IMPLEMENTING THE PRIMARY HEALTH CARE STRATEGY: A MĀORI HEALTH PROVIDER PERSPECTIVE

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Abstract

This paper discusses the development of Ngāti Porou Hauora (NPH), an East Coast Māori health provider, into a Primary Health Organisation (PHO), the cornerstone of the Primary Health Care Strategy (PHCS). It illustrates how NPH's structure, philosophy of care and service delivery were compatible with the frameworks underpinning both the PHCS and He Korowai Oranga: The Māori Health Strategy, thus facilitating PHO development. The paper also examines some of the challenges of implementing the PHCS, such as integrating a population health approach, the appropriateness of key performance indicators and issues to do with community participation and partnership, funding and contracting. It concludes that, while larger Māori health providers like NPH and those that have formed equitable partnerships with other third sector providers have been strengthened by the strategies and have some valuable lessons for the primary health sector, there remain inherent risks for smaller Māori health providers.

INTRODUCTION

With the introduction of the Primary Health Care Strategy (PHCS) in 2001, the New Zealand Government aimed to establish a primary health care structure providing comprehensive coordinated services to enrolled populations and reducing inequalities in health status (King 2001). This was to be achieved through the development of Primary Health Organisations (PHOs), which would receive capitated funding and be required to:

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- undertake population health initiatives alongside patient-centred primary care
- broaden the range of providers and skills used in integrated primary care delivery
- improve access to services for disadvantaged populations
- ensure community participation in health care service decision-making and governance.

Implicit in this was a community development approach and an emphasis on intersectoral work at both individual and population levels.

This holistic approach was quite new to the New Zealand primary health care scene that had traditionally been focused on general practitioner clinical services and funded on a fee-for-service basis. But for many Māori and other third sector primary health providers,[2] whose structures, philosophies and approaches to primary care provision already sat very comfortably with this new direction, the changes were welcomed for the most part. Although the new structures have been problematic for some of the smaller Māori heath providers, others have developed relatively quickly into or within PHOs because their governance structures and strategic aims around access to care were compatible with the Strategy and the demographic features of their populations qualified them for full population funding. Their approaches to health care delivery have been further validated by the release of *He Korowai Oranga: The Māori Health Strategy* (HKO) (King and Turia 2002a) in 2002, and its action plan *Whakatataka* (King and Turia 2002b).

Using Ngāti Porou Hauora (NPH) as a case study, this paper examines the implementation of the PHCS within a well-established and relatively large Māori health provider. Following a brief background on the development of PHOs, Māori health providers and NPH, we examine how NPH's structure, philosophy of care and service delivery were compatible with the frameworks underpinning PHCS and HKO and how this facilitated the transition into a PHO. We then go on to describe a number of challenges that have been encountered in the PHO development process that may have relevance for other providers. Finally, we conclude that, although the strategies have strengthened larger Māori health providers like NPH and those that have formed equitable partnerships with other third sector providers, there remain inherent risks for smaller Māori health providers.

2 Crampton (1999) defines the third sector as "the non-government, non-profit sector". He goes on to say, "Third sector primary care organisations started having a significant presence in New Zealand in the late 1980s, have tended to draw on broad public health definitions of primary health care, and have tended to adopt community development approaches".

PRIMARY HEALTH ORGANISATION DEVELOPMENT

Since the introduction of the PHCS in 2001 and the establishment of the first PHOs in July 2002, significant changes have occurred within the primary health care sector. The formation of PHOs has occurred much more rapidly than Government originally intended. Although the original timeframe to enrol the entire New Zealand population was 8–10 years, by October 2004, 91% of the population was enrolled by 77 PHOs. Over three-quarters of Māori, almost all Pacific peoples and almost 80% of those in the most deprived areas (NZDep deciles 9 and 10) were enrolled and services were available at reduced or low cost to approximately half the general population (King 2004:97, Spencer 2004). While there has been general support from providers for the overall direction of the reforms, some of the implementation processes have been challenged, not least the inconsistencies in contracting and monitoring between the 21 District Health Boards (DHBs) with whom PHOs obtain contracts (Austin 2003, Perera et al. 2003). Indeed while some DHBs are happy to contract with small[3] PHOs, others are not (*New Zealand Doctor* 2005a).

