under Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Change in Circumstances:</td>
<td>D.23.3</td>
</tr>
<tr>
<td></td>
<td>o Advising DHB of any changes in circumstances.</td>
<td>J.8.8 to J.8.11</td>
</tr>
<tr>
<td></td>
<td>• NHI Compliance:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Internal management systems required to manage NHI compliance requirement.</td>
<td></td>
</tr>
<tr>
<td>General business</td>
<td>• Associated Property Costs (e.g. Rent, rates, utilities)</td>
<td></td>
</tr>
<tr>
<td>overheads</td>
<td>• Vehicles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Computers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Debt servicing costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Legal costs</td>
<td></td>
</tr>
<tr>
<td>Business and Financial</td>
<td>• Business Planning and Budgeting</td>
<td>D.17.3</td>
</tr>
<tr>
<td>Management</td>
<td>• Termination for fraud:</td>
<td>D.22.1</td>
</tr>
<tr>
<td></td>
<td>o Appropriate systems in place to detect and prevent fraud - where management services extend to financial management.</td>
<td>E.2</td>
</tr>
<tr>
<td></td>
<td>• Insurance:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Provision and maintenance of insurance to cover business and assets against risk.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continuing need to demonstrate that the PHO is a not profit body, responsive to its communities, and all contracted providers can influence decision-making.</td>
<td></td>
</tr>
<tr>
<td>Management Service/Tasks</td>
<td>Description</td>
<td>Contract Reference</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------</td>
<td>--------------------</td>
</tr>
</tbody>
</table>
| **Payment for Services:** | o Capitated payments only made to PHO:  
  • Management distributes payments to contracted providers.  
  • Management to ensure that contracted providers do not claim for fee for service payments from DHB.  
  o Services funded on a capitated bases with prior approval:  
  • Management develops or co-ordinates proposals for SIA and HP funding.  
  o Claiming requirements:  
  • Management submits claims for providers and disburses payments  
  o Payments:  
  • Disbursement of CBF payments to providers, including mediation of disputes with HealthPAC and reconciliations of under/over payments.  
  o Recovery of overpayments and costs of audit | F.3.2, F3.3 |
| **Risk Management:** | o Development and implementation of policies and practices aimed at managing risk (e.g. such as legal, financial and political).  
  o Responsibility for acts and omissions of respective employees, contracted providers, other contractors, agents.  
  o Notification of problems - general obligation to discuss and remedy problems  
  o Resolving Disputes: management of services or alternative arrangements in place in the event of disputes.  
  o Uncontrollable Events:  
  • Obligations of the affected party - management likely to play a key role in liaising between a provider and the PHO Board in reporting the nature of the event and in restoring services following an uncontrollable event. | F.5, F.10, F.11, F.13, D.3, D.14, D.16.4, D.20.2 |