Funding formulae, governance issues and internal PHO relationships have also been stumbling blocks. With respect to the funding formulae, the intention of Government was to target resources at high-need populations first. PHOs with registers that met the high-need criteria (registered populations where 50% or more were Māori, Pacific and/or of NZDep deciles 9 and 10) qualified for the more generous Access funding formula. Others were granted the Interim funding formula, a lower per capita amount targeted at the young and the old with a view to augmentation as further funding came on stream (Ministry of Health 2002).

However, the differential in the formulae has attracted considerable criticism. In particular, those PHOs whose populations were considered less high need as a group, but who nevertheless had many individuals with high need, have complained that Access providers have been able to offer lower-cost services to their enrolled populations more quickly and, arguably, attract patients from providers that did not have this advantage (Barnett and Barnett 2004, Spencer 2004). Consequently, by the end of 2004 Government had announced that they intended to expedite the PHCS implementation process, with all PHOs on Access formula funding by the end of 2007 (*New Zealand Doctor* 2005b).

Governance requirements have also been an issue. Many general practitioners are in private practice and there has been some reluctance to include community members in

3 A small PHO is commonly considered to be one with fewer than 20,000 enrolled patients. Most third sector PHOs belong in this category. In October 2004, 39 of the 77 PHOs had fewer than 20,000 people while 24 had fewer than 10,000 (*New Zealand Doctor* 2005a)

governance because of a potential influence on their professional and business practices. In an effort to reduce general practitioner resistance to the new structures, the community participation imperative became increasingly watered down in successive versions of the PHCS policy (Neuwelt and Crampton 2004). Indeed part of the rapid development of non-third-sector PHOs has been enabled by the tolerance that many DHBs have shown in relation to governance and community participation practices that did not strictly meet the requirements of the initial strategy. At the fifth joint Ministry of Health/Non-Government Organisations (NGO) Health and Disability Forum held in March 2004, the tension between the business and community service models was identified as a pressing issue for DHBs, and one of the key concerns raised by NGOs was their lack of meaningful participation at governance level because of "perceived GP and mainstream provider capture of PHOs" (Ministry of Health 2004a).

Provider relationships within PHOs have also posed difficulties. A few PHOs have collapsed altogether and in others some partner providers have left because the member provider-groups have not been able to work together (*New Zealand Doctor* 2005b).

MĀORI HEALTH PROVIDERS

The number of Māori health providers has burgeoned over the past decade. Following the restructuring of the health system in the early 1990s new opportunities opened for Māori health provider contracts under the newly established Regional Health Authorities (Crengle 1999). This continued through successive restructuring, so that by 2004 there were 240 such providers throughout the country (King 2004). While many of these providers hold small specific contracts, others are much larger and offer a wide range of services, including medical, nursing, allied health professional services and community care. The commonality, irrespective of size, has been the "ownership" of the provider by a tribal or community-based group, the lack of medical dominance in governance and the use of tikanga Māori or Māori-defined frameworks for understanding health and delivering health care (Crengle 1999). Also, Māori providers have generally focused on providing easier access to services for their clients and have been driven by the evident disparities in health between the Māori and non-Māori communities (see Reid et al. 2000, Ajwani et al. 2003). Both of the latter are now features of the PHCS, and remain so despite political challenges about focused efforts to address these inequalities.