<table>
<thead>
<tr>
<th>Staff management costs</th>
<th>Staff overhead costs (wages and salaries not otherwise allocated, redundancy?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications and Marketing</td>
<td>Advising enrolled population how to access services (marketing and communication function)</td>
</tr>
</tbody>
</table>
| Human Resources | • Staff Recruitment  
  • Staff development and training |
<table>
<thead>
<tr>
<th>Management Service/ Tasks</th>
<th>Description</th>
<th>Contract Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and training (for all staff) on Maori health policy, Maori values and belief;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support and development of the Maori workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensuring compliance with legislation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development, management and implementation of HR policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information &amp; Communications Technology (ICT)</td>
<td>Installation, development, maintenance and management of appropriate IT systems (including support)</td>
<td></td>
</tr>
<tr>
<td>External Liaison and Collaboration</td>
<td>• Attending regular meetings with DHB re:</td>
<td>C.4.1</td>
</tr>
<tr>
<td></td>
<td>o Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o How contractual relationship functioning including areas of improvement</td>
<td>D.15</td>
</tr>
<tr>
<td></td>
<td>o How services are being delivered including areas of improvement</td>
<td>H.4.1</td>
</tr>
<tr>
<td></td>
<td>o Wider primary care sector issues</td>
<td>H.4.4</td>
</tr>
<tr>
<td></td>
<td>• Participation in Advisory Committees.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maintaining inter-sectoral linkages at PHO level.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maintaining collaborative working relationships with community health services, DHB and non-government organisation public health providers, ACC and relevant non-health agencies.</td>
<td></td>
</tr>
<tr>
<td>Contract Management</td>
<td>• Sub-contracting - Contract development, negotiation and implementation with providers.</td>
<td>A.2.2</td>
</tr>
<tr>
<td></td>
<td>• Completing negotiations of final PHO agreement - management need to ensure that they are aware of and/or participate in the negotiations at a national level to resolve outstanding issues.</td>
<td>A.5</td>
</tr>
<tr>
<td></td>
<td>• Managing and implementing variations to DHB agreement.</td>
<td>D.9, D.10, D.11, D.12</td>
</tr>
<tr>
<td></td>
<td>• Continuing Agreements:</td>
<td>J.5</td>
</tr>
<tr>
<td></td>
<td>o Possible requirement to negotiate on other contracts that may be held by the PHO</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td><strong>PLANNING, CONTROL AND CO-ORDINATION</strong></td>
<td></td>
</tr>
<tr>
<td>Business Planning</td>
<td>• Strategic and Annual Planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preparation of business cases for PHO Board (e.g. SIA and Health Promotion funding etc).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rural reporting</td>
<td></td>
</tr>
<tr>
<td>Community Liaison</td>
<td>Consultation and engagement with community.</td>
<td></td>
</tr>
<tr>
<td>Practice Management</td>
<td>• Register requirements:</td>
<td>E.5.1</td>
</tr>
<tr>
<td></td>
<td>o Maintaining the register of enrolled population (according to specifications contained in “CBF</td>
<td></td>
</tr>
<tr>
<td>Management Service/ Tasks</td>
<td>Description</td>
<td>Contract Reference</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------</td>
<td>--------------------</td>
</tr>
</tbody>
</table>
| **Protocols**             | • Contracted Providers do not claim under Section 88 - management of provider claiming protocols  
                          • Exit of Practitioners:  
                          o Development and implementation of protocols to manage this issue in accordance with business rules/enrolment rules.  
                          • Declining Services:  
                          o To ineligible people - implantation of PHO protocols via practice manuals, training. | A.2.3  
                          D.5  
                          E.7 |
| **Research, Analysis and Service processes** | • Ensuring sufficient services to meet demand  
                          o Analysis of population, ratio of GPs to population etc and reporting function  
                          • Population awareness:  
                          o Use of DHB needs analysis and/or other appropriate evidence, to plan, prioritise and deliver services which are appropriate for the demographic make-up and health needs of population.  
                          • Access for High Need Groups:  
                          o Agreeing with DHB the services and activities undertake to improve access for high need groups.  
                          • Health Promotion Services:  
                          o Agree with DHB on health promotion activities to be undertaken. | H.3.5 and H.3.6  
                          H.5.1 to H.5.3 |
| **Co-ordination/Service Linkages** | Working with providers to consider how best to co-ordinate care of enrolled population. | H.7 |
| **Maori Health Action Plan** | • Maori Participation:  
                          o Integration of Maori participation (as appropriate) in all levels of governance, service planning, development and implementation within organisation.  
                          o Education and training (for all staff) on Māori health policy, Māori values and beliefs  
                          o Support and development of the Māori workforce  
                          o Consulting with and ensuring that key Maori stakeholders contribute to decision-making.  
                          o Development of a monitoring strategy that reviews and evaluates whether Maori needs are being met.  
                          • Maori Health Action Plan:  
                          o Development of a Maori Health Action Plan in consultation with the DHB and key Maori stakeholders (iwi, Maori communities and providers). | E.3.1  
                          H.2.2 |
<table>
<thead>
<tr>
<th>Management Service/ Tasks</th>
<th>Description</th>
<th>Contract Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o Develop performance measures as part of reporting requirements.</td>
<td>H.9.1 to H.9.7</td>
</tr>
<tr>
<td></td>
<td>o Implement activities described in Maori Health Action Plan and monitor Maori health initiatives and health gains (evidence and demonstration of how implementation of the Plan has improved health outcomes and/or access for Maori).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Review annually and amend accordingly.</td>
<td></td>
</tr>
<tr>
<td>Pacific Health</td>
<td>Working with Pacific communities and providers in planning and delivering services to contribute to the reduction in Pacific peoples’ health inequalities (where provide services for Pacific communities)</td>
<td>H.2.3</td>
</tr>
</tbody>
</table>

4. PERFORMANCE MONITORING AND REPORTING

Compliance with eight minimum criteria
System development to ensure that the PHO is complying with the government’s eight minimum criteria for PHOs

Clinical Governance and Training
Development of clear lines of responsibility and accountability for the overall quality of clinical care offered through providers.

Daily record of Service User
Need to ensure that every practitioner (providing any first level services or general medical services) keeps a comprehensive and readily accessible daily record in respect of every Service User.

Audit
- Responsible for auditing the performance of contracted providers, in particular:
  - Auditing the registers maintained by contracted providers
  - Auditing the information that contracted providers are required to provide
  - Clinical audit of contracted providers
- Regular audit of providers of immunisation services
- Immunisation Services - service objectives: monitoring performance targets

Quality improvement
- Quality assurance systems for provision of services by PHO and contracted providers (documented, implemented, evaluated)
- Ensuring services delivered are culturally appropriate
- Complying with all legal, regulatory and professional requirements
- Consumer complaints process

Reporting Requirements
- Public reporting:
  - Annual report and annual financial statements to be available to the public
- To DHB or Payment Agent:
  - Details of patient register (quarterly to DHB payment agent)
<table>
<thead>
<tr>
<th>Management Service/Tasks</th>
<th>Description</th>
<th>Contract Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>payment agent)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Changes to Practitioners (monthly to DHB payment agent)</td>
<td>I.5</td>
</tr>
<tr>
<td></td>
<td>o Service utilisation (quarterly, to DHB payment agent)</td>
<td>I.6</td>
</tr>
<tr>
<td></td>
<td>o Immunisation services (quarterly, either to DHB or payment agent)</td>
<td>I.7</td>
</tr>
<tr>
<td></td>
<td>o Rural reporting - strategies; funding premium (quarterly to DHB)</td>
<td>I.8</td>
</tr>
<tr>
<td></td>
<td>o Yearly Report (annual to DHB)</td>
<td>I.9</td>
</tr>
<tr>
<td></td>
<td>o Maori Health Action Plan (biannually to DHB)</td>
<td>I.10</td>
</tr>
<tr>
<td></td>
<td>o Health promotion and access proposals (biannually, DHB)</td>
<td>I.11</td>
</tr>
<tr>
<td></td>
<td>o Quality indicators and targets (to DHB)</td>
<td>I.12</td>
</tr>
<tr>
<td></td>
<td>o Clinical performance indicators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Ad hoc reports - provision of information/reports from time to time to DHB</td>
<td>I.14</td>
</tr>
</tbody>
</table>

5. REFERRED SERVICES MANAGEMENT

**Pharmaceutical and Laboratory Management**

- Managing Referred Services:
  - Responsible for managing referred services for enrolled population, including monitoring and reviewing, and providing feedback on practice.
  - Supporting peer group processes
  - Facilitators and educators

"Capital Strategy Limited - Review of PHO Management Services"
Appendix 4: Survey/Questionnaire

2004 Review of Primary Health Organisations (PHOs) Contracted Management Services: Survey/Questionnaire

He mihi tēnei ki a koutou katoa ngā iwi o ngā hau e whā. Kia koutou e ngākau nui nei ki te tautoko ki te manaaki i tēnei kaupapa nunui. Tēna koutou, tēna koutou, tēna koutou katoa.

Greetings to you from around the country.
To those of you participating in this project, tēna koutou, tēna koutou, tēna koutou katoa.

Thanks for your time and participation in this project.
This survey/questionnaire forms part of the Ministry of Health’s review of contracted PHO management services. Please note that individual responses will remain confidential to Capital Strategy.

*Please complete Part A (questions 1 to 17) and questions 18 and 19 of Part B prior to your meeting with Capital Strategy.*

*The remaining questions in Parts B and C will be discussed and completed at the meeting (they are provided here for your information as to the basis of the discussion).*

**Date of Interview/Meeting:**

**Name of PHO:**

**PHO attendee(s):**

**PHO person(s) completing questionnaire & contact details (if different from above):**

**Capital Strategy attendee(s):**

Please contact the following if you have any queries:

Cathy Jordan: 09 817 7665; 027 251 4648  cathy@capitalstrategy.co.nz
Kelvin Norgrove: 021 630-288  kelvin.norgrove@win.co.nz
John McCardle: 027 292 0112  john@capitalstrategy.co.nz
### Part A: PHO General Information

1. **Name of PHO:**
   
2. **Address of PHO:**
   
3. **DHB(s):**
   
4. **Number of providers and area serviced by PHO (general description):**
   
5. **Establishment Date:**
   
6. **Enrolled Population:**
   - At Establishment Date:
   - Latest Estimate (incl Date):
   