While a New Zealand Institute of Economic Research report (NZEIR 2003) has noted the lack of a comprehensive national database on the development and progress of Māori health providers over the past decade, a number of success stories have been recorded. These are providers who have developed projects based on community and Māori development principles that address the key aims of the PHCS (see Robinson and Blaiklock 2003, Earp and Matheson 2004). The policy and structural changes

brought about by the PHCS have for the most part been welcomed by Māori health providers as they closely resemble those that these providers have adhered or aspired to. The frameworks detailed in *He Korowai Oranga: Māori Health Strategy* (King and Turia 2002a) have further validated Māori health providers' whānau-based holistic models of health care provision and provided a blueprint for mainstream services for Māori. Taking into account the Treaty of Waitangi principles of partnership, participation and protection, it focuses on four pathways: the development of whānau (family or extended family), hapū (subtribe), iwi (tribe) and Māori communities; Māori participation in the health and disability sector; effective health and disability services; and working across sectors. Its companion document, *Whakatataka: Māori Health Action Plan 2002–2005* (King and Turia 2002b), details a step-by-step approach to implementing these four pathways by identifying milestones, measures and responsibilities.

The establishment of PHOs has, at least in principle, engaged many Māori health providers with mainstream primary health providers, since in order for the latter to meet some of the criteria for becoming a PHO they have had to develop strategic relationships with their local Māori health providers. However, in an examination of how PHO development might impact on Māori health, NZIER (2003) warned of some potential risks for Māori providers. Not least of these were that enrolment criteria disadvantaged providers without front-line medical services, as is the case for many Māori providers, and that since many Māori providers were small they might not have the capacity to provide the required range of services without forming alliances that jeopardised their autonomy. Nevertheless, while the risk of marginalisation for Māori health providers within some PHOs remains a very real problem, some of the larger Māori providers have been able to transition into a PHO relatively easily and maintain a strong position, particularly where they comprise the major or sole partner within the PHO. Ngāti Porou Hauora is a case in point.

NGĀTI POROU HAUORA

Ngāti Porou Hauora Incorporated (NPH) was established as a not-for-profit charitable organisation in 1994 after considerable consultation with local communities. Its aim was to ensure the ongoing locally controlled provision of sustainable, appropriate, high-quality, integrated health services to all people (approximately 6,000) within the Ngāti Porou rohe, covering some 200 km of the East Coast of the North Island from Potikirua near Hicks Bay in the north to Te Toka-a-Taiau, Gisborne, in the south.

Since its inception, NPH has been owned and managed by a Board of elected community members representing the various local communities of the East Coast, and it has provided services at low or no cost to its registered patients. The first health service contract, obtained in 1995, was for residential mental health. NPH went on to integrate the general practice clinics on the East Coast and obtained increasing

numbers of other service contracts. By 1997 it had 20 service contracts and signed a Heads of Agreement with Tairawhiti Healthcare Ltd. In 1998 the first CEO was appointed and a formal management structure was put in place. The following year NPH signed a direct contract with the Health Funding Authority for the majority of East Coast health services and later that year health facilities and assets, including Te Puia Springs Hospital, were transferred to NPH ownership under a Community Trusts Assistance Scheme. Some major health education and health promotion contracts, including Māori Mobile Nursing, Regional Asthma & Diabetes and Smoking Cessation contracts, followed.

The organisation's growth was further expedited when, in September 2000, it expanded into urban Gisborne with the establishment of a primary health service in Kaiti. This health clinic, Puhi Kaiti Hauora, offered full GP services and considerably increased NPH's registered population. The purchase of another urban clinic in 2002 further added to the population base.

NPH currently provides a range of personal health, public health, disability support and mental health services to an enrolled population of just under 13,000 patients, 5,500 of whom reside in the rural coastal regions and the remainder of whom reside in Gisborne and surrounds. Although it is owned and governed by Ngāti Porou, NPH offers services to all comers within the Tairawhiti region, as a "by Māori, for all" service. The significant majority of enrolled patients (76%) are Māori, most of whom are Ngāti Porou. Non-Māori clients are mostly Pākehā, although many of Gisborne's small Pacific community are enrolled patients. The organisation employs over 170 people, comprising 123 full-time equivalent staff, many of whom have strong whānau links to the communities they serve.