7. **% of high needs patients or ethnic breakdown:**
   
8. **Funding Formula:**
   - Interim
   - Primarily Interim, with Access Practices
   - Access
   - Primarily Access, with Interim Practices

9. **Number of PHO employees (including contractors and temps; excluding service providers):**
   - Full-time
   - Part-time

10. **Please indicate range of health services provided:**
   
---

*Capital Strategy Limited - Review of PHO Management Services*
11 **PHO Governance Structure** *(please tick the appropriate box)*

- [ ] Trust
  How are trustees/board members appointed?
  __________________________

- [ ] Company (non-profit)
  Who are the shareholders? (eg. providers)
  __________________________

- [ ] Incorporated Society

- [ ] Other *(please advise)*
  __________________________

- [ ] What Committees do you operate (eg Clinical Governance Committee)
  *(please name)*

12 **Number of Board members, composition and whether they are an affiliated member of another Board:**

<table>
<thead>
<tr>
<th>No. of Board Mbrs</th>
<th>Background of Representatives</th>
<th>Affiliated member of another Board <em>(Y/N?)</em>; if Yes, please advise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Professionals</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Community Representatives</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Independent Representatives</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Other <em>(please advise)</em></td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

*Total:*

13 **Is your PHO independent or affiliated to another organisation?**

- [ ] Independent
- [ ] PHO is a provider
- [ ] Affiliated to parent organisation *(please advise name of parent organisation):*

14 **Has your PHO signed a contract with your DHB(s):**

- [ ] Yes, version: __________________________
- [ ] If No, reason? __________________________

15 **What is the origin of your PHO** *(eg new start up, already established IPAs etc):*

______________________________________________
16 **Who provides management services for your PHO?**

*Note: may give more than one answer*

- PHO provides own management services
- Contracted out (e.g. to a management services organisation)
- Providers/practices undertake management services

17 **Documents Provided to Capital Strategy (requested in covering letter)**

- Contract between PHO and DHB (Section J only)
- Sample contract between PHO and provider
- Company constitution or trust deed (whichever applicable)
- Management Services contract (if applicable)
- PHO Strategic Plan (or Establishment Plan)
- Maori Health Action Plan
- Pacific Health Plan
- PHO Business Plan
- PHO Annual Report
- PHO Financial Statements:
  - Most recent year end if no published Annual Report available
  - Most recent monthly and/or quarterly management accounts to PHO Board
- List of employee positions/job titles
- Other *(please advise)*:

<table>
<thead>
<tr>
<th>Additional Comments:</th>
</tr>
</thead>
</table>

*Documentation will remain confidential and will not be copied or made available to others*
Part B: PHO Contracted Management Services

This section is structured as follows:

- **Defining** “management services” (B1)
- PHO **delivery** of management services (B2).
- Financial: **Cost** of providing and the **funding** of management services (B3).

The following table (question 18) will form the basis of discussion:

- Management services/tasks are grouped into five key functions.
- The coverage of management services within these key function areas potentially encompasses “management services” under the DHB/PHO contract.
- The list is not exhaustive but forms the basis for discussion. Some services may/may not be covered in the contract.
- A separate more detailed list (from which this table is drawn) has been provided for your information and reference.
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management services functions</td>
<td>Coverage</td>
<td>Who provided by (i.e. PHO, Practice, MSO) or not</td>
<td>If not provided, why not? (e.g. not relevant, low priority)</td>
<td>Annual Operating Expenditure (if available)</td>
<td>Funding source (e.g. management services fee)</td>
<td>Relative level of provision of services (rate from 1 'inadequate' to 5 'adequate')</td>
</tr>
<tr>
<td>Governance</td>
<td>• PHO Board</td>
<td>PHO</td>
<td></td>
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<tr>
<td></td>
<td>• PHO Management</td>
<td></td>
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<tr>
<td>General Management</td>
<td>• Administration (data management/ records)</td>
<td></td>
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<td></td>
<td>• General business overheads (e.g. rent and other associated property operating costs, computers, vehicles, debt servicing costs)</td>
<td></td>
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<td></td>
<td>• Business/Financial Management (inc budgeting, insurance, payment for services, risk management, demonstrating PHO not for profit body)</td>
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<td></td>
<td>• Staff management costs</td>
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<td></td>
<td>• Communications and Marketing</td>
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<td>• Human Resources</td>
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<td></td>
<td>• Information Communications &amp; Technology</td>
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<td></td>
<td>• External Liaison and Collaboration</td>
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<td></td>
<td>• Contract Management</td>
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<tr>
<td>Planning, Control and Coordination</td>
<td>• Business Planning (including strategic and annual planning, preparation of business cases for PHO Board)</td>
<td></td>
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*Capital Strategy Limited - Review of PHO Management Services*
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<tr>
<td>Management services functions</td>
<td>Coverage</td>
<td>Who provided by (i.e. PHO, Practice, MSO) or not</td>
<td>If not provided, why not? (e.g. not relevant, low priority)</td>
<td>Annual Operating Expenditure (if available)</td>
<td>Funding source (e.g. management services fee)</td>
<td>Relative level of provision of services (rate from 1 ‘inadequate’ to 5 ‘adequate’)</td>
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<tr>
<td>• Community liaison (i.e. consultation and engagement with community)</td>
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<td>• Practice Management (enrolment register)</td>
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<tr>
<td>• Protocols</td>
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<td>• Research, Analysis and Service processes</td>
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<tr>
<td>• Co-ordination/Service linkages</td>
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<tr>
<td>• Maori Health Action Plan (including Maori Participation)</td>
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<tr>
<td>• Pacific Health Plan</td>
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<tr>
<td>Performance Monitoring and Reporting</td>
<td>• Compliance with eight minimum criteria</td>
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<td>• Clinical governance and training</td>
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<td>• Daily record of Service User</td>
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<td>• Audit</td>
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<td>• Quality management</td>
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<tr>
<td>• Reporting Requirements</td>
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<tr>
<td>Referred Services Management</td>
<td>• Pharmaceutical and Laboratory Management</td>
<td></td>
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<td>• Other (please identify)</td>
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<tr>
<td>Other</td>
<td>• (Please identify)</td>
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</tbody>
</table>
19 What does your current budget include for the costs of management services and associated funding, for 2003/04 (and forecast for 2004/05)

<table>
<thead>
<tr>
<th>Items</th>
<th>2003/04</th>
<th>Forecast 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Issues to consider at interview:**
Are management services accounted for or budgeted for as a group? Evidence of expenditure and forecasts in management accounts?

Comments: ________________________________

________________________________________

B1: Defining Management Services

20 How does the table in Q18 compare with your view of what constitutes “management services” under the PHO contract?

**Issues to consider at interview:**
Compare what actually undertaken with Capital Strategy draft list
Should management service functions be better defined, i.e. more definitive within the contract?
Would PHOs benefit from the development of ‘best practice’ guidelines/methodology/procedures for core management services?
When does a management activity cease to be PHO management activity and become a practitioner’s activity?

________________________________________

21 Other comments:

________________________________________

________________________________________

________________________________________
B2:  Delivery of PHO Contracted Management Services

22  Does your PHO have the appropriate capacity to deliver management services?

Issues to consider at interview:
Now?
In the future?
Any particular areas where you need assistance?
What specific areas are not being fully funded re management services?
Or not being delivered as well as they could be due to insufficient funding?
To what extent are reduced management services being delivered, if so where and why? What needs to be undertaken to provide the full level of service?
What are the areas of cost risk?

23  Are there any particular issues related to the delivery of management services that your PHO has had to address since establishment?

Issues to consider at interview:
Requirement for additional resources?
Unable to deliver to preferred level? Reliance on ‘in-kind’ (ie unpaid) contributions and efforts from practices.
How has the PHO responded to the challenge of administering management services? How much time is spent by CEO/executive officer on driving and managing change in business practices? Is there a focus on leading practices toward meeting the objectives of the Primary Healthcare Strategy?

24  What is your view of shared services for management services across PHOs?

Issues to consider at interview:
Has your PHO considered this?
Do you think the size of your PHO warrants consideration of this?

25  Other comments:
B3: Financial: Cost of providing and the funding of management services

26 Do you levy providers/practices to pay for management services for your PHO?

☐ Yes, please advise type and amount _____________________ ______________
☐ No

27 Do you pay providers/practices to undertake or contribute to management services for your PHO?

☐ Yes, please advise type and amount _____________________ ______________
☐ No

28 Did your PHO receive an Establishment Funding grant?

☐ Yes, please advise amount ________________________________
☐ No

Issues to consider at interview:
Amount?
How has this been used?
Has there been some cross-subsidisation between establishment costs and management costs?

29 Do you receive assistance from the DHB for providing management services?

☐ Yes, please advise type (eg. research and analysis, service provider funding)

☐ No

30 Is management services funding pooled with other funding streams once it is received by the PHO or are separate accounts maintained?