NPH offers a holistic health service to all its enrolled patients, with a stated emphasis on improving whānau and hapū health and preventing disease. The core focus is on providing integrated and comprehensive primary health services, backed up on the East Coast by the small GP-run hospital at Te Whare Hauora o Ngāti Porou in Te Puia Springs. Primary health services are offered throughout the region by multidisciplinary primary health care teams that are based in eight community clinics, six of which are spread throughout the East Coast communities and two of which are located in urban Gisborne. The multidisciplinary teams comprise kaiawhina (community health workers), practice nurses, general practitioners and receptionists. On the East Coast the teams also include rural health nurses, a physiotherapist, counsellors, community support service workers and dental health workers. Service contracts include Well Child, Whānau Ora,[4] Community Support Services, Palliative Care, Disease State

4 Whānau Ora is defined in HKO as "Māori families supported to achieve their maximum health and wellbeing".

Management, Auahi Kore (smoke-free), Green Prescription[5] and the Ngāti & Healthy Prevent Diabetes Programme. In accordance with a holistic approach to health it has ventured into projects such as health research, alternative power research, and water and sewerage reticulation to township.

Te Whare Hauora o Ngāti Porou is a small hospital located at Te Puia Springs on the East Coast. It provides Accident and Emergency services, acute in-patient and long-stay care, access to elective surgery at Gisborne Hospital and day surgery. In addition, midwifery and mental health services and the administrative arm of the organisation are based there. Mental health services include a level-two residential care facility, (Mental Health) Duly Authorised Officers, sub-acute mental health services, independent supported living, community mental health, dual diagnosis, alcohol and drug-related counselling, problem gambling, and child and adolescent mental health services.

NPH has Memoranda of Understanding (MOUs) with a wide range of organisations, including Te Rūnanga o Ngāti Porou, the Turanganui Primary Health Organisation, Work and Income, the Housing New Zealand Corporation, the New Zealand Police, the University of Otago and Industrial Research Ltd. It is also an active member of Health Care Aotearoa, a national organisation of third sector health care providers, and Te Matarau, a national organisation of Māori Development Organisations.

NPH is governed by a Board of democratically elected community representatives who meet monthly and have a responsibility to feed back to their communities. Service users and whānau can contribute to service planning and delivery by attending Board meetings, which are open to the public and rotate geographically. A kaumātua/kuia network is in place and regular consultation hui are held.

NGĀTI POROU HAUORA PHO DEVELOPMENT

Ngāti Porou Hauora became a Primary Health Organisation in October 2002, three months after the first two PHOs were established. Its catchment is the Tairawhiti region where it serves just under a third of the population of about 45,000. It is one of two PHOs in the area, the other being Turanganui PHO, which was established at the same time. Ngāti Porou Hauora has PHO partnerships with a number of small providers, most of which are based in Gisborne where its breadth of services is not as extensive as on the East Coast. These partnership relationships are loosely configured by an MOU with no formal financial or governance arrangements. The partners are Te Aitanga a Hauiti Hauora, Ngā Maia Midwives, Pacific Island Community Trust, Tracey Walker

5 A Green Prescription is a health professional’s written advice to a patient to be physically active as part of the patient's health management.

Physiotherapist, Employ Health and, more recently, Plunket, Men for Change and CCS.

As for most providers, Ngāti Porou Hauora's transition to a PHO was a time-consuming process because of administrative requirements and technological hiccups. However, unlike many other providers, NPH required little in the way of structural change, since its approach to health care delivery and governance was consistent with PHO requirements and the philosophical underpinnings of the PHCS. It was a not-for-profit organisation governed by a Board of democratically elected community members, had a whānau-centred kaupapa Māori model of practice, provided a range of both population and primary health care services at no or low cost, and had a number of outreach services on the East Coast. It had a database of registered patients and met the requirements for Access formula funding as its population was predominantly Māori (76%) and/or resided in geographical locations classified as NZDep deciles 9 and 10 (84%). In addition, a significant proportion of the patients resided in rural areas.

Consistencies with the PHCS and HKO were further evident in service provision. Health promotion activities were integrated into primary health care provision, intersectoral relationships were established, a research plan had been developed and workforce development had been a focus.