☐ Pooled
☐ Separate Accounts

Comments:

Issues to consider at interview:
Where does revenue/expenditure for management services lie in accounts?
Where does the expenditure for infrastructure costs lie? Is funding for infrastructure taken from the management services fee or other funding streams?
Has PHO ‘top sliced’ other contracts to fund management services costs?
If PHO top slices:
Where do they fund the requirement management services from?
Is delivery of other services reduced?
How much is top-sliced as a % of funds received for management services (i.e. how much extra do they need to sufficiently fund management services?)
What are other revenue sources can be directed to the PHO?

31 What is the range in fluctuation in your management services funding in the past year?

Issues to consider at interview:
Change in funding from quarter to quarter due to change in enrolled population
Effect on sustaining management services, investment in PHO infrastructure and staff

32 What are your views on the level of management funding for PHOs?
Rate the adequacy of management services funding to deliver required management services under the PHO contract
☐ Rate on a continuum of 1 (inadequate) to 5 (Adequate)
☐ Don’t know

If rated 1-3 please explain why not considered adequate

33 Describe the components of funding your PHO receives: i.e. what component/% are management fees?

Issues to consider at interview:
Are there any costs associated with management services that are not covered by the contract? What are they and what is their approx annual cost?

34 What are your views on the basis of the management services fee?

Issues to consider at interview:
Should the management services fee be tied to the number of enrolled patients? If not, what criteria should it be based on?
Do you have any suggestions for alternatives or changes to the funding arrangement for management services? (eg quality bonuses)
In terms of the funding process, should the direct funding relationship for management services be between the PHO and the DHB (i.e. the DHB has discretion over funding arrangements for PHOs within its overall budget set by the Ministry)?
35  **What factors do you expect to generate increases in management services costs in the future?** (Please number in order of significance of impact on costs)

- [ ] Targeted health programmes (eg. Immunisation, Breast screening)
- [ ] DHB requirements (eg Clinical performance indicators reporting)
- [ ] Primary Health Care Strategy
- [ ] Referred services management
- [ ] CarePlus
- [ ] Other (please advise): __________________________________________
- [ ] Don’t know

*Comments:*

---

**Issues to consider at interview:**

- **Approximate increase in cost?**

---

36  **Other comments:**

---

*Capital Strategy Limited - Review of PHO Management Services*
Part C: Other Services and Funding

37 Are you currently receiving funding for the following?

- SIA
- Health Promotion
- CarePlus
- Other (not first service) *(please indicate)*

Probe in interview:
To what extent do the above help fund management services?

38 In making applications for above funding, is an allowance for the costs of management and administration included or excluded?

- Included
- Excluded

39 For those to which you answered yes in 37 above, please indicate which current staff members (by job title) manage or deliver:

SIA

Health Promotion

CarePlus

Other (not first service) *(please indicate)*:

40 Other comments:
Appendix 5: PHO Correspondence

The following information is attached:

- Letter from Dr Pat Tuohy, Acting Deputy Director-General, Clinical Service Directorate, Ministry of Health to participating PHOs (with a copy to their respective DHBs), 28 April 2004.


- Letters from Capital Strategy to participating PHOs, 30 April and 14 May 2004.
Dear [Name]  

[CEO]  
[PHO]  
[Address]

The Ministry is conducting a review of management services that primary health organisations (PHOs) are contracted to deliver. The review will provide a comprehensive assessment of contracted PHO management services, the cost of providing these services, and the options available to the Ministry for purchasing these services in the medium to long term.

The review is in response to concerns raised about the adequacy of the management fee. The Ministry is thus reviewing the management services funding for PHOs to ensure that PHOs are better placed to implement the Primary Health Care Strategy now and into the future.

The Ministry has contracted a consulting firm, Capital Strategy Limited, to undertake the review on its behalf.

The review will include collecting information from a sample of 15 PHOs across the country. This will include meetings/interviews with each PHO and relevant DHBs. The sample identified is representative of the diverse nature of PHOs, in terms of their enrolled population, funding formulae, size, background, ethnic composition, rural and urban coverage, and the management experience of the PHOs.

The sample has been approved by the Ministry and the cross-sector Advisory Team overseeing the project. A list of the 15 PHOs is attached for your information.

I am writing this letter to recommend that your PHO take part in the review of the management services of PHOs, to be undertaken over April to June 2004.