Health promotion contracts were undertaken by kaiawhina, who were integral members of their local primary health centre teams. Service contracts had historically been structured as far as possible using a kaupapa Māori framework that was consistent with community and Māori development principles. Prior to the release of the PHCS and HKO, service contracts had at times required concerted negotiation because they differed from established contracting frameworks and mainstream practices. For example, when funding was made available for one full-time equivalent (FTE) to undertake a Whānau Ora contract on the East Coast, rather than employ one person to travel throughout the region, this contract was divided into five 0.2 FTE contracts and a local person from each of five communities was appointed to work within their own community. These kaiawhina were each "embedded" in their community, with an intimate knowledge of the people and their needs. Over time these kaiawhina positions grew, as further contracts (such as smoking cessation and Green Prescription) were obtained and similarly divided up. Similarly, the role of NPH rural health nurses was much more comprehensive than that of a typical public health or district nurse. It is inconceivable in rural Māori communities, such as the East Coast, for a nurse to visit the home to vaccinate a baby, for example, and not be prepared to also attend to the grandmother's diabetes or the child's cut hand. The scope of work being undertaken by the kaiawhina or rural health nurse in each community was

therefore woven together holistically, enabling them to provide a comprehensive service to their people.

The implementation of the PHCS and HKO validated these practices, enabling the contracts to be renegotiated more easily. In addition, during the PHO establishment process when the more rigid and compartmentalised contracts and reporting processes were renewed, a large number of separate contracts were amalgamated into a large Whānau Ora contract that could be delivered and reported on in a manner more conducive to the needs of the community and consistent with the values and mission objectives of the organisation (refer Ngāti Porou Hauora 2004). Although Whānau Ora forms the basis of HKO, in order that it can be applied appropriately at tribal and local levels, the concept is not prescriptive. In NPH's case the concept has been interpreted at two levels. Firstly, in the clinical setting, the clinical teams, particularly the kaiawhina and rural health nurses, use their relationships and intimate knowledge of the community to work with the whole whānau, as described above. Secondly, at a public health level, projects work for whānau wellbeing with coordinated efforts from a number of sectors. This intersectoral work has included strategic relationships with Work and Income and the Housing New Zealand Corporation, a developing Whānau Ora project that aims to explore the relationship between housing and whānau health status (Ministry of Health 2004b) and involvement with academic researchers on a range of research projects.

As far as possible NPH took Mason Durie's *Te Pae Mahutonga* (Durie 1999) as the framework for its health promotion and public health work because of its holistic approach to wellbeing. The framework employs the symbolism of the Southern Cross as a navigational tool. The constellation's four stars represent: Mauri Ora (access to te ao Māori, or the world of Māori); Waiora (environmental protection); Toiora (healthy lifestyles) and Te Oranga (participation in society), while its two pointer stars represent Ngā Manukura (effective leadership) and Mana Whakahaere (autonomy), the resources and conditions required to achieve the vision. The organisation's health promotion plan comprises a matrix based on these objectives and capacities with tinorangatirotanga (self-determination) as a guiding principle for the practical applications in each component. Consistent with this approach is a recently initiated two-year community-based intervention, Ngāti and Healthy, that uses a population approach to reduce the prevalence of diabetes risk in the East Coast communities, identified to be at high levels in a pre-intervention prevalence survey (Tipene Leach et al. 2004). The intervention is being led by a multidisciplinary NPH team, with kaiawhina taking a lead role within their communities and the inclusion of other local organisations and businesses. It takes a broad Māori perspective on factors affecting health behaviours, has strong community support and is being evaluated by a research partnership between NPH and the University of Otago.

Application of a community development approach has also been evident in the field of workforce development. The organisation provides employment to a significant number of Ngāti Porou on the East Coast. There is a policy to train and move workers into more skilled positions within the organisation, for example, from kaiawhina to information technology, and from administration to management. In addition, the organisation provides a range of health professional training scholarships to encourage Ngāti Porou people to undertake medical, dental, nursing or physiotherapy training, and to bring this expertise back to the region. Mainstream forms of workforce development are also evident in the sponsorship of many of its general practitioners through the General Practice Primex training and its nurses through postgraduate courses. In addition, the organisation has developed as a training site with placement positions for local nursing students, medical students and both overseas and New Zealand postgraduate medical trainees.

KEY CHALLENGES

Despite the ideological match with the new primary health care direction and the strong position in which NPH was placed, it has encountered a number of challenges in implementing the PHCS that are of potential relevance to other providers.

Population Health versus Clinical Care: Marrying Two Paradigms

A key feature of the PHCS is the requirement for primary health services to now focus on improving the health of a population by undertaking health promotion and other public health initiatives, including the collection of population-level data. This is new for most primary care providers, and there are recognised philosophical differences between the public health and primary health paradigms (Ministry of Health 2003). Health promotion and disease prevention have been important components of many Māori health provider contracts – indeed, for many, the only components (Crengle 1999). While it could be argued that population health as a concept is well understood by Māori organisations with their collective view of health, nevertheless, several issues arise from attempting to implement population health strategies within the primary health setting.

A key difficulty has been prioritising long-term population strategies over the immediate health needs of individuals, particularly in a highly morbid population. A central element of population health care is the collection of population-level health data in order to understand health status and need and, then, to create strategic direction for the improvement of a population's health. Pressing clinical demands often take precedence over collection of data like the "Get Checked" diabetes monitoring, and, as it is time consuming, it is either put aside or allocated to a separate worker in a

separate encounter. It is then a challenge to ensure that this information is either integrated back into patient care or considered in a population health framework.

The real challenge for PHOs is in the consideration of these data for their application to population health objectives. Who in primary health care management or general practice has the public health skills to analyse such data, to plan public health strategies and to implement appropriate programmes? There is a very real risk that public health, once again, becomes the Cinderella of patient care as clinical doctors are hired over public health consultants and competing organisational interests prevent aggregations of PHOs running large-scale population health operations with expert staff.

In addition, PHO health promotion money has been minimal at $2.00 per head, a sum vastly less than what is required to undertake robust initiatives. Although NPH's Ngāti & Healthy project is a community-based population health approach to diabetes prevention, the funding has not come from the PHO funding streams but rather from a range of other sources, including Te Kete Hauora and the Public Health Directorate of the Ministry of Health, SPARC (Sport and Recreation New Zealand) and several community funding agencies.

Appropriateness of Performance Indicators

The implementation of the PHCS has required the development of performance indicators to ensure that the key objectives are being met. Interim indicators were developed through a modified Delphi process in 2003. These included nine clinical and five administrative indicators – among them, achieving specified rates for immunisation, cervical and breast screening, disease and smoking status coding and service utilisation (*New Zealand Doctor* 2003). These have since been further developed by a Technical Advisory Group with minimal Māori representation and been amalgamated with indicators for referred services (such as laboratory and pharmaceutical services) management into a single PHO Performance Management Programme with a strong fiscal focus. The performance indicators cover financial, clinical and process performances, with target measures to be agreed between the local DHB and PHO, using national guidelines and funding assigned to agreed targets (Ministry of Health 2004c).

A key issue here is what should be measured in order to gauge the effectiveness of services for Māori, and who decides what these measures are. Crampton and colleagues (2004) have noted that the increasing complexity of primary health care calls for more performance measures that accommodate differing perspectives. Reid (2004) goes on to say, "It is no longer sufficient or appropriate to measure the levels of immunisation, cervical smearing, and recording blood pressure in a general practice – however a much broader approach to the evaluation of 'quality' is necessary".

While services to improve access to care and service utilisation rates are considered perfomance indicators, from a Māori health provider perspective the proposed framework does not consider some of the other dimensions of health care that are important to Māori communities, such as levels of whānau and spiritual wellbeing, culturally appropriate service delivery and a prioritised commitment to Māori workforce development. As Durie (2003) has stated, "In moving from input and output measures to measures of outcome, as signaled in the strategy,[6] there is a corresponding need to frame indicators around Māori perspectives of health".