As part of the project, the consultants may also assess information on management costs from other similar health organisations and other industry sectors, to use for comparative purposes.

The results of the interviews and research will be analysed and summarised in a report that answers the following questions:

**Capital Strategy Limited - Review of PHO Management Services**
Are PHOs performing the management services outlined in PHO service agreements?

Where are PHOs deficient in providing the management services outlined in the service agreements?

What are the main contributors to deficiencies in providing the management services outlined in the service agreements?

What is the cost to PHOs of providing the full level of management services?

How do management costs vary between PHOs?

What aspects of the PHO influence the efficient and effective provision of management services?

How do management costs vary between PHOs by size?

Is the current management services fee appropriate?

Are there lessons from other sectors that can be applied to the structuring and purchasing of PHO management services?

Should the Ministry and DHBs change any aspects of its policy to achieve optimal PHO management results?

Consultants from Capital Strategy will be in touch with you within the next week to arrange a time to meet with you over the subsequent two to three weeks.

All information gathered will be treated in the strictest confidence and will be used only for the preparation of the report.

This project is an important part of the ongoing evaluation of the situation of PHOs and I recommend you take part. If you have any queries about whether you should take part please contact Dr John Marwick, Principal Clinical Adviser, Primary Health Team at the Ministry of Health (Ph 04 496 2052 john_marwick@moh.govt.nz).

A copy of this letter has been sent to the primary care team in your DHB.

Yours sincerely

Pat Tuohy (Dr)
Acting Deputy Director-General
Clinical Service Directorate

Enc.
Media Release

28 April 2004

Review of Primary Health Organisation management services

During the next few months some Primary Health Organisations (PHOs) will be asked to take part in the review of PHO management services.

The Ministry of Health is conducting a review of management services that PHOs are contracted to deliver. The review will provide a comprehensive assessment of contracted PHO management services, the cost of providing these services, and the options available to the Ministry for purchasing these services in the medium to long term.

Ministry of Health Acting Deputy Director-General of Clinical Services Dr Pat Tuohy said the review was in response to concerns raised about the adequacy of the management fee.

``The Ministry is thus reviewing the management services funding for PHOs to ensure that PHOs are better placed to implement the Primary Health Care Strategy now and into the future," he said.

Consulting firm Capital Strategy Limited has been contracted to do the review.

It will include collecting information from a sample of 15 PHOs across the country. This will include meetings/interviews with each PHO and relevant District Health Boards (DHBs). The sample identified is representative of the diverse nature of PHOs, in terms of their enrolled population, funding formulae, size, background, ethnic composition, rural and urban coverage, and the management experience of the PHOs.

The sample has been approved by the Ministry and the sector advisory team overseeing the project. This team includes representatives from PHOs and DHBs.

As part of the project, the consultants may also assess information on management costs from other similar health organisations and other industry sectors, to use for comparative purposes.

The results of the interviews and research will be analysed and summarised in a report that answers the following questions:

- Are PHOs performing the management services outlined in PHO service agreements?
- Where are PHOs not fully providing the management services outlined in the service agreements?
- What are the main contributing factors where PHOs are not providing the management services outlined in the service agreements?
- What is the cost to PHOs of providing the full level of management services?
• How do management costs vary between PHOs?
• What aspects of the PHO influence the efficient and effective provision of management services?
• How do management costs vary between PHOs by size?
• Is the current management services fee appropriate?
• Are there lessons from other sectors that can be applied to the structuring and purchasing of PHO management services?
• Should the Ministry and DHBs change any aspects of its policy to achieve optimal PHO management results?

All information gathered will be treated in the strictest confidence and will be used only for the preparation of the report.

``This project is an important part of the ongoing evaluation of the situation of PHOs and I recommend that they take part," Dr Tuohy said.

A list of the 15 PHOs identified to take part in the review is attached.

ENDS

For more information contact:
Marama Ellis
Media Advisor
Ministry of Health
DDI: 04 470 0620
Mobile: 021 802 622
mailto:marama_ellis@moh.govt.nz
30 April 2004

[PHO]

Dear

Review of Primary Health Organisation Management Services

We have been contracted to carry out a review of contracted PHO management services for the Ministry of Health. You will have already received a letter from the Ministry explaining the project.

We have selected your PHO as one of 15 that we would like to include in a survey. The 15 PHOs were chosen in conjunction with the Ministry in order to reflect a range of different characteristics: a mix of funding formulae, both big and small organisations, some rural, some urban and some provincial, as well as some serving Maori and Pacific populations.