Some work has been undertaken on developing frameworks that take a Māori worldview in measuring the effectiveness of public policies (Durie et al. 2003) and, more specifically, health services (Ministry of Health 1995) for Māori. The latter, *He Taura Tieke,* was developed under the guidance of the Ministry of Health following research and consultation with Māori and is structured around three key components: technical and clinical competence, structural and systematic responsiveness and consumer satisfaction. Within each of these components are a number of areas around which a service's effectiveness from a Māori perspective is exemplified and then measured using a range of questions. For example, the framework gauges evidence of Māori-appropriate services on a number of dimensions, including competence and safety, monitoring, health philosophical framework, Māori development and workforce development, access, information and participation. Despite being developed with the Ministry of Health, it has not been applied at the DHB level and does not form the basis of DHB contractual requirements or performance indicator assessment. Rather it has primarily been designed for and used by providers to gauge the effectiveness of their own services. Although a little cumbersome, this framework has clearly structured components and checklist questions that take a Māori standpoint on health, and it could serve well as the basis for Māori (and even mainstream) health provider performance indicators.

Community Participation and Partnership

The PHCS requires community participation in PHO governance and promotes partnerships between providers and consumers. However, the interpretation of this Strategy requirement has been considerably modified since the implementation process began (Neuwelt and Crampton 2004). Issues concerning the provider–community partnership relationship have arisen out of the historical power provider groups held and continue to hold within the newly formed PHOs. NPH's system of governance and community participation is one of the few that meets and, indeed, goes further than the ideal stated in the PHCS.

6 "Strategy" here refers to the Ministry of Health's 2000 *The New Zealand Health Strategy,* but could equally be applied to the *Primary Health Care Strategy.*

Interestingly, having a community-owned and community-governed PHO has brought its own tensions. For example, NPH's PHO partners have not been altogether happy with their position within the governance model. They have felt, probably because the NPH PHO Board is in fact the old NPH (Provider) Board, that they are not represented and have sought some form of representation on the Board for their organisations. However, the Board comprises community representatives rather than provider representatives and the MOU relationship does not require any change to this. Partner provider groups wanting input into governance issues are required to do so through their local community Board representative, who is encouraged to attend quarterly partner hui.

Governance models such as this, in which provider groups must work through an elected community representative, are diametrically opposed to historical primary health care governance models where providers dominated. Concerns raised by NGOs at the 2004 MOH/NGO Forum (Ministry of Health 2004a) were based on NGOs, as community representatives, feeling excluded or marginalised by powerful mainstream health providers at the PHO governance level. In the NPH case the issue is turned on its head in that the PHO partners are considered more as provider groups by a Board of elected community representatives. The PHCS provider–community partnership directive was initiated to enable more community input into primary health care service delivery where hitherto this had been lacking or absent. Whether there are to be limits on the extent of community control is an issue that has not yet been debated. In the NPH case, the novelty of the exclusively community representative governance structure and the apparent tension in the term "PHO partners" mean that care is needed in working with this as-yet-uncharted relationship issue.

Funding and Contracting Issues

Like other relatively small PHOs, NPH found the PHO per capita funding for management costs grossly inadequate, since infrastructure costs are not directly proportionate to the number of enrolled patients. Negotiating a lump-sum payment for smaller PHOs was time consuming but facilitated by the collective bargaining power of the organisations Health Care Aotearoa and Te Matarau, most of whose members were small providers. Similarly, being a rural health provider involves certain baseline costs that cannot be covered by per capita funding. While PHO funding processes did accommodate rural health needs to some extent, they did not do so to a sustainable level. Indeed, prior to PHO formation NPH had received a Special Area subsidy that was greater than the new level of PHO funding for the area. Considerable time and negotiation was needed before a satisfactory arrangement was reached that enabled the continuation of free services to the East Coast population.