Either Cathy Jordan, Kelvin Norgrove or I will be in touch with you to arrange a suitable time to meet. It is anticipated meetings will be held over the next two to three weeks. We will be forwarding you in advance, a copy of a survey questionnaire to be discussed during the meeting.

We urge you to participate in the project. It will not take a lot of your time. The cooperation of all PHOs will mean that we will be able to provide the Ministry of Health with a comprehensive report of the status of its funding of contracted management services for PHOs at the present time.

Enclosed is a list of the documentation we ask you to provide prior to our meeting. This will help us to be more fully aware of the situation and circumstances of each PHO. If you have any additional documents you think would be useful for the project please include them.

If it would be easier to send these documents electronically please email them to cathy@capitalstrategy.co.nz. We would be grateful to receive the documentation by Thursday 6 May 2004.
I realise that these are fairly tight deadlines. Our brief is to report back to the Ministry at the end of June. We would therefore appreciate it if you could give this matter your urgent attention.

Please note that our company has been hired by the Ministry to provide an independent review.

Thank you for your help.

Yours sincerely

John McCardle
Director
Enc.

**Review of PHO Management Services**

**Documents Requested by Capital Strategy**

1. Contract between PHO and DHB
2. Sample contract between PHO and provider
3. List of contracted providers
4. Management Services Contract (if applicable)
5. PHO Strategic Plan
6. PHO Business Plan
7. PHO Annual Report
8. PHO Financial Statements:
   - Most recent year end if there is no published Annual Report available
   - Most recent set of monthly and/or quarterly management accounts reported to the PHO Board
9. List of employees and job titles
14 May 2004

[PHO]

Dear

Review of Primary Health Organisation Management Services

Meeting Details

We confirm details of our meeting as follows:

Date:

Venue:

PHO Attendees: In addition to yourself, please feel free to invite other available PHO staff/representatives you consider appropriate (e.g. the Chair of the PHO).

Capital Strategy Attendees: John McCardle (027 292 0112)
Cathy Jordan (027 251 4648)

PHO Questionnaire

We attach the PHO Questionnaire. This will form the basis of discussion at our meeting.

We would appreciate if you could complete Part A (questions 1 to 17) and questions 18 and 19 of Part B prior to our meeting.

The remaining questions in Parts B and C will be discussed and completed at the meeting (they are provided here for your information as to the basis of the discussion – although feel free to complete them prior to the meeting).

Documents Requested by Capital Strategy

Our emailed letter of 30 April included a list of documents that would assist us to be more fully aware of your PHOs circumstances.
We would appreciate receiving copies of the requested documents prior to our meeting. In addition, we would also like copies of your Maori Health Action Plan, Pacific Health Action Plan, Trust Deed or Constitution (if applicable). With respect to the DHB-PHO contract, we would only require a copy of Section J.

We look forward to meeting with you.

Yours sincerely

John McCardle
Director

Enc.
## Appendix 6: Acknowledgements

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<tr>
<th>Organisation</th>
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<tr>
<td>Auckland DHB</td>
<td>Utulei Antipas (Pacific Health Manager)</td>
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<td>Aseta Redican (General Manager Pacific Health)</td>
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<td></td>
<td>Simon Royal (Programme Manager Primary Care)</td>
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<td>Auckland Pacific Health Trust Board</td>
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<td>Julia Carr (Portfolio Manager)</td>
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<td>Dev Oza (Manager Planning, Risk and Internal Audit)</td>
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<td>Counties Manukau DHB</td>
<td>Kim Arcus (Project Manager Primary Care)</td>
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<td>Petra van den Munckhof (National Coordinator)</td>
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<td>Health Rotorua</td>
<td>Jeremy Mihaka-Dyer (Service Development Manager)</td>
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<td>Dr Helene Carbonatto (General Manager, Planning &amp; Funding)</td>
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<td>Jon Foley (Senior Analyst, Primary Health Team, Clinical Services</td>
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<td>Karen Koopu (Manager Maori Development Service Development, Maori Health</td>
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<td>Dr John Marwick (Principal Clinical Advisor, Primary Health Team,</td>
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<td>Dianne Gibson (CEO)</td>
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<tr>
<td>Northland DHB</td>
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<td>Peter Ellison (Kaiwhakahaere Hauora M ori Te Poari Hauora-rohe ki t go)</td>
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<td>Wellington Independent Practice Association (WIPA)</td>
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References


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