One of the positive features of the proposed PHO structure was that a population approach would be applied to both service delivery and contracting. Capitated funding of an enrolled population replaced the more fragmented fee-for-service funding and the myriad of small service contracts came under a more global contracting arrangement. However, in practice, funding has not proved to be as global as anticipated, since a number of funding streams and contracts have resulted. For example, in addition to the standard front-line services capitation funding, monies have also been allocated for Services to Improve Access, Reducing Inequalities Contingency Funding, Management Fees, Health Promotion and Care Plus. Each of these funding streams must have its own plan, reporting schedule and financial accounting. Although not as fragmented as previously, these funding arrangements are nevertheless time consuming and probably more fragmented than necessary.

CONCLUSION

The implementation of the Primary Health Care Strategy and He Korowai Oranga has required some major changes in the organisation and structure of primary health care in New Zealand. Although there has been general support for the overall direction of the changes, the impact on providers has been varied and in some cases contentious (Perera et al. 2003). However, many Māori and other third sector providers have adapted relatively well and quickly to the changes because their organisational structures and models of care fitted comfortably with these new frameworks.

Because of its community-based governance and practice focus, the Māori health provider Ngāti Porou Hauora was in a relatively strong position to embody the philosophical and practical direction advocated by the two strategies and its transition into a PHO was relatively smooth. Nevertheless, there have been ongoing challenges in the process of PHO development. Collecting population health data and applying it meaningfully within a context of funding constraints and pressing clinical demands from a population with high levels of morbidity and co-morbidity has been a key challenge. Achieving performance indicators that have not been designed specifically for Māori communities and providers, particularly when these are to be linked to ongoing funding, is also a challenge. Similarly, ensuring adequate funding levels for smaller and rural providers and maintaining a non-fragmented range of contracts require ongoing attention. On balance, however, becoming a PHO has strengthened NPH as a provider and it seems more than ready to meet the identified challenges.

Many of NPH's experiences during this PHO development phase are likely to be mirrored by other Māori health providers, particularly those large enough to become a PHO by themselves and those able to partner equitably with other third sector or similar providers. Certainly Māori health providers have developed a strong sense of identity over the past decade, and are reluctant to lose that (*New Zealand Doctor* 2005a).

However, while the philosophies of the PHCS and HKO have strengthened the position of many Māori providers, validating their modes of practice, some smaller providers remain vulnerable, particularly those that are minor partners in a PHO dominated by general practice and those that have been required to develop relationships with other provider groups with which they have historically had little contact and little in common. While a number of positive outcomes have been recorded from this relationship development, some mainstream providers may have created partnerships with Māori health providers just because they need to in order to qualify as a PHO, but with no real understanding of the nature of partnership. Indeed, some commentators have cautioned about the gap between policy and practice for Māori health and challenged non-Māori public health providers to form authentic partnership alliances with Māori to ensure improvements in health outcomes for Māori (Ratima and Ratima 2004).

This risk for small Māori providers is further increased if they hold mainly health promotion contracts, as is often the case. Health promotion and population health have historically been undervalued in primary health care. Even where a PHO has good intentions to integrate these functions, where these roles are undertaken by different provider groups who are only in the developmental stages of relationship building, it may be easy for historically prevailing power relations to continue.

For these reasons a number of smaller Māori PHOs have remained adamant that, despite missing out on the advantages of economies of scale, they do not wish to be amalgamated into a larger PHO but rather intend to remain independent providers catering to a "niche" Māori market (*New Zealand Doctor* 2005a)

On a more positive note, it could be argued that Māori and other third sector providers have much to teach the primary health care sector. In essence their frameworks for governance and service delivery have served as a model for many of the changes being undertaken within this sector. Whether their models of practice are more effective at addressing the longstanding disparities in health outcomes between Māori and non-Māori is yet to be determined. However, as a first step, these providers have improved access to their services through low fees, culturally appropriate approaches to health care and outreach services (Crampton et al. 2000). The fact that their approaches have informed the new direction for primary health care as laid out in the PHCS suggests that they offer some hope for reducing hitherto intractable disparities. While the pervading influence of historical power relations requires continuous vigilance during the change process, with wider structural support Māori and other third sector providers are in a position to move from strength to strength in becoming central players in the primary health care environment and to ensure disadvantaged populations receive the health care and programmes they require so that inequalities in health status begin to reduce.

